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The effects of domestic violence on women's occupations

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THE EFFECTS OF DOMESTIC VIOLENCE ON WOMEN'S OCCUPATIONS

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CERTIFICATE OF APPROVAL

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Abstract

Domestic violence has become a major issue in the health care system and occurs across the lifespan from children to the elderly. The purpose of this study was to identify the impact of being a victim of domestic violence on the occupations of women. Two major research questions were posed:

1. How does experiencing domestic violence affect a woman's perception of her occupational identity?
2. How does experiencing domestic violence affect a woman's perception of her occupational competence?

The study group consisted of 10 women who had experienced domestic violence in the past six months. The control group consisted of 24 women who had not experienced domestic violence in the past six months. All participants completed a demographic survey, the Occupational Self-Assessment (OSA), and the Adult Self-Perception Profile. A significant difference was found between the groups for five of the 29 categories of the OSA within the skills/occupational performance and environment subsections. A significant difference was found between the two groups for three of the 12 domains on the Adult Self-Perception Profile, including global self-worth, intimate relationships, and adequate provider domains.

These findings suggest that occupational therapists have an appropriate role in the intervention of women who have experienced abuse. However, further research is necessary in order to determine appropriate intervention strategies.

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I would like to take this opportunity to thank my advisors, Sue Leicht and Marilyn Kane, for their endless time and patience spent reading drafts, answering lots of questions, finding people to fill out surveys, setting up my elective fieldwork, and offering support and encouragement when I needed it the most. This would not have been possible without the two of you!!

Dedication

I would like to dedicate my thesis to my parents who have supported and encouraged me throughout my long college career. Words cannot express how much your love and support has helped me through this challenging and emotional time in my life. Thank You!!!

Table of Contents

List of Tables

List of Figures

The Effects of Domestic Violence on Women's Occupations

Chapter One: Introduction

Domestic violence is a growing problem in today's society and is the cause of many injuries and disabilities seen by occupational therapists (Helfrich & Aviles, 2001). There are many risk factors that could contribute to domestic violence. An alarming factor is the increased risk a person has by just being a female. Almost all research done considers the victim to be female with a male abusive partner (Council on Ethical and Judicial Affairs, American Medical Association, 1992). Other risk factors include a history of being abused as a child, beginning living with a partner, legally marrying, pregnancy, separation from military service, loss of a job, new signs of independence by the woman, and separation or divorce (Helfrich, Lafata, MacDonald, Aviles, & Collins, 2001).

The effects of domestic violence on the victim can be very serious and difficult to treat. Emotional and physical injuries or disabilities are the most prevalent (Jaffe, Wolfe, Wilson, & Zak, 1986). A woman can experience interference with her daily roles and functioning, such as childcare or employment. Financial difficulties, homelessness, and general impairment in every day occupations are also common (Helfrich et al., 2001). In addition to women, children who witness domestic violence in the home also exhibit lasting effects. These effects typically carry over into school and include poor self-esteem, decreased attention span, poor problem-solving skills, and behavior issues (Thormaehlen & Bass-Feld, 1994).

The process of breaking free from an abusive partner can be a difficult and long process. While preparing to leave the abusive situation, the victim must try to continue

with her every day life and fulfill the obligations to her family and work, but this is often difficult to do. After a woman has successfully escaped from her abuser, she must try to rebuild her idea of "self" and regain a normal lifestyle (Merritt-Gray & Wuest, 1995).

The barriers to recovery can be very difficult to overcome if the woman does not have a support network or family on whom she can rely. Escaping from an abusive partner and keeping her children safe can cause increased stress for the woman. Limited finances can cause a problem if the woman needs to relocate herself and her children to get away from her abuser; or if they need counseling, or therapy services to assist them in recovery (Holtz & Furniss, 1993). These services are needed for injuries, disabilities, and emotional/psychological problems that may arise. Post-traumatic stress disorder is very common among women who have survived abuse, as well as children who have witnessed abuse.

Occupational therapy can play a key role in the recovery of a woman who has been abused. The level of intervention depends on the occupational therapist's experience, attitude, and knowledge of domestic violence; the client's individual needs; and the setting in which the intervention will take place. An occupational therapist can provide direct intervention for self-care activities, group activities, and other services depending on the client's needs (Helfrich & Aviles, 2001). Occupational therapists can provide indirect services to clients who have been abused by training other professionals to facilitate groups, and to act as a consultant for community-based programs (Helfrich & Aviles, 2001).

The occupational therapist may use a number of theories or models of practice to plan for and treat a client who has experienced abuse. A model of practice appropriate to

use with this type of client is the Model of Human Occupation by Gary Kielhofner, which addresses the four main dynamic concepts of volition, habituation, performance capacity or performance skills, and environment. According to Kielhofner (2002e), volition can be defined as "a pattern of thoughts and feelings about oneself as an actor in one's world which occur as one anticipates, chooses, experiences, and interprets what one does" (p. 44). Volition also encompasses one's values, interests, and personal causation. Habituation is the routine in one's life based on the person's values and roles. Volition and habituation work very closely together in that volition drives habituation. One needs motivation and anticipation in order to have routine throughout one's daily life. Performance capacity or performance skills refer to one's ability to perform activities based on one's physical and mental capacities and skills. The level of one's volition and habituation depends on one's physical and mental capacities (Kielhofner, Tham, Baz, & Hutson, 2002). The environment is defined by Kielhofner (2002b) as the "particular physical and social features of the specific context in which one does something that impacts upon what one does and how it is done" (p. 111). Based on this model of practice, occupational therapy can provide services that address each of these four dynamic concepts.

Occupational therapy can provide many services, including provision of a support network, for a woman who has been abused. Froehlich (1992) states that a good therapist-client relationship, trust, and confidentiality are key components of the therapeutic process. He based his opinion on past publications regarding occupational therapy intervention for diagnoses such as multiple personality disorder and post-traumatic stress disorder. Once this is in place, an occupational therapist can provide

basic life skills training, coping strategies, relaxation training, and group activities to help a woman recover from domestic violence (Froehlich, 1992).

Currently, there is little research available in the area of domestic violence and occupational therapy due to the fact that it is an emerging practice area. A small, but recent body of research has come from the University of Illinois at Chicago by Christine A. Helfrich, PhD, OTR/L and her colleagues. Helfrich et al.'s work focuses on how occupational therapy has a role in the intervention process for women who have experienced abuse. It can be concluded from the paucity of literature that more research on domestic violence is still needed in the field of occupational therapy.

Problem Statement

Domestic violence has become a major issue in the health care system and occurs across the lifespan from children to the elderly. Some research exists that indicates occupational therapy can play a role in this field (Helfrich & Aviles, 2001). More research is needed in order to determine to what degree abuse affects women's occupations and the potential role occupational therapy can play in the intervention of domestic violence.

Rationale

"Up to four million women are abused each year with as many as two million suffering serious injury and 2,000-4,000 suffering death at the hands of their husbands, boyfriends, or former partners" (Keller, 1996, p.1). Domestic violence has become a huge problem in today's society with many cases going unnoticed (Council on Ethical and Judicial Affairs, American Medical Association, 1992; Neufeld, 1996). The effects are long lasting and cover a wide range of problems.

According to the National Domestic Violence Hotline (n.d.), domestic violence costs the United States from $5-10 billion annually in medical costs, legal fees, shelters and foster care, sick leave, absenteeism, and non-productivity at work. Health care costs may decrease if domestic violence were identified and treated early. If health care professionals recognized the abuse earlier, women would be able to begin the process of escaping the abusive relationship and recovery earlier. This, in turn, would decrease the number of violent attacks and further injury. The injuries that result from the abuse may have lasting effects on women's occupations and daily roles, which would indicate a need for occupational therapy services.

Occupational therapists need to be aware of the signs of abuse and how abuse impacts everyday occupation. Since the National Domestic Violence Hotline (n.d.) reports that approximately one-third of all women in the United States experience some form of abuse in their lifetime, it is likely that occupational therapists will frequently be treating women who have experienced abuse. Further, when girls reach adulthood, they tend to take on new roles, such as mother, wife, employee, caregiver, etc. If women are being abused in a relationship, these roles may be compromised. Everyday occupation is affected as well, in that she may experience a loss of motivation, identity, and control needed to perform the activities assigned to each role.

Purpose

The purpose of this study is to identify the impact of being a victim of domestic violence on the occupation of women.

Definition of Terms

Destruction of Property or Pets – "this includes the breaking of property or her favorite objects, hurting or killing her pets or giving away objects" (Helfrich et al., 2001, p. 11).

Domestic Violence - "any act carried out with the intention of physically or emotionally harming another person who is related to you by blood, present or prior marriage, or common law marriage, having (or having had) a child in common, or having (or having had) a dating relationship. This also includes a person with a disability and their personal assistant. Domestic violence includes physical abuse, sexual abuse, emotional abuse, economic abuse, destruction of property or pets and stalking" (Helfrich et al., 2001, p. 9-10).

Economic Abuse – "someone who is being economically abused may have endured any of the following: having money taken away, being prevented from getting or keeping a job, and/or being made to ask for money" (Helfrich et al., 2001, p. 11).

Emotional Abuse – "someone who is being or has been emotionally abused may have endured any of the following: verbal abuse, intimidation, threats, isolation, restriction of activities, humiliation, insults, ignoring of needs, lying, and/or breaking promises" (Helfrich et al., 2001, p. 10).

Habituation – "an internalized readiness to exhibit consistent patterns of behavior guided by our habits and roles and fitted to the characteristics of routine temporal, physical, and social environments" (Kielhofner, 2002c, p. 63).

Human Occupation – "the doing of work, play, or activities of daily living within a temporal, physical, and sociocultural context that characterizes much of human life" (Kielhofner, 2002d, p. 1).

Occupational Competence – "the degree to which one sustains a pattern of occupational participation that reflects one's occupational identity" (Kielhofner, 2002a, p. 120).

Occupational Identity – "composite sense of who one is and wishes to become as an occupational being, generated from one's history of occupational participation" (Kielhofner, 2004, p.162).

Performance Capacity – "ability for doing things provided by the status of underlying objective physical and mental components and corresponding subjective experience" (Kielhofner, Tham, Baz, & Hutson, 2002, p. 97).

Physical Abuse – "someone who is being or has been physically abused may have endured any of the following: hitting, punching, kicking, biting, being thrown or tied down, choking, smothering, burning, being threatened with a weapon, refusal of help when sick or injured, and/or being driven recklessly to frighten her" (Helfrich et al., 2001, p. 10).

Sexual Abuse – "someone who is being or has been sexually abused may have endured any of the following: being forced to have sex, injury during sex, weapons used intravaginally, orally or anally, coerced to have sex without protection, sexual criticism, or flaunting extra-marital affairs" (Helfrich et al., 2001, p. 10-11).

Stalking – "someone who is being stalked is being followed, placed under surveillance, or the subject of any conduct which places her in reasonable apprehension of immediate or future bodily harm, sexual assault, confinement or restraint" (Helfrich et al., 2001, p. 11).

Volition – "a pattern of thoughts and feelings about oneself as an actor in one's world which occur as one anticipates, chooses, experiences, and interprets what one does" (Kielhofner, 2002e, p. 44).

Chapter Two: Literature Review

"Domestic abuse is not a single explosive incident of hitting; it is the building of tensions that contributes to the ever-existing nature of the abusive relationship" (Gosselin, 2003, p.110). Domestic violence has become a recognized "social problem" with increased attention over the past few decades (Lempert, 1996). Due to the increase in the incidence of domestic violence, professionals are treating clients with this underlying problem more frequently. Occupational therapists must look at how domestic violence affects every occupation in which their client participates on a daily basis.

This literature review will discuss a range of issues related to domestic violence, the effects of abuse on women's occupations, and potential occupational therapy interventions.

Incidence of Domestic Violence

For the purposes of this study, it was assumed that the victim was female and the abuser was male, which was the most frequently described situation in the literature reviewed. However, it is acknowledged in the literature that abuse occurs in other types of intimate relationships (i.e. female abuser and male victim, gay or lesbian relationships).

The highest risk factor for being a victim of domestic violence is being female. In fact, more than 90% of crimes related to domestic violence are against women (Holtz & Furniss, 1993). This factor was consistent in all of the literature reviewed. Domestic violence occurs in all racial, religious, ethnic, educational, and socioeconomic populations around the world (Neufeld, 1996; Salber & Taliaferro, 1995). The Women's Domestic Violence Helpline (n.d.) also stated that "domestic violence happens in every

community, social class, family income, level of education, occupation, and ability" (p. 2). According to Neufeld (1996), in the United States domestic violence against women results in more injuries that require medical attention than rape, motor vehicle accidents, and muggings combined. Statistics also show that domestic violence is the most frequent reason why women are admitted to the emergency room (Holtz & Furniss, 1993). This "epidemic" accounts for 25% of suicide attempts per year made by women as well as for approximately 4,000 homicides per year (Holtz & Furniss, 1993). According to Browne (1997), from 1988-1991 there were 7,168 deaths caused by one partner killing the other. Nearly two-thirds (64%) of these deaths were women killed by their male partners (Browne, 1997).

The incidence of domestic violence against women is very difficult to quantify due to the fact that many women are often afraid or ashamed to report the abuse and may endure it for years (Centre for Social Development and Humanitarian Affairs, 1993). Often, women do not feel that abuse is worth reporting and also feel that they will not receive support from their family and friends because their abusers have isolated them (Miller & Wellford, 1997).

A common myth mentioned in much of the literature was that battering is associated with alcohol and/or drug abuse by the abuser. In actuality, it may be involved in some cases, but it usually occurs as a result of the violence. A woman or a man may resort to alcohol or drugs in order to try to ignore or mask the fact that they are being abused or being the abuser (Holtz & Furniss, 1993; King & Ryan, 1989). Another myth discussed in the literature is that women will not disclose to their doctors the cause of their injuries so it is a waste of time to ask. In actuality, women will discuss their history

of abuse if they feel comfortable with the doctor and feel that they will not be judged in any way (Holtz & Furniss, 1993; King & Ryan, 1989).

Types of Abuse

Abuse can take on many forms. Helfrich et al., (2001) described six categories of domestic violence, including physical abuse, emotional abuse, sexual abuse, economic abuse, destruction of property or pets, and stalking. These types of abuse are defined below with the common indicators that are seen by or reported to professionals.

Physical abuse.

Someone who is physically abused is defined as "having endured any of the following: hitting, punching, kicking, biting, being thrown or tied down, choking, smothering, burning, being threatened with a weapon, refusal of help when sick or injured, and/or being driven recklessly to frighten her" (Helfrich et al., 2001, p. 10). Major indicators of physical abuse include bruises in unusual places, cigarette or rope burns, facial or genital lacerations, unexplained orthopedic injuries, sudden change in behavior, and internal injuries (Helfrich et al., 2001). Gosselin (2003) also identifies some other common indicators of physical abuse including human bites, poisoning, wincing, and pulled hair.

Sexual abuse.

Someone who is sexually abused is defined as "having endured any of the following: being forced to have sex, injury during sex, weapons used intravaginally, orally or anally, coerced to have sex without protection, sexual criticism, or flaunting extra-marital affairs" (Helfrich et al., 2001, p.10). Bruises around women's breasts or genitals, unexplained genital infections, unusual vaginal or anal bleeding, torn or bloody

underclothing, and history of rape are all indicators of sexual abuse (Helfrich et al., 2001).

Emotional or psychological abuse.

Someone who is emotionally or psychologically abused is defined as "having endured any of the following: verbal abuse, intimidation, threats, isolation, restriction of activities, humiliation, insults, ignoring of needs, lying, and/or breaking promises" (Helfrich et al., 2001, p. 10). Helfrich et al. (2001) offers the following as indicators of this type of abuse: emotional upset or agitation, extreme withdrawal, and a history of verbal mistreatment. The abuser may try to impose his feelings, moods, and emotions on the woman while demanding love from her. The abuser may also try to blame the woman or have her take responsibility for his abusive actions, such as drunken outbursts, emotional withdrawal, and insane yelling (Tifft, 1993).

Economic abuse.

Economic, financial, or material exploitation/abuse is defined as "having endured any of the following: having money taken away, being prevented from getting or keeping a job, and/or being made to ask for money" (Helfrich et al., 2001, p. 11). There are many indicators of economic abuse, which are often overlooked or rarely recognized as abuse. Some indicators include sudden change in bank account balances, unauthorized withdrawal of funds, and failure to allow the woman to take part in financial obligations (Helfrich et al., 2001, p. 25). If the woman is employed, she may experience increased absenteeism and decreased productivity due to the abusive situation at home, which results in less income (Groetsch, 1996). On the other hand, a woman in an abusive

situation may try to pay for her abuser's treatment in order to try and save the relationship even if she does not have the money to support herself and her children.

Destruction of property or pets.

The destruction of property or pets is defined by Helfrich et al. (2001) as "the breaking of property or her favorite objects, hurting or killing her pets, or giving away objects" (p. 11). The destruction of a woman's property or her pets is considered domestic violence because it is a deliberate act of violence against the victim and may cause psychological distress (Conner, 2004).

Stalking.

Helfrich et al. (2001) define stalking as "being followed, placed under surveillance, or the subject of any conduct which places her in reasonable apprehension of immediate or future bodily harm, sexual assault, confinement, or restraint" (p. 11). Stalking can occur both during and after a relationship. The woman may be constantly monitored by her partner during all activities throughout their relationship. Stalking may occur after a relationship has ended because the man may be trying to get the woman back (Helpguide, 2004).

Indicators of Abuse

According to Veltkamp and Miller (1990), there is a list of prominent indicators of domestic abuse that are common physical, behavioral, and psychological factors for professionals' awareness. The physical indicators include unexplained bruises and welts; unexplained fractures in various stages of healing; chronic pain in back, pelvic region, chest or neck; injury to body areas usually covered by clothing or hair; and explanation of injuries that do not make sense (Veltkamp & Miller, 1990). Behavioral indicators that

are tell-tale signs of abuse include emotional limits or blunted affect, extreme withdrawal or aggressiveness, apprehension or fearfulness, depressive features, eating disturbances, alcohol or drug abuse, compulsive behaviors, and suicidal thoughts and/or attempts. Obvious psychological indicators are irritability or restlessness, sleep disturbances, concentration difficulties, an exaggerated startle response, anxiety, phobias or obsessions, and depression (Veltkamp & Miller, 1990; Helfrich et al., 2001; Neufeld, 1996). All of these indicators may not be seen at once. The indicators seen by professionals will be relevant to the areas of clinical practice and may depend on the therapeutic relationship.

The Cycle of Violence

In L.E. Walker's (1979) classic text on this subject, *The Battered Woman*, she outlines the cycle of violence common in many abusive relationships. Her cycle theory begins with the tension-building phase or stressor, which includes verbal harassment, threats of abuse, and minor battering incidents (Walker, 1979). The second phase is known as the acute battering or explosion phase (Walker, 1979). During this phase, the most serious and life-threatening injuries occur. The woman clearly does not understand why the abuse is occurring and has a high level of confusion and denial. The two main characteristics of the second phase are the lack of control by the victim and the lack of predictability in the abuser (Crisis Support Network, 2003). The woman often is unable to predict her abuser's mood and when the abuse will occur. The third and final phase is considered the honeymoon phase in which the abuser tries to reconcile, apologize, and make promises to never abuse her again. The abuser reinforces that his relationship with the victim is normal and that he loves her. The cycle will continue to recur unless the woman escapes from the abuse. Typically, the cycles become more violent over time and

the abuser gains more control over the victim. The battering phases become more frequent and the honeymoon phases become shorter and less promising (Helfrich & Aviles, 2001; Holtz & Furniss, 1993; Veltkamp & Miller, 1990; Walker, 1979; Worcester, 1992). Each act of violence becomes more intense and severe over time, and the abuser's expressions of regret and love decrease or completely disappear (Browne, 1997).

Characteristics of Abusers

Abusers tend to display some common characteristics. These characteristics include, but are not limited to: low self-esteem; holding a traditional viewpoint of the role of men and women in a relationship; blaming others for behaviors; never taking responsibility for these behaviors; a dual personality (i.e. loving and caring one moment and abusive the next); and taking control of the woman's finances, social contacts, her form of birth control, and many other areas of her daily life (Holtz & Furniss, 1993; Veltkamp & Miller, 1990). According to Salber and Taliaferro (1995), the most researched risk factor for men to become abusers is that they had witnessed abuse in the home during their childhood. All abusers are by no means the same, but often display these common behaviors.

Groetsch (1996) describes three categories of abusers. Category One abusers are considered the "least dangerous." An abuser who falls into this category has no reported history of abuse in his current or past intimate relationships. According to Groetsch (1996), the Category One abuser "reportedly does not use weapons, does not systematically torture his victims, and does not seek to mutilate or to disfigure his spouse's face or torso" (p. 5). The woman who is abused by a Category One abuser

typically has less severe injuries because of the abuser's impulse control, as compared to the lack of impulse control seen in the Category Two or Category Three abuser. A Category One abuser tends to display aggression towards the woman following any type of traumatic or stressful experience (i.e. loss of job, speeding ticket). A Category One abuser typically responds very well to intervention (Groetsch, 1996).

The Category Two abuser is considered to be "moderately dangerous". This type of abuser has limited impulse control and sporadically abuses the victim. A Category Two abuser has had less of a history in abusive relationships than a Category Three abuser. Abusers in this category are more likely than Category One abusers to use alcohol and drugs in order to cover up psychosocial problems. When the abuser is under the influence of alcohol or drugs, he becomes more dangerous. A Category Two abuser displays aggression because he is easily triggered by external sources (i.e. coworkers, problems at work), as well as by his internal issues (i.e. stress, low self-esteem). Prognosis for a Category Two abuser is fair given his ability to have some insight, some degree of remorse, and motivation needed to participate in treatment (Groetsch, 1996).

The Category Three abuser is considered to be "very dangerous". Groetsch (1996) states that the Category Three abuser "batters their intimate on a chronic, ongoing, and systematic basis" (p. 9). The Category Three abuser is also often referred to as a "serial batterer" because he has a history of abusing other intimate partners in the past. This type of abuser usually sets out to permanently injure or disable the woman by planning his assaults. He often emotionally or psychologically abuses the woman in addition to the physical abuse. The Category Three abuser may have an underlying personality disorder, such as Borderline Personality Disorder, that can often be the cause

of why he abuses his victim (Groetsch, 1996). Borderline Personality Disorder is defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* as an individual who has "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts" (American Psychiatric Association, 1994, p. 280). The individual typically displays a pattern of unstable self-image, impulsivity, suicidal behavior, mood instability, and difficulty controlling anger (American Psychiatric Association, 1994). The Category Three abuser is very difficult to treat because he lacks the insight needed to recognize that he has a problem. He has little or no motivation to change his behavior so prognosis is very poor (Groetsch, 1996).

Effects on Victims

Domestic violence produces many short-term as well as long-term effects on both the abused woman and her children.

Women.

Short-term effects that a woman faces may include emotional or physical injury or disability, interference in her everyday role function, financial difficulty, and homelessness. Long-term effects may include continued physical or mental disability, loss of role identity, loss of family ties and support systems, loss of employment, homelessness, and in the most severe cases, death (Helfrich et al., 2001). The woman may also have a poor work history due to absences caused by injury and stress, which makes it difficult to support her children (Helfrich & Aviles, 2001). In some cases, the woman is not allowed to have a job because the abuser wants to be the main provider for his family, thereby leading to a lack of job skills. Typically, the abuser holds an old-

fashioned viewpoint that the man provides for his family and the woman stays home to raise the children.

Jaffe et al. (1986) also describe the Battered Women's Syndrome (BWS), which is defined as "a prolonged pattern of depressed affect and a general sense of helplessness, fear, and social withdrawal" (p. 625). Salber and Taliaferro (1995) go on to describe this battering syndrome as "the syndrome of dominance and control by the perpetrator leading to increasing entrapment of the victim" (p.3). BWS has also been compared to post-traumatic stress disorder because of the psychological response that occurs after an abusive situation. BWS has been recognized and used as a legal defense if a woman retaliates against her abuser and is prosecuted in a court of law (Holtz & Furniss, 1993).

Children.

Children may experience indirect abuse because they witness the domestic violence occurring within the home (Gosselin, 2003). According to Stark and Flitcraft (1988), approximately 50% of men who abuse their wives also abuse their children. If the child or children are being abused, a woman is less likely to be aware of the situation because her attention is on her own abusive situation. The woman may feel too overwhelmed to notice or accept the fact that her abuser is also abusing her children (Gosselin, 2003).

The children may have feelings of guilt and shame, a lack of trust for adults, poor self-esteem, and may display helplessness and hopelessness (Thormaehlen & Bass-Feld, 1994). Post-traumatic stress disorder is also a very serious and recurrent disorder that occurs among children in this situation. It may affect the children for months or even years. It can interrupt everyday function in school and at home due to the symptoms of a

decreased attention span, decreased concentration, and poor problem-solving skills. Jaffe et al. (1986) found that "in a recent study of 102 children (ages 4-16 years) from violent families, children of battered women were rated significantly higher in behavior problems and lower in social competence than were those in the non-violent comparison group" (p. 625). Other characteristics of these children are withdrawal, anxiety, increased level of aggression, behavior problems, and poor coping strategies (Helfrich et al., 2001; Jaffe et al., 1986; Thormaehlen & Bass-Feld, 1994).

During the recovery process, a woman and her children may experience post-traumatic stress disorder (PTSD). PTSD is defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* as an individual having been "exposed to a traumatic event in which they or others were threatened with death or serious injury" and "during the event they responded with fear, helplessness, or horror" (Fauman, 1994, p. 217). The symptoms associated with PTSD must occur for a minimum of one month in order to be diagnosed. Some common symptoms include recurrent dreams of the abuse, increased psychological distress, decreased affect, sleep disturbance, flashbacks, increased startle reaction, and outbursts of anger (Gosselin, 2003).

Despite all of these negative effects on the woman and her children, the woman tends to leave her abuser on average five to seven times before finally staying away for good (Helfrich & Aviles, 2001). It is very important for professionals to be aware of this fact. It is difficult to assist a client with the escape and recovery process. The client may not be ready to leave her abuser, or may leave and then return to the situation (Helfrich & Aviles, 2001). The overall process of leaving an abusive situation and recovering may be a long one.

Escape and Recovery Process

Merritt-Gray and Wuest (1995) discuss the process of leaving an abusive relationship by describing the three subprocesses of counteracting abuse. These three subprocesses are: relinquishing parts of self, minimizing abuse, and fortifying defenses.

Relinquishing parts of self begins as the initial response to being abused and is considered the first subprocess of counteracting abuse. Most women report having no initial sign of oncoming abuse from their partner. Types of abuse include torturing, brainwashing, degrading, stalking, threatening, and isolating. The women become so scared that they let the abuser control them, both mentally and physically (Merritt-Gray & Wuest, 1995). Further, women begin to believe that the degrading remarks made by the abuser are actually true. At this stage, women blame themselves, believing that they are the cause of the abuse. The women do not want to face the fact that they are actually being abused and that their partner is the one to blame. Following denial and self-blame, women may minimize the abuse.

The second subprocess of counteracting abuse is minimizing abuse. Abused women develop strategies to minimize abuse by protecting, reasoning, and fighting back (Merritt-Gray & Wuest, 1995). The protecting strategy consists of ways to withdraw from a dangerous situation. The woman ignores, agrees, avoids, delays, plays dead, and has witnesses present in order to protect herself from potential harm. For example, a woman may have her children present so that the abuser will not hurt her in front of them. Reasoning is also a strategy used by abused women. The woman will try to reason with herself about the abuser's motives and try to encourage him to seek help. For example, a woman may try to explain to the abuser how he has hurt her and then encourage him to

seek counseling in order to stop his behaviors. Reasoning occurs because a woman still feels that there is hope that the abuse will decrease and her relationship will continue. The strategy of fighting back includes calling the police, pressing charges, and protecting the children. Pressing charges is usually the most successful method used by women because the police officers often try to make the woman realize that she has been unnecessarily harmed, and that her children are also at risk (Merritt-Gray & Wuest, 1995; Lempert, 1996). Another technique that can be successful for women is being passive. This includes allowing the abuser to control the woman and the woman showing no emotion during abusive acts. These strategies often help the woman to preserve a sense of self in order to survive the abusive relationship (Lempert, 1996).

Fortifying defenses is a necessary step to the road to recovery. This third step readies a woman to leave the relationship and never return. Fortifying defenses includes strategies such as enhancing capability, creating space and distancing, experiencing a caring relationship, making a plan for escape, and surviving crises (Merritt-Gray & Wuest, 1995).

"Enhancing capability" refers to being involved in community leisure programs or activities, becoming very involved at work, or taking a night class, which further helps the woman to survive her abusive situation. These opportunities must be readily available. Often a friend or family member encourages the woman to participate. "Creating space" includes finding a safe place for the woman to think about her situation. Again, this usually involves a friend or family member who provides feedback and support. Often, a friend or family member will take the woman in temporarily so that she is able to gain control of her situation and begin to make decisions about her future plans

to leave the abuser for good. "Distancing", which is very similar to being passive, is a strategy the woman may use during the actual abusive situation, which includes partially removing one's self mentally during the act. Some also may turn to alcohol, medications, or illegal drugs to distance themselves from the abuse. Fortifying defenses may also entail "experiencing a caring relationship." Women need a caring relationship in order to realize that not all relationships are violent and that they deserve to be listened to and cared about. Typically, these relationships occur with coworkers or acquaintances. "Making a plan for escape" is particularly helpful for a woman in an abusive relationship because it helps one develop a sense of control and motivation to actually leave a partner. The final way to fortify defenses is by "surviving crises". Surviving a stressful or traumatic crisis (e.g. at work or home) gives a woman more confidence in her ability to escape her abusive relationship. Friends or family members can also assist in helping a woman to survive a crisis by offering transportation and a safe place to go in order for her to escape (Merritt-Gray & Wuest, 1995).

A woman's employer and her family can be key advocates for her decision to leave and never return to the abusive relationship. Both can be important support systems greatly needed by a woman in this position (Merritt-Gray & Wuest, 1995).

Breaking free is considered the transition stage between counteracting abuse and never returning to the situation. Women tend to distance themselves from their home and set up their own new home away from the abuser. Withdrawal from the abuser is an effective way for the woman to realize the effects that the abusive situation has had on her, as well as to regain a sense of self. A woman withdraws from her abuser in order to secure her independence and to regain control in her life (Merritt-Gray & Wuest, 1995).

Once a sense of control has been established, the woman must learn how to deal with and know how to react to men again, especially if she wants another intimate relationship. Even though she is feeling more in control of her life, she must still remember to listen to herself in order to completely heal from the abuse (Landenburger, 1989).

Barriers to Escape and Recovery

The escape and recovery process can be a long journey for the woman. There are many potential barriers that may prevent a woman from leaving her abusive relationship. These barriers include children, fear of retaliation, lack of a safe environment to go to, lack of job skills, financial dependency, emotional ties to the abuser, and a lack of knowledge about abuse among professionals. Presence of children in the home is a major obstacle that a woman will face. The woman may be concerned for the effects on the children due to separation from their father and/or child custody battles, as well as fear for her children's safety and well-being. The woman may be afraid that her abuser will retaliate and try to harm or steal her children away from her (Gosselin, 2003).

Fear of retaliation is an obvious barrier because the woman often is acutely aware of how her abuser reacts when she acts against his wishes. Many women lack a safe environment once leaving their abuser due to the isolation from family and friends. Once the woman leaves the abusive situation, she may be afraid of not having the financial means to support herself and her children because of her lack of allowed input into the household finances (Gosselin, 2003). The woman may fear losing custody of her children. The woman may feel ashamed and embarrassed because of the societal expectations to maintain custody and care for her children (Holtz & Furniss, 1993).

The woman may have a lack of job skills or financial independence because her abuser did not allow her to maintain employment (Council on Ethical and Judicial Affairs, American Medical Association, 1992; Holtz & Furniss, 1993). If the woman is employed, she may have difficulty obtaining flexible work schedules or time-off policies. Legal costs and medical or psychological costs, along with limited or no insurance may also lead to financial hardship for the woman. Gosselin (2003) also states that the woman may experience financial hardship due to the fact that she may be forced to seek out alternate housing for her and her children once she escapes the abusive relationship.

Emotional ties to the abuser are a common barrier to leaving and recovering because most often the woman is bonded by legal marriage. Denial and self-blame are common feelings held by the woman because she often loves her husband and does not want her relationship to end due to the abuse. She may convince herself that she is to blame for her husband's behavior. Another barrier develops in the "honeymoon phase" of the cycle of violence. During the "honeymoon phase", the woman starts to feel hopeful that her situation will improve. It becomes very difficult to persuade a woman to leave her abusive relationship during this phase. Finally, feelings of helplessness are also common because most often the woman feels that she is stuck in this position and will never be able to escape and lead a normal safe life (Council on Ethical and Judicial Affairs, AMA, 1992; Holtz & Furniss, 1993).

A commonly researched barrier for women with regard to recovery from abuse is that both physicians and therapists lack the knowledge to adequately serve this population (Council on Ethical and Judicial Affairs, American Medical Association, 1992; Johnston, Adams, & Helfrich, 2001). The treating physician and/or therapist may lack the

knowledge of key resources that could potentially assist the woman in escaping and recovering from the abuse. Research shows that physicians hold many of the societal misconceptions about abuse and may be reluctant to question the woman about her safety, which leads to repeated visits to the physician due to an underlying cause of undiagnosed abuse (Council on Ethical and Judicial Affairs, AMA, 1992; Neufeld, 1996).

Seeking Services

Women in abusive situations tend not to seek out services because they hope that the abuse will just "go away" or they fear that their abuser will find out and the abuse will escalate (Holtz & Furniss, 1993). Women are often seen in the emergency room for their injuries, but most of the time the treating physician will not recognize their complaints are a result of domestic violence (Council on Ethical and Judicial Affairs, AMA, 1992). If a woman discloses information about abuse to her physician, she may be referred to women's shelters, law enforcement, community support programs, psychological services, or health care specialists. Many of these community resources are unavailable or are very limited in smaller cities and rural areas (Council on Ethical and Judicial Affairs, AMA, 1992). The woman may be referred to health care specialists along with her other referrals for her specific physical injury, such as to physical or occupational therapy, as well as to counseling services for emotional or psychological issues. The woman's children may be referred to physical therapy, occupational therapy, or counseling services through the school system.

Effects of Domestic Violence on Occupation

Through the use of databases such as Cinahl, Pubmed, PsycInfo, and Expanded Academic ASAP, few to no articles for keywords "occupational therapy and domestic

violence" and "effects of abuse on occupations" were found (i.e. Cinahl had no hits for both sets of keywords and PsycInfo had two hits for each). The researcher concluded that there is little to no research on this topic currently available.

Although there is currently little to no research on the direct effects of domestic violence on occupation, it can be speculated that abuse can affect all areas of occupation and occupational identity. Each of the areas of Kielhofner's Model of Human Occupation could potentially be affected because they are dynamic in nature and overlap. Experiencing abuse and its short and long term effects could compromise or change one area and in turn compromise or change all areas of a woman's occupations (Helfrich & Aviles, 2001; McColl, 2002).

Specific occupations may be affected by experiencing domestic violence. Since the abuser may not allow the woman to maintain employment, she may have a lack of job skills and financial resources. If the woman is employed, she may experience increased absenteeism and decreased productivity due to injuries sustained from the abuse (Groetsch, 1996).

The psychological effects of abuse may also hinder the woman's occupational identity. The abuse may cause difficulty sleeping, difficulty concentrating on tasks, anxiety, and depression (Veltkamp & Miller, 1990). If a woman is experiencing these effects from her abusive situation, it will be more likely that her everyday occupations would be affected. Employment and parenting would be thought to be the most affected by these psychological effects, but little to no literature exists in this area.

Defining Occupational Therapy and the Model of Human Occupation

According to Neistadt and Crepeau (1998), occupational therapy is defined as "the art and science of helping people do the day-to-day activities that are important to them despite impairment, disability, or handicap" (p. 5). The American Occupational Therapy Association (2004) defines occupational therapy as "skilled treatment that helps individuals achieve independence in all facets of their lives and gives people the 'skills for the job of living' necessary for independent and satisfying lives" (p. 3).

The Model of Human Occupation (MOHO) by Gary Kielhofner is the basis of the domestic violence research currently underway at the University of Illinois at Chicago headed by Christine Helfrich, PhD, OTR/L. Therefore, MOHO is an appropriate approach to use when studying how domestic violence affects the everyday functioning of abused women. Kielhofner (2002d), in his Model of Human Occupation, defines human occupation as "the doing of work, play, or activities of daily living within a temporal, physical, and sociocultural context that characterizes much of human life" (p. 1). Kielhofner defines occupational identity as a "composite sense of who one is and wishes to become as an occupational being, generated from one's history of occupational participation (Kielhofner, 2004, p. 162). The four main concepts covered under the model are volition, habituation, performance capacity, and environment, all of which influence occupational identity and occupational performance. Every individual possesses the personal characteristics of volition, habituation, and performance capacity. In order to develop an occupational identity and a sense of occupational competence, each individual must participate, perform, and develop new skills in each environment in which they live and work (Kielhofner & Forsyth, 2002b). These four main areas all may

become compromised or changed when a woman experiences abuse. All of these areas interact together and are dynamic in nature. If one of these areas is changed or compromised due to abuse, then it will affect the other three, thus affecting occupational functioning or identity.

Kielhofner (2002e) defines volition as "a pattern of thoughts and feelings about oneself as an actor in one's world which occur as one anticipates, chooses, experiences, and interprets what one does" (p. 44). This concept of volition can further be described as how one perceives their own life story and how their decisions reflect the path that individuals want to pursue in their life (Baron, Kielhofner, Goldhammer, & Wolenski, 1999). Volition is expected to be affected greatly by domestic violence. According to Helfrich and Aviles (2001), some issues that arise are the woman's sense of control over her decisions in everyday life; her perception of her skill level and confidence to participate in activities as defined by her roles; her values related to her independence and ability to care for her children; and her general interests and meaningful activities (Helfrich & Aviles, 2001).

Habituation is "an internalized readiness to exhibit consistent patterns of behavior guided by our habits and roles and fitted to the characteristics of routine temporal, physical, and social environments" (Kielhofner, 2002c, p. 63). Baron et al., (1999) describe roles as a way to provide the individual with a sense of identity and habits that result from how the individual behaves in a certain environment. Habituation is expected to be affected by an abusive relationship. It may be affected when there are issues related to how a woman spends her day, what activities she participates in, the freedom to change her mind, and having control of her time (Helfrich & Aviles, 2001). A woman

may also be aware of when the abuse will occur and will assume certain roles in order to lessen the abuse. For example, a woman typically takes on the role of housekeeper and may clean her house in excess in order to satisfy her abuser, thus decreasing the chance of being abused on that particular day.

Performance skills and performance capacity are very similar and also are expected to be affected by abuse. Performance "refers to one's innate capacities, which are the foundation for skilled performance" (Baron et al., 1999, p. 16). Skill includes "motor, process, and communication/interaction elements, which are for dealing with the physical world and objects, events and procedures, and the sociocultural surroundings" (Baron et al., 1999, p. 16). Performance capacity refers to the "ability for doing things provided by the status of underlying objective physical and mental components and corresponding subjective experience" (Kielhofner, Tham, Baz, & Hutson, 2002, p. 97). Thus, performance skill (physical, emotional, and cognitive) may be either a facilitator or a barrier to surviving an abusive relationship. If a woman perceives that she has the skills needed to cope and seek help in the situation, then she may feel adequate and in control. Lacking performance skills may be a barrier in that she may feel that she is unable to escape or perform activities to the standard that the abuser imposes upon her (Helfrich & Aviles, 2001). Performance skills and capacity are also associated with the concept of the lived body. The lived body can be defined as "the experience of being and knowing the world through a particular body" (Kielhofner, Tham, Baz, & Hutson, 2002, p. 83). Each individual learns how to perform different skills through experiences in his or her daily life, thus people learn about the world through the experience of being a particular person (Kielhofner, Tham, Baz, & Hutson, 2002). Domestic violence can affect all areas

of a woman's daily life, especially her participation in occupations. If she is able to maintain a sense of control over the occupations that are meaningful to her, she may be able to cope in her abusive situation. However, by experiencing domestic violence, she may not have the skills or opportunities needed in order to participate in occupations that could be meaningful to her, which directly relates to the concept of the lived body.

Kielhofner (2002b) describes the environment as the "particular physical and social features of the specific context in which one does something that impacts upon what one does, and how it is done" (p. 111). Context, according to the *Occupational Therapy Practice Framework* by the Commission on Practice (2002), includes cultural, physical, social, personal, spiritual, temporal, and virtual, and refers to "a variety of interrelated conditions within and surrounding the client that influence performance" (p. 623). In the case of domestic violence, the environment is expected to become a barrier for the woman. Since occupations take place in the physical and social environment, it becomes difficult for a woman to perform her daily tasks if she is being abused in the home. Conversely, other environments may become facilitators. She may use work and any leisure time as a way to escape from the abuse and allow her time to make decisions about her future. Physical and social supports are also part of the environment. A woman will not be able to perform her daily occupations needed to fulfill her roles if she does not have the support of the other people in her environment (Helfrich & Aviles, 2001).

In summary, each of these dynamic areas of one's life may be affected differently by abuse. There is currently no research available stating the degree to which each of these areas is affected by domestic violence. In the literature, a few authors speculated

on the affects of abuse in each of these areas, but they offered no support for their speculation (Helfrich & Aviles, 2001; Froehlich, 1992).

Possible Roles of the Occupational Therapist

A major role for therapists is to act as an advocate for the client once they have disclosed the abuse. Thus, an occupational therapist could identify or secure safety, support, and resources. Once an occupational therapist is aware of the client's abusive situation, the client's safety is the number one concern (Helfrich & Aviles, 2001). The occupational therapist could refer his or her client to shelters or other safe places in order to escape from the abuser. Support from the treating therapist is also very important for the client. The client needs to feel comfortable when disclosing information about her situation and must be able to trust the therapist so that intervention can be efficient and effective. Resources could be available from the therapist as well. Resources could include information on shelters, support groups, and other intervention services. Even though a woman discloses abuse and is supported by her therapist, she may not be ready to leave her abuser. The occupational therapist must understand what stage of the cycle of violence the woman is in, and that there may be many other reasons why the woman is not accepting intervention and escaping the abusive relationship. These reasons may include fear of further abuse, love, lack of relocation sites, pressure from friends and/or family, guilt, and children, etc. (Helfrich & Aviles, 2001).

There are seven steps outlined by Veltkamp and Miller (1990) that therapists, such as occupational therapists, can follow when treating a person who is thought to be in the battering phase of an abusive relationship: (a) identify the abuse; (b) manage the acute medical problems including physical and psychological; (c) take a history of the assault;

(d) manage the acute emotional problems of the victim; (e) safeguard the victim against further abuse; (f) design a treatment plan and follow-up plans; and (g) follow the legal requirements for collection of evidence, documentation, and report of abuse (Veltkamp & Miller, 1990). Further treatment should be outlined with the client in order to address the long-lasting effects of abuse and to complete the recovery process.

The initial contact with the victim should include assessing their risk for more harm and to begin gathering information to assist in organizing a plan of action. Throughout the intervention process, the occupational therapist should encourage and facilitate occupations in which the client can participate. The occupations should be familiar to the client, those that she feels are important in dealing with current deficits, and able to be reintegrated into her everyday life. Stress management techniques in order to assist the healing process should also be included. Occupations (i.e. job skill training, activities of daily living, time management) will help to redefine the client's previous roles that were lost to the abusive situation and help to recreate the woman's identity (Koch, 2001). By addressing the affected areas of occupation, such as volition, habituation, and performance skills, the woman will experience a greater sense of control and develop new or lost skills that were not present during the abusive relationship. Howard and Howard (1997) state that "when difficult times arise, occupation, particularly work and the purposeful use of time, may be the means through which meaning in life is restored" (p. 181). Currently, intervention plans are very individualized and generally occupational therapists only see women who are abused and referred for another reason (i.e. physical injury). Occupational therapists will then use occupation for the physical and psychological benefits of participating in the task.

In order to effectively treat a client who has been abused, the occupational therapist must choose an appropriate assessment tool to determine the individual needs and goals for intervention. An important area for occupational therapy is to identify which aspect of occupational performance and identity has been impacted by the experience of abuse.

Occupational Therapy Assessment Tools

The Model of Human Occupation has five assessment tools that would be appropriate to use for this population. These are the Occupational Performance History Interview-II, Occupational Self-Assessment, Assessment of Motor and Process Skills, Assessment of Communication and Interaction Skills, and the Volitional Questionnaire. The *Occupational Therapy Practice Framework* outlines the process of intervention of through the use of assessments. The therapist initiates this process by developing an occupational profile (Commission on Practice, AOTA, 2002). The occupational therapist begins with global questions addressing the client's safety in her home and living situation. The five assessment tools provide a comprehensive look into self-care skills, communication/interaction skills, self-assessment skills, and occupation-related life history. The only literature found to use occupational therapy assessments as a base for treating a client with domestic violence stated that the use of these five MOHO-based assessments provides a complete review of the client's functional issues related to the abuse (Helfrich & Aviles, 2001). Helfrich and Aviles (2001) reviewed each of these assessments as part of their research, and the usefulness of each in evaluating clients with domestic violence is outlined below.

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

The OPHI-II is an interview that an occupational therapist can administer to a client who she suspects or knows is being abused by her partner. This one to two hour interview addresses past, current, and future occupational experiences. It includes rating scales that explain the client's values, self-esteem, lifestyle pattern, and environmental supports and constraints (in this case, abuse). A weakness of this assessment is that it is not specific to abusive relationships; however, it may assist the occupational therapist in determining the client's life patterns and problem solving abilities (Helfrich & Aviles, 2001). Another weakness may be the length of time needed to administer the assessment. The OPHI-II takes 45-60 minutes to complete, which may be difficult in an acute setting or during short-term contacts with the client.

Occupational Self-Assessment (OSA).

The OSA is a self-report, which is designed to measure a woman's self-perception of her abilities, satisfaction with her performance, and her views of the environment's effects on her performance (Helfrich & Aviles, 2001). According to Kielhofner and Forsyth (2002a), the OSA is an assessment that covers the majority of MOHO concepts. It also facilitates collaboration of the therapist and client on goals, as well as future treatment. The OSA is appropriate to use the first time the therapist has contact with the client to identify the client's particular area of difficulty. The OSA takes approximately 10-20 minutes to complete and is typically followed with a 15-minute discussion. According to Helfrich and Aviles (2001), it is often difficult for women who have been abused to make their own choices because of fear of their abusers. This fear may become a problem because it does not allow for an accurate picture of her self-perception and

satisfaction with her occupations, thereby skewing the results. The occupational therapist needs to discuss the woman's environment, and her ability to function and carry out her daily occupations once she returns home. The occupational therapist also needs to examine the skill areas being performed well in therapy, and inquire whether the client will be able to perform equally well once they are discharged (Helfrich & Aviles, 2001).

The OSA is appropriate to use with women who are "at a higher functional level, have some insight, have adequate cognitive skills for reflection and planning, have the ability to realistically appraise themselves, have basic reading skills, and have a desire to collaborate in setting and achieving their own therapy goals" (Baron et al., 1999, p. 33). A strength of the OSA is that it is client-centered and allows the woman to identify problems, as well as affirm her strengths (Baron et al., 1999). A weakness of the OSA is that it only measures a woman's perception of her occupational competence and does not actually measure her objective occupational functioning. Another weakness of the OSA is that it may not be appropriate for all clients because it requires a higher level of cognition in order to complete accurately.

Assessment of Motor and Process Skills (AMPS).

The AMPS is a 30-40 minute observation tool used to measure motor and process skills during routine tasks. The client must choose tasks of importance, which allows her to feel in control of her actions (Helfrich & Aviles, 2001).

According to the AMPS website (2003), the results of the AMPS can help to answer four main questions regarding the client: "1) Why does this person experience difficulty?; 2) What level of task challenge can this person manage?; 3) Is this person a candidate for restorative interventions based on the use of restorative occupation or

compensatory interventions based on the use of adaptive occupation?; 4) Has this person's ADL performance improved as a result of our interventions?" (p. 2).

A strength of the AMPS is that the treating therapist must be trained and deemed a reliable rater. Training, which currently costs $750, consists of a 5-day workshop with hands-on experience using the AMPS. In order to become a reliable rater, the therapist must view and score AMPS observations and then complete 10 observations following the training. This allows for rater calibration to determine the individual severity of rating and to secure reliability. Following these steps, the occupational therapist can then administer the AMPS (AMPS, 2003). A weakness of the AMPS is that it is currently a task-based assessment and requires a specific set-up in the clinical setting in order to accurately complete the tasks. Another weakness of the AMPS is that not all therapists are certified to administer the AMPS due to cost and length of training.

Assessment of Communication and Interaction Skills (ACIS).

The ACIS is an observation tool used to analyze behavior of the client when interacting in individual and/or group settings. Social appropriateness is observed throughout the assessment (Helfrich & Aviles, 2001). Kielhofner and Forsyth (2002a), suggest that the ACIS would be appropriate to use when a problem in the area of communication and interaction skills has already been identified by another assessment and a more detailed assessment of the problem is needed. A weakness of the ACIS is that it does not assess a woman's specific communication styles, which may be important because of the past influence of her abuser. The woman may have had appropriate communication and interaction skills in the past, but the abuse may have had an effect on these skills. As a result, it may be very difficult for the woman to complete tasks, such as

scheduling appointments, running errands, and going shopping (Helfrich & Aviles, 2001). Another weakness of the ACIS is the time and situations needed in order to accurately complete the assessment. The ACIS takes about 45-60 minutes to complete and requires the therapist to observe the client in a social situation. It may not always be easy to set-up and observe for this length of time.

Volitional Questionnaire (VQ).

The VQ allows the therapist to observe and rate the client while participating in work, leisure, or daily living tasks in three to five contexts. The VQ is a 14-item scale that describes behaviors reflecting values, interests, and personal causation. Kielhofner and Forsyth (2002a) would again suggest the use of the VQ when a problem with volition has already been identified by a more global assessment or screening and more depth is needed. This assessment is appropriate for persons with extreme volitional problems due to environmental stresses or social trauma (i.e. domestic violence) (Kielhofner, 2002e).

A few strengths of the VQ are that it is appropriate for all ages and provides valuable information regarding a person's volition. Although there may be no obvious weaknesses for the VQ, it must be kept in mind that the VQ is a very specific assessment only used to measure a client's volition in a particular environment (Kielhofner, Forsyth, de las Heras, Hayashi, Melton, & Raymond, 2002).

Adult Self-Perception Profile (ASPP).

Despite not being a MOHO-based assessment, the ASPP by Messer and Harter (1986) is an appropriate tool to use with clients who have experienced abuse. The ASPP is a 15-minute self-assessment that contains 12 domains used to measure a woman's self-perception of her different experiences. The 12 domains include global self-worth, sense

of humor, intimate relationships, intelligence, household management, morality, adequate provider, physical appearance, athletic competence, nurturance, sociability, and job competence.

A few strengths of the ASPP are that it is fairly simple to administer and the therapist does not need special certification in order to administer the assessment. A weakness of the ASPP is that validity tests have not been completed, therefore it cannot be concluded that it actually measures what it is intended to measure (Messer & Harter, 1986).

These assessments assist the occupational therapist in evaluating how a woman functions in her environment while looking at her situation in a holistic manner. These assessments test each of the four main areas of MOHO and assist the occupational therapist in developing an effective intervention plan for each individual client who has experienced abuse.

Intervention Strategies

According to Helfrich and Aviles (2001), the occupational therapist can take one of five paths after identifying abuse of a client. They are:

1. Follow legal requirements to report abuse.

   The occupational therapist must consult the mandatory reporting laws for domestic violence in each state. It may not be mandatory that they report cases of domestic violence, or it may depend on the severity of the situation. If the occupational therapist is treating children or the elderly, there are many states that have mandatory reporting laws for reporting cases of child and elder abuse. The occupational therapist must also keep

in mind the specific Code of Ethics under which they practice. According to Helfrich and Aviles (2001), they state that "it should become standard practice for occupational therapists to consider it ethically necessary for the domestic violence to be addressed" (p. 69).

2. Initiate referral to resources or services.

   Some initial referrals that an occupational therapist may make are for emergency housing, legal advice and assistance, domestic violence counseling, services for children, psychotherapeutic counseling, and medical care. Information should be given to clients in a way that keeps her safe, but informed of her options. Both the client's judgment and the therapist's come into play here as to what is the safest way to provide the information regarding counseling and intervention services.

3. Offer direct treatment.

   Occupational therapists have an ethical obligation to tell a woman her treatment options, which may include, through the use of occupation, addressing any physical conditions and perceived functional deficits, identification of roles, activities of daily living, environmental modifications, educational options, and/or vocational treatment.

4. Provide indirect services.

   An occupational therapist may train other service providers in facilitating programs (i.e. activity groups, parenting skills groups, stress management) and carrying out other services when the therapist is not present. The

occupational therapist may also act as a consultant for community-based programs.

5. Utilize program consultation.

   The occupational therapist may act as a consultant when developing programs targeted at this population. The occupational therapist has skills and knowledge that are relevant and important to consider when developing programs to assist women who have been abused (Helfrich & Aviles, 2001).

Occupational therapy direct intervention is most effective immediately following the battering phase because this is the point at which the victim feels most vulnerable. The woman may be more open to options and community resources, and motivated to seek treatment, directly following an abusive incident because she is able to recognize how the abuse is affecting her overall lifestyle. It is important that the treating therapist provides the woman with resources and other options before she enters the "honeymoon stage" of the cycle. Once her relationship begins the honeymoon stage again, the woman will be less likely to admit there is a problem in her relationship and to seek assistance because she feels that she will be able to save her relationship (Worcester, 1992; Helfrich & Aviles, 2001).

If the intervention plan includes direct treatment of the victim, occupational therapy services could provide many options. Through the use of occupation, the victim could work on developing skills needed to successfully perform her desired roles, improve her independent living skills, implement environmental adaptations, explore new roles, and obtain educational or vocational intervention (Helfrich & Aviles, 2001).

According to McColl (2002), there are seven ways in which occupation can be used during a stressful situation, for instance domestic violence. First occupation is a means to survive. Participating in occupations is a natural, biological need instilled in every person (McColl, 2002). People use occupation in order to survive in their environment, from activities of daily living to safety and sustenance needs. Occupation can also help a person survive a difficult situation by allowing them to find the source of stress. Second, occupation can act as a diversion from the stress of the difficult situation. Occupational therapists use occupations during treatment sessions to divert one's attention away from pain, frustration, and disability. At the same time, occupation is being used therapeutically to increase a person's skills and abilities. Third, occupation can address the concept of mastery over the environment. This idea parallels Kielhofner's concept of self-efficacy, which addresses how persons use their own capacity to impact the different aspects of their lives (Kielhofner, 2002e). By participating in occupations, one realizes the skills that they have and the control they possess over their environment. Fourth, occupation forces one to maintain the habits of daily life. Participating in everyday occupations allows for maintenance of occupational competence. By maintaining a daily routine, one retains the idea that life goes on throughout a stressful situation. If a person is unable to maintain their normal routine, then they may lose motivation and control over their life goals and future activities (McColl, 2002). McColl (2002) states that a fifth way to deal with a stressful situation is to use occupation as a means of support. By being involved in occupations, a person may help others while coping with stress. Helping others may be a strategy to cope with the difficult situation and allow for "tend and befriend" reactions (Taylor, Klein, Lewis,

Gruenwald, Gurung, & Updegraff, 2000). Women may be trying to cope with the abuse and befriend other women in a similar situation. Sixth, by being in a stressful situation, persons may be more likely to lose their identity and be unstable in their outlook on life. A person's occupational identity is developed based on past occupational experiences. Occupations can be used therapeutically to assist with regaining their past identity and allowing them to realize who they really are. Finally, occupation offers a link to one's spiritual self. The meaning of life may be restored through the use of occupation during difficult times. All of these areas may be compromised when experiencing an abusive relationship. By participating in occupation in one of these seven ways, the process of surviving, breaking free, and rebuilding their lives may become easier. The use of occupation during a stressful time, such as escaping from a violent relationship, may assist with coping, increase a sense of hope, and promote a sense of well-being (McColl, 2002). In order to use occupation as a therapeutic tool, professionals must be aware of the signs of domestic violence as well as the benefits of occupations for recovery.

The lack of research on domestic violence may indicate a lack of knowledge among occupational therapists. This may suggest that there is a need for more education in the area of domestic violence. One study of registered occupational therapists (OTRs) and certified occupational therapy assistants (COTAs) showed that 68% of its participants do not feel that they are adequately prepared to identify cases of spouse abuse. Even more (70%) do not feel that they are prepared to provide either interventions or referrals to women being abused (Johnston, Adams, & Helfrich, 2001). These statistics show how unaware occupational therapists are of this problem; and they may be treating victims of spouse abuse on a daily basis without the knowledge of the indicators

of abuse. The abuse may be the underlying cause of why the client is seeking attention, but she may be too afraid to disclose this information. In order to increase awareness, training should be done as mandatory in-services or continuing education courses in one's professional career. Online continuing education courses are available and open to occupational therapists, such as a course entitled *Domestic Violence II: Intimate Partner Violence* (Professional Development Resources, n.d.).

After researching domestic violence and the role that occupational therapy has in treating clients who have been abused, it is clear that there is a need for more research in the field of occupational therapy on this topic. The research that is available is primarily from the University of Illinois at Chicago by Christine Helfrich, PhD, OTR/L and her colleagues. Helfrich et al.'s research is based on MOHO and is an introduction into this newly developing area of practice. Currently, Helfrich is researching life skills training for victims of domestic violence, and the effects of domestic and community violence on function from a program development perspective. While it has been speculated that the women's occupational self is impacted by abuse and that it can be addressed by occupational therapy intervention, there is no evidence to support this. Once this research has been conducted, it could help occupational therapists to develop programs and intervention strategies that would benefit the clients who have experienced domestic violence.

Chapter Three: Methodology

The method by which the researcher conducted this study, as well as how the data was analyzed is explained in this chapter.

Research Questions

1. How does experiencing domestic violence affect a woman's perception of her occupational identity?
2. How does experiencing domestic violence affect a woman's perception of her occupational competence?

Participants and Selection Method

This study aimed to compare the occupational identity and competence of women who have experienced domestic violence with those of women who have not experienced domestic violence. The procedures were reviewed and approved by the Human Subject Review Board at Ithaca College on November 11, 2003. Participants had to be: 1) the caregiver/guardian of at least one child under the age of 18; and 2) between 18-50 years of age. The study group consisted of participants who had experienced abuse in the last six (6) months so that the researcher could obtain an accurate picture of how the women's daily occupations were affected. Participants in the control group could not have experienced domestic violence in the last six (6) months. Participants were required to have children in order to determine how parenting and childcare occupations were affected by domestic violence. Research shows that the highest rates of violence among women occur between the ages of 18-29 years (Low, Monarch, Hartman, & Markman, 2002). Participants were required to be in the age range of 18-50 years of age because this age group is most likely to have younger children.

The researcher chose a survey design. A sample of convenience was used to collect the data. Regional public sites, such as the local shopping mall and regional women's advocacy centers, were contacted and the surveys were distributed to women through an agreement with management. The participants voluntarily completed the survey. When present, the researcher read the recruitment statement (see Appendix A) to the participants and then the participants read the tear-off cover page. Since the researcher was unable to be present at the advocacy center, the director was contacted through a phone call and asked if the surveys may be sent to their facility for review and participant recruitment. Upon receiving the surveys, the director was required to read the alternate recruitment statement (see Appendix A) to the participants and later mailed the completed anonymous surveys in an envelope to the Occupational Therapy department at Ithaca College. The participants were informed that by returning the surveys they were demonstrating informed consent.

Once the women agreed to participate, they completed a demographic survey, which also included questions regarding their history of domestic violence (see Appendix B). Following the survey, the women completed the Occupational Self Assessment (OSA), which assessed the individual's perception of her occupational identity in areas such as volition, habituation, skills/occupational performance, and environment (see Appendix C). Finally, the participants were asked to fill out the Adult Self-Perception Profile, which measured the individual's perceived competency in different domains of their life (see Appendix D). Total time to complete the survey and both assessments was approximately 15-30 minutes. The participants were asked to place their surveys and assessments in a pre-addressed postage paid envelope and to drop them in the mail.

Participants who filled out the survey through the advocacy centers were asked to place their survey in an envelope and the director mailed them to the researcher.

Since the researcher was unable to get an adequate response rate at the local shopping mall, surveys were handed out to women on the Ithaca College campus. Surveys were also given to the research advisors to hand out to women outside of the Ithaca College community who had children in the age group specified. The researcher obtained a total of 34 participants who met the criteria.

Operationalization of Variables

A demographic survey was used to collect data including the age of each woman, highest level of education obtained, current intimate relationship status, how many children they had and their ages, and questions related to domestic violence (see Appendix A). For the purposes of this study, participants were classified as experiencing domestic violence if they answered "yes" to one or more of the following questions: "In the last six (6) months, (a) Has your partner ever threatened you?, (b) Have you been physically hurt by your partner?, and (c) Has your partner abused the children?", or (d) if they answered "no" to "Do you feel safe in your relationship?." In order to be placed in the control group, participants were required to answer "no" to all of the above questions with the exception of answering "yes" to "Do you feel safe in your relationship?."

How does domestic violence affect a woman's perception of her occupational identity?

Human occupation is defined as "the doing of work, play, or activities of daily living within a temporal, physical, and sociocultural context that characterizes much of human life" (Kielhofner, 2002d, p. 1). Kielhofner also goes on to define occupational

identity as a "composite sense of who one is and wishes to become as an occupational being, generated from one's history of occupational participation" (Kielhofner, 2004, p.162). Each woman's perception of her occupational identity was assessed using the Occupational Self-Assessment through each subsection, which included volition, habituation, skills/occupational performance, and environment. The OSA was used as a global measure and each subsection was included under this assessment.

Kielhofner (2002e) defines volition as "a pattern of thoughts and feelings about oneself as an actor in one's world which occur as one anticipates, chooses, experiences, and interprets what one does" (p. 44). The Occupational Self-Assessment is used to assess each woman's perceived level of volition. The Adult Self-Perception Profile also measured a woman's perceived competence in the area of global self-worth, which is similar to the concept of volition. They are similar because they each look at one's overall sense of worth and how they play a role in their world.

Kielhofner describes habituation as "an internalized readiness to exhibit consistent patterns of behavior guided by our habits and roles and fitted to the characteristics of routine temporal, physical, and social environments" (Kielhofner, 2002c, p. 63). Habituation was measured using the Occupational Self-Assessment.

According to the Commission on Practice's (2002) *Occupational Therapy Practice Framework*, context includes cultural, physical, social, personal, spiritual, temporal, and virtual, and refers to "a variety of interrelated conditions within and surrounding the client that influence performance" (p. 623). In the Occupational Self-Assessment, context is described as physical, social, and personal elements in the case of domestic violence and is measured in the environment subsection. Physical context is

defined as "nonhuman aspects of contexts, including the accessibility to and performance within environments having natural terrain, plants, animals, buildings, furniture, objects, tools, or devices". Social context is "availability and expectations of significant individuals, such as spouse, friends, and caregivers, including larger social groups that are influential in establishing norms, role expectations, and social routines". Personal context includes "age, gender, socioeconomic status, and educational status" (Commission on Practice, AOTA, 2002, p. 623).

How does experiencing domestic violence affect a woman's perception of her occupational competence?

Occupational competence is defined by Kielhofner (2002a) as "the degree to which one sustains a pattern of occupational participation that reflects one's occupational identity" (p. 120). The Adult Self-Perception Profile measures one's perception of competence in the following domains: sociability, job competence, nurturance, athletic abilities, physical appearance, adequate provider, morality, household management, intimate relationships, intelligence, sense of humor, and global self-worth (Messer & Harter, 1986).

Sociability refers to "one's behavior in the presence of others" (Messer & Harter, 1986, p. 4). Job competence is how one perceives their "competence in their major occupation, job, or work" (1986, p. 4). Nurturance "involves the process of caring for others" (1986, p. 4). Athletic abilities "pertain to the concept of abilities related to sports" (1986, p. 4). Physical appearance refers to "the way one looks and is tapped by items such as feeling attractive, being happy with the way one looks, and being satisfied with one's face and hair" (1986, p. 4). Adequate provider is defined as "supplying the

means of support for oneself and one's significant others" (1986, p. 4). Morality is "one's behavior based on standards of conduct, of what is right and wrong" (1986, p. 5). Household management refers to "guiding or handling activities in the household" (1986, p. 5). Intimate relationships "imply close, meaningful interactions or relationships with one's mate, lover, and/or very special friend" (1986, p. 5). Intelligence is defined as "the ability to learn and know" (1986, p. 5). Sense of humor "pertains to the ability to see the amusing side of things" (1986, p. 5). Global self-worth is "one's global perceptions of worth, independent of any particular domain of competence/adequacy" (1986, p. 5).

Measurement Instruments

The participant's age, education level, marital status, number of children and their ages, and history of domestic violence was collected through the use of a demographic survey. The questions related to domestic violence were obtained from an article by Brenda Neufeld, MD (1996) entitled *SAFE Questions: Overcoming Barriers to the Detection of Domestic Violence.* The demographic survey was reviewed for content validity by a sociologist.

The Occupational Self-Assessment (OSA) assesses the participant's perception of her occupational identity and how the environment impacts their occupational adaptation. It includes a two-part self-rating form with section one addressing occupational functioning and section two addressing the subject's environment.

The OSA was originally called the Self-Assessment of Occupational Functioning (SAOF). In 1999, reliability and validity tests were completed on the SAOF. The examiners found acceptable levels of test-retest reliability of the SAOF using intraclass correlation coefficients for the subscales (.70 for volition subscale, .74 for habituation

subscale, .74 for performance subscale, and .68 for environment subscale) and total scores (.87) (Henry, Baron, Mouradian, & Curtin, 1999). Internal consistency was also found to be acceptable using Cronbach's alpha (.83 for volition subscale, .70 for habituation subscale, .66 for performance subscale, and .88 for total score) (Henry et al., 1999). The SAOF was concluded to be reliable and valid, but further research was needed in order to increase the validity (Henry et al., 1999). Based on these findings, the SAOF was revised and renamed the Occupational Self-Assessment. The OSA has content validity based on two international studies. The first study of the OSA was completed on a sample of participants who were diverse in language, culture, race, disability status, and age. The study included 202 participants (112 females and 90 males) ranging in age from 18 to 92 years. The OSA was found to validly measure most participants in the areas of the competence scale (94.1% of participants), environmental impact scale (96% of participants), values concerning occupational competence (95.4% of participants), and values concerning environmental impact (97.5% of participants) (Baron et al., 1999). According to these findings, the OSA scales are valid and useful. Future revisions hope to increase the sensitivity of the instrument (Kielhofner, Forsyth, Federico, Henry, Keponen, Oakley, & Pan, 2002).

The Adult Self-Perception Profile measures one's perceptions of competence in the following 12 domains: sociability, job competence, nurturance, athletic abilities, physical appearance, adequate provider, morality, household management, intimate relationships, intelligence, sense of humor, and global self-worth. This profile is more specific in that it actually measures one's self-perceived competence within twelve (12) different domains of an adult's life. All of these areas can potentially be affected by

abuse and are important to take into consideration when treating a client who has experienced domestic violence. The 12 domains all directly relate to everyday occupations of women.

Psychometric studies have been completed on the Adult Self-Perception Profile in order to confirm reliability. The internal consistency reliabilities have been researched on each subscale of the Adult Self-Perception Profile using Cronbach's Alpha with scores ranging from .65 to .91 for both samples. The reliability testing was done on two sample populations. Sample A included 141 parents ages 30 to 50 years who came from intact, upper middle class families. Sample B included 215 mothers with children less than three years of age from lower and middle class families. For Sample A, the lowest reliability was found in the Adequate Provider subscale due to misinterpretation of these items. For Sample B, the reliability was adequate for each subscale (Messer & Harter, 1986). Validity of the Adult Self-Perception Profile has not been reported.

Data Analysis

The data was compiled and analyzed using the *Statistical Package for Social Sciences (SPSS), Version 11.5 for Windows*. A p-value of .05 or less was used to determine significance for this study. Descriptive statistics were used to identify the study group and the control group. The ages of the participants were described using mean, range, standard deviation, and mode. The highest level of education obtained by the participants was described using frequency tables. The length of the current relationship was described using mean, range, and standard deviation. The participants' age at which their current relationship was formalized was described using mean, range, and standard deviation. The number of children under the age of 18 years was described

using mean, range, and mode. Independent samples t-tests were then run to compare the study and control groups for differences in age, length of relationship, age at which the relationship was formalized, and number of children under age 18. A Mann-Whitney U Test and Crosstabulations were used to compare the control and study groups for highest level of education obtained. The ages of the children for the control and study groups were compared using a frequency table in the following age groups: 0-1 year, 2-3 years, 4-5 years, 6-12 years, 13-14 years, and 15-18 years.

Frequency tables were used for both groups to describe how many participants were currently in an intimate relationship, whether or not they are currently living with that person, and whether or not that relationship has been formalized. Crosstabulations were used to compare the difference between both groups for how many participants were currently in an intimate relationship, whether or not they are currently living with their partner, whether or not that relationship has been formalized, and if they had children in the age groups specified. Frequency tables were also used to describe the answers given to the questions regarding history of domestic violence.

The standard scoring procedures outlined in *A User's Manual for the Occupational Self-Assessment, Version 1.0* (1999) was used to score the participants' responses. The scores for the competence ratings were ranked from problem (1), all right (2), and well (3), as well as the value ratings from not so important (1), important (2), and extremely important (3). Finally, gaps between competence and value ratings were identified in each item. Gaps were calculated by subtracting the competence rating from the value rating. A numeric gap score of 2 represented the greatest dissatisfaction of perceived occupational performance, a 1 represented some dissatisfaction, and a score of

0 represented satisfaction. For the purposes of this study, the researcher then added up the gap scores for each subsection (skills/occupational performance, volition, habituation, and environment) and used a t-test to compare the gaps between the control and study groups in order to find a significant difference.

The standard scoring procedure for the Adult Self-Perception Profile included calculating subscores for each of the 12 domains. A total score is not calculated. The subscores are calculated by taking the mean score for each domain, which ranged from 1 to 4. According to the *Manual for the Adult Self-Perception Profile* by Messer and Harter (1986), each item is scored either 1, 2, 3, or 4 where 1 represented the least adequate self-judgment and 4 represented the most adequate self-judgment. Mean scores are calculated by adding the 4 items and then dividing by 4, except for the global self-worth domain, which required adding the 6 items and then dividing by 6. Mean scores for each domain were also compared between the study and control group. A t-test was then used to compare each domain between the study and control groups in order to determine if a significant difference existed.

Limitations, Delimitations, & Assumptions

Two limitations of this study were that it was a sample of convenience and a small sample size, which may limit the generalizability of the results. Since the participants used throughout this study do not represent the whole population, the results of this research may not be generalized to all women who have or have not experienced domestic violence. Another limitation of this study was that there was no question on the demographic survey regarding past history of domestic violence or type and severity of violence. If a woman had experienced domestic violence in the past, the long lasting

effects could potentially affect the data. The researcher also did not question whether or not the woman had sought support services related to abuse in the past, which may affect the results as well. A delimitation of this study was the selection criteria for participants. The women were required to be 18-50 years of age and to have at least one child under the age of 18 years in order to participate. This study only focused on women who had children and experienced domestic violence in the past six months. Three assumptions that the researcher made prior to beginning the study were: (a) there will be a difference in perceptions of occupational identity, volition, habituation, performance skills, environments, and perceptions of occupational competence between the two groups, (b) the women will report honestly and are capable of reflecting on these items on the tests, and (c) that the chosen tests will actually measure what they claim.

Chapter Four: Results

For this study, the researcher had a total of 34 participants that met the inclusion criteria. A summary of the results is presented in this chapter.

Characteristics of the Participants

The mean age of the participants (N=34) was 35.5 years, with a range of 24 to 50 years of age, mode of 47 years, and a standard deviation of 7.51. "Graduated from college" was identified as the highest level of education obtained by 44.1% of the participants (N=34). "Some college" was identified as the highest level of education obtained by 26.5% of the participants. "Graduated from high school or GED" was identified as the highest level of education obtained by 14.7% of the participants. "More than a college degree" was identified by 8.8% of the participants and 2.9% for each identified themselves as having completed "some high school" and "graduated from 8th grade".

Ninety-one percent of the participants (N=34) were currently in an intimate relationship (i.e. spouse, boyfriend, partner, significant other). The mean length of this relationship was 12.53 years, with a range of 2 to 26 years and a standard deviation of 7.07. Eighty-seven percent of participants (n=31) were currently living with their spouse, boyfriend, partner, or significant other. Eighty-seven percent of participants (n=31) reported that this relationship had been formalized (i.e. marriage, domestic partnership, civil union), and a mean age at which this occurred was 26.15 years (n=27). The mean age at which the relationship was formalized ranged from 16 to 46 years with a standard deviation of 6.38.

All of the participants were required to have at least one child under18 years of age. The mean number of children was 1.97, with a range of 1 to 5 children (mode = 1) under the age of 18 years. Fifty-nine percent of the participants (n=29) had children between the ages of 6 and 12 years. Thirty-one percent of the participants (n=29) had children 2 to 3 years of age. Twenty-eight percent of the participants (n=29) had children 0 to 1 year of age. Twenty-one percent of the participants (n=29) had children 4 to 5 years of age. Finally, 17.2% of the participants (n=29) had children 13 to 14 years of age and 20.7% (n=29) had children 15 to 18 years of age.

Eighty-four percent of the participants (n=32) reported that they felt safe in their current relationship. Twenty-four percent of the participants (n=33) reported that their intimate partner had threatened them in the past six (6) months. Nine percent of the participants (n=33) reported being physically hurt by their partner in the past six (6) months. Fifteen percent of the participants (n=33) reported that their intimate partner had abused the children in the past six (6) months.

An independent samples t-test was used to see if a significant difference existed between the study and control group for age, length of relationship, age the relationship was formalized, and the number of children under age 18. A significant difference was not found between the two groups for these variables (see Table 1 for details). A Mann-Whitney U Test was used to compare both groups for highest level of education obtained (n=33) and as can be seen in Figure 1 a significant difference was identified (U=47, p= .01). The control group was identified as having obtained a higher level of education as compared to the study group. A nominal by nominal crosstabulation was done to determine if there was a significant difference between the study and control groups for

current intimate relationship, currently living with that partner, relationship formalized, and having children in each of the specified age groups. A significant difference using Cramer's V was found for currently being in an intimate relationship (n=33, V = .39, p= .03). A significant difference was also found for currently living with that partner (n=31, V=.43, p= .02). A difference between the two groups was not identified in the remaining areas (see Table 2 for details).

Effects of Domestic Violence on Perception of Occupational Identity

An independent samples t-test was used to see if a significant difference existed between the study and control groups in each of the 29 gaps of the OSA. A significant difference (t(28)= -2.68, p=.02) was found in Gap 2 "Physically doing what I need to do" (M(abused)=.57, SD(abused)=.54; M(not abused)=-.13, SD(not abused)=.63). Gap 6 "Getting where I need to go" was found to have a significant difference (t(15.2)= -2.64, p=.02) (M(abused)=.14, SD(abused)=.38; M(not abused)=-.35, SD(not abused)=.57). A significant difference (t(27)= -2.21, p=.04) was found in Gap 8 "Managing my basic needs" (M(abused)=.43, SD(abused)=.79; M(not abused)=-.18, SD(not abused)=.59). Gaps 2, 6, and 8 were located in skills/occupational performance subsection under the "Myself" section of the OSA. Gap 24 "Basic things I need to live and take care of myself" had a significant difference (t(29)= -3.01, p=.01) (M(abused)=.75, SD(abused)=.89; M(not abused)=-.09, SD(not abused)=.60). A significant difference (t(29)= -2.05, p=.05) was identified in Gap 27 "People who do things with me" (M(abused)=.75, SD(abused)=1.04; M(not abused)=.04, SD(not abused)=.77). Both Gap 24 and 27 were located in the "My Environment" section of the OSA. The rest of the Gaps of the OSA were not found to have a significant difference (see Table 3 for details).

An independent samples t-test was used to determine if a significant difference between the study and control groups for each of the subsections of the OSA existed. A significant difference was not found for the skills/occupational performance, volition, habituation, and environment subsections (see Table 4 for details).

Effects of Domestic Violence on Perception of Occupational Competence

An independent samples t-test was used to see if a significant difference occurred between the study and control groups in each of the 12 domains of the Adult Self-Perception Profile. A significant difference ($t(28)=2.78$, $p=.01$) was found in the global self worth domain (M(abused)=2.13, SD(abused)=.63; M(not abused)=2.95, SD(not abused)=.75). The intimate relationships domain had a significant difference ($t(28)=3.44$, $p=.00$) (M(abused)=2.13, SD(abused)=.58; M(not abused)=3.11, SD(not abused)=.73). A significant difference ($t(27)=2.94$, $p=.01$) was found in the adequate provider domain (M(abused)=2.25, SD(abused)=.69; M(not abused)=3.21, SD(not abused)=.82). No significant differences existed between the study and control groups for the remaining domains (see Table 5 for details).

Chapter Five: Discussion

The number of participants for this study who reported experiencing domestic violence directly reflects with the national average that one-third of all women experience abuse at some point in their lives (National Domestic Violence Hotline, n.d.). Another study by Tjaden and Thoennes (2000) stated that nearly one-third of African American women and one-fourth of white women will experience domestic violence in their lifetimes. The only other demographic area of significance for this study was that the women who had not experienced abuse had a higher level of education when compared to women who had experienced abuse. According to the literature, there should be no difference because domestic violence occurs in all levels of education, socioeconomic statuses, races, religions, ethnicities, classes, families, and occupations (Neufeld, 1996; Women's Domestic Violence Helpline, n.d.). This surprising finding may simply be an artifact of how and where the researcher collected the data, which came from people who may have a higher socioeconomic status as a result of their education. According to 2000 census data, approximately 58% of Ithaca residents have a bachelor's degree or higher (ePodunk, 2005). It can be speculated that since Ithaca, New York has a very educated population (due to Ithaca College and Cornell University) that our small sample did not correlate with this finding.

How does experiencing domestic violence affect a woman's perception of her occupational identity?

The results of the Occupational Self-Assessment (OSA) found that significant differences existed in only 5 of the 29 gap scores. There was no difference found in any of the four major subsections including volition, habituation, performance skills, and

environment. However, differences were found in some of the individual items within the performance skills and the environment subsections. For example, in the area of performance skills, differences existed in the gaps entitled "Physically doing what I need to do", "Getting where I need to go", and "Managing my basic needs". As for the main area of environment, differences existed in the gaps entitled "Basic things I need to live and take care of myself" and "People who do things with me".

It was speculated that volition would be affected, but the results of this study did not show any significant difference between the study and control groups. Volition was thought to be affected because a woman who has experienced abuse may have difficulty establishing a sense of control over her decisions, her overall confidence level, and her ability to participate in her daily roles and occupations. Typically, women who have experienced abuse have been under their abusers' control for a long time and do not feel confident in making everyday decisions independently. The results of this study show that volition was not affected; however, further research would be needed in order to prove the actual impact of abuse on volition. It is suggested that further research focus on volitional issues such as a woman's sense of control over her decisions; her perception of her abilities and skills needed to participate in her daily roles; and her general interests and meaningful activities (Helfrich & Aviles, 2001).

The researcher also speculated that habituation would be affected by domestic violence. The result of this study shows that there was no significant difference in this area between the study and control groups. Habituation refers to issues regarding a woman's sense of control over her time and the way she uses a routine on a daily basis. It was speculated that habituation would be affected by domestic violence because of the

past research regarding the abusers' control and power over his victim and how little freedom most women who are abused experience. However, women may feel that since their daily occupations are so structured by their abusers, that their sense of habituation and routine are not affected by abuse. Further research would be needed in order to fully explore the impact of abuse on habituation and how it affects the woman's roles that help her to develop a sense of identity.

There was not a significant difference in performance skills and performance capacity between the study and control groups. It was speculated that this area would show a difference because domestic violence could possibly affect how a woman copes with abuse and how she participates in occupations. The woman may or may not feel like she has the adequate skills needed to cope with abuse, escape, and recover from her abusive relationship. She also may or may not be allowed to participate in the occupations that she once enjoyed or was obligated to do. According to Helfrich and Aviles (2001), the woman may lack performance skills such as basic work skills and life skills. The abuser typically has total control of the woman and does not allow her to hold a job. Occupations done in the home are typically under his control and need to be completed to his standards. Thus, the woman may lack basic life skills, such as budgeting, parenting, home management, and stress management, due to the abuser's high level of control (Helfrich & Aviles, 2001). A lack of significance in this area may indicate that the women have decreased insight into their actual abilities.

There was no significant difference found between the overall environments of the study and control groups. Since the environment becomes a barrier for a woman in an abusive relationship, it was speculated that the results of this study would show a

difference between the two groups. A significant difference was identified in the physical ("Basic things I need to live and take care of myself") and social ("People who do things with me") subcomponents of environment. The physical components of the environment, such as objects and spaces, may not be available to a woman who is being abused because her abuser may limit these components. According to the literature, the environment becomes a barrier for the woman because she is unable to participate in and perform the occupations of her choice and under her control if she is being abused in the home. The social components of the environment, such as family members and friends, may not be available to a woman because her abuser has isolated her from these sources of support. The woman will also not be able to perform her occupations if she does not have the social and physical supports needed to complete the tasks. Typically, the woman gives up occupations that used to give her satisfaction and a sense of accomplishment because she does not have the physical and social supports needed from her abusive environment (Helfrich & Aviles, 2001).

The study and control groups were very similar in all of the subsections covered in the OSA, but the gap scores that were identified as having a statistically significant difference show the areas where an intervention focus would be most appropriate to focus on for women who have experienced abuse. This study found that women who have experienced abuse have difficulty with physically participating in their daily routine, having transportation or locating public transportation, managing or having the resources to have her basic needs met, and having friends and/or family with whom to do activities. This result directly relates to the literature that suggests that the woman often is isolated from family and friends because her abuser does not allow her to be in contact with them

(Holtz & Furniss, 1993). Based on these findings and the literature, occupational therapy intervention could include activities of daily living (ADL's), accessing community resources (i.e. transportation), social skills, and time management techniques (Helfrich & Aviles, 2001; King & Ryan, 1989; Froehlich, 1992). Further research is needed in order to determine the efficacy of these proposed intervention strategies for women who have experienced abuse.

How does experiencing domestic violence affect a woman's perception of her occupational competence?

The results of the Adult Self Perception Profile found that there were statistically significant differences between the perceptions of occupational competence for the study and control groups in 3 out of the 12 domains. These included global self-worth, intimate relationships, and adequate provider. It is interesting to note that global self-worth was found to be of significance and volition was not. These two areas are very similar in scope; yet only one was found to be of significance. Global self-worth and volition are very similar by definition because both look at one's overall sense of self and how they play a role in their world. Global self-worth could have possibly been found to be significant because it is more specific to one's perception of worth as opposed to volition. Global self-worth only looks at how one feels about one's self and the level of self-esteem. A woman in an abusive relationship typically has a low self-esteem because of ongoing verbal and physical abuse by her abuser (Helfrich et al., 2001).

The domain of intimate relationships was identified as having a statistically significant difference because a woman who has experienced abuse is not going to have as meaningful interactions, as compared to the control group, with her boyfriend or

husband because of her abusive situation. The domain of adequate provider was identified as having a statistically significant difference because a woman who has experienced abuse typically has more difficulty in adequately supporting, both physically and socially, her abuser or her children. For example, typically, the abuser does not allow the woman to work, resulting in a lack of financial support for her family. Based on these findings, occupational therapy intervention for women who have experienced domestic violence could include increasing self-esteem; identifying roles and skills; introducing new occupations or bringing back a lost occupation; locating resources for counseling, shelters, and assistance; parenting skills; education; and vocational training. Further research would be needed to determine if these intervention strategies were effective for this population.

Chapter Six: Summary

In summary, the findings of this study may not be generalized as this study used a sample of convenience. It also only included women between the ages of 18-50 years who had at least one child under 18 years who had or had not experienced domestic violence in the past six months.

The results of the Occupational Self-Assessment (OSA) found that significant differences existed in only 5 out of 29 gap scores. There were no statistically significant differences found in any of the four subsections including volition, habituation, performance skills, and environment. However, statistically significant differences were found within the individual items of performance skills and the environment.

The results of the Adult Self-Perception Profile yielded statistically significant differences between the perceptions of occupational competence for the study and control groups in 3 out of 12 domains. A statistically significant difference was found in the domains of intimate relationships, adequate provider, and global self-worth. These findings potentially provide occupational therapists with areas to focus on during intervention, such as increasing self-esteem, addressing basic life skills, social skills, and role identification.

Based on these findings, it can be concluded that more research is necessary. Research is needed in more specific areas of volition, habituation, performance skills, and environment in order to determine if and how these areas are affected by domestic violence. This study looked at all of these dynamic areas together and how they affect one another instead of looking at them individually. Future studies should choose one area (i.e. volition) and identify whether or not that area is truly affected by domestic

violence. Research is also needed to determine the efficacy of the intervention strategies used for this population. Finally, more research is needed to determine the effects of domestic violence on specific occupations of women in order to develop effective intervention strategies.

This study was intended to be broad in the hopes that it would further spark an interest in research in the field of occupational therapy and domestic violence. Every therapist is likely to treat a woman or child affected by domestic violence sometime in their career and it is crucial to be aware of not only the signs and effects of abuse, but also the areas in which to focus for effective intervention.

Table 1

The Difference between Means of Numeric Demographic Information for Women Who Have Experienced Abuse vs. Women Who Have Not Experienced Abuse

Demographics	Abused		Not Abused		*t*	*df*	*p*
	M	*SD*	*M*	*SD*			
Age in years	33.30	8.03	36.52	7.40	1.12	31	.27
Length of relationship	11.38	5.68	12.93	7.57	.53	29	.60
Age relationship was formalized	27.50	6.35	25.76	6.50	-.58	25	.57
Number of children under 18 years	2.50	1.35	1.78	.90	-1.80	31	.08

Table 2

The Difference between Nominal Demographic Information for Women Who Have Experienced Abuse vs. Women Who Have Not Experienced Abuse

Demographics	Abused		Not Abused		*Cramer's V*	*p*
	Yes	*No*	*Yes*	*No*		
Current intimate relationship	80%	20%	100%	0%	.39	.03*
Currently living with partner	62.5%	37.5%	95.7%	4.3%	.43	.02*
Has relationship been formalized	75%	25%	91.3%	8.7%	.21	.24
Child 0-1 year	25%	75%	30%	70%	.05	.79
Child 2-3 years	50%	50%	25%	75%	.24	.20
Child 4-5 years	25%	75%	20%	80%	.06	.77
Child 6-12 years	75%	25%	50%	50%	.23	.23
Child 13-14 years	25%	75%	15%	85%	.12	.53
Child 15-18 years	12.5%	87.5%	25%	75%	.14	.47

*$p \leq .05$

Table 3

The Difference between Gaps on the Occupational Self-Assessment (OSA) for Women Who Have Experienced Abuse vs. Women Who Have Not Experienced Abuse

Gaps	Abused		Not Abused		*t*	*df*	*p*
	M (Yes)	*M(No)*	*M(Yes)*	*M(No)*			
Gap 1 – Concentrating on tasks	.13	.64	-.09	.52	-.94	29	.35
Gap 2 – Physically doing what I need to do	.57	.54	-.13	.63	-2.68	28	.01**
Gap 3 – Taking care of the place where I live	-.13	.99	.35	.78	1.38	29	.18
Gap 4 – Taking care of myself	.25	.71	.09	.67	-.586	29	.56
Gap 5 – Taking care of others for whom I am responsible	.13	.35	.17	.58	.23	29	.82
Gap 6 – Getting where I need to go	.14	.38	-.35	.57	-2.64	15.2	.02*
Gap 7 – Managing my finances	1.00	.93	.57	.95	-1.13	29	.27
Gap 8 – Managing my basic needs	.43	.79	-.18	.59	-2.21	27	.04*
Gap 9 – Expressing myself to others	.43	.79	.30	.82	-.35	28	.73
Gap 10 –Getting along with others	.13	1.46	-.17	.58	-.57	29	.41
Gap 11 – Identifying and solving problems	.13	1.13	.00	.60	-.40	29	.69
Gap 12 – Relaxing and enjoying myself	.86	1.22	.00	.74	-1.77	7.40	.12

*$p \leq .05$ **$p \leq .01$

Gaps	Abused		Not Abused		*t*	*df*	*p*
	M (Yes)	*M (No)*	*M(Yes)*	*M(No)*			
Gap 13 – Getting done what I need to do	.63	1.06	.09	.79	-1.52	29	.14
Gap 14 – Having a satisfying routine	.38	1.19	-.09	.61	-1.06	8.38	.32
Gap 15 – Handling my responsibilities	.13	.64	.26	.69	.49	29	.63
Gap 16 – Being involved	.50	1.07	-.35	.57	-2.14	8.44	.06
Gap 17 – Doing activities I like	.13	.64	-.26	.69	-1.39	29	.18
Gap 18 – Working towards my goals	.38	.74	.26	.96	-.30	29	.76
Gap 19 – Making decisions	.13	.64	-.17	.39	-1.58	29	.13
Gap 20 – Accomplishing what I set out to do	.25	1.04	.22	.85	-.09	29	.93
Gap 21 – Effectively using my abilities	.13	.99	.00	.85	-.34	29	.73
Gap 22 – A place to live and take care of myself	.50	.93	.09	.53	-1.18	8.70	.27
Gap 23 – A place where I can be productive	.50	.93	.09	.60	-1.18	9.11	.27
Gap 24 – Basic things I need to live and take care of myself	.75	.89	-.09	.60	-3.01	29	.01**
Gap 25 – Things I need to be productive	.13	1.13	.04	.37	-.20	7.52	.85
Gap 26 – People who support and encourage me	.50	1.20	.22	.67	-.64	8.59	.54

*$p \leq .05$ **$p \leq .01$

Gaps	Abused		Not Abused		*t*	*df*	*p*
	M (Yes)	*M (No)*	*M(Yes)*	*M(No)*			
Gap 27 – People who do things with me	.75	1.04	.04	.77	-2.05	29	.05*
Gap 28 – Opportunities to do things I value and like	.50	1.31	.13	.69	-.76	8.41	.47
Gap 29 – Places where I can go and enjoy myself	.38	1.06	.22	.74	-.47	29	.65

*$p \leq .05$ **$p \leq .01$

Table 4

The Difference between Subsection Subscores for the Occupational Self-Assessment (OSA) for Women Who Have Experienced Abuse vs. Women Who Have Not Experienced Abuse

Subsections	Abused		Not Abused		*t*	*df*	*p*
	M	*SD*	*M*	*SD*			
Skills/Occupational Performance	4.00	3.83	.68	4.76	-1.68	27	.11
Volition	1.00	2.83	.04	2.95	-.80	29	.43
Habituation	3.00	4.04	-.05	2.34	-1.90	7.32	.10
Environment	4.00	6.30	.64	2.63	-1.46	7.90	.18

Table 5

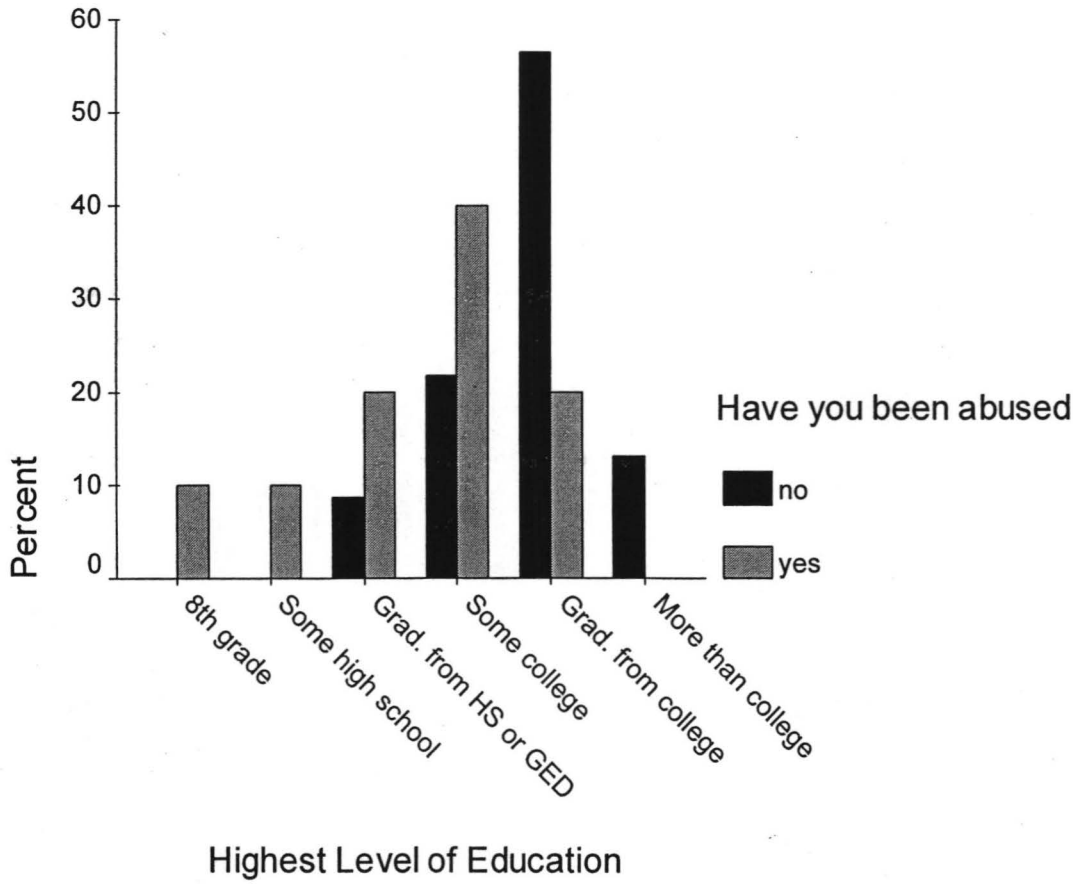
The Difference between Domain Subscores for the Adult Self Perception Profile for Women Who Have Experienced Abuse vs. Women Who Have Not Experienced Abuse

Domain	Abused		Not Abused		*t*	*df*	*p*
	M	*SD*	*M*	*SD*			
Global Self Worth	2.13	.63	2.95	.75	2.78	28	.01**
Sense of Humor	2.88	.58	3.05	.59	.74	29	.47
Intimate Relationships	2.13	.58	3.11	.73	3.44	28	.00**
Intelligence	2.63	.42	2.69	.73	.25	28	.81
Household Management	2.38	.84	3.04	.79	1.99	27	.06
Morality	2.97	.66	3.36	.54	1.66	28	.11
Adequate Provider	2.25	.69	3.21	.82	2.94	27	.01**
Physical Appearance	1.97	.67	2.34	.72	1.27	28	.22
Athletic Competence	1.72	.90	2.13	.80	1.19	28	.24
Nurturance	3.50	.58	3.50	.55	.00	27	1.00
Sociability	2.50	.77	2.83	.74	1.07	28	.29
Job Competence	3.03	.83	3.20	.84	.50	28	.62

** $p \leq .01$

Figure 1

Highest Level of Education Obtained by Women Who Have Experienced Abuse and Women Who Have Not Experienced Abuse



Appendix A

ALL-COLLEGE REVIEW BOARD
FOR
HUMAN SUBJECTS RESEARCH
COVER PAGE

Investigators: Brooke Arsenault, OTS
Department: Occupational Therapy
Telephone: (607) 273-7136 (518) 359-7685
(Campus) (Home)
Project Title: The Effects of Domestic Violence on Women's Occupations
Abstract: (Limit to space provided)

Domestic violence has become a very serious problem in today's society with as many as four (4) million women being abused each year. Domestic violence can include physical, emotional, sexual, and economic abuse (Helfrich, Lafata, MacDonald, Aviles, & Collins, 2001). Many cases go unnoticed by the woman's family, coworkers, friends, and even health care professionals.

The effects on the victim can be very serious and often difficult to treat. A woman can experience interference with her daily roles, occupations, and general functioning, especially in the areas of childcare and employment. Kielhofner (2002) defines human occupation as "the doing of work, play, or activities of daily living within a temporal, physical, and sociocultural context that characterizes human life". Long-term effects may include physical or mental disability, loss of role identity, loss of family ties and support systems, loss of employment, homelessness, and in the most severe cases, death (Helfrich, Lafata, MacDonald, Aviles, & Collins, 2001).

Domestic violence has become a major issue in the health care system and occurs across the lifespan from children to the elderly. Considerable research has been done in all allied health care fields, except occupational therapy. Research is needed in order to determine the efficacy, need, and role of occupational therapy treatment of abused clients, as well as the effects of abuse on occupations.

The purpose of this study is to identify the impact of being a victim of domestic violence on the occupations of women. This study will compare 15 to 20 women who have not experienced domestic violence to 15 to 20 women who have experienced domestic violence. The participants will be asked to fill out a survey, the Occupational Self-Assessment, and the Adult Self-Perception Profile. The survey will include demographic information and history of abuse (if any). The participants will be informed that their participation is voluntary and will be kept confidential throughout the study.

Proposed Date of Implementation: October 2003
Brooke Arsenault, OTS Sue Leicht, MS OTR/L BCN Marilyn Kane, MA OTR/L
Print or Type Name of Principal Investigator and Faculty Advisor

Signature (Use blue ink) Principal Investigator and Faculty Advisor

ALL-COLLEGE REVIEW BOARD
FOR
HUMAN SUBJECTS RESEARCH
CHECKLIST

Project Title: The Effects of Domestic Violence on Women's Occupations

Investigator(s): Brooke Arsenault, OTS

Investigator HSR Use	Use Only Items for Checklist
x	1. General information
x	2. Related experience of investigator(s)
x	3. Benefits of the study
x	4. Description of subjects
x	5. Description of subject participation
x	6. Description of ethical issues/risks of participation
x	7. Description of recruitment of subjects
x	8. Description of how anonymity/confidentiality will be maintained.
x	9. Debriefing statement
x	10. Compensatory follow-up
x	11. Appendix A - Recruitment Statement
x	12. Appendix B - Informed Consent Form (or tear-off Cover Page for anonymous paper and pen/pencil surveys)
NA	13. Appendix C - Debriefing Statement
x	14. Appendix D - Survey Instruments
NA	15. Appendix E - Glossary to questionnaires, etc.

Items 1-8, 11, and 12 must be addressed and included in the proposal. Items 9, 10, and 13-15 should also be checked if they are appropriate - indicate "NA" if not appropriate. This should be the second page of the proposal.

Human Subjects Proposal

1. General Information about the Study

a. **Funding:** There are no external sources of funding for this project. All costs will be met by the Occupational Therapy Department as part of its graduate curricular expenses and the graduate student.
b. **Location:** This study will be conducted at a local advocacy center, women's shelter, a mall, and a grocery store through the use of a survey and two OT self-assessments. All data will be analyzed at Ithaca College.
c. **Time Period:** The surveys will be administered beginning in October of 2003 and data will be collected until the end of the fall semester. The research project will be completed by March 2003.
d. **Expected Outcome:** The results of this study will be used as part of the principal researcher's thesis. The results may be presented at a professional conference and eventually published in a professional journal.

2. Related Experience of the Researcher and Faculty Advisors

Brooke Arsenault is an occupational therapy graduate student. Her research experience is limited to the occupational therapy curriculum at Ithaca College. Related courses include Research Methods in Occupational Therapy, Research Methods Seminar, and Biostatistics. She has written a literature review on domestic violence from an occupational therapy perspective.

The faculty advisors for this study are Sue Leicht, MS OTR/L, BCN and Marilyn Kane, MS OTR/L. Sue Leicht has been an occupational therapist for 21 years with experience and Specialty Certification in Neurological Rehabilitation. She has also undertaken several extensive advanced training courses related to the evaluation and treatment of client's with Cerebral Vascular Accident (CVA)/Stroke. As part of both her undergraduate and graduate studies she has taken several courses in statistics and research design. As a faculty member in occupational therapy she teaches in both the clinical courses related to stroke at both the undergraduate and graduate level and research methods courses. Sue has also been involved in several research projects including the investigation of Reflex Sympathetic Dystrophy in CVA patients and Clinical Reasoning of Occupational Therapists. She is currently conducting research (with assistant professor Marilyn Kane of Ithaca College) on using the Dynavision 2000 to improve occupational performance in post-CVA clients. Sue has conducted another group research projects: one looking at the Hand Function of Children with an experienced and award winning researcher from Cornell University, the other looking at the relationship of motor return after CVA and functional performance. She is also writing a doctoral research proposal for her doctoral studies at the University of Queensland in the area of upper extremity return after a CVA, evidenced based practice and clinical reasoning.

Marilyn Kane is an assistant professor in the occupational therapy department. She has been an occupational therapist for approximately 30 years. She has been involved in assessment tool and program development (Functional Needs Assessment for Chronic Psychiatric Patients), and the associated analysis of the tool/program effectiveness with that population. She has successfully supervised four (4) graduate student theses and one group research course (six [6] graduate students). She is currently

conducting research (with assistant professor Susan Leicht of Ithaca College) on using the Dynavision 2000 to improve occupational performance in post-CVA clients. She is also conducting research (with assistant professor Donna Twardowski) on the effectiveness of using a disability simulation learning experience with occupational therapy students to change attitudes towards individuals with disabilities.

3. Benefits of the Study

There is a lack of research and literature concerning the effects of domestic violence on a woman's occupations. This study would provide insight into how domestic violence impacts the occupations of women. This is necessary in order to be able to design future occupational therapy intervention programs for clients who have experienced abuse.

No direct benefits to the subjects are expected.

4. Description of Subjects

This study will compare approximately 15 to 20 women who have not experienced domestic violence to approximately 15 to 20 women who have experienced domestic violence. Women will be selected from a sample of convenience by contacting a local advocacy center and women's shelter. Subject recruitment will also take place by surveying women randomly at a local mall or grocery store. Subjects must meet the following criteria: 1) have at least one child under the age of 18; 2) is 18-50 years of age; 3) 15 to 20 subjects have experienced domestic violence in last six months and 15 to 20 subjects have never experienced domestic violence. Subjects must have children in order to determine how parenting and childcare occupations are affected by domestic violence. Research shows that the highest rates of violence among women occur between the ages of 18-29 years (Low, Monarch, Hartman, & Markman, 2002). Subjects must be in the age range of 18-50 years of age because this age group is most likely to have younger children. The researcher would like to have abuse experienced within the past six months in order to determine the acute, immediate effects that abuse has had on a woman's overall lifestyle.

5. Description of Subject Participation

The subjects will voluntarily complete a survey, which will ask demographic information and history of domestic violence (see Appendix D). A tear-off cover page describing the study will be attached to the surveys. The subjects will be informed that by returning the surveys, they will be demonstrating informed consent (see Appendix B). Following the survey, the women will then be assessed using the Occupational Self-Assessment (OSA) (see Appendix D), in order to determine how a woman's occupations are affected by domestic violence as compared to a woman who has not experienced domestic violence. Finally, the subjects will be asked to fill out the Adult Self-Perception Scale (see Appendix D), which measures the individual's perceived competency in different domains of their life. Total time to complete survey and both assessments is approximately 15-30 minutes. The subjects will be asked to place their surveys and assessments in a drop box.

Regional women's advocacy centers will be contacted and through an agreement with management, the researcher will survey random women. The researcher will read

the recruitment statement (see Appendix A) and the subjects will read the tear-off cover page, fill out the survey, and complete both the Occupational Self-Assessment and the Adult Self-Perception Scale. Informed consent is assumed by the subjects returning the surveys. In the event that women's advocacy centers wish to distribute and collect the surveys without the researcher present, the subjects will be recruited through an anonymous mail survey. Regional agencies will be contacted through a phone call and asked if the surveys may be sent to their facility. Upon receiving the surveys, the director will be required to read the alternate recruitment statement (see Appendix A) to the subjects and later mail the completed anonymous surveys to the OT department at Ithaca College.

6. Ethical Issues

a. Risks of Participation

Minimal risk is anticipated for this study. It is possible that the subjects may feel uncomfortable with some of the subject matter; however, they will be informed that if this does occur they can choose whether or not to answer the question.

b. Informed Consent

Informed consent is unnecessary for this study because it is assumed by the subject returning the surveys. Anonymity is not possible because the primary researcher will be in contact with the subjects while collecting data. A tear-off cover page describing the study will be attached to the surveys (see Appendix B).

7. Recruitment of Subjects

a. Recruitment Procedures

Regional public sites, such as grocery stores and malls, as well as regional women's advocacy centers will be contacted and through an agreement with management, the researcher will survey random women. The researcher will read the recruitment statement (see Appendix A) and the subjects will read the tear-off cover page, fill out the survey, and complete both the Occupational Self-Assessment and the Adult Self-Perception Scale. Informed consent is assumed by the subjects returning the surveys.

In the event that women's advocacy centers wish to distribute and collect the surveys without the researcher present, the subjects will be recruited through an anonymous mail survey. Regional agencies will be contacted through a phone call and asked if the surveys may be sent to their facility. Upon receiving the surveys, the director will be required to read the alternate recruitment statement (see Appendix A) to the subjects and later mail the completed anonymous surveys to the OT department at Ithaca College.

b. Inducement to Participate

No inducement to participate will be provided in this study.

8. Confidentiality/Anonymity of Responses

The subjects will be informed that their information will be held confidential. Anonymity of responses will be attempted by offering a drop box for all responses and no names will be recorded on data sheets.

9. Debriefing

The subjects will be informed that they can receive a report of the results by contacting the primary researcher. No other debriefing is necessary.

10. Compensatory Follow-Up

No compensatory follow-up will be needed or offered for this study.

Recruitment Statement

"The purpose of this study is to determine how domestic violence affects women during their daily activities as compared to women who have never experienced domestic violence. The study is designed to determine what areas of a woman's daily routine and roles are most affected by abuse. The information gathered through these surveys will help occupational therapists to design more effective intervention programs for their clients who have experienced abuse.

I realize that this may be a sensitive subject and that some questions may be difficult to answer. All surveys are to be held completely confidential. Please do not write your name or any identifying information anywhere on the surveys. You may withdraw at any time prior to or while filling out the surveys. You must be a woman between the ages of 18 and 50 years old and have at least one child under the age of 18 years in order to participate in this study. Thank you for assisting me in my research. Do you have any questions?"

Alternate Recruitment Statement
(To be used in women's advocacy centers)

Dear (Name of Director),

Thank you in advance for helping me to obtain research data in this sensitive, yet important area. Your assistance is truly appreciated. In attempting to maximize the results of this effort, it is important to help the various participants understand the purpose of the study. At the same time, it is equally important to assure them that their participation is completely anonymous and strictly confidential. I'm sure your reassurance in that regard will go a long way in setting the tone for a successful data gathering effort.

As a suggested approach, I would like to recommend that you hand out the survey packet to women in as comfortable setting as possible. Afterwards, please read the following to the women as a means of educating them to the purpose and desired outcomes of the study:

"The purpose of this study is to determine how domestic violence affects women during their daily activities as compared to women who have never experienced domestic violence. The study is designed to determine what areas of a woman's daily routine and roles are most affected by abuse. The information gathered through these surveys will help occupational therapists to design more effective intervention programs for their clients who have experienced abuse.
I realize that this may be a sensitive subject and that some questions may be difficult to answer. All surveys are to be held completely confidential. Please do not write your name or any identifying information anywhere on the surveys. You may withdraw at any time prior to or while filling out the surveys. You must be a woman between the ages of 18 and 50 years old and have at least one child under the age of 18 years in order to participate in this study. Thank you for assisting me in my research. Do you have any questions?"

Again, thank you for helping me conduct this important research. Please contact me at (607) 273-7136 if you have any questions or comments.

Sincerely,

Brooke Arsenault, BS

Tear-Off Cover Page
The Effects of Domestic Violence on Women's Occupations

My name is Brooke Arsenault and I am a graduate occupational therapy student at Ithaca College. I am conducting research for my thesis on how a woman's roles, daily activities, and employment are affected by domestic violence. As part of that research, I am conducting a survey for women who have never been abused, as well as women who have been abused. Following the survey, you will be asked to complete two (2) self-rating questionnaires regarding the different roles and activities that you participate in throughout your life. The survey and questionnaires should take approximately 15-30 minutes to complete. The information obtained is intended to assist occupational therapists in developing intervention programs for women who have experienced abuse. There are no direct benefits of this study expected for completing this survey and questionnaires. Please feel free to leave any questions blank and/or stop filling out this survey at any time. If you find any of the issues discussed in this survey to be disturbing, please feel free to contact your local Advocacy Center or physician for assistance.

When you have completed the survey and questionnaires, please place them in the drop box located on the table. Feel free to return a blank or incomplete survey. **PLEASE DO NOT WRITE YOUR NAME ANYWHERE ON THIS SURVEY.**

PLEASE DO NOT FILL THIS SURVEY OUT IF YOU ARE UNDER THE AGE OF 18 OR OVER THE AGE OF 50.

Please tear this page off and keep it for your records. Informed consent is implied when you return this survey and questionnaires. Thank you for assisting in my research.

Brooke Arsenault
Occupational Therapy
Ithaca College

Appendix B

The Effects of Domestic Violence on a Woman's Occupations

Brooke Arsenault
Occupational Therapy Graduate Student

Directions: Please fill in or circle the answer that best describes you.

1. What is your current age? _____
2. How many years of schooling have you completed:
   a. ____ More than a college degree
   b. ____ Graduate from college
   c. ____ Some college
   d. ____ Graduated from high school or GED
   e. ____ Some high school
   f. ____ Graduated from 8th grade
   g. ____ Less than 8th grade
3. Are you currently in an intimate relationship (i.e. spouse, boyfriend, partner, significant other)?
   Yes If you answered **yes**, please proceed to question 4.
   No If you answered **no**, please proceed to question 7.
   4. How long has this relationship been established? _____
5. Are you currently living with your spouse/boyfriend, partner/significant other?
   Yes No
6. Has this relationship been formalized (i.e. marriage, domestic partnership, civil union)?
   Yes No
   a. If **yes**: At what age was your relationship formalized (i.e. marriage, domestic partnership, civil union)? _____
7. Are you currently the guardian/caregiver/parent of one or more children under age 18?
   Yes No
   a. If **yes**: How many children under age 18? _____
   b. Please list the age of each child: _____
8. Do you feel safe in your relationship?
   Yes No
9. In the last six (6) months, has your partner ever threatened you?
   Yes No
10. In the last six (6) months, have you been physically hurt by your partner?
    Yes No
11. In the last six (6) months, has your partner abused the children?
    Yes No

Appendix C

Occupational Self Assessment Follow-up Form

Myself

Step 1: Below are statements about things you do in everyday life. For each statement, *circle* how well you do it. If an item does not apply to you, cross it out and move on to the next item.

Step 2: Next, for each statement *circle* how important this is to you.

	I have a problem doing this.	I do this all right.	I do this well.	This is not so important to me.	This is important to me.	This is extremely important to me.
Concentrating on my tasks.	Problem	All right	Well	Not so important	Important	Extremely important
Physically doing what I need to do.	Problem	All right	Well	Not so important	Important	Extremely important
Taking care of the place where I live.	Problem	All right	Well	Not so important	Important	Extremely important
Taking care of myself.	Problem	All right	Well	Not so important	Important	Extremely important
Taking care of others for whom I am responsible.	Problem	All right	Well	Not so important	Important	Extremely important
Getting where I need to go.	Problem	All right	Well	Not so important	Important	Extremely important
Managing my finances.	Problem	All right	Well	Not so important	Important	Extremely important
Managing my basic needs (food, medicine).	Problem	All right	Well	Not so important	Important	Extremely important
Expressing myself to others.	Problem	All right	Well	Not so important	Important	Extremely important
Getting along with others.	Problem	All right	Well	Not so important	Important	Extremely important
Identifying and solving problems.	Problem	All right	Well	Not so important	Important	Extremely important
Relaxing and enjoying *myself.*	Problem	All right	Well	Not so important	Important	Extremely important
Getting done what I need to do.	Problem	All right	Well	Not so important	Important	Extremely important
Having a satisfying routine.	Problem	All right	Well	Not so important	Important	Extremely important
Handling my responsibilities.	Problem	All right	Well	Not so important	Important	Extremely important
Being involved as a student, worker, volunteer, and/or family member.	Problem	All right	Well	Not so important	Important	Extremely important
Doing activities I like.	Problem	All right	Well	Not so important	Important	Extremely important
Working towards my goals.	Problem	All right	Well	Not so important	Important	Extremely important
Making decisions based on what I think is important.	Problem	All right	Well	Not so important	Important	Extremely important
Accomplishing what I set out to do.	Problem	All right	Well	Not so important	Important	Extremely important
Effectively using my abilities.	Problem	All right	Well	Not so important	Important	Extremely important

Occupational Self Assessment Follow-up Form
My Environment

Step 1: Below are statements about your environment (where you live, work, go to school, etc.). For each statement, *circle* how this is for you. If an item does not apply to you, cross it out and move on to the next item.

Step 2: Next, for each statement *circle* how important this aspect of your environment is to you.

	I have a problem doing this.	I do this all right.	I do this well.	This is not so important to me.	This is important to me.	This is extremely important to me.
A place to live and take care of myself.	Problem	All right	Well	Not so important	Important	Extremely important
A place where I can be productive (work, study, volunteer).	Problem	All right	Well	Not so important	Important	Extremely important
The basic things I need to live and take care of myself.	Problem	All right	Well	Not so important	Important	Extremely important
The things I need to be productive.	Problem	All right	Well	Not so important	Important	Extremely important
People who support and encourage me.	Problem	All right	Well	Not so important	Important	Extremely important
People who do things with me.	Problem	All right	Well	Not so important	Important	Extremely important
Opportunities to do things I value and like.	Problem	All right	Well	Not so important	Important	Extremely important
Places where I can go and enjoy myself.	Problem	All right	Well	Not so important	Important	Extremely important

Appendix D
WHAT I AM LIKE

These are statements which allow people to describe themselves. There are no right or wrong answers since people differ markedly. Please read the entire sentence across. *First* decide which one of the two parts of each statement best describes you; then go to that side of the statement and check whether that is just *sort* of true for you or *really* true for you. You will just check ONE of the four columns for each statement.

	Really True for Me	Sort of True for Me				Sort of True for Me	Really True for Me
1.	____	____	Some adults like the way they are leading their lives.	**BUT**	Other adults don't like the way they are leading their lives.	____	____
2.	____	____	Some adults feel that they are enjoyable to be with.	**BUT**	Other adults often question whether they are enjoyable to be with.	____	____
3.	____	____	Some adults are not satisfied with the way they do their work.	**BUT**	Other adults are satisfied with the way they do their work.	____	____
4.	____	____	Some adults see caring or Nurturing others as a contribution to the future.	**BUT**	Other adults do not gain a sense of contribution to the future through nurturing others.	____	____
5.	____	____	In games and sports some adults usually watch instead of play.	**BUT**	Other adults usually play rather than just watch.	____	____
6.	____	____	Some adults are happy with the way they look.	**BUT**	Other adults are not happy with the way they look.	____	____
7.	____	____	Some adults feel they are not adequately supporting themselves and those who are important to them.	**BUT**	Other adults feel they are providing adequate support for themselves and others.	____	____
8.	____	____	Some adults live up to their own moral standards.	**BUT**	Other adults have trouble living up to their moral standards.	____	____
9.	____	____	Some adults are very happy being the way they are.	**BUT**	Other adults would like to be different.	____	____
10.	____	____	Some adults are not very organized in completing household tasks.	**BUT**	Other adults are organized in completing household tasks.	____	____
11.	____	____	Some adults have the ability to develop intimate relationships.	**BUT**	Other adults do not find it easy to develop intimate relationships.	____	____
12.	____	____	When some adults don't understand something, it makes them feel stupid.	**BUT**	Other adults don't necessarily feel stupid when they don't understand.	____	____

	Really True for Me	Sort of True for Me			Sort of True for Me	Really True for Me
13.	_____	_____	Some adults can really laugh at themselves.	**BUT**	Other adults have a hard time laughing at themselves.	_____ _____
14.	_____	_____	Some adults feel uncomfortable when they have to meet new people.	**BUT**	Other adults like to meet new people.	_____ _____
15.	_____	_____	Some adults feel they are very good at their work.	**BUT**	Other adults worry about whether they can do their work.	_____ _____
16.	_____	_____	Some adults do not enjoy fostering the growth of others.	**BUT**	Other adults enjoy fostering the growth of others.	_____ _____
17.	_____	_____	Some adults sometimes question whether they are a worthwhile person.	**BUT**	Other adults feel that they are a worthwhile person.	_____ _____
18.	_____	_____	Some adults think they could do well at just about any new physical activity they haven't tried before.	**BUT**	Other adults are afraid they might not do well at physical activities they haven't ever tried.	_____ _____
19.	_____	_____	Some adults think that they are not very attractive or good looking.	**BUT**	Other adults think that they are attractive or good looking.	_____ _____
20.	_____	_____	Some adults are satisfied with how they provide for the important people in their lives.	**BUT**	Other adults are dissatisfied with how they provide for these people.	_____ _____
21.	_____	_____	Some adults would like to be a better person morally.	**BUT**	Other adults think that they are quite moral.	_____ _____
22.	_____	_____	Some adults can keep their household running smoothly.	**BUT**	Other adults have trouble keeping their household running smoothly.	_____ _____
23.	_____	_____	Some adults find it hard to establish intimate relationships.	**BUT**	Other adults do not have difficulty establishing intimate relationships.	_____ _____
24.	_____	_____	Some adults feel that they are intelligent.	**BUT**	Other adults question whether they are very intelligent.	_____ _____
25.	_____	_____	Some adults are disappointed with themselves.	**BUT**	Other adults are quite pleased with themselves.	_____ _____
26.	_____	_____	Some adults find it hard to act in a joking or kidding manner with friends or colleagues.	**BUT**	Other adults find it very easy to joke or kid around with friends and colleagues.	_____ _____
27.	_____	_____	Some adults feel at ease with other people.	**BUT**	Other adults are quite shy.	_____ _____

	Really True for Me	Sort of True for Me				Sort of True for Me	Really True for Me
28.	_____	_____	Some adults are not very productive in their work.	**BUT**	Other adults are very productive in their work.	_____	_____
29.	_____	_____	Some adults feel they are good at nurturing others.	**BUT**	Other adults are not very nurturant.	_____	_____
30.	_____	_____	Some adults do not feel that they are very good when it comes to sports.	**BUT**	Other adults feel they do very well at all kinds of sports.	_____	_____
31.	_____	_____	Some adults like their physical appearance the way it is.	**BUT**	Other adults do not like their physical appearance	_____	_____
32.	_____	_____	Some adults feel they cannot provide for the material necessities of life.	**BUT**	Other adults feel they do adequately provide for the Material necessities of life.	_____	_____
33.	_____	_____	Some adults are dissatisfied with themselves.	**BUT**	Other adults are satisfied with themselves.	_____	_____
34.	_____	_____	Some adults usually do what they know is morally right.	**BUT**	Other adults often don't do what they know is morally right.	_____	_____
35.	_____	_____	Some adults are not very efficient in managing activities at home.	**BUT**	Other adults are efficient in managing activities at home.	_____	_____
36.	_____	_____	Some people seek out close relationships.	**BUT**	Other persons shy away from close relationships.	_____	_____
37.	_____	_____	Some adults do not feel they are very intellectually capable.	**BUT**	Other adults feel that they are intellectually capable.	_____	_____
38.	_____	_____	Some adults feel they have a good sense of humor.	**BUT**	Other adults wish their sense of humor was better.	_____	_____
39.	_____	_____	Some adults are not very sociable.	**BUT**	Other adults are sociable.	_____	_____
40.	_____	_____	Some adults are proud of their work.	**BUT**	Other adults are not very proud of what they do.	_____	_____
41.	_____	_____	Some adults like the kind of person they are.	**BUT**	Other adults would like to be someone else.	_____	_____
42.	_____	_____	Some adults do not enjoy nurturing others.	**BUT**	Other adults enjoy being nurturant.	_____	_____
43.	_____	_____	Some adults feel they are better than others their age at sports.	**BUT**	Other adults don't feel they can play as well.	_____	_____
44.	_____	_____	Some adults are unsatisfied with something about their face or hair.	**BUT**	Other adults like their face and hair the way they are.	_____	_____

	Really True for Me	Sort of True for Me				Sort of True for Me	Really True for Me
45.	_____	_____	Some adults feel that they provide adequately for the needs of those who are important to them.	**BUT**	Other adults feel they do not provide adequately for these needs.	_____	_____
46.	_____	_____	Some adults often question the morality of their behavior.	**BUT**	Other adults feel that their behavior is usually moral.	_____	_____
47.	_____	_____	Some adults use their time efficiently at household activities.	**BUT**	Other adults do not use their time efficiently.	_____	_____
48.	_____	_____	Some adults in close relationships have a hard time communicating openly.	**BUT**	Other adults in close relationships feel that it is easy to communicate openly.	_____	_____
49.	_____	_____	Some adults feel like they are just as smart as other adults.	**BUT**	Other adults wonder if they are as smart.	_____	_____
50.	_____	_____	Some adults feel that they are often too serious about their life.	**BUT**	Other adults are able to find humor in their life.	_____	_____

References

American Occupational Therapy Association, Inc. (2004). *What is occupational therapy?* Retrieved November 1, 2004, from http://www.aota.org

American Psychiatric Association. (1994). *Desk reference to the diagnostic criteria from DSM-IV.* Washington, DC: American Psychiatric Association, Inc.

AMPS. (2003). *Assessment of motor and process skills.* Retrieved April 12, 2004, from http://www.ampsintl.com

Baron, K., Kielhofner, G., Goldhammer, V., & Wolenski, J. (1999). *A user's manual for the occupational self-assessment, version 1.0.* Chicago: Model of Human Occupation Clearinghouse.

Browne, A. (1997). Violence in marriage: Until death do us part? In A.P. Cardarelli (Ed.), *Violence between intimate partners: Patterns, causes, and effects* (pp. 48-69). Boston: Allyn and Bacon.

Centre for Social Development and Humanitarian Affairs. (1993). Strategies *for confronting domestic violence: A resource manual.* New York: United Nations Publications.

Commission on Practice, American Occupational Therapy Association. (2002). Occupational therapy practice framework: Domain and process. *American Journal of Occupational Therapy, 56,* 609-639.

Conner, M.G. (2004). *About domestic violence against women.* Retrieved January 3, 2005, from http://www.crisiscounseling.com

Council on Ethical and Judicial Affairs, American Medical Association. (1992). Physicians and domestic violence: Ethical considerations. *Journal of American Medical Association, 267*(23), 3190-3193.

Crisis Support Network. (2003). *The cycle of violence.* Retrieved November 20, 2003, from http://crisis-support.org

ePodunk. (2005). *Ithaca, NY: Education.* Retrieved January 28, 2005, from http://www.epodunk.com

Fauman, M.A. (1994). *Study guide to DSM-IV.* Washington, DC: American Psychiatric Press, Inc.

Froehlich, J. (1992). Occupational therapy interventions with survivors of sexual abuse. *Occupational Therapy in Health Care, 8*(2-3), 1-25.

Gosselin, D.K. (2003). *Heavy hands: An introduction to the crimes of family violence* (2nd Ed.). Upper Saddle River, NJ: Prentice Hall.

Groetsch, M. (1996). *The battering syndrome: Why men beat women and the professional's guide to intervention.* Brookfield, WI: CPI Publishing.

Helfrich, C.A., & Aviles, A. (2001). Occupational therapy's role with victims of domestic violence: Assessment and intervention. *Occupational Therapy in Mental Health, 16*(3/4), 53-70.

Helfrich, C.A., Lafata, M.L., MacDonald, S.L., Aviles, A., & Collins, L. (2001). Domestic abuse across the lifespan: Definitions, identification, and risk factors for occupational therapists. *Occupational Therapy in Mental Health, 16*(3/4), 5-34.

Helpguide. (2004). *Domestic violence and abuse: Types, signs, symptoms, causes, and effects.* Retrieved January 4, 2005, from http://www.helpguide.org

Henry, A.D., Baron, K.B., Mouradian, L., & Curtin, C. (1999). Reliability and validity of the self-assessment of occupational functioning. *The American Journal of Occupational Therapy, 53*(5), 482-488.

Holtz, H., & Furniss, K.K. (1993). The health care provider's role in domestic violence. *Trends in Health Care, Law & Ethics, 8*(2), 47-53.

Howard, B.S., & Howard, J.R. (1997). Occupation as spiritual activity. *American Journal of Occupational Therapy, 51*, 181-185.

Jaffe, P., Wolfe, D.A., Wilson, S., & Zak, L. (1986). Emotional and physical health problems of battered women. *Canadian Journal of Psychiatry, 31*(7), 625-629.

Johnston, J.L., Adams, R., & Helfrich, C.A. (2001). Knowledge and attitudes of occupational therapy practitioners regarding wife abuse. *Occupational Therapy in Mental Health, 16*(3/4), 35-52.

Keller, L. (1996). Invisible victims: Battered women in psychiatric and medical emergency rooms. *Bulletin of the Menninger Clinic, 60*(1), 1-21.

Kielhofner, G. (2002a). Dimensions of doing. In G. Kielhofner (Ed.), *Model of human occupation: Theory and application* (3rd ed., pp. 114-123). Philadelphia: Lippincott Williams & Wilkins.

Kielhofner, G. (2002b). The environment and occupation. In G. Kielhofner (Ed.), *Model of human occupation: Theory and application* (3rd ed., pp. 99-113). Philadelphia: Lippincott Williams & Wilkins.

Kielhofner, G. (2002c). Habituation: Patterns of daily occupation. In G. Kielhofner (Ed.), *Model of human occupation: Theory and application* (3rd ed., pp. 63-80). Philadelphia: Lippincott Williams & Wilkins.

Kielhofner, G. (2002d). Introduction to the model of human occupation. In G. Kielhofner (Ed.), *Model of human occupation: Theory and application* (3rd ed., pp. 1-9). Philadelphia: Lippincott Williams & Wilkins.

Kielhofner, G. (2002e). Volition. In G. Kielhofner (Ed.), *Model of human occupation: Theory and application* (3rd ed., pp. 44-62). Philadelphia: Lippincott Williams & Wilkins.

Kielhofner, G. (2004). The Model of Human Occupation. In G. Kielhofner (Ed.), *Conceptual foundations of occupational therapy* (3rd ed., pp. 147-170). Philadelphia: F.A. Davis Company.

Kielhofner, G., & Forsyth, K. (2002a). How to know the client best: Choosing and using structured means of gathering information. In G. Kielhofner (Ed.), *Model of human occupation: Theory and application* (3rd ed., pp. 280-295). Philadelphia: Lippincott Williams & Wilkins.

Kielhofner, G., & Forsyth, K. (2002b). Thinking with theory: A framework for therapeutic reasoning. In G. Kielhofner (Ed.), *Model of human occupation: Theory and application* (3rd ed., pp. 162-178). Philadelphia: Lippincott Williams & Wilkins.

Kielhofner, G., Forsyth, K., de las Heras, C.G., Hayashi, J., Melton, J., & Raymond, L. (2002). Observational assessments. In G. Kielhofner (Ed.), *Model of human occupation: Theory and application* (3rd ed., pp. 191-212). Philadelphia: Lippincott Williams & Wilkins.

Kielhofner, G., Forsyth, K., Federico, J., Henry, A., Keponen, R., Oakley, F., & Pan, A. (2002). Self-report assessments. In G. Kielhofner (Ed.), *Model of human*

occupation: Theory and application (3rd ed., pp. 213-236). Philadelphia: Lippincott Williams & Wilkins.

Kielhofner, G., Tham, K., Baz, T., & Hutson, J. (2002). Performance capacity and the lived body. In G. Kielhofner (Ed.), *Model of human occupation: Theory and application* (3rd ed., pp. 81-98). Philadelphia: Lippincott Williams & Wilkins.

King, M.C., & Ryan, J. (1989). Abused women: Dispelling myths and encouraging intervention. *Nurse Practitioner: American Journal of Primary Health Care, 14*(5), 47-54.

Koch, M. (2001). Occupational therapy and victim advocacy: Making the connection. *Occupational Therapy in Mental Health, 16*(3/4), 97-110.

Landenburger, K. (1989). A process of entrapment in and recovery from an abusive relationship. *Issues in Mental Health Nursing, 10*(3-4), 209-227.

Lempert, L.B. (1996). Women's strategies for survival: Developing agency in abusive relationships. *Journal of Family Violence, 11*(3), 269-289.

Low, S.M., Monarch, N.D., Hartman, S., & Markman, H. (2002). Recent therapeutic advances in the prevention of domestic violence. In P.A. Schewe (Ed.), *Preventing violence in relationships: Interventions across the life span* (pp. 197-221). Washington, D.C.: American Psychological Association.

McColl, M.A. (2002). The foundation: Occupation in stressful times. *The American Journal of Occupational Therapy, 56*(3), 350-353.

Merritt-Gray, M., & Wuest, J. (1995). Counteracting abuse and breaking free: The process of leaving revealed through women's voices. *Health Care for Women International, 16*(5), 399-412.

Messer, B., & Harter, S. (1986). *Manual for the adult self-perception profile.* Denver, CO: University of Denver.

Miller, S.L., & Wellford, C.F. (1997). Patterns and correlates of interpersonal violence. In A.P. Cardarelli (Ed.), *Violence between intimate partners: Patterns, causes, and effects* (pp. 16-28). Boston: Allyn and Bacon.

National Domestic Violence Hotline, Texas Council on Family Violence. (n.d.). *What is domestic violence: National statistics.* Retrieved March 18, 2004, from http://www.ndvh.org

Neistadt, M.E., & Crepeau, E.B. (1998). Introduction to occupational therapy. In M.E. Neistadt & E.B. Crepeau (Eds.), *Willard & spackman's occupational therapy* (pp. 5-12). New York, NY: Lippincott.

Neufeld, B. (1996). SAFE questions: Overcoming barriers to the detection of domestic violence. *American Family Physician, 53*(8), 2575-2580.

Professional Development Resources. (n.d.). *Domestic violence II: Intimate partner violence.* Retrieved January 28, 2005, from http://www.pdresources.org

Salber, P.R., & Taliaferro, E. (1995). *The physician's guide to domestic violence.* Volcano, CA: Volcano Press.

Stark, E., & Flitcraft, A. (1988). Women and children at risk: A feminist perspective on child abuse. *International Journal of Health Services, 18*(1), 97-118.

Taylor, S.E., Klein, L.C., Lewis, B., Gruenwald, T., Gurung, R.A.R., & Updegraff, J. (2000). The female stress response: Tend and befriend not fight or flight. *Psychological Review, 107*, 411-429.

Thormaehlen, D.J., & Bass-Feld, E.R. (1994). Children: The secondary victims of domestic violence. *Maryland Medical Journal, 43*(4), 355-359.

Tifft, L.L. (1993). *Battering of women: The failure of intervention and the case for prevention.* Boulder: Westview Press.

Tjaden, P., & Thoennes, N. (2000). *Extent, nature, and consequences of intimate partner violence: Findings from the national violence against women survey.* Washington, DC: National Institute of Justice and the Centers for Disease Control.

Veltkamp, L.J., & Miller, T.W. (1990). Clinical strategies in recognizing spouse abuse. *Psychiatric Quarterly, 61*(3), 179-187.

Walker, L. (1979). *The battered woman.* New York, NY: Harper & Row Publications, Inc.

Women's Domestic Violence Helpline (Manchester). (n.d.). *What is domestic violence?* Retrieved April 12, 2004, from http://www.wdvh.org.uk/helpline.htm

Worcester, N. (1992). The role of health care workers in responding to battered women. *Wisconsin Medical Journal, 91*(6), 284-286.