UNIVERSITY of INDIANAPOLIS®

School of Occupational Therapy

Reclaiming Occupational Identity After Domestic Violence or Addiction

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May, 2019

A capstone project submitted in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree from the University of Indianapolis, School of Occupational Therapy.

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A Capstone Project Entitled

Reclaiming Occupational Identity After Domestic Violence or Addiction

Submitted to the School of Occupational Therapy at University of Indianapolis in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree.

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Reclaiming Occupational Identity After Domestic Violence or Addiction

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Abstract

Domestic violence and addiction recovery are similar in that they both can cause occupational deprivation and a loss of occupational identity (Javaherian, 2006; Steward & Fischer, 2015). This doctoral capstone experience took place at a Midwestern domestic violence shelter that also houses a women's recovery program. Through a needs assessment, it was determined that the organization as well as the populations served would benefit from the development of a life skills group program to teach skills to increase confidence and independence in living outside of the shelter. This group program was developed and the effectiveness of the groups and continuous quality improvement were found using an anonymous post-group survey. The survey consisted of four Likert scale questions to measure the effectiveness and three open ended questions to ensure quality improvement. Based on the participants' responses, the groups were shown to be effective through the comparison of average scores of knowledge and confidence with the topics before the groups and after the groups.

Reclaiming Occupational Identity After Domestic Violence or Addiction

Introduction

Occupational therapy helps people of all ages and abilities do the things they want and need to do through the therapeutic use of daily activities, or occupations. Occupational therapy practitioners enable people of all ages to live life to its fullest by helping them promote health, and prevent injury, illness, or disability, or to live with these as normal as possible (American Occupational Therapy Association, 2019). There are five domains of occupational therapy. These five domains are occupations, client factors, performance skills, performance patterns, and contexts and environments (American Occupational Therapy Association, 2014). Life skills fall under the domain of occupation in the category of instrumental activities of daily living (IADLs), and are critical occupations for sustaining independence. Instrumental activities of daily living include shopping, meal preparation and cleanup, financial management, child rearing, home establishment and management, communication management, care of others, care of pets, driving and community mobility, health management and maintenance, religious and spiritual activities and expression, and safety and emergency maintenance (AOTA, 2014). Someone who has experienced domestic violence may have limited occupational competence in IADLs as a result of the abuse. Likewise, someone who is recovering from an addiction may also have limited occupational competence in IADLs as a result of his or her addiction.

Domestic violence is defined as the intentional intimidation, physical assault, battery, sexual assault, or any other abusive behavior used in order to systematically establish a pattern of power and control by one intimate partner over the other (National Coalition Against Domestic Violence, n.d.). It is common for multiple types of abuse to be present in the same intimate relationship (NCADV, n.d.). According to the National Coalition Against Domestic Violence

(n.d.), one in four women and one in nine men experience some form of domestic violence in their lifetime. Experiencing abuse has a large impact on every aspect of the victim's life, which in turn affects the individual's ability to engage in daily occupations (Javaherian, 2006).

Addiction is defined as a complex chronic disease that affects functioning of the mind and body (Center on Addiction, 2018). It causes damage to social and familial relationships as well as schools, workplaces, and neighborhoods. The most common symptoms of addiction include continual use despite consequences, fixation on using, inability to quit, increased tolerance, and withdrawal. According to the Center on Addiction (2018) one in seven American's age 12 or older have an addiction to some substance. Substance use is an occupation in itself and will take priority over other occupations for the user (Wasmuth, Crabtree, & Scott, 2014).

The purpose of this doctoral capstone project is to design a group program that pulls from the foundations of occupational therapy to increase independence in women in addictions recovery and survivors of domestic violence. The group program derived from this project will focus on IADL training and leisure exploration occupations.

Literature Review

Domestic Violence

Characteristics. Domestic violence can impact all aspects of a person, including physical, psychological, and emotional health as well as self-esteem and feelings of isolation (Francis, Loxton, & James, 2017). When asking survivors to formulate goals for domestic violence recovery, common themes found by researchers were goals about gaining self-esteem and insight into one's own feelings (Lloyd et al., 2017). Experiencing abuse as a child, either through witnessing domestic abuse with parents or being abused oneself nearly doubles one's

likelihood of being in an abusive relationship as an adult (Akyazi, Tabo, Guveli, İlnem, & Oflaz, 2018). Adults who had these experiences as a child often have a difficult time identifying abuse in their relationships, as they may normalize these behaviors (Francis et al., 2017). Victims may try to convince themselves that they are not in an abusive relationship to protect themselves or their children from feelings of shame, fear, failure, or guilt associated with being in an abusive relationship. Sometimes it takes leaving the relationship for the victim to then see the abusive behaviors as what they are (Francis et al., 2017).

Power and control wheel. The Power and Control wheel is a frequently used diagram that demonstrates how an abuser uses the different types of abuse to establish power and control over the victim (Domestic Abuse Intervention Project, n.d.). Physical and sexual assaults, or the threat of them, are the most common forms of domestic violence. Regular use of other abusive behaviors, combined with these, establishes a much larger pattern of abuse. The physical attacks may happen somewhat infrequently, but the fear of violent attacks allows the abuser to control the victim's life. The Power and Control Wheel was developed to help others understand the patterns of abuse commonly used by abusers (DAIP, n.d.). The Power and Control Wheel can be seen in Figure 1. At the center of the wheel is power and control. Spurring from the wheel are the different types of abuse, including coercion and threats, intimidation, isolation, emotional abuse, minimizing, denying, or blaming, using children, economic abuse, and male privilege. Physical and sexual abuses encapsulate all of these to complete the wheel (DAIP, n.d.).

Occupational therapy and domestic violence. Survivors of domestic violence have lost a lot of their independence and often have needs in the occupations of activities of daily living (ADLs), IADLs, work, education, leisure, play, and social participation (Javaherian, 2006). It is possible that survivors are learning how to participate in some of these occupations for the first

time after leaving the abusing relationship. Occupational therapists are not working with this population to specifically treat the individual for being a survivor of violence or in the shelters, but instead occupational therapists typically work with victims of domestic violence in other settings where the client is being treated (Javaherian, 2006). This population may require some special care or need assistance in getting help and occupational therapists should be prepared to assist them find resources (Javaherian, 2006). This is a sensitive population and it is very important to maintain a therapeutic relationship with the client and they may require a different approach than other clients (Javaherian-dysinger & Underwood, 2011). An occupational therapist could analyze the current educational programs at the facility, and if the site has a program that addresses these and determine how to integrate more OT ideas into the pre-existing program. The occupational therapist could synthesize the new program with a pre-existing one, or could personalize the program to each client and tailor the program to the individual. The occupational therapist could evaluate by conducting interviews and using functional assessments determine the individual client's occupational needs and to develop an intervention plan (Javaherian-dysinger & Underwood, 2011).

Addiction Recovery

Etiology of substance use disorder. Substance use disorder results from the use of drugs in 10 different classes (American Psychiatric Association, 2013). These classes are: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants, tobacco, and other or unspecified drugs. Caffeine is the only substance that does contribute to substance use disorder. When a person uses a drug, he or she will experience a rewarding experience described as a "high." Sometimes the euphoric high is so intense that the person will neglect other daily activities in favor of the drug. Every person does not have the same disposition to substance use

disorder; a person's genetics and environment can influence his or her self-control and incidentally, his or her likelihood to use substances (APA, 2013). In the DSM-5, there are four criteria for the diagnosis of substance use disorder, each of which has symptoms described:

A. Impaired Control;
    a. Overuse of the substance, either taking larger quantities or for a longer span than recommended;
    b. Desire to decrease or stop substance use but unable;
    c. Time getting, using, or recovering from the use of the substance takes up a large part of day;
    d. Experiencing cravings and urges to use the substance;
B. Social Impairment;
    a. Not managing school, work, or home tasks due to substance use;
    b. Continuing use when substance use is straining relationships;
    c. Giving up meaningful activities because of substance use;
C. Risky Use;
    a. Continuing substance use when it creates a dangerous situation;
    b. Continuing to use, even after physical or psychological diagnosis that could be caused by or aggravated by the substance;
D. Pharmacological Indicators: Tolerance and Withdrawal;
    a. Requiring a larger dose to get the desired affect;
    b. Developing withdrawal symptoms that are relieved by taking the substance (APA, 2013).

When a person demonstrates at least two of the four criteria, they qualify for the substance use disorder diagnosis. The number of symptoms demonstrated determines the severity of substance use disorder. Two to three symptoms indicates a mild severity, four to five indicates a moderate severity, and six or more symptoms indicate severe substance use disorder (APA, 2013).

Most people who seek addiction recovery services have already tried to quit on their own and failed (Melemis, 2015). A large part of recovery services focus on relapse prevention by seeking to provide skills and support to the participants. There are three stages of relapse; relapse is actually a gradual process. The first stage of relapse is emotional relapse. In this stage the individual is not explicitly thinking about using, instead they may think about the last time they used and how they do not want to be that way again. In this stage the individual may internalize emotions and isolate oneself, not go to or share at meetings, shift focus to others, and/or lack self-care. As time in this stage increases, the individual begins to feel uncomfortable with his or herself and begins to think of ways to escape. Following the emotional relapse stage is the mental relapse stage, which is an internal fight where part of the individual is urging the individual to use while another part of the individual is resisting. (Melemis, 2015). As individuals go deeper into the mental relapse stage they begin to resist the urge to use less and less and may even create a plan for relapse. After mental relapse reaches the final stage, physical relapse; where the individual is using drugs again (Melemis, 2015). Physical relapse is the most difficult stage to stop. While the individual may believe that he or she will just use a small amount, and then go back to abstaining from the substance, any amount of physical relapse can result in uncontrollable use or thinking about use (Melemis, 2015).

Occupational therapy and addiction recovery. People who suffer from addictions will often identify stigma against addiction as a barrier to feelings of belonging (Blank, Finlay, &

Prior, 2016). This means that these individuals may not engage in social interactions as a result of feeling like they do not belong with general society due to feelings of stigmatization. Therefore, people with addictions tend to create social environments filled with other people who are addicted or in recovery for themselves, and isolate themselves from others, including family and friends (Blank et al., 2016). Steward and Fischer (2015) argue that addiction is not an occupation in itself, but rather is the excessive use of engagement in the occupation of drug use. Based on this assumption, it can be inferred that occupational therapy does not address addiction specifically, but rather the engagement in unhealthy occupations that lead to addiction. This sets occupational therapy apart from other substance use treatments as it addresses the drug use specifically, rather than the addictive personality that encourages continued drug use (Steward & Fischer, 2015). Addictions directly affect a person's identity, motivation, and routines as defined by the American Occupational Therapy Association (2014; Wasmuth et al., 2014)

Occupational therapy can address the unhealthy occupation of drug use through introducing healthy occupations as a replacement. Wasmuth and Pritchard (2016) found that engagement in a community-based theater program increased individuals with substance use disorder's accountability and occupational engagement. This community-based program provided a new social environment and a new occupation for the participants (Wasmuth & Pritchard, 2016). Occupational therapy brings a fresh perspective to addiction recovery, as there is no other profession that addresses ADLs and IADLs, lifestyle choices, social environments/participation, time management, transportation, and community reintegration. Occupational therapy's unique scope of practice allows the occupational therapist to address the client as a whole as well as the individual factors of the client and his or her surroundings in order to treat the occupation of substance use (Robinson, Fisher, & Broussard, 2016). Through

the replacement of substance use for a healthy occupation, occupational therapy could be a key step in preventing relapse (Wasmuth et al., 2014). Individuals who engage in an activity that they enjoy may help them to ease their minds and reduce anxiety and emotional relapse while they are engaging in the activity (Wasmuth et al., 2014).

Theoretical Support

Diffusion of Innovations Theory. The Diffusion of Innovations Theory requires not only introducing a new construct, but also taking the time to explain it and advocate for the idea, finding an accepting social system that wants to adopt the innovation, and communication channels, how the word of the idea will spread (Scaffa, Reitz, & Pizzi, 2010). This theory originally developed to describe how individuals adopt new products or behaviors (Scaffa et al., 2010). In the Diffusion of Innovations Theory the innovator is the one who came up with the idea, then the early adopters are the ones who take the idea to influence society, sometimes taking credit for the idea (Scaffa et al., 2010). Early majority adopters are a large group that follows what the early adopters do. The late adopters tend to wait to adopt the new idea until overwhelmed by peer pressure. Finally, the laggards are the last to adopt the idea (Scaffa et al., 2010). The doctoral candidate developing this program is the innovator of the idea and the partnering organization is the early adopter for the women's recovery and domestic violence survivor programs. It is the hope of the doctoral candidate that after the group is adopted by those programs that they can then begin to be used with the organization's community dwelling programs and perhaps even in the organization's jail program as the early majority adopters. The group protocols should be detailed enough for the idea to be diffused to the different programs. These steps will be used to develop the program and hopefully spread the word of the program to

occupational therapists and other domestic violence shelters in order to get occupational therapy more involved with these populations.

Model of Occupational Empowerment. The Model of Occupational Empowerment demonstrates the relations between environments, occupational deprivation, and learned helplessness and how these can be remediated by occupational therapy programming (Fisher & Hotchkiss, 2008). This model shows how a disempowering environment, such as poverty, substance abuse, physical abuse, legal programs, and limited social support can cause occupational deprivation that results in occupational incompetence and an unhealthy occupational identity. This occupational incompetence and unhealthy identity then reinforce learned helplessness, as the individual does not feel confident enough to change behavior patterns that promote homelessness, joblessness, limited education, and decreased health and wellness. Through an empowering occupational therapy program such as empowerment groups, power groups, social support, and student involvement this cycle can be broken to empower the participants to develop positive occupational identities and competence. This goes on to promote positive occupational change that results in self-efficacy and behaviors that come from meeting goals, maintaining employment, establishing a home, and achieving family unity (Fisher & Hotchkiss, 2008). This will be optimal to guide this project due to physical abuse and violence and substance abuse defining disempowering environments, and from what was been learned through a needs assessment, many residents served at this organization are incompetent in some IADLs, have limited social support and limited education, and do not have jobs. These populations will greatly benefit from an empowerment occupational therapy program.

Cattaneo and Goodman (2015) found that The Empowerment Process Model was effective when used with domestic violence survivors. This model is similar to the Model of

Occupational Empowerment in that it shows how social context impact one's ability to define goals, carry out actions to lead to goal achievement, and observe the impact of these actions. The model shows how these three steps each can influence and be influenced by community resources, knowledge, skills, and self-efficacy (Cattaneo & Goodman, 2015). Although they are different models, The Empowerment Process Model and Model of Occupational Empowerment are similar, and therefore it can be assumed that the Model of Occupational Empowerment will be effective to be used with the domestic violence survivor population being served as the Empowerment Process Model has been shown to be effective. The Model of Occupational Empowerment is a better fit for this specific project due to this project's specific focus on increasing occupational competence and confidence in the participants.

The present doctoral capstone project's purpose is to create a group program that would allow domestic violence survivors and women in addiction recovery to explore leisure occupations and gain knowledge about performing IADLs and developing work skills. It would increase the clients' occupational participation and performance in these areas. This project is aimed to at developing a program that they can continue to implement with the residents of the shelter in order to help them prepare for life outside of the shelter.

Screening/Evaluation

Needs Assessment

The needs assessment was conducted to better understand the needs of the populations served as well as the organization itself. The needs assessment was given to several staff members including case managers, client assistants, and legal advocates. The questions that made up the needs assessment can be found in Table 1. The American Occupational Therapy Association (2017) lists formal education participation, sleep preparation and participation,

health management, employment seeking and acquisition, care of others, play, work performance, safety and emergency maintenance, social participation, and financial management as areas of occupation that are affected by domestic violence. Researchers looking at substance use disorder and occupational therapy found that there are few programs that focus on restoring old or engaging in new occupations for this population (Leppard, Ramsay, Duncan, Malachowski, & Davis, 2018). Women who engage in leisure activities while in addiction recovery are less likely to relapse than those who do not (Leppard et al., 2018). When someone engages in substance use as an occupation, his or her occupational identity is defined by the substance use. When in recovery, the individual loses that identity (Wasmuth, Crabtree, & Scott, 2014).

As predicted by the previous research, needs identified by the organization staff included life skills deficits such as budgeting and financial management, personal care and hygiene, organizational skills, parenting, and social skills, as well as leisure activity deficits in the clients. Staff also identified a lack of healthy coping skills by the clients, and the current groups being broad, generally unorganized, and irregularly timed. Specific coping skills that were described as ones that would be valuable for the populations served by this organization included adjusting to change and/or the loss of a relationship, dealing with guilt and grief, and self-expression. The staff stated that there are not a lot of leisure activity exploration options here at the shelter, but women's recovery residents are allowed a two-hour pass per day where they can leave the shelter to do leisure activities and the domestic violence residents are able to come and go as long as they are back by curfew at 10:00 p.m. The organization has passes to the local YMCA that the residents are able to use during their pass time for exercise. The organization encourages the women's recovery residents to be engaged in Alcoholics Anonymous and Narcotics Anonymous

functions such as dances and barbeques for socialization and leisure, and will make extensions to pass time on an individual basis so residents can go to these events. Residents are also encouraged to connect with friends and family while staying at the shelter. When asked about the residents' general knowledge base staff said it depends on the resident and their background, but they tend to see a need of basic knowledge in life skills areas. One staff member suggested starting with a basic question to determine the knowledge level at the beginning of each group.

Psychological factors that affect the residents' abilities to sustain an independent lifestyle were described by staff as other mental health diagnoses and lack of mental health care, fear, problem solving, prioritizing, having backup plans, and emotional pain. The staff described the difficulty adjusting to the shelter roles as due to the loss of freedom and privacy, struggling with the structure and meeting with their case managers, and following the rules. One staff member reported that in her opinion, the residents that have the easiest time adjusting to the shelter are the women's recovery residents who come directly from jail, as they are already used to community living, rules, and structure. Priorities for the shelter were to see the residents' succeed, encouraging them to seek psychological help as needed, finding them housing for when they leave the shelter, and the Protective Order Project the shelter houses. Barriers seen by the staff when providing services to the residents included fear/apprehension about the shelter, fear of the shelter working with legal systems like Child Protective Services, residents being untrusting and resentful, and their other mental health conditions being untreated.

Current groups topics addressed by the organization are domestic violence education, art group, women's recovery group, nutrition, personal enrichment, and previously, parenting. One of the staff members described a weakness of the current groups being it is hard to schedule them at a time where all residents of the shelter can attend. The residents often have a busy schedule,

which often includes court meetings, child visitations, work or searching for work, any appointments they may have, and for the women's recovery program an intensive outpatient program and probation hearings. The current groups all combine the domestic violence and women's recovery programs with the exception of the women's recovery program group that meets once a week. Most staff reported that the needs of both populations show a lot of overlap and the residents benefitting from engaging with each other in groups. One staff member reported that she believed the residents would benefit more from separate groups and topics. Chief concerns with the current groups were described as the difficulty finding a time that accommodates all residents, limited group topics, and that the residents are not getting enough from the groups when they leave the shelter unsuccessfully.

Comparing to Other Areas of Occupation Therapy

Refugees often experience disruptions in their occupational lives due to displacement and resettlement (Crandall & Smith, 2015). The new environment is often more technologically advanced than their original environment and the refugees may have trouble adjusting to this new technology. Some may be coming from areas that do not have electricity. Refugees often lack formal education, and even those who are educated struggle finding employment due to their credentials being unrecognized in their new country. Crandell and Smith (2015) developed a life skills program to address the changes the refugees are facing. This population benefitted from sessions on grocery shopping, managing finances, leisure exploration, crafts, cooking, and cultural sharing. Although this population is different than the populations served, the residents at this shelter have moved to a new environment with different rules and may not have background information on life skills. The refugees who participated in Crandell and Smith's

(2015) life skills program reported that the groups were very helpful but they would forget the information if they were not given handouts.

Occupational therapists have a role in health promotion. In order to promote health, it must be ensured that individuals are participating in their meaningful occupations (Holmberg & Ringsberg, 2014). Occupational therapists can work in health promotion through helping clients by providing education for health and assisting to develop personal and life skills. Health promotion is a prerequisite for empowerment (Holmberg & Ringsberg, 2014), which is vital for the populations served by this organization as mentioned in the literature review and why the Model of Occupational Empowerment was chosen to guide this project. Occupational therapy in health promotion tends to be done at the organizational or societal level, striving to create a community that is more inclusive and promotes health more effectively (Holmberg & Ringsberg, 2014). This aligns with the goals of this project as well as what was suggested by the needs assessment results. The populations served by this organization would benefit from more effective health promotion through more effective engagement in their meaningful occupations.

Adults with intellectual disabilities are at risk for occupational alienation without the opportunity to engage in meaningful activities and enrich their occupational experiences (Mahoney, Roberts, Bryze & Kent, 2016). The individuals that participate in day programs are often more supported and given more opportunities to engage in meaningful occupations than those who do not because of the programming at the day programs. Staff support at these programs also encourages the individuals to participate in the programs (Mahoney et al., 2016). Although the populations served at this organization are different, the same applies. These populations are at risk if not given the opportunity to engage in meaningful occupations. As

mentioned in the needs assessment, providing support and programs to promote occupational engagement and competence is something that currently lacking at this organization.

Implementation

Participants of this doctoral capstone experience implementation were all women ages 25 to 55 who were staying at a domestic violence/women's recovery program at a Midwestern non-profit shelter. Group attendance is strongly encouraged at the facility if the residents are in the building at the time of the group. Residents are discouraged from taking pass time during scheduled group times; therefore residents typically only miss groups for work, intensive outpatient program, court, or school. Informed consent was verbally obtained by all participants during each group session, the group leader explained that the post surveys will be used to write a paper for the purpose of this doctoral capstone experience about the groups' effectiveness and that no participant identifiers will be collected or used. Post-surveys were anonymously filled out and placed upside down in the center of the table at the end of group to promote anonymity. The two groups were each rated independently and a black star identifier was placed at the bottom right corner of post-surveys to indicate that these belonged in the women's recovery group. This strategy helped to distinguish between the two groups while maintaining anonymity.

The life skills group program implemented consisted of nine group topics: resume building, budgeting, meal planning and grocery shopping, leisure exploration, coping skills, positive self-expression, parenting, health management, and home management. Groups occurred twice a week, so all groups were administered in a five-week span. The groups were all evaluated in a post-group survey by the attendees, and prior to sessions occurring, the site mentor approved each group protocol. Each group topic was researched, a group activity was developed, and the protocol was written. Protocols included questions for discussion to process, generalize,

and apply the group topic to everyday life. All group activity handouts were the participants to keep for reference upon leaving the facility. Once the group had been administered, group feedback was used to make any needed adjustments. Upon completion of any adjustments being made, the groups were placed in a binder with a protocol and copies of all handouts with a section for each group. This allows for the groups to be effectively replicated by facility staff or interns upon the completion of this doctoral capstone experience. Digital copies of all materials were additionally provided to the facility via flash drive.

The post-survey consisted of four Likert-scale style questions and three open-ended questions. The Likert-scale questions were used to measure the effectiveness of the group, while the open-ended questions were used to make adjustments to the groups to increase their effectiveness. The Likert-scale questions asked the attendee to rate confidence and knowledge before and after the group on a scale of one (not at all) to five (very much/well). Averages and standard deviations from the post-group survey Likert-scale questions are available in Table 2. Comparisons of the before and after Likert-scale questions can be found in Figure 2. Each of the groups' ratings for confidence and knowledge before the group are lower than the groups' ratings for confidence and knowledge after the group, which indicates that the participants were able to increase the confidence and knowledge in the topics to increase independence upon discharge from the facility.

Leadership

This implementation process was made possible by the leadership skills of this doctoral candidate. Leadership skills were fundamental to this implementation due to the group structure. The doctoral candidate led the groups independently and was utilized as a source of guidance by the attendees. This doctoral capstone experience project encompassed self-directed program

development. The doctoral candidate had to complete a needs assessment and take information derived from that to develop the group programs and individual session content. It was important to make sure that the programs developed met the needs of the doctoral candidate as well as of the facility, and to be sustainable upon completion of the doctoral capstone experience. Due to the partnering organization being non-profit, it was important for the group activities to be low cost and to utilize resources already at the facility. The doctoral candidate had to complete a lot of exploration at the facility to ensure that the groups were appropriate but still engaging for the participants. The doctoral candidate met with numerous staff at the organization in order to determine the specific needs of the organization and the resources that were available.

Staff Development

Staff development occurred during this doctoral capstone experience due to the promotion and advocacy for the profession of occupational therapy. Many of the staff at the site did not know what all occupational therapy entails or how it could be used with the populations served. The doctoral candidate created a handout for the staff and social work students during the doctoral capstone experience that describes occupational therapy and how it can be implemented in many different fields. The doctoral candidate would also frequently discuss the group protocols being developed with staff members and explained how these topics will be beneficial for the domestic violence survivor and substance abuse recovery residents at the facility. The director of the facility asked that the doctoral candidate share the group post-surveys with her in order to adopt the post-survey for all groups performed by staff members. It is the hope of the facility staff that using the post-survey will be an effective way to catalog the group services provided in order to receive additional grant funding for the facility.

Discontinuation and Outcome

Quality improvement was completed throughout this project through feedback from the site mentor and post-group surveys. The site mentor read and approved all groups prior to the doctoral candidate leading the groups, and any modifications suggested were made prior to the initiation of group that week. An example of a modification made was adding a sheet to the budgeting group that lists average costs of living locally for those group members who do not have experience with paying their own expenses. Quality improvement occurred through the post-group surveys in the three open ended questions. The open ended questions asked one thing the participant liked about the group, one thing the participant would change about the group, and one thing the participant learned from the group. These questions were used to determine if the group participants were learning what the group was intended to teach, what worked well in the group, and how the quality of the group could be improved in the future.

Expected outcomes of this doctoral capstone experience were that the doctoral candidate would: demonstrate skills and foundational knowledge in working with survivors of domestic violence and women in recovery; apply critical thinking and evidence-based principles, grounded in theories of occupational, in order to develop a program that will influence the health and wellbeing of the populations served; demonstrate professional development and continuing competence through regular meetings with the site mentor and reflecting throughout the experience; demonstrate holistic and client-centered practice that reflects the values of the partnering organization as well as the foundations of occupational therapy; use leadership and advocacy skills to advocate for the populations served; and demonstrate competence in the implementation of theory and program development in a way that meats the needs of the organization and the populations served. Goals developed to accomplish these objectives were

that the doctoral candidate would develop at least six occupation-based life-skills groups for the residents of the shelter, create an additional educational program for the populations served to help them advocate for themselves which they would rate at least a 3/5 on a confidence and a knowledge of the area scale, and that the doctoral candidate would score herself at least a 6/10 on a Likert scale addressing confidence when working with vulnerable populations. These goals were all the Expected, or 0, score on a goal attainment scale. All three of these goals were achieved or surpassed in the completion of this doctoral capstone experience.

Response to Society Needs

As established in the literature review of this paper, survivors of domestic violence have lost their independence while in the abusive situation. While in the abusive relationship they experience occupational deprivation in ADLs, IADLs, work, education, leisure, play, and social participation (Javaherian, 2006). Depending on the length of the abusive relationship and the survivor's experiences prior to the relationship, it is a very real possibility that that individual never got the opportunity to engage in those activities (Javaherian, 2006). Someone recovering from substance use will likely experience occupational deprivation in these occupations as well due to their excessive engagement in the occupation of drug use (Steward and Fischer, 2015). This doctoral capstone experience addresses society's needs for these populations by simulating engagement in these life skills, providing ways to engage in these occupations, and giving informational handouts to encourage carry over to independent living outside of the shelter. The group on leisure exploration is especially important for the women's recovery population as it offers healthy occupations to replace the unhealthy occupation of substance abuse in order to prevent relapse (Wasmuth et al., 2014).

Overall Learning

Throughout this project the doctoral candidate has interacted with organization staff, residents, residents' families, and the organization's board of directors. The doctoral candidate attended the organization's full staff meetings each month where the staff and board of directors would discuss residents, shelter activities, upcoming trainings, and any other concerns that have arisen. The doctoral candidate also sat in on a pre-admission visit for a potential resident who is blind. The doctoral candidate gave insight into potential, simple modifications that could make the residence more accessible for the blind individual, and once that individual moved into the shelter, the doctoral candidate assisted with shelter mobility until the individual was safe on her own. The shelter staff frequently asked the doctoral candidate to meet with clients to go over different IADL and ADL tasks and other topics more in depth than the groups covered. The doctoral candidate learned effective communication with superiors and gained confidence in addressing the board members in a professional manner. The board members and staff valued the doctoral candidate's opinion and the doctoral candidate learned how to interact with other disciplines as peers, rather than as a student looking for direction. Due to the self-directed nature of this doctoral capstone experience, the doctoral candidate developed increased time management skills, communication skills, and confidence when working with clients in groups and one-on-one.

The doctoral candidate would effectively communicate with the residents of this shelter daily. The doctoral candidate would have groups twice a week with the residents where there were very specific, intentional interactions between the doctoral candidate and the residents. The doctoral candidate would also interact with the residents by walking around the shelter and striking up conversations to build rapport and to stay updated on their lives and the challenges

they face. The doctoral candidate would suggest meeting with a resident who is facing a challenge that the foundations of occupational therapy could help to solve. The doctoral candidate would schedule a time to meet with the resident and then prepare for the meeting. The doctoral candidate actively engaged with the residents to ensure their comfort and confidence in the doctoral candidate's ability to address their problems and concerns. The doctoral candidate came to be viewed as a source of knowledge and support by the residents.

Leadership and Advocacy

The doctoral candidate grew in leadership skills while completing this doctoral capstone experience. This is in part due to the self-directed nature of the doctoral capstone experience. The doctoral candidate independently developed all groups before receiving feedback from the site mentor, volunteered for 'side jobs' that were not included in the doctoral capstone experience outcomes, and participated in full staff meetings. The doctoral candidate was viewed as a knowledgeable source to the residents. The doctoral candidate would facilitate a discussion after each group to help the participants process, generalize, and apply the information to everyday life. Facilitating discussion was difficult for the doctoral candidate at first, due to lack of participation from the group members, but with practice the doctoral candidate became more comfortable encouraging the participants to talk with the group. The life skills groups taught skills to help the participants advocate for themselves outside of shelter, as well as advocated for the importance of occupational therapy to the participants and the other disciplines represented at the facility. The doctoral candidate actively advocated for occupational therapy at all full staff meetings and advocated for occupational therapy when discussing concerns about clients with other staff.

Conclusion

The program developed during this doctoral capstone experience was found to be effective with the populations it was created to address. The staff at the organization stated that they noticed a difference in many of the residents, as well as the residents Likert-scale ratings on the groups' post-surveys showing that on average the participants gained confidence and knowledge on the topic. The group protocols developed during this doctoral capstone experience will continue to be used by the facility to teach the residents life-skills to live independently outside of the shelter.

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Table 1
Needs Assessment Questionnaire

	Question
1	What areas do you feel the residents could improve in? i.e. Financial management, childcare, meal prep, shopping, etc.
2	What type of coping skills do you think would be most valuable for the populations served?
3	Do you have a way for them to currently explore leisure activities, if so, what are they?
4	How common do you see domestic residents go back to their abusers? Does this reduce with more stays at the shelter?
5	Do you think that the areas of improvement for the residents are the same for women's recovery and domestic violence residents or do you think they would benefit from separate group topics/sessions?
6	Do you find that the resident's have a base knowledge about financial management, budget planning, childcare, meal preparation, sexual health, communication management, health management, social participation, etc., when they get to the shelter or do you think that they would benefit from some basic education as well?
7	What group topics are currently being used?
8	In what way do you see psychological factors affecting the resident's ability to sustain an independent lifestyle?
9	Do you find that new residents have a difficult time adjusting to the roles and routines expected at the shelter for the women's recovery program? What about the domestic violence program?
10	What are your priorities for the shelter right now?
11	What barriers do you experience when providing services to your residents?
12	What is your chief concern with the current group programs?

Note. This questionnaire was administered to the organization staff verbally. As all questions are open ended the answers varied in length. Depending on the response to the question, some would lead to further discussion that is not listed on the questionnaire. Question 4 was unable to be answered by anyone, there is not any current research on re-admittance rates at this organization but is a potential area for further research.

Table 2

Group Statistics Table

	Number of Participants	Average knowledge before the group	Standard deviation knowledge before the group	Average confidence before the group	Standard deviation confidence before the group	Average knowledge after the group	Standard deviation knowledge after the group	Average confidence after the group	Standard deviation confidence after the group
Resume Building	7	3.71	1.11	3.00	1.53	4.57	0.53	4.43	2.00
Budgeting	7	2.86	1.21	2.14	1.07	4.29	0.76	4.14	1.07
Meal Planning	10	4.20	1.03	4.30	1.06	4.70	0.67	4.70	0.67
Leisure Exploration	13	4.92	1.03	3.77	1.30	4.38	0.77	4.46	0.78
Coping Skills	10	3.20	0.96	3.00	1.40	4.60	0.52	4.10	0.99
Self-Expression	10	3.40	0.97	3.35	1.16	4.40	0.70	4.20	0.79
Parenting	6	4.33	0.52	4.17	0.75	4.67	0.82	4.83	0.41
Health Management	13	4.54	0.88	4.15	0.90	4.85	0.55	4.85	0.55
Home Management	8	4.50	0.93	4.38	0.92	4.88	0.35	4.88	0.35

Note. This table shows the average and standard deviation for each of the Likert-scale questions on the post-group survey as well as the number of participants in each group.

Figure 1. Power and Control Wheel

Figure 1. The Power and Control Wheel, developed by the Domestic Abuse Intervention Project (n.d.), demonstrates the different types of abuse used to establish power and control over the victim in between acts of physical and sexual assault.

Figure 2. Group Effectiveness

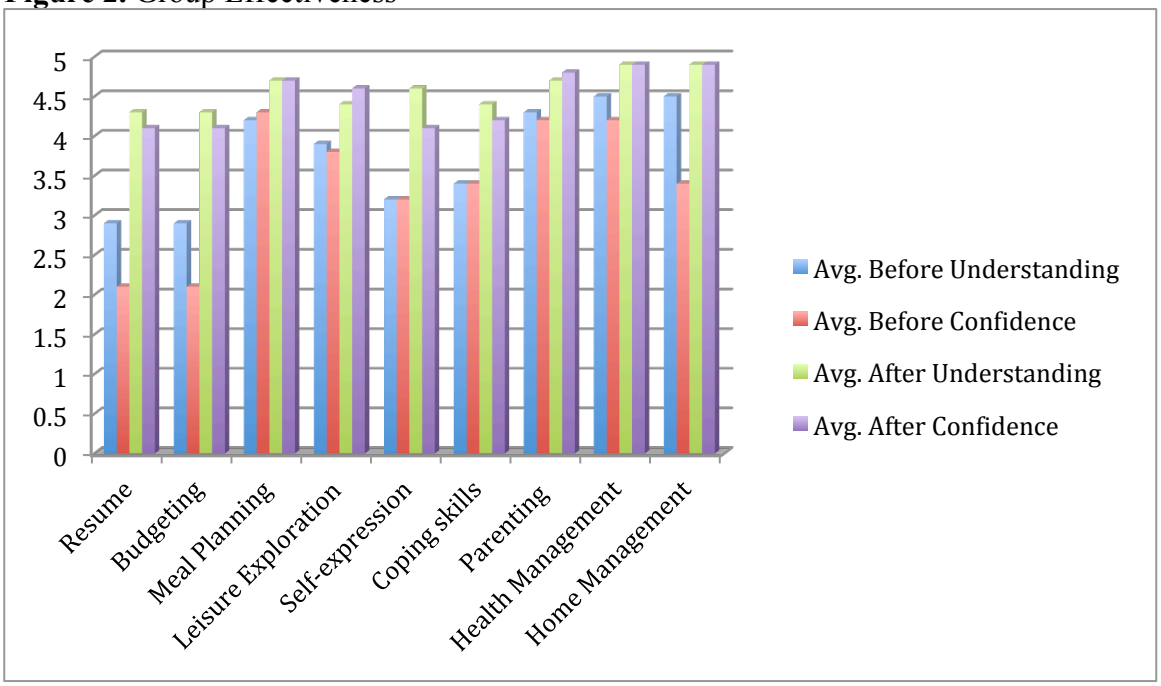

Figure 2. This chart shows the Likert-scale ratings from the participants of each group. The blue bars represent the average understanding of the group topic by the members for the corresponding group. The red bars represent the average confidence before the group in that topic. The green bar represents the average understanding after the group's completion by the group members. The purple bar represents the average confidence felt by the group members in their independence with that topic after the completion of the group.