

# The 20<sup>th</sup> Vona du Toit Memorial Lecture 2007:

## Proposing the social atom of occupational therapy: Dealing with trauma as part of an integrated inclusive intervention.

**Vivyan Alers (BA Social Work (Stellenbosch), MSc, Occupational Therapy**

Occupational Therapist in Private Practice - Psychiatry and Paediatrics; Director: Acting Thru Ukubuyiselwa 017/119 NPO- Occupational therapy for trauma survivors and sensory integration dysfunction

### ABSTRACT

Occupational therapy today needs to re-position itself in context to be relevant to the traumatised psyche of the South African nation. The social atom of the profession needs to relate more congruently to groups, communities and populations. Addressing the secondary causal issues underlying impairment, means our practice will increasingly become multi-modal, using experience and theory from medical, social, environmental, phenomenological and ethnographic models. Occupational therapy in South Africa needs to take the imperative of contextual relevance forward by attending to the traumatic subtexts of practice. Four propositions are suggested.

1. Inclusive, holistic practice applies to both individuals and collectives.
2. Occupational therapy is located in a social atom that enables it to be a significant role-player for social change.
3. The social atom of occupational therapy paves the way for working with the traumatised individuals and communities.
4. Service providers should manage vicarious traumatisation proactively.

My hope is that these four propositions will galvanise debate about the contribution of occupational therapy to the healing of a society traumatised by violence and other forms of oppression and abuse.

**Key words:** Creative participation, Social Atom, Sensory integration, Trauma survivors, Compassion fatigue

### Introduction

It is an honour yet a daunting task to follow in the footsteps of the previous recipients of this recognition of dedication to the profession of occupational therapy. My sincerest thanks for the support and encouragement from my family, all the colleagues, students, friends and most importantly, the people who trusted me enough to 'be' their occupational therapist. 'Being' an occupational therapist for over thirty years has been rewarding not least because I have come to appreciate the functional, self-empowered, spontaneous, integrated and participating occupational human being in the people we serve. The whole human acting and interacting in context is the core philosophy of human self-actualisation. While this perspective on the occupational human is an intrinsic goal of occupational therapy I will argue that we need to reaffirm our role in addressing the contexts, the social atoms as it were, in which people live their lives. My career has progressed through practice in the psychiatric and paediatric fields, with particular interest in sensory integration as an organising frame of reference for understanding the occupational human. I have enjoyed academic teaching, thrived on occupational group therapy and found psychodrama with trauma survivors particularly rewarding. I have worked in hospitals, community settings and the non-profit organisational contexts. The title of this presentation integrates the experiences from all of these fields.

The central message of this lecture is that occupational therapy today needs to re-position itself in context to be relevant to the traumatised psyche of the South African nation. Such a re-positioning and orientation of practice trends includes becoming more sensitised to the post-apartheid historical and sociopolitical situation in the country and identifying ways in which we can contribute towards addressing the causes and consequences of abuse and violence in all its forms. To deal with this agenda we will also need to address the occupational implications of the HIV pandemic. The social atom of the profession, as it is situated as a profession in the service of humans as social beings, needs to readjust what occurs at the micro level in working with individuals to relate more congruently at the macro level in working with groups, communities and populations. Phrased differently this means becoming Afrocentric, cognisant of

the collective, and working actively within the available networks to address the occupational consequences of individual and social trauma. Therapists, in thinking of society or the collective when dealing with impairments and functional limitations at an individual level, will shape contextually relevant practice. By considering and addressing the possible secondary causal issues underlying the impairment, our practice will increasingly become multi-modal, using experience and theory from medical, social, environmental, phenomenological and ethnographic models to guide our actions. The point here is that the occupational human is a social being. What happens to his or her body functions and structures cannot be separated from what happens to his or her social, political or environmental context. The time has arrived for occupational therapy in South Africa to take the imperative of contextual relevance forward by attending to the traumatic subtexts of practice. To do this I suggest four propositions. I start with a brief review of Vona du Toit's Model of Creative Participation<sup>1</sup> arguing that it is currently being applied in a professionally restrictive manner, using trauma and sensory integration as an example. In so doing, I illustrate Proposition One which suggests that inclusive, holistic practice applies to both individuals and collectives. Proposition Two suggests that occupational therapy is located in a social atom that enables it to be a significant role-player for social change. To illustrate this, I review selected frames of reference of theoretical relevance in dealing with trauma and argue that occupational therapy requires an eclectic mix of practice models in order to be contextually relevant. Using examples from practice within the therapeutic spiral model<sup>2</sup>, I then illustrate Proposition Three which suggests that the social atom of occupational therapy paves the way for working with the traumatised individuals and communities. The lecture concludes with Proposition Four which suggests that service providers should manage vicarious traumatisation proactively. Using practical examples of occupation-focused work that is currently being done in South Africa I argue that contextually relevant practice also involves attending to impact of trauma and violence on service providers. My hope is that these four propositions will galvanise debate about the contribution of occupational therapy to the healing of a society traumatised by violence and other forms of oppression.

## Proposition One: Inclusive, holistic practice applies to both individuals and collectives

At the beginning of my career during 1970, whilst investigating training in the United Kingdom, I approached Black Nottley Occupational Therapy Department to obtain information and was asked “Why do you want to train in the UK when you have the best training in South Africa under Vona du Toit?” I realised then that Vona du Toit was internationally renowned and highly respected throughout the world. Unfortunately I did not meet her, but studied at the Vona du Toit College in Pretoria in the 1970s. She was a visionary who left a wealth of ideas, concepts, philosophies, and the integrative links between them, for occupational therapists to debate in subsequent years. At that time, Vona du Toit was restricted by the profession being under the wing of the medical profession. We are now in a different stage of the profession’s development with a scope of practice spanning different sectors including health, education, labour, justice, agriculture, to name a few. We are able to apply a far wider range of theories than those situating us in the biomedical model in order to direct our actions in the service of the South African people. The profession is now able to bring its expertise not only to the individual but also to the community. We have a role to play in policy and advocacy to address the ‘being’ of people through an appreciation of their occupational essence. That takes us full circle back to Vona du Toit’s original vision of creative ability as the essence of integrated, inclusive practice but on a scale wider than the individual with a health problem.

By merging our frames of reference, theoretical concepts and our experiential learning we will give a truly holistic approach to the person and the social atom within which she/he operates. Since the 1970s there has been a lot of interest in the mind-body continuum in occupational therapy. What I am proposing is that this continuum should be situated in a particular context. Holism and functionality is the occupational therapy approach and philosophy, encompassing the bio-psycho-social-interactive model. We have been restricted by the medical model in attending to the first three of these and need to reintroduce the latter. For example while the International Classification of Functioning (I.C.F)<sup>3</sup> the Diagnostic Statistical Manual (D.S.M. IV)<sup>4</sup> and the International Classification of Disease (I.C.D. -10)<sup>5</sup> are useful nosologies for categorising human behaviours in health and illness, their use limits us to the medical model of understanding humans as occupational beings.

The model of the mind-brain-body inter-dependence shows that mental phenomena are both caused by and emerge from neuro-physiological processes. Mental phenomena act on, and influence ongoing large-scale neuro-physiological processes within the individual. What happens internally is in fact echoed externally as the individual interacts in context.

Fisher *et al* stated that “The complex causal relationship between the mind and brain-body is synchronous. It is simultaneous and non-linear.”<sup>6,34</sup> It was this aspect that influenced the creation of the spiraling process of self-actualisation to blend sensory integration theory with the model of human occupation<sup>7</sup>. With the development in occupational therapy relating to the mind and brain-body, Kielhofner<sup>8</sup> stressed the need for a compilation of occupational therapy models to achieve a more complete explanation of human activity at an individual level. This does not however go far enough. Ayres<sup>9</sup>, like du Toit, described the eliciting, by the therapist, of the individual’s effective self-directive involvement in the activity. She discussed that unless the child “wills” to act on the environment, he will not do so. Fulfillment is related to the right combination of challenge and success, the “just right challenge”, and is an integral part of engendering this “will”. Kielhofner’s “volition” and Ayres’ “will” relate to the same concept. Vona du Toit described this “volition and action” twenty years prior to this, in the 1970s. But this is just one part of the social atom of occupational therapy. If we get stuck here, which I believe is what happens when we apply du Toit’s model in a linear, medicalised way, we will not be offering the people of South Africa the full potential of occupational therapy. I believe that we can go further and broader by thinking differently about the ways in which we apply existing models of practice.

For example, Fisher *et al* refer to the concepts of self-reflective processes associated with the performance of adaptive motor behaviour as “reflections-in-action” and “reflections-on-action”<sup>6,35</sup>. The sequential spiral process of self-actualisation as part of the Conceptual Model of Sensory Integration described by Fisher *et al* in 1991, was later described by Bundy *et al* in 2002 as the spiral process of sensory integration<sup>7</sup>. This process has a parallel concept in the theory of Vona du Toit’s<sup>1</sup> Model of Creative Ability. Although Vona du Toit’s model is based on a linear trajectory, the concept of the sequential hierarchical levels is similar to the spiral levels of the self-actualisation in the process of sensory integration. I propose that the spiral process of self-actualisation, where each level of the spiral process of occupational performance leads to the next level, is the same as the delineation of Vona du Toit’s movement to the next creative ability level. This movement process is complex, integrated and holistic using the mind and brain-body concepts. It however remains focused on performance components; this is, as you will see again, only part of what occupational therapy should be addressing.

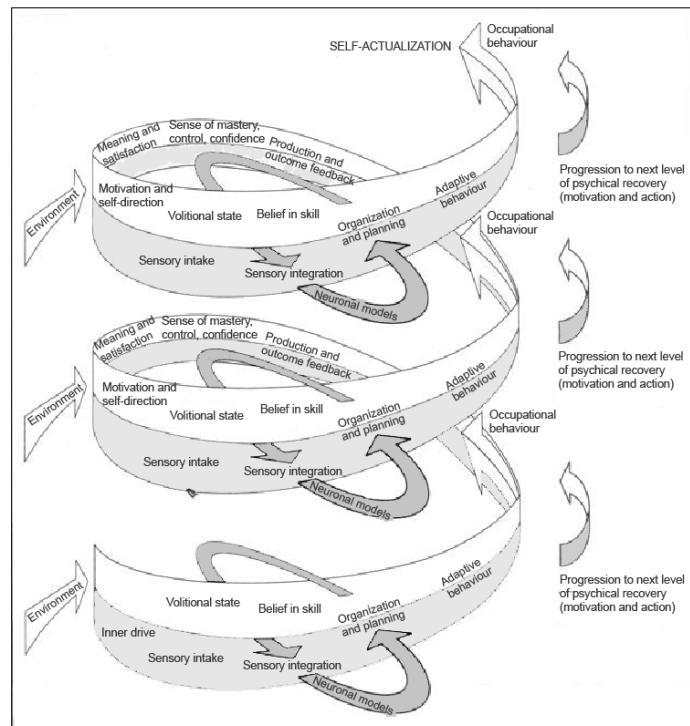


Figure 1: The spiral process of self actualization<sup>6</sup> or the spiral process of sensory integration<sup>7</sup> (with permission) with the progression of motivational and action levels using the Model of Creative Ability<sup>1, 25</sup>

7. Bundy AC, Lane SJ, Murray EA. *Sensory Integration Theory and Practice* 2nd ed. Philadelphia: F.A. Davis Company, 2002. 496p.

If the Model of Creative Ability were superimposed onto the spiral process of self-actualisation shown in the process of sensory integration, together with the synchronous interdependence of mind and brain-body, the flow from the images of action would lead to the adaptive behaviour and reflection in action and ultimately to adaptive occupational behaviour (Figure 1). Vona du Toit’s Model of Creative Ability does not stand alone, but shows inter-dependence and intra-dependence on the spiral process of self-actualisation and is a dynamic interaction that is unique to each individual. I would argue however that the individual is always part of a social atom and as such we can impact on communities by recognising self-actualisation not only as a singular but also as a collective, social process. If the Creative Ability Model is viewed from this perspective, it has scope to be used as a guideline not only for treatment of impairments but also as a heuristic framework for social change. Rather than the reductionistic and prescriptive role that the Creative Ability Model has played in the past it also offers a potential model for plotting collective change in occupational behaviour in groups. The concepts that du Toit put forward in the 1960s were

well ahead of her time, and now need to be given credit and put into the perspective of the spiral process of self-actualisation leading to collective development. Proposition One therefore enables the mind and brain-body concept to expand to include the interactive, socially situated dimensions of the occupational human.

Let me now make this practical. With the onset of a psychiatric illness, Vona du Toit argued that the person's creative ability level regresses and is often lowered to the level of explorative action. However, with recovery the brain-body is able to regain the previous creative ability level and the appropriate occupational behaviour. Bundy *et al*<sup>7</sup> describe the structural and behavioural plasticity of the brain related to the adaptive change as a result of experience, adding that sensory integrative treatment with adults clearly indicates they have the potential for significant change in adaptive functioning. These changes can lead to new responses or adaptive behaviour, which in turn lead to "reflection on action". When the experience relates to a positive "reflection on action" it reinforces this action, resulting in occupational behaviour that is matched to temporal and contextual demands. The changes of occupational behaviour relate to the levels of motivation underpinning action in the social, work, leisure and personal care occupational performance areas described by Vona du Toit<sup>1</sup>. The "social" aspect is included in each of the occupational performance areas of productivity, leisure and personal care and thus does not operate on its own. The aspect of "spontaneity" relating to motivation and action in Vona du Toit's model also needs to be incorporated as it shows that the "just right challenge" is imperative to a positive adaptive response. This then will result in an adaptive interaction towards changed occupational behaviour.

Eliciting the "intrinsic motivation", or "spontaneity", or the "optimal occupational performance", or "adaptive behaviour" is the pivotal role that occupation is seen to play in enabling humans to "do", "to be" and to "become"<sup>10</sup>. Groups of individuals affected by abuse and traumatised by violence can be enabled to achieve greater personal and collective creativity, motivation and actualisation with due recognition of du Toit's stages of recovery. In other words, traumatic experiences have a pervasive effect on all areas of an individual's occupational performance. Collectively traumatised people become occupationally restricted. In line with Proposition One, I am suggesting here that the creative ability of groups of people, in fact whole communities affected by trauma, can be described by using Vona du Toit's model. Proposition One in other words suggests that Vona du Toit's Model not only relates to the Medical Model, but also the Bio-psycho-social Model, the Self-Actualisation Model and the Occupational Model when applied to the social atoms within which individuals operate. In summary then, bringing my first proposition to bear on this analysis of Vona du Toit's stance towards practice means that the profession needs to recognise that the demands of our context require us to think and work beyond the individual to a group, collective and population level. Moving beyond the reductionistic, positivist parameters of her original application of the Model of Creative Ability, towards a reinterpretation at a population, systemic level will promote contextually relevant practice.

For this lecture I developed the "Animal Adventure" or "It's My Turn To Talk Now...." pack of cards as triggers for reflection<sup>11</sup>. The card deck represents the community, and each individual card represents the individuals in the community. One card can be positioned in a space that allows it to be used as an observing ego, as a position to look at your self / practice from a different perspective. The observing ego is a neutral observer to narratively labeled behaviour<sup>2</sup>. Are you possibly caught in a rut of thinking about occupational therapy at an individual, impairment level only? What does your observing ego suggest may be ways of expanding your practice towards socially orientated goals? Now include the concepts of the self-reflective processes, namely the "reflections-in-action" and "reflections-on-action".<sup>6,35</sup> "Reflections-in-action" are described as the thoughts, sensations and feelings experienced during an action, whereas the "reflections-on-action" relate to the thoughts, sensations and feelings experienced after the action has occurred. Hopefully this reflective journey relates and gives meaning to the four propositions raised in this lecture. But let us return briefly to Proposition One and its application to trauma.

I am fascinated by the influence of trauma on occupation and have found the use of psychodrama for trauma survivors in the community to be particularly transformative of participants' occupational behaviour. While the link between sensory integration and trauma is an interesting concept, it has not been researched conclusively.

Trauma challenges a person's belief in their safety, attachment, trust or betrayal, lifestyle, sense of belonging and ego states. This is not a transient state of imbalance, as it can have lasting emotional effects on a person and by implication on whole communities subject to pervasive violence, especially when experienced during childhood, which in turn can influence attachment styles. When these experiences are shared by whole communities, their collective creative participation becomes stunted. With childhood abuse there is often resultant interpersonal effects in adult life. Occupational therapists have a vital role in their intervention to recognise the challenges that trauma adds not only impairment, but also disablement to the communities as a whole. To assess this appropriately means we have to look beyond the impairment, to the context in which the person lives his/her life. The omissions on the person's part of mentioning traumatic events during narrative story telling also relates to the stigma attached to talking about the effects of the trauma. When trauma is identified it also needs to be addressed in the intervention strategies to truly honour the holism of the occupational therapy's philosophical belief. Children may play trauma out in their games, as a five-year old child did in my therapy sessions. She insisted on bringing her imaginary dogs into the therapy room and needed to have a ritual of discipline. One day she played that she was a fierce lion caught in the net, and she was unable to focus on any other activity. It was later confirmed that her father was physically abusing her. This child developed her imaginary dogs to protect herself, just as in the film "Chocolat"; Anouk had her imaginary kangaroo, Pantouf, to keep her company when she was distressed.

Bringing Proposition One to bear on this individual story implies that the profession has a contribution to make in developing mechanisms for communities and populations that are traumatised. How may this be operationalised in practice? A basic understanding of the neurobiological constructs of trauma for the individual is needed first before applying it to the communities.

The correlation between sensory integration and trauma memories is apparent in over-arousal, sensory defensiveness and sensory shut-down, but the understanding of the neurobiology is often overlooked. The symptoms are similar but the primary cause is different. The complexity of the limbic system and Jean Ayres' explanation of the influence and interplay of other sensory systems on the limbic system is an integral part of beginning to understand this correlation. The negative effects of trauma can recur when triggered by a situation or flashback and this may happen years after the incident. This trigger may be from a sensory stimulus such as sound, smell, vision or touch. Bessel van der Kolk describes the interplay of the mind and body after trauma, and the physiological effects in his article "The Body Keeps the Score"<sup>12</sup>. His recent research on the neurobiology of trauma memories becoming "stuck" in the amygdala, thus not being processed through the hippocampus to the cortex, and Kate Hudgins' concept of "trauma bubbles" are used to illustrate the process of flashbacks.

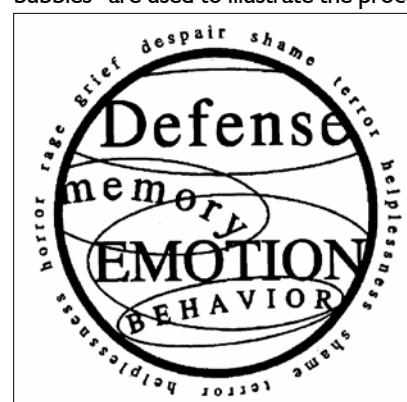


Figure 2: The trauma bubble<sup>2</sup>

Hudgins describes trauma bubbles (Figure 2) as "encapsulated spheres of active psychological awareness that contain unprocessed experiences. These experiences are dissociated and split off from conscious awareness. Like bubbles, they can be popped unexpectedly, pouring images, sensations, sounds, smells and tastes into awareness without words."<sup>2,21</sup>

Van der Kolk<sup>12</sup> has shown that when trauma occurs, the Broca's area shuts down, thus the verbal aspects related to the trauma are difficult to access. This links with the trauma bubbles overwhelming feelings that they release when they burst and the inability to put these feelings into words. At a mind level, trauma immobilises. Collectively, trauma will therefore potentially trap communities in restricted patterns of creative ability. The whole concept of the spontaneity and sensory integration is also an aspect that is influenced by trauma experiences, and how thresholds of stimulation would vary after trauma. The lasting effects of trauma would also have a long-term effect on spontaneity, also judging the "just right challenge", especially relating to ego states.

In a nutshell, to put in place the complexities of the constructs and the concepts described is really to use all experiential and learnt knowledge to approach the client, be it an individual or a group, in a truly holistic manner. My challenge to all occupational therapists is to look at the extent to which we each really apply this when engaging with the emerging needs and capacities of the people with whom we work across the spectrum of practice paradigms from the medical through the developmental to the social, from the individual to the group to the community? Or are we still stuck in the medical paradigm of assessing and treating patients, clients and people in the communities?

In line with Proposition One, I suggest that we need to question the validity in the South African context of the theoretical concepts used. We need to bear in mind that Maslow's hierarchy of needs was generated with a Western capitalistic conception of self, relating to individualism. Motivation is seen to be a linear developmental process to satisfy hierachal needs of ascending complexity. We do not need to disregard this; rather we need to put it into its correct context and include Max Neef's<sup>14</sup> matrix of the human scale development (Table I). His alternative world views follow a matrix which allows multiple re-entering at different levels and relates to collectivism. Max-Neef describes the distinction between needs and satisfiers which are constant through all human cultures and across historical time periods. What changes over time and between cultures is the way these needs are satisfied. It is important that human needs are understood as a system, namely that they are interrelated and interactive.

## Proposition Two: Occupational therapy is located in a social atom that enables it to be a significant role-player for social change

Occupational therapy operates within a social atom which is intra-professional, inter-professional and trans-disciplinary.

The definition of social atom is "Moreno's term for the network of significant others in a person's life"<sup>13:106</sup> (Figure 3). For the purposes of the second proposition I replace 'person' with 'profession'. The social atom can be diagrammatically depicted as a spider with the self at the middle and the relationships termed in a negative or positive interaction.

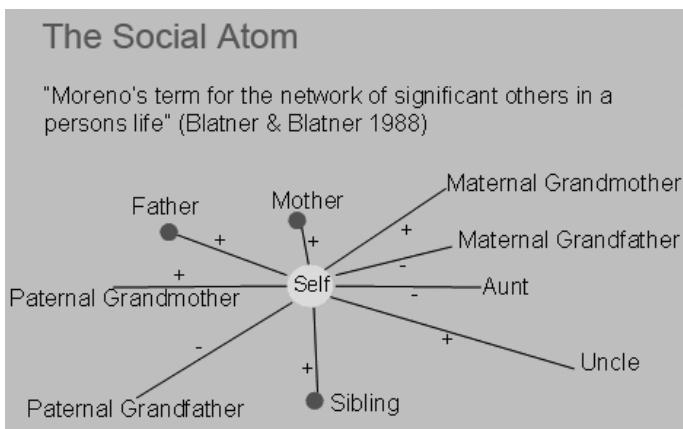


Figure 3: The Social Atom

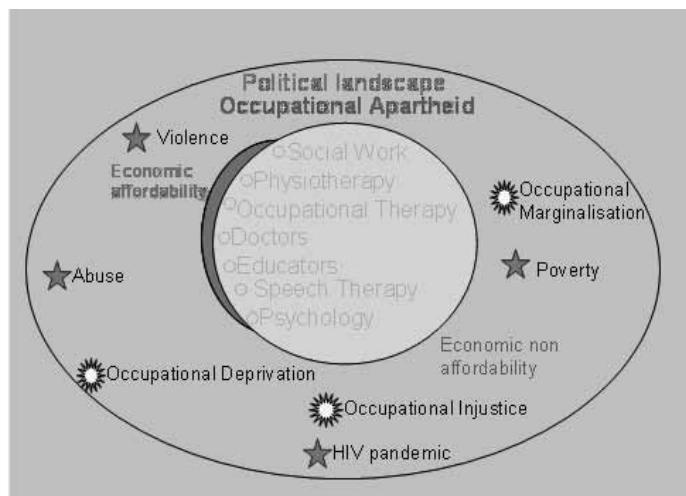


Figure 4: The Political Landscape and Occupational Apartheid surrounding service provision and economic non affordability in the South African context

To make this proposition practical we can put this into the African context so that the "Social Atom" for example may be embedded in the games children play. This "Tok-Tok" game is a culturally accepted diversion that is played on one's own or in a group as regular debriefing on a personal level. It is called "Tok-Tok" derived from the sound of the knocking of the stones, translated into English it is called "Talk-Talk" derived from the communications elicited. Stones are used to represent family members with a stone for the self, and the game portrays the communication between the family members when the stones are hit against each other. The player communicates freely as the stones are hit with the different people's communication dialogue. This is a really practical self empowerment, conflict resolution and self expression medium that is meaningful within the African context. I have observed this game in many different settings so it is part of every day life within the African cultural setting, and I have been surprised that it has not been more widely used therapeutically. When teddy bears were available together with stones the teddy bears were used to cuddle and not used for any communication purposes, whereas the stones were used for communication.

If we take the social atom and relate it to occupational therapy it would represent significant other partners in the professional arena. When considering Proposition Two we notice the gaps that are created with the present application of occupational therapy within the medical model. Gaps in the occupational therapy profession appear to be overtly apparent in the correctional services, restorative justice services, the NGO sector and involvement in social development. We need to consider where the gaps are in the 'here and now' of occupational therapy in this country. What are the influences that are guiding our practice? Are we still destined to follow the Eurocentric practice methods or are we as South Africans self-actualised enough to develop ourselves for our unique country? Returning to Max-Neef's matrix, can we plot the satisfiers for the needs, more specifically the occupational therapy satisfiers to the needs of the country?

When we consider the financial affordability of health and wellness services in South Africa there is a crescent moon representation of this and a full moon representation of the non-affordability of these services (Figure 4). The occupational therapy 'community service practice' year is addressing this aspect to a degree. The question is whether the exit competencies of our graduates match the demands of the context within which they need to work across various service sectors.

When we look at the political landscape of the country we see the devastating effects of poverty, violence, abuse and the HIV/Aids pandemic. The self-perpetuation of these phenomena through the generations does not bode well for a productive occupationally fulfilling future for all South Africans. These devastating effects and lack of facilities and opportunities can immobilise people and

communities, yet their survival nature has a stronger influence on being, doing, becoming and interacting<sup>14</sup>. This resilience or survival can be related to the occupational therapy profession.

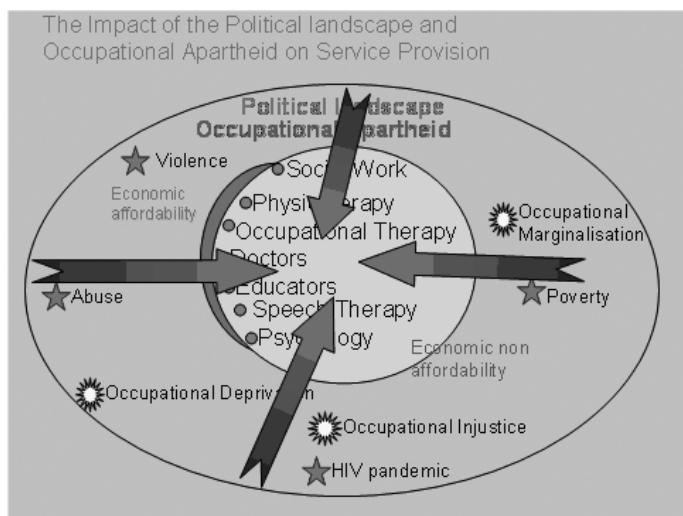


Figure 5: The impact of the Political Landscape and Occupational Apartheid on service provision

When we consider the occupational apartheid together with the political landscape we see a bleaker picture (Figure 5). As Kronenberg and Pollard describe, "Occupational apartheid is based on a premise that some people are of different economic and social value and status than others"<sup>15:65</sup>. They further explain that "Occupational apartheid results from political constraints which may extend to encompass all aspects of daily living and human occupation through legal, economic, social and religious restrictions, and can be found as a consequence of chronic poverty and inequality in many countries across the globe."<sup>15:66</sup> It is important to understand that "Occupational injustices occur within a system of occupational apartheid"<sup>15:66</sup>.

Townsend and Wilcock state that occupational injustice occurs "when participation in occupations is barred, confined, restricted, segregated, prohibited, underdeveloped, disrupted, alienated, marginalised, exploited, excluded or otherwise restricted"<sup>10</sup>.

Occupational deprivation and occupational marginalisation are occupational science concepts described in Watson and Swartz<sup>16</sup>. These concepts when closely examined, align with Vona du Toit's notions of restricted creative ability. My second proposition urges the profession to move towards a greater appreciation of our potential scope of practice.



Figure 6: The proposed Occupational Therapy Social Atom

The occupational apartheid and the political landscape have a profound impact on the service provision of occupational therapy. When we analyse disability we can see that poverty and disability

are linked. An improvement in one is to alleviate the other. Disability is about social prejudice and not about impairment. Therefore the position of occupational therapy towards social development and community development is imperative to alleviate poverty and disability.

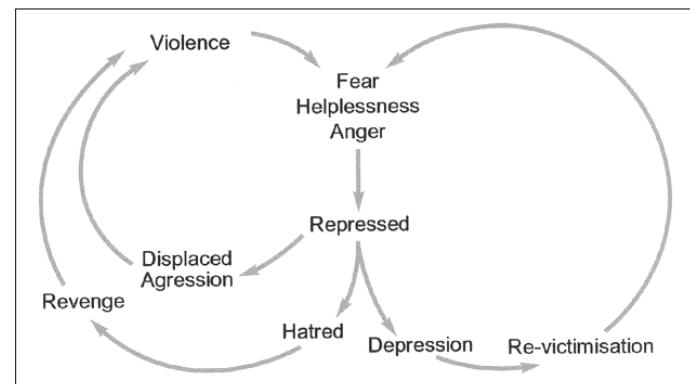


Figure 7: Cycle of Violence. Sinani / KwaZulu-Natal Programme for Survivors of Violence<sup>18</sup>

Occupational therapy needs to position itself within its social atom (Figure 6) not only with the traditional medical fraternity but with the professions that influence the society's development, for example sociologists, anthropologists, social geographers, development practitioners and correctional practitioners.

When we consider the geographical distribution of the population and the influence of the legacy of the apartheid regime on this distribution, South Africa is still socially fragmented, making the need for a social atom in occupational therapy of particular importance. The migration of families and especially breadwinners moving between rural and urban areas has had a profound influence on cultural changes within the population. The fact that the majority of the older generation of the disenfranchised population is illiterate, and the younger generation is becoming literate, causes another dimension for the possibility of cultural erosion and undermining of respect of the older generation together with the emergence of abuse by the younger generation. This contributes to another dimension of domestic violence.

Duncan states "...the realities of poverty, violence and resource limitations in South Africa will continue to restrain our ability to provide all the occupational therapy services we think are needed. This is an ethical dilemma that requires an accurate analysis of social health care values and the ability to balance moral duty and the consequences of our decisions"<sup>17:5</sup>.

Violence has become an every day phenomenon in societies across the globe. Abuse still has a shroud of unspeakable stigma attached to it. The word 'perpetrator' or 'perpetrator of violence' creates a stigma and fear in the health professionals mind, but there is a connection between the 'victim' and the 'perpetrator'. Research has shown that 'perpetrators' are, more often than not, 'past victims' or 'trauma survivors' (Figure 7). When we look at the correctional services in this country, occupational therapists are not prominent, yet the contribution we could make in the rehabilitation of offenders is vast.

An example of an opportunity missed for our profession but that was taken by the Arts profession is the William Humphries Art Gallery (WHAG) in Kimberley, which started the WHAG Ubuntu Prison Project. The women are taught to make art by sewing pictures onto squares of black cotton using vibrant colours and their own designs. The embroidery is signed with the person's prison number. At first the women felt useless and commented that they could not design nor do embroidery. Now with the success of the project they feel proud of their work, earn an income from selling the work at art exhibitions, and their behaviour in the prison has improved. Some of these embroideries have won national art competitions. This emotional upliftment, purposeful participation and motivation have led to creative portrayals of experiences of their lives in their

embroideries. The stories they tell could certainly be used for a range of purposes from the therapeutic through to social transformation. I suggest that du Toit's model could quite readily be applied as a theoretical rationale for the transformation that occurred amongst these women.

Opportunities taken have been the Outeniqua Wheelchair Challenge OCC which has become a yearly event and has grown from 27 entrants in 2002 to 430 entrants in 2007. This is for the physically disabled using any mobility device. This project carried out by Ester Watson won the Albie Sachs Award for 2007. Another innovative development has been the "Facing Up" NPO run by Roshan Galvaan and Leisl Kent with youth at risk in Lavender Hill. It is an occupational enrichment service within two health promoting schools. In 2005 they obtained funding from the ESKOM Energy and Sustainability Programme. Their environmental project developed a game called "Energywise". They entered the Volvo Adventure competition and at the finals in Sweden they received third prize out of forty-seven countries. Other innovative programmes may be spearheaded by occupational therapists, but we tend to hide our heads under a bushel. Our pride in what we can promote and achieve needs to be more overt.

South Africa supports a restorative justice system with certain categories of perpetrators. This changes the focus of the justice system to include not only the perpetrator but also the victim or trauma survivor into the restoration process. Opportunities abound for occupational therapists to take the challenge and move into the restorative justice services. Restorative justice means that the trauma survivor has a right to opportunities to return to their former functional abilities. Occupational therapists have the expertise to enter this field, especially regarding the transformative medium of occupational group therapy and occupational trauma therapy.

Relating Proposition Two to practice, a group, who had become paraplegics from gunshot wounds, expressed their thoughts after ten sessions of occupational group therapy which included occupational psychodrama. These groups were held in the community of Ivory Park, Midrand, under the auspices of Acting Thru Ukubuyiselwa 017/119 NPO which was funded by Themba Lesizwe and the European Union. The group named themselves The Mpumelelo Group meaning the "Success Group". These anonymous reports were obtained three months after the groups had been completed.

One group member said:

*"The group gave me confidence for facing life's challenges and improved my motivation. Generally it helped me to face life. You know what disability does to you... Getting and creating chances, one can go far. We started on a lower base, and disability can put you down and make you afraid. The group had values, sharing thoughts and to be in the same shoes as others. The process of the group was supporting each other through this. Getting results such as seeing others change for the better, to do something for them. I have since been chosen for a learnership. I was surprised to be the best to be chosen at present for the learnership. I would like to see more groups like this for the disabled to motivate us to go further."*

Another feedback comment was:

*"Life was really good before the accident, after the accident life was not good mentally and spiritually. There were more problems with the family, and it was more than just the accident, as my world was turned upside down. At that time I was unable to cope with anyone. I was left with only my God and my Ancestors. After I attended these groups I was able to solve my own problems and my spirituality came back, and a feeling of Ubuntu. The most special part was the claiming of strengths, as I did not know the meaning of my strengths. My inner strength really built me up. The groups enabled me to bring back my mental and spiritual part of me. I realised my loneliness from the cards used, especially loneliness regarding my children. I now have courage to confront this. The group healed my spirit with support from the group. I felt that it was a safe group to open up. I would like the group to carry on."*

These comments suggest significant changes in creative participation, volition and action. The re-attainment of functional meaning attribution to their lives also proves the value of occupational group therapy. Captured here is the application of Proposition One and the possibilities of Proposition Two.

Putting this into another context the CSIR model of the "Cycle of Crime and Violence"<sup>18</sup> shows the cycle of a dysfunctional family where vulnerability is increased by poverty, and through this vulnerability offending behaviour occurs. The cycle completes itself by the engagement in a life of crime and poverty is thus entrenched. Substance abuse has an integral role in this cycle, leading to child neglect, child victimisation and possibly later conflict with the law. The children grow up to become young adults without hope and thus substance abuse restarts the cycle. To break this cycle, trust, hope and self dignity need to be engendered.

### **Proposition Three: The social atom of occupational therapy paves the way for working with the traumatised individuals and communities**

My third proposition is that the social atom of the occupational therapy profession provides the basis for working in the trauma field. However if my first proposition of theoretical restructuring and the second proposition of the realignment of relationships outside the medical fraternity is not taken seriously by the profession, this unique opportunity will be missed. Occupational therapists have always dealt with physical and emotional trauma, yet have not acknowledged it overtly and addressed it in its all-encompassing dimension at a population level. The political landscape of our country left a legacy of highly traumatised communities who would gain substantially from the adoption of Proposition Three. We also have not adequately looked at the effects of vicarious traumatisation on ourselves as professionals, nor have we developed a strategy to combat this.

When thinking of the qualities that service providers need to have to work in the trauma sector (*Table II*) we can consider the following. Occupational therapists certainly have an appropriate fit to these qualities, which relates to the vigorous training expectations of all the universities of South Africa.

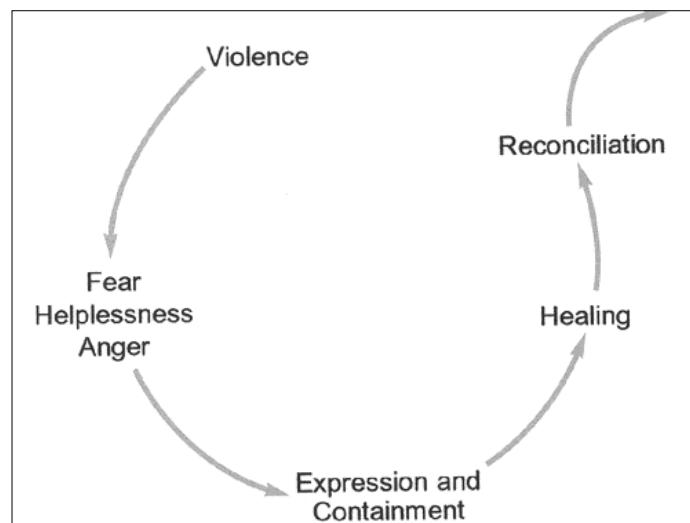


Figure 8: Cycle of Peace. Sinani / KwaZulu-Natal Programme for Survivors of Violence<sup>19</sup>

The most exciting aspect of working with trauma survivors is the concept of breaking the perpetuation of the trauma cycle. The Sinani Model of Violence and Peace<sup>19</sup> (Figure 8) describes this process powerfully. "The Cycle of Violence" depicts how violence perpetuation happens if intervention is not effective or meaningful. When intervention is appropriate "The Cycle of Peace" can occur. This is where occupational therapists can make a really meaningful contribution.

Subsistence				
Protection				
Affection				
Understanding				
Participation				
Idleness				
Creation				
Identity				
Freedom				
	Being	Having	Doing	Interacting

Table I: Max Neef's Matrix of Human Scale Development<sup>14</sup>

The qualities service providers need to work in the Trauma Sector				
<b>T</b> <b>Tenacity</b> —the inherent determination to facilitate self empowerment				
<b>R</b> <b>Reliable Relationships</b> —trustworthy, safety and containment in a professional relationship				
<b>A</b> <b>Adaptability</b> —the flexibility to fulfill the needs of the trauma survivor				
<b>U</b> <b>Unwavering commitment</b> —a steadfast commitment to encouraging internal meaning attribution				
<b>M</b> <b>Mastery of techniques and models</b> —self confidence and experience in the techniques and models used				
<b>A</b> <b>Appropriate boundaries</b> —boundaries for safety to express self				

Table II: The qualities service providers need to work in the trauma sector

An aspect that was very meaningful to me from the film "The Interpreter" was when Sylvia Broome, played by Nicole Kidman, said "Revenge is the weakest form of grief". That sums up the concept that the perpetrator has been a trauma survivor in the past.

In my experience and training in the Therapeutic Spiral Model, which is a complex model using psychodrama for trauma survivors, I have found it to be truly trans-cultural, innovative and self-empowering. The concepts and constructs of the Therapeutic Spiral Model make therapeutic intervention more accessible to those who might not explicitly identify themselves as trauma survivors or seek traditional counseling, or those who might be from cultures where Western psychotherapeutic methods are not the norm. In community settings, the goal is to enable people to label their own reactions and those of people around them and to counter those with rational thinking; also to recognise traps that arise from irrational fear responses; and finally to build community and individual strengths in order to overcome the weaknesses and anxieties produced by violence. Communities that can come together around strengths can more effectively face traumatic times. The premise that this model embodies is that personal empowerment begins with the recognition and utilisation of one's own strengths.

The Therapeutic Spiral Model is based on the three strands of the spiral: building energy, providing experience and making meaning of the experience. Using role theory, it normalises the internalisation of trauma into 'roles' and gives clients a non-shaming way to talk about their self-experience. The Trauma Survivor's Intrapyschic Role Atom<sup>20</sup> is used in every drama as a clinical reference guide. It ensures that at any one time more 'positive' roles are present on the stage than 'negative' ones. Such roles include: transpersonal, interpersonal and personal strengths, the containing double and the observing ego. With the creation of safety and containment within the group, the building of self-resources through the exploration of strengths and the use of the observing ego as a witness, the individual is able to consciously experience and label the different proactive perceptions related to the trauma. The witness is an important therapeutic piece in trauma, and especially abuse, as the breaking of the secrecy surrounding it lessens the stigma and promotes healing.

This then brings me back to where I started this lecture; linking the individual with the social, linking the body and mind with the collective. It is widely documented that the autonomic nervous system is influential in the arousal level of a person and that a 'calm alert state' is strived towards as this is the most productive state of body and mind. The optimal 'calm alert state' becomes compromised in the presence of trauma, as normally the parasympathetic and sympathetic systems are at play and work to regulate the neuro-physiological state of the body. When the sympathetic system over rides or shutdown occurs, a collection of symptoms emerges which has come to be known as Post Traumatic Stress Disorder, or PTSD. This may occur many years after a traumatic incident and may be triggered by flashbacks or by a "trauma bubble" bursting. The reactions to traumatic incidents is very varied and extremely complex. Bessel van der Kolk, a psychiatrist from Harvard University, describes how action methods are more effective than talk therapy<sup>21</sup>.

Within the Therapeutic Spiral Model<sup>22</sup>, the action trauma team is a further construct to create a safe container. The Therapeutic Spiral Model encompasses the very essence of psychiatric occupational therapy. The primary clinical goal of the Therapeutic Spiral Model is to prevent triggering uncontrolled regression and unconscious abreaction with experiential methods. The team works together for the benefit of the group and also serves as a support to the team members to prevent compassion fatigue.

The usual sequence of the Therapeutic Spiral Model follows the choice of scarves to be a concrete representation of the person's personal (or inner) strength, interpersonal (or outer) strength and transpersonal (or upper) strength. This is followed by the discussion in pairs of the representational meaning attribution given to these strengths and later a personal self-presentation of the strengths to the group. A uniquely South African phenomenon was that participants in the groups felt pride in wearing their strengths. This prompted the adaptation of this concept to a 'fashion parade' when used with adolescent groups. The strengths are then individually placed in the room and specifically constructed into a circle to represent safety and containment. Observing ego cards are chosen and placed around the room to be a witness to the experience and to be a place where a different perspective of a situation may be perceived. These strengths are then also constructed into an art project which is named a "Soul Portrait" such as masks, shields or banners. Action sociometry is used to identify connections between members in the group, for example each person is asked to put their hand on the person they would choose to act as themselves in an occupational psychodrama. This depicts the 'tele' between the members of the group and the interconnectedness within the group. Then the occupational psychodrama would be enacted and eventually everybody would be involved in the occupational psychodrama and making their own meaning attribution for themselves. The closing ritual to ensure confidentiality of the group is called the "Thumb Thing" where hands are joined together by holding another person's thumb to form a circle, and with this connection each person pledges their name as a confidentiality contract. In South Africa this was adapted to the "Thumb Thing with nthlonepo" [Zulu for respect] which is an addition of putting the left hand on the right forearm to show that no other harmful device is hidden behind the back. With elders in the community the "Thumb Thing" was contraindicated due to painful effects of arthritis, and the proximity to perform the "Thumb Thing" was difficult with people in wheelchairs. Thus the "Thumb Thing" was further adapted to the "Sijabana" configuration with the meaning of "Elbow nudge to remember". This encompassed the hugging of self for self-respect together with the joining of both hands on either side with the person on either side, forming a circle. Again, in African tradition, both hands are visible and the connection with others endorses the confidentiality.

#### Proposition Four: Service providers should manage vicarious traumatisation proactively

Self-respect is a core theme that needs to be addressed when dealing with trauma survivors. Self-respect encompasses self-awareness

and nurturance, self-control and the concept of 'choice' in the occupation of life. To be able to make this 'choice' the assumption is made that the person has the intrinsic motivation and 'will to act' or the 'volition' to have self-reflection to engender self-respect. As occupational therapists we all feel that our volition is high, our actions are purposeful and our ability to make choices is appropriate. Health professions, especially occupational therapists, enter their chosen profession because of an empathetic attunement and sensitivity regarding others. Do we ever consider ourselves in the position of vicarious traumatisation? When we look at Proposition Two, with the political landscape and occupational apartheid repercussions, occupational therapists are certainly at risk for vicarious traumatisation. The philosophy of occupational therapy is to engage people in "dignified participation in meaningful occupations"<sup>14,83</sup> to be integrated into society, included in all aspects of life and thus improve quality of life. This is an enormous responsibility especially in the light of the current situation in South Africa. The risk factors for vicarious traumatisation are:

- the exposure to the stories and images of traumatic experiences;
- the person's empathetic sensitivity to the suffering seen;
- any personal unresolved emotional issues that relate to the suffering seen.

Beth Hudnall-Stamm describes this process which can lead to compassion fatigue.

"There is a soul weariness that comes with caring and from daily doing business with the handiwork of fear. Sometimes it lives at the edges on one's life, brushing against hope and barely making its presence known. At other times, it comes crashing in, overtaking one with its vivid images of another's terror with its profound demands for attention; nightmares, strange fears and generalised hopelessness"<sup>23</sup>.

Somehow compassion fatigue is something that occupational therapists do not acknowledge, and do not consider the risks or consequences from the type of work done. We consider ourselves 'resilient' and able to cope with adversity. This 'resilience' could well be the manifestation of the 'soul weariness' described by Hudnall Stamm<sup>23</sup> and the fabrication of defense mechanisms to protect the self. When compassion fatigue starts to take hold, could we consider it together with Vona du Toit's concepts of the lowering of volition and action, thus the lowering from contribution centred to passive centred participation? The tertiary educational institutions and each occupational therapist need to take a stand to combat compassion fatigue by using reflective journaling and ego strength building. Reflective journaling encourages clinical reasoning, self-growth and deeper self-understanding. Ego strength building helps resource the soul and the being of a person. Both reflective journaling and ego strength building of occupational therapists will have a profound effect on the quality of occupational therapy intervention offered.

There is an attitude in our profession that certainly needs attention for the profession to move forward to offer an integrated, inclusive intervention to our communities and society. This proactive and nurturing attitude needs to begin with the self then grow to encompass the communities we serve.

I challenge each occupational therapist to allow their personal strength to develop, to influence their utilisation of therapeutic integration, experiential knowledge and theoretical knowledge. Combine this with the broadening spiral of the contribution towards integrated, inclusive intervention. If the person's mind is open to this, their reflection will grow and blossom to give satisfaction and meaning attribution to the participation in the productive growth of the occupational therapy profession.

JL Moreno said to Sigmund Freud in 1912 "You analyse peoples' dreams. I teach them the courage to dream again"<sup>24</sup>. The "courage to dream again" is the essence that I would like to engender in all occupational therapists working in South Africa, to realise the potential that the profession can offer the country. Let us all strive to develop our own unique South African philosophies and models to comprehensively address our worthwhile contribution to society. This is the challenge.

## References

1. Du Toit V. Patient volition and action in occupational therapy. 2<sup>nd</sup> rev. ed. Pretoria: Vona and Marie du Toit Foundation, 1991.
2. Hudgins KM. Experiential Treatment for PTSD. The Therapeutic Spiral Model. New York: Springer Publishing Company, 2002.
3. World Health Organisation. International classification of functioning, disability and health. Geneva. W.H.O. 2001. <<http://www.who.int/classifications/icf/site/onlinebrowser/icf.cfm>> (7 July 2008).
4. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4<sup>th</sup> ed. Washington, D.C.: The American Psychiatric Association. 1994.
5. WHO. International Statistical Classification of Diseases and Related Health Problems. 10<sup>th</sup> Revision. (ICD-10). 2007. <<http://www.who.int/classifications/apps/icd/icd10online/>> (7 July 2008).
6. Fisher AG, Murray EA, Bundy AC, eds. Sensory integration theory and practice. Philadelphia: F.A. Davis Company. 1991.
7. Bundy AC, Lane SJ, Murray EA. Sensory Integration Theory and Practice 2<sup>nd</sup> ed. Philadelphia: F.A. Davis Company, 2002. 496p (with permission).
8. Kielhofner G. A model of human occupation theory and application. 2<sup>nd</sup> ed. Baltimore: Williams and Wilkins. 1995.
9. Ayres AJ. Sensory integration and learning disorders. Los Angeles, California: Western Psychological Services. 1980.
10. Townsend L, Wilcock AA. Occupational justice and client-centred practice: a dialogue. Canadian Journal of Occupational Therapy, 2004; 71(2): 75-87.
11. Alers VM. African Adventure Cards. 2007. <<http://actingthru.org.za/adventurecards.html>> (14 July 2008).
12. Van der Kolk B. The Body Keeps the Score. Memory and the Evolving psychobiology of Post Traumatic Stress. 1994; Harvard Review of Psychiatry, 1(5): 253-265.
13. Blatner A. Blatner A. Foundations of Psychodrama History, Theory and Practice. 3<sup>rd</sup> ed. New York: Springer Publishing Company, 1988.
14. Max-Neef M. Human Scale Development: Conception, Application and Further Reflections. New York: Apex Press, 1991.
15. Kronenberg F, Algado S, Pollard N. Occupational Therapy Without Borders: Learning From The Spirit of Survivors. London: Elsevier Churchill Livingstone, 2005.
16. Watson R, Swartz L. eds. Transformation through occupation. London: Whurr, 2004.
17. Duncan M. The 18<sup>th</sup> Vona du Toit Memorial Lecture: Our bit in the calabash. South African Journal of Occupational Therapy, 1999; 29(2): 3-9.
18. Holtmann B. "Crime prevention technology sheds light on underlying problem". ScienceScope November 2007. 2007. <[http://www.csir.co.za/dpss/pdf/ss\\_safetysec.pdf](http://www.csir.co.za/dpss/pdf/ss_safetysec.pdf)> (7 July 2008).
19. Sinani. Model of Violence and Model of Peace. In: Crouch RB, Alers VM, editors. Occupational Therapy in Psychiatry and Mental Health 4<sup>th</sup> ed. London: Whurr Publishers. 2005: page 316.
20. Kellerman PF, Hudgins MK. Psychodrama with Trauma Survivors Acting Out Your Pain. London: Jessica Kingsley Publishers, 2000.
21. Wiley MS. "The Limits of Talk. Bessel van der Kolk wants to transform the treatment of trauma." Jan/Feb Psychotherapy Networker 2004. <[http://www.traumacenter.org/products/pdf\\_files/Networker.pdf](http://www.traumacenter.org/products/pdf_files/Networker.pdf)> (7 July 2008).
22. Hudgins K. "Therapeutic Spiral Model" 2000 <<http://www.therapeuticspiral.org>> (7 July 2008).
23. Hudnall – Stamm B. Secondary Traumatic Stress – Self Care Issues for Clinicians, Researchers and Educators. Maryland: Sidran Press, 1999.
24. Moreno J.L. Psychodrama. Vol. I. New York: Beacon House, Beacon. 1946.
25. Alers VM. Sensory Integrative Therapy with Chronic Schizophrenic Patients. M.Sc. dissertation, University of the Witwatersrand. Unpublished, 2004.

## Author's address

Vivyan Alers: vivyan.alers@gmail.com