This article presents an approach to the emerging occupational therapy role in a community-based interdisciplinary traumatic stress program. Specifically, an occupational therapy model, the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Townsend & Polatjako, 2007), is linked to a particular trauma model of practice, Herman’s (1997) Triphasic model. These will be discussed in order to: 1) understand the occupational performance challenges of people who manage the impact of trauma in their daily lives and 2) to identify how occupational therapists can work with people who live with trauma in order to facilitate recovery.

Service background
The Traumatic Stress Program of Eastern Health, Newfoundland and Labrador, focuses on service delivery to individuals who experience a specific kind of trauma called complex or Type II trauma (see definition below). The service is provided at the tertiary level and is staffed by a team of trauma therapists (professional backgrounds include social work and psychiatric nursing) as well as an occupational therapist. It emerged in 2006 as a result of an identified gap in services for individuals who presented in emergency services and required access to appropriate and extensive trauma counseling.

Trauma is defined as a bodily or mental injury usually caused by an external agent (Rosenbloom & Williams, 2010). “Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life” (Herman, 1997, p. 33). From this perspective, once someone has experienced trauma it becomes more difficult to engage in everyday activities.

Complex (Type II) trauma
Complex (Type II) psychological trauma refers to repetitive or prolonged exposure to traumatic stressors that involve harm or abandonment and often occur at developmentally vulnerable periods in a person’s life (Courtois & Ford, 2009). It affects as many as one in seven to one in ten children. Often perpetrated by someone known to the victim, it usually involves a fundamental betrayal of trust in primary relationships. This is why Type II trauma is associated with a much higher risk for the development of post-traumatic stress disorder (PTSD) than Type 1 (single incident) trauma (33-75% risk versus 10-20% risk) (Courtois & Ford, 2009).

Clients who attend the Traumatic Stress Program have complex PTSD and often face a number of occupational challenges. A key criterion for the diagnosis of PTSD is impairment in the functioning of life skills such as the ability to socialize, work, attend school, or manage family responsibilities (Baranowsky, Gentry, & Schultz, 2011). Features of PTSD may include a combination of the following: difficulty regulating affective impulses and traumatic re-enactments, alterations in attention and consciousness, alterations in self-perception, difficulty in interpersonal relationships, impairment of life skills, and difficulty establishing a system of meaning that offers hope for the future (Rosenbloom & Williams, 2010).

Herman’s (1997) Tri-Phasic model conceives the recovery from complex trauma to proceed in three stages: safety and stabilization, remembrance and mourning (trauma memory processing), and reconnection. During stage one, the primary goal of recovery is to enable the person to make a gradual shift from a state of ‘unpredictable danger’ to a state of ‘reliable safety’, meaning that individuals begin to trust stimuli from the environment and their own reactions. During stage two, the survivor, in a non-linear fashion, processes traumatic memories and how these events have shaped their life. The third stage of recovery involves the reshaping of one’s identity through participation in meaningful occupation and healthy relationships (Baranowsky et al., 2011; Courtois & Ford, 2009; Herman, 1997). It is during Herman’s third stage of recovery that the occupational therapy core skill of enablement (Townsend & Polatjako, 2007) is particularly helpful. During
this third stage of recovery, the opportunity to engage in meaningful occupation is recognized as essential in actualizing posttraumatic growth, and subsequently, recovery.

The CMOP-E and the impact of trauma
Occupational therapists who are interested in developing their role within trauma services may choose to use the CMOP-E (Townsend & Polatjako, 2007) for three main reasons. Firstly, the model may help to generate an understanding of the unique impacts of trauma on everyday life. Impacts of trauma specified within the core constructs of CMOP-E are described in Table 1, above. Secondly, CMOP-E can be used to guide the recovery process with individuals who experience complex trauma. As such, it provides a framework with core constructs to identify the challenges in occupational performance and engagement during each phase of treatment and recovery. In addition, using CMOP-E can be a valuable asset to an interdisciplinary team approach to trauma. For example, CMOP-E helps survivors and team members generate an understanding that occupation occurs in the context of the person’s daily life, and of the interaction of person, occupation and environment (Townsend and Polatjako, 2007).

The emerging role of occupational therapy within a Traumatic Stress Program
Pre-screening: When participants first begin the program, they enter a pretreatment phase where screening and intake occur and an individualized treatment plan is developed. The occupational therapist first meets with the client during this phase to assist with assessment and goal setting by completing the Canadian Occupational Performance Measure (COPM) (Law et al., 1994). The COPM enables the client to understand how trauma affects all areas of their lives, allowing them to develop and prioritize their goals for the program and their larger recovery journey (Harper, Stalker, & Templeton, 2006).

Phase I: Safety. Participants, (either through an individual or group stream), partake in education about trauma and traumatic response/re-enactment. Safety planning and the introduction of coping skills also occur. Within this phase, the occupational therapist co-facilitates a Safety and Wellness Recovery Action Plan (WRAP) group. Created by Copeland (2002), WRAP is an extensive wellness plan that identifies triggers, warning signs and strategies to cope. While many WRAP groups are peer run, this modified Safety and WRAP group requires additional knowledge and expertise in teaching the trauma-specific safety skills of self-soothing, grounding, containment, and expression strategies, as well as the ability to practice self-rescue (Baranowsky et al., 2011). It is anticipated that this group will be eventually co-facilitated by a trained peer.

Phase II: The trauma story. Survivors work with trauma therapists individually or in groups to prepare for telling their trauma story and to process, remember and mourn the loss associated with the impacts of trauma on their lives. Topics include establishing healthy boundaries, self-esteem, shame, guilt and forgiveness. The occupational therapist may co-facilitate this work in a group setting, however, at present, does not do this trauma-processing work individually with clients.

Phase III: Reconnection and aftercare. The primary goals in this phase are to identify disconnection with oneself and one’s community and to redefine a future in terms of posttraumatic growth and resilience (Baranowsky et al., 2011). The occupational therapist works with clients individually and in groups during this phase and the treating trauma therapist will provide additional one-to-one and/or group support. In addition, a peer may co-facilitate an alumni group (see description in Table 3). Intervention enables the survivor to focus on engagement in meaningful occupation by ensuring that the safety needs of the individual are met. (Bryant, Craik,
The majority of goals chosen by participants are focused on reconnecting with social and leisure occupations as well as work or school. Groups emphasize the value of engaging in healthy occupation and may lead to the client changing occupational performance skills and patterns to promote wellness, role competence, satisfaction and improved quality of life (Cara, 2005). In addition, participation in meaningful occupation provides a distraction from stressful thoughts and events while also promoting feelings of competence and control with the learning of new skills (Scaffa, Gerardi, Herzberg, & McColl, 2006). Table 2, below, describes current reconnection and aftercare trauma groups and Table 3 describes groups that are under development.

Table 2. Reconnection and aftercare trauma groups

<table>
<thead>
<tr>
<th>Life in Balance</th>
<th>Healthy Relationships and Reconnection</th>
</tr>
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<tbody>
<tr>
<td>Focus: Creating wellness and balance in self-care, leisure and productivity occupations.</td>
<td>Focus: Building healthy relationships and community access/awareness.</td>
</tr>
<tr>
<td>Method: Uses digital photography as a storytelling method to move beyond trauma, represent oneself, build skills and create change.</td>
<td>Method: Uses a combination of education and self-reflective activities to reconnect with oneself and one’s community.</td>
</tr>
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</table>

Table 3. Reconnection and aftercare trauma groups in development.

<table>
<thead>
<tr>
<th>Vocational Support</th>
<th>Alumni</th>
<th>Express Yourself</th>
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<tbody>
<tr>
<td>Focus: Exploring return to school and/or work.</td>
<td>Focus: Survivor/peer support.</td>
<td>Focus: Learning new skills and alternate ways to express and process thoughts and emotions.</td>
</tr>
<tr>
<td>Method: Education, support and exploration of community resources to support return to school and work opportunities.</td>
<td>Method: Drop-in style, loosely structured with some education and activity components (no time limit on participation in this group).</td>
<td>Method: Uses a combination of visual arts, music and movement activities for self-expression.</td>
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</table>

Conclusion

Developing the role of an occupational therapist on any interdisciplinary team can be a daunting challenge. This article provides an illustrative example of a successful addition of occupational therapy services within an interdisciplinary traumatic stress program. A back-to-basics approach of using research evidence and the alignment of an occupational therapy model with a trauma recovery model remains critical to the success of developing the emerging role. The fact that these models are congruent results in being better able to both generate a rich and situated understanding of occupational performance strengths and challenges and to identify recovery-promoting solutions with people who manage this level of trauma.

References


About the author

Dana Snedden, BSc (OT), BSc (Psych), is an occupational therapist at the Traumatic Stress Program of Eastern Health, in St. John’s, NL. She can be contacted at (709) 752-4226.