Moving Towards an Abolitionist Praxis: Roots, Blossoms, and Seeds from an Occupational Therapy Doctoral Resident

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Abstract: This essay traces my personal roots as an Asian-American woman with a father diagnosed with bipolar disorder and the impact of my lived experiences on my professional journey as a pediatric mental health occupational therapist. I highlight three exemplary client stories from my year as a doctoral resident at a community-based mental health agency that have furthered my critical analysis of our current child welfare system. Finally, I reflect upon the importance of collectively developing an abolitionist praxis as occupational therapists and health workers at large who are committed to building equitable systems of care that do not further harm structurally marginalized community members.

Keywords: child welfare system, abolition, transformative justice, BIPOC mental health

I began my occupational therapy doctoral residency at the tail end of a personally and collectively destabilizing summer in August of 2020. The COVID-19 pandemic was raging across the world, embers of the George Floyd uprising aglow, and both my summer fieldwork experience at Skid Row Housing Trust and deepening involvement in grassroots community organizing in Los Angeles Chinatown had ignited in me an acute awareness of the structural violence people face daily in simply trying to survive.

Suddenly, spending another year at an academic institution in order to pursue a doctoral degree had lost its shiny appeal. I felt disillusioned and purposeless.

Uprooted.

But uprootedness can be transformative. Uprootedness requires a reevaluation of previously occupied spaces and modes of thinking and being. It necessitates the creativity of finding new homes to inhabit that better suit our innate drive to survive and thrive in collectivity with others. Uprootedness requires a return to our roots so that they can grow strong enough to sustain new sprouts and blossoms.

So I returned to my roots.

Roots

I conceptualize my roots as my "why." The story of how I came to be where I am constantly shapeshifts as I gain new perspectives, but there are elements that I know to be steadfastly true when considering the why that has driven me throughout my adult life.

My roots begin in a home in suburban San Diego, where I grew up falling asleep listening to the eclectic mixture of Cantopop and bebop jazz that drifted into my room from my dad's adjacent study. One night when I was 10 years old, the music stopped.

That was the night the cops were called, and my dad was placed on an involuntary psychiatric hold that facilitated his physical absence from our family for weeks and his emotional absence for years. Bipolar disorder was the verdict, daily lithium pills were the sentencing.

And thus began my quest to understand why.

I became a deeply introverted child, discouraged by my Chinese immigrant parents from processing familial traumas aloud and finding my solace in books and music that took me to faraway places. This way of being would continue into college, where I threw myself into studying neuroscience and taking pre-med courses to understand why. Surrounded by a new ecosystem, I was thrilled by the prospect of finally figuring out why someone could be in so much pain in this world and therefore inflict so much pain onto others. I also grew interested in question of "how"—if "why" could not be answered, at least I could think about how to best support people experiencing mental health challenges in a way that uplifted their dignity and humanity.

But the answers neuroscience and the biomedical approach provided didn't satisfy me. To explain this pain away as a problem in the wiring of the brain that could be fixed with a chemical capsule never felt sufficient to me in understanding my dad's lived experience and my own childhood trauma. So I pursued a new pathway: that of an occupational therapist.

Occupational therapy is defined by the American Occupational Therapy Association (n.d.) as

> the only profession that helps people across the lifespan to do the things they want and need to do through the therapeutic use of daily activities (occupations). Occupational therapy practitioners enable people of all ages to live life to its fullest by helping them promote health, and prevent—or live better with—injury, illness, or disability. (The occupational therapy profession section, para. 1)

I became concerned with questions about our daily actions as human beings and how they limit and/or expand our health; I also began to think about how we could expand our health to more meaningfully engage in daily life despite, and with, the unique limitations we all have. And though occupational therapy has yet to offer complete solutions, I feel that this pathway has offered a more holistic landscape upon which I can continue to consider the question of why—along with other related questions that have since branched off from this original root.

I pursued my residency at a community-based mental health agency that supports children and families experiencing mental health challenges due to experiences of trauma and abuse, perhaps as a way of returning to these roots. Pediatric mental health is still an emerging setting for occupational therapists (Mahaffey, 2016), but I felt compelled by a deep empathy and drive to use creative therapeutic activities to better support children and families in gaining the skills to live in ways that felt healthy and meaningful to them while navigating experiences of trauma and abuse.

Throughout my doctoral residency year, I continued to trace my roots, each time finding new meaning in them. From every reconsideration emerged a new direction I could take with my thinking and my practice as an occupational therapist, and some of these directions bloomed in ways that I feel are important to continue to nurture.

Blooming

The most meaningful moments during my residency were quiet moments. Moments of connection with the youth and families I supported throughout the year. Moments of coming to an understanding of a new truth or simply being able to articulate a question from the messiness in my mind. They were "in-between" moments, not destinations that might be highlighted as an "accomplishment." Perhaps the best way to illuminate some of the quiet moments that changed me this year is through storytelling. Perhaps when a root transforms into a flower, it is telling a story.

Gabriela

In September of 2020, I began working with "Gabriela" (pseudonym), a six-year-old girl who had been sexually abused by a family member and as a result, developed an intense anxiety when occupying small spaces such as restrooms and elevators. Working with Gabriela, I learned intimately about the ways that trauma is encoded in the body—though Gabriela has not been able to verbally articulate details about the harm that was done to her, she has repeatedly shared that she fears "getting stuck" in small spaces and visibly exhibits increased anxiety and hyper-vigilance when doors of small spaces are closed. Her mother has shared that Gabriela's anxiety has interfered with their family's community engagement and is a source of both frustration and guilt, reminding her of the trauma she could not prevent from happening to her daughter.

As a doctoral resident and newly licensed occupational therapist, I approached my early sessions with Gabriela trying earnestly to apply the knowledge I had learned in school, using occupation-based interventions such as arts and crafts and individualized games to teach Gabriela coping strategies for decreasing her anxiety in small spaces so that activities of daily living, such as using the restroom, could become easier for her. Though she was able to tolerate longer and longer periods in small spaces with the door closer and closer to being shut completely, her anxiety persisted. One session, I decided to try something different and encouraged Gabriela to engage in a storyboarding activity to begin deconstructing/reconstructing her trauma narrative (Figure 1).

Figure 1

Gabriela's Storyboard

Note. Gabriela's figure was created by me in collaboration with Gabriela in a telehealth session wherein I asked her for descriptions and allowed her to choose images and colors.

Asking open-ended questions to facilitate Gabriela's telling of her own story, I felt gratified when she was able to independently identify some of the coping strategies for decreasing anxiety that we had practiced, such as butterfly breathing, visualizing her dog, and singing silly songs. But I was surprised to see the way that she chose to resolve her own story—with her mother using a hammer to break open the small space so that Gabriela would not get stuck.

In this moment, I was struck by the metaphorical power of Gabriela's narrative; she had ultimately located safety and strength within a meaningful relationship, rather than within herself. I realized that in my fixation on individualizing treatment for Gabriela, I had neglected the power within the relationship between Gabriela and her mother. I had failed to wholly acknowledge the power in Gabriela's mother negotiating with Gabriela's abuser without Department of Child and Family Services (DCFS) involvement, cutting off contact with him directly in order to hold him accountable for the harm he had caused, while establishing a safe environment for Gabriela. In doing so, Gabriela's mother demonstrated that families possess the agency to determine their own futures in powerful ways if they are allowed and supported in exercising this agency.

Though treatment sessions have become inconsistent recently due to Gabriela's mother's tumultuous second pregnancy, I dream of the possibilities when healing from trauma is viewed as a relational and collective process rather than an individual one. What would it look like to support Gabriela and her mother in co-creating a trauma narrative together, to support them in identifying what their "hammers" really are? Considering this question has helped me to implement more relational, family-centered interventions within my practice as an occupational therapist, interventions that lean into families' natural strengths instead of simply focusing on individual-level coping strategies.

Gigi

In January of 2021, I learned what state intervention in a relational process of healing could look like. I began working with "Gigi," a five-year-old girl diagnosed with Fetal Alcohol Spectrum Disorder (FASD), and her legal guardian, whom Gigi called Auntie. During a collateral session with Auntie, she shared with a primary mental health therapist and myself that she had recently become upset at Gigi when Gigi refused to push her bike up the hill to their house. "Seeing red," Auntie decided to retrieve a spoon from the home and used it to hit Gigi's bottom. After the session, the primary therapist let me know that she had informed DCFS about the incident, and they would be paying a visit to the home.

The next week, Auntie let us know that a DCFS social worker and a sheriff had indeed paid a visit to the home to conduct an investigation. Auntie expressed that Gigi had become highly dysregulated upon being questioned and shared afterwards that she "didn't like talking to the police." Auntie also shared that the sheriff had told her that he "understood why I did it and said he wished more parents would." When I asked Auntie what reflections she had from the experience, she paused and said, "I learned to keep my mouth shut next time."

As health professionals, we are mandated reporters who are taught we must report suspected incidences of child abuse. I was not taught in school to question the system of mandated reporting, the ways it disproportionately and violently affects poor and working-class Black and Brown families by criminalizing them, leading to familial ruptures and removals that are oftentimes irreversible (Children's Bureau, 2021; Goodman & Fauci, 2020). I was not taught what actually happens after the report is made.

After our session with Auntie, I sat with my messy feelings about what had happened. Though the investigation was closed for this particular family early on, I felt that my silence and confusion throughout the process had amounted to complicity in a problematic and oppressive system—allowing a child to be further traumatized after a negative experience with their caregiver, therapeutic trust to be broken, and the potential for irreparable harm to the family.

In weeks following, I attempted to support Auntie in identifying her own triggers and alternative non-punitive responses she could use to address Gigi's difficult behaviors, but I could sense that Auntie felt that she could no longer be completely honest with us about challenges with Gigi. Though some therapeutic recommendations may have been helpful in nurturing the relationship between Auntie and Gigi, a pressure had been placed on Auntie to "perform" a certain way as caregiver in order to evade future traumatic child welfare visits. This experience helped me develop a more critical analysis of the current child welfare system, a desire to reimagine my own participation as a mandated reporter, and a need to further interrogate and transform the ways we keep children safe and healthy as a society.

Aubrey

In May of 2021, I learned that "Aubrey," a 15-year-old participant of a storytelling group that I had co-facilitated for teens with FASD, had been hospitalized for expressing suicidal ideation.

Given my own lived experience with my father's psychiatric hospitalization as well as the connection I had felt to Aubrey during the teen group, this news immediately brought a flurry of emotions. I felt sadness that Aubrey had reached this point, fear that she would attempt to follow through, and anger that our health system's current "best practice" when people express suicidal ideation is to hospitalize and isolate them from their community. However, these emotions would become more complicated after I learned more and more pieces of the story.

Aubrey ended up being hospitalized for a little over a week. I learned later that Aubrey had refused to sign the safety contract given to her at the hospital due to her mother refusing to return Aubrey's phone back to her. Upon debriefing with Aubrey's mom later on, I learned that she had overheard Aubrey talking to an older man and found that Aubrey had nude pictures of herself on her phone. Aubrey's mom felt that she needed to take away Aubrey's phone to keep her safe, especially due to the particular vulnerabilities that teens diagnosed with FASD may have in terms of being taken advantage of sexually. As a homeschooled teen who had just moved to a new neighborhood during a pandemic and one who had always felt "different" due to her disability, Aubrey deeply resented her mother for taking away one of her only sources of social connection.

Although Aubrey's time at the hospital was not necessarily the traumatic experience that I had assumed it would be, it was nevertheless an ineffectual response to her mental health symptoms, isolating her further when the root of her challenges was social isolation—and further widening the rift between Aubrey and her mother. Having only provided direct occupational therapy services to Aubrey for a few months now, I won't pretend to have meaningfully healed the relationship between Aubrey and her mother or successfully provided Aubrey with safer ways of attaining social connection, though I am trying. However, bearing witness to Aubrey's story, I am left with the understanding that mental health challenges are social/relational challenges and thus, our solutions to them ought to be social/relational as well. What would it have looked like to provide Aubrey with deeper relational connections when she expressed suicidal ideation, instead of isolating her? What would it have looked like for her to be surrounded by peers or family members who could support her emotional process or even providers who could mediate a conversation between Aubrey and her mom so that they could meet in understanding rather than further alienation?

In each of these relationships, I came to new understandings about why and how. I gained new insights into why someone may experience mental health challenges as well as new perspectives about the process of healing from mental health challenges. Moments of connection transformed the way I approach occupational therapy and mental health work, and yet perhaps what these moments have really shown me is that I need to continue asking "why" and "how." In challenging my individual modes of thinking and being, these stories have inspired me to want to challenge collective ways of thinking and being—to transform systems rather than individuals, because that is how we build a better world for all. Thus, in considering the next chapter of my own story as an occupational therapy practitioner, I think about the seeds that have been planted in me this past year.

Seeds

The stories of Gabriela, Gigi, and Aubrey intertwine in my mind as examples of how current systems of "care" are at best insufficient, and at worst violent. But they also serve as partial blueprints for what positively transformed systems of care could look like. Seeds that have emerged from each story include:

- **Gabriela:** Gabriela's story serves as an example to me of the limits of individualized mental health services and even community-based mental health services. How can we, as occupational therapists, move past individualized interventions, non-profit service-based approaches, and community-*based* practice (where sites of intervention are simply located within the community), and into community-*centered* (Hyett et al., 2015) or even community-*driven* practice (where communities themselves are being transformed and strengthened)? How can we interrogate the professionalization of care (which positions those who have received institutional training as experts of healing) and instead position ourselves as facilitators who uplift the power inherent to the families we support and their communities? In considering Gabriela's trauma, I also wonder, as occupational therapists, how can we support the occupational healing of those who have been harmed while simultaneously working to prevent future harm by transforming the conditions that allowed or caused the harm to occur in the first place? Though I don't have complete answers, I am inspired by the analysis and work of organizations such as Bay Area Transformative Justice Collective (2021) and Generation Five (Kershnar et al., 2007), which creatively utilize transformative justice approaches to address child abuse. For example, one tool promoted by the Bay Area Transformative Justice Collective is "pod-mapping," or leveraging existing relationships within an individual's social network in order to create pods that can support survivors of violence as well as hold harm-doers accountable (Mingus, 2016).

- **Gigi:** Gigi's story reveals the ways in which the current child welfare system and mandated reporting can, in fact, cause further trauma/harm to children and families, serve as an expansion of the carceral state, and undermine therapeutic relationships without addressing the root causes of situations that may be labelled as "suspected child abuse." Therefore, building on the seeds related to Gabriela's story, how can we collectively create non-punitive, community-centered/community-driven alternatives to mandated reporting that actually address the root causes of harmful situations (instead of causing more harm after harm is committed)? In my state of confusion after Gigi and her caregiver were investigated, I found resonance in abolitionist child welfare discourses and movements that have existed for decades in the US. For over 20 years, renowned legal scholar and reproductive justice advocate Dorothy Roberts has called for a critical assessment of the racist history of the child welfare system, asserting that reforms have only further entrenched this problematic institution and that abolition of the child welfare system, or what she better describes as the "family regulation system," is necessary for the genuine health of Black families living in the US (Roberts, 2002, 2022). Grassroots organizations led by Black mothers who have been deeply harmed by the child welfare system, such as JMacForFamilies in New York City, have demanded the abolition of

child protective services and for providers to engage in "mandated supporting" instead of mandated reporting (Schwartz, 2020). Collectives of social work students, scholars, activists, and directly impacted families are coalescing to form a movement to amplify these demands for abolition and reimagine the child welfare system entirely (Movement for Family Power, 2020; Network to Advance Abolitionist Social Work, 2022; Social Workers Against Mandates, 2021; upEND, 2020). I feel aligned with calls to abolish mandated reporting laws (Inguanta & Sciolla, 2021) and even the "family regulation system" at large (Roberts, 2020), but I recognize that such work takes time and deep re-imagination and organizing. In the meanwhile, while the system of mandated reporting is in place, how do I navigate my relationship to it in a way that aligns with my own values and beliefs?

- **Aubrey:** Aubrey's story serves as another example of the ineffectiveness of what can be conceptualized as "carceral care," mental health systems that coercively isolate people from their communities rather than seeking to strengthen community bonds and address the root causes of mental health crises, whether the roots are more interpersonal or systemic in nature. In considering Aubrey's story, I find it helpful to return to the occupational therapy profession's roots in the Moral Treatment and Arts and Crafts movements, where occupational therapists acted as activists advocating for participation in meaningful activities over the use of chains and restraints in treating people with mental health challenges (Bryant et al., 2019; Peloquin, 1989). How can we honor our roots in de-carcerating care and build a collective movement to support meaningful participation in daily life for all people—which is what I understand to be a core principle of occupational therapy?

These are some of the seeds that I hope to sow and give new roots to in the next phase of my work as a mental health occupational therapist. Given my firsthand experiences—both personally and professionally—with the limitations and problems of our current "care" systems, it has become of the utmost importance to me to try my very best, in ways both little and big, to uphold values of abolition, transformative justice, and community care in my practices as an occupational therapist. And I believe that all occupational therapists must sincerely consider these values and frameworks if we are serious as a profession about fighting oppressive structures and facilitating meaningful engagement in daily life for all people. But is it truly possible for healthcare workers to bring transformative change when "professionals face the contradictions of being insiders whose work supports the very same relations of ruling that their activism is targeting to change" (Townsend & Marval, 2013, p. 221)?

For now, I believe that these are contradictions worth rigorously unpacking as occupational therapists/health workers whose roles in intimately caring for clients can also afford us unique analyses of the systems we work within. Previous scholarship has suggested that centering the self-determination of families we work with; increasing collaboration among community organizations, neighbors, and schools; forming coalitions to engage in direct actions; and participating in public education to raise critical consciousness are practices that can support occupational therapists in developing a justice-based abolitionist praxis that minimizes harm towards structurally marginalized communities and instead builds supportive alternative

structures (Inguanta & Sciolla, 2021; Townsend & Marval, 2013). However, beyond existing scholarship, health workers across disciplines and sectors must continue to come together with our clients and patients in order to fundamentally re-imagine what our systems of care could look like and determine strategies to achieve these visions without expanding the carceral state, which has been proven time and time again to be diametrically opposed to the equitable care that is needed to support the collective healing of all members of our society. Following the lead of our social work peers, occupational therapy practitioners have recently developed a grassroots Abolitionist occupational therapy space to begin the necessary work of co-creating an occupational therapy-specific abolitionist praxis (Abolitionist OT, n.d.), and I feel hopeful about this important beginning.

Research problematizing mandated reporting policies and the child welfare system at large has been there. For decades. Besides the aforementioned rigorous scholarship of Dorothy Roberts, other literature since at least the 1990s has highlighted how mandated reporting undermines therapeutic relationships and is fundamentally unable to address the complex biopsychosocial and poverty-based roots of child abuse and neglect (Levine et al., 1995; Melton, 2005; Miller et al., 2013). Perhaps more importantly, directly impacted families have been advocating for fundamental change since the system's inception (Raz, 2020). Quite frankly, it's unfortunate that it took multiple problematic experiences to lead me to uncover and listen to what was already there to begin with, whether that's an indictment of health professional education systems or more generally, the professionalization of care. Now the question is—as we listen, what can we do?

I remember that I came into my residency after the summer of 2020 hoping to do something extraordinarily innovative, something groundbreaking. But in the end, I am left with more questions than outcomes or answers. I am changed internally and charged with the intention to leverage my privileges as a health professional and collaborate with others to uplift the voices of directly impacted people and enact systemic and structural-level changes that better support the mental health of people like my dad and the children and families I have encountered this year. To achieve this, I believe that cultivating an abolitionist praxis is critical.

And though I still hold a lot of uncertainty around the how, I now also hold the unwavering belief that change related to our child welfare and healthcare systems needs to be radical. Funnily enough, the word *radical* was originally defined as "of, relating to, or proceeding from a root" (Merriam-Webster, n.d.). In pursuing new roots, I will continue to return to original roots and remember the flowers I have grown along the way.

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