

Statement  
of the  
American Occupational Therapy Association

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Subcommittee on Health

By

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Mr. Chairman and Members of the Subcommittee, thank you for giving the American Occupational Therapy Association (AOTA) the opportunity to testify before the Subcommittee to address the challenges of providing optimal identification and treatment of Post Traumatic Stress Disorder (PTSD). My name is Dr. Carolyn Baum. I am the immediate past President of AOTA. I am also a professor of occupational therapy and neurology and the Elias Michael Director of the Program of Occupational Therapy at the Washington University School of Medicine in St. Louis, Missouri.

### **AOTA and the Profession of Occupational Therapy**

AOTA and I are grateful to the Chairman and Members of the Subcommittee for your leadership in addressing the health care needs of the approximately 8 million veterans enrolled in the U.S. Department of Veterans Affairs (VA) health care delivery system. As the professional association representing occupational therapy, AOTA has more than 38,000 members dedicated to providing the health care and rehabilitative services that help people recover and gain the skills needed to return to family, work and community life.

The goal of occupational therapy is to enable individuals with functional impairments, regardless of the cause, to attain their maximum level of participation and independence. With injured veterans, this can mean helping the veteran learn how to manage activities necessary for maintaining a household—everything from cooking and washing laundry to handling financial affairs; it can mean learning to manage medications; it can mean coping with triggers to prevent anxiety or anger and learning strategies to manage the health conditions associated with their injuries. Occupational therapists help wounded warriors return to their military roles and responsibilities or transition into civilian life; we do this by helping them to develop or regain the skills and strategies that allow them to be successful in all areas of their lives.

Our purpose in this statement is to share the unique role that occupational therapy plays in helping veterans recover from Post Traumatic Stress Disorder (PTSD). We also want to provide recommendations for improving the system of care for this all-too-common disorder among our veterans. This is particularly true in today's environment as many of the returning veterans from Iraq and Afghanistan have sustained serious injuries and been exposed to operational conditions that make PTSD a natural reaction to these extraordinary stresses. While immediate focus is necessary on veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), it must also be noted that the effects of PTSD, if unidentified and untreated, can be delayed and can impact people many years after the trauma took place. Experience with WWII veterans reaching the age of retirement and their increasing identification and struggle with PTSD raises a flag of caution for Korean War and Vietnam veterans. The importance of follow-up screenings to identify individuals who are living with delayed-onset PTSD can't be overemphasized. This need alone provides a strong argument for the full use of occupational therapists for the ongoing assessment of PTSD signs and symptoms for all those who may be affected.

Mr. Chairman, we at the American Occupational Therapy Association are aware that the conflicts in Iraq and Afghanistan continue to increase the Veteran Administration's patient workload. From consultation with our members within the VA, we have heard that they are

struggling to maintain the quality care for which they are known as a result of the increased demand for rehabilitation services. Of concern to AOTA and our members is the need for an increased focus on rehabilitation that will meet the needs of the veteran as he or she faces serious problems that require comprehensive rehabilitation services. There must be a continuum of rehabilitation in hospitals, outpatient clinics, and community rehabilitation centers. Because of the severity of their injuries and conditions, many injured veterans need rehabilitation in their home environment, in order to assess the modifications needed for them to be functional in their homes. Many who are in wheelchairs need an occupational therapist's help to work with building contractors to design and build an accessible route into and out of their homes. Rehabilitation does not stop when veterans are discharged from hospital or medical care; the process continues with post-rehabilitation fitness, community reintegration, social reconnection and work accommodations. All of these are areas in which occupational therapists play an important role.

Occupational therapy rehabilitation can be viewed developmentally and includes four phases: biomedical, client-centered, community-based and independent living. All four phases of rehabilitation may be necessary, as recovery occurs across time. The focus moves from medical treatment to assistance with recovery, to helping people achieve their goals and finally to helping them return to their roles in service, in families and communities, and learn to live with a disabling condition. To determine the specific rehabilitative needs of each veteran, it is necessary to conduct a multidimensional assessment of the person, of the environment and the occupational needs of the individual, to choose the most effective approach (Christiansen, Baum, 2005).

The effective treatment of PTSD and the return of veterans back into their family and community life requires an integrated system of care that includes assessment, goal setting, treatment, and learning to "self-manage" life after injury.

### **The Role of Occupational Therapy in PTSD Treatment**

Occupational therapy is probably best known for the rehabilitation of individuals after illness or injury, for example, stroke, loss of vision, traumatic brain injuries (TBI), and physical burns, wounds, and amputations. However, occupational therapists treat individuals with functional impairment regardless of the specific cause and go beyond the range of physical injury or illness to include the mental and cognitive impairments that can cause disabling conditions. (Gerardi, Newton, 2004).

Occupational therapy's approach to addressing health needs stems from a body of knowledge that is translated from neuroscience, occupational science and environmental science and from evidence-based interventions that recognize the importance of engagement in life and activities in maintaining and restoring health. Occupational therapists and occupational therapy assistants use a body of knowledge and evidence-based interventions that identify the causes of difficulties that are limiting participation. In the case of veterans, these are obstacles that limit their ability to reintegrate into military or civilian life.

In brief, occupational therapy is based on the following evidence-based constructs: (1) Health is linked to engagement in occupation (Haapanen et al, 1996; 1997; Blair & Connelly, 1996; Samitz, 1998, Dorn et al, 1999 and Pennedo & Dahm, 2005. (2) A healthful, balanced lifestyle is

maintained by habits developed and sustained from engagement in daily occupations (Wilcock, 1998). (3) Lack of occupation leads to physiological deterioration and the loss of ability to perform competently in daily life (Kielhofner, 1992). (4) People need to make use of their capacities through engagement in individually motivating and ongoing occupations, and if they pursue this need, they will, enhance their health (Wilcock, 1993).

Occupational therapy uses a client-centered approach to rehabilitation that differs from traditional biomedical therapies. The approach and expertise of occupational therapy practitioners enables them to consider the client's needs, the environmental factors and the family concerns to help the veteran develop and implement effective strategies to overcome disability and maximize quality of life. In client-centered rehabilitation, the strengths and desires of the patient are significant tools for recovery and the therapist is engaged by the veteran to assist them with the achievement of personal goals that will help them return to family, work and community life (Christiansen, Baum, 2005).

The unique perspective of occupational therapy is highly prized by the Army for combat and operational stress control and that model should inform the use of occupational therapy within the VA. AOTA understands the variations in the nature of combat stress and the deeper aspects of PTSD, but the Army model deserves additional attention from the VA and the Subcommittee because occupational therapy brings a third dimension to the system of care commonly employed for PTSD treatment within the VA. Pharmaceutical intervention and counseling are essential aspects of PTSD treatment but they do not use therapeutic activity nor focus as specifically as occupational therapy does on the reduction of functional impairment and the maximization of function and performance. Medication, counseling, and engagement and participation in social and therapeutic activities are all critical tools in helping veterans to recover from PTSD.

Veterans with PTSD have difficulty performing their daily life roles and activities because they reexperience events, and avoid certain activities because they are numbing and/or result in a state of hyperarousal, anxiety or even anger. Consider for example, a soldier who is driving on routine patrol and when a roadside bomb explodes under the vehicle. The soldier might experience a life-threatening injury, or witness the death of a unit member in the vehicle. Upon returning stateside, the individual with PTSD might experience disturbing flashbacks of the event triggered simply by getting behind the wheel of a car, or by driving in general. The individual might then avoid driving altogether, creating a negative spiral that affects his or her ability to engage in important activities involving everything from employment to community and social participation. But occupational therapy can help.

A study by Erica Stern, at the University of Minnesota, compared the driving behaviors and driving related anxiety of 150 soldiers who had returned from OIF to 49 soldiers who had not been deployed. Returned Soldiers' reporting on their past 30 days of American driving, reported significantly worse driving behaviors (with a large percentage of OIF soldiers reporting that they sometimes or always fell into combat driving behaviors, e.g., drove through stop signs (25%), drove in the middle of the road or into oncoming traffic (23%), drove erratically in a tunnel (11%), made turns or lane changes without signaling (35%). Nearly a third of the group had been told that they drove dangerously. These soldiers were a general sample, without known

PTSD, yet in addition to their slips into combat driving behaviors, they also reported significantly more frequent anxiety than their non-deployed comrades. Twenty percent were anxious when driving at any time, with larger numbers being anxious in specific civilian driving situations that mimic combat threats associated with driving, e.g., when driving near roadside debris (31%), near parked cars (25%), through tunnels/underpasses (19%), in slow or stopped traffic (41%), at night (28%), and when passed by other cars (31%), or another car approached quickly or boxed them in (49%). These Soldiers were a convenience sample without known PTSD or head injury. When we hear how their driving is effected, we can easily understand the ways that driving and other daily activities are likely to be changed in soldiers with PTSD.

An occupational therapist would work with the veteran to address the functional impairment caused by the PTSD symptoms. The therapist might use simulated or virtual reality driving experiences in a safe and controlled environment in order to help the veteran extinguish or reframe negative mental or physical reactions.

Overall, an occupational therapist would help the veteran with PTSD through a graduated series of desensitization experiences *within the context of daily activities*. This is done by grading the individual's reactions to traumatic associations at baseline, and a variety of techniques (i.e. relaxation exercises, guided imagery and visualization) to counteract and reduce the reaction to disturbing thoughts and images. Strengthening a person's general coping skills can be addressed by identifying the activities and behavior associated with positive outcomes. Therapists also work with veterans with PTSD to engage in activities that will help them manage or ameliorate depressive symptoms and/or excessive anxiety, and address issues of substance abuse.

For a person with PTSD, occupational therapists might address issues of cognitive executive function, such as memory, planning or organizational skills, that are limiting the individual's performance. They address this by using cognitive behavioral strategies and assist the individual with learning and developing compensatory strategies to improve performance and maximize independence. Another approach used by occupational therapists in task analysis; breaking down complex tasks into manageable parts. This strategy can be effective with activities as basic as bathing and dressing to something as complex as balancing a checkbook or even returning to a particular job.

Such an approach is important for the treatment of PTSD as the person must not only address the issues they experience during acute episodes, but they must also learn strategies to use at a later time when they have recurrent episodes. It is also important to include the families in this process as they can be instrumental in the recognition of problems that require professional attention. They also need to understand what their loved one is experiencing. Occupational therapy's unique approach is to work with the person in regard to the interaction of all aspects of their life and environment.

### **Occupational Therapy in the Veterans' Administration**

The VA has made significant strides in preparing to meet the needs of returning OIF/OEF veterans but work remains to be done. AOTA urges Congress to continue to monitor how the VA uses occupational therapists and other professionals to assure that quality care is provided and

that the full scopes of practice of all professions are brought to bear to meet veterans' needs. Veterans deserve every service and intervention that professionals have been trained to provide. But they should receive services only from qualified professionals.

Throughout the VA system, but particularly within the Polytrauma Rehabilitation Centers, there should be a special focus on appropriate training and on evidence-based practice. Monitoring how each profession is integrated into the team should be done to provide for continuous quality improvement in these facilities.

Additionally, AOTA is concerned about the fragmented way the VA integrates or more problematically, does not integrate occupational therapists and other professionals into multidisciplinary teams for assessment and treatment of PTSD. While VA and Department of Defense (DoD) treatment guidelines for PTSD exist and include occupational therapy, it is the experience of our members that the inclusion of occupational therapists varies from site to site. This variation does not ensure full access to effective treatments and AOTA encourages the committee to look at this issue in detail. It is also our concern that because of the primary role occupational therapy plays in the assessment and treatment of other conditions like TBI, low-vision and traumatic amputations, veterans with PTSD are not getting the access to occupational therapy they need. Occupational therapists are simply not as readily available as they need to be to address PTSD because their workload is so high in other areas. Additional therapists are needed to address PTSD because the unique, activity-based focus of occupational therapy is so critical to recovery from PTSD, particularly during the community reintegration phase of recovery.

It is possible for the private sector to supplement the Veteran's Administration. Occupational Therapists at Washington University School of Medicine in St. Louis are currently contracted to provide services with three of our community based programs. Veteran's referred to us are evaluated by the *Community Practice Program* in their home to determine the issues that may be limiting their ability to care for themselves or others, get in and out of their homes if they are using mobility devices; and to determine if their home arrangements support them in daily tasks like toileting, bathing, preparing meals and maintaining the household. Their needs and goals are determined based on real life needs. If they have unmet mobility or work needs they are referred to either the *Washington University Enabling Mobility Center* (EMC) where they are evaluated and receive mobility and other equipment that will maximize their independence. If needed, they begin a program of post rehabilitation fitness (similar to what is provided at the Intrepid Center at Fort Sam Houston). It is in the fitness program where the veteran can re-build their strength and endurance while socializing with other persons with mobility limitations on equipment designed for people in wheelchairs. If the veteran has a cognitive impairment and needs additional rehabilitation to be able to work or return to school they are referred to our *Occupational Performance Center* (OPC) where they learn strategies to perform work tasks and are assisted in maximizing their work potential using both simulated and then actual work tasks. The OPC team works with employers to create the right environmental fit to use the capacities of the worker. In this program people have gone back to complex jobs like nursing, teaching and the law in addition to trade jobs.

Considerations for the Committee's Attention

1. In order to increase the numbers of occupational therapists within the VA, AOTA urges the Subcommittee to *consider expanding loan repayment programs to ensure that the VA remains an attractive employment option*. This is particularly important because salaries in the VA do not tend to be as high as salaries in other health care settings. The Bureau of Labor Statistics (BLS) estimated that in 2006, the last year for which data is available, the average salary for an occupational therapist was \$62,510. This month, there are two positions at the Palo Alto Polytrauma Rehabilitation Center that are offering \$50,599 and have been open since last July 2007. This variation in salary and subsequent inability to fill the positions is troubling. It is even more alarming when placed in the context of California salaries for occupational therapists for 2006, which averaged \$73,120. That represents a more than \$20,000 salary gap between what is being offered by the VA for a highly complex position treating veterans with polytrauma compared to the statewide average salary. To add to our concern Mr. Chairman, there are additional occupational therapy and rehabilitation positions that were recently posted at that facility as well. The need is not being met by these salary differentials.
2. The BLS data indicates that occupational therapists and occupational therapy assistants are two of the fastest growing professions, with a projected 33% increase in overall positions by 2017. *AOTA urges the Subcommittee and the VA to vigilantly attend to recruitment and retention issues as the market for therapists becomes increasingly competitive.*
3. *AOTA encourages the VA to conduct a thorough, system-wide salary survey to ensure that the VA remains competitive and able to attract the quality, experienced staff necessary to ensure the best care for our veterans.* Sites like the four Polytrauma Rehabilitation Centers and the 17 Polytrauma Network sites require the highest quality staff with significant training and experience in treating veterans with multiple injuries and illnesses, often including PTSD. In hearing from our members from the Polytrauma Network and from others across the country, continuing education is an area that requires additional attention. This is particularly true in relation to the most severely injured veterans where expertise in multiple areas of practice is necessary. Veterans deserve best practices based on current research and evidence.
4. In discussions with the VA National Office, AOTA has offered to work with the VA to develop and implement training modules related to some of the areas of greatest need. This training would be developed with civilian and VA participants to benefit from their collective knowledge, experience and expertise. AOTA is ready to collaborate again with the VA, as we have in the past and we urge the VA to partner with AOTA to help meet the continuing education needs of occupational therapists and occupational therapy assistants within the VA.
5. AOTA encourages the committee to hold a hearing on rehabilitation and reintegration of veterans and invite participation of the national associations, like AOTA, that represent the professions most involved in these phases of recovery in the VA. Such a panel would address best practices, multidisciplinary communication and service coordination to

ensure veterans receive the highest quality and most efficient care. The hearing would inform the Subcommittee on the way various professionals are being used by the VA to meet veterans' needs and provide suggestions for improvement and enhancement of current systems of care.

6. Finally, I would like to address the importance of coordination between the VA and the Department of Defense (DoD) in regard to the transition from active duty to veteran status. It is essential that the VA and DoD ensure continuity of care for all veterans, but especially for those with PTSD and TBI. While the roles and responsibilities of each organization are different, the service member does not process the immediate transformation of their change in status as quickly as the paperwork is done. For service members becoming veterans because of injuries sustained on active duty, the transition can be overwhelming. The Army and other services have established Warrior Transition or similar units to allow recovering soldiers to engage in treatment in familiar circumstances and surroundings. During this stage, VA rehabilitation counselors can meet with soldiers to help create a continuous transition. These counselors often collaborate with the occupational therapists caring for the soldiers in the Warrior Transition units. This is particularly relevant to PTSD because of the prominent role occupational therapists play in Army Combat Stress Control units.

Mr. Chairman, in conclusion I want to reiterate that occupational therapy has expertise in the treatment of functional impairment resulting from a broad range of conditions faced by veterans and should be explicitly included in systems of care or treatment teams established to treat veterans and their families during the acute stages of recovery through the rehabilitation and community reintegration phases. It is the unique treatment focus contributed by occupational therapy—not the replacement of other services—that can help veterans regain control of their anxiety and their future so that they can return to relationships and activities of meaning and purpose in their lives.

Roughly 750 occupational therapists are currently employed by the VA, but many more will be necessary to meet the needs of the new generation of veterans. Occupational therapy allows veterans with PTSD to return to activities of meaning that deliver a sense of normalcy and belonging to veterans and their families.

Thank you for the opportunity to provide testimony to the Subcommittee. AOTA looks forward to working with Congress and the VA to ensure that the profession of occupational therapy is doing everything in its power to meet the needs of our veterans. Mr. Chairman, I would be happy to answer any questions you or the Subcommittee might have. Thank you.

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