Supporting Our Military Families: A Case for a Larger Role for Occupational Therapy in Prevention and Mental Health Care

Alison M. Cogan

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More than 2 million U.S. military servicemembers have deployed to Afghanistan or Iraq since September 11, 2001. Unlike during prior conflicts, many servicemembers leave spouses and children behind. Long, multiple deployments cause strain on family at home, with new challenges arising when servicemembers return from combat and reintegrate into family and civilian life. In World Wars I and II, occupational therapy practitioners played a significant role in supporting servicemember reintegration. However, their presence in program delivery in this practice area is limited. Occupational therapy researchers and practitioners can make a valuable contribution by helping families tailor daily activities and routines to address challenges and optimize health and wellness. However, barriers such as reimbursement for services, workforce availability, and access to military families have limited the profession’s full engagement. Advocacy is needed to help establish occupational therapy as a key component of the mental and preventive health care teams serving military servicemembers.

months in a war zone, nor do they fully address how family roles, routines, and expectations shift during the course of a deployment cycle.

Historically, occupational therapy practitioners have played a significant role in the rehabilitation and reintegration of servicemembers, particularly with wounded warriors and those suffering from “shell shock,” a condition that would now be classified as PTSD. For example, during World War I, occupational therapy aides working with soldiers used craft activities such as weaving, leatherwork, and woodwork to aid in recovery and, in some cases, develop skills that could help the soldier earn a living after he recovered (Creighton, 1992). During World War II, occupational therapy practitioners were again crucial to helping soldiers with psychological trauma return to work and civilian life, and they increased the occupational therapy scope of practice to include teaching activities of daily living, training in the use of prosthetics, fabricating orthotics, and leading therapeutic groups (Gritzer & Arluke, 1985).

Today, occupational therapy practitioners treat military servicemembers in the rehabilitation context for conditions such as head trauma, orthopedic injury, and limb amputation. However, occupational therapy research and service delivery to support reintegration of military personnel with mental health challenges into civilian life has not gained traction, likely as a result of the diminished presence of occupational therapy in the mental health care system (Gibson, D’Amico, Jaffe, & Arbesman, 2011). Now is an opportune time for occupational therapy researchers and practitioners to take action that will restore the profession’s role in supporting the reintegration of military servicemembers and broaden its perspective to include military family members in the process.

**Mental Health Diagnoses and Care Utilization Among Military Families**

Use of mental health services by military servicemembers, their spouses, and children has increased significantly over the past decade and is correlated with the intense deployment cycles that have been characteristic of OEF and OIF. Military family members have described the postdeployment phase, which begins when the servicemember returns home and typically lasts from 3 to 6 mo, as the most challenging (Mmari, Roche, Sudhinaraset, & Blum, 2009). Recent research has shed some light on the psychological issues facing all family members.

**Servicemembers and Combat-Related Mental Health Issues**

As the servicemember tries to reintegrate into the family unit and civilian life, signs of PTSD may emerge. Three key symptoms that must be present for a diagnosis of PTSD are reexperiencing trauma, avoidance and numbing, and hypervigilance (U.S. Department of Veterans Affairs, 2010). Other disruptive symptoms may also be present without a diagnosis of PTSD. For example, common issues with which servicemembers may struggle during this time include difficulty sleeping, headaches, nightmares, anger, hopelessness, and irritability (U.S. Department of Veterans Affairs, 2010). A recent study identified occupational performance difficulties in relationships, school, physical health, sleep, and driving for servicemembers who had recently returned from combat (Plach & Sells, 2013).

In a study that included Army and Marine personnel returning from OIF or OEF deployments, Hoge et al. (2006) reported that 18% of active component and 21% of Reserve and National Guard members had a positive screen for a mental health concern on the Post-Deployment Health Assessment Form (PDHA). However, among servicemembers who had deployed to OIF, 31% attended at least one outpatient mental health visit within the first year after their return, of whom fewer than 8% had received a mental health referral on the basis of their PDHA score (Hoge et al., 2006). These data indicate a discrepancy between the screening process and actual needs for support. Difficulties for which servicemembers sought care during the postdeployment phase included controlling anger, confiding in others, getting along with one’s spouse and children, taking care of one’s health, and “belonging in ‘civilian’ society” (Sayer et al., 2010, p. 593). Suicide is a growing concern, with suicide deaths eclipsing combat fatalities of active-duty Army soldiers and Marines in 2012 (Kovatch, 2013). These issues create significant strain on the servicemember’s family life and make the transition back to daily life in the civilian world seem insurmountable.

**Challenges for Military Spouses and Children**

Although they do not experience combat trauma, the extended and frequent separations from their military servicemember have an impact on all family members. Compared with spouses of servicemembers who were not deployed, spouses of deployed servicemembers used mental health services 19% more for cumulative deployments of 1–11 mo and 27% more for cumulative deployments of >11 mo (Mansfield, Kaufman, Engel, & Gaynes, 2011). The most frequently observed diagnoses were depressive, sleep, anxiety, acute stress, and adjustment disorders (Mansfield et al., 2011). Children with a deployed parent attended more outpatient visits for mental and behavioral health care (Gorman, Eide, & Hise-Gorman, 2010). Mansfield, Kaufman, Engel and Gaynes (2011) reported a positive correlation between mental health diagnoses and longer parental deployment periods in children ages 5–17.

Every individual in the family of a servicemember can be powerfully affected by protracted separations that result from combat deployments and the stressful reintegration period that follows (Gorman et al., 2010; Mansfield et al., 2010, 2011; Sayer et al., 2010). Problems that begin during deployment do not suddenly resolve when the servicemember returns home. In fact, the servicemember’s own mental health issues can exacerbate problems experienced by other family members, even if no one in the family has been diagnosed with behavioral or mental health concerns.
Potential Role for Occupational Therapy

Clearly, gaps exist in both research activity and service provision addressing the challenges inherent in the postdeployment transition period that the profession of occupational therapy is well suited to address. Efficacious interventions need to be developed and provided to help military families build the skill sets, habits, and routines needed in everyday life to overcome obstacles they face. However, accomplishing this aim will require the profession to seize opportunities and negotiate barriers.

Opportunities for Research and Intervention

Existing research has focused exclusively on psychological outcomes. Disruptions in roles and routines during the reintegration process are frequently referenced in the literature, although these concerns have not been systematically investigated to gain a detailed understanding of how they affect individual and family functioning and engagement in health-promoting daily activities. Exploration of the ways in which disability of either a parent or a child in a military family may complicate or exacerbate stresses inherent in military transition periods is missing. Occupational therapy researchers are well equipped to investigate these areas because of the profession’s unique concentration on the relationship between daily activities and health, as well as its emphasis on facilitating full participation in life in the presence of disability.

Research in occupational therapy can provide the conceptual framework to guide the development of interventions that target needs not being met through existing programs. Evidence already exists for the effectiveness of a lifestyle-based, preventive occupational therapy program for improving health outcomes in older adults (Clark et al., 1997). Similar interventions could be developed and tested for efficacy in both preventing negative family outcomes and facilitating community reintegration of veterans. In this context, preventive care could focus on areas such as improving stress management, managing PTSD symptoms and other common postdeployment problems (e.g., headaches and insomnia), and readjusting to living and working in the civilian world by helping families to embed health-promoting routines and activities into daily life. For families coping with the serious mental illness of a family member, occupational therapy can be part of a client- and family-centered treatment program based on a recovery model (Gibson et al., 2011).

Barriers to Occupational Therapy Service Provision

Although the occupation-related needs of servicemembers, veterans, and their families are substantial and occupational therapy services have the potential to be extremely beneficial, several service delivery barriers will need to be overcome. These barriers include payment for services, identification of military-connected people, capacity of the occupational therapy workforce, and stigma attached to mental health services.

The first barrier is the absence of a clear-cut policy for provision of occupational therapy preventive or mental health care. TRICARE is the insurance provider for most active-duty families, and according to its handbook for the standard plan, coverage for prevention services is limited to a few screenings and tests and specifically excludes stress management and “lifestyle modifications” from its coverage (TRICARE, 2012). This is the category into which a preventive occupational therapy intervention would most likely fall. Moreover, occupational therapy practitioners are not authorized mental health providers under TRICARE, which may limit access for those seeking help for psychiatric conditions. Occupational therapy requires a physician referral and is only covered when it is determined to be medically necessary for the treatment of a covered condition (TRICARE, 2008).

On further investigation, however, TRICARE does not have any blanket policies that apply to all plans or all of those who are covered (TRICARE, personal communication, January 24, 2013). Instead, a variety of plans are available through TRICARE, with coverage decisions made on a case-by-case basis. Customization of this kind makes possible negotiation with providers for coverage of preventive or mental health interventions provided by an occupational therapist, even though such interventions are not currently included in standard care.

Beyond the benefits included through TRICARE coverage, the DoD supports the provision of preventive and mental health interventions by offering resources such as Military OneSource, a website that contains information about different aspects of military life and a toll-free number for immediate phone counseling; the Families OverComing Under Stress™ (FOCUS) project, a resilience-based intervention that emphasizes family communication strategies and is delivered by counseling professionals (Lester et al., 2012); and the Yellow Ribbon Reintegration Program, which includes postdeployment events for National Guard and Reserve members to help them connect to local services. However, this recent emphasis on mental health and preventive care has not yet altered the typical benefit package provided through TRICARE insurance plans.

A second barrier is reaching veterans who have separated from the military. For those who are receiving care through the Veterans Health Administration (VA), coverage for health promotion interventions is limited to services delivered by a primary care provider, with family members not typically included in the plan. Veterans and their families may have private insurance coverage and can then access care in a variety of settings; however, they may not always self-identify as being connected to the military. Throughout the U.S. health care system, screening processes are not standardized to identify military-linked patients and families at the start of treatment, but they could be incorporated with minimal effort. Were such intake procedures in place, occupational therapy practitioners across a range of community settings would be better able to tailor treatment planning, as well as identify relevant local resources in accordance with specific military family needs. With more than 1 million more service members projected to separate from the military by 2016 (White House, 2011),
such screening will be essential for connecting veterans to care.

A third possible barrier is that the occupational therapy workforce may not have the capacity to support mental health and preventive care for the military-connected population. As of 2010, fewer than 3% of occupational therapy practitioners surveyed identified mental health as their primary practice area, and only 2% identified a community setting that includes prevention and wellness as their primary workplace (AOTA, 2010). However, a recent shift to emphasize a recovery model in mental health care has created an opportunity for the profession to demonstrate its value as a critical component of the mental health treatment team (Gibson et al., 2011). Moreover, the Accreditation Council for Occupational Therapy Education (ACOTE’s) standards for occupational therapy professional programs require mental health coursework as part of the curriculum; therefore, graduates of those programs are qualified to work in such a role. With more than 4,000 people graduating from occupational therapy professional programs annually in recent years, many new practitioners could fill these positions (Harvison, 2012). Responding to this particular societal health need could strengthen the profession through both the development of new evidence to support interventions and the creation of a niche in the mental health care system.

A fourth barrier that needs to be dealt with is that when services are readily available and covered by insurance, some servicemembers will not seek assistance for mental health issues because of the stigma. Nearly half of active-duty members surveyed believed that they would be viewed as weak and treated differently by unit leaders if they sought mental health care (Kim, Thomas, Wilk, Castro, & Hoge, 2010). Active-duty members consistently reported higher rates of self-perceived stigma compared with National Guard soldiers in the same survey, although more National Guard soldiers reported concerns about the financial cost of care (Kim et al., 2010). At 12 mo postdeployment, only 27% of National Guard and 13% of active-duty servicemembers who indicated having a mental health problem had used some kind of professional support in the previous month (Kim et al., 2010). The military is actively working to change its culture with an antistigma campaign to encourage servicemembers to seek help while reassuring them that their careers will not be damaged (Dingfelder, 2009). Paradoxically, a potential advantage of occupational therapy’s not being perceived as part of mental health care in the military is that stigma may be reduced when accessing an occupation-based preventive or rehabilitative program. In fact, occupational therapy programs, framed as health and well-being support, could conceivably provide a gateway to other kinds of mental health treatment when necessary.

Implications for Occupational Therapy

The profession of occupational therapy must capitalize on opportunities as well as work to overcome barriers to provide needed support to military families. Occupational therapy research can help fill existing gaps in the understanding of the effect of deployments on daily life, and this knowledge can be used to develop manualized treatment approaches. These novel occupational therapy interventions can, in turn, improve health outcomes and life quality of servicemembers and their families, complementing other services such as those offered through the FOCUS project and traditional mental health care. The profession can take action in the following ways:

- Develop and test the efficacy of occupational therapy programs for military-connected families. The development of an evidence base for preventive and mental health practice with military families is critical to the profession’s ability to have an impact in this area. A lifestyle-based preventive program, similar to the complex, manualized intervention developed by Clark et al. (1997), could serve as a model for a family-centered program aimed at improving health outcomes and community reintegration. Alternatively, the process developed by Davidson and Radomski (2012) for helping individuals and families develop new habits and routines that align with their goals and vision for the future could be further researched and, eventually, widely disseminated. These intervention approaches provide a useful starting point for outcome studies. Such investigations may target military-connected personnel either with or without disabilities. Designated funding from the American Occupational Therapy Foundation (AOTF) to support such studies could help to promote this action.

- Ensure that the identification of military status is standard in all occupational therapy evaluations. Efforts are underway in many school districts across the nation to identify children who are part of a military family. However, occupational therapy practitioners are likely to encounter military family members or veterans in almost any community practice setting who may not self-identify as being connected to the military. Practitioners should consistently inquire and subsequently document whether a person is military connected, adjust treatment accordingly, and be knowledgeable about what pertinent services are available locally.

- Advocate for a larger role for occupational therapy in mental health. Coverage for occupational therapy interventions for mental health and preventive care, although negotiable, remains unclear under TRICARE insurance plans. This complication stems from the larger issue of diminished occupational therapy presence in mental health care over the past several decades. Because of the profession’s emphasis on everyday activity and work adjustment, occupational therapy services are unique and complement interventions offered by other mental health specialists. Acceleration of relevant research, expansion of student fieldwork opportunities in mental health, and growth of the workforce with expertise in provision of occupational therapy mental health services will enhance the effectiveness of advocacy efforts. Lobbying efforts by the American Occupational Therapy Association (AOTA) and the American Occupational Therapy Political Action
Committee (AOTPAC) should continue to emphasize the profession’s role in mental health, such as the current initiative to build support for the Occupational Therapy in Mental Health Act (H.R. 1037).

- Build understanding of the profession’s diverse scope of practice. Occupational therapy is well established in the military context as a rehabilitation provider for people with physical injuries and disability. This familiar perception of occupational therapy as unrelated to mental health can paradoxically be helpful for reducing stigma when services are accessed for a family-centered, occupation-based intervention aimed at promoting a family’s well-being through the reintegration process. However, the profession must first reach out to the military community and create widespread understanding of the breadth of occupational therapy services. Coordinated lobbying efforts to educate military and political leaders about the occupational therapy scope of practice would be effective strategy.

Risks of Inaction

Other professionals will likely try to address the unmet needs of military families should occupational therapy researchers and practitioners fail to capitalize on these opportunities. Social work and psychology are well established in the military context both within the DoD health system and as authorized mental health providers under TRICARE. Their national organizations actively promote practice and research with military-connected populations in their respective professions. For example, the National Association of Social Workers (NASW) published NASW Standards for Social Work Practice With Service Members, Veterans, and Their Families (NASW, 2012), and several academic programs offer courses, certificates, or specializations in military social work. Psychology professionals developed the FOCUS intervention, which has been widely implemented across military installations. The occupational therapy profession must act resolutely to be recognized and accepted in the context of mental health with military-connected populations.

Summary

The wars in Iraq and Afghanistan have been unprecedented in many ways. They are the longest conflicts in the history of the United States. The demographics of military personnel have changed from previous eras to include considerably more servicemembers with families. However, we are only beginning to understand the heavy burden of prolonged and repeated deployments on servicemembers, their spouses, and their children.

Evidence-based occupational therapy interventions for both preventive and mental health care could be of significant benefit to servicemembers, veterans, and their families. However, the current payment structure of TRICARE and the VA may not consistently offer coverage for these services. Advocating for reimbursement of services that address the unmet needs of military families may lead to a restoration of the profession’s role in mental health and firmly establish the profession as a leader in preventive care in other contexts. Building on the existing evidence base, research evaluating occupational therapy intervention for military-connected families will further support advocacy efforts.

OIF has officially concluded, and OEF is scheduled to end in 2014. Nearly 1.5 million servicemembers have already left the military in the past decade, and many more will follow in the next few years. Occupational therapy services could be valuable to help these veterans and their families manage the process of reintegrating into civilian life. This issue does not, however, end in 2014. As evidenced by prior wars, the effects of combat experience are lasting. The long-term impact of the intensive deployment cycle on young children in military families has yet to be fully appreciated. True to our Centennial Vision of meeting society’s occupational needs, our profession must prepare itself to meet these ongoing challenges. ▲

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References


Hoge, C. W., Auchterlonie, J. L., & Milliken, C. S. (2006). Mental health problems, use of mental health services, and attrition...


