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Guest Editorial

# Posttraumatic Stress Disorder and Work

This special issue of *WORK: A Journal of Prevention, Assessment & Rehabilitation* entitled, "Posttraumatic Stress Disorder and Work," describes programs and interventions that helped individuals with Posttraumatic Stress Disorder (PTSD) engage in occupation. These interventions took place in diverse settings and varied in length depending on the needs of the clients. Settings included the community (Precin, Article 1), war (Matilla et al., Article 2), a school (Maxwell, Article 3), a Welfare-to-Work program (Precin, Article 5), a hospital (Precin, Article 6), a community-based occupational therapy clinical setting (Champagne, Article 7), a private practice (Precin, Article 8), and a lawyer's office (Precin, Article 9). This special issue begins with descriptions of programs that helped many individuals with PTSD return to work as quickly as possible. In Article 1 (Precin), workers displaced after the 9/11 terrorist attack were placed in new jobs as soon as they were ready to work again after receiving psychological trauma intervention through a rehabilitative employment program created for this purpose. This program helped them avoid further financial problems and depression that can occur if lengthy periods of unemployment occur. The U.S. Army Combat Operational Stress Control Unit enabled soldiers to be rapidly redeployed (Matilla et al., Article 2). A Welfare-to-Work program offered services to enable individuals with disabilities such as PTSD to work (Precin, Article 5).

Yet, individualized, long-term, creative interventions were necessary for individuals with more profound symptoms, co-existing disorders, or chronic childhood abuse. O., from Article 6 (Precin), was a victim of ongoing satanic ritual abuse that resulted in her acquiring PTSD and dissociative identity disorder. The staff spent an initial period building trust and assessing O. followed by occupational therapy intervention using the modality of a treadmill that prepared her for return-to-work after an eight-month psychiatric inpatient hospitalization. Beth, in Article 7 (Champagne), was diagnosed with PTSD and Depression and displayed sensory processing symptoms. She was able to increase her work performance and occupational engagement through the Sensory Modulation Program and Cognitive Behavior Therapy. Jakee, in Article 8 (Precin), suffered neglect; physical, verbal, and emotional abuse; and had been exposed to sexual perversions throughout her childhood. She selected her own intervention, performing in rock concerts, which fit her specific symptoms and interests and was able to execute it with the help of an occupational therapist. And finally, an expert witness' evaluation of a plaintiff with PTSD (Article 9, Precin) demonstrated that it is possible to develop adequate coping mechanisms to manage symptoms of PTSD in order to function in diverse roles of choice.

So, given a traumatic experience(s), who acquires PTSD and who does not? Given intervention for severe symptoms, who can learn to adapt well enough to engage in occupation and who cannot and why? Maxwell highlighted differences in socioeconomic status, chronic versus acute trauma, gender, and social supports using an analysis of two very different literary characters in Article 3. Lopez discussed the intricacies of resilience and vulnerability in relation to trauma in Article 4.

These chapters collectively indicate that the causes of trauma are as varied as the symptoms they cause and resilience and vulnerability are contingent upon many different internal and external factors. As these chapters show, it is possible to tailor interventions according to the context of individuals with PTSD to help them engage in occupation.

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