The need for rehabilitation services for individuals returning from military service has perhaps never been greater. Since October 2001, approximately 1.64 million U.S. military personnel have deployed as part of Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) (Tanielian & Jaycox, 2008). The current theater of military operations in Iraq and Afghanistan are resulting in a new generation of veterans with complex physical injuries and psychological and emotional trauma. Medical innovations and advanced body armor technology have enabled over 90% of military personnel injured in the OEF/OIF conflicts to survive injuries that would likely have been fatal in previous wars (Hyer, 2006; Lew et al., 2007). It is estimated that for every military personnel killed in these wars, there are at least sixteen wounded, and many will return to the United States with some type of disability. In addition to physical disabilities, the number of soldiers discharged with mental health diagnoses is estimated to be at a rate of over 20% (Hoge, Auchterlonie, & Milliken, 2006; Seal, Bertenthal, Miner, Sen, & Marmer, 2007).

The size of the number of military personnel incurring disabilities in the current military conflicts is larger than has been seen in the US in over three decades. The scope and severity of the personal, vocational, social, and economic impact of service-related disability has not yet been fully realized and the numbers will continue to escalate well past the end of military action. Certified Rehabilitation Counselors (CRCs) can and should play an important role in working with veterans with disabilities as they reintegrate into work and social roles. Specialized training and education related to vocational and psychosocial rehabilitation make CRC’s uniquely qualified to address the holistic needs of veterans and their families; and (5) the call for rehabilitation to develop researchers that focus on veterans’ issues.

Rehabilitation counseling should take a central role in the services provided to military personnel discharged with a disability. Rehabilitation professionals are in an ideal position to provide appropriate services to disabled military veterans who wish to return to gainful employment and a rewarding quality of life. A number of important issues need to be addressed to further understand and implement the most effective rehabilitation counseling services for OEF/OIF veterans with disabilities. For example, there is not yet reliable information available about the employment status of either retired active duty personnel, or the military reservists who, as a result of disability, are not able to return to their previous employment. Nor is there information about the specific vocational rehabilitation needs of such individuals, or how effectively these needs are being addressed.

The Department of Veterans Affairs Veterans Benefits Administration’s Vocational Rehabilitation and Employment (VR&E) service is vested with delivering Vocational Rehabilitation (VR) services to veterans with service-connected disabilities; in addition, for a variety of reasons, many recently
disabled veterans will also be served by state VR agencies and this number will likely increase in the next few years. Because many of the veterans will no longer be able to engage in the work roles and tasks they performed prior to their military service, due to the nature of the commonly incurred disabilities and injuries (e.g., amputation, head injury, psychological disorders), effective vocational services will require specialized knowledge of the psychosocial, medical, and vocational aspects of this growing number of consumers.

There will be a significant impact across the U.S. occupa
tional structure due to the numbers of veterans returning to work with a new disability. Issues including effective assessment, training and retraining, work accommodation, employment consulting, and case management are subjects that rehabilitation coun-
selors are well-prepared to address; however, these issues have not been experienced in this context and to this extent in decades.

These issues will continue to emerge as critical topics of rehabili-
tation research and practice in the next few years. Further, regard-
less of the nature and severity of injuries sustained in Iraq and Afghanistan conflicts, the number of new rehabilitation issues specific to OEF/OIF veterans, with which rehabilitation counselors may be very effective, but that may require additional training or education beyond what is currently provided.

The purpose of this paper is to provide an overview of the current and prospective rehabilitation counseling issues faced by OEF/OIF veterans with disabilities, and to present a five-pronged approach that addresses emerging rehabilitation needs.

This approach is summarized here, and each element is further
discussed below. This five-pronged approach, or roadmap, includes:
(1) making an issue of rehabilitation needs, (2) focusing on distinct employment needs for veterans; (3) using self-management techniques to prevent and manage secondary disabilities; (4) focusing on the holistic needs of veterans and their families; and (5) the call for rehabilitation to develop therapies that focus on veterans’ issues. Using the elements of the roadmap, we begin with an overview of the rehabilitation issues associated with the OEF/OIF conflicts.

Overview: The Current Situation

In this overview we provide a brief review of the current situation of OEF/OIF combat and the physical and psychological disabilities that are commonly experienced. The employment situation for returning veterans and Reservists is also described.

The Current American Military Forces

The nature of the combat and the demog-
rphy of the U.S. military force involved in the OEF/OIF conflicts presents a historically unique profile. The recent war theater deployments have seen a very different type of soldier than past military combat and present a different type of client for rehabilita-
tion counselors upon discharge. One important difference from prior wars is that the OIF/OEF conflicts “mark the first time that the United States has attempted to fight an extended conflict with a post-Cold War all-volunteer force” (Tanielian & Jaycox, 2008, p. 22). As a result, the current conflicts involve a larger proportion of Reservists. Indeed, it is estimated at any one time 30-50% of military personnel deployed in Iraq are reservists.

Each military service has personnel in two components:
 Active and Reserve. The active component includes personnel who are full-time, active duty forces. The Reserve Component includes Reserve (Army, Navy, and Marine Corps) and National Guard (Army, Air Force) forces (Tanielian & Jaycox, 2008). In force was modified by the Act of Defense of Defense for Active Component: the Air Force had 65% percent; the Navy, 83% per-
cent; and the Marine Corps, 82% (Department of Defense, 2008 cited in Tanielian & Jaycox, 2008). The remainder of each serv-

ice is made up of reservists.

Military reservists are much more likely to be married, and have been employed outside of the military before being deployed. (In 2004, approximately 52% of the total military force was married vs. 50% of the Under Secretary of Defense for Personnel and Readiness, 2005). Reservists also tend to be older than the Active Component, and in 2004 the Government Accountability Office reported that the Reserve Component had five times the proportion of service personnel aged 45 and older compared with the Active Components (United States Government Accountability Office, 2005).

The current military personnel exposed to trauma are much more likely to survive and be deployed into battle. This is due to the nature of the current OIF/OEF combat has resulted in new patterns of polytraumatic injuries, and resulting disabilities that many as 100,000 soldiers had been wounded, injured or otherwise disabled with conditions that are not readily identifiable, includ-
ing mild brain injury and psychological conditions such as post-
traumatic stress disorders (PTSD).

In a more recent analysis, RAND Corporation conducted a comprehensive study of the post-deployment health-related needs associated with post-traumatic stress disorder, major depression, and traumatic brain injury among OEF/OIF veterans. Based on this study, about 14% of the deployed forces and their families sampled from 24 geographic areas, substantial rates of men-
tal health problems in the past 30 days were identified, with 14% of participants screening positive for PTSD, 14% for major depression, and 19% reporting a probable traumatic brain injury (TBI) during deployment (Tanielian & Jaycox, 2008). Assuming that the prevalence of conditions is comparable to current estimates of the service members who had been deployed for OEF/OIF as of October 2007, the researcher’s estimate that approximately 300,000 to 400,000 veterans in the 18 to 24 year old age range or major depression and PTSD, and 320,000 individuals have experienced a probable TBI during deployment (Tanielian & Jaycox, 2008). “About one-third of those previously deployed have at least one of these conditions, and about 5% report symptoms of all 3 conditions” (Tanielian & Jaycox, 2008, p. xxi). Further, some groups, including military reservists, who have left military service may be at high-
er risk of experiencing these conditions (Tanielian & Jaycox, 2008).

Physical and Psychological Disabilities

The survival rate of injured military personnel in OIF/OEF is more than 90% due to advances in battlefield medical treatment and advanced protective gear (Hyer, 2006). Service members injured are surviving injuries that would have been fatal in past conflicts. The severity of their injuries, however, can result in a lengthy transition from injury to veteran.

The nature of the current OEF/OIF combat has resulted in new patterns of polytraumatic injuries, and resulting disabilities that many as 100,000 OEF/OIF veterans who separated from active duty between 2001 and 2005 and sought care from VA medical facili-
ties, Seal et al. found that 25% had received mental health diag-
oses of which 60% were diagnosed in the past year. Over 30% of the sample had received either mental health or psychoso-
cial diagnoses. Most initial mental health diagnoses (66%) were made in primary care settings. Younger veterans (18 to 24 years) were at greater risk for receiving mental health and PTSD diag-
oses, compared to those 40 years or age of older.

In the area of mental health, there are many specific and potentially unique rehabilitation issues that are emerging and that will require identification and development of training and educa-
tion for CRCs. For example, we can expect a large percentage of veterans to experience mental health issues after their mili-
tary service ends. A recent Insurance Information Institute report (II, 2006) suggests that few employers or insurance claims staffs are trained to properly identify the disabling conditions that may emerge in the post-service period. Issues such as training employ-
ers about monitoring for mental illness may become an important role for CRCs.

Employment Issues for Returning Veterans and Reservists

In 2005, the National Defense Act mandated transition assis-
tance to meet the needs of mobilizing National Guard members, mainly to address the needs of those returning from the wars in Iraq and Afghanistan. Included in this act was the Disabled Transition Assistance Program (DTAP), designed to serve the needs of individuals who are disabled at the time of demobiliza-
tion. This act was a needed first step to address the employment needs of the large numbers of military reservists returning from war with disabilities that prevent them from returning to their previ-
ous employment, or that make necessary adaptations to return success fully to work.

According to the Bureau of Labor Statistics (BLS, 2006) of the U.S. Department of Labor, in August 2005, the unemployment rate for all veterans of the U.S. Armed Forces was 3.9%. However, there were 3.4 million Gulf war veterans (those who served anytime since August 1990) in the labor force, and the job-
less rate for these veterans was 5.2%. About 11% of all veterans have service-connected disabilities (with a higher rate among Gulf war veterans). Among males, 18 to 24 years old, veterans have a significantly higher jobless rate than non-veterans (17.2% vs. 10% for those 18 years and younger). In January 2002 and August 2005, about 5 in 155, 167,000 reported a service-connected disability (BLS, 2006). In addition, Gulf war veterans in the 18 to 24 year old age range have unemployment rates almost double the general population, in part due to the high rate of mental and physical disabilities resulting from deployment (BLS, 2006).

According to a recent Insurance Information Institute report (II, 2006), it is estimated that over two million military personnel will serve in the OIF/OEF conflict. The military reserves are now 30% are considered “citizen soldiers” from the National Guard and Reservists (II, 2006). Specifically, as of October 31, 2007, 616,811 military personnel have participated in OEF or OIF. Of these, approximately, 1.2 million were active mili-
tary, and 455,009 (approximately 28%) were reserve forces (Office of the Under Secretary of Defense, 2007).

There has been little published information about the employ-
ment situation of Reservists who have become disabled. However, one recent study suggested that the likelihood of even non-dis-

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displaced veterans will also be served by state VA agencies and this number will likely increase in the next few years. Because many of the veterans will no longer be able to engage in the work roles and tasks they performed prior to their military service, due to the nature of the commonly incurred disabilities and injuries (e.g., amputation, head injury, psychological disorders), effective vocation counseling and job placement services will require specialized knowledge of the psychosocial, medical, and vocational aspects of this growing number of consumers.

There will be a significant impact across the U.S. occupa- tional structure due to the numbers of veterans returning to work with a new disability. Issues including effective assessment, training and re-training, work accommodation, employment consult- ing, and case management are subjects that rehabilitation coun- selors are well-prepared to address; however, these issues have not been experienced in this context and to this extent in decades. These issues will continue to emerge as critical topics of rehabil- itation research and practice in the next few years. Further, regard- less of the numbers in Iraq and Afghanistan conflicts, there are new rehabilitation issues specific to OEF/OIF veterans, with which rehabilitation counselors may be very effective, but that may require additional training or education beyond what is currently provided.

The purpose of this paper is to provide an overview of the current and prospective rehabilitation counseling issues faced by OEF/OIF veterans with disabilities, and to present a five-pronged approach to meeting these emerging rehabilitation needs. This approach is summarized here, and each element is further discussed below. This five-pronged approach, or roadmap, includes: (1) infusing veterans’ issues into rehabilitation training; (2) focusing on distinct employment needs for veterans; (3) using self-management techniques to prevent and manage secondary disabilities; (4) addressing polytraumatic injury disability (PTID); and (5) the call for rehabilitation to develop researchers that focus on veterans’ issues. By utilizing the elements of the roadmap, we begin with an overview of the rehabilitation issues associated with the OEF/OIF conflicts.

Overview: The Current Situation

In this overview we provide a brief review of the current findings on veterans’ combat and physical and psychological disabilities that are commonly experienced. The employment situation for returning veterans and Reservists are also described.

The Current American Military Force

With the nature of the combat and the demog- raphy of the U.S. military force involved in the OEF/OIF conflicts present a historically unique profile. The recent war theater deployments have seen a very different type of soldier than past military combat and present a different type of client for rehabil- itation counselors upon discharge. One important difference from prior wars is that the OEF/OIF conflicts “mark the first time that the United States has attempted to fight an extended conflict with a post-Cold War all-volunteer force” (Tanielian & Jaycox, 2008, p. 22). As a result, the current conflicts involve a larger proportion of Reservists. Indeed, it is estimated at any one time 30-50% of military personnel deployed in Iraq are reservists.

Each military service has personnel in two components: Active and Reserve. The active component includes personnel who are full-time, active duty forces. The Reserve Component includes Reserve (Army, Navy, and Marine Corps) and National Guard (Army, Air Force) forces (Tanielian & Jaycox, 2008). In force was the rate of polytrauma in the U.S. Army Reserve force in OEF/OIF. The Army Reserve, a primary military source for Non-combatant, the Air Force had 65% percent; the Navy, 83% per- cent, and the Marine Corps, 82% (Department of Defense, 2008 cited in Tanielian & Jaycox, 2008). The remainder of each serv- ice is made up of reservists.

Military reservists are much more likely to be married, and have been employed outside of the military before being deployed. In 2004, approximately 52% of the total military was married (Office of the Under Secretary of Defense for Personnel and Readiness, 2005). Reservists also tend to be older than the Active Component, and in 2004 the Government Accountability Office reported that the Reserve Component had five times the proportion of service personnel aged 45 and older compared with the Active Components (United States Government Accountability Office, 2005).

The current military personnel exposed to trauma are much more likely to experience a deployment, due to the injuries sustained in military combat in urban areas being female (Hoge et al., 2006). Women accounted for approximately 14% of the total military in 2004, the Under Secretary of Defense for Personnel and Readiness, 2007).

As compared to the civilian workforce, the military has more Blacks and fewer Hispanics, Whites, and Asian Americans/Pacific Islanders (Tanielian & Jaycox, 2008). Also, military personnel are less likely to have spent any time in active duty, with 60% of the active duty enlisted force being the ages of 17 and 24 (Tanielian & Jaycox, 2008).

Physical and Psychological Disabilities

The survival rate of injured military personnel in OEF/OIF is more than 90% due to advances in battlefield medical treatment and advanced protective gear (Hyer, 2006). Service members injured are surviving injuries that would have been fatal in past conflicts. The severity of their injuries, however, can result in a lengthy transition from injury to injured veteran. The nature of the current OEF/OIF combat has resulted in new patterns of polytraumatic injuries, and resulting disabilities that are being treated in veteran services due to the high energy explosives with shrapnel, which cause ultra-high velocity fragmentation injuries, often to the extremities. The Blast Polytrauma Trauma (BPT) from one of these improvised explosive devices require an average of five sur- geries, and it is estimated that these recent conflicts have been responsible for an estimated total of 28,000 to 30,000 surgeries (Hyer, 2006). An estimated 47% of Defense (DoD) reported 1,031 individuals had had amputations, of whom 750 had major limb amputations (Fischer, 2008).

The DoD has reported that approximately 29,300 soldiers have been physically injured in Iraq through March 8, 2008 (White, 2008). Estimates from the United States Government Accountability Office (2005) suggested that, through 2005, as many as 180,000 soldiers had been wounded, injured otherwise disabled with conditions that are not readily identifiable, includ- ing mild brain injury and psychological conditions such as post- traumatic stress disorders (PTSD).

In a more recent analysis, the RAND corporation conducted a comprehensive study of the post-deployment health-related needs associated with post-traumatic stress disorder, major depression, and traumatic brain injury among OEF/OIF veterans. Based on data collected from 1,965 previously deployed individ- uals sampled from 24 geographic areas, substantial rates of men- tal health problems in the past 30 days were identified, with 14% of participants screening positive for PTSD, 14% for major depression, and 19% reporting a probable traumatic brain injury (TBI) during deployment (Tanielian & Jaycox, 2008). Assuming that the prevalence of these conditions remains constant for the service members who had been deployed for OEF/OIF as of October 2007, the researcher’s estimate that approximately 300,000 men and 120,000 women of the nearly 200,000 reported in- jury and 220,000 individuals have experienced a probable TBI during deployment (Tanielian & Jaycox, 2008). "About one-third of those prolonged deployed at least some of the past 90 days had symptoms of all three conditions, and about 5% report symptoms of all 3" (Tanielian & Jaycox, 2008, p. xxi). Further, some groups, including military reservists, who have left military service may be at high- er risk of experiencing these conditions (Tanielian & Jaycox, 2008).

A recent analysis by Seal et al. (2007) further highlights both the high rates of psychological disorders and the higher preva- lence among specific groups. In their review of the records of over 100,000 OEF/OIF veterans who separated from active duty between 2001 and 2005 and sought care from VA medical facili- ties, Seal et al. found that 25% had received mental health diagno- ses, with more than twice the diagnosis. Over 30% of the sample had received either mental health or psychosocial diagno- ses. Most initial mental health diagnoses (66%) were made in primary care settings. Younger veterans (18 to 24 years) were at greater risk for receiving mental health and PTSD diag- noses, compared to those 40 years of age or older.

In the area of mental health, there are many specific and potentially unique rehabilitation issues that are emerging and that will require identification and development of training and educa- tion for CRCs. For example, we can expect a large percentage of veterans to experience mental health issues after their mili- tary service ends. A recent Insurance Information Institute report (II, 2006) suggests that few employers or insurance claims staffs are trained to deal with post-deployment health-related issues. There is almost no information about adjusting to work with veterans with mental health issues.

Employment Issues for Returning Veterans and Reservists

In 2005, the National Defense Act mandated transition assis- tance to meet the needs of mobilizing National Guard members, mainly to address the needs of those returning from the wars in Iraq and Afghanistan. Included in the act was the Disabled Transition Assistance Program (DTAP), designed to serve the needs of individuals who are disabled at the time of demobiliza- tion. This act was a needed first step to address the employment needs of the large numbers of military reserves returning from war with disabilities that prevent them from returning to their pre- previous employment or, that make necessary adaptations to return successfully to work.

According to the Bureau of Labor Statistics (BLS, 2006) of the U.S. Department of Labor, in August 2005, the unemployment rate for all veterans of the U.S. Armed Forces was 3.9%. However, there were 3.4 million Gulf war veterans (those who served anytime since August 1990) in the labor force, and the job- less rate for these veterans was 5.2%. About 11% of all veterans had service-connected disabilities (with a higher incidence among Gulf war veterans). Among males, 18 to 24 years old, veterans have a significantly higher jobless rate than non-veterans (17.2% vs. 10.4%). Of the nearly 1.3 million males in the age range between January 2002 and August 2005, about 5,167,000 reported a service-connected disability (BLS, 2006). In addition, Gulf war veterans in the 18 to 24 year old range have unemployment rates almost double the general population, in part due to the high rate of mental and physical disabilities resulting from deployment (BLS, 2006).

According to a recent Insurance Information Institute report (II, 2006), it is estimated that over two million military personnel will serve in Iraq and Afghanistan. Many of the veterans (30%) are considered “citizen soldiers” from the National Guard and Reservists (II, 2006). Specifically, as of October 31, 2007, 1,688,811 military personnel have served in operations OEF or OIF. Of these, approximately, 1.2 million were active mil- itary, and 455,009 (approximately 28%) were reserve forces (Office of the Under Secretary of Defense, 2007).

There has been little published information about the employ- ment situation of Reservists who have become disabled. However, one recent study suggested that the likelihood of even non-dis-

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Infusion of information in the rehabilitation counseling curriculum and trainings should focus on the ability to recognize and screen for disabilities, particularly non-visible and psychological disabilities that are typical to OEF/OIF combat (e.g., TBI, PTSD, Tinnitus, Auditory Processing Deficit), and the mental health issues associated with them. Rehabilitation counselors should be familiar with and be able to identify an overview of the VA Polytrauma centers for both PTSD and TBI. An example of a three-item clinical screen for PTSD includes the following questions: 1) Have you ever seen anyone yourself engaged in direct combat where you discharged your weapon?; 2) During this deployment did you ever feel you were in great danger of being killed? (Hoge et al., 2006). A similar three-item screen for further evaluation can be used for TBI: (1) Have you ever been in a blast/explosion (or close proximity), vehicular crash, or fall;? (2) Have you ever been rendered unconscious;? (3) Have you ever had a head trauma? (Lew et al., 2007). A positive response to any of the above six questions would indicate to the counselor that more significant evaluation of the individual is needed.

In addition, counselors should be aware of some of the subtle signs of TBI, such as difficulty reading when no vision problem exists, and tinnitus (Lew et al., 2007). Hearing loss and problems with auditory processing may also alert the counselor to check for a possible TBI more thoroughly. Individuals with PTSD often try to deal with the situation on their own through the use of substances, gambling, or self-medicating treatments that have been developed for use in the VA Polytrauma centers for both PTSD and TBI. An example of a three-item clinical screen for PTSD includes the following questions: 1) Have you ever seen anyone engaged in direct combat where you discharged your weapon?; 2) During this deployment did you ever feel you were in great danger of being killed? (Hoge et al., 2006). A similar three-item screen for further evaluation can be used for TBI: (1) Have you ever been in a blast/explosion (or close proximity), vehicular crash, or fall;? (2) Have you ever been rendered unconscious;? (3) Have you ever had a head trauma? (Lew et al., 2007). A positive response to any of the above six questions would indicate to the counselor that more significant evaluation of the individual is needed.

In focusing on Direct Employment Needs for Veterans (e.g., Bishop, Frain, & Tschopp, 2008; Devins & Shneck, 2000), Rehabilitation professionals are uniquely trained to help in this area of multiple rehabilitation issues. Veterans return from active duty in Iraq and Afghanistan. This discussion addresses: (1) infusing veterans’ issues into rehabilitation training; (2) focusing on direct employment needs of veterans; (3) understanding self-management techniques to prevent and manage secondary disabilities; (4) using a Family Resiliency Model to address the holistic needs of veterans and their families; and (5) for rehabilitation to develop researchers that focus on veterans’ issues.

### Infusion of Veterans’ Issues into Rehabilitation Training

Infusion of military issues into the existing training of rehabilitation counselors and professionals mirrors the national push for veteran services for military personnel who have become disabled. Currently, the majority of textbooks in the core rehabilitation training courses do not specifically address veteran issues. A review of recently published rehabilitation counseling textbooks failed to identify more than brief and general references to the wars and their implications for the professions. Perhaps for this reason veteran issues do not receive particular attention in textbooks and curriculums of rehabilitation counselors (Chan, Leathy, Saunders, Tarrydas, Ferrin & Lee, 2003), and likely are not emphasized in classroom or in-service training of rehabilitation professionals. To the extent that this is the case, it reflects a decrease in the need for rehabilitation counseling services for acutely disabled veterans over the past decade, with the wars in both Iraq and Afghanistan being the largest sustained combat operations since the Vietnam War, the training situation is quickly changing (Litz, 2008). We therefore call on educators, textbook authors, and in-service training providers and groups, such as the Regional Rehabilitation Continuing Education Programs (RCEPs), to recognize this growing need of those entering or currently employed in the rehabilitation field to have knowledge concerning veteran’s disability issues. In particular, until a more complete understanding of the mental health needs that veterans are likely to be involved in (frequently this involves multiple systems concurrently).

### Using Self-Management Techniques to Prevent and Manage Secondary Disabilities

Self-management has been broadly defined as learning and practicing the skills necessary to carry on an active and emotionally satisfying life in the face of a chronic condition (Lorig, 1993). High levels of self-management have been associated with increased perceived control over both illness-related and non-illness-related aspects of life and better health outcomes (e.g., Bishop, Fran, & Tschopp, 2008; Devins & Sheek, 2000). Self-management typically includes taking one’s medications, following recommended diet and exercise programs, and showing up for scheduled appointments with medical providers. Initial studies in the rehabilitation field suggest that individuals with high levels of self-management are less likely to...
of recently published rehabilitation counseling textbooks failed to ran issues are not seen as an important part of the roles and functions of rehabilitation counselors. Perhaps for this reason Velvet for rehabilitation counseling services for acutely disabled veterans. To the extent that this is the case, it reflects a decrease in the need for rehabilitation counseling services for acutely disabled veterans over the past 10 years, with the wars in Afghanistan and Iraq being the largest sustained combat operations since the Vietnam War, the training situation is quickly changing (Litz, 2008). We therefore call on educators, textbook authors, and in-service training providers and groups, such as the Regional Rehabilitation Continuation Education Programs (RCEPs), to recognize this growing need of those entering or currently employed in the rehabilitation field to have knowledge concerning veteran’s disability issues. In particular, until a more complete understanding of the roles and functions of rehabilitation counselors is achieved, early distress and symptoms of PTSD are not good predictors of long-term adaptation. For instance, 40% of veterans with chronic PTSD did not initially show Acute Stress Disorder. Thus problems that are apparent in both screening tools and courses about these services will enable more effective counselor advocacy and rehabilitation planning. In particular, employment-based services provided through Vet Centers, Compensated Work Therapy through the Veterans Affairs and the National Defense Authorization Act of 2005 (NDAA) have suggested that Reservists change employers due to stigma like leads to many veterans having undiagnosed mental disorders (Kilgore, Strez, Castro, & Bond, 2006). When a disability is involved, when a disability is involved, then veterans without a disability. Counselors can also share information with employers about the benefit of short-term reassignment with veterans who are experiencing anxiety as a way to reintegrate at a pace that is consistent with their long-term needs of both employer and employee (Freey & Hofboll, 1995).

In addition to helping employers understand their various roles in the reintegration of veterans, rehabilitation counselors have significant training and skills to help veterans understand their occupational options when returning from war with a disability (e.g. Chan et al., 2003).

With specialized skills and knowledge related to employment reintegration, employer education, and transferable skills analysis, it appears that rehabilitation counselors are well-prepared to be at the forefront of delivering rehabilitation services to veterans who have a disability. Counselors should be involved in rehabilitation plan development, job seeking skills, employer recruitment, and placement services in order to have the most successful long-term outcomes for veterans.

Using Self-Management Techniques to Prevent and Manage Secondary Disabilities

Self-management has been broadly defined as learning and practicing the skills necessary to carry on an active and emotion ally satisfying life in the face of chronic condition (Eng, 1991). High levels of self-management have been associated with increased perceived control over both illness-related and non-il lness-related aspects of life among veterans (e.g. Bishop, Fran, & Tschopp, 2008; Devins & Shneck, 2000). Self-management typically includes taking one’s present role in the present ongoing recommended diet and exercise programs, and showing up for scheduled appointments with medical providers. Initial studies in the rehabilitation field suggest that individuals with high levels of self-management are less likely to
acquire secondary disabilities including mental health issues such as stress (Fray, Bishop, & Tischopp, 2008).

Interestingly, veterans with disabilities are likely to have low self-management skills due to both the types of disabilities that are common among veterans and because of individual character- istics of many veterans. Individuals with PTSD, as a group, are less likely to adhere to medical treatment advice, per- haps because of a perception of a "foreshadowed future" which lessens the investment a person is likely to make into their health care, and the instantiation of appropriate self-care for individuals with the illness, resulting in maladaptive responses to the disorder such as substance use and the likelihood of further comorbid medical problems (Department of Veterans Affairs Office of Research and Development Working Group, 2006). As a group, military veterans are also less likely to seek out services that are seen as mental health-related due to the stigma and perceived threat to career that can result from a mental health visit on the veteran’s military record (Hoge, Castro, et al., 2004; Kessler & colleagues, 2005; in press; Newell et al., 2004). Secondary disabilities are potentially the biggest barrier to long-term employment for veterans with disabilities. Secondary disabilities can result from untreated medical conditions, from not adhering to medical regimens, or from attempting to self-treat mental health problems as seen by individuals using alcohol or other substances to relieve stress related to their dis- ability. The results of secondary disabilities and the negative effects they have on outcomes are well documented in the rehabil- itation and medical literature (e.g., Munschauer & Weistock-

To address the concern of self-management, Bishop and Frain (2007; Frain, Bishop, Tischopp, & Chan, 2007) have developed self-management scales to assess self-management for people with disabilities. These scales break self-management into seven self-care areas: physical self-care, social support by meaning, and then planning ways to address short-comings in self-manage- ment, rehabilitation counselors can take an important first step with clients towards containing secondary disabilities.

*Using a Family Resiliency Model to Address the Holistic Needs of Veterans and their Families*

The Resiliency Model of Family Stress, Adjustment, and Adaptation has been recognized as an appropriate model for reha- bilitation counselors by numerous authors (e.g., Frain, Biven, Tischopp, Lee, Tansey & Chronister, 2007; Kosculek, 2004; Lustig, 1997). This theory of family resiliency is perhaps most suited for rehabilitation of military veterans as the model was val- idated by Metzler and colleagues (1999) and their clients and families (e.g., McCubbin and McCubbin, 1991). The theory provides a concep- tual model for understanding family influences and how they may be utilized in facilitating success in the rehabilitation counselling process. Rehabilitation Counselors can use this model to include families of veterans in the rehabilitation of the veteran in three essential ways: (a) identifying appropriate resources, (b) improving problem-solving and coping skills, and (c) reframing disabling conditions. The Resiliency Model would appear to hold promise in facilitating positive rehabilitation and employment outcomes for veterans, the overall efficiency of rehabilitation counseling services, and the personal satisfaction of rehabilitation counselors.

Research investigating the predictors of outcome of chronic illness and disability has increasingly recognized the importance of the family’s role in the recovery of the individual, and the effects of the illness or disability on other fam- ily members (Degeneffe & Lynch, 2006; Storer, Farte, Johnson, & Greenberg, 1987). Both individuals and families are greatly affected by the diagnosis, with some studies suggesting that fam- ilies are even more substantially affected than individuals with the illness or disabilities (e.g., Kay & Lezak, 1999; Kosculek & Lustig, 1998). Logically, Florian and Krulik (1991) described family members of persons with disabilities as a targeted treat- ment. A family population who, due to the nature of their experience an array of adverse physical, psychological, and social difficulties, including depression, anxiety, reduced social support, difficulties related to role changes, substance use, communication difficulties, and physical health problems (Degeneffe & Lynch, 2006; Kosculek & Lustig, 1998; Lezak, 1998). These difficulties may in part be due to the increasing cost of chronic illness and dis- ability and a system that has shifted the burden of many responsi- bilities onto families that were previously provided by traditional health care professionals (Kosculek, 2006). As a group that scores high on order and structure does not appear to follow health care orders at a rate similar to civilians.)

Although national research agencies (e.g., National Institutes of Health, Centers for Disease Control and Prevention, and National Institute for Rehabilitation Research and Dissemination) have increasingly recognized the importance of funding research directly or indirectly applicable to veterans, rehabilitation counsel- ing has, in the opinion of the authors, lagged behind other mental health and allied health professions in addressing the need for research in the rehabilitation of veterans. We therefore also encourage the prioritizing of rehabilitation counseling research aimed at addressing the rehabilitation needs of veterans.

**Conclusion**

American wars and the profession of rehabilitation counsel- ing are historically, inherently, and inextricably linked. The reha- bilitation counseling profession originated in response to the reha-

*References*


The American Psychological Association. (2004). The American Psychological Association’s guideline for the clinical assessment of adults with disabilities associated with subsequent American wars has acted to shape and define the profession. In the face of the current American conflicts, the rehabilitation counseling profession must further engage itself in the struggles of America’s military veter-

The arts in war and peace: Art and war: The depiction of war in art. New Haven, CT: Yale University Press.


acquire secondary disabilities including mental health issues such as stress (Abuin, Bishop, & Tischopp, 2008).

Interestingly, veterans with disabilities are likely to have low self-management skills due to both the types of disabilities that are common among veterans and because of individual characteristics of many veterans. Individuals with PTSD, as a group, are less likely to adhere to medical treatment advice, perhaps because of a perception of a "foreshadowed future" which lessens the investment a person is likely to make into their health care. Yet, the instance of appropriate self-care for individuals with the illness, resulting in maladaptive responses to the disorder such as substance abuse and the likelihood of further comorbid medical problems (Department of Veterans Affairs Office of Research and Development Working Group, 2006). As a group, military veterans are also less likely to seek services that are seen as mental health-related due to the stigma and perceived threat to career that can result from a mental health visit on the veteran’s military record (Hoge, Castro, et al., 2004; Kogon, 2005). The admission that a veteran who is seeking mental health services may indeed be seeking help for a disability due to PTSD is not uncommon in everyday practice, especially for those veterans with a history of injury, medical trauma, or combat-related psychological trauma. The presence of secondary disabilities is potentially the biggest barrier to long-term employment for veterans with disabilities. Secondary disabilities can result from untreated medical conditions, from not adhering to medical regimens, or from attempting to treat self-management mental health problems as seen by individuals using alcohol or other substances (Shewchuk & Elliott, 2000). Conversely, difficulties related to role changes, substance use, communication, and psychological and social resources and limitations. These scales break self-management into seven essential ways: (a) identifying appropriate resources, (b) improving problem-solving and coping skills, and (c) reframing disabling conditions. The Resiliency Model would appear to hold promise in facilitating positive rehabilitation and employment outcomes for veterans, the overall efficiency of rehabilitation counseling services, and the personal satisfaction of rehabilitation counselors. Furthermore, the Resiliency Model of Family Stress, Adjustment, and Clinical Psychology, 72(8), 897. Retrieved March 31, 2007: http://www.bls.gov/cps/163-184). Washington D.C.: American Psychological Association. Weiss-Fernandez, R., et al., (2004). Journal of Consulting and Clinical Psychology, 72, 417-433. Fischer, H. (2008). United States Military Casualty Statistics: Operational and Operation Enduring Freedom (CRS Report No. RS22452). Congressional Research Service, Library of Congress.


Service-connected (SC) disability: A disease or injury determined to have occurred during military service. The Veterans' Administration assigns a disability rating as a percentage from 0% -100% disabled.ii. Note: These two measures might not fully capture all veterans' disabilities. Veterans with disabilities (called â€œSpecial Disabled Veteransâ€) are covered under the new rules of the Vietnam Era Veterans' Readjustment Assistance Act (VEVRAA). Veterans with and without disabilities may also be eligible for hiring preferences.vii. Veterans included in these estimates could have served as long ago as the Vietnam era or as recently as the Gulf War era II. Military Veterans bring experience and skills of great value to the workforce. This document describes services that help Veterans with a disability enter the workforce and find fulfilling employment.Â The disability does not need to be connected to active military service to be eligible for this program. SPPCs also help people with disabilities get information about current job opportunities and reasonable accommodations.Â VA Vocational Rehabilitation & Employment Services for Veterans with Disabilities helps transitioning Service Members and Veterans with service-connected disabilities and barriers to work prepare for, find, and keep employment.