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, & Milftink, 2006c; Seal, Bertenthal, Miner, Sen, & Marmot, 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 CRCs 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 (VRAE) 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, train- ing 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 issues that were seen in Iraq and Afghanistan conflicts, there are likely to be 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 the following issues: (1) rehabilitation needs, (2) focusing on distinct employment needs for veterans; (3) using self-management techniques to prevent and manage secondary disabilities, (4) disability awareness and sensitivity training as a holistic needs of veterans and their families; and (5) the call for rehabilitation to develop researchers that focus on veterans’ issues. By following 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 fight against terrorism in OEF/OIF combat and the physical and psychological disabilities that are commonly experienced. The employment situation for returning veterans and Reservists are also described.

The Current American Military Force

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 consists of 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 1.6 million—70% of the Under Secretary of Defense for Active Component; the Air Force had 65% percent; the Navy, 83% percent, 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 reserves had been married, and 47% had experienced combat deployments (Tanielian & Jaycox, 2008). 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 be younger than those deployed in earlier conflicts. Differences in the military services are also noted: the Air Force reserves were the oldest, and the Army the youngest. The current conflicts have seen a very different type of soldier than past military combat. The median age of personnel in combat areas being female (Hoge et al., 2006). Women accounted for approximately 14% of the total mil- itary force in the active component 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).

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 more likely to have a service-connected disability. In 2005, 32% of injured personnel were disabled, and 24% of injured personnel were 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 a telephone study of veterans, 30% of those previously deployed had PTSD symptoms, 14% had major depression, and 19% had a probable traumatic brain injury (TBI) during deployment (Tanielian & Jaycox, 2008). Assuming that the 30% figure was projected to the nearly 340,000 OIF service- men 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). Among the 30% of those previously deployed who have at least one of these three con- ditions, and about 5% report symptoms of all 3 of these conditions (Tanielian & Jaycox, 2008, p. xxi). Further, some groups, including military reserves, that who have left military service may be at higher 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 employment. The nature of the current OEF/OIF combat has resulted in new pat- terns of polytraumatic injuries, and resulting disabilities that require intensive medical care in physical and occupation- al rehabilitation, mental health care, and individualized and spe- cialized employment placements (Veterans Health Administration [VHA], 2005).

Polytrauma is defined as injury to the brain in addition to other body parts or systems resulting in physical, cognitive, psy- chological, or psychosocial impairments and functional disability (VHA, 2005). Among injured personnel, the Veterans Administration (VA) reports that 60% have some degree of trau- matic brain injury (TBI). Common injuries include head injury and injuries to extremities (Hyer, 2006). The primary cause of injury in Iraq results from the use of high-energy explosives with shrapnel, which cause ultra-high velocity fragmentation injuries, often to the extremities. The blast-related polytrauma 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 veterans received treatment for a disability (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, with an overview of therehabilitation issues associated with Iraq war with disabilities that prevent them from returning to their 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 (a higher rate than among Gulf war veterans). Among males, 18 to 24 years old, veterans have a significantly higher jobless rate than non-veterans (17.2% vs. 0.4%). By 2005, the overall unemployment rate was 5.2%, and 5.5% for Gulf war veterans. According to the Bureau of Labor Statistics, 1,638,817 military personnel have been deployed in operations OIF/OEF. Of these, approximately, 1.2 million were active military, and 455,809 (approximately 28%) were reserve forces (Office of the UnderSecretary 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-
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 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 whether the veteran is in Iraq and Afghanistan conflicts, there will need to be 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 addressing the emerging rehabilitation needs. This approach is summarized here, and each element is further discussed below. This five-pronged approach, or roadmap, includes: (1) incorporating rehabilitation into the OEF/OIF National Guard Transition Assistance Program; (2) focusing on distinct employment needs for veterans; (3) using self-management techniques to prevent and manage secondary disabilities; (4) using family and resiliency models to address holistic needs of veterans and their families; and (5) the call for rehabilitation to develop strategies that focus on veterans’ issues. By 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 fightingsunlight 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

In the wake 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 theaters 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 fulltime, active duty forces. The Reserve Component includes Reserve (Army, Navy, and Marine Corps) and National Guard (Army, Air Force) forces (Tanielian & Jaycox, 2008). In the main, the Reserve component comprises the 10% 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 be employed than the employed deployed in the Active Component in combat areas being female (Hoge et al., 2006). Women accounted for approximately 14% of the total military in 2007. 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 of the recent conflicts tend to be younger than the 20-30% of the active duty enlisted force between the ages of 17 and 24 (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 injur to veteran. The nature of the current OEF/OIF combat has resulted in new patterns of polytraumatic injuries, and resulting disabilities that are unique to each member in physical and occupational health care, mental health care, and individualized and spe-
cialized employment placements (Veterans Health Administration [VHA], 2005).

Polytrauma is defined as injury to the brain in addition to other body parts or systems resulting in physical, cognitive, psy-
chological, or psychosocial impairments and functional disability (VHA, 2005). Among injured personnel, the Veterans Administration (VA) reports that 60% have some degree of tra-
umatic brain injury (TBI). Common injuries include head injury and injuries to extremities (Hyer, 2006). The primary cause of injury in Iraq results from the use of high-energy explosives with shrapnel, which cause ultra-high velocity fragmentation injuries, often to the extremities. The blast polytrauma 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). As of February 2008, the Department 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 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, 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 the RAND study, “55% of the 112,000 OEF/OIF vete-

nals sampled from 24 geographic areas, substantial rates of men-
thal 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 PTSD is 10% of the overall veteran population, 14,300 (10% of 142,000) of the survey sample had been deployed for OEF/OIF as of October 2007, the researcher’s estimate that approximately 300,000 veterans who served in Iraq and Afghanistan in the years 2001 and 2002 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 three con-
ditions, and about 5% report symptoms of all of these” (Tanielian & Jaycox, 2008, p. xii). Further, some groups, including military reserve members that do not 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-
ience among specific groups. In their review of the records of over 100,000 OIF/OEF 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-
noses and 59% received more than one diagnosis. Overall 30% of the sample had received either mental health or psychoso-
cial diagnoses. Most initial mental health diagnoses (60%) 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 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 (III, 2006) suggests that few employers or insurance claims staffs are trained to recognize PTSD. In particular, PTSD begins to 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 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 reservists returning from war with disabilities that prevent them from returning to their prev-
ious employment, or that make necessary adaptations to return success-
tfully 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 anywhere 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 (72% of which were 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%). In 2005, about 5,000 veterans became unemployed. According to the Bureau of Labor Statistics, January 2002 and August 2005, about 5 in 157,000, 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).
of recently published rehabilitation counseling textbooks failed to over the past thirty years; however, with the wars in Afghanistan and Iraq issues are not seen as important part of the roles and functions of rehabilitation counseling. Perhaps for this reason veteran issues are not seen as a primary focus of rehabilitation counseling, and their implications for the profession. Perhaps for this reason veterans are not identified as a separate and distinct population in rehabilitation counseling.

Infusing Veterans’ Issues into Rehabilitation Training
Infusion of military issues into the existing training of rehabilitation counselors and professionals mirrors the national push for veterans services for military personnel who have become disabled. Currently, the majority of textbooks in the core rehabilitation counseling curriculum do not specifically address veteran issues. A review of recently published rehabilitation counseling textbooks failed to identify military issues, the wars, and the conflicts 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, text 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 issues faced by veterans emerging or currently employed in the rehabilitation field to have knowledge concerning veteran’s disability issues. In particular, until a more complete understanding of the issues faced by veterans emerging or currently employed in the rehabilitation field to have knowledge concerning veteran’s disability issues.

Infusion of information in the rehabilitation counseling curriculum and training 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, depression and anxiety) and to treat them. Transfer of information to military veterans. Rehabilitation counselors should be familiar with symptoms and treatment 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 wounded, dead or killed?; 2) Have you ever engaged in direct combat where you discharged your weapon?; 3) 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, such as alcohol and drugs. Trauma-related symptoms may also be seen in individuals with PTSD who have chronic pain. Rehabilitation counselors should be aware of these symptoms and be familiar with some of the subtle signs of PTSD, such as the use of self-management techniques to 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.

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Rehabilitation professionals are uniquely trained to help in this manner, because they are the only ones who have active duties with veterans with disabilities. Having experience working with employ- ers, rehabilitation professionals help employers understand the laws and accommodations that may be needed to facilitate a suc- cessful reintegration back into work when a veteran returns with a disability. For instance, many rehabilitation counselors work closely with employers and employment groups to be an educa- tional resource about the ADA, and can build upon this relation- ship. Knowledge concerning the USAWA may be used to help military veterans understand their role when employers are active in the military reserves, and how concepts such as reasonable accom- modation and undue hardship apply to returning veterans with and without a disability. Counselors can also share information with employers about the benefit of short-term reassignment with vet- erans who are experiencing anxiety as a way to reintegrate at a pace that matches the long-term needs of both employer and employee (Freedy & 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 disabil- ity (e.g. Chan et al., 2003).

With specialized skills and knowledge related to employment reintegraction, employer education, and transferable skills analysis, it appears that rehabilitation counselors are well-prepared to be at the forefront of allied services for military veterans who have a disabili- ty. Counselors should be involved in rehabilitation plan develop- ment, 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 a chronic condition (Eng, 2005). High levels of self-management have been associated with increased perceived control over both illness-related and non-ill- ness-related aspects of life among veterans (Bower, 1997; e.g. Bishop, Fran, & Tschopp, 2008; Devins & Sheeck, 2000). Self-management typically includes taking one’s medication as prescribed, following recommended diet and exercise programs, and showing up for scheduled appointments with med- ical 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 anxiety (Fain, 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 motivation a person is likely to make into their health care. This is likely the instance 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 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; Koglin, 2002). Military veterans are less likely to seek these 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; Koglin, 2002). Military veterans are 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; Koglin, 2002).

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 (Fain, Bishop, & Tischopp, 2007) have increasingly recognized the importance of funding research directly or indirectly applicable to veterans, rehabilitation counseling has, in the opinion of the authors, lagged behind other mental health and allied health professions in responding to 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. 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 counseling has, in the opinion of the authors, lagged behind other mental health and allied health professions in responding to 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. 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-
bilitation needs of military veterans. The medical advances, societal shifts, and combat-related disabilities associated with subsequent American wars have added to the already existing problems and the current American conflicts, the rehabilitation counseling profession must further engage itself in the struggles of America’s military veterans, and must do so expediently.

The wars in Afghanistan and Iraq have created a new wave of individuals with disabilities. As such, the rehabilitation field needs a roadmap for understanding in its role in supporting veterans with disabilities in their rehabilitation goals. By implementing the five-pronged approach outlined here, the rehabilitation field can bring about a change to the way in which rehabilitation can further engage itself in the struggles of America’s military veterans, and must do so expediently. The wars in Afghanistan and Iraq have created a new wave of individuals with disabilities. As such, the rehabilitation field needs a roadmap for understanding in its role in supporting veterans with disabilities in their rehabilitation goals. By implementing the five-pronged approach outlined here, the rehabilitation field can bring about a change to the way in which rehabilitation can.

Call for Rehabilitation to Develop Researchers that Focus on Veterans’ Issues

The final aspect of rehabilitations roadmap acknowledges that, in the question of the Veterans, both the military and the landscape of war and the current legislative action. In order for rehabilitation to continue to provide appropriate interventions, researchers need to look towards future needs for this group. By supporting researchers in this line of interest through grants, journal space, and other outlets, the rehabilitation field will show that it is invested in continuing to provide effective services to veterans with disabilities.

References


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acquire secondary disabilities including mental health issues such as anxiety (Fain, Bishop, & Tschopp, 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 “forsaken future” which lessens the investment a person is likely to make into their health care, and the initiation 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 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; Koglin, 2008). Not only does the group that scores high on order and structure does not appear to follow health care orders at a rate similar to civilians.

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 (Substance Use or Stress related to their disease/disability). The results of secondary disabilities and the negative effects they have on outcomes are well documented in the rehabilitation and medical literature (e.g., Munschauer & Weissbrodt-Miller, 2009; Kocsis & Lustig, 1998). Logically, Florian and Krulik (1991) described family members of persons with disabilities as a targeted treatment population. The literature suggests that, for example, a spouse who wishes to quit his or her job in order to care for his or her disabled spouse may be less likely to work. Therefore, a long-term goal may include the spouse returning to work.

Call for Rehabilitation to Develop Researchers that Focus on Veterans’ Issues

The final aspect of rehabilitations roadmap acknowledges that “It is the responsibility of the rehabilitation profession 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 veterans, and must do so expeditiously.” The wars in Afghanistan and Iraq have created a new wave of veterans, the majority of whom have been exposed to traumatic experiences and are grappling with the challenges of readjusting to civilian life. The field of rehabilitation counseling is well positioned to meet the needs of these veterans, but it must do so in an expeditious manner.

To address the concern of self-management, Bishop and Fain (2007; Fain, Bishop, Tschopp, & Chan, 2007) have developed self-management scales to assess self-management for people with disabilities. These tools can be used to break down the experience of a disability into seven distinct factors that allow the counselor’s insight into the interventions necessary to promote self-management with clients (e.g., care of oneself, social support, coping by meaning making, and then planning ways to address short-comings in self-management, 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 rehabilitation counselors by numerous authors (e.g., Fain, Bishop, & Tschopp, 2008). Rehabilitation counselors should use early interventions that include the family unit to facilitate support and understanding about the course of the disability, helping them cope with the situation. This means finding alternative solutions, and calling upon the field of rehabilitation to develop researchers that focus on veterans’ issues. Through the progression of these wars, the rehabilitation needs of veterans are growing; to effectively respond to these changes, the field of rehabilitation must also update to accommodate this growing population.

Acknowledgments

This research was funded by a grant from the Commission on Rehabilitation Counselor Certification.

References


Amerian wars and the profession of rehabilitation counseling are historically, inherently, and inextricably linked. The rehabilitation counseling profession originated in response to the rehabilitation needs of employees of World War I military veterans. The military advances, sociological shifts, and combat-related disabilities associated with subsequent American wars have acted to shape and redefine 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 veterans, and must do so expeditiously.

The wars in Afghanistan and Iraq have created a new wave of individuals with disabilities. As such, the rehabilitation field needs a roadmap for understanding its role in supporting veterans with disabilities in their rehabilitation goals. By implementing the five-pronged approach outlined here, the rehabilitation field can bring positive outcomes to veterans and their families. A successful rehabilitation field can increase positive outcomes to many veterans and their families through the following actions: infusing veterans and families into the workforce training, focusing on the needs of veterans and families, and calling upon the field of rehabilitation to develop researchers that focus on veterans’ issues.

Through the progress of these wars, the rehabilitation needs of veterans are growing; to effectively respond to these changes, the field of rehabilitation must also update to accommodate this growing population.


