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, & Milftken, 2006c; Seal, Bertenthal, Miner, Sen, & Marmet, 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 rehabilitation 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 differences in Iraq and Afghanistan conflicts, these issues will serve as 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 for managing these emerging rehabilitation needs. This approach is summarized here, and each element is further discussed below. This five-pronged approach, or roadmap, includes (1) making rehabilitation issues visible; (2) focusing on distinct employment needs for veterans; (3) using self-management techniques to prevent and manage secondary disabilities; (4) developing research on polytrauma and 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 anywhere since August 1990) in the labor force, and the job- less rate for these veterans was 5.2%. About 11% of all veterans have a service-connected disability (a higher percentage 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 800,000 veterans discharged between January 2002 and August 2005, 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 Iraq and Afghanistan. The population aged 18 to 24 years 30% are considered "citizen soldiers" from the National Guard and Reservists (II, 2006). Specifically, as of October 31, 2007, 168,811 OEF/OIF veterans had been deployed 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-
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.

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Overview: The Current Situation

In this overview we provide a brief review of the current fightings, the nature of the combat and the demographics 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 conflict and result in different numbers. The nature of the current conflicts of OEF/OIF conflicts is very different compared to previous conflicts, resulting in new patterns of polytraumatic injuries, and resulting disabilities that are commonly incurred in physical and occupational rehabilitation, mental health care, and individualized and specialized 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, psychosocial, or psychosocial impairments and functional disability (VHA, 2005). Among injured personnel, the Veterans Administration (VA) reports that 60% have some degree of traumatic 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 trauma 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, 2008). About 60% of the 47% of the U.S. 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 100,000 soldiers had been wounded, injured or otherwise disabled with conditions that are not readily identifiable, including 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 survey, 10% of all veterans denied by VA were sampled from 24 geographic areas, substantial rates of mental 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 RAND sample is representative of the service members who had been deployed for OEF/OIF as of October 2007, the researcher’s estimate that approximately 300,000 to 350,000 veterans were deployed. Using data from the U.S. Census Bureau, an estimated 322,000 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 conditions, and about 5% report symptoms of all 3” (Tanielian & Jaycox, 2008, p. xii). Further, some groups, including military reserved and those 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 post-injury life.

The nature of the current OEF/OIF combat has resulted in new patterns of polytraumatic injuries, and resulting disabilities that are commonly incurred in physical and occupational rehabilitation, mental health care, and individualized and specialized employment placements (Veterans Health Administration [VHA], 2005).

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 OIF/OEF veterans who separated from active duty between 2001 and 2005 and sought care from VA medical facilities, Seal et al. found that 25% had received mental health diagnoses of whom more than one diagnosis. Over 30% of the sample had received either mental health or psychosocial 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-
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 in OEF/OIF issues. 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 pre-
vious 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 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 (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. 9.7%). Both groups were below the national unemployment rate of 5.8% in January 2002 and August 2005, about 1 in 5, or 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 Iraq and Afghanistan. These veterans, about 100,000, or 30% are considered “citizen soldiers” from the National Guard and Reservists (II, 2006). Specifically, as of October 31, 2007, 168,811 military personnel have had tours of operations OEF or OIF. Of these, approximately, 1.2 million were active mil-
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ment situation of Reservists who have become disabled. However, one recent study suggested that the likelihood of even non-dis-

infused with information on veterans’ issues. It is important for rehabilitation counselors to be aware of the veterans’ issues in order to provide appropriate services. Rehabilitation counselors may be the first to detect symptoms of PTSD or TBI among veterans and to refer them for further evaluation. They can also provide veterans with information on the availability of services such as counseling, employment assistance, and disability benefits. Rehabilitation counselors can also assist veterans in understanding their rights and responsibilities under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994, the Rehabilitation Act of 1973, and the National Defense Authorization Act of 2005 (NDAA).

In addition, rehabilitation counselors can play a crucial role in the reintegration of veterans into civilian life. They can provide guidance on employment-related issues such as job training, job placement, and career development. Rehabilitation counselors can also help veterans identify and develop transferable skills that can be applied to different jobs or industries. They can also assist veterans in navigating the complex system of veterans’ benefits and services, including the Department of Veterans Affairs (VA) and the Department of Labor.

Rehabilitation counselors can also help veterans in dealing with the emotional and psychological impact of their service. They can offer counseling services, help veterans connect with mental health professionals, and provide referrals to support groups and other community resources. Rehabilitation counselors can also assist veterans in accessing specialized treatments such as trauma-focused cognitive behavioral therapy (TF-CBT) or eye movement desensitization and reprocessing (EMDR), which are effective in treating PTSD.

In summary, rehabilitation counselors play a vital role in the reintegration of veterans into civilian life. They can provide a wide range of services and support to veterans, including employment assistance, education, mental health services, and access to veterans’ benefits and services. Rehabilitation counselors can help veterans overcome the challenges they face during reintegration and help them achieve their goals for a successful transition from military to civilian life.
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, depression, post-traumatic stress disorder) and the need for referral information for military veterans. Rehabilitation counselors should be familiar with some overview of an extensive study that has 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 portrayed as a victim of combat, or did you ever engage 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 one 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 (e.g., alcohol, drugs), display symptoms such as insomnia, nightmares, hypervigilance, anxiety, and difficulty remembering critical events (Eswaran et al., 2006). PTSD and TBI should be noted to any of the counselors that more investigation may be necessary.

Rehabilitation counselors will see many veterans long after they have been discharged from their military role. Due to unique aspects of disabilities that are typical of OEF/OIF combat veterans this population may benefit from rehabilitation services. Rehabilitation services has always been employed. Accordingly, it is important for rehabilitation to use its strength and understanding of this area when implementing services for veterans with disabilities. Foremost, it is important to acknowledge that the disability of military personnel will become productive members of the employment world, many thriving and growing from their experiences (Bryant, 2004). In addition, low utilization of mental health services by veterans due to stigma likely leads to many veterans having undiagnosed mental disorders (Kilgore, Stenz, & Cottrell, 2000). Thus, problems that are present in both veterans and non-veterans, such as the escalator principle, which informs employers that they must retire at a salary and position that would have been achieved by the reservist if they had not been called to war. Understanding of how VA systems and services, such as how disability ratings are determined will be critical. Finally, since there are many excellent services available to military veterans, of which the veteran and counselor may not be aware, it is important that they are aware of these services. Thus, it is important that within the next several years books 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 Hospitals, and the Disabled Transition Assistance Program should be familiar to rehabilitation counselors working with veterans.
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 ‘foreshadowed future’ which lessens the investment a person is likely to make into their health care and may be the instigator 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; Kugler, 2004). For example, a minority of a veteran 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. Secondary disabilities are often noted to significantly affect the quality of life and the ability that a veteran has, and the literature also suggests that illnesses and disabilities present new opportunities for growth, challenge, and satisfaction (Bennet & Wrubel, 1989; Dupuis, 1989; Grin, 1986; Malmacher, Tinkmen, & Dikmen, 2002; Perles, Kinsella, & Crowe, 1999). Successful adaptation to disabilities on the part of family members can reassure the part-recipient and family members that a system is in place to support and help with the disability. Veterans, as a group, face numerous problems due to the common injuries of war. Posttraumatic stress, traumatic brain injury, and polytrauma can all result in diminished problem-solving skills and poor self-care. The need for interventions to teach problem-solving skills and resourcefulness is great in both the veteran and the family unit. With significant family and social roles to maintain, the impact of disabilities is historically, inherently, and inextricably linked. Rehabilitation counselors must also update to accommodate this growing population.

Acknowledgements

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References


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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 solve their problem. Secondary disabilities related to mental health may specifically impact the veteran’s employment by increasing the risk of additional disabilities, the effects of the illness or disability on other family members (DeGennre, Lynch & Neria, 2006). As a group, families and individuals are greatly affected by the diagnosis, with some studies suggesting that families are even more substantially affected than individuals with the illnesses or disabilities (e.g., Kay & Lezak, 1999; Kosciulek & Lustig, 1998). Logically, Floran and Krulik (1991) described family members of persons with disabilities as a targeted treatment population whom rehabilitation counselors should target. These populations have 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 (Degennre & Lynch, 2006; Kosciulek & Lustig, 1998; Lezak, 1986). These difficulties may in part be due to the increasing cost of chronic illness and disability and a system that has shifted the burden of many responsibilities onto families that were previously provided by traditional health care providers (Auchter, Delaune, & Green, 1996; Machamer, Tenkin, & Dikmen, 2002; Perlesz, Kinsella, & Crowe, 1999). Successful adaptation to disabilities on the part of families can result in greater independence and self-efficacy, and family functioning may actually improve over time (Kreutzer, Gervasio, & Campbell, 1994). The effects of disability on the family are chronic illnesses such as HIV and cancer, and psychologically, as each family brings to the situation a unique set of physical, psychological, and social resources and limitations.

Veterans, as a group, face numerous problems due to the common injuries of war. Posttraumatic stress, traumatic brain injury, and polytrauma can all result in diminished problem-solving skills and poor self-care. The need for interventions to teach problem-solving skills and resourcefulness are great in both the veteran and the family unit. With significant family and social support the veterans and families demonstrate better outcomes (Litz, 2008). Rehabilitation counselors should use early interventions that include the family unit to facilitate support and understanding of the disabling condition and its impact on the veteran. One way of doing this is requesting, at initial meetings, that each member provide short-term and long-term goals for themselves, as well as the veteran and the family. The goals can be mutually set, shared with the counselor, and the family, so the counselor can help the family see how choices are available that can impact the short-term and long-term goals for both the individual and the family. For example, a spouse who wishes to quit his or her job in order to take care of the veteran with a disability may be making a very good short-term decision because of the great amount of need early in a disability due to the number of hospital and medical visits. However, in time, these needs may lessen and the spouse may lament the loss of career and income that has resulted from their decision to quit 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 rehabilitation roadmap acknowledged that the veteran is not only a member of the veteran’s family but a part of 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.

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 on rehabilitation and its effect on outcomes are well documented in the 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 social support and the role of family influences on the recovery of the individual, and the effects of the illness or disability on other family members (Degennre & Lynch, 2006; STORER, FRATE, JOHNSON, & GREENBERG, 1987). Both individuals and families are greatly affected by the diagnosis, with some studies suggesting that families are even more substantially affected than individuals with the illnesses or disabilities (e.g., Kay & Lezak, 1999; Kosciulek & Lustig, 1998). Logically, Floran and Krulik (1991) described family members of persons with disabilities as a targeted treatment population whom rehabilitation counselors should target. These populations have 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 (Degennre & Lynch, 2006; Kosciulek & Lustig, 1998; Lezak, 1986). These difficulties may in part be due to the increasing cost of chronic illness and disability and a system that has shifted the burden of many responsibilities onto families that were previously provided by traditional health care providers (Auchter, Delaune, & Green, 1996; Machamer, Tenkin, & Dikmen, 2002; Perlesz, Kinsella, & Crowe, 1999). Successful adaptation to disabilities on the part of families can result in greater independence and self-efficacy, and family functioning may actually improve over time (Kreutzer, Gervasio, & Campbell, 1994). The effects of disability on the family are chronic illnesses such as HIV and cancer, and psychologically, as each family brings to the situation a unique set of physical, psychological, and social resources and limitations.

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The need for rehabilitation services for individuals returning from military service has perhaps never been greater. - Journal of Rehabilitation Resource: http://www.saset.arizona.edu/programs/vets/clearinghouse/documents/roadmap.pdf. Recommended. Assessment based vocational curriculum manual. Individual and group counseling are available for Veterans and their significant others. The centers also provide substance abuse information, referrals and job counseling and can be reached at (800) 905-4675. To find your local Vet Center, call (800) 827-1000, or visit online at: www.vetcenter.va.gov. Veterans and disabled veterans preference. To be eligible for Veterans Preference under New Jersey Law, Veterans must have served on active duty during one of the following periods: service-connected disabilities, or who are officially listed as MIA by the U.S. Department of Defense may claim $500 per year for four years of college or equivalent training. To qualify, the Veteran must have been a state resident and the child must be a resident.