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Creating A Veteran Centered Wellness Treatment Model For Successful Reintegration

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Creating A Veteran Centered Wellness Treatment Model For Successful Reintegration

by

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A Capstone Document Submitted to the faculty of

Governors State University

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ABSTRACT

In today's society the issue of reintegration following combat deployment among American Operation Enduring Freedom (OEF) and Operation Iraq Freedom (OIF) veterans has been met with significant barriers. The purpose of this study was to examine current wellness models and to create a model that will assist veterans with reintegration into society. The current models will be examined to identify if the needs of the veterans are being met who are returning from combat and to examine community agencies, Department of Veteran Affairs and the Department of Defense programs and services essential to meeting their needs. A grounded study was conducted by utilizing existing data on the subject matter. The research study gave a voice to veterans who are reintegrating back into society and particularly veterans of combat tours of duty, and provided clinicians with insights that will enable them to improve their clinical services for this population. This study also aided the researcher in creating a wellness model that will assist the veteran and their family with reintegration within the community. This study will add to the body of knowledge and potentially contribute to a future blueprint for the successful wellness treatment approach for reintegration for returning veterans.

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DEDICATION

This work is dedicated to my late grandmother Florence Davis who inspired me to become a part of an elite group of men and women the United States Military. To all the fallen military soldiers both domestic and foreign. To all those that have and those that continue to serve in the United States Military thank you for your service.

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The completion of my dissertation and subsequent doctoral degree has been a very long journey. I believe that I can do all things through Christ that strengthens me, and this has become my mantra and will remain with me. One thing that will always stay with me from this chapter in my life is that when God has a plan for your life he will definitely see and guide you through until you achieve the plan. I am reminded about that biblical story of David and Goliath. I was David and my dissertation was Goliath and as you can see with God's grace and mercy Goliath has been yet again slayed.

I have completed yet another chapter in the book called life and it feels amazing. However, I could not have succeeded without the invaluable support of others in my life. Without my supporters, especially the select few that I am about to mention, I may have not completed the dissertation in a stable mental state.

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CHAPTER 1. INTRODUCTION TO THE PROJECT

This project entitled, “Creating a Veteran Centered Wellness Treatment Model”, is designed to address the needs of Iraq and Afghanistan veterans. Iraq and Afghanistan veterans typically have served multiple deployments and are in need of 21st century models of treatment to aid in their post war recovery and reintegration. This project offers to create a wellness model approach to be used in the treatment of these veterans to address their trauma, reintegration and overall health needs.

According to Berg (2011), 2.2 million United States (U.S.) soldiers, marines, airmen, and sailors have served overseas in the past decade in the wars in Iraq and Afghanistan. The combatants have successfully returned home from combat, however many face serious psychological and social challenges in reintegrating into society

Due to the increased public awareness of PTSD, problems after the war in Vietnam, the length and frequency of recent deployments, there is an increase chance of exposure to traumatic events, which decreases the likelihood of successful reintegration. Therefore the study sought to address the relevance of trauma focus and veteran centered treatment modalities for successful reintegration. More specifically, this research project was designed to answer the following questions: (a) How important is the role of trauma in the recovery and reintegration of Iraq and Afghanistan veterans; (b) How would a veteran centered wellness treatment approach aid OEF and OIF veterans

to successfully reintegrate into civilian life; and (c) What are the variables involved in developing a Veteran centered wellness treatment approach?

Evaluating the different wellness models in relation to the reintegration process will offer insight into the creation of a model that will be trauma focused and veteran centered. Furthermore the U.S. Department of Veterans Affairs' (DVA) and Department of Defense (DOD) role in facilitating the transition from combatant life to civilian life. A new wellness model that provides a better understanding of the prevalence and nature of trauma among these veterans and their experiences will help assure better life outcomes for these Americans who have served their nation in these times of conflict.

Research Problem

Current theoretical models of wellness do not serve the needs of veterans from the Iraq and Afghanistan wars. Current Wellness models do not include the dynamics of war and post war trauma as a central focus of treatment and recovery. This project seeks to develop a new theoretical perspective of wellness for Iraq and Afghanistan veterans. Hence, the research problem statement is trauma a salient factor in the development of a wellness model for Iraq and Afghanistan veterans. Can successful post war recovery and reintegration for Iraq and Afghanistan veterans be accomplished by the development of a Veteran centered Treatment model?

Purpose of the Study

The purpose of the study is to create a theoretically sound and viable wellness treatment model that serves the needs of Iraq and Afghanistan veterans in a clinical treatment setting. The development of a new wellness treatment model is meant to serve as the etiology of addressing the needs of veterans in the 21st century. This study sought to identify the most significant factors associated with trauma and a veteran centered wellness model that would foster successful reintegration into the community among the military veterans.

This research project is designed to answer the following questions: a) How important is the role of trauma in the recovery and reintegration of Iraq and Afghanistan veterans; (b) How would a veteran centered wellness treatment approach aid OEF and OIF veterans to successfully reintegrate into civilian life; and (c) What are the variables involved in developing a Veteran centered wellness treatment approach?

In order to have a clearer understanding of what is being proposed there are terms that are very important to the review of literature. The following operational definitions will provide insight into the military culture as well as help one gain a better understanding of why a trauma focused veteran centered wellness model is needed to help OEF and OIF Veterans achieve and experience a successful reintegration.

Operational Definitions

- **Action strategies** - The purposeful, goal-oriented activities that agents perform in response to the phenomenon and intervening conditions.
- **Afghanistan Combat Veteran** - A veteran that has had direct exposure to acts of military conflict in Afghanistan.
- **Battle minded**- Is both the mental orientation developed during a combat zone deployment.
- **Causal Conditions** - These are the events or variables that lead to the occurrence or development of the phenomenon. It is a set of causes and their properties.
- **Clinical** – Involving or based on direct observation of a patient.
- **Consequences** - These are the consequences of the action strategies, intended and unintended.
- **Context** - Hard to distinguish from the causal conditions. It is the specific locations (values) of background variables. A set of conditions influencing the action/strategy. Researchers often make a quaint distinction between active variables (causes) and background variables (context). It has more to do with what the researcher finds interesting (causes) and less interesting (context) than with distinctions out in nature.
- **Deployment** – Is the movement of armed forces and their logistical support infrastructure around the world.

- Grounded Theory - It is a general method. It is the systematic generation of theory from systematic research. It is a set of rigorous research procedures leading to the emergence of conceptual categories.
- Intervening conditions - Similar to context. If we like, we can identify context with moderating variables and intervening conditions with mediating variables. But it is not clear that grounded theorists cleanly distinguish between these two.
- Iraq Combat Veteran – A veteran that has had direct exposure to acts of military conflict in Iraq.
- Military Sexual Trauma (MST) – Is the term that the Department of Veterans Affairs uses to refer to sexual assault or repeated, threatening sexual harassment that occurred while the Veteran was in the military. It includes any sexual activity where someone is involved against his or her will – he or she may have been pressured into sexual activities, may have been unable to consent to sexual activities, or may have been physically forced into sexual activities. Other experiences that fall into the category of MST include unwanted sexual touching or grabbing; threatening, offensive remarks about a person's body or sexual activities; and/or threatening or unwelcome sexual advances.
- Phenomenon - This is what in schema theory might be called the name of the schema or frame. It is the concept that holds the bits together. In grounded theory it is sometimes the outcome of interest, or it can be the subject.
- Post-Traumatic Stress Disorder (PTSD)– A condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typ-

ically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world.

- Reintegration - To integrate again into an entity
- Trauma - A deeply distressing or disturbing experience.
- Traumatic Brain Injury (TBI) - Is a nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness.
- Veteran - A person who has served in the military.
- Wellness Model – Wellness model is an active process of becoming aware of and making choices toward a healthy and fulfilling life.

CHAPTER 2. REVIEW OF THE LITERATURE

OIF/OEF Reintegration Issues

Since America's engagement in the post-September 11 "war on terrorism", over two million U.S. service members have been deployed to Iraq (OIF, Operation Iraqi Freedom) or Afghanistan (OEF, Operation Enduring Freedom) approximately 27% of whom have been deployed more than once. Approximately 1.64 million of these individuals have been deployed at an average rate of 2.2 times for lengths of 12-15 months. An estimated 10-20% of Iraq and Afghanistan deployments consist of National Guard and Reservist (Duckworth, 2009; Waterhouse & O'Bryant, 2008; U.S. Census Bureau [USCB], 2011).

In 2011, President Obama announced the official drawdown of Iraq and Afghanistan combat soldiers. The drawdown of soldiers from Iraq and Afghanistan has brought about significant changes for those soldiers returning home from combat. The significant changes that have impacted the Operation Enduring Freedom and Operation Iraqi Freedom veterans consisted of uncertainties. It produces an increased perception of stress, anxiety, substance abuse, an increase in suicide, emotional instability, relationship conflict, unemployment, homelessness, and high mental and physical symptoms. The stress and anxiety is a result of several themes that have emerged throughout the literature.

As of March 20, 2009, the Department of Defense (DOD) reported the total number of deaths in OIF veterans had reached 4,261, in which 102 of them were female service members, and 31,131 service members were wounded. Over 50% of the wounds

were the result of Improvised Explosive Devices (IED), which are planted in roads, markets, trash cans, vehicles, and other hard to detect locations (Fisher, 2009). In OEF veterans they reported 663 deaths, fourteen of which were female service members, and 2,725 service members have been wounded (Fischer, 2009). Since the DOD report of 2009 the numbers of both wounded and killed have increased in both operations. According to the organization Iraq and Afghanistan Veterans of America (IAVA), as of June 2010, the DOD recorded that the fatalities in Afghanistan increased to 1,078 and the total of number of troops wounded in both OEF and OIF reached 36,757. Army units in OIF described how 93% of soldiers report being shot at or receiving small arms fire, 95% report seeing dead bodies or seriously injured comrades, and 48% report being responsible for the death of an enemy combatant (Reger & Moore, 2009).

In contrast with prior conflicts, service members experienced more repeat tours, greater perceived level of danger due to the continuous risk of unconventional means of warfare, and diverse military cultures (i.e., Army, Navy, Marine Corps, Air Force) serving together (Manderscheid, 2007). The effects of these circumstances on veterans' lives over time are not clear; however, as early as 2007, Resnik and Allen observed that a significant number were at risk of poor community reintegration upon returning home from deployment (Resnik & Allen, 2007).

Approximately 44 % of returning service members and veterans reported a range of difficulties readjusting to post deployment status (Institute of Medicine of the National Academies, 2013). "Coming home" is an immersive experience, involving all realms of life and influencing health and well-being (Wands, 2013). Many service members and

veterans encounter the interrelated and simultaneous tasks of processing combat experiences while reentering a civilian life that has changed in their absence. The disability associated with physical and psychological injury is far reaching, affecting self-care, employment, education, relationships, marriages, finances, home, and civic and community life (Resnik, Clark, & Borgia, 2011). The reality that issues can exist in isolation or in combination further complicates the transition back home and increases the likelihood that no two experiences are identical.

In addition to the stress of deployment, multiple tours, and the duration of deployment, there are a myriad of stressors that soldiers have to cope with such as being separated from loved ones, environmental extremes, and their living conditions. The most predominant combat stressors include:

Seeing destroyed homes and villages; seeing dead bodies or human remains; engaging in firefights or coming under small arms fire; engaging in hand-to-hand combat; being attacked or ambushed; personally knowing someone who was seriously injured or killed; being wounded or injured oneself; and being directly responsible for the death of an enemy combatant. (Gifford, 2006, p. 17).

Seventy-five percent of soldiers in OIF have reported witnessing both death and someone being severely wounded (Lewis, 2006). In addition, the accumulation of low level stressors over a period of time, for example, boredom, lack of sleep, long work hours, extreme weather conditions, and inadequate living quarters can have a negative impact on service members (Cozza, Benedek, Bradley, Grieger, Nam & Waldrep, 2004; La Bash, Vogt, King & King, 2009).

Themes

There are two themes that emerged from this research. First, veterans from Iraq and Afghanistan conflict of war need to receive substantive care in all aspects of their life. Second, trauma needs to be at the center of any wellness model proposed to assist this population.

Veteran's Needs

There are multiple reasons why veteran's lives are complicated, which is the reason why treatment needs to be comprehensive. The major needs for veterans that are reintegrating back into society are individually based. However, there are some needs that are similar for OEF and OIF veterans that are returning from combat. OEF and OIF veterans have a higher risk of mental health problems and face more frequent military to civilian community transition issues (Schell & Marshal, 2008). Approximately 70% of veterans surveyed from these wars report difficulty transitioning from military to civilian communities. Difficulty with community reintegration is associated with overall mental health (Sayer, Noorbaloochi, Frazier, Carlson, Gravely, & Murdoch, 2010). The current conflicts in Iraq and Afghanistan have seen an increase in Traumatic Brain Injury (TBI) and a decrease in injuries seen in previous wars (USDVA, 2011b).

Over 30% of OEF and OIF veterans confront the 'invisible wounds of war' such as Post-Traumatic Stress Disorder (PTSD), depression, or Traumatic Brain Injury (TBI) (Adamson et al., 2008). Comorbid mental health disorders such as post-traumatic stress disorder (PTSD), anxiety, depression, and alcohol and substance abuse that resulted from

or were exacerbated by combat exposure have been reported (Manderscheid, 2007). A current study of Iraq and Afghanistan veterans, among those who reported interaction with the criminal justice system, 56% reported alcohol-related charges and 5% reported drug-related charges (IAVA, 2012).

The battle-mindset of soldiers within the combat theater is what has kept them alive, yet one must question how soldiers are supported in abandoning these vital coping methods, which were adaptive and served as survival mechanisms during combat, but can develop into mental health issues and adverse adjustment reactions as they attempt to navigate reentry into civilian life and for years afterward (Lewis, 2006). The Army's study of earlier periods of the Iraq war, found 17% of soldiers surveyed to be suffering from symptoms of depression, anxiety, and post-traumatic stress disorder. The Veterans Health Administration (VHA) found that approximately 16% of the OIF and OEF veterans seeking care from the Department of Veteran Affairs (DVA) have been diagnosed with possible symptoms of PTSD (CRS, 2011). There is an ample body of empirical data that explores the pathological outcomes of war, specifically PTSD (Lewis, 2006; Paulson & Kripper, 2007; Milliken, Auchterlonie & Hoge, 2007). However, there is limited research on how veterans cope on a daily basis, particularly during the reintegration process.

When returning to civilian life, factors confronting service members and causing increased stress during re-entry appear to be the challenges of adapting to changes within the family system, redefining roles and re-negotiating expectations and division of household responsibilities, financial stress, difficulty modulating strong emotional and

behavioral reactions, high risk, adrenaline seeking behavior, use and abuse of drugs and alcohol and feeling that they no longer fit into civilian society. According to a report by the Iraq & Afghanistan Veterans of America (2012), 65% of veterans reported their deployment and return caused strain in their relationships, with 31% of these relationships ending in separation or divorce. Veterans who have a spouse and children are returning to changed roles within the family system, and may feel estranged from their spouse and children. Additionally, there is less focus on the behavioral outcomes of combat exposure (Killgore, Cotting, Thomas, Cox, McGurk, Vo, Castro, & Hoge, 2008) and adjustment reactions for both the individual warrior and his or her family or loved ones during the reintegration period.

According to the National Coalition for Homeless Veterans (NCHV) (2012), 107,000 veterans (or 23% of the U.S. homeless population) are homeless per night. In 2011 the National Coalition for Homeless Veterans reported that 37% of veterans surveyed stated they needed help finding housing, and 25% sought homeless services through the DVA. The DVA estimates 107,000 veterans are homeless each night in the United States (DVA, 2014). An estimated 44,000 to 66,000 veterans are considered to be chronically homeless (NCHV, 2012).

Although African Americans/Blacks account for only 12.8% of the general population and those who consider themselves Latino/Hispanic account for 15.4% of the general population, these ethnic groups disproportionately represent approximately 56 % of the veteran homeless population (NCHV, 2011). In a study conducted by the United States Interagency Council on the Homeless (USICH), (2013), 70% of homeless veterans

reported experiencing alcohol, drug, or mental health problems. Women veterans with children who are homeless are disproportionately high among veterans from the Iraq and Afghanistan wars. Women veterans who are homeless are more likely to have mental illness or a history of sexual trauma than their male counterparts (NCHV, 2011; USICH, 2013).

In addition to the emotional challenges of community reintegration, veterans are returning to an economy where jobs are scarce and they are disproportionately at risk for unemployment (12.1% vs. 8.3% of the general population) (U.S. Bureau of Labor & Statistics, 2012). According to Flavin (2011), there are currently 1 million unemployed veterans. In 2012, the U.S. Bureau of Labor & Statistics (USBLS) reported a 12.1 % unemployment rate among veterans (4% higher than that of the general population). According to Thomas (2011), 17 % of members reported being unemployed, 33% are seeking alternative employment and 66% of veterans surveyed believe that their skills are not being used optimally in their current place of employment. The NCHV (2011) reports 45% of veterans surveyed stated they needed help finding a job.

Among those who are at risk for losing their lives after returning home, 46% of veterans surveyed reported coping with a range of suicidal issues (Rudd, Goulding, & Bryan, 2011). In June 2012, the Pentagon announced the suicide death rate (154, that year) of active military service members was higher than the rate of combat deaths. This was the highest suicide rate reported since the beginning of the wars in Afghanistan and Iraq (Williams, 2012). The 2004 Special Committee Report (to the 109th Congress)

revealed that Iraq veterans had a higher suicide rate than that of first Gulf War and the Vietnam War veterans (Harrell & Berglass, 2011; Tsai, Pietrzak, & Rosenheck 2013).

OEF and OIF veterans are returning home with two types of scars, which are visible and invisible. Visible scars are those that are seen and invisible scars (trauma) are those that are not seen, which are harder to treat and manage as well as have a full understanding of them. The invisible scars make it difficult for veterans and their family members to reintegrate back into civilian culture. When the scars are not treated veterans experienced an increase in substance abuse, suicide, homelessness, unemployment, intrapersonal and interpersonal conflict, mental and emotional instability and self-medication (i.e., over-the-counter drugs (OTC), prescribed and illegal medication).

Wellness Models

Over the past several decades, wellness approaches have become a manner of intervention in the delivery of counseling services for combat veterans from Iraq and Afghanistan and have received increased attention in the literature. Wellness models emerged over time as an alternative to the medical model of treatment.

“Wellness” as a holistic concept of health combining physical, mental, spiritual and social well-being dates back to the 1950s, but wellness goes back even further, prior to our current understanding (Knapp, 2001). American intellectual and religious movements began to be associated with the term wellness beginning as early as the 1950s and promoting better personal health through living a better life. What we understand wellness to be today began in the 70’s.

Quimby (1864) suggested that the primary sources of physical health are one's mental and spiritual state of being. The central idea is that divinity expresses itself in human beings and manifests itself in "health, supply, wisdom, love, life, truth, power, peace, beauty, and joy" (Declaration of Principles, as quoted in Anderson 1995). Quimby (1864) and Eddy (1875) basic assumption was that a healthy body was the product of a healthy mind and spirit. According to Whorton (1982) he suggested that Fletcher maintained that the key to health was positive thinking and the behavioral changes that such positive thinking could bring about for individuals seeking wellness treatment. Kellogg (1932) emphasized that one's state of mind contributed greatly to health and emphasized not only clean living, but also clean thinking.

While figures such as Kellogg (1932), Quimby (1864), Eddy (1875) and Fletcher (as cited in Whorton, 1982) contributed to the development of the concept of wellness, the use of the term wellness in connection with this concept was the accomplishment of a fascinating individual, Dunn (1961). Dunn therefore defined high-level wellness as "an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable. High-level wellness requires that the individual maintain a continuum of balance and purposeful direction within the environment where he is functioning (Dunn 1961, p.4-5).

Wellness has been defined as a concept that includes taking responsibility for your own health, creating a full and balanced lifestyle and being the best person you can be. Wellness refers to a holistic approach in which mind, body, and spirit are integrated. It is a way of life oriented toward optimal health and well-being in which body, mind, and

spirit are integrated in a purposeful manner with a goal of living life more fully (Myers, Sweeney, & Witmer, 2000).

The concept of Wellness has evolved as a construct that is linked with Health. Multiple definitions and models relating to Wellness have been developed since the 1960's. Additional to these is the construct of "psychological wellbeing", which may be considered as embedded in the Wellness construct. Bandura (2001), suggest that wellness is a state of being in which a person's awareness, understanding and active decision-making capacity are aligned with their values and aspirations. Wellness has been described as the active process through which the individual becomes aware of all aspects of the self and makes choices toward a more healthy existence through balance and integration across multiple life dimensions (Hettler, 1980; Witmer & Sweeney, 1992).

Wellness is a construct reflecting the process of enhancing life quality by integrating and balancing one's physical, mental, and spiritual well-being (Ardell, 1977; Dunn, 1977; National Wellness Institute, 1989). Attending to wellness is consistent with the philosophies and objectives of counseling psychology and other counseling professions. The objectives of these counseling fields include promoting development in conjunction with prevention and psychoeducation (Myers, 1992), emphasizing healthy personality factors and client strengths (Maslow, 1970), and enhancing positive coping resources (e.g., Gibson & Brown, 1992; Lightsey, 1996).

The concept of wellness originated within the medical field as an alternative to a traditional view of health as merely the absence of disease (e.g., Antonovsky, 1979; Ardell, 1977; Dunn, 1977). In delineating the difference between wellness and health,

Dunn (1977) described wellness as a dynamic process of maximizing an individual's potential. In contrast, health is considered as a passive state of freedom from illness.

Striving for wellness is a unique process of integrating different personal strengths and interests in ways that maximize individuals' potential within their social environments (Ardell, 1977; Dunn, 1977). Maslow's (1970) notion of self-actualization appears to have qualities consistent with this highly subjective and individualized conceptualization of wellness. Wellness models; however, also tend to emphasize the holistic nature of the concept, positing it as integrated and balanced functioning of an individual's body, mind, and spirit (Ardell, 1977; Dunn, 1977; Hettler, 1984; National Wellness Institute, 1989).

For example, Lightsey's (1996) model views wellness (or well-being) as a multidimensional concept consisting of the intrapersonal variables of generalized self-efficacy, dispositional optimism, and the balance of positive and negative thoughts (Lightsey, 1996). Beyond conceptualizing wellness as a multidimensional construct, many of these models combine the various dimensions to view wellness as a single predictor variable (Hettler, 1984; National Wellness Institute, 1989; Witmer & Sweeney, 1992). Wellness may be an indicator of one's self concept or sense of psychological harmony as successively and iteratively one attains satisfaction of basic physiological needs (Maslow, 1999) to those at a higher level of self-actualization.

Wellness is a state of being in which a person's awareness, understanding and active decision-making capacity are aligned with their values and aspirations. Wellness has been described as holistic (Witmer and Sweeney, 1999) and client centered (Frisch,

2001) with emphasis placed on the client's capacity to make their own choices and create their own style of life to achieve personal fulfillment.

Ardell (1999), states, "Wellness is about perspective, about balance and about the big picture. It is a lifestyle and a personalized approach to living your life in such a way that you enjoy maximum freedom, including freedom from illness/disability and premature death to the extent possible, and freedom to experience life, liberty and the pursuit of happiness. It is a declaration of independence for becoming the best kind of person that your potentials, circumstances and fate will allow" (1999, p. 1). Ardell's definition recognizes and emphasizes that wellness is individualistic, multi-dimensional, and dynamic in nature. This philosophy is further clarified by understanding alternate ideologies for considering wellness models in counseling.

Wellness is becoming the preferred way of conceptualizing how reintegration needs to be addressed in society. In contrast to the modernist philosophy, which typically characterizes Western culture, the wellness movement acknowledges the existence of multiple perspectives and belief systems (Gonzalez, 1997). The wellness movement and postmodernism both adopt the view that worldviews are neither "right" nor "wrong." Banks states that the "wellness theorist sees neither separatism nor total integration as ideal societal goals, but rather envisions an open society, in which individuals from diverse cultural, ethnic, and social-class groups have equal opportunities to function and participate" (p. 117). Thus, the wellness theorist supports holistic environments as in which veterans learn to appreciate and function in their own cultural communities, appreciate other cultures, and function in mainstream culture.

Wellness has been theoretically identified as an important component of mental health and an appropriate area for the research and practice activities of counselors. However, there is a lack of theoretical consensus regarding whether the construct of wellness is best represented as a function of its individual dimensions or as a composite of those dimensions.

Wellness Models guiding the study

The wellness movement in psychology and counseling has resulted in increased attention to the importance of a new wellness model. However, the importance of wellness in society, research suggests that wellness approaches are not receiving sufficient attention in the literature. Lopez & Rogers (2001), suggest that the counseling and psychology field has been in the forefront of psychology specialties in terms of dedication to engaging in wellness research and theorizing. Many of the models of wellness that are used to guide clinical and psychology have arisen from work that began in the counseling field. A vigorous example of a counseling psychology piece that has and continues to be influential in counseling and psychology is the framework of the wellness wheel developed by Witmer and Sweeney (1991). The influence of this framework, proposes that the wellness model is composed of central concepts, espoused by other wellness models and can be viewed as a five-component model of wellness: spirituality, self-regulation, work, friendship, and love (Witmer and Sweeney, 2000). Research in counseling has also relied on the model.

Several scholars have provided definitions for the term wellness as it relates to work in reintegration. Dunn (1961), considered by many as the “founding parent of

wellness,” defined it as “An integrated method of functioning, which is oriented toward maximizing the potential of which the individual is capable, within the environment in which [she or] he is functioning” (p. 4). He was the first nationally recognized U.S. medical doctor to explore the concept of wellness. Dunn defined wellness as the ultimate goal toward which all people should strive is based on Maslow’s idea of self-actualization, an idea to which Dunn paid extensive attention to during his research (Dunn 1961, p. 159- 165).

Ardell (1999) who is the current leader in the arena of wellness wrote the first wellness book entitled *High Level Wellness*, which offered several definitions of wellness. He suggests that wellness is a “dynamic or ever changing, fluctuating state of being” (p. 5). He also adds that wellness is “giving care to the physical self, using the mind constructively, channeling stress energies positively, expressing emotions effectively, becoming creatively involved with others, and staying in touch with the environment.” Wellness involves the development, refinement, and practice of lifestyle choices and self-regulation that resonate with personally meaningful frames of reference.

Wellness Models

Scholars in the counseling profession have conducted much of the research on wellness models in none combat related settings. However, few works exist outlining the wellness model needed by clinicians working with combat veterans. Models of Wellness have developed concomitantly with a paradigm shift in the modern conceptualization of health (Bandura, 2001). The shift occurred with the redefining of health by the World Health Organization. They defined health as “a state of complete physical, mental and

social well-being and not merely the absence of disease or infirmity” (World Health Organization, 1999).

The literature review addresses samplings of frameworks that have been developed by scholars to explore the characteristics of wellness models. However, there is only one current model that is based in counseling theory, that being the Wheel of Wellness, first introduced in the early 1990s (Sweeney & Witmer, 1991; Witmer & Sweeney, 1992) and later modified to incorporate new findings relative to issues of diversity and self-direction (Myers, Sweeney, & Witmer, 2000). While this review does not represent an exhaustive list of the models of wellness models and responding that have been proposed, it does address several seminal works that have been influential in the field.

Dunn Wellness Model

Dunn’s (1961) notion of wellness was a matter of potential and movement rather than stasis was adopted in particular from Allport and Maslow (Allport 1955; Maslow 1954). Allport’s theory of personality emphasized the importance of self-esteem and a realistic sense of self in the development of the mature individual, which provided the basis for emotional security and warm emotional ties with others (1955). For Dunn, in turn, these were basic building blocks of mental wellness what he referred to as “maturity in wholeness” (Dunn 1961, p. 143-150). By the same token, Maslow contributed to Dunn’s definition of wellness. One of the elements of high level wellness is that it acknowledges the ultimate goal toward which all people should strive is based on Maslow’s idea of self-actualization, an idea to which Dunn paid extensive attention (Dunn 1961, p.159- 165). An occasional article addressed the topic of wellness

(Kaufmann 1963), although it was not really until the early 1970s that Dunn's ideas began to gain wider currency.

Dunn described five core elements of the fully developed concept of wellness as:

(1) Wellness is a continuum rather than a specific fixed state. All individuals, depending on their particular circumstances, are located somewhere along the continuum between death and wellness; (2) Wellness is a holistic approach to health, encompassing physical, mental, social, cultural and spiritual dimensions; (3) Mental wellness is the responsibility of the individual and cannot be delegated to someone else; (4) Wellness is about potential—it involves helping the individual move toward the highest state of wellbeing of which he or she is capable; and (5) Self-knowledge and self-integration is the key to progress toward high level wellness.

While all these elements were already present in Dunn's philosophy of wellness, additional development came after him by several others. Based on the work of Dunn, Travis developed a wellness inventory to assess an individual's state of wellness on a total of 12 dimensions, ranging from self-love to nutrition, exercise and social environment, among others (1975). One of the most significant contributions from Travis to the concept of wellness was a much greater emphasis on individual responsibility. Travis believed that it was the responsibility of each individual to move toward high level wellness.

While Dunn's (1961) wellness philosophy remained a set of ideas without much immediate practical application, Travis translated Dunn's ideas to a concrete program that involved learning relaxation strategies, self-examination, communication training, coaching to encourage creativity, improved nutrition, fitness, and visualization techniques (Travis 1975). Travis main idea was to help clients get to know themselves better, so that they could take better care of themselves (1975). However, there was one scholar that

challenged the belief of Travis, his name was Ardell. Ardell rejected the spiritual aspect of wellness, as he has contempt for any “insight” that religion might have to offer.

Ardell's High Level Wellness

The works of Ardell, (1977) were instrumental in presenting these ideas to the public at large. Indeed, he was primarily responsible for making wellness a household term. It was in 1977 when Ardell began to concentrate and redefine wellness. Ardell has written 18 books on wellness, produced a successful wellness newsletter, founded a wellness center and developed a series of wellness models.

The model first appeared in the book *High Level Wellness* (1977) and was illustrated as a simple circle with five dimensions, which included self-responsibility, physical fitness, stress management, nutritional awareness, and environmental sensitivity. His next model appeared in the book entitled *14 Days to High Level Wellness* (1982). This illustration was a similar circle with five different dimensions: 1) self-responsibility, 2) relationship dynamics, 3) meaning and purpose, 4) nutritional awareness and physical fitness, and 5) emotional intelligence. His most recent model consists of three domains and 14 skill areas, follows: 1) the physical domain that consists of exercise and fitness, nutrition, appearance, adaptations/challenges, and lifestyle habits; 2) the mental domain that consists of emotional intelligence, effective decisions, stress management, factual knowledge, and mental health; and 3) the meaning and purpose domain, which consists of meaning and purpose, relationships, humor, and play (Ardell, 2009).

Ardell (2004) presented a paper at the National Wellness Conference where he argued that the wellness movement would be better off without its past concern with spiritual approaches to well-being:

The wellness movement in general and national conferences in particular have been supported and shaped over a quarter of a century by persons, mostly from the medical or religious communities, oriented to such notions as mind/body/spirit, alternative healing methods, 12 step and other approaches to recovery from emotional traumas and an inordinate fondness for consensus/congeniality, harmony, righteous cooperation and uncritical love. This has given many the impression that wellness is mushy, vague, New Age and quasi-religious. It is, at least insofar as the National Wellness Institute is concerned, but do we want this to continue and, more important, how would YOU like to perceive and thus pursue a wellness lifestyle? This session offers an alternative view of wellness focused on critical thinking, personal responsibility, physical fitness, a secular quest for added meaning and purpose and a comprehensive, positive view of health set far beyond the margins of normalcy and moderation (Ardell, 2004).

Hettler has labeled Ardell as being controversial because he has consistently pursued wellness from a completely rationalist and secular point of view (Hettler, 1998). In the world of wellness it was more about his ability to convey ideas effectively than the originality of his ideas that have made him such a commercial success.

Hettler's Six Dimension of Wellness

Hettler (1998) describes wellness as the active process through which the individual becomes aware of all aspects of the self and makes choices toward a more healthy existence through balance and integration across multiple life dimensions. The Six Dimensions of Wellness Model emphasizes that teaching people how to live and influencing healthy life choices would have much greater impact on survival than anything physicians or counselors are likely to accomplish.

Achieving wellness is about finding balance in these six dimensions. This is a lifelong process of moving toward improving your physical, intellectual, emotional, social, spiritual, and environmental well-being. The six dimensions establish critical components of wellness, along with ways to analyze your personal level of wellness. The six dimensions of Hettler are: social, occupational, spiritual, physical, intellectual and emotional. Physical Wellness encompasses the need for physical activity, understanding of diet and nutrition, discouragement of the use of harmful substances and personal responsibility for medical and self-care. Social Wellness encourages contributing to one's environment and community through involvement in preserving societal and natural environmental stability; it encompasses the quality of our relationships, satisfaction in our social roles, our sense of belonging, and feelings of love and acceptance.

Occupational Wellness is founded on the principle of personal satisfaction and enrichment of life through work. Meaningful work, which requires development, is also correlated to attitude and personal choice. Spiritual Wellness embodies the beliefs and attitudes towards nature and the meaning making an individual undertakes to identify what has ultimate value to them (Hawks, 2004; NWI, 2003). It is evident in the search for and understanding of how life is, or ought to be and thus the choice of direction and resulting feelings of life's purpose. Intellectual Wellness meshes together the state of one's knowledge, skills, and creativity for problem solving and learning (Hawks, 2004; NWI, 2003). Enhancement is possible through seeking challenges and actively striving to reach a potential and share with others. Emotional Wellness is representative of the awareness; understanding and management of one's feelings and behaviors related to

these such as the ability to experience and express the full range of human emotions in appropriate ways including stress and relationship management (Hawks, 2004; NWI, 2003).

Witmer & Sweeney Wheel of Wellness and the Indivisible Self

Sweeney and Witmer (1991) and Witmer and Sweeney (1992) developed the original Wheel of Wellness model, which included seven sub-tasks in the self-direction life task based on Individual Psychology (Sweeney, 1998). The Wheel of Wellness model evolved from an examination of the existing knowledge base relative to components of wellness. It is unique in that Individual Psychology (Adler, 1954) provides the unifying theme for organizing and explaining the components of wellbeing. They identified a number of characteristics that correlated positively with healthy living, quality of life, and longevity. These characteristics were organized using Adler's proposed three major life tasks of work, friendship, and love and the two additional tasks of self and spirit that Mosak and Dreikurs (1967) described as integral to understanding Adlerian theory.

The Wheel of Wellness model was modified from seven to five tasks with the addition of new subtasks of self-direction, bringing the total to 12 (Myers et al., 2000). These five tasks are essence or spirituality, work and leisure, friendship, love, and self-direction. The life task of self-direction is further subdivided into the 12 tasks of (a) sense of worth, (b) sense of control, (c) realistic beliefs, (d) emotional awareness and coping (e) problem solving and creativity, (f), sense of humor, (g) nutrition, (h) exercise, (i) self-care, (j) stress management, (k) gender identity, and (l) cultural identity. These life tasks interact dynamically with a variety of life forces, including but not limited to one's

family, community, religion, education, government, media, and business/industry (Witmer and Sweeney, 1992).

The model was hypothesized as circumplex, with spirituality as the core and hierarchically most important component of wellness. This placement of spirituality in relation to the other life tasks was supported in the literature (e.g., Mosak & Dreikurs, 1967) as well as in more recent theoretical and empirical writings (e.g., Kemp, 2000; Mansager, 2000). Surrounding the individual in the Wheel of Wellness are life forces that affect personal wellness: family, religion, education, business/industry, media, government, and community. Global forces were also depicted as forces affecting the individual.

The Wellness Evaluation of Lifestyle (WEL; Myers, 1998; Myers, Witmer, & Sweeney, 1996) was developed to assess each of the components in the Wheel of Wellness model. Early research using the instrument led to the work life task's being further subdivided into work and leisure. Seven studies were conducted over several years to improve the psychometric properties of the WEL, including factor analyses and structural analyses (Hattie, Myers, & Sweeney, 2004; Myers, 1998). The structure of wellness was reexamined because the hypothesized interrelationships among the components of the Wheel of Wellness and the assumed circumplex structure were not supported (Hattie et al., 2004).

They also propose the need to adopt and further develop current wellness modes for use with diverse clientele (Myers, Witmer, and Sweeney, 1996). Myers, Witmer and Sweeney (1996), identified that after conducting seven studies and reviewing the final

analysis of the factor structure it led to the creation of the new Invisible Self model of wellness. The wellness approach clearly suggests a movement away from a deficit model towards an approach that focuses on the enhancement of the strengths and assets of clients. Meyers and Sweeney emphasizes the importance of understanding the environmental context of potential clients (2004).

The Indivisible Self model provides a foundation for evidence-based practice for mental health and counseling practitioners (Myers et al., 2000). It is based on characteristics of healthy people and thus can be considered to be strength-based; it is choice-oriented in that wellness behaviors reflect intentionality in lifestyle decisions; and it is theoretically grounded (Myers et al., 2000). Practitioners can use the model, with or without the accompanying assessment instruments to help clients understand the components of wellness, the interaction of those components, and the manner in which positive change can be created through a focus on strengths as opposed to weaknesses (Myers et al., 2000).

Thus, the Indivisible Self (i.e., creative self, social self, essential self, physical self and coping self) presents yet another means of incorporating Adlerian theory and methods into the mainstream of research and clinical practice (Sweeney & Witmer, 1991). Adler proposed that holism (the indivisibility of self) and purposiveness were central to understanding human behavior and that such understanding required an “emphasis on the whole rather than the elements, the interaction between the whole parts, and the importance of the man’s social context (Ansbacher & Ansbacher, 1967 p. 11-12). This philosophy provided a structure for making sense of studies in which wellness emerged

as both high-order and seemingly indivisible factor and as a factor comprised of identifiable sub-components as originally hypothesized. Wellness involves the acute and chronic effects of lifestyle behaviors and choices throughout an individual's lifespan (Myers, Sweeney, & Witmer, 2001).

The Essential Self is comprised of four components: spirituality, self-care, gender identity, and cultural identity (Myers et al., 2000). Spirituality, not religiosity, has positive benefits for longevity and quality of life, and it was viewed by Adler as central to holism and wellness (Mansager, 2000). Conversely, carelessness, avoidance of health-promoting habits, and general disregard of one's well-being are potentially signs of despair, hopelessness, and alienation from life's opportunities, reflected in loss of a sense of meaning and purpose in life (Myers et al., 2000).

Adler spoke of the Creative Self as the combination of attributes that each individual forms to make a unique place among others in his or her social interactions (Adler, 1954; Ansbacher & Ansbacher, 1967). There are five components to this factor: thinking, emotions, control, positive humor, and work (Myers et al., 2000; Sweeney & Witmer, 1991). As research and clinical experience suggest, what one thinks affects the emotions as well as the body (Myers et al., 2000). Enriching one's ability to think clearly, perceive accurately, and respond appropriately can decrease stress and enhance the humor response that medical research has shown affects the immune system positively (Bennett, 1998).

The Coping Self has four components: realistic beliefs, stress management, self-worth, and leisure (Myers et al., 2000). Irrational beliefs are the source of many of an

individual's frustrations and disappointments with life. The Coping Self, then, is composed of elements that regulate our responses to life events and provide a means for transcending their negative effects (Myers et al., 2000; Sweeney & Witmer, 1991). Learning to become totally absorbed in an activity where time stands still helps one not only cope with, but also transcend others of life's requirements (Csikszentmihalyi, 2000). Leisure opens pathways to growth in both creative and spiritual dimensions.

The Social Self includes two components: friendship and love. Friendship and love can be conceived of as existing on a continuum and, as a consequence, are not clearly distinguishable in practice (Myers et al., 2000; Sweeney & Witmer, 1991). What is clear, is that friendships and intimate relationships do enhance the quality and length of one's life. Isolation, alienation, and separation from others generally are associated with all manners of poor health conditions and greater susceptibility to premature death, while social support remains in multiple studies as the strongest identified predictor of positive mental health over the lifespan (e.g., Lightsey, 1996; Ulione, 1996).

The Physical Self factor includes two components, exercise and nutrition (Myers et al., 2000). These are widely promoted; unfortunately, often over-emphasized to the exclusion of other components of holistic well-being that are also important (Myers et al., 2000; Sweeney & Witmer, 1991). The research evidence is compelling with regard to the importance of exercise and nutrition, especially with changes over the life span. Not surprisingly, preliminary data suggest that "survivors" (i.e., individuals who live longest) attend to exercise and diet/ nutrition (Bernaducci & Owens, 1996).

Veterans Affairs Wellness Approach

With the number of soldiers returning from Iraq and Afghanistan and the potential increase of veteran enrollment for services the Department of Veteran Affairs (DVA) and Department of Defense(DOD) are obligated to provide a wellness approach that will support a successful reintegration. Determining the extent and nature of disability faced is critical in developing interventions that best meet the needs of the service members and Veterans who return from conflict (Resnik et al., 2012; Resnik, & Reiber, 2012). In 2007, the lack of a brief, psychometrically sound measure of reintegration post-deployment was suggested as a factor contributing to a lack of research on the reintegration issues faced by service members and their families (American Psychological Association, 2007). Department of Veterans Affairs researchers similarly identified this need and responded.

Helping this cohort of Veterans to adjust and return to full participation in community life roles is also a VA research priority (Resnik, Clark, & Borgia, 2011; Resnik et al., 2012). For example, in 2008, the State of the Art (SOTA) conference on TBI convened and sought to advance knowledge gaps and determine relevant research questions to advance the understanding and treatment of TBI via several topical foci, including community integration for those with TBI (Kupersmith et al., 2009). The National Center for PTSD is dedicated to research and education on trauma and PTSD, working to assure that the latest research findings help those exposed to trauma (PTSD: National Center for PTSD, 2014).

Hinojosa and Hinojosa (2011) highlighted the significance of military friendships when tackling the challenges of deployment and suggest that they may serve an important

role in post-deployment reintegration. Connections with others and choosing to have a positive attitude have also been reported as methods utilized in an attempt to resolve issues faced upon return home (Wands, 2013). Despite efforts by federal and state governments to implement programs that address reintegration difficulties and promote community (re)integration post-deployment, evaluation of the effectiveness of these programs is lacking (Sayer et al., 2010; Danish & Antonides, 2013).

The DVA current approach to helping veterans are time rigid and evidenced based models. The approach consists of peer counseling, support groups and peer-to-peer programs that focus on thought process and disputation of negative thoughts and images rather than trauma. The Vet Center Program was established by Congress in 1979, out of the recognition that a significant number of Vietnam era veterans were still experiencing readjustment problems. Vet Centers are community based and part of the U.S. Department of Veterans Affairs. The goal of the Vet Center program is to provide a broad range of counseling, outreach, and referral services to eligible veterans in order to help them make a satisfying post-war readjustment to civilian life.

On April 1, 2003, the Secretary of Veterans Affairs extended eligibility for Vet Center services to veterans of Operation Enduring Freedom (OEF) and on June 25, 2003, Vet Center eligibility was extended to veterans of Operation Iraqi Freedom (OIF) and subsequent operations within the Global War on Terrorism (GWOT). The family members of all veterans listed above are eligible for Vet Center services as well. On August 5, 2003, VA Secretary Principi authorized Vet Centers to furnish bereavement counseling services to surviving parents, spouses, children and siblings of service

members who die of any cause while on active duty, to include federally activated Reserve and National Guard personnel.

Readjustment counseling is a wide range of psycho social services offered to eligible veterans and their families in the effort to make a successful transition from military to civilian life. Readjustment Counseling Services include individual, family, group bereavement, Military Sexual Trauma (MST), substance abuse, employment assessment and referrals, Veterans Benefits Administration (VVA) benefits and referrals and some medical screening (i.e., TBI, Depression and etc.). Although the services that are provided by the DVA readjustment counseling program are substantial; however, they do not address all the needs of veterans.

Identifying the most effective vocational and family support approaches is viewed as critical to successful community integration (Sayer et al., 2010). Additionally, as far as we are aware, an assessment of the attitudes and experiences of key supporters in the Veteran's life remains a void. Much research is being focused on those who receive services from within the DVA system of care, while less is known about the Veterans who seek care outside of DVA facilities (Finley et al., 2010). This is important because a recent article by Sayer et al. reported that approximately 56 percent of OIF/OEF/OND Veterans were not enrolled in the DVA and that of those enrolled, 40 per-cent were not classified as combat Veterans (Sayer et al., 2010). An additional concern is that many of the problems reported to date are out of the realm of traditional medical practice. Sayer et al. cautioned that mental health practitioners may be overwhelmed by the demand for services (Sayer et al., 2010). BATTLEMIND (2008), developed by the Walter Reed

Army Institute, is a mental health preparatory training given to soldiers three to six months post deployment and prior to redeployment (Slone & Friedman, 2008).

BATTLEMIND is a set of skills warriors have utilized during war. The following represents how this framework is a survival mechanism in combat and can potentially be maladaptive in civilian life. Deconstructing these vital skills that are learned behaviors for warriors during combat is crucial in the reentry process.

Slone and Friedman (2008) describe, for example, how service members may feel that he or she and their buddies are the only ones who will ever understand what they experienced during wartime and what they may be going through in the aftermath. The training highlights the warriors' inner strength to face fear and adversity, complete tasks, with courage and that combat stress reactions in the theater are normal responses in reaction to an abnormal environment (Slone & Friedman, 2008). The training emphasizes the combat skills that helped a warrior survive and how to transition those skills and ingrained way of coping in civilian life (Slone & Friedman, 2008). Prior to returning home, warriors are reoriented to learning adaptive responses and habits that are acceptable in civilian life while still maintaining the discipline, safety and focus of a soldier. Issues during reintegration begin to surface when soldiers are not able to make the shift from warrior to civilian.

Department of Defense Wellness Approach

All branches of the military have programs dedicated to providing assistance to service members and Veterans with combat-related injuries or illnesses resulting from their involvement in the OIF/OEF/OND conflicts (Perla et al., 2013). Whereas the

Department of Defense does not have a uniform definition of reintegration, its post-deployment programs emphasize areas including relationships, employment or schooling, access to benefits, health-care, and housing; in other words, domains relevant to full participation in community life (Sayer et al., 2011). Though variance in definition exists, the consensus of the articles included in this review of the literature reveals that similar to the goals of TBI rehabilitation, service members and Veterans who have successfully (re)integrated post-deployment are productive participants at home, their place of work or school, and within their community (Kupersmith et al., 2009). Recognizing that successful (re)integration has a subjective component, this definition of community (re)integration will be used for the purposes of this study.

The Army's preemptive response to managing the mental health of its soldiers was to establish the Mental Health Advisory Team (MHAT), which monitors military personnel's mental health status in the theater of war (DOD, 2003). However, the mental health screenings conducted in the combat theater cannot determine if stress reaction symptoms will persist when the service member is removed from the combat situation.

In April 2003, the DOD mandated all returning troops to complete a Post Deployment Health Assessment (PDHA) in the country where the warrior was posted or within two weeks post-deployment. Studies conducted using data from PDHA screenings found that 10% of service members returning from Iraq screened positive for PTSD and 5% for depression (Ramchand, Karney, Oscilla, Burns & Caldarone, 2006). The authors indicated that the low rates may have been attributed to both the stigma attached to reporting mental health symptoms, the PDHA was not confidential, and military and

service members' concerns that a mental health diagnosis could potentially delay their return home (Ramchand, Karney, Oscilla, Burns & Caldarone, 2006). The military has implemented both a pre- and post-mental health screening protocol; however, the post-screening is measured upon direct reentry, which is problematic as many soldiers may experience delayed traumatic stress symptoms.

Combat Operational Stress Control (COSC) encompasses all Marine Corps policies and programs to prevent, identify, and holistically manage psychological injuries caused by combat or other operational demands (Department of Defense, 2009). The two primary goals of COSC are to maintain a ready fighting force and to protect and restore the health of Marines and their family members. To these ends, the COSC program, in its current form since 2008, provides decision-making tools for service members and their families to build resilience, identify stress responses, and mitigate problem stressors. Over delivery of information briefs immediately following deployment often overwhelms participants and mitigates the impact of reintegration content (DOD, 2009). A key success factor for COSC and OSCAR is the integration of peer-to-peer support structures for the Marines. This format emphasizes the overarching intent of the program to facilitate Marines supporting fellow Marines in need, rather than a strict referral program for mental health services (DOD, 2009).

In 2008, the Joint Family Support Assistance Program (JFSAP) was launched to provide outreach and assistance to active duty, National Guard, and reserve military families who are geographically isolated from installation resources (DOD, 2008). The main objective of the program is to enhance military family resilience and readiness

through the provision of available resources at the local level (DOD, 2008). A major component of the program is the compilation of local resources, which is accomplished by members of the JFSAP team in each state and territory. JFSAP provides a single, one-stop source for accessing several different resources to support service member reintegration after deployment.

Warrior Mind Training (WMT) (2009) is a mental fitness training program designed specifically for the U.S. Armed Forces and veterans. The main objective of WMT is to provide service members with a foundation of mental tool and techniques needed to achieve success in any endeavor and in any phase of the deployment cycle, on the job and at home (DOD). Effective mind training allows individuals too consciously and deliberately change the way they think, feel, and behave, influencing how the body responds to stressful or high pressure situations. WMT's primary strength as a reintegration program is its unique ability to be customized to meet the needs of various participant groups at various points in the deployment cycle (DOD, 2009). WMT's holistic approach to mental health and hygiene is relevant to military issues and situations, but the techniques provided are adaptable and can also be used to address issues while on duty.

The National Guard Yellow Ribbon Reintegration Program (2008) is a legislatively mandated program designed to provide information, services, referrals, and proactive outreach programs to Service Members and Families of the National Guard and Reserves throughout all phases of the deployment cycle (DOD, 2008). The Yellow Ribbon Reintegration Program (YRRP) mission is to assist, collaborate, and partner with

Services, and agencies at the lowest level possible in order to provide Service members, Veterans, and Family members with informational events and activities, referrals, and proactive outreach services throughout the phases of deployment or mobilization (DOD, 2008). Their goal is to prepare National Guard and reserve service members and loved ones for mobilization; to sustain families during mobilization; and to support healthy reintegration of military reserve members back into communities, employment and civilian life (DOD, 2008). Without the nearby availability of resources such as child care, mental health counseling, behavioral counseling, or regular interaction with military peers, service members in the Guard and reserve often face difficulties identifying resources. The YRRP events are vital to creating awareness and networks with service providers and family support personnel in the services.

Total Force Fitness (TFF) (2010), a concept designed to address the needs of a military that requires continuous performance, resilience, and rapid recovery (Jonas, O'Connor, Deuster, Peck, Shake & Frost, 2010), provides not only a promising structure for examining reintegration following deployment, but also a starting point for developing appropriate metrics for measuring the success of reintegration a notable deficit in the current reintegration literature. Total Force Fitness comprises multiple components of both mind and body fitness. The TFF model includes eight fitness domains essential to the health and well-being of a service member. These include four "mind" domains: (1) psychological, (2) behavioral, (3) social, and (4) spiritual fitness; and four "body" domains: (1) physical, (2) environmental, (3) medical and (4) nutritional fitness (Rounds, 2010).

The TFF paradigm, in addition to being an established and well-defined model within the DOD, has several other characteristics and strengths that make it an ideal candidate for application to reintegration. TFF creates a more holistic mind-body view of fitness and unifies approaches and goals across the services to create a joint military culture. It is consistent with the consensus among the services that a comprehensive reintegration program, including various aspects of wellness and a strong family component, should be developed (Pisano, 2010). Although these metrics have not yet been evaluated empirically for use in the domains, they offer a potential mechanism for reintegration assessment and evaluation. The development of an overall TFF metric has been acknowledged as a priority for current and future research (Jonas, et al., 2010).

Conclusions from the literature

This review highlights some of the gaps in the research that has been conducted on several wellness models within society. The review is also being concluding by looking at the positive and negative aspects of the DOD wellness model approach. Literature investigating the place, impact and purpose of Wellness supports its potential for creating positive change in the personal and professional lives of veterans. Gaps in the current literature; however, present challenges to clinicians.

The DOD has been working diligently in collaboration with the DVA to create a program that will decrease maladaptive behaviors and increase successful reintegration for returning OEF and OIF veterans. There is a paucity of research relating to the empirical clarification, measurement and implications of cultural, environmental and gender influences relating to Wellness, within the Combat Veteran context. It is also important to note that none of the current Wellness models actually address the veteran

framework necessary for an individual to learn about and thus become aware of or understand and make choices about their own Wellness.

The outcome of a Wellness lifestyle is a capacity to contribute in positive and meaningful ways to one's community, society and the welfare of the earth. An individual who adopts a Wellness lifestyle aims to balance the multiple dimensions of their health and wellbeing in concert with their environment.

The DOD wellness approaches mentioned in table 1, do not address trauma from a holistic or wellness standpoint. The models do not focus on the number of deployments that veterans have been exposed to during their time of service nor the trauma that they have experienced during that time. The DVA and the DOD views the reintegration of veterans into society through a non-dimensional lens, which focuses on the medical model that consist of medication management and symptom management. The models within the DOD program focus on the mental, spiritual, physical and emotionally components of a being, yet the programs do not address the trauma that exist.

Many of the problems that veterans endorsed, including social functioning, employment issues, anger control, and spiritual struggles, fall outside the traditional scope of medical practice. DOD mental health providers, who usually have the requisite skills to address these issues, may struggle to keep up with the demand. Furthermore, it remains unknown whether evidence-based treatments for reintegration for OEF and OIF veterans would lead to satisfactory improvements in functional and readjustment outcomes. Because the DVA and DOD are two of largest providers for returning combatants, it was important to focus initial attention on this large and important group.

Although federal and state governments have implemented programs to promote community reintegration post-deployment, evidence of the effectiveness of these programs is lacking. Furthermore, although more than half of OEF and OIF combat veterans had an interest in receiving readjustment services through a DVA medical facility and DOD program, not all health care providers have the training skills to incorporate veteran centered treatment and trauma focused treatment.

The wellness approaches delivered by the DOD, has been researched extensively, and the impact of the model has been well documented. However, there has been little research conducted on the model in regards to trauma experienced by the combat veterans and their successful reintegration back into civilian culture. Nevertheless, the current programs are not conducive for veterans that are reintegrating back into society. Research suggests that there have been previous models of wellness that have been proposed.

Limitations of Wellness Approach

Several limitations to the DOD wellness approach are worth noting. The models were all composed of interventions and programs that focused on the veteran within their military branch, which may have influenced the reintegration of veterans from OEF and OIF. The DOD treatment approach was and is geared towards teaching veterans how to cope, however the models did not focus on the trauma that the veterans experienced, the number of deployments in which all these components are essential in successful reintegration.

One of the major limitations were the recommendations that were made to the DOD after the initial review of the core models that were being utilized to assist soldiers

and veterans with reintegration. After initial review of the DOD models four core recommendations were suggested for DOD line leaders, Directors of Psychological Health/Behavioral Health, and Directors and Program Managers of Reintegration Programs to implement when working with veterans and returning soldiers.

Recommendation one was to develop a cross-service, cross-agency definition and approach to reintegration. The rationale for the recommendation was to increase collaboration between the DOD and the DVA because agencies need to maximize benefits while potentially conserving resources and limiting redundancy.

Recommendation two is to improve access to care, education, and resources. This recommendation will allow programs to address the needs of the veterans and service members regarding reintegration support. Recommendation three is to implement an integrated approach to reintegration, which needs to be a holistic approach to reintegration support. The support will provide resources at a variety of points during the deployment cycle. This will help address the needs of the service member families and communities. This holistic approach will provide individuals with the education and resources they need to prepare, and succeed in, reintegrating, regardless of their point in the development cycle.

The last recommendation is to develop and implement reintegration assessment procedures and metrics. The measures will assess the needs of service members, their families, and their communities during the reintegration process to help facilitate the development and adaptation of support programs. Although the recommendations have been made, no recommendation for the inclusion of trauma and veteran centered focused

treatment was recommended. The DOD models do not focus on the relationship between trauma and reintegration.

Despite these limitations, findings are consistent with the DVA (2009) who found that the veteran population needs interventions that are trauma focused and veteran centered. The DOD is still struggling to support the veterans and perfect their multiple roles, especially as a reintegration provider. Prior to the review of literature, wellness models for reintegration have not been studied specifically with the OEF and OIF population. The review of literature also included several other wellness models that were ineffective in assisting veterans with successful reintegration.

This review of the literature study provided an introductory conceptualization of wellness approaches as they relate to OEF and OIF veterans and successful reintegration. If treatment was more veteran centered and trauma focused, the veteran's reintegration may have been somewhat different. Wellness models were focused on the symptomatology of the veteran versus the trauma that the veteran experienced. A trauma focused intervention may have yielded different findings based on the review of literature.

Trauma if not treated appropriately will manifest and influence the utilization of maladaptive behaviors. The maladaptive behaviors can and will increase the symptoms of PTSD through thought suppression, behaviors used to control some symptoms while enhancing other symptoms, avoidance about their trauma, substance abuse or medication to control anxiety, which prevents a change in interpretations and rumination, which increases the feelings of hopelessness, nervous tension, dysphoria, and intrusive

memories of the traumatic event. The major problem is that the behaviors become habitual; when the veteran is triggered the behavior is automatic.

Trauma impacts OEF and OIF veterans in a variety of ways. The first is that families suffer because the veteran is triggered by the smallest things, which lead to anger, rage, inability to communicate effectively, and an increase in symptoms of PTSD. Trauma needs to be a part of the wellness model because it encompasses the person from a holistic point of reference. Processing a veteran's trauma is increasingly important when assisting veterans with successful reintegration back into civilian life. The proposed wellness model will address reintegration from a veteran centered and trauma focused wellness approach.

At the core, the wellness model that is being proposed will assess participants' health risks, deliver tailored educational and lifestyle management interventions, veteran centered and trauma focused interventions that are designed to lower risks and improve reintegration. The wellness approach will promote a healthy lifestyle for veterans, maintain or improve mental health, health and wellbeing.

Implications for Veterans

Although the "underlying philosophy of reintegration for veterans rests on a foundation designed by the DOD and DVA", results of this literature review raise the question of how effectively wellness is being emphasized in treatment of veterans. As evidenced in a recent study (Myers et al., 2006), wellness is being incorporated in some military reintegration programs in a variety of ways. Early treatment interventions before discharge might accommodate not only the soldiers within the unit, other veterans who have competing responsibilities may also benefit. Trauma focused treatment will offer

veterans a way to process the trauma and not just work to manage the symptoms. Family support is an important issue and some veterans may perceive the current wellness models as being inconsistent or conditional. Wellness and trauma focused approach will increase the number of successful integration. A trauma focused and veteran centered wellness approach will help provide a healthy foundation for successful reintegration and individual growth within the OEF and OIF population.

If left untreated, these problems could have deleterious effects not only on the individual, also on his or her family, community, and society as a whole. Barriers to treatment initiation include attitudes and beliefs, financial and logistical problems, system-level factors that limit access to services among combat veterans, post-trauma experiences perceived as invalidating of their services. Utilization of a trauma focused wellness paradigm will provide a blue print for distinguishing and assessing the multiple dimensions of successful reintegration that converge in veterans' lives to either strengthen or weaken overall quality of life. It is apparent in the literature that there is an absence of trauma focus, which leads to the research questions.

RESEARCH QUESTIONS

1. How important is the role of trauma in the recovery and reintegration of Iraq and Afghanistan veterans?
2. What are the variables involved in developing a Veteran centered wellness treatment approach?
3. How would a veteran centered wellness treatment approach aid OEF and OIF veterans to successfully reintegrate into civilian life?

In view of the literature, it is important that future wellness models for veterans be designed to gain greater insight into how wellness interventions for OEF and OIF veterans can assist with successful reintegration.

CHAPTER 3. METHODS

Research Design

Glaserian Approach

In 1967 Glaser and Strauss developed the methodology of grounded theory.

Grounded theory has two goals: (1) to generate a theory that explains how an aspect of the social world “works” and (2) to develop a theory that emerges from and is therefore connected to the very reality that the theory is developed to explain (Glaser 1967).

Strauss and Corbin, (1990) defines grounded theory approach as a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon.

One of the reasons that grounded theory has received increased attention is because this method emphasizes understanding the “voice” of the participant to build a theory about phenomena. Strauss and Corbin (1990), two of the researchers who have been instrumental in defining grounded theory methodology, state that theory is “discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon” (p. 23). In the current study existing data and notes were analyzed to develop a theory that explains the experiences of veterans in regards to reintegration back into society. This theory addresses the challenges confronted and strategies used by current wellness programs, as well as factors that impact service provision in diverse settings.

The start of the study proposed different approaches to grounded theory that were not the same. In this study the area of interest was initially broad, being concerned with

OEF and OIF veteran's wellness through a trauma focused wellness model. The potential vast number of competing possibilities in the literature, led to a decision to interview (data review) wellness models proposed by the DOD. This was intended to increase theoretical knowledge and find a clearer direction from the field rather than literature. Thus, from the outset, a path was chosen that was closer to Glaser's approach than that opposed by Strauss.

Research

Finally, the research competency area addresses understanding how to conduct culturally sensitive research to study veteran populations (Rogers et al., 1999). Rogers et al. (1999) recommend that researchers be skilled in using quantitative and qualitative research procedures and that they be knowledgeable about conducting program evaluations to determine the effectiveness of programs and services for OEF and OIF veterans. In conducting research, competent researchers recognize the social, linguistic, and cultural context in which the research takes place and they acknowledge and eliminate possible biases.

Model development

Rogers et al. (1999) do not identify any particular research that was instrumental to the development of the recommendations they propose. Review of the references cited in the article suggest that the authors reviewed literature addressing issues such as effectiveness of wellness models, barriers to treatment, cross-cultural issues in each branch of services, quality of life for veterans, and maladaptive behaviors.

Interviewing (data review)

The data review of the four models involved using multiple stages of data collection and the refinement and interrelationship of categories of information. The data review will help increase theoretical knowledge and determine variables important for wellness of veterans overall. They will also help to find a clearer direction for developing future veteran focused wellness models.

While qualitative methods have been widely used in the fields of anthropology, sociology and nursing, the use of these methods in psychology is a relatively recent development (Ponterotto, 2002). A particular qualitative methodology that has received attention in the psychology research is grounded theory (Pope-Davis, Torporek, Ortega-Villalobos, Ligiero, Brittan-Powell, Liu, Bashshur, Codrington & Liang, 2002). One of the reasons that grounded theory has received increased attention is because this method emphasizes understanding the “voice” of the participant to build a theory about phenomena. Strauss and Corbin (1990), two of the researchers who have been instrumental in defining grounded theory methodology, state that theory is “discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon” (p. 23).

In the current study interviewing (data review) were analyzed to develop a theory that is veteran centered and trauma focused. This theory addresses the need for trauma focused and veteran centered interventions for successful reintegration for OEF and OIF veterans, as well as factors that impact service provision in diverse settings.

For the purposes of this project, DOD wellness programs were operationalized in terms of reintegration for OEF and OIF veterans. DOD programs with at least three of the holistic domains were included in the study. As discussed earlier, reintegration is often conceptualized as a positive series of events, including reunions with family and friends and a return to one's pre-deployment life, it also may be a time of personal struggle for service members. Reintegration is essentially a social and economic approach with an open time frame, primarily taking place in communities at the local level.

Research Design

Data Collection

Sources of data for the current project included an in-depth literature review of the different wellness models that are currently being utilized to assist veterans with reintegration. The literature review was used to develop the proposed theory of wellness for OEF and OIF returning veterans. The literature review focused on gathering information about the strategies that are utilized when responding to the needs of returning veterans and the challenges faced in civilian environments. Specifically, data was analyzed about the needs of veterans and the approaches in which the clinicians were performing assessments, consultations, and counseling with OEF and OIF veterans. A secondary focus included exploring the factors that impacted veteran's ability to experience a successful reintegration.

Interview

The primary data collection method was a literature review of wellness approach. The researcher had previous experience conducting literature reviews and data analysis during

graduate training. The literature review began with a brief introduction of why reintegration is so important for OEF and OIF veterans. The researcher utilized the data to gain more insight into the barriers that were prohibiting veterans from achieving a successful reintegration and the needs of the veterans. The second portion of the literature review provided detail literature about the utilization of wellness programs within society and the Department of Defense. The researcher utilized the data to analysis any factors that facilitated or hindered their ability to effectively deliver services and the advantages and disadvantages of utilization within the DOD programs. Finally, the researcher concluded with addressing the need and importance for a veteran centered and trauma focused wellness approach.

Researcher Notes

In addition to interviewing the data, a secondary source of data was the researcher notes. Researcher notes were included in the analysis involved in generating the theory. The researcher's data was coded separate from the interviewing data and provided a means to validate the information from the researcher. Notes were taking from the researcher that provided services to over fifty OEF and OIF veterans with whom they worked.

Description of Participants

A purposeful sampling technique was used to select wellness models for this project. Purposeful sampling is described as choosing "particular subjects to include because they are believed to facilitate the expansion of the developing theory" (Bogdan & Biklen, 1998, p. 65). Since the purpose of the current study was to develop a theory

that needed to increase and enhance the reintegration of OEF and OIF veterans back into civilian life, data included theories that have been identified as the most effective in providing reintegration services to OEF and OIF veterans.

Four models that were been utilized to assist veterans with successful reintegration served as the primary data set in this study. All of the models were initiated through the Department of Defense. The wellness models consisted of services for the families; services only for certain branches or veterans, different areas within the holistic paradigm, and information based only. Two of the models included all four elements of wellness and two were composed of three of the four areas of wellness. However, neither model focused on trauma and/or the methods of processing trauma to assist in successful reintegration. The most important criteria for the model being analyzed in the project were the largest and most direct relationships with OEF and OIF veterans. The second criteria were the amount of utilization of the models as it relates to reintegration for OEF and OIF veterans. The role of utilization in this project is important because it either validates the efficacy of the program or discounts the program.

Measures

Thick description

Thick description is described by Lincoln and Guba (1985) as a way of achieving a type of external validity. Rich and thick description of study elements allows those reading the study to decide if results can be transferred to other populations of interest (Creswell, 1998). Holloway (1970), refers to thick description as a detailed account of field experiences in which the researcher makes explicit the patterns of cultural and social relationships and puts them in context. Detailed information about how the

literature was chosen and the criteria for analysis were outlined in this chapter. Also, in addition, an in-depth study was included in the project and background information about each wellness approach interventions, longevity of the program, veteran make-up, holistic components, and utilization for OEF and OIF veterans was reported.

After the literature review and summary field notes were taken, which included a review of the information provided by the researcher, as well as the researcher reflections regarding the convergence and divergence of the information provided in the data review in regard to the literature. Information about the literature review and significant components that were a part of the summary notes were documented. Throughout the data analysis and interpretation processes documenting the development of the emerging theory records were kept.

Procedures

Theoretical Sampling

In 1967, Glaser and Strauss advocated for theoretical sampling as a central part of grounded theory. Theoretical sampling is tied to the purpose of generating and developing theoretical ideas, rather than being aimed either at producing findings that are representative of a population or at testing hypotheses (Fassinger, 2005). Theoretical sampling can be defined as “the process of data collection for generating theory whereby the analyst jointly collects, codes and analyzes his/her data and decides what data to collect next and where to find them in order to develop his theory as it emerges” (Glaser, 1978, p.30). Theoretical sampling attempts to discover categories and their elements in order to detect and explain interrelationships between them. Theoretical sampling is different from many other sampling methods in a way that rather than being representative of population or testing hypotheses, theoretical sampling is aimed at

generating and developing theoretical data. Theoretical sampling is a central tenet of classic grounded theory and is essential to the development and refinement of a theory that is grounded in data. In the current project, theoretical sampling was used to identify wellness programs. The current researcher sampled specific experiences and incidents within the literature data and researcher notes to confirm and elaborate on emerging findings.

Data Analysis

In 1998, Strauss and Corbin described data analysis as a process of breaking down, organizing, and reassembling data to develop a different understanding of phenomena. In accord with procedures outlined by Strauss and Corbin (1998) regarding data analysis for grounded theory research, the following coding procedures were implemented in the current project: open coding, axial coding, and selective coding. This section describes how data were deconstructed, and subsequently reorganized to provide an understanding of how a veteran centered and trauma focused wellness approach would increase the numbers of successful reintegration for OEF and OIF veterans.

Open Coding

Strauss and Corbin (1998) state that the “first step in theory building is conceptualizing” (p. 103). The purpose of open coding is to begin the process of breaking data down into concepts or representations of objects and events. Scholarly literature, existing data, notes and memos were reviewed and broken down into phrases and sentences that represented the researcher’s main ideas.

Review of data from the literature resulted in a list of over five concepts and wellness interventions. An example of concepts gleaned from the first note above include, “working through spiritual and mental trauma involves understanding the integration of trauma and wellness.” A concept from the second note is, “working in diverse settings involves understanding the differences that people experience in the present and past life.” Concepts involving trauma elements are the clinicians need to have knowledge of combat trauma were grouped under the category, “Trauma,” and vocational, family, housing, and etc., were categorized under “Veteran’s Needs.” This grouping of concepts into categories, or abstract explanatory terms, represents the second step in the coding process. The goal of this coding phase was to generate a list of categories regarding the barriers and perceptions of OEF and OIF veterans. Through the process of comparing the concepts for similarities and differences a list of 11 categories was constructed.

The next analysis step involved coding literature using the category list generated. The researcher coded the data and assigned categories independently in each passage. For example, consider the “Trauma” category. The note for this category, included information gained from the data that addressed the conditions and interactions during deployments for veterans and the number of deployments that veterans experienced. Additionally, the number of traumas experienced was also noted. While soldiers may have experienced one deployment the amount of trauma experience may have been more than anyone person could process. Most clinicians would diagnosis this as post-traumatic stress disorder, others would say it is a part of war and it comes with being in the military. The researcher suggests that a true understanding of how combat trauma impacts the soldier and will aid in the veteran experiencing a successful reintegration.

Axial Coding

Strauss and Corbin (1998) state that the purpose of axial coding is to “begin the process of reassembling data that were fractured during open coding” (p. 124). This phase of analysis began by grouping category notes into main and subcategories. Through the process 2 main categories representing the wellness deficiencies emerged.

The “Trauma” category includes the soldiers experience during and after deployment. Notes and existent data were examined to determine the properties of this main or more encompassing category. The “Trauma” category included information about the different experiences that soldiers have within the different branches of military services (e.g. Marine Corps, Army, Navy, Air Force, National Guard, Reserve Units), and the impact of deployments (e.g. number of deployments, impact on National Guard and reserves). Additionally, relational statements, or statements derived from the data denoting associations between this category and others, were developed. Based on the trauma that the soldiers experience and others denoting a relationship between the numbers of deployments that soldiers experience during their military service time, a relational statement were developed, linking the main categories of “Trauma” and “Veteran Needs.”

Selective Coding

Strauss and Corbin (1998) state that “selective coding is the process of integrating and refining categories” (p. 142). The primary goals of this step of analysis were to develop an overarching theoretical scheme explaining how each of the categories related to each other, and to identify a core category that explained veteran’s trauma and their maladaptive behaviors after deployment.

In this step of analysis the main categories were examined for similarities and differences. Literature representing each of the main categories were sorted and reviewed. This resulted in the emergence of four constructs, or overarching theoretical categories. One of the constructs that emerged was labeled “Deployment” and involved the main categories representing experiences during deployment of OEF and OIF veterans trying to reintegrate after deployment; the main category of “Trauma” was included in this construct. A second construct, “Maladaptive Behaviors,” represented the behaviors of veterans suffering with trauma and the impact that the participants named that impacted their experiences of reintegration. One of the main categories included in this construct was “Veteran’s Needs.”

The development of a scheme linking the constructs was a result from the analysis of relational statements. For example, one of the relationships proposed in the theory involves the relationship between the number of deployments of OEF and OIF veterans and maladaptive behaviors. This relationship was partially based on the relational statement discussed above that stated that multiple deployments that include traumatic experiences contribute to the development of maladaptive behaviors.

The narrative describing the emergent wellness approach was developed explaining the factors involved in trauma work with OEF and OIF veterans. The one core category that represented veteran’s successful reintegration was due to the review of the scheme. Finally, the notes and data from the literature were reviewed to evaluate its fit to the theory proposed. The specific components of this theory will be shared in the next chapter of this text.

To evaluate the fidelity of the source information obtained through literature reviews and notes were analyzed. Comparison of literature to the theory generated through analysis of researcher notes, literature reviews provided confirmation to the main concepts proposed in the theory. For example, the current theory includes constructs that

involved the physiognomies and approaches on which clinicians rely. These findings were validated by literature reviews, existent data, researcher notes that noted the use of similar techniques and qualities in their observations of clinicians. The next chapter will review the project findings in regard to the research questions that guided this study, and results will be compared to existing research in the field.

CHAPTER 4. RESULTS

The purpose of the current study was to develop a wellness approach that was veteran centered and trauma focused to assist OEF and OIF veterans with successful reintegration back into society. Grounded theory methodology was used in this effort to analyze interviewed data (literature review) and the researcher notes. The study explored the efficacy of wellness approaches for reintegration for OEF and OIF veterans; emphasis was placed on the techniques utilized and the variables that impacted the successful reintegration of returning OEF and OIF veterans. Following the examination of the research questions, the limitations of the study will be addressed, as well as the implications of study findings.

Research Question#1: How important is the role of trauma in the recovery and reintegration of Iraq and Afghanistan veterans?

The main question that guided this research explored how important the role of trauma was in the recovery and reintegration of Iraq and Afghanistan veterans. Information provided by the study imparted insight into the goals, and philosophies that are needed to guide clinicians as they attempt to help veterans with processing their trauma during recovery and reintegration. It also shed light onto the specific interventions that may be helpful for veterans.

Briefly, some of the veterans that utilized the DOD wellness models encountered homelessness, substance abuse, divorce, legal problems, unemployment, and even attempted suicide. There was a mismatch when the military training, beliefs, or values of combat veterans were in conflict with the mainstream ideals espoused by society, clinicians, and their family. A sampling of the ways in which DOD wellness models attempted to address the trauma of veterans was limited and increasingly difficult for

veterans and their families. Some of the techniques that were utilized included Prolonged Exposure, Cognitive Process Therapy, medication, and time-focused group therapy. Analysis of the cumulative responses from veterans in reaction to the challenges presented by the utilization of the DOD wellness model revealed that a holistic set of trauma interventions were needed to assist veterans with successful processing of their traumatic experiences. Veteran's manner of recovery and reintegration into civilian culture was characterized by attempts to address the trauma that they have experienced during their deployment. This goal was represented in the core category of the emergent theory, which is entitled, "Restoring a sense of Wellness."

Trauma Knowledge

One of the characteristics that clinicians need to possess comes from the current study and is considered as being essential when working in recovery and reintegration with OEF and OIF veterans. Possession of trauma knowledge is a construct commonly addressed when discussing trauma competence in clinical settings. This concept was not fully addressed during treatment modalities within the current models of wellness.

Responses addressed the importance of having an understanding of a range of trauma issues. Findings from the current study suggest that part of recovery and reintegration for OEF and OIF veterans involves having an understanding of specific cultural variables. Researchers in the field of mental health, and findings from the current project add that clinicians need to understand trauma and how trauma impacts recovery and reintegration (Wands, 2013).

While responses in the current project revolved around having knowledge of trauma for specific OEF and OIF veterans, the importance of possessing an understanding of the differences that occur within OEF and OIF veterans also emerged.

This is consistent with the calls by S. Sue (1998) for dynamic sizing abilities, and by Ridley et al. (1994) for counselor plasticity. An aspect of both of these concepts involves the ability to validly generalize about trauma issues while acknowledging within group and individual differences.

A common philosophy was central to achieving the veteran's goal of restoring a sense of wellness. First, the DOD participants conveyed an awareness of the impact of ineffective treatment modalities for veterans as they struggle to process their trauma. As reviewed earlier, a commonality found in most of the wellness models in regards to veteran reintegration and interventions involves the ability to recognize the impact of trauma. When intervening in combat veteran reintegration situations the literature that was analyzed in the current study provided a valid explanation of how important it is to help veteran's process their trauma through holistic channels. However, there was a lack of veteran centered trauma focused interventions being utilized to help veterans with successful reintegration.

The common goal of lessening the impact of cultural variables, and the subsumed philosophy of embracing and respecting combat trauma, guided the interventions that were utilized in this diverse culture. The next section of this chapter provides an in-depth examination of the second research question. The emergent theory proposes that wellness treatment for OEF and OIF veterans is best understood as an interactive relationship between the barriers encountered in the Department of Defense, what the wellness programs bring to the veteran's environment, how the wellness program assist the veteran within his/her environment, and the factors that impact these interactions. Analysis resulted in one overarching category, entitled 'Restoring a sense of wellness,' which fosters awareness and enjoyment of the physical, emotional, spiritual and social

aspects of life. Under this central category are three main variables labeled

“Deployment,” “Maladaptive Behaviors,” and “Impacting Variables.”

Research Question#2: What are the variables involved in developing a veteran centered wellness treatment approach?

There were three variables that the research substantiated as being important in the development of the proposed wellness model and the emergent theory. Following a format similar to Richie et al. (1997) results are discussed using particular terms to indicate the frequency of endorsement. The phrases “the majority of,” “many,” and “most” were used to discuss concepts expressed by at least more than half the veterans in the wellness programs. “A few” was used to indicate concepts expressed by less than half of the veterans that participated in the different wellness approaches.

The section begins with an exploration of the variable labeled, “Deployment.” This variable describes the central challenges that veterans experience from multiple deployments in Afghanistan and Iraq. Following this is a description of the deployment component of the theory. The behaviors and strategies relied on are examined in sections named, “Deployment” and “Maladaptive Behaviors”. Finally, the chapter concludes with an examination of the Impacting Variables section that discusses other factors that are affecting the treatment and successful reintegration of OEF and OIF veterans.

Deployment

While veterans expressed many positive aspects of the different wellness programs this section highlights some of the challenges encountered due to multiple deployments. The literature review acknowledges several common areas of difference that presented challenges. Differences in multiple deployments are discussed and how they impact the veteran’s reintegration. Particular challenges encountered when veterans

are working towards reintegration after deployment. Deployment can and has been hard on families especially the veteran's spouse. Veterans that struggle with deployment related difficulties may bring back disturbing images, thoughts, emotions, and behavioral reactions to certain triggers, as well as physical injuries from these wars that are not easily put aside upon return home. The family members have established new routines while the veteran was deployed and also face readjustment issues when he or she returns home and is expected to resume his or her family role. The readjustment challenges are more difficult when veterans return with mental and physical health problems that cause significant distress and/or impair their ability to participate in major life activities as they may have done prior to deployment. The study showed a higher prevalence of mental health diagnoses in spouses of active duty U.S. Army soldiers during deployments to Afghanistan and Iraq compared with spouses of non-deployed soldiers.

Multiple Deployments

The wars in and around Iraq and Afghanistan have been staffed on a rotational basis. This approach spreads deployments over the entire pool of deployable service members. Due to the length of the Afghanistan and Iraq military operations, there have been multiple deployments for many personnel, especially soldiers and marines. The Afghanistan and Iraq Wars are fundamentally different from previous wars in their heavy dependence on the Reserve component and National Guard troops (IOM, 2010). This demographic group makes up about 44% of U.S. veterans separated from active duty after having served in Afghanistan and Iraq. The Afghanistan and Iraq War veterans that

have been deployed more frequently experienced less time between deployments (dwell time) to recuperate than planned (IOM, 2010).

Throughout the literature and the researcher notes, veterans described the challenges that they experienced during reintegration is mainly due to their experiences during multiple deployments. Multiple deployments have and will continue to lead to family conflict, communication breakdown, maladaptive behaviors and post-traumatic stress disorder. Situations described by the researcher notes involved not only issues that arose from multiple deployments, but also from demographical make-up of military soldiers during deployments. Deployment and combat trauma exposure are associated with increased risk for psychiatric disorders, including PTSD, other anxiety disorders, alcohol abuse, depression, and suicide (IOM, 2008).

A subsequent population-based longitudinal study of Iraq War soldiers suggest that the rate of mental health problems increased substantially during the first six months after returning from deployment, particularly among Reserve and National Guard soldiers, demonstrating that symptom assessments immediately post-deployment underestimate the mental health burden in returning service members (Milliken et al., 2007). Deployment related environmental exposures present an additional concern. In one recent assessment, approximately 90% of Afghanistan and Iraq War veterans reported worrisome exposures to air pollution or poor air quality (e.g., sandstorms, burn pits), 81% to petrochemicals, 37% to contaminated food or water, and 21% to depleted uranium (Teichman, 2012).

The research was unable to identify which deployment was most impactful on the lives of veterans and their family members. When researching the treatment and assessment process the major variable of trauma was not included in the data. Obvious challenges arose when veterans seeking assistance during multiple deployments were removed from active duty and medically separated. One strategy used in the DOD to combat unsuccessful reintegration for veterans was to increase the number of clinical personnel on the missions and require mandatory debriefings after deployment (DOD 2008). However, the literature review also discussed some of the challenges that occurred with this strategy. There were a lot of veterans and soldiers that did not utilize the services for fear of medical separation.

While not all interactions with the military approaches were negative, literature suggests that veterans did express some concern over being medically separated and judged by fellow soldiers. Concerns involved the use of individuals not qualified to serve as clinicians because they did not have the educational or psychological expertise to adequately provide clinical services for trauma. Unqualified clinicians may not have an understanding of the importance of trauma treatment; thus, providing clinical services that only address the symptoms and not the cause of the symptoms.

Maladaptive Behaviors

The demands, stressors, and conflicts of participation in war can also be traumatizing, spiritually and morally devastating, and transformative in potentially damaging ways, the impact of which can be manifest across the lifespan. The literature showed that there are several maladaptive behaviors that veterans utilized to self-soothe or self-medicate. The behaviors consisted of substance abuse, attention seeking

behaviors, power seeking behaviors, converting to anger, workaholism, revenge, legal issues and different addictions.

The top two maladaptive behaviors for OEF and OIF veterans were substance abuse and legal problems, with power seeking behaviors and converting to anger shortly behind them in the tally (Greenberg & Rosenheck, 2009). These substances involved alcohol, illegal drugs, over-the counter-drugs and prescribed medication. Researcher notes showed that OEF and OIF veterans who suffered with PTSD and utilized substances for self-medication were more than twice as likely to have a record of committing a violent offense after deployment. The literature provided insight into how untreated trauma fosters the development of maladaptive behaviors within OEF and OIF veterans.

Veterans began using the maladaptive behaviors to escape discomforts in life. They fail to realize that the behaviors are not helping the situation these maladaptive behaviors make things much worse and only aid in numbing. Combat veterans choose these behaviors because of several reasons. The first reason is because of faulty logic (behavior is reasonable to them). The second is that the behavior can appear to be working in the beginning. The third reason is because they are trying to fit in with others. Meaning that if they have seen family and friends confront life's problems by turning to alcohol or drugs they will do the same. The fourth reason is that the behavior allows them to escape from the trauma in that moment. The last is because they are prepared to accept deterioration in their life for the brief reprieve that these maladaptive behaviors can sometimes bring.

In 2007, 3% of the U.S. veteran population was involved in the criminal justice system at any one time (Blue-Howells, Clark, Van den Berk-Clark, & McGuire 2013).

Despite lower annual rates of incarceration, many who serve or have served in the military have one or more lifetime encounters with the justice system. The literature suggested that more than one-half of U.S. veterans in the DVA substance use disorder treatment programs had a lifetime history of three or more arrests. Greenberg & Rosenheck (2009) suggest that witnessing family violence, lack of stable living environments, combat exposures, mental health problems, and substance abuse have all been implicated in veterans' legal problems.

The number one reason a veteran would reevaluate his or her current behavior is the impact that it will and can continue to have on the veteran and their family. For example, the continued use of substance abuse can lead to a great deal of misery and also deterioration in the current condition. If the veteran continues with the behavior he or she will have a harder time processing the trauma, which will contribute to future misery.

Impacting Variables

Researcher notes cited several variables as barriers to treatment and successful reintegration. Some notes expressed that attending and participating in different wellness models were beneficial for symptom management it was not beneficial for processing and understanding the root cause of the symptoms. In terms of war-zone experiences, perceived threat, low-magnitude stressors, exposure to suffering civilians suffering, and exposure to death and destruction, have each been found to contribute to risk for chronic PTSD. It should also be emphasized that the trauma of war is colored by a variety of emotional experiences, not just horror, terror, and fear. There are so many barriers that inhibit OEF and OIF veterans from receiving the proper care.

The lack of confidence in the VA and the fear of stigma are major reasons for the decision not to seek mental health services, there are other possible explanations. Part of the readjustment difficulty is that during pre-deployment training, the veteran has been trained to survive by any means necessary in a combat zone. Stigma of treatment was a variable that impacted the veteran from experiences and having a successful reintegration. The researcher notes stated the veterans felt that asking for help was like saying, "I am weak, I cannot cut it and I am useless".

The researcher notes describes a typical scenario of a marine who returns home after being treated at her Marine base for depression and PTSD symptoms. At home she is asked if she has killed someone during combat and her response was one of anger, rage guilt shame and avoidance of the question. However, her friends and family were not sure how to react or respond. The marine and her family wanted treatment; however, she was unable to continue treatment due to the long waitlist at the DVA, and was forced to cope with her reactions and symptoms on her own. This was one case note that described an OEF and OIF veteran's experience. Although the marine was unable to receive trauma treatment, she was able to receive treatment in the form of medication and talk therapy with no focus on her wellness or trauma that she experienced.

Lack of family and community support was another barrier for treatment and successful reintegration. Most wounded soldiers in the literature were perceived as a hero, one who is brave, strong, and honored whereas the stigma associated with mental health wounds deems those who have them as weak. It was founded that 60% of soldiers did not seek mental health treatment, fearing the stigma and possible losing their career

advancement. The stigma also contributed to increase use and abuse of substances for returning OEF and OIF service members.

The research gives validity to the need for a new innovative wellness model that will be veteran centered and trauma focused that meets the specific and multifaceted needs of OEF and OIF veterans. Effective care for returning veterans must incorporate all aspects of care.

Research Question#3: How would a veteran centered wellness treatment approach aid OEF and OIF veterans to successfully reintegrate into civilian life?

A veteran centered wellness treatment approach will aid OEF and OIF veterans in successful reintegration by restoring a sense of wellness. Restoring a Sense of Wellness is the centerpiece of the model, which is also known as the core category in grounded theory. According to Strauss & Corbin (1998), the core category in grounded theory research is the centerpiece of the model, an abstraction that represents the main theme of the research. Researchers assert that the core category demonstrates “analytic power” in its ability to “pull the other categories together to form an explanatory whole” (Strauss & Corbin, 1998, p. 146). In this project the core category was determined after examining the “pieces” of the puzzle about reintegration for OEF and OIF veterans (Deployment, Maladaptive Behaviors and Impacting Variables) and asking the questions, “How important is the role of trauma in the recovery and reintegration of Iraq and Afghanistan veterans? What are the variables involved in developing a Veteran centered wellness treatment approach? How would a veteran centered wellness treatment approach aid OEF and OIF veterans in successfully reintegrate into civilian life?” The core category of the current theory, entitled “Restoring a Sense of Wellness”, is discussed in this section.

Core Category: Restoring a Sense of Wellness

The first step in responding to veteran challenges involves possessing the ability to recognize when situations may be related to differences in deployments and demonstrating a respect for these differences. The word “education” is used in the core category title; this word represents a form of learning in which the knowledge, skills, values, beliefs, and habits of a group of people are transferred from one generation to the next through storytelling, discussion, teaching, training, or research. The major focus in this project involved OEF and OIF veterans. When discussing the challenges that returning veterans experienced it is important to note that they were the result of their traumatic experiences. In summary, the core category reflects not only the challenges of veterans, but also the underlying trauma that guided their reactions.

Summary of the Study

The current policies and programs that try to address the needs of service members and veterans that are and have returned from Iraq and Afghanistan returning from hazardous deployments require an understanding of the deployment-related health and reintegration problems that they may face. Information on the prevalence of these problems is needed to improve detection and ensure the availability of appropriate and timely health and other services. Post-deployment mental health problems in service members need to be evaluated soon after they return from the war, which will aid in the process of successful reintegration for the veteran and the family.

Several common areas of challenge were identified by the literature review. These challenges were related to interactions between veterans with multiple deployments and clinicians that were affiliated within the DOD wellness models. While acknowledging the obstacles faced within this diverse population, literature suggests that

veterans expressed that they encountered clinicians who did not understand their traumatic experiences and was unable to express empathy. For example, while some veterans would share about being told to keep driving regardless of what was in the road (killing women and children) was certainly a situation that some of the clinician was unable to help the veteran process. Similarly, while some clinicians worked with veterans that experienced this combat situation over multiple times during their deployments. These experiences made it more challenging for the veteran and the clinician to effectively process the trauma during the counseling session.

Project participants (wellness models and researcher notes) described a number of variables that were influential to the current study. The information provided by the study demonstrated that there is a need for a veteran centered trauma focused wellness model. The way to assist veterans with successful reintegration is through a wellness approach that addresses the needs of the veterans and the trauma that the veteran has sustained. Without addressing the trauma and assisting the veteran with his or her needs reintegration will not be successful and suicide, homelessness, and maladaptive behaviors will continue to increase. Acquiring knowledge about the specific cultural and environmental variables influencing veterans was an action engaged in by the current utilization of the DOD wellness approaches.

Conclusion

The purpose of the current project was to create a wellness model that would aid in successful reintegration of OEF and OIF veterans. Results show that veteran's responses to reintegration can be characterized by attempts to restore themselves back to a sense of wellness that resulted from differences in deployment experiences,

maladaptive behaviors and impacting variables. The techniques veteran's used to reintegrate involved reliance on particular wellness models within the Department of Defense and maladaptive behaviors. Through data and researcher notes, the current wellness models that have been utilized to assist veterans with reintegration back into civilian culture lacked a veteran centered focus, trauma focus interventions and a holistic approach. The main strategies that will be utilized for successful reintegration consist of relationship building, veteran centered, trauma interventions (therapeutic techniques) and a holistic approach (spiritual, physical mental and emotional). Three variables were noted to influence veterans responding to reintegration into civilian culture. Data explored deployment issues, maladaptive behaviors, and impacting variables that impacted the reintegration of veterans. The present chapter presented the researchers findings as they relate to the research questions. The final chapter will conclude with an examination of the proposed wellness model and the description of the emergent theory.

CHAPTER 5. DISCUSSION

Discussion Related to Findings of the Study

The goal of the current investigation was to use grounded theory methodology to design a wellness model that was veteran centered and trauma focused to assist OEF and OIF veterans with successful reintegration. Analysis resulted in a model of wellness that is centered on the successful reintegration for OEF and OIF veterans. The wellness model addresses the goals of veterans who are trying to reintegrate back into the civilian culture with minimal resistance, while addressing the challenges and the variables that impact successful reintegration. In this chapter, the components of the model will be discussed in regard to successful reintegration for OEF and OIF veterans.

The chapter begins with a discussion of the project findings, and how the components of the emergent theory relate to research conducted in the field of wellness treatment for OEF and OIF veterans. The next section reviews the main qualities and strategies that may be deemed as helpful when working with this population, and discusses them in the context of previous research on components of wellness models that are utilized in reintegration of OEF and OIF veterans' literature.

Overview of the Emergent Theory

This chapter begins with an overview connecting all of the pieces of the puzzle explaining how OEF and OIF veterans respond to reintegration. As discussed in the methods section, the proposed relationships between constructs were distinguished after review of literature and the researcher notes. The emergent theory is represented in Figure 1. The theory postulates that a veteran centered trauma focused wellness approach is best understood as an interaction between five variables: multiple deployments, maladaptive behaviors, the impacting variables, the clinical strategy use and external

Specific Interventions

Consistent with the current model, many researchers contend that the provision of culturally competent services involves cognitive and behavioral aspects (S. Sue, 1998). The cognitive aspects of competence are often categorized into trauma and wellness awareness and knowledge's, while the behavioral aspects involve wellness skills.

Findings from the current project suggest that veteran's manner of recovery and reintegration involved separate, but interrelated components. One component involved the undesirable influences that impede the wellness interactions. These undesirable influences represent incongruent cognitions and perceptions that guide the veteran's recovery and reintegration. Many of the cognitive aspects of the emergent theory were similar to the areas of awareness and understandings discussed in other works. The second component involved the stages of healing within the wellness center model that will be utilized by the clinician and veteran. The wellness model theory consists of three stages that will provide support and a healthy transition for successful reintegration for the veteran and his or her family. The stages are stabilization, reprocessing (working through the trauma) and reintegration.

Stabilization

Stabilization is being defined as the freedom from crises or significant emotional, behavior, spiritual, and or relational turmoil. Stabilization within the wellness model will be composed of the therapeutic alliance, bio-psychosocial assessment, crisis plan, symptom management, client's resources and strengths. This stage of therapy is where the clinician will look at several key components in the veteran's life (i.e., reasonable

factors that impact the successful reintegration of OEF and OIF veterans. These factors are bound together by the unifying theme of traumatic experiences.

As depicted by the box enclosing the diagram in Figure 1, the interactions discussed in this model occur in the context of trauma among OEF and OIF veterans. The theory proposes that a veteran centered trauma focus therapy creates a therapeutic environment where OEF and OIF veterans can achieve successful reintegration. One source of under desirable influences encountered within the OEF and OIF veterans involved deployment experiences and the number of deployments. Additionally, there were differences between their values, beliefs and behaviors. These circumstances foster a setting with increased chance of suicide, substance abuse, legal trouble, and family conflict between veterans and their family members, consequently impacting the manner in which the family interacts.

The veterans' manner of responding is represented in the core category, "Restoring a Sense of Wellness." This category was placed in the uppermost figure to demonstrate its influence on the undesirable influences. The "Restoring a Sense of Wellness" construct addresses the philosophies and goals that provide a framework to guide the characteristics and strategies that will be utilized in the model for OEF and OIF veterans.

There were also external variables that influenced the veteran's responds in relation to reintegration. Some factors facilitate the wellness model approach for veterans, while others impede it efforts in regards to successful reintegration. The theory proposes that relationship building, veteran centered, trauma interventions (therapeutic techniques) and holistic approaches (spiritual, physical mental and emotional) will impact how veterans will succeed in reintegration.

amount of coping skills, sufficient amount of positive material in their life, the willingness of the veteran to look at past issues, what are the secondary gains, etc.).

The therapeutic alliance is a process that will develop diligently from session to session. Safety, rapport, empathy, and trust are a part of building a therapeutic alliance. This alliance is important because trauma can only be worked through when a secure bond is established with the therapist. It will allow the veteran to hold his or her psyche tighter when the threat of physical disintegration is re-experienced (Burbidge, 1995). When there is no authentic alliance it not only impact the relationship it also precludes healing and the client is unable to grow out of early attachment schemas.

Bio-psychosocial assessment will be an important part of the stabilization period. The assessment will give the therapist and the clinical team a better understanding of the person from a holistic viewpoint. The veteran will be able to benefit from physical, spiritual, mental, emotional, family and vocational services based on their assessment. By implementing the assessment a series of questions will establish the most important elements in each holistic sphere and a better treatment plan may be derived.

Crises are temporary and manageable. The last stage of stabilization is when the clinician and the veteran prepare a crisis plan together. The crisis plan is a plan that the veteran will complete when the he or she is feeling well. The plan will be clear and specific. The veteran will collaborate with the clinician and the clinical team. As the veteran transition from the stage of stabilization they will share their crisis plan with those that are listed as supporters. The crisis plan consists of several sections. Section one is the section that the veteran writes in detail the symptoms that will indicate that they need help. Section two lists any medications, herbs, vitamins, and alternative medication

that they are currently taking. Section three describes the medication that has helped in a crisis and medications that have made things worse. Section four lists the people who the veteran wants to take over for them when the symptoms arise. Section five is the last section, which describes what others can do that are helpful and not helpful.

The most important thing about the stabilization stage is that it is the beginning of successful reintegration for veterans within their family and community. The last component in stabilization is making sure that the right coping strategies are in place before the veteran transition into the next stage of healing, which is the stage of reprocessing (working through the trauma). The right coping strategies are essential when working with veterans who have experienced trauma. The strategies will help veterans with affect regulation, anxiety reduction and help them cope as they work through the trauma.

Reprocessing (Working through the Trauma)

The proposed wellness model is veteran centered and trauma focused, which makes this stage an important component within the model. Trauma takes a toll on the body as well as the mind. The clinician needs to have a working knowledge of trauma and how it impacts the veteran's quality of life. Trauma work is critical when assisting the veteran with successful reintegration.

There is always the possibility that the veteran can become overwhelmed, experience anxiety, panic attacks, flashbacks, or worse re-traumatization, so every therapist needs to have a clear and workable definition of trauma. The working through stage consists of veteran trauma therapy, which includes: 1) understanding the phenomenon of trauma symptoms and how they impact a person's quality of life, 2) the

ability to observe and fully understand the state of the autonomic nervous system and 3) mind, body and soul oriented tools for managing, stopping, and reducing symptoms associated with trauma.

Most clinicians focus on overcoming avoidance of trauma memories. The clinicians that will be utilizing the proposed wellness model will focus on using holistic treatment modalities as a vehicle for enhancing self-reflective processing of emotion and information. This process will assist the veteran with enhanced emotion and information processing, which will increase the capacity to choose not to avoid, and instead they will confront, recall fully, and reconstruct distressing current experiences and past memories. Freedom from trauma memories or trauma-related distress is not the true antithesis to intrusive re-experiencing. The true antithesis is having the capacity to choose whether, when, and how to recall and make sense of those memories. The treatment modalities will consist of body/mind work, yoga, mindfulness, meditation, energy healing, guided imagery, Emotional Freedom Technique (EFT), Eye Movement Desensitization Reprocessing (EMDR) and Somatic Experiencing.

Reintegration

Reintegration is the last and final stage of trauma work. Interventions are one of the key components to assisting veterans with reintegration back into the civilian culture. Reintegration occurs and is most successful when the veteran is able to take the skills learned during stabilization and the insight that was gained during reprocessing and utilize them for wellness. Healing will come full circle when the veteran terminates therapy and is able to utilize the skills obtained in the helping process.

The Department of Veteran Affairs and the Department of Defense has many reintegration programs however only a fraction of military personnel will have the opportunity to go through one of them when they separate from the service. One of the problems that veterans have experienced during reintegration is that some clinicians have no idea the attachment that veterans have to their military identity or how to help them establish his or her new civilian identity. The proposed wellness model will help veterans achieve a successful reintegration by the utilization of a veteran centered and trauma-focused model. The model will assist veterans with redefining his or her life purpose, the things the veteran like and what they are good at, and most of all build off the veteran's former skills taught in the military.

CHAPTER 6. CONCLUSIONS

The present project represents the first attempt to develop a theory of recovery and reintegration for OEF and OIF veterans using grounded methodology. The emergent theory proposes that a veteran centered trauma focus wellness approach will facilitate successful recovery and reintegration back into civilian culture and eliminate maladaptive behaviors by restoring sense of wellness for veterans. The techniques used in this theory consist of veteran centered approaches, trauma focus interventions and holistic treatment modalities that enhance the veteran's ability to process traumatic experiences, decrease the methods of self-medicating and increase the likelihood of successful recovery and reintegration.

The new wellness model relies on the utilization of interventions and techniques that are veteran centered, holistic (i.e., spiritual, mental, physical, and emotional) and trauma focused (mindfulness, exposure treatment, cognitive restructuring, yoga, meditation, etc.). Some of the main steps that were taking involved working to understand the military culture in relations to OEF and OIF veterans, and gather and impart knowledge to clinicians about trauma as it relates to military deployments. Research showed that OEF and OIF veterans in regard to recovery and reintegration, wellness issues, specific traumatic experiences, and issues surrounding their deployments, impacted the actions taken as they readjust to civilian culture.

This research expands previous work in the area of wellness for veterans. It provides a research-based framework to explain Veteran Education Theory System goals and functioning with OEF and OIF veterans. It also provides evidence to support some of the conceptualizations regarding the interventions and approaches involved in working with such a diverse population. The proposed theory has implications for

those training clinicians practicing in the field. While the current results advance the wellness approaches for recovery and reintegration for OEF and OIF veterans, several areas of research are needed to further advance the field.

CHAPTER 7. IMPLICATIONS OF THE STUDY

Accordingly, the design and implementation of the designed wellness model can be used to make this unconscious to conscious, active and voluntarily process; a process to help OEF and OIF veterans with successful reintegration back into civilian culture.

Findings from this project suggest pathways for future research. First, researchers may consider using interview methodology to explore the experiences of a larger, more representative group of OEF and OIF veterans. As discussed in the limitations section, the DOD wellness models in the current project raise the question of how effectively wellness is being emphasized in treatment of veterans.

Research suggests that veterans deployed in different regions of the country have varied military occupational series, and consequently they may have different trauma experiences during deployment. Future work may also aim to include a breakdown of the different branches of the military to increase the representation from different military groups.

While the current project focused on the wellness models in relation to reintegration and recovery for OEF and OIF veterans, there is also a need to explore recovery and reintegration encountered within other combat zone eras. Additional research may target gaining an understanding of how veterans experience recovery and reintegration as it relates to different demographics such as religion, sexual orientation, and physical ability. Although this was not the focus of this project, the fact that challenges related to these differences were noted throughout the data that this is an area worthy of future attention.

A third research suggestion regards perspective. The primary data source for the current project involved existing literature. Even the secondary source of the

researcher's notes concentrated on what was observed in the veterans. Future research may want to explore interactions in wellness settings, placing more emphasis on the perspective of veterans and their family members. Research could examine interactions from the perspective of veterans, spouses, and children, within a veteran centered and trauma focused wellness approach as they work with clinicians.

Finally, the current project offered a broad picture of the current utilization of wellness approaches offered by the Department of Defense. Researchers may want to use a mixed-method methodology to take a more detailed, in-depth look at the challenges, strategies, and intervening variables that are at work when engaging in each of these roles.

Results demonstrate the importance of a veteran centered trauma focused wellness approach as vehicles for developing these areas for successful recovery and reintegration. In particular, training experiences that will include direct contact with individuals that have experienced trauma, which is seem to be perceived as especially beneficial. Practitioners may choose to seek out immersion experiences and consultation with knowledgeable peers to facilitate their development of trauma and military culture understandings and awareness.

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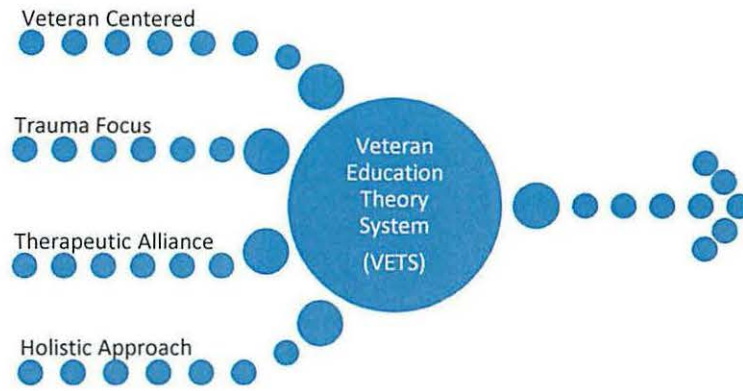
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APPENDICES

Name of Program	Program Overview	Total Force Fitness (TFF) Domains Covered	Key Insights/Lessons Learned
Joint Family Support Assistance Program	JFSAP augments existing family programs to provide a continuum of support and services based on member and family strengths, needs, and available resources. The primary focus of support is families who are geographically dispersed from a military installation.	<ul style="list-style-type: none"> ● Psychological Fitness ● Behavioral Fitness ● Social/Family Fitness 	<p>Having a one-stop source of information on benefits access allows for support across multiple programs and services.</p> <p>Coordination with state and local communities is essential to engaging rural populations.</p> <p>The same level of family support services should be provided to families far away from military communities as is provided to families near military communities.</p>
Warrior Mind Training	WMT is based on mind-focusing techniques that warriors have utilized for thousands of years to maintain focus during battle and to reintegrate into society after the battle is over.	<ul style="list-style-type: none"> ● Psychological Fitness ● Behavioral Fitness ● Spiritual Fitness 	Psychological and emotional inoculation is important components to preventing combat-related stress.
Yellow Ribbon	YRRP is a DOD-wide effort, in partnership with federal organizations including the Veterans Administration and the Department of Labor, to help National Guard and reserve service members and their families connect with local resources before, during and after deployments, especially during the reintegration phase that occurs months after service members return home.	<ul style="list-style-type: none"> ● Psychological Fitness ● Behavioral Fitness ● Social/Family Fitness ● Spiritual Fitness 	<p>Tailoring programs for various audiences maximizes participant engagement.</p> <p>Programs should be scalable to several regions across the country.</p> <p>Program content varies significantly depending on location.</p>
Combat Operational Stress Control	The COSC program provides decision-making tools for service members and their families to build resilience, identify stress responses, and mitigate problem stressors. The end-state goal of the program mirrors the COSC goal of creating mission-ready service members, families, and commands.	<ul style="list-style-type: none"> ● Psychological Fitness ● Behavioral Fitness ● Social/Family Fitness ● Spiritual Fitness 	<p>Peer-to-peer counseling is an effective way to normalize access to mental health support.</p> <p>A program-centric approach to reintegration is not as important as effective delivery of tools to manage stressors.</p>

Table 1 DOD Wellness Models for Veteran Reintegration



Veteran Centered	Trauma Focus	Therapeutic Alliance	Holistic Approach
Military Culture	History of Trauma	Trust	Spiritual
Veteran Identity	Trauma Symptoms	Knowledge of Therapist Factors	Mental
Veteran's world view and Perspective	Impact of Trauma On Quality of Life	Capacity to Develop the Alliance	Emotional
Family Support		Capacity to Maintain the Alliance	Physical

Figure 1

Theory of Successful Reintegration for OEF and OIF Veterans Back Into Civilian Culture