



Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Webinar Series

July 9, 2015, 1-2:30 p.m. (ET)

“Clinician’s Guide: Assisting Family Members Coping with Traumatic Brain Injury”

Hello and thank you for standing by. At this time, all participants have been placed in a listen-only mode for the duration of today's conference. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to Dr. Brooke Heintz.

Thank you and you may begin.

Welcome and thank you for joining us today for the DCoE Traumatic Brain Injury July webinar, Clinician's Guide: Assisting Family Members Coping with Traumatic Brain Injury. My name is Brooke Heintz. I'm a Clinical Social Worker and an Education Network Coordinator providing contract support for the Defense and Veterans Brain Injury Center. I will be your moderator for today's webinar.

Before we begin, let's review some webinar details. If you experience any technical difficulties, please visit: www.dcoe.mil/webinars to access troubleshooting tips.

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Today's presentation, references, resources, and Continuing Education accredit statements are available for download from the Files pod and will be archived in the online Education section of the DVBIC website. All who wish to obtain Continuing Education credit or Certificate of Attendance who meet eligibility requirements must complete the online CE Evaluation. After this webinar, please visit: www.dcoe.cds.pesgce.com to complete the online CE Evaluation and download or print CE Certificate or Certificate of Attendance. The evaluation will be open through Thursday, July 9, 2015.

Throughout the webinar, you are welcome to submit technical or content-related questions via the Question and Answer pod located on the screen. All questions will be anonymous. Please do not submit technical or content-related questions via the Chat pod.

I will now move on to today's webinar, Clinician's Guide: Assisting Family Members Coping with Traumatic Brain Injury. The Centers for Disease Control and Prevention report that in one year alone, traumatic brain injuries accounted for approximately 2.2 million emergency department visits, 280,000 hospitalizations, and 50,000 deaths. Those who survive a TBI may experience short- and long-term effects, such as alterations in thinking, sensation, language, behavior and emotions, which impact the entire family. Family members are often at a loss to understand these problematic behaviors while assisting their loved ones in daily routines and during times of stress.

This webinar will address family challenges and adjustment following TBI. Discussion will include teaching caregivers coping mechanisms and specific problem-solving strategies associated with optimal adjustments. Lastly, the presentation will highlight readily-available resources for clinicians and family members.

At the conclusion of this webinar, participants will be able to recognize and describe ineffective coping techniques among distressed family members; differentiate the elements of effective and ineffective problem-solving; and evaluate ways in which family members can learn effective problem-solving skills to promote healthy methods of coping and adjustment.

I would now like to introduce our presenter, Dr. Timothy Elliott. Dr. Elliott is a licensed psychologist and holds his board certification in rehabilitation psychology. He is a Professor of the College of Education and Human Development at Texas A&M University. His research has examined adjustment processes among persons living with chronic and disabling health conditions, with particular emphasis on the role of social problem-solving abilities and other factors that predict adjustment following disability.

His research team pioneered the use of long-distance technologies in providing problem-solving training to family members of persons with acquired disabilities, including those with TBIs.

He is a member of the Defense Health Board's Neurological/Behavioral Health Subcommittee to provide advice on psychological/mental health issues and neurological symptoms or conditions among service members and their families. He is a former member of the American Psychological Association Presidential Task Force on Caregivers. He is also an editor of the Journal of Clinical Psychology.

Thank you for joining us today, Dr. Elliott -- your turn to take over the show.

Thank you very much for that kind introduction. I appreciate the opportunity to speak to you today about working with family caregivers, particularly as it pertains to traumatic brain injury.

A bit of a caveat to begin with, it is true you are hearing a very pronounced Southern accent. It's best that I remind myself to pace myself because if I start going very fast, I think I'm incomprehensible. And not too many people are accustomed to hearing an excited Southern accent. So I'll try to pace myself accordingly, and we'll hit all the high points. And hopefully, you will have some questions or some observations based on your own experience or other issues that you've encountered; and there will be things that we can discuss and enrich the learning opportunity today.

Please be advised that the things I will be discussing really represent my personal and professional opinions and are based on my available experiences and presumed expertise – really don't represent the DoD or the DVBIC. I don't have any financial reports with any particular vendor or contractor, and I don't intend to discuss the off-label/investigative or unapproved use of commercial products or devices.

Let's discuss a little bit of the background information that we know to a certain degree might be common knowledge. But I think it's important that we go over this and make sure that we're all on the same page; namely, that TBI is the signature wound of Operation Enduring Freedom and Operation Iraqi Freedom. A large number of our veterans incurred a brain injury in the line of duty, and a number of those wounded have accompanying complications that necessitated some major changes in how the Department of Defense and Veterans Affairs had to treat these injuries.

And while this might seem like a bit of a history lesson, for those of us who were involved in rehabilitation and associated issues prior to 9/11, we've seen these changes; and we have been a part of the response, either in how we train our psychologists or our colleagues and the changes we've seen as well in our research base, speaking in terms of my own work as well as what I see as a journal editor and as a grant reviewer.

We know that caregivers in general, and specifically caregivers of our veterans, are to understand and have available information and receive education about things specifically like TBI and also like PTSD as early as possible. But many families report back to us for many reasons (audio break) additional support. So in this presentation, we're going to review basic information about family adjustment issues, including some (audio break) available to us; coping, following life with TBI. And we'll discuss specific coping and problem-solving strategies that we studied and that we work on.

So we're going to discuss ways TBI caregivers can learn how to identify and cope with the specific issues and problems they face and, in that process, teach them some critical skills in self-regulation that will help them optimize their adjustment now and over time. And also that we'll all be able to recognize indicators of ineffectual adjustment, ineffectual coping. We'll discuss problem-solving, particularly effective problem-solving skills, and ways that we might be able to help family members learn effective problem-solving strategies.

First, we have a polling question. And it might be very helpful for us to take just a few moments and consider the primary type of health care organization in which you practice. So if you would, please respond to this polling question; and we'll take a look at our results.

[Pause for responses]

Okay, it appears that 44% of our participants today are affiliated with the VA health care facility. I don't know if you can all see that, but that's the significant majority of what we have and then another 20% in a military treatment facility. That's going to be very interesting for the discussion today and the relevance of some of the information that we'll be talking about.

Here's another polling question. And as you'll see early on in the talk, this is an important one: Please select the type of caregiver you see most often in your clinical work or your practice. You see your options there.

[Pause for responses]

Okay, the large majority of us today, 70%, most often work with OEF/OIF veterans. And then we have 13% working with Vietnam era veterans and then Other, which would be in general. And so I think for the majority of you then, you'll find some of my comments at times may be a bit redundant. Hopefully there will be new information which we can contrast, as we'll see in this next slide, what we know in recent work comparing pre- and post-9/11 caregivers because it's important for us to appreciate how this cohort, this generation, differs and the responses that have been needed as part of ongoing policy.

And please keep in mind when I talk about these things that I in my other work, work with caregivers in general across a variety of disabilities. And I have current work right now, as part of a team, looking at caregivers of stroke survivors in Germany. So we're doing a variety of different things, and it's interesting to contrast and see parallels in some of these conditions and the experiences that family caregivers have. But of these populations, we see interesting demographics, patterns, and issues that are experienced by family caregivers of veterans of post-9/11 veterans.

If you take a look at this slide – and this information in the next few slides, most of it, is available from a great study from the RAND Corporation available as of last year. And it's in your reference section here, so it's easily accessible to you. From their report, we have over 5.5 million military caregivers in the United States right now; and approximately 20% of those are caring for persons served post-9/11. Already you can see that is minority; it is a significant minority, but already we see a contrast with this "significant minority" and the type of caregiver most of you see. Over 70% of you work with these particular caregivers. We see an interesting pattern already in what's occurring in our clinics and in our services.

To contrast further, the RAND report did a very good job in looking at the differences – and by the way, they canvassed initially like over 27,000. And then of that, they classified individuals who met criteria for caregivers pre-9/11, post, as well as in the civilian sector; and they excluded others, like family caregivers of children, for these analyses and the results that we'll be discussing.

Notice the differences that we have in the family caregivers pre versus post. You have a larger percentage, over half of the family caregivers for post-9/11 veterans are spouses, as opposed to adult children who are often caring for veterans who are pre-9/11. Also notice the percentage again – over one-

third of the caregivers of post-9/11 veterans are under age 30. We have a younger cohort of caregivers. That presents its own unique issues and challenges. And typically when you think about that, you think about dependent children, younger children, also in the house, as opposed to what you sometimes see with older adults caring for their aging family member.

Notice in the next slide you have some very significant differences in terms of the incidence, the occurrence of behavioral health conditions that we see, more often in post-9/11 veteran caregiving scenarios. Similarly, there's a greater percentage – over half of those particular veterans have and meet criteria for a VA disability rating, much higher than what we see in the pre-9/11 caregiving scenarios.

And now when we break down into specific problems, if you will, some of these could be construed as objective problems as a part of comorbidities, diagnostic conditions, other things that are documented. We have a much higher percentage – notice, over 91% of those responding were post-9/11 military veterans – reporting problems with mental health and substance abuse issues. And then neurological conditions as well, which is a bit surprising – neurological conditions in this bar graph are referring to things like multiple sclerosis, Parkinson's, and dementia.

And chronic health conditions, disabilities that impair movement – notice the high percentage as well of problems with hearing and vision. And then, of course, the highest percentage occurs with TBI. You see a much lower percentage of veterans with TBI pre-9/11. This is part of the comorbidity picture that we have – clinical picture that we have. And we're working with these family caregivers. They quite often have multiple problems in addition to co-occurring with TBI. These present very interesting and new issues for us across all health care systems really.

Now let's take a look at this; this question really concerns how these caregivers are adjusting. And this refers to a probable major depressive disorder. I want to point out something to you. In all of our research, we know that this particular instrument – the Patient Health Questionnaire, the PHQ, and for those of you who are familiar with it, this is the eight-item version -- for those of us who study depression, we know this is a conservative instrument. In other words, it is more likely, if you will, to underestimate the incidence of depression or, you could argue, a more accurate estimation of the likelihood of a depressive disorder.

It doesn't necessarily pick up someone who is, say, very distressed but not necessarily depressed. Many of our other self-report measures do that. So when we're looking at 38% of these caregivers reporting problems with a probable major depressive disorder, this really jumps out at me. This is much, much higher of course, as you see in the bar graph, than what we see with pre-9/11 military caregivers. And it's certainly higher than what we see in civilian caregivers. And by the way, this is a fairly good estimate of what we see in general in our clinics of family caregivers among people in general. But these figures are all much higher than what we see among people in general, those who are not in a caregiver role per se.

Caregiving is often associated with distress, although I do want to give you a couple of insights from recent research that are coming up that I think will be helpful for us in putting this information in context. The bullet point here is that we have a high probable rate, if you will, of depression among these caregivers we're working with. Similarly, we have a high rate of anxiety. Notice how high this is; this is getting up into like 44% or 43%; and it's much higher than what we've seen. Again, anxiety often associated with general distress is something that we see a lot in family caregivers generally; but this is much higher, like double the rate in many cases, of what we see in many caregiving episodes. So there are some real concerns that we have here in what we would consider treatable conditions.

Now, this next slide – again from the RAND report – is enlightening for a lot of reasons. You see some commonalities. It's true; caregiving is very challenging at several levels -- including resources, including time demands, including available face time for other family members, restriction of leisure activities. But these top three are very interesting when we think about post-9/11 military caregivers. You might argue these are a bit subjective, and I'm not going to argue that point. I think that's actually something we want to keep in mind – that some of these issues might not be readily apparent to us as clinicians or as objective observers, or that we might find reports of emotional distress or change in personal plans to be like part of what one should expect when they're in a caregiver role.

But we don't necessarily appreciate the degree to which this causes incredible strain or stress, particularly on younger families or families in midlife that had a lot of plans, goals, expectations, that are part of the physical lifespan experience that many of us anticipate having until major life stress occurs, off time life events. Particularly that can occur when we have traumatic disabilities that occur in young adulthood and middle adulthood.

Notice, too, the high rate of caregivers reporting that the change and the display of particular behaviors from the care recipient is very upsetting. These, again, are sorts of things that thwart routine and assumed goals of everyday life, very challenging. And as we'll discuss, these may be also the sorts of things that caregivers might receive education about; but they're really not prepared to deal with in the home. That is not an unusual experience among family caregivers generally.

The next slide we see something that's aspirational, that's admirable; and it's something we would also consider reasonable. This slide and the next slide are taken directly from statements from the VA that it's recognized that we know these individuals and these family caregivers should be involved; they merit attention; and as you read here, the VA strives to ensure that all families and patients receive necessary support services to enhance the rehabilitation process. This involves a multitude of levels, of clinical, social, and logistical support to ensure a smooth transition and continuous care.

This is interesting because in general among family caregivers, this is often – I would say usually – not acknowledged, that family caregivers need not just a smooth transition, but access to continuous care and a system of support that helps them in the home. Indeed, this is the sort of thing with many of our other policies in the general civilian sector, we're pushing and advocating for this kind of statement.

Where exactly do caregivers get this information? Well, again, here's an aspirational and reasonable statement that I wish others would appreciate and incorporate. There are programs that are going to be made available, in the inpatient, outpatient, and in the home setting that we want to provide caregivers with training that would help them care for the veteran – their loved one, their family member. And, again, see the website here. There are actually many good resources here; and I'll refer to several of these specifically in terms of the caregiver toolbox, online training that is available. You'll see another slide specifically about this, as well as a support hotline.

I want to emphasize again, these are not things that are typically available at all in the civilian sector to caregivers of TBIs, spinal cord injuries, cancer, of many different sorts of chronic and disabling conditions. They don't have these sorts of resources available in such an organized fashion like we see from the VA.

But here's the breakdown. What do caregivers tell us? Well, if you'll look again from the RAND report and you go to my far right here in the bar graph, you do see a higher percentage of post-9/11 military caregivers telling us that they do and they have received structured caregiving education and training. Respite care at the opposite end, not so much. There may be a lot of reasons for that, but you see a higher percentage among civilian caregivers for that. Remember, a lot of age-related episodes involved with that.

You see other sorts of things, like a higher rate of patient advocates – higher rate of a helping hand in general and some financial stipend. Notice you don't even see a bar there for civilian caregivers because that just, in general, doesn't exist for most people. And you see a higher rate of religious support as well. But notice what I have in the middle there. There's something that we see over and over again in family caregiving issues. And that is, most of these programs are designed to treat the patient first, the veteran first. And what's available for the family caregiver, particularly in the rehabilitation program, is like an afterthought or is incidental to the rehabilitation program.

And then you see in the top corner something that's particularly disconcerting – that roughly two-thirds of the family caregivers with probable depression report they have not received care from a mental health provider. So when you put this together, you think in terms, yes, they received some information relative

to the immediate care needs of the veteran, probably as part of the rehabilitation program; but they're not necessarily receiving services specific to their own unique needs.

I want to want to move along here for a variety of reasons now that we've waded through that information. I'm going to reiterate this point several times, as we see in this next slide. First, just in general, TBI ranges in severity from mild – a concussive event – to more severe, moderate types of TBI. And here's the point that we're going to have to deal with over and over again in our work. That is, most of the research to date, certainly prior to 9/11, and still up until only recently, most of the available research, best available evidence for intervention and for working with caregivers, most of that was conducted with individuals in the civilian sector who had severe or moderate TBI. And information about best practices for those with mild TBI, particularly as we talk about multiple concussive events, and their caregivers – that kind of evidence has been lacking.

Let's talk a little bit briefly about the incidence of mild and severe. Among veterans, the incidence is much higher for mild TBI. And you see it really stands out in this graph that's available from the Department of Defense. It's maintained, as you can see, for over 10 years now. Similarly, notice the way it's incurred. Brain injury is often incurred mostly from like falls – 21% -- among enlisted personnel. And by the way, many TBIs most probably occur in garrison; and a relatively small percentage occurs as a function of combat – if you notice, the sliver down here for 8%.

Our information from the civilian sector though stands in stark contrast. And I believe this chart represents best available information from the CDC. Falls are the number one cause now – recognized as the number one cause of brain injury in the United States, over 40%. And when we take a look at those numbers, many of those now – where I can remember 20 years ago when we were talking about motor vehicle accidents, car accidents, those things were the number one cause of brain injury. But now, as the population ages – and we see this in the data – older people, prone to falls, are the ones who are really responsible for this number going up and the percentage.

Notice too that probably 75% of TBIs, at least in the civilian sector, are due to minor TBIs. But keep in mind, these are not necessarily multiple concussive events, like we see in combat veterans. And it's also estimated that there are many other individuals who incur TBIs that simply don't report to the emergency room, and they show up in other places where we're now doing research – like in prison, like in women's shelters as a function of domestic violence, that sort of thing.

But these differences in research and these differences in clinical work really present some problems for us that we've adjusted to over the years. But we have to take into consideration that we need more information; indeed, we've seen a lot of research now concerning veterans with mild TBI, multiple concussive events, and co-occurring Post-Traumatic Stress Disorder. And so we have been working hard to update this information across the literature base to inform best practice.

You see in this slide too that – and, again, I realize in many ways, as we would say, I'm preaching to the choir. But it's important to think about these differences, I believe. So with multiple concussive events, as many as 7 out of 10 among those in combat according to 2008 data, that you have co-occurring PTSD. And so you have this interesting clinical overlap of multiple mild TBI events incurred in combat and co-occurring PTSD. That increases with the rates of repeated deployments, which we see quite often.

And so we know, when we're talking about our current veterans, that PTSD often accompanies TBI. But TBI doesn't necessarily always accompany PTSD at all. And so when we look particularly at our best evidence prior to these issues, we also take into consideration that many of the clinicians who are working with severe and moderate TBI and outside the VA system have a great unfamiliarity with PTSD. And so there are certain things that we still see sometimes, but they are not necessarily recognizing – and, again, we're doing a lot of work on this – that they don't recognize necessarily as part of the clinical picture. Some things like irritability, some mild cognitive deficit, fatigue, anxiety – those overlap between PTSD and TBI.

The clinicians very well-versed in TBI aren't necessarily quick to pick up on issues like flashbacks or nightmares or hypervigilance – things unique to PTSD that also require some attention. And this is part of a clinical picture that our family caregivers must face and live with, many of them, day to day.

Now, for the next half, if you will, of our discussion today, let's think about ways we can go about assisting these caregivers – the needs that they have, ways to do it. And I think what we have in this slide is a nice template in thinking about dealing with mental health issues. Now I realize many of you don't necessarily have the training, per se, to intervene on mental health issues. Mental health service is not necessarily what you do.

Nevertheless, like we see in this outline available from Samsung, there is training available for people in general to recognize and acknowledge mental health issues. And in this case, we're talking about mental health issues of family caregivers. And so this is a nice template to keep in mind that I think our helping professions in general across the rehabilitation enterprise can keep in mind when we interface with family caregivers, and we're trying to make some determination about appropriate services or issues that should be addressed.

And so I'm trying to increase our responsiveness, using this template that we have available – first-aid guidelines available from Samsung, we want to talk about quickly: assessing the level of distress, listening without judgment, providing some reassurance, but particularly guiding them towards information, encouraging the seeking of appropriate professional help, and encouraging self-help and other support strategies.

When we assess levels of distress, in general it's important that we check our assumptions at the door; all of us walk around with a prototype in our mind, and we cannot help but to look for confirming evidence and not attend to disconfirming evidence. We do know from the latest research that in general it appears many caregivers – and we're going to learn more about this – are actually very resilient. So we don't want to stereotype all family caregivers. Many caregivers are doing quite well, and they don't come back to us. We certainly are seeing that now in research in the civilian sector.

And how do we assign resilience? In general, from one of the best available models, it's an absence of distress, absence of depression, of anxiety. It's just not there. They might be tearful and afraid that it's been used since they are coping "ugly." But that doesn't mean simply because they are tearful that they are depressed – a little bit more needs to go into that to make that determination. And probably what we see in resilient caregivers, as well as resilient veterans, is maintenance of a sense of humor and positive emotions. These are very unique characteristics to people that we're seeing who are resilient.

And, yes, in some of the best available research we're seeing from colleagues like George Bonanno, referenced here, a large percentage of veterans are resilient pre-deployment, during deployment, and even following multiple deployments. I think it's important we remind ourselves of that and make sure we know that research exists. And in caregivers, Bill Haley at University of South Florida, is doing some of the best available research, in my opinion now, on understanding resilience among caregivers. His work has been largely with stroke caregivers, but I think it's very important because he's not necessarily relying on clinic samples when he conducts his work.

Objective assessment is required. Official diagnoses should only be made by those qualified professionals, regardless of your system.

One of the instruments used quite often now in primary care, the Patient Health Questionnaire -- you can use a screening device. Sometimes I've seen this with two items that assess depression, and you see these in front of you now. And then there's a two-item screener for anxiety. When you have a response to any of these that more than half the day the caregivers experience in these particular symptoms, that's an indicator that this individual might be experiencing significant distress that needs to be thoroughly evaluated by a professional. And this might be sufficient to trigger certain services and recommendations for the individual.

So if you take a look at these items -- and I know that they're used quite often, for example, by nurses in some primary care clinics, and this instrument is free to download and use and it's considered one of the more reputable and useful instruments available to us that I can recommend -- that would give you an idea of the relative level of distress.

Now, what about the problem? What is specifically stressful? Marilyn Spivack, at National Head Injury Foundation and also the Brain Injury Association, has often -- I've been around her many times when she has said this interesting little quote, "If you've seen one person with a brain injury, you've seen one person with a brain injury." You can't assume what the problem is for any particular family caregiver. Family caregivers are the experts on their daily lives, and that's a very interesting thing to keep in mind. They're the ones who are living with the situation. It's important to listen to what they tell us.

We know, from life stress literature, that stressors are very different. Some are very sudden, like onset of a disability or a car accident; and others are very gradual, for example, chronic problems with communication in a particular married couple. These are problems that would predate the injury or the TBI, if you will. They are life events versus everyday hassles. They can be a part of parenting, frustrations that occur. They can add to and accumulate in negative emotions and aggravation over time.

And then some things are objective, like there's a hearing problem, like there's a diagnosis of PTSD -- this has been objectively available to us versus the objective experience of the caregiver -- which is just as valid and needs to be addressed in their words, as they experience it, as they see it. We want to focus on the caregiver's report and experience.

In some focus groups that we've done with caregivers in TBI -- and you can find other work that gets into subjective experience for people like Jeff Kreutzer, Virginia Commonwealth University. Here is a list of some of the things caregivers have told us that are very, very subjective in some cases and very stressful, but not necessarily apparent to us as clinicians and practitioners, ranging from financial issues to being reclusive to being impulsive, needing alone time, et cetera.

When we want to respond to the caregiver, we've got to be careful about reassurance. Keep in mind that if we have a distressed caregiver, evidence indicates that is the best available information to us that this person needs some sort of response. They don't seem to get better on their own. It's a clear signal that some assistance is required. We want to match the assistance with the unique needs and problems experienced by the caregiver.

And we want, and caregivers deserve, accurate information about TBI. They need this. We know this from our rehabilitation programs. But unfortunately, a lot of this occurs during the inpatient rehabilitation or an outpatient, where the focus is first for the patient or the veteran; and secondly the unique needs of the caregiver are addressed so it's not tailored or streamlined in a way that fits the caregiver's experience and their particular problem.

So I want to recommend to you these great materials that are available online, free downloads, PDFs. And I've recommended these to people actually in civilian sectors as well. There are several of these that are provided -- as you see, they're in color -- working with family caregivers unique to the military veteran situation. And they have many that are really very good about, as you see here, PTSD; specific sorts of pain that are associated with TBI. Headaches, for example, and other sorts of pain occur at fairly high rates following brain injury.

And incidentally, that sort of headache pain is not associated with PTSD. It's one of those things that indicate TBI is one of the major issues going on here. And these handouts and downloads -- caregivers can then walk through and, as we'll talk about, problem solve what some of these symptoms are; how often they occur; and what possible triggers might be involved, as well as potential solutions.

We also see a download for dizziness. I think there's one for sleep, ways to improve memory. And these are for the caregiver to use, not necessarily for you as the clinician to use with them although you could choose to do that if you have that time and as part of your practice.

Also the support line – encourage use of the support line. To me, these are things that we could have available to hand out, to make sure they have -- and maybe you already do this. They have a card, and they know they can make these phone calls and follow up – not just on assistance, but also if they qualify for unique programs that are available to veteran families and military caregivers. I want you to take a look at those things.

From the RAND report, though, we know that many of these caregivers – even though these things are high quality and they're available – many of them don't really necessarily have access to them or they don't know about them. And what we want to do is make sure they know about them, and we want to make sure that they are streamlined and tailored and they fit the unique caregiver experience.

Problem-solving training is something that I've been doing for many years and conducted several randomized clinical trials, and I'm going to talk a little bit about that now in the remaining time and give you some assurance that these are things that we've studied. We've published this work, and others are doing this work as well.

Coping, in general, we think about in terms of problem-focused and emotion-focused. Problem-solving training is really problem-focused, but it incorporates and recognizes and acknowledges the role of emotion-focused coping. Now, in doing that, I'm going to sound very biased toward this very proactive instrumental, purposeful, problem-oriented coping style. That's what I do, and my orientation is quite (inaudible) and behavioral.

But I have to give props to the emotion-focused work. You see, I think everybody has a go-to emotion-focused strategy. And one of the things that we're seeing in the resilience literature is that resilient people, they don't overuse these; but they know how to use them. And in particular, we see it in the fact that they are able to maintain positive emotions even during times of crisis. Maintaining positive emotions and a positive emotional life seems to be the key element in adjustment generally. So I don't want to give the appearance that I'm discounting these; this is a great cartoon by Gary Larson. Sometimes you just need that hit of ice cream. Maybe it's chocolate for you; I tend to be a butter pecan kind of guy.

We've called our work project-focused, and I'll explain this as we go along. You can look at these studies that are available to you in the peer review literature. We're going to talk about facts, optimism, creativity, understanding, and solving problems. And we want to do this in a way that these are skills the caregiver possesses, and they implement on their own. It is important that you understand that you're not the one to do the problem solving per se, but to help caregivers appreciate these problem-solving strategies.

Good problem-solvers across all sorts of conditions – medical diagnostic conditions as well, across the age span from adolescence up – they tend to use rational and problem-focused coping under stress and under routine conditions. They tend to be assertive; interpersonal skills are part of their repertoire. They tend to be conscientious; they tend to have a greater sense of control over what happens to them. Whether it's true or not, it's important they believe that and thing that. And in process, they report fewer health problems; health complaints probably is a better word to use there. They might have health conditions, but they report fewer complaints.

They tend to report lower levels of distress, fewer problems with depression and anxiety. They tend to be higher in quality of life and (inaudible) actions.

Problem solving training -- I like to break it down into two components. It's very helpful (inaudible) that acknowledges the role of emotions, as well as proactive and goal-oriented relief. I talked about the problem orientation component. It's very instrumental in regulating and warding off negative emotions. It doesn't discount them; but problem-solvers read those sorts of things, as you'll see. But we want to promote a sense of confidence and competence, like they do. They're a little bit more inhibited in impulsive reactions, and they tend to have a higher level of motivation when problem orientation is high.

When problem orientation is low, you can look at this slide and think the opposite of everything that I'm going to say if problem solvers have negative self-statements, positive orientation. A positive problem solver has positive self-statements. Problems are not seen as overwhelming; they're challenging. When a problem occurs, they don't lose all their goals; they re-goal. They're able to go to Plan B or Plan C if they'll value rational thinking. But I'm going to again emphasize, it doesn't mean they are impersonal or they are without emotions.

Specific cognitive strategies here – and what we want is to value and learn ways to identify the problem. That sounds a lot easier than it actually is. In our work with caregivers, this is actually one of the tougher things to do. And we'll look at a worksheet here in a minute on how the health caregivers think about the problems they have and identify the ones or the one they want to work on. Big problem-solvers will generate solutions. They'll take a look at those choices, implement a solution; and then they will evaluate the progress.

Let's go over our acronym here and what it means. When we talk about facts, the "F" in focus, that's reading everything. And notice, this is systematic; it's effortful. We want caregivers to stop and look at their problems and think about them in such a way that they start to have a handle on them, and that includes getting available information and all the facts about a particular problem they identify. Maintain a sense of optimism and don't fall into a negative mindset. Think about goals being creative, about possible solutions. That includes integrating accurate information available about, say, TBI or PTSD, as the case may be.

Understanding those things and understanding, when you look at a possible solution, short-term and long-term benefits, and then implementing that solution that maximizes the likelihood of the most satisfactory result. Of course one of the first reactions you have from caregivers, as well as people in general, is I don't have time for this. Well, that's kind of the point. We need to get to that point. We need to get where we realize this is valuable information; and in our work – these are valuable skills – in our work, we have seen we tend to work with caregivers a little bit before they realized and they could start implementing these things on their own and in their own way. I'll give you some examples as we move along here.

Let's talk about facts, define the problem and answer questions about who, what, when, and where. What about this particular situation makes it a problem? Why is this a problem? And notice, working with families, it might be something that's well within your range of professional service. So it might be a speech problem; it might be a memory problem or an executive deficit.

But by and large, in the home, family caregivers report these things that are not so obvious to us -- whether it's the care recipient loses their temper with a teenager or, as we've seen in some of our work, they weren't complaining so much about the things we anticipated are part of rehab but in one memorable case, the issue was a teenager acting out. We wanted to think in terms of TBI; but, in fact, the family system had been disrupted. And the problem that was agitating the responsible family members was that the teenager wasn't minding or going along with family rules anymore with this problem -- shift of authority and how discipline and expectations were being set and followed through.

We've also had to deal with uncomfortable situations – and I can say this as a psychologist – where we thought the issue was dealing with the care recipient and all of the particular needs and ADLs, activities of daily living. No, the problem was the care recipient kept hitting on women, kind of like he was doing prior to the injury, only now it was with visitors who were coming in or a home health nurse who was coming in. So that required a very different set of strategies for this person to deal with, as opposed to the sorts of things we typically think about, say, with cognitive rehabilitation.

And when I said earlier caregivers often have trouble defining the problem, it's because they often have several problems, many problems. And to get them to nail down one or two or a handful is very difficult. Now, we've found ways to do this using a (inaudible) procedure. My colleagues in Germany are doing this right now. But in general, walk through issues you see in Step I here, be very specific; and you hope they will explore ways problems might overlap or that they stem from one particular problem.

So we would have caregivers, for example, look at the sorts of ways one particular problem related to this. So it was a behavior from the care recipient that was then related to a sense of discouragement or anger or frustration from the caregiver; and then work with them to put all of that together.

And here's one of the worksheets that you can use. Many of these are available – and you see the reference here – if you go to Art Nazu's work, he has several books, Art and Chris Nazu – great scholars in problem-solving training. They've certainly influenced my work. You'll see my many references to their work. We use things like this. If you look at a problem and you can identify the problem, then what really is the goal that's being forwarded or that you want when you think about a solution to this? What would other people look at it and think? What would the care recipient think or what is their experience?

And then if I were to look at it objectively, what would it be like? What is it you want to accomplish by trying to solve this problem? What's the ideal outcome? You want to help caregivers thoughtfully and effortfully consider these sorts of things.

By the way, writing these sorts of things down, we know from cognitive behavioral research, increases the likelihood that, A, the information will be retained and, B, it increases the likelihood that the caregiver will act on this particular information and how they're processing this information.

Reading emotions rather than reacting to emotions is very important. So we would teach caregivers if you are experiencing irritability, anger, nervousness, or sadness, this is telling you something. It's telling you that we need to stop and think about what's going on because it's very important that we understand these emotions, what are their triggers, why are they occurring, what's being lost, what's being frustrated, what goals? If you're frustrated, that implies a goal was involved whether that goal was expressed or not. Well, what is that goal? What is it that we want?

So reading feelings is a very important component of problem-solving training, as well as thinking about identifying what happened, what was going on before, say, this particular problem behavior occurred? What happened immediately after?

This is one of the things that comes up, by the way. We don't want caregivers to avoid the situation, any more than we want, say, veterans of PTSD to avoid. It's like a go-to strategy. And, again, I may be preaching to the choir, but avoided behavior, avoided coping, putting things off or trying to get away from situations, those are inadvertently reinforcing the existence of the problem and increasing the likelihood this problem will occur again and again.

Being impulsive and careless might add win problems. Being avoided, over time this problem will exacerbate and maybe create other problems. But avoidance is a go-to strategy that is incredibly unproductive, and it's another reason why we want caregivers to be more proactive. Notice being optimistic involves these sorts of adaptive thoughts. And, yes, it takes time and effort; but you can do this. This is what successful people do. These are the things that are ordinary or part of life or part of my service, my experience, as a military caregiver. And with assistance, we're going to move through this and grow through this. These are adaptive ways of thinking that we want to perpetuate and promote with the caregivers that we work with.

These are negative thoughts that signal a variety of other problems. We don't want people to go down this road. Many of our distressed caregivers are already here, which is why we need to work and address some of these things or help them, if you will, argue against these points and develop more adaptive ways of thinking.

Generating solutions – we would have brainstorming activities that we would just, without critique, tell us what are the many different ways this problem could be solved or what would that look like, and without judging. It would not be unusual to see a caregiver talk about things: It will just go away; something miraculous will occur; I'll pray, and it will disappear; or, this will happen; or, they're going to behave

differently than they did before once they get outpatient therapy; or, once we get approved for outpatient therapy, this behavior will be taken care of.

Well, that's all well and good. You want them to write that down, but you also want them to start thinking about a variety of other sorts of things and push them to think of different strategies and then evaluate them. So they would write down – and notice, again, this is effortful – write down the specific solution and what the advantages/disadvantages are.

You can also put up the likelihood of this occurring – the likelihood of this solution actually being something that might happen. And you help them start to pay attention to the ones that are likely or reasonable or in their control that they might be able to do something about. And that can range from a variety of things, say, a TBI-specific strategy to promote learning or retaining information or decrease the likelihood of a headache occurring or promoting sleep, addressing fatigue. It could be very specific to things like that, as well as looking at triggers for flashbacks or other sorts of problems from, say, existing comorbid conditions like PTSD.

Making the decision is also tricky, and this is also something that you want caregivers to be aware of. You want to find that solution that best fits their problem. But be aware; there's going to be some change in the system when you do this. Some of that we've anticipated; some of it we might not have anticipated. But choose the solution that works best, put it into action, and then see what happens. And being resilient means we're going to go back to Plan B if we need to. We will take a look at Plan A and see if there's something we need to do differently. Maybe it's a matter of consistency in how we were working; maybe we misread something. But you want to help reinforce the notion that this is what you should be doing. And we just get new information and we try again. And we try again, whatever that is.

And, yes, sometimes there are changes to the system for the better; and sometimes there are things that happen. And you will often see problems that persist exist because there is, to some degree, some benefit somewhere. And so when that's lost, there can be a bit of a backlash. There are things that we might need to take into consideration or hope that the caregiver will incorporate that new information.

Notice, again, from this worksheet that's available – and these are the sorts of things that we use this in our work. Listing the possible solutions and then going to the possible positive or negative benefits of each solution, the likelihood of success in implementation. Are you going to do this? Can you do this? And walk through these different sorts of things.

Now, it's really good for the caregiver to pick out one or two; but sometimes there are going to be several things there, including looking for appropriate support services from elsewhere, particularly from services that are available as part of ongoing care in the VA.

And then implementing the solution – again, once implemented, good problem solvers will evaluate how it turned out. They want to know, did this work? What didn't work? If it did work, did it start new sorts of problems? Did something new happen in the wake of this solution, some change in the system? This is part of the ongoing evaluative process. It's iterative, but it's a way of empowering the caregiver so they are seeing what's going on because you want them to be able to do this independently, years from now, on their own and generalize to other scenarios so they can do this evaluative piece.

And as one caregiver told us later after she was doing this and making a list on her own recognizance by the way. She was making a list of the problem she was working on and solutions; and she was putting them up on her refrigerator. This is during the course of a year of problem-solving training. And then she tells us quite candidly, she kind of looked at us and said, "You know, I think this is really all about coping." It was a moment we should have in our marketing materials. But she, again, and this is when behavior change is working best, she started to implement things that would work for her, remind her; and she figured that out on her own. That's what you want to see. And you get that sense of empowerment as they have this skill set now.

Again, a way of looking in this slide of possible effects the solution had on others. Was it something that you wanted? Was this satisfactory or less than satisfactory?

Let me give you a few concluding thoughts. Some of this I've mentioned a little bit as we were going along, but I want to reiterate some of these things. We want caregivers to take care of themselves. And honestly, when we talk about this stuff – and I've seen it whether we're in gerontology or we're talking with mothers of children with severely disabling conditions – caregivers will often try the fallback position. It gives them a sense of self-sacrifice. This is something that has to do within the process, not taking care of themselves. It's a real problem in many caregiving scenarios where they do not exercise, they do not eat well, or they will not go to the doctor like they should for their own primary care.

Some of it is a time constraint; we understand. But it's very important for caregivers to understand that taking care of themselves will have benefits to them and potential benefits to the care recipient as well. In fact, if you look at our paper that we published in 2012, you'll see that as caregiver depression went down in response to problem-solving training, care recipient depression went down as well. They were clearly yoked.

We want caregivers to take care of themselves. So that might include thinking about diet, maintaining their own primary care, leisure activities. And participation is a big issue for family caregivers. And honestly, I think when leisure restriction occurs and activity restriction occurs, caregivers lose the opportunities to experience positive emotions, much like we saw on that slide earlier about the ice cream truck. They are denying themselves things that help keep them balanced and maintain their quality of life and their life satisfaction and subjective well-being. That's a huge part of adaptive, well-adjusted people in general.

And so we want that for the care recipient, but for the caregiver as well. These are things that are very important to them that help promote positive emotions. And positive emotions are associated with creative thinking and problem-solving incidentally. There might be a reciprocal relationship that we'll learn more about it in ongoing work.

I want you to pay attention to some of these things too. I've trained many doctoral students here at Texas A&M. And some of them are now working in the VA, the majority actually. And they come back and they tell me that these great self-help apps that they're now working with, veterans as well as with family caregivers. And notice these are available in part from funds from the Department of Defense and affiliated institutes.

Encourage family caregivers to take a look at some of these things that are very helpful. Notice some of them, like Mindfulness Coach, might be unusual to you; but they're very helpful, as well as some things very concrete, like the mild TBI pocket guide. There are a variety of things out there to help caregivers cope, take care of themselves, do some self-care and self-regulate, as well as identifying symptoms and looking at very specific issues and resources that they can utilize, like with hotline numbers.

I also want to reiterate that there are what we call stress buffers that include good interpersonal skills, conflict management skills, and thinking about ways to access social support. And that includes a variety of things. And one of the things that will come up quite often – and we've seen caregivers do this – you saw earlier in the slide about religious coping or religious behaviors. Well, one of the things unfortunately we've seen is that churches vary just like people vary. So we've heard stories in which churches were incredibly accommodating of, say, a care recipient's abhorrent or impulsive behavior or inappropriate comments. But we've also heard very tearful accounts of churches that asked the caregiver not to come back in and not to bring him back in again. And this was a church they had a membership with all their life.

Well, part of the interpersonal skill set here is to realize, think that through. Not all churches are this way. There are other religious groups. And this is a loss; but, again, problem solve. And it might also get into some effective conflict management skills as well. But it would not be irrational to point out that it does not necessarily have to be this way. That's not something we normally associate with religious behavior; but it

helps the caregiver have some sense of power and control rather than, again, facing something that could feel overwhelming and unfair and unjust and pushing them out. But it certainly overlaps into these other ways in which we access, and encourage people to access and utilize available social support.

In my presentation, I hope one of the things I've done is pushed this sense of hope and this sense of optimism that people can maintain. And I love this quote from Martin Luther King, and it's a line for you to remember -- that even though we accept finite disappointment, never lose infinite hope.

I think we're at a point now we can open it up to different issues and maybe some comments and questions and points of discussion.

Thank you, Dr. Elliott, for your presentation.

If there are any further questions that you haven't already submitted for our presenter, please submit them now via the Q&A pod located on the screen.

[Pause for responses]

This month's highlighted program is the Defense and Veterans Brain Injury Center's Traumatic Brain Injury Recovery Support Program. The program connects service members and veterans who have sustained a TBI, their family members and caregivers, to TBI and psychological and psychological support services, as well as other medical and non-medical resources. It ensures that clients are supported and connected and stay connected to appropriate resources as they progress through the entire continuum of caregiver recovery.

Due to physical or cognitive psychological symptoms, as well as complex treatment programs, service members or veterans with TBI may be at risk of dropping out of treatment or getting lost in many of the systems of care. They may experience difficulties successfully participating in their treatment or confusion about treatment recommendations, coupled with emotional and behavioral symptoms. Recovery support specialists, or RSSs, establish ongoing relationships with clients to empower them with resources that advance their care and understanding of TBI.

When a client enters the program, an RSS will speak with them by phone or in person about the issues they're having in treatment, other medical or psychological health conditions, strengths and limitations, family issues, changes in duty station, or other relevant issues. The RSS provides follow-up services by completing regular check-in calls to provide support and track TBI symptoms in recovery for up to 24 months, or longer if necessary. The RSS will also assist in finding and accessing TBI and psychological health clinical care services, supportive services, and other information as a client enters into the rehabilitation stage of care, return to duty, or any other transition into civilian life.

The RSS serves as a point of contact to access TBI resources in communities also where the client resides. For further information about the services provided by the TBI Recovery Support Program, please download the program fact sheet or client brochure from the website: www.dvbic.dcoe.mil/tbi-recovery-support-program. You can also download these documents from the pod over on the left-hand side.

All right, let's move into some questions from the audience. And you still have a few minutes if you would like to submit at this time. Let me switch my screen back over myself.

Thank you.

I'm looking at some of these; and I want you to understand, at times you're using acronyms I don't understand. But being mindful of the time, I want to hit two or three things right quick like. Christine O'Hare, for example, mentions the new Michigan study of family caregivers that pays them to participate in networks and retreats that are available to them at no cost. I don't know the recent research about that, but these are very interesting policy developments that are occurring. And also the VA has a program as

well to support caregivers. I know that's one of the things that we would like to see available to other family caregivers in general, so I can assure you a lot of people are watching and thinking about this right now for the policy implications that it will have.

But in terms of specific effects, I think it's a great idea in general; but we'll have to see how it actually comes about in practice. I will say my understanding – and I think I'm correct in this – is that it's been a bit surprising of the number of family caregivers who haven't taken advantage of some of these things.

There are a couple of questions – and this is one from Doug Lee – about caregivers who are sacrificing themselves. They're obviously dedicated to their care recipient; and yet, it's apparently that it's at some detriment and distress to themselves. They're not receiving services; and that's another question. How do you go about helping the family member and the caregiver pursue services when it's apparent to you that they need them, but they're not doing it?

This issue of self-sacrificing and not seeking help is probably a function of two or three things including stigma, a stigma about mental health issues; a sense of being conflicted, that they're somehow in competition with the needs of the care recipient. And it's not unusual to see those sorts of things. Now, I'm not discussing motivational interviewing today; but I know colleagues who have used that in a way to help the caregiver recognize or walk to some realizing, if you will, walk them toward realization that taking care of themselves is an important way to help them take care of the care recipient, both in the short term and the long term. And that does require a dialog, a conversation.

And in a way, you're planting the seed; you're helping working them toward that insight. And it might not come overnight, but you hopefully can maintain that course; so then they begin to realize. You make it clear that certain things are available to them, and it would be in the best interest of them and their care recipient to evaluate and look at those sorts of things.

(inaudible) wants to recommend the BrainAid.com app. I'm not familiar with that one, but it's from a brain injury coalition in California. All of these things, I think you have to take a look at recommendations from others. I try to be really clear on what I know and what I don't know, and I want to be careful about making recommendations to certain things that are unproved and we don't have research available on.

Bob Burnham asks a question about decrease in TBI symptoms over time, even with minimal treatment. That's tricky, Bob. That's tricky for a lot of reasons. We do see very resilient people who do well -- learn strategies from a brain injury, and do very well over time. There's also a parallel line of research that particularly for multiple concussive events – we're worried about that – and what we see in severe TBI and moderate TBI, that there might be some chronic problems over the lifespan, even affecting health functions like, say, endocrine functioning.

But you're getting out of my realm of expertise. I can tell you there are some papers coming out in Journal of Neurotrauma that are addressing this. John Corrigan wrote a great paper recently about looking at traumatic brain injury as a chronic condition. So there is a bit of a buzz about this right now to understand what are the ongoing needs over the lifespan for people in general and our veterans with brain injury; and as those needs are dynamic and unfold over time, how do we best respond.

Dr. Elliott, I have two questions here for you as well if I can jump in, sorry about that.

Please, go ahead.

Per the RAND study, the Hidden Heroes recommendations, to provide high-quality education and training to help military caregivers understand the roles and teach them the necessary skills, how do we stress to clinic leadership to make the availability of time and training for clinicians in practice to be able to provide this education?

What a problem – you know, this is a problem in the civilian sector. We know what we need to do for family caregivers. We've known for 25 years so much of this information, and yet we're all oppressed from

billable time and billable units. And if it's not a reimbursable activity, then it might as well not exist. Well, that just doesn't work. And there are many comments about this – about how we take advantage of caregivers in general; and even going further into our history, about how it has taken advantage of women and seeing it as women's work. You'd be surprised how many times I have still had to deal with that issue, ranging in a variety of different policy interactions and implications.

It is the sort of the thing that we do recognize in word, like we see on these websites and in materials. But in practice, I know clinicians are pushed to deal with the activities which they're supposed to be accountable for. (inaudible) this kind of advocacy with administrators, with clinical leaders, if you will, that this is part of the treatment and clinical picture. There is a piece at which we have to be assertive; we have to maintain this argument; and we have to think about ways in which we can do this sort of thing -- like using long-distance technologies, like telephone contacts, that can be very effective and, frankly, they're unbelievably low cost. We could do these things, and I think we would see the benefit over time.

More than that, I can simply say we have a great colleague right now working on the Institute of Medicine report on family caregiving, Richard Stoltz. I know these are the sorts of things that will be pressed upon us in general as our population continues to age. So I think we're going to see more of a policy discussion. Again, how is that going to translate down to where the boots are on the ground, if you will, or the frontline service provider? We know this should occur; and we hope, between what we see in policy statements and feedback from frontline service providers, that we're going to put greater recognition on these issues to help these caregivers in the home.

Absolutely, and I hope those policy changes occur. So what I hear you saying is that there is probably going to be a trend over a period of time that would lend itself for providers to have the resources, availability, and time to also address the full spectrum of care, including the needs of their support systems, which would be wonderful.

I have one last question for you in regard to the differences between civilians and service personnel. While there is research out there in the civilian sector and there is civilian education material, how well do you think that these caregiver strategies that kind of have been developed for civilians will translate over to the military population?

My first go-to answer there is look at these materials that are available at the VA and the DoD sites. These are great and rich materials; and they're organized well, I think, for the needs of veterans who are recipients of care and for their caregivers. That's the first thing I would say. I would encourage you to go to these materials, some of which I have available here that you can download, and I've certainly provided the Web links. I would go there first before I tried to evaluate the materials that could be handed out for civilians because I really do think that what we have at these websites from the VA and the DoD – they're high quality. And they integrate so many medical health and behavioral issues in a way that you just don't see in the civilian sector.

Some of those materials are good, about things like fatigue or depression or anxiety -- I'm talking about materials for civilian family caregivers and TBI -- but they don't address PTSD. And you've got to acknowledge the comorbid issues that we face with veterans from OEF and OIF; you've got to deal with the comorbidities. So I would say go first to these materials that we've provided here for you. They're rich; they're really good. Go there first and implement those, and think later about the civilian materials.

And I hope I'm not sounding biased in that. I really like these sorts of things, and I have told other people in the civilian sector about these materials. I think they're really good and could even be used by civilian caregivers at times.

Thanks so much. Dr. Elliott, I cannot speak for everybody else; but I can truly appreciate that accent you have. We've all been really looking forward to this presentation since it had been rescheduled, and it's been well worth the wait. Based on registration, there was a large interest in caregiver adjustment, distress, and coping skills. And the takeaways from today's presentation include not only a deeper understanding of the potential stress experience of the caregiver, but it also provided education about

practical, solution-based tools and resources for clinicians, which we don't frequently see or get in these types of presentations. So thank you for that.

These are the things that I think are needed in order to assist the loved ones of those in treatment. While further research needs are evident from this presentation as well, it's also clear that having and including family members and even friends in the treatment and in considering their needs through their loved ones' treatment and care will be beneficial for the overall care spectrum for everyone.

I would like to thank you so much for bringing this to the awareness, these education tools for our clinicians. It's exciting to imagine the potential impact of the overall quality of care when providers are able to address the needs not only of their identified patients, but also of those in their support system through their treatment continuum.

So after this webinar – oops, I'm sorry, did you have anything else?

No, I was agreeing.

Why, thank you.

After the webinar, please visit www.dcoe.cds.pesgce.com to complete the online CE Evaluation and download or print your CE Certificate or Certificate of Attendance. This online CE Evaluation will be open through Thursday, July 23, 2015.

To help us improve future webinars, we encourage you to come and complete the feedback tool that will open in a separate browser on your computer. To access the presentation and resource list for this webinar, you may download them from the Files pod on the screen or at the DVBIC website, dvbic.dcoe.mil/online-education. An audio recording and edited transcript of the closed captioning will be posted to that link in approximately one week's period of time.

The Chat function will remain open for an additional 10 minutes after the conclusion of today's webinar to permit attendees to continue social networking with each other. The next DCoE psychological health webinar topic, Alcohol Misuse in the Military: Screening Brief Intervention and Referral to Treatment, is scheduled for July 23, 2015, from 1:00 p.m. to 2:30 p.m. Eastern Standard Time. And the next DCoE traumatic brain injury webinar, titled Returning to College after Concussions and Mild Brain Injuries, is scheduled for August 13, 2015, from 1:00 p.m. to 2:30 p.m. Eastern Standard Time.

Again, thank you so much for your attendance and have a rockin' day.