



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

April 10, 2014, 1-2:30 p.m. (EDT)

Family Caregiver Support after Traumatic Brain Injury (TBI)

Welcome and thank you for standing by. At this time, all participants are in a listen-only mode and will remain in a listen-only mode throughout the duration of the call. Today's conference is being recorded. If you have any objections to the recording, you may disconnect at this time. I would now like to turn the meeting over to Miss Lauren Goudy. Miss Goudy, You may begin.

Good afternoon and thank you for joining us today for the DCoE Traumatic Brain Injury April webinar. My name is Lauren Goudy. I am a speech language pathologist and senior clinical consultant, providing contract support for the Defense and Veterans Brain Injury Center. I will be your moderator for today's webinar.

Before we begin, let us review some webinar details. Live closed captioning is available through Federal Relay Conference Captioning. Please see the pod beneath the presentation slides. Adobe Connect and Defense Connect online are the technical platforms hosting today's webinar. Should you experience technical difficulties, please visit dcoe.mil/webinars to access troubleshooting tips. If you cannot connect via Adobe Connect or Defense Connect online, please continue to listen via the phone and go to dvbic.dcoe.mil/online-education to download the slides. There may be an audio delay as we advance the slides in this presentation. Please be patient as the connection catches up with the presenter's comments.

During the webinar, please submit technical or content-related questions via the question box. The question box is monitored and questions are forwarded to the moderator for response during the question-and-answer session during the last half hour of the webinar. Our present will field as in questions as time permits. Please feel free to identify yourself to other attendees via the chat box, but refrain from marketing your organization or products.

Today's presentation and resource list are available for download from the files box below and will be archived in the online education section of the DVBIC website. If you preregistered for this webinar and want to obtain a CE certificate or a certificate of attendance, you must complete the online CE post-test and evaluation. After the webinar, please visit <http://continuingeducation.dcri.duke.edu/> to complete the online CE evaluation and post-test and download your CE certificate or certificate of attendance.

We are pleased to announce that CE credit is now available for social workers. The Duke Medicine website online CE evaluation and post-test will be open through Thursday April 17th, 2014, until 11:59 p.m. Eastern Standard Time.

Family caregivers require and benefit from specialized support, education, and understanding from health-care professionals as they move through stages of adaptation that often correspond with the treatment and recovery of a service member who sustained a traumatic brain injury. In 2010, the Defense and Veterans Brain Injury Center, in collaboration with the Defense Health Board, developed "Traumatic Brain Injury: A Guide for Caregivers of Service Members and Veterans." This guide contains four modules that provide in-depth information for family caregivers of service members or veterans with TBI. This includes information to help family caregivers understand TBI, how to advocate, help children cope with TBI, and how to navigate services and benefits.

This webinar will review common emotional and cognitive responses, caregiver responsibilities, learning needs, and educational interventions. This discussion will explore how to build a therapeutic alliance with families and resources for professionals to enhance their understanding of the family caregiver's experience and perspective.

At the conclusion of this webinar, participants will be able to illustrate common emotional responses and role responsibilities of family caregivers during the acute and rehabilitation stages, identify signs and symptoms of secondary traumatic stress in family caregivers, educate family caregivers about two self regulation techniques to enhance parasympathetic nervous system function, and construct effective skill building strategies to educate, empower, and encourage family caregivers during the crisis and rehabilitation stages.

I would now like to introduce our presenter, Janet Cromer. Janet Cromer is a medical and psychiatric registered nurse with extensive experience in clinical leadership and educator positions. Miss Cromer is a licensed psychotherapist who specializes in psychological aspects of medical illness, stress and trauma, resilience, mind/bodily health, and creativity and healing. She has been involved in the brain injury community since 1998 as a psychotherapist, support group facilitator, educator, and advisory board member.

Miss Cromer speaks throughout the United States about stress resilience, compassion fatigue, family caregiver mental health, and is the author of "Professor Cromer Learns to Read," a couples new life after brain injury. She holds an MA from Lesley University Graduate School Division of Counseling Psychology and Expressive Arts Therapies. She is a registered art therapist, board certified professional counselor, and certified compassion fatigue educator. Thank you for your participation, and welcome, Miss Janet Cromer.

Thank you very much, Lauren, and thank you for joining us today. This afternoon I'll talk about psychological aspects of the family caregiver's experience. We'll review stages of adaptation that parallel the service member's treatment stages. The emphasis will be on interventions that health-care providers can offer to support and education family caregivers.

Let's begin with the basics of why family caregivers matter. First of all, when you have so much that needs to be done for the wounded service member. The first live-scale national study on family caregiver needs of caregivers of veterans was just released in 2010, and that was a study conducted jointly by the National Alliance for Caregiving funded by United Health Foundation, and they had a cohort of 452 family caregivers, and the caregivers range from caring for people who have been wounded anywhere from World War II to Operation Enduring Freedom and

Operation Iraqi Freedom, so a very wide range. Very important to note that 30% have provided care for ten or more years.

Care giving is often a decades long experience. 80% said that the veteran had at least two specific conditions. This often included a combination of chronic medical issues and some psychological issues. And 68% considered this situation very stressful. 47% stopped work or took early retirement, and this is an ongoing issue as far as family finances and the benefits like social security, retirement funds that caregivers have as they then age. Most important, 30% have children under the age of 18 and 70% of those said they spend less time with children than they would like. This is a very important topic, and on April 24th you'll be having another webinar about the needs of children whose parents are in the military. We won't be talking very much about children's needs today because that deserves its own time.

77% of the respondents reported sleep deprivation. Now the sleep deprivation is important because it can go on for years, for physical and emotional reasons and caregiving duties that go into the nighttime or keeping a person safe. But it's particularly interesting now as we understand the role that sleep has in critical thinking, functioning, and brain health, and even aging and the importance of getting adequate night's sleep.

Although I'm focusing on a lot of the problems identified in this study, caregivers are overwhelmingly proud of the service they provide, and many of them say they would do it all over again, even though the stress level and level of burden are very high. This study also compared military caregivers to non-military and all of the military caregivers reported two and three times the stress levels of non-military, and that was often due to the resources they had available or had not yet located, or the conditions, the multiple conditions and polytrauma they were dealing with.

Just last week, after these slides had already been made, I found out that the Rand Corporation had just released a very important study called "Hidden Heroes: Americas Military Caregivers." That study surveyed 5.5 million caregivers. They identified that there are 5.5 million military caregivers spanning all of the military actions in the United States.

For our purposes, probably very important to note that 1.1 million caregivers are caring for someone who served after September 11th, 2001, 1.1 million around the country. Most people would probably be very surprised to hear that 40% of those 1.1 million are very, very young, between the ages of 18 and 30. They're also caring for younger individuals who have an in addition to physical conditions, serious mental health or substance abuse conditions. Many of them were not connected to formal support networks and display a lack of knowledge about what was available, and also, 33% of that 1.1 million lacked health insurance, which was they were attending to their own physical and psychological issues, a very good study. We'll return to the recommendations for both of these studies at the end of this discussion.

There has been a lot of research and many books written on the needs of families and changes in families following traumatic brain injury or acquired brain injury. Dr. Arthur Dell Orto has worked in this field for a very long time, and some of the findings that he has about factors that contribute to potential family problems after brain injury include that chronic or unremitting stress, inadequate interpersonal skills, communication, problems solving, especially after brain injury. The timing in the person's life trajectory that the injury occurred, the social isolation, the ongoing grief, and changes in the sexual relationship, which, until recently, were not often addressed as part of rehabilitation.

On the left side, if you compare that to some of the situations that current caregivers find themselves in, you can see that there's quite an overlap and the potential for potential family problems. Some of the situations I've heard about from the staff of military facilities are some of the disagreements that could come up between the generations. There may be a young spouse and a parent who disagree about what the meaning is of the injury, how best to proceed with care, where the wounded warrior should recover, things like that, the stages of family lifecycle.

As we said, 40% of these new caregivers are very young, just beginning their own adulthood. Many very recently married, and many with very young children, and many caregivers move to be with the recovering service member at Walter Reid or other polytrauma centers for very long periods of time, and they usually leave behind a job, and it takes years out of their career and contributes to financial pressures.

Let's take a moment to get more information about you and your work situation. If you could just take a moment to please go through these polling questions, what percentage of time is a family caregiver present for your interactions, whatever your clinical specialty might be in your current work situation? Do you already offer educational programs for family caregivers? And do you have a resource to refer family caregiver for mental health counseling at your work location or nearby, that you're aware of? We'll come back to those answers.

All right, thank you very responding to quickly. About approximately 30% of the time the family caregiver is present. That means a lot. I'm going to be speaking both as a family caregiver myself, myself husband had a severe brain injury several years ago, and it was through the efforts of every member of the rehabilitation team that I became prepared to care for him at home, so being present really matters. A very large percent so far, almost 58%, have educational programs already in place. It would be interesting to hear more of the details of whether that's group format or printed materials that you use. And over half right now, 56%, do have mental health counseling facilities available. That's great.

I want to spend a moment on the therapeutic partnership, because it's the foundation of providing support and education. Without it, not much goes far. Caregivers are in a difficult situation where it's very hard to gain their trust, very hard for them to trust, mostly because so much is at stake. This is a brand new world and there's so much to learn and adjust to.

Some tips on building that therapeutic partnership center around communication. And it's always important for us to remember to be careful about the language we use and the assumptions that underlie our choice of words. Often health-care professionals will quickly start to refer to the patient as your loved one, you know, which you want to participate in the care of your loved one, you'll be taking your loved one home.

It's really important to back up a few minutes there and ask about the relationship between the caregiver and the patient before the brain injury occurred. I know many situations. I facilitated support groups for caregivers for several years, and I've heard more than once the stories that we were on the verge of divorce and then he had this brain injury, and I decided to stay and take care of him. But it's been a very difficult relationship because of that. Or I was very angry. I didn't want him to join the military. I warned him something bad could happen, and now what's supposed to happen to his children. So people have a lot of feelings and a lot of back history, just it helps the relationship you will have with the caregiver if you can back up and ask about it before making assumptions.

We also assume, as health-care professionals, everybody knows what the rules are. It's very helpful to have some printed information, and a photo guide is even great if you happen to have photographs that you can put in a patient's room who all the people on the treatment team are and what those letters after their names mean, and what they can expect from you, from each different member. And if you can assign a fairly consistent communicator, that helps tremendously.

Also, caregivers are often expected to jump in and become a team member without knowing what that means or what's expected of them, so the more we can clarify all of these things before saying the family won't show up for education sessions, the family doesn't want to learn to take care of the amputation, you know, stop and ask why and explain the importance of why you want them to be involved. Often you will find that they're caring for an elderly relative at home and a young child and trying to hold down a job. There's always a reason.

To increase your own understanding of these issues and empathy, invite caregivers to speak at conferences, at your grand rounds. There are now many, many books being written by military caregivers, as well as service members, and great blogs, really good blogs being written by military caregivers, particularly people with brain injuries and PTSD. It's worth reading them to see what life is like after the person leaves the hospital and to acquaint yourself with some of the coping skills and the resourcefulness, as well as the needs.

There's one phrase that caregivers hate to hear. As I nurse I said it a million times, very well intentioned and that's, "Take care of yourself, you have to take care of yourself" to the caregiver. It makes us flinch because we hear it so often from so many people, and it's not that we don't want to. Most people really do want to take care of themselves but don't know how in this crisis, this totally new situation, don't know that it's already to leave the bedside. They're terrified something terrible will happen if they do, or they don't yet understand the need to prioritize self care. It's very important to lay down that foundation early in treatment, because once the person goes home from a hospital setting, they're much less apt to follow through, they're going to have much less time and fewer resources if they haven't started learning how to care for themselves in the hospital.

There are certain questions you can ask. They look pretty basic, but they're really powerful questions that you can use in any setting at any stage, and the answers will change with the stage that people are in. The first one is how are you? You wouldn't believe how seldom caregivers are asked that question. One military caregiver said to me, "Within a few weeks I started to feel like I just existed as my husband's appendage, like I was making up the arm a that had been amputated. All they ask is how's he doing. Are you doing this for him? Are you doing that? No one ever asked how I'm doing." So it's very simple but just stop, touch the person's arm if that seems appropriate, make eye contact, and ask, "How are you?" You'll probably get an answer you weren't anticipating.

We talked about asking about the relationship at the time of the injury and now, how are you feeling about this person now? How are you feeling about being a caregiver? A lot of people, if they're a parent or a spouse, don't even use that word. But it's important for them to understand that they're entering a whole new world, a whole new role, and things are going to be changing for them, and you have resources.

Often professionals tell me that they don't ask these questions because they don't have time to really listen to what they anticipate as a deluge of responses from someone who is highly stressed and emotional. But if you asked what's the one hardest part for you today, what's the

hardest part right now, you help the kid get rid of getting flooded while they're thinking about it, and to give you something specific that you can probably work with and make a suggestion around.

Another issue that comes up a lot between professionals and families is having different goals, different goals for the wounded service member, different priorities, and not understanding each other's point of view. So you can often ask what is your biggest hope? What's your first goal for the service member? What do you hope will happen? That answer will tell you whether that's realistic or not and will also give you information so that you can include some of the family's priority in with the team's priority.

Many caregivers are what I call "triple-decker caregivers these days," so always ask what are the stressors that are in your life that we should understand? What else would you like us to know about you? I hear time and again a caregiver say I have a son who has autism, he was doing fine but he just started high school. They don't have the resources, his behavior is out of control right now, and my husband's father fell and broke his hip and moved in with us last year, and now my husband has a TBI. I call that "triple decker caregiving," and they're usually balancing a job, so just ask about that, because you may be able to help them start to triage and bring in some outside supports.

Caregiver adaptation is a developmental process. It goes through many stages, many phases, and takes quite a long time, just as a developmental process of adaptation takes place for the wounded service member. I chose this model because it's a general parallel of the process of treatment that the wounded service member goes through and the times when you would be most apt to have contact with them. But each stage is not cut and dry. We know that about any kind of stage model. It's also not time limited, and the emotional responses and challenges can overlap between stages. But it's a way to start thinking about this.

For our purposes today, we won't get into the long-term care stage. We'll focus on the crisis, rehabilitation, and transition home. The first stage is the crisis stage, and this is the time from the moment of injury to early rehabilitation. It often involves a lot of time in intensive care units, perhaps many surgeries, and although I know you start rehab right from the beginning, this is the acute period.

The key challenges for the family caregiver are to start to understand this language that they've never heard before. It's hard enough to understand medical information but especially when it gets into the brain, who has any exposure to that in advance. Making critical decisions on behalf of another person, not just for one's self, making medical decisions in the face of enormous uncertainty. Nobody can guarantee that if we do this procedure there will be this outcome one year from now. We don't have that kind of assurance. Starting to figure out who to trust, who can be a reliable resource, triage your own life.

This whole crisis stage is about everything being out of control, the family's life has been blown out of the water. They can't control whether the service member lives or dies or recovers. They're not getting answers that give them a sense of control very often. So a big goal is to start to learn to take control in healthy ways. Also, learning that very important role of being an advocate and case manager that will continue for many years to come.

Some of the emotional responses that you're apt to see and that can take many forms, first about shock. I think we really underestimate the degree of shock that many family members are in when we first meet them and when they're first called upon to make those critical medical

decisions, emergency decisions, ICU decisions. We have to become much more aware of how often we're asking them to make decisions in shock and what other resources they might need to help during that time.

Family members often tell me that they're terrified of making decisions, although it has to happen very quickly, because they're afraid that when the person with the brain injury wakes up they'll say, "I hate you for keeping me alive. Why did you put me through this if this is the best it's going to be." An enormous amount of responsibility is tied up in that. Denial can be a very protective function you think. Sometimes we leap in to fast I think to say the family is in denial. Well, that's a very protective function at the time, and what we call denial is often a lack of understanding, a lack of information, mixed with global hope.

In the beginning, hope is this giant overarching umbrella. It's as big as the sky, and the global hope is that something will happen, a miracle will happen, combined with medical treatment, that will restore the person to who they were before, that there take care of all the medical issues, bring back the personality and the family's life can go on. Grief starts right in the beginning, often mixed with anger at the circumstances, anger with the person, with the brain injure anger, anyone else who was involved, and often, anger at the staff because you're the easy target who is there delivering the message, and enormous bewilderment and confusion.

Family caregivers tell me, "I show up at the rehab hospital, I stay there 12 hours a day. I'm taking notes. I'm doing everything they tell me, but in my head I'm totally bewildered, and I'm thinking, what happened? Where did our life go?" So people exist with this mix of feelings all the time. They coexist. This is also called a "heroic phase." In the beginning the family says, "I can go the distance. I'll do whatever it takes to get him back to full health. I don't care what I sacrifice myself. I can go the distance." And people can run on adrenaline for weeks and months before they finally crash.

One problem to be very aware of is the potential for acute traumatic stress response. I've read this on many, many blogs. I hear it in support groups all the time, what it's like to see your family member in the bed in the intensive care unit. Lee Woodruff and her wonderful book, when she speaks about her husband's -- blogs traumatic brain injury and battle says that I'll never forget going to the hospital in Germany, the top of his head had been removed to allow his brain to expand, and his brain was like a giant brioche is the word she uses. Everyone has their own word for seeing that. People say he looked like a monster. That image doesn't go away, and we need to attend to that. The whole experience of the sites and sounds of ICU, the appearance of other patients, the stories industries you hear from other family members is very overwhelming. Let's just look at that a little bit more.

It's very important to monitor and to educate family members about this, secondary post-traumatic stress. There was a study done in Switzerland a few years ago, 2011, and one of the first studies to really survey family members of intensive care unit patients who had had TBIs. They were not military. This was in a civilian hospital. But more than 50% of the family members -- and it didn't matter what their relationship was, if they were spending time in the ICU and knew the person well, more than 50% had a clinically significant post-traumatic symptoms in the first few weeks, and some of this continued much longer than that.

More severe with relatives of patients with poor Glasgow Coma Scale, as you might anticipate. The impact on it with this is very important. These are the same people who are going to be making decisions and running their family life. If these initial mental health issues are not addressed and treated, it can complicate the adjustment and participation in treatment.

I think it's very under-recognized and underreported, because families don't know what's going on themselves, and they think it's just part of normal process. But I hear it when a new member comes into a support group that's an established group and we go around and do introductions and tell about the story or when life changed, even caregivers who the family member had the accident a few years ago will go into an autonomic response. They'll tell the story of seeing the person for the first time as if it had just happened. And they will also say that the main reason they don't get to sleep is because of intrusive images or reliving that day or that first period of time. So it's important to ask them about it.

During the first stage here are some crisis and some interventions to take during the crisis stage. Screening, and you can do this with some simple pen and paper tests or by interview questions; however you do it, but very important to provide education that this is part of what might happen for the caregiver, as well as for the staff to understand. Also when someone is going through intense emotional responses, that has cognitive consequences also. If somebody is very anxious, very depressed, very traumatized, they're not going to be taking in the information and imprinting it, retaining it, and being able to draw on it later. So a repeat everything that's important, use multimedia, ask how the person learns best. Some people learn best by reading. Some people like to be shown diagrams, pictures. Some people don't want to see the pictures, but ask them.

And who can they involve in decision making? You can be very helpful with this during the crisis. Is there somebody back home that you could set up a Skype line with that they can talk about the decisions they're making. Is there an ethics person, an ethics team in your facility that could come and help them work out the pros and cons of quality of life issues, things like that, but who can help. Don't leave them alone to make that decision.

This is where you start to introduce very important skills that we introduce every day. They're very important going forward. They're going to need all this, how to organize the information that's flowing towards them very quickly, what kind of large notebook online app can you do, how do you do problem solving? Walk someone through that problem-solving process? And very important, encourage to focus on this moment what's happening today. Even though they have lots of long-term decisions to think about, but when you're dealing with uncertainty, that ability to stay focused on what's happening right now is going to serve them very well.

This is also the time to introduce basic mind/body self regulation skills, autonomic nervous system self regulation skills. You can teach these things in very short periods of time, diaphragmatic breathing and suggesting when to do it. It's very good to stop and take a few breaths, relax your shoulder, relax your pelvis before going into the patient's room, before going into a difficult meeting just stop and do that. Progressive muscle relaxation, you don't have to do the whole body. I often teach caregivers imagine all the stress that's in your body is running down across your shoulders, down your left arm into your left hand. Now as you inhale, curl that hand into a really tight fist and hold it, and then as you exhale, let all that stress run out through your hand. And you can do that with their hands, their feet. You can teach them to do a whole body progressive muscle relaxation. It's very good. It helps them to get to sleep. But teach people brief things that they can do, brief interventions that calm the nervous system.

Medication models, I find that mindfulness is a great model within a lot of treatment. It's very hard to do if you've never medicated before. I've taught medication in many hospitals, and what usually works best is have a phrase that they can repeat, a phrase like "I am at piece, I am

calm," just repeat it, or a few words from a prayer. Prayer is very effective to use as a phrase in meditation.

The biggest thing you can do is be a role model, model how you handle stress in meetings. We're watching you all the time. Family caregivers are watching every move you make. We're watching how you handle communication when the patient is agitated. We're watching how you handle behavioral issues, and we know you have extremely hard jobs that are very stressful. And we can tell which staff members handle their stress well and which do not. So this is your opportunity to model the skills that the caregiver needs to build.

One of the best experiences we had is my husband peach pathologist, Jennifer, would start each of her sessions by saying, "Wow, it's been a really busy day, let's all just take a moment and take a few relaxed breaths, shake out our hands, settle in the chair and focus our attention in this room." And she'd model a couple of breaths. Allen and I would do it. And she got a much better session with immediate ability to focus than bringing in all the distractions and hurriedness from the rest of the day. So just model those things, and, of course, it affects your stress level. And imagine what it would be like to start a team meeting by saying, let's just take a moment to focus, take some breaths, relax.

Some more crisis intervention, so the stage one. Get material on the post-traumatic reaction. Sometimes it doesn't come up until after discharge when the person goes home and feels like she's having a nervous break down. Also be aware that it can seem acute and a very appropriate response early on, but if not treated it becomes chronic, and many caregivers go on to develop PTSD. I've heard many people say that they're formally diagnosed with it.

Caregiver traumatic stress, the symptoms would fall under the same categories that you're used to, that's the intrusive memory, reliving events, the signs of hyperarousal. Hypervigilance can be hard to sort out because caregivers have to have hypervigilance, especially when they're responsible for a person's safety, a person's physical mobility issues, communication issues. So they become very hypervigilant, but figure out what's the crossing the line with that when they can't turn it off when they have the opportunity to, and then the avoidance symptoms.

I think we see some of this when we say the wife used to come in and now she's stopped and we haven't heard from her. She's not showing up for the education sessions, she's not participating in treatment, what's going on? Sometimes that's part of the withdrawal and numbing that goes on as part of this stress reaction. It's important to ask about that.

Respond very well to some of the cognitive behavioral treatments that you're familiar with that you're using with service members now, but sometime with depression and traumatic stress responses we expect that of family member, so we don't treat it. And I'm always emphasizing the importance of recognizing that someone is having an expected emotional response, but don't deny them treatment just because it's considered a normal response. It's an extreme response for that person related to that situation and deserves treatment.

There's a wonderful slogan that I believe is inscribed on the wall of the National Intrepid Center of Excellence, and it says their mission statement, "Reduce suffering, instill hope, and address moral injury." So what I ask is that you please extend the same mission to any of the family caregivers that you see in your practice. It sums everything up absolutely beautifully.

Let's move on to the sec stage, which is during rehabilitation. And this is approximately from early rehabilitation to the discharge home. This could be a very short period, or as we've seen

some polytrauma centers, this can go on for a few years, but some of the key challenges are understanding what the changes are now in life, which ones are more apt to be permanent, which ones will respond to treatment, and how do you make meaning of that sacrifice, or that loss? How do other members of the family make meaning of that? How do you shape what you should expect and hope for? At this point, that global hope starts to take more concrete forms and get directed at some priorities of what the family's hope and recovery will be like, and it's important to ask that. Again those questions, the answers will change at each stage of treatment.

This is where the person is probably trying very hard to manage all the other areas of work and family life may not know much about the laws regarding family leave and need a lot of information about things like that, other resources for financial assistance. Practicing a more consistent stress plan, this a time to sit down, have someone on the team sit down with the person and explain the whole physiologic total body and mind stress response and the need to have something that you can do, a technique that helps body, mind, and spirit at least once a day, and the importance of putting this into writing. I always say at each stage of treatment sit down and just write down a very short treatment plan with the caregiver, for the caregiver, as well as all the treatment plans you do for the service member.

This is enormously hard, learn to carry over all the roles. Most family members do not have experience being a nurse, being a speech language pathologist, a physical therapist, and each professional has the responsibility for their role. But think about this, when the person goes home, the family caregiver may assume up to six or seven or ten roles. And many people say to me, "I never wanted to be a nurse. I don't want to take care of other people's bodies. I don't want to change bandages, and now they're telling me I have to learn how to take care of this amputation. I have to teach him to read and write again and continue what they started in the hospital. I've never even taught a child to read and write, how do I do that? I have to manage all his behavior issues, and I think he's behaving like an adolescent. And they're telling me it's up to me to have him stop drinking. How do I do that?" It's an enormous responsibility that needs to be talked through.

Ask the caregiver if there's any option at all to prioritize which roles and which responsibilities he or she feels most prepared to deal with, that's the first level, which would they feel like they could learn to do, and which would they prefer not to be involved in at all. For instance, giving physical care, very personal physical care to the wounded service member can have a big affect on the couple's relationship and sexual relationship, and it's often better to involve an aid, a home health aid or somebody else who is employed to do that, and leave the spouse out of it. But we don't stop to ask, you know, which would you prefer to do and not do, if there is any option to do this, and what other services that can be brought in. Sometimes we expect that that one caregiver will take care of it all.

During the rehabilitation stages another set of emotional responses that can emerge, it's more common for depression to start to be prominent, and this is tied in with ambiguous loss, which we'll talk about in just a moment. Often people talk about stranger syndrome. This can be permanent or it may be temporary, but it's due to the personality, cognitive, emotional changes in the wounded service member that leaves a spouse or even a parent to feel like this is a stranger I'm taking home. How am I going to get to know this person all over again, and he doesn't remember me. He doesn't know our children. Couldn't tell you how we met, what am I supposed to do?

And often in the first throes of being grateful that the person survived, nobody mentions this. Other times, with the degree of brain injury, if it's more on the mild to moderate side, professionals may say, "You know, he's doing great. He can communicate. He seems like a nice person," while the family member is saying, "This isn't him at all. The personality has really changed," and they whisper about it for a while before they tell you.

This is where a lot of ambivalence come out, ambivalence about what they're taking on as a caregiver, ambivalence about what the roles in the family will now be and whether they can do that, and reality slams. One caregiver described this as its like a giant fist came through the kitchen window in my kitchen and slammed me in the solar plexus. It's like a physical blow to the belly, and this is the realization that, oh, he's probably not going to be able to go back to doing the job. He's probably not going to be the father he always was. We're probably not going to have those dreams we had. We have to have new dreams, if that's even possible. But it's a very physical reaction that has a lot of stress related to it. And, again, there's a pride and satisfaction of being participants. You see it every day. The caregivers who do absolutely amazing jobs for very long periods of time. Caregivers often feel crazy because the emotions can be very contradictory, very unstable, and need a lot of reassurance that this is also normal then.

Let's talk a little bit more about ambiguous loss and chronic sorrow. Sometimes the terms are used interchangeably, but I think some important key points that apply to them both are very important to know. The first is that it's not pathological. This is a type of sorrow that goes on for a very long time because the cause of the grief is always present. When a person dies, the type of loss we're used to, we have community rituals, we have roles, and everyone knows what to expect. There's a set period for mourning, and then the person, if they're lucky, gets some assistance in moving on. But with a brain injury, where cognitive skills are lost, personalities change, life looks very different, there are no community rituals around that. The person is alive. He came back alive, and so many other people died. So it can be very hard to address and not sound ungrateful and unappreciative. But the issue is that the person is there but not there in the same way that they were before.

Dr. Pauline Boss [ph] has done an enormous amount of work on ambiguous loss, and she defines two main types that I think make a lot of sense when you explain them to people. The first is when the service member is physically absent but psychologically present. This would be when he or she is deployed and the family is thinking about them at dinner every night, they're thinking about what dad would say, that I hit that home run today. So they're psychologically present.

The second type is when the person is physically present but psychologically very changed in ways that makes them absent. They're emotionally or cognitively missing. They can't be the same person that you loved and knew, and this is very hard because it stays that way. The source of loss doesn't end. It continues on for quite some time. Dr. Boss has a lot of guidelines for treatment about learning to live with this. It's not something you get past. You integrate it into your life and kind of master it and develop a new identity, a new identity for the person with the brain injury and for the caregiver, and revise what it means to be a family, to be in love, and what new things you're hoping for, very important issue. Every time we explain this to family caregivers, they'll inevitably say, "So that's exactly what I was going through, and I just thought I was crazy."

Let's go on to some rehabilitation stage interventions that you can do. Listen to the ambivalence. Don't be frightened by it. People have to work their way through what they're

going to commit to, what this new relationship is going to be like, what they're willing to do as far as involvement. Normalize that for them, but at the same time, refer them for treatment if that seems appropriate.

People need new outlets. You have new emotions when you're in a crisis, when you're in a whole new situation, life is going in a new direction. You don't even have words for the emotions sometimes. Support groups can be extremely effective, especially if they use a psychoeducational model, journaling, and visual journaling. As an art therapist, I often recommend this for the experiences we don't have words for exactly. And it can start with the words we use, even though they may seem stale or redundancy, and one exercise is just to take a piece of paper and fold it in half, and on one side draw what your stress feels like right now, what are the words you use. Are you saying "I'm tied up in a knot and I'm ready to explode?" Just draw that. Anyone can draw cartoon or something like that. On the other side of the paper draw how you would rather feel. What would that look like if that changed, if the knot became untied and smooth? Where would you go if you could explode out of this situation or how would you counter the situation?

And once you're drawn that contrast, just stop and think of what would be a few steps to start taking to get from the first side to the second. And almost everybody can do this exercise, and it can be really meaningful to see your stress on paper. Getting some sort of exercise and career goal, caregivers spend weeks, month, years hovering by a bedside sitting. Any exercise outlet you have in your facility, whether it's walking up and down stairs or if there's a gymnasium caregivers can use, that's terrific.

By the time someone is in rehab, the person may be ready for more meditation training, again, starting with ten minutes of breathing, repeating a phrase, or getting into some mindfulness practices, especially body scan, teaching a person to start at the top of the body and just scan down through each section nonjudgmentally as you breathe and recognize what you feel and what parts are very tight or tense or sore, what parts are holding in emotion. You know, and that may be something you want to talk or support person about afterwards or it may be something you can work with relaxing with grieving and muscle relaxation.

One thing that's been found to be a very important factor in resilience in across the board situations Southwick and Charney have done a lot of work on resilience, and it's having someone who is a realistically resilient role model. This isn't a person who does everything perfectly or has a lot more resources than you'll ever have, it's somebody you can relate to, identify with, maybe someone who is a few years ahead in this process than you are, and you can make that introduction. Often they can meet through group, through the hospital, a volunteer caregiver who has come back and willing to sort of companion with a newer caregiver can be a tremendous resource. Some hospitals have set that up, and then all the detail resources and materials.

I'm very familiar with that DVBIC "Family Caregiver Manual after TBI: Everything Caregivers Need to Know." Boy, I wish I had had that when my husband first had his brain injury, and thank you very much for making it available to the public on the DVBIC website. I recommended it to many, many caregivers. No one can take in all that information at once but it's there when you need to go back and do that, when you want to go back and look at it. Another interesting thing to ask people to do to start to understand what the changes and losses have been is to ask them to just make a list of what have been the changes in your life so far, what have been in the changes in the service member's life as a result of this injury. On the other side of the paper -- you see I'm big on this column A, column B -- on the other side of the paper, what have been

the changes to your life, small and large since this injury took place. And often it's first time people will stop and say, "Wow, you know, I haven't been in touch with any of my friends, I left work that I really love," in addition to all the relationship issues, it can really help.

And let's move on to the third stage, the transition home, and moving towards a new normal. And at the time when people first begin rehab or go through crisis the idea that there could ever be a new normal sounds totally absurd, and yet the majority of people really do reach this point, especially when they've had good rehabilitation and a lot of resources after discharge. Some of the challenges are once you get home now you start really updating the family roles, and family rituals and routines, depending on the abilities, what kinds of modalities have to be included in rehabilitation and treatments, what kind of support you have. This is also say when people the most stressful time is not usually just continuing rehabilitation, it's filing all those paper for disability, it's finding out how to get the financial services that they desperately need.

Also during this time issues rise that you might not anticipate. Away from the hospital, it's totally normal for there to be a little regression in skills and confidence that has to be rebuilt, but also different behavioral issues can come with the change in environment. Most people's homes are a lot noisier, there's a lot more stimulation, more people coming and going, young children oftentimes that make it much harder for someone with a brain injury to control the stimulation level, and they're really faced, inevitably now, with the changes in who they used to be and who they are now, and it may be that they'll gain back a lot of that, but if not, coming home, going to your workshop, sitting in your office, going into your children's room at night to say good night and realizing you're having trouble reading those books to them is when it all really hits very hard.

There are the issues with couples of dependence versus independence. For the caregiver who knew the person they're caring for when everything was at their worst and their safety had to be protected at all times, it can be very hard to let the person start to take a walk by themselves, to start to drive again, to start to become more independent, and the caregiver may need some support and education around the importance of doing that. Also, important to start educating the caregiver about burnout and compassion fatigue, this total depletion of energy, mentally, physically, spiritually, that's a very significant health risk and very, very common in longer-term caregivers or caregivers for people who are severely disabled mentally or physically, so make sure you have lots of handouts about that and talk to the person about the signs to report.

Some of the emotional responses we hear about are that combination, that mixed feeling of oh, thank God, we're finally home, we can start to feel normal again, we can start to get our life back, balanced with oh, my God, there's no nurse to call, or the physical therapist isn't here. What if he falls in the bathroom? What am I going to do at night if he has one of those PTSD episodes and puts his fist through the wall? So there's a lot of that insecurity that comes up too.

This is also when caregivers tend to become more depressed. They run on adrenaline, run on involvement, run on heroism for a long time. But once somebody is home is when the depression symptoms tend to come out stronger. So, again, making sure there's a resource available for an evaluation for that, and education to recognize it. Caregiver depression is a little different in that caregivers tend to shut down. They don't stay in bed with the covers over their head. They're energizer bunnies. They keep going, so a lot of people don't recognize it for what it really is.

You notice I have exhaustion as one of the emotional responses on each stage, and that's because it's a reality physically and emotionally that needs to be addressed by respite breaks

and by other support services, but especially that weaving short breaks into every day and periodic for change of scenery to leave the house leave the person they care for, whether it's for a weekend, an overnight, or longer, it's very important for that exhaustion part.

Let's talk about some interventions. One of the things that sometimes gets overlooked is the unanticipated emergencies. It could be that the person had a problem managing agitation and anger in the hospital but it got better over time. He worked out behavioral strategies. There may have been medications that were effective, so it got better. But once the person is home and there are more sources of anxiety, more sources of humiliation as they try to do something and realize it's not as easy as it used to be, I think humiliation is often underestimated as a cause of anxiety and agitation and anger. The psychiatric issues can flair up again.

Also, some people have a post-traumatic reaction to a lot of the medical treatment they had. If they were intubated for a long time in intensive care or restrained for a long time, that might come up in a form of PTSD once they're home, and it's important to know about. The caregiver really needs to plan. Who you going to call at 2:00 a.m. when this surfaces? Are there medications you should have on hand? How can you keep yourself safe if that's an issue. We often send people home with follow-up appoints, but until they appointment two or tree weeks from now, they may not know who to call.

Again, this is the time to revise the caregivers own stress resilience plan. And any techniques you're teaching the service member about managing post-traumatic stress or anxiety, include the caregiver in that session. The caregiver will also use these strategies herself or himself and can also coach the service member, but very important to know. When you're putting together that resource packet -- and I know you have tremendous numbers of resources, I think people can see on the screen here -- you might include some of the civilian support organizations, because many people will turn to them also, organizations such as the Well Spouse Association, just is wellspouse.org, have now opened up to military members and are really encouraging military caregivers to join them. They have special programs for them. So it's a great resource. Let them know about that, because once people go home they tend to want to use community resources, especially these younger caregivers, as well as the military, and Veterans Administration.

Okay, let's go back to the study that we talked about in the beginning, the caregiver or veteran serving on the home front, and some of the recommendations, I think, we've covered a lot of them, but let's just look through them and see if there are any that you're already doing or think would be worthwhile to include, the caregivers guides, can't emphasize that enough, and one way is to connect caregivers to each other. In surveys they identified that that was one of the biggest resources. This is going on a lot online. There are many forums and support groups that are happening online, which is very helpful, because many caregivers can't leave the house, they can't go out in the evening. They don't have child care, and maybe the person with the brain injury can take care of the kids at night or can't stay alone, so they often don't utilize in-person support groups. But there are many excellent groups online now, forums, and blogs.

Establish a peer mentoring program, I'd be interested in hearing if anybody has that. That's proven to be very useful. And teach how to advocate for themselves, as well as teaching case managers to include advocacy for caregivers. Many case managers who were surveyed in this particular study said they didn't really know much about that at all. They knew about service members resources but not caregivers. One thing people really need, especially as time goes on, is legal assistance, estate planning, planning for longer-term care, planning for what happens if the caregiver becomes ill. Who is going to take care of children, things like that.

One thing that's really needed is sources of respite that can take care of wounded service members overnight or for a week? The Alzheimer's community has done a very good job. They have a lot of models of this, where a caregiver who takes care of someone is Alzheimer's at home can bring that person to a specialized center for a week, for a couple of days, knowing that they'll get good care there while they can go away. Unless someone is taking care of the wounded service member, the caregiver is not going to relax at all. So we need much more overnight respite care and services where very well-trained aids could come to the house and provide respite care. I think some of this is self evident from that study.

And from the Rand Corporation study, they have the same points, but they really recognize the value that knowledge is power, and I always say that to caregivers too. If you want to empower yourself, you have to learn everything you can at every step of the way. But the Rand Corporation study recommended empowering with very high quality study and ongoing training. And I would say one big need in the community is coaches long after somebody as left the rehab setting and new issues develop, or you want to take their treatment to a new level. But there may not be a speech language pathologist readily available, where can you go to get coaching, especially when a new behavioral issue comes up or the service member wants to learn a new skill, we need people who can come to the house, step in, teach us how to help them learn that.

The Rand Study also recommended -- that study really focused on the fact that 33% of the caregivers did not have health insurance and the impact that had on them seeking services, and so making them aware of where they could get that service. They also recommended that there would be a lot more public awareness of the critical role that military caregivers play and the value of that role, and I notice that we're seeing more of that in the media. There have been profiles of caregivers who weren't famous people on the cover of "Parade" magazine and different newspaper and magazine articles, very important to do. And plan for the future by making available a database of all the programs that are available as time goes on the service needs change.

I think that about rounds up our part of this. We have many resources and references available. These are some of the references I used in preparing these slides that I think are particularly good to read, and I think you can see on the screen a lot of the publications and educational materials available, for the military sources.

Thank you Miss Cromer. Great a great presentation. If you have any questions for Miss Cromer, please submit them via the question box located on the upper left-hand side of your screen. Before we move on to the Q&A session, I would like to provide a short product brief about the recovery support program, and free downloadable resource available on the DVbic website.

The recovery support program's mission is to optimize successful engagement, treatment, and recovery from TBI, by providing TBI expertise, resources, and support to the military and veterans communities, and facilitating connections across the entire continuum of recovery and spectrum of care. Service members, including National Guard and reservists, and veterans who have sustained a TBI, family members, or caregivers are eligible for this program. Client services includes support, education, advocacy, and connection to TBI services and other resources for clients as they negotiate and transition through complex systems of care. For referrals and more information, visit info@dvbic.org.

Now we'll go through a couple downloadable resources. "Traumatic Brain Injury: a Guide for Caregivers of Service Members and Veterans" is a 900-page resource for caregivers of service members and veterans with moderate to severe or penetrating TBI. This guide, published in 2010, is the result of congressional action and cooperation from a panel comprised of TBI survivors, family members, and experts appointed by the White House, and the Department of Defense, and Health and Human Services.

Congress took action to support caregivers by passing the National Defense Authorization Act of 2007. Section 744 mandated the development of coordinated, uniform, and consistent training curricula to be used in training family members in the provision of care and assistance to members and former members of the armed forces with traumatic brain injury. DVBIC was selected to facilitate this process because of its nearly 20 years of service to active duty military, their beneficiaries, and best friends with traumatic brain injuries. This comprehensive resource is broken down into the following four modules: Introduction to TBI, understanding the effects of TBI and what you can do to help, becoming a family caregiver for a service member or veteran with TBI, and navigating services and benefits.

A complementary resource, the "Caregiver's Companion to the Guide" contains information that may be needed on a daily basis in the hospital or rehabilitation center. It includes a glossary of medical and TBI terms, list of military terms, blank diagrams of the brain, and contact information of the health-care team members. In addition to the guide for caregivers of service members and veterans, DVBIC also developed the family need lines, which includes these booklets: "Addressing family needs," this booklet is essential to families with a service member or veteran with a TBI. "Everyone in the Family is Affected" and this tool will assist during that time of transition. "Taking Care of Yourself While Taking Care of Others," this booklet offers coping techniques for caregivers and families who are trying to manage stress, anxiety, or sadness while caring an injure service member of veteran. Experts provide advice on relaxation and self care. All of these resources can be downloaded at the DVBIC website.

It's now time to answer questions from the audience. We are monitoring the question box and will forward questions to our presenter for our response. If you have not already done so, you may submit questions now via the question box located on the screen. We will respond to as many questions as time permits. So let's start with our first question, which is, "What special considerations should providers keep in mind when family members are not able to be physically present during any one of the phases," So, for example, if a wife has to remain at home to keep a child in school?

Yes, I imagine that would be a very difficult situation for everybody involved, and today's technology offers a lot of options for that that weren't available even ten years ago. So inviting the wife to -- making sure that there is a way for the wife of this home to be set up with all that technology, or at least the very basics, if there is a way to do that, making sure there is Skype set up, making sure that they have a good internet connection, and bringing the laptop right into the patient's bedside so the family can talk with the wounded service member, bringing that right into the team meeting. And setting up appointment times to go to review questions or pass along information would probably be helpful. And asking about what resources are available for a family support, mental health needs in that community that the person is in, that's something that the staff would probably do some research and provide that information.

Great. Wonderful. Our next question is, "Can you provide a bit more information on resilience models?"

Resilience models, there are many. It's become a big field of specialization within positive psychology, but even before that there were a lot of resilience models being developed in catastrophic illness and chronic illness, and then there's a lot of information that's come up. A book that's on the reading list on resilience, Southwick and Charney, "Resilience: The Science of Mastering Life's Greatest Challenges." There's a lot more information coming out on the science of resilience, what goes on in the brain and in practical habits and attitudes and emotional responses.

And Dave identified ten resiliency factors that I think are really good to know about because they do cross over, and they include things like physical fitness, cognitive flexibility, spirituality, having a positive role model, realistic optimism, and they did many of their studies on people who had gone through horrendous medical situations, but also prisoner of war camps and have been through PTSD. So their book is very interest to me, because they chose some of the hardest situations for any of us to survive. But those are some of the factors. And then within the model they talk about how to develop those factors during therapy, through community resources, and all of that. Dr. Dell Orto has a longstanding model of resilience that's used in rehabilitation setting. There's books also on the resource list.

Wonderful. Our next question is, "During your personal experience as a family caregiver, what is something that a provider did that you didn't mention, that helped you cope and truly understand the recovery process. I think, even though I had been a nurse for 20-some years at the time of Allen's brain injury, I knew nothing about brain injury, and it's such a specialized field and it's just horrifying to see the person that you love and knew so well become this other person as they emerge from coma, go through that stage of amnesia or/and severe agitation, which Allen had for a very long time. I was terrified that it was never going to end.

So one of the things that the staff did that was very helpful was kind of normalize the horrors for me in the sense of explaining, they educated me a lot about what an emergent process might include and which parts might last for a while, which parts we hoped weren't going to last forever, and what I could do to help soothe him, to communicate him when he was in those phases. Unfortunately they had to explain why he had to be restrained so many times. I mean these things are just wicked for family members to observe when you know this person is very changed and would be mortified to see himself going through it. So for me it was explaining the processes and why. I was a real why person. I wanted all the education I could get and kind normalizing it.

And also the other thing they did that was tremendous was teaching me to recognize the significance of every little teeny improvement and to celebrate that, and realize that these things add up. They seem very small at time and they're hard thought, he had a very severe brain injury, and I tell that to caregivers now, you know, celebrate at every turn, every improvement that you see, they're all small gold stones in this long road that you're building.

Great advice. And our next question is, "Can you expand a bit on the challenges that young family caregivers may face?" So you mentioned that in the Rand study. What special considerations should the provider keep in mind?

I have to admit I was stunned when I read that Rand study, that 40% of current family caregivers are between 18 and 30 years old, and to think of the enormous responsibility and changes that they're going to be going through. I think one thing to consider is what was this person's life experience up to this time. What other very difficult situations have they gone through and handled? How was that? Are they scarred by that or are they resilient because of

that? What kinds of skills do they have already? But also, considering the upheaval that's going on in the relationship that was probably a very new relationship to begin with. So many people have babies right before they go off or while their home on leave, so there are these very young children and how will this impact the caregiver's ability to bond with the baby and give the attention that the child needs? All kinds of services might be available for that. What's the emotional maturity level, and, again, how much can we expect a caregiver to take on, asking more about that.

Other considerations would be school and career, where were they on that personal trajectory that now has to be interrupted, and will they be able to get back to that at some point. You know, further down the road, by the time someone is ready to go home and getting into longer-term care giving, which I know a lot of these young families are doing very long-term care giving, I always say try to identify one dream or goal you have for yourself, separate than caregiving, and set aside some resources and little bits of time to get back to that, you know, if it's something you could still -- it may be something you were doing, pursuing a particular career or training. You can maybe still take some classes online, or maybe you have to revise that dream, but what's the new dream and how can you start taking steps towards that for yourself. The relationships that the young caregiver will have with other people in if family, friends and acquaintances of the co-workers, military colleagues of the service member, there may need to be more family therapy sessions set up between the parents, young spouses, girlfriend, boyfriend, to address who is going to be doing what.

And one of the big issues for every family is coming to a shared understanding of the brain injury, what it's meaning is, what the impact is, what to expect. And often people have very divergent views of that, and it helps to have some professional intervention, and I think the younger the caregiver is the more important that becomes, and all the issues around children that you'll be discussing on April 24th must really come into that too.

Absolutely.

And peer groups, setting up peer groups if they have traveled from their home to a treatment center like Walter Reid, or down in Florida, making sure that there are recreational activities and respite activities that these young caregivers can join in together that fit in with what they would do socially anyway. You know, what kind of restaurants or movies do they want to go to? Do they want to go bowling? What do they want to do? But that they all do that together. People are an enormous support for each other.

Wonderful. I think we have time for one more question. "What are two emergencies or situations that providers should prepare caregivers for prior to discharge?"

I think the emergency that scares caregivers the most is the psychiatric emergency when somebody first comes home, and it could be usually involve some loss of control, getting very angry. It could be a realization that you're not able to go out and drive a car like you thought you were going to. You're not taking off. In fact, you can't. You don't have the cognitive ability to drive a car, and now this young wife is telling you that you can't, and it all falls on her. Sometimes we see this rage attack that comes up or it could be a post-traumatic stress symptom, and it can flair up very quickly. We know that the treatment plan will be to try to identify triggers and prevent the triggers and work on means of calming sooner. But when it first happens, having some sort of emergency plan.

I always tell caregivers, if you need to, don't be afraid to call the police, you know, if that's what it takes, or call a neighbor, call another person who may be able to reason with the service member. But they should always have a psychiatric emergency hotline they can call, somebody that they can physically bring the person to who can do an evaluation and then start a better kind of treatment.

Another one would be kind of a medical emergency that can happen at home related to that person's condition, and that might be a seizure. Maybe once some of the seizures may have been controlled in the hospital, but once they get home and they're on different diet, their medication schedule is different, the stress level is different, and there may be a seizure, so making sure that the caregiver knows exactly what to do, maybe how to explain it to children that may be witnessing, it and how to get help afterwards.

Thank you, Miss Cromer, for this very important presentation.

Thank you.

As providers in both civilian and military health-care settings, we have the privilege of helping our patients improve their quality of life, but we sometimes forget that we also have an incredible opportunity to impact the family caregivers during the recovery process as well. So today we heard some actionable tips that we can all implement to make sure that we're truly supporting both the patient and the family caregiver.

Thank you again, Miss Cromer, for your presentation.

You're welcome, and thank you very much for the work that you all do.

After this webinar, please visit <http://continuingeducation.dcri.duke.edu/> to complete the online CE evaluation and post-test and download your CE or certificate of attendance. The Duke Medicine website online CE evaluation and post-test will be open through Thursday, April 17th, 2014, until 11:59 p.m. Eastern Standard Time. To access the presentation and resource list for this webinar, you may download them from the files box below or at the DVBIC website, dvbic.dcoe.mil/onlineeducation. An audio recording and edited transcript of the closed captioning will be posted to that link in approximately one week.

The next DCoE psychological health webinar topic, "Psychological Health and Resilience of Children in Military Families" is scheduled for April 24th, 2014, from 1:00 to 2:30 p.m. Eastern Standard Time. The next DCoE Traumatic Brain Injury webinar topic, "Post-Traumatic Headaches," is scheduled from May 8, 2014, from 1:00 to 2:30 p.m.. Thank you again for attending, and have a great day.