

Chapter 9

PERFORMANCE AND SELF-MANAGEMENT, WORK, SOCIAL, AND SCHOOL ROLES

LESLIE DAVIDSON, PhD^{*}; CAROL SMITH HAMMOND, PhD, CCC/SLP[†]; PAULINE MASHIMA, PhD, CCC/SLP[‡]; LESLIE NITTA, CCC/SLP[§]; JENNY OWENS, OTD[¶]; MARY RADOMSKI, PhD[‡]; MAILE T. SINGSON, CCC-SLP^{**}; MARSEY WALLER DEVOTO, OTD^{††}; ALINE WIMBERLY, OTR/L, CBIS^{‡‡}; AND JOETTE ZOLLA, OT^{§§}

INTRODUCTION

SECTION 1: SELF-MANAGEMENT ROLES

CANADIAN OCCUPATIONAL PERFORMANCE MEASURE

OCCUPATIONAL SELF-ASSESSMENT

FATIGUE AND SLEEP ISSUES AFTER CONCUSSION/MILD

TRAUMATIC BRAIN INJURY

MEDICATION MANAGEMENT

INTERVENTION: FATIGUE AND SLEEP ISSUES AFTER CONCUSSION/

MILD TRAUMATIC BRAIN INJURY

INTERVENTION: MEDICATION MANAGEMENT

INTERVENTION: BILL PAYING AND MONEY MANAGEMENT

CLINICIAN TIP SHEETS

SECTION 2: SOCIAL ROLES

REENGAGING WITH SPOUSES, CHILDREN, AND FRIENDS

ASSESSMENT OF COMMUNICATION AND INTERACTION SKILLS

ACTIVITY CO-ENGAGEMENT SELF-ASSESSMENT

DYADIC ADJUSTMENT SCALE

INTERVENTION: REENGAGING WITH SPOUSES, CHILDREN, AND

FRIENDS

CLINICIAN TIP SHEETS

SECTION 3: RETURN TO SCHOOL

RETURNING TO SCHOOL

CLINICIAN TIP SHEETS

SECTION 4: RETURN TO DUTY

INTERVENTION: PERFORMING WORK ROLES

RETURN TO DUTY VALIDATION PROGRAM

CLINICIAN TIP SHEETS

REFERENCES

SECTION 5: PATIENT HANDOUTS

^{*}Director, Occupational Therapy, Shenandoah University, 1460 University Drive, Winchester, Virginia 22601

[†]Research Speech Pathologist, Audiology/Speech Pathology, Durham Veterans Affairs Medical Center, # 126, 508 Fulton Street, Durham, North Carolina 27705

[‡]Chief, Speech Pathology Section, Department of Surgery, Otolaryngology Service, Tripler Army Medical Center, 1 Jarrett White Road, Tripler Army Medical Center, Honolulu, Hawaii 96859

[§]Speech-Language Pathologist, Greater Los Angeles Veterans Affairs Healthcare System, Sepulveda Ambulatory Care Center, 16111 Plumber Street, Building 200, Room 2409/Gold Team, Sepulveda, California 91343

[¶]Occupational Therapist, Warrior Resiliency and Recovery Center, Blanchfield Army Community Hospital, Building 2543, Room 118, 650 Joel Drive, Fort Campbell, Kentucky 42223

^{¶¶}Clinical Scientist, Courage Kenny Research Center, 800 East 28th Street, Mail Stop 12212, Minneapolis, Minnesota 55407

^{¶¶¶}Speech Language Pathologist, Traumatic Brain Injury Program, Veterans Affairs Pacific Island Health Care System, Traumatic Brain Injury Clinic, Specialty Clinic Module 8, 459 Patterson Road, Honolulu, Hawaii 96819

^{¶¶¶¶}Occupational Therapist, Military Share Brain Injury Program, Shepherd Center, 2020 Peachtree Road Northwest, Atlanta, Georgia 30309

^{¶¶¶¶¶}Formerly, Occupational Therapist, Warrior Resiliency and Recovery Center, Traumatic Brain Injury Clinic, Fort Campbell, Kentucky

^{¶¶¶¶¶¶}Occupational Therapist, Brain Injury Clinic, Courage Kenny Rehabilitation Institute, Allina Health, 800 East 28th Street, Mail Stop 12210, Minneapolis, Minnesota 55407

INTRODUCTION

Although most people recover from concussion/mild traumatic brain injury (c/mTBI) within 3 months of injury,¹ some experience symptoms that interfere with the performance of life roles and tasks related to activities of daily living (ADLs), instrumental activities of daily living (IADLs), work, and maintaining social relationships. For example, one of the most common complaints after concussion is ongoing issues with fatigue.² Patients report both physical and mental fatigue that affects their ability to efficiently perform daily and weekly ADLs,

IADLs, and work responsibilities. Pain and cognitive inefficiencies may also make self-management tasks more effortful or error laden.

The overarching goal of occupational therapy assessment and intervention is to enable patients to return to valued roles and activities.³ Doing so involves understanding the patient's priorities, identifying impairments and inefficiencies that interfere with performance, and intervening to enable the patient to reengage in valued roles and activities in everyday life.

SECTION 1: SELF-MANAGEMENT ROLES

CANADIAN OCCUPATIONAL PERFORMANCE MEASURE

Purpose/Description

The Canadian Occupational Performance Measure (COPM) is an individualized standardized measure that is administered during initial assessment to specify the patient's priorities for therapy and baseline status in areas of functioning; it is repeated to objectify progress toward goals and outcomes of therapy (Exhibit 9-1). The COPM is a semistructured interview that uses an ordinal scale to quantify changes in client-reported performance and satisfaction in areas of self-care, productivity, and leisure.

Recommended Instrument Use: Practice Standard

- This test is an essential inclusion in an initial occupational therapy assessment to identify patients' priorities and to inform the development of the occupational therapy intervention plan.
- It should also be readministered as an outcome measure, quantifying the extent to which the patient has experienced ap-

preciable improvements in occupational performance.

Note: The COPM may not be appropriate for individuals who lack self-awareness of deficits.⁴ In these situations, family members may be invited to participate in the COPM interview, presuming their treatment priorities are endorsed by the patient.^{4,5}

Administration Protocol/Equipment/Time

The COPM is comprised of the administration manual, scoring cards, and test worksheet. It takes 20 to 40 minutes to administer as follows:

1. The therapist asks the client to identify issues of concern in areas of self-care, productivity, and leisure.
2. The client rates the importance of these issues using a 1-to-10 scale (10 signifying most importance).
3. The client chooses up to five areas to be the focus of occupational therapy intervention.

EXHIBIT 9-1

CANADIAN OCCUPATIONAL PERFORMANCE MEASURE

The Canadian Occupational Performance Measure can be found in the following: Law M, Baptise S, McColl MA, Carswell A, Polatajko H, Pollock N. *Canadian Occupational Performance Measure*. 2nd ed. Toronto, Canada: Canadian Association of Occupational Therapists–Association Canadienne d'Éducation Publications; 1994. Available through Canadian Associations of Occupational Therapists: www.caot.ca.

4. The client rates his or her current level of performance and satisfaction for each area of concern again using a 1-to-10 scale (10 representing the highest level of performance and satisfaction).
5. After a negotiated period of occupational therapy intervention, the client again rates his or her performance and satisfaction for the (up to) five areas addressed in occupational therapy.

Groups Tested With This Measure

The COPM has been tested on and used to measure outcomes of occupational therapy services with a variety of diagnostic groups, such as those with traumatic brain injury (TBI),^{6,7} including c/mTBI.^{4,5} The COPM has been used with other diagnostic groups⁸ (see the list of important references at www.caot.ca/copm/description.html for more information).

Interpretability

The COPM was designed to measure outcomes of therapy based on the individual client's priorities and perceptions of status and improvement. Although COPM scores have been evaluated in aggregate to evaluation program outcomes,^{4,5} the COPM is not a norm-referenced measure.⁹ Rather, it was designed to measure occupational performance as individually defined.⁹

Scoring

The occupational therapist calculates the total performance score by adding the performance scores of up to five areas, then dividing by the number of problem areas (obtaining an average from 1 to 10). The total satisfaction score is calculated in the same manner. The difference between initial evaluation and subsequent scores (change score) can be used to measure treatment outcome.⁸

Minimal Detectable Change

The minimal detectable change (MDC) at 95% (MDC_{95}) was calculated based on data from the COPM test-retest evaluation involving 26 community-dwelling individuals with stroke and yielded the following¹⁰:

- COPM performance $MDC_{95} = 1.65$
- COPM satisfaction $MDC_{95} = 1.82$

This means that a patient's before and after scores (pre-post score) would need to change by 1.65 for the COPM performance score and by 1.82 for the COPM satisfaction score to be 95% confident that true change occurred (rather than measurement error).

Minimal Clinically Importance Differences

As cited by Trombly and colleagues,⁴ Law et al reported that COPM performance and COPM satisfaction change scores exceeding 2 represent clinically significant change.¹¹

Responsiveness Estimates

The COPM appears to be sensitive to the before-after effects of treatment and to treatment versus nontreatment for individuals with brain injury. Numerous studies have reported statistically significant differences in pre-post COPM performance and satisfaction scores of clients with acquired brain injury (including mTBI) associated with occupational therapy intervention.^{4,5,7} Jenkinson and colleagues⁶ reported statistically significant COPM performance changes based on 10 clients with brain injury ($P = 0.018$), and relative ratings ($P = 0.008$) for those who received community-based outpatient intervention; change scores for the same period for a similar group ($n = 15$) who did not receive intervention and that of their relatives did not reach statistical significance.

Reliability and Validity Estimates

Interrater Reliability

Interrater reliability (as determined by comparing client's performance self-ratings and that of relatives) is acceptable. Jenkinson and colleagues⁶ found that COPM performance ratings for participants and that of their relatives were not significantly different. In an outpatient occupational therapy outcomes study, clients with TBI and their family members did independent ratings of COPM performance at admission, discharge, and follow-up.⁴ Similar to the Jenkinson's⁶ findings, there were no significant differences in patient-relative ratings at any of these intervals.

Interrater Agreement

Interrater agreement (as determined by comparing problem prioritization when the COPM was administered by two occupational therapists) is

moderate. The COPM was administered twice (average of 7 days between) to 95 patients with various diagnoses who were newly referred to outpatient occupational therapy.¹² Sixty-six percent of the activities prioritized at the first administration were prioritized at the second.

Test-Retest

Test-retest reliability for client COPM performance and satisfaction ratings is good. Cup and colleagues¹⁰ administered the COPM twice to patients with stroke (mean interval of 8 days) and found high levels of correlation between the first and second sets of COPM scores. The Spearman’s rho correlation coefficient for test-retest performance scores was 0.89 (P < 0.001) and 0.88 (P < 0.001) for test-retest satisfaction scores.

Test-retest reliability for problem identification is moderate. In the same study, of the 115 problems identified during the first administration of the COPM, 64 (56%) were also identified at the second administration.¹⁰

Concurrent (Criterion) Validity

Treatment-related changes in the COPM score for persons with TBI are consistent with other measures of self-reported goal achievement. Sixteen outpatients with TBI (some mild) who received outpatient occupational therapy realized statistically significant improvements in self-identified goals as measured by admission-discharge comparisons on goal attainment scaling (P < .001), COPM performance (P < .001), and satisfaction measures (P < .001).⁴

Discriminant Validity

Unique problems may be evaluated with the COPM. Cup and colleagues¹⁰ found that the COPM measures a different construct than other stroke-related activity-participation standardized measures, including the Barthel Index, Frenchay Activities Index, and Stroke Adapted Sickness Impact Profile-30. None of the scores on the standardized measures of function significantly correlated with the COPM but they all significantly correlated with one another.

OCCUPATIONAL SELF-ASSESSMENT

Purpose/Description

The Occupational Self-Assessment (OSA; Exhibit 9-2)¹³ is a paper-and-pencil self-report designed to help occupational therapists understand patients’ self-perceptions of occupational competence, valued areas of functioning, priorities, and the perceived impact of the environment on performance. This information may be used in treatment planning, as a means to develop patient-therapist rapport and partnership,¹⁴ and to document outcomes of care.¹⁵

The OSA is composed of two parts. Part I includes a series of statements about everyday activities (eg, “concentrating on my tasks”). These statements were derived from the Model of Human Occupation¹⁶ and relate to skills and occupational performance, habituation, and volition.¹⁴ The patient uses a four-point scale to rate his or her competence specific to each statement, then uses a four-point scale to indicate the extent to which the area is important to him or her (Exhibit 9-3). Finally, the patient reviews the list to select the four areas he or she aspires to change. Part II involves a series of statements that measure environmental supports.

Recommended Instrument Use: Practice Option

The OSA may be used to establish treatment priorities during the occupational therapy evaluation process. For some patients who have difficulty generating ideas or conversation about problem areas, the OSA may be preferable to the less-structured COPM.

Administration Protocol/Equipment/Time

Clinicians should refer to the administration manual for detailed instructions specific to

EXHIBIT 9-2

OCCUPATIONAL SELF-ASSESSMENT

The Occupational Self-Assessment is available from:

Model of Human Occupation Clearinghouse
 Department of Occupational Therapy
 University of Illinois at Chicago
 1919 West Taylor Street
 Chicago, IL 60612
www.moho.uic.edu

EXHIBIT 9-3
OCCUPATIONAL SELF-ASSESSMENT—MYSELF

Step 1: Below are statements about things you do in everyday life. For each statement, circle how well you do it. If an item does not apply to you, cross it out and move on to the next item.
 Step 2: Next, for each statement, circle how important this is to you.
 Step 3: Choose up to 4 things about yourself that you would like to change. You can also write comments in this space.

Name: _____ Date: _____

	I have a problem doing this.	I have some difficulty doing this.	I do this well.	I do this extremely well.	This is not so important to me.	This is important to me.	This is more important to me.	This is most important to me.	I would like to change.
Concentrating on my tasks.	Lots of problems	Some difficulty	Well	Extremely well	Not so important	Important	More important	Most important	
Physically doing what I need to do.	Lots of problems	Some difficulty	Well	Extremely well	Not so important	Important	More important	Most important	
Taking care of the place where I live.	Lots of problems	Some difficulty	Well	Extremely well	Not so important	Important	More important	Most important	

Reproduced with permission from Baron K, Kielhofner G, Iyenger A, Goldhammer V, Wolenski J. *A User's Manual for the Occupational Self Assessment (OSA)*. Version 2.2. Chicago, IL: University of Illinois at Chicago; 2006: 48.

administration and scoring. It takes approximately 30 minutes to administer and discuss the OSA; the manual, score sheet, and a pencil are required.

Groups Tested With This Measure

The OSA has been tested on persons with physical disabilities as well as those with psychiatric disabilities¹⁵; it has been translated into multiple languages.

Interpretability

Norms

No norms are reported.

Scoring

OSA responses are used in a collaborative process. Therapists should particularly take note of activities that are both rated as problematic *and* of great value to the patient and use this information to guide treatment planning.

Mean Detectable Change

No information reported.

Reliability and Validity Estimates

Rasch analysis was used in three iterative studies involving over 500 subjects.¹⁷ Findings suggest good internal validity and that it is adequately sensitive and reliable in distinguishing between levels of perceived occupational competence.

FATIGUE AND SLEEP ISSUES AFTER CONCUSSION/MILD TRAUMATIC BRAIN INJURY

Patients often report ongoing fatigue issues after sustaining concussion.² Patients may report both physical and mental fatigue that affects their ability to efficiently perform their daily and weekly ADLs, IADLs, and work responsibilities. Problems with fatigue and sleep typically require medical management, which includes comprehensive assessment. Occupational therapists may contribute to that effort and inform their intervention plan by formal and informal patient interviews and by administering standardized assessment tools (eg, Epworth Sleepiness Scale¹⁹ [ESS], Fatigue Severity Scale²⁰ [FSS]).

Strength of Recommendation

The US Department of Veterans Affairs (VA) and Department of Defense (DoD) Clinical Practice Guideline for Management of Concussion/Mild Traumatic Brain Injury¹⁸ does not recommend any specific fatigue or sleep assessments over others. The assessments described in this section are considered options.

Assessments

Epworth Sleepiness Scale

The ESS (available at www.epworthsleepinessscale.com/about-epworth-sleepiness/) is a self-administered, eight-item questionnaire used to measure daytime sleepiness in adults.¹⁹ The ESS

involves rating how likely people are to fall asleep in eight different situations or activities (scale of 0 to 3). It does not ask how often people actually fall asleep in these situations; just the chance of doing so. The total ESS score provides an estimate of a person's level of sleepiness in daily life but does not specify what factors contribute to sleepiness or diagnose specific conditions. It measures one aspect of a person's sleep-wake health status.

Recommended Instrument Use: Practice Option. If patients describe daytime sleepiness as a barrier to their performance of everyday tasks, the ESS may be used as a baseline measure of sleep-wake health status.

Administration Protocol/Equipment/Time. Most people can answer the ESS independently in 2 or 3 minutes. Only the questionnaire and a pencil or pen are needed.

Groups Tested With This Measure. The ESS was normed on healthy adults and has been used with various clinical populations, including adults with TBI.²¹ However, its use with persons who have sustained c/mTBI is unknown.

Interpretability

Scoring. The total ESS score is the sum of the eight items; scores range from 0 to 24 (the higher the score, the higher the person's daytime sleepiness).

Norms. A study of healthy Australian adults (N = 72) reported an average ESS score of 4.6 (95% confidence interval 3.9 to 5.3). The normal range

was defined as 0 to 10, although approximately 10% to 20% of the general population has ESS scores greater than 10.²²

Responsiveness estimates. The ESS may not be suitable for retest over periods of days or weeks (given the instructions to rate likelihood of sleepiness in “recent times”).

Reliability Estimates

Internal consistency. There is a high level of internal consistency as assessed by Cronbach’s alpha (0.88 to 0.74 in four different groups of patients).²²

Test-retest. Total ESS scores are reliable over a period of months ($\rho = 0.82$).²²

Validity Estimates

Construct. The ESS measures average sleep propensity in eight situations. The ESS scores differ between normal subjects and individuals with obstructive sleep apnea, which is known to increase sleepiness.²²

Fatigue Severity Scale

The FSS (available at www.mainedo.com/pdfs/FSS.pdf) is designed to evaluate the impact fatigue has on a patient. A recent systematic review of fatigue measures suggested that the FSS demonstrated good psychometric properties and has the ability to detect change over time.²³

Recommended Instrument Use: Practice Option. Occupational therapists may administer the FSS when patients indicate that fatigue is a barrier to their performance of everyday tasks. The FSS total score can help the therapist determine when referral to a physician for further evaluation is in order.

Administration Protocol/Equipment/Time. The FSS contains nine statements. The patient rates the severity of his or her fatigue symptoms by reading each statement and then circling a number from 1 to 7, based on how accurately it reflects his or her condition during the past week and the extent to which he or she agrees or disagrees that the state-

ment applies. The higher the value, the stronger the agreement with the statement.

Groups Tested With This Measure. The FSS has been used to assess fatigue in many clinical populations, including individuals with multiple sclerosis, stroke, Parkinson’s disease,²³ and mild to moderate TBI.²⁴

Interpretability

Scoring. Two scoring methods have been described: summing a total score and calculating an average score. A total score (obtained by summing ratings of the nine statements) of 35 or less suggests that the individual may not be suffering from fatigue. Patients who score 36 or more should be referred to a physician for further evaluation.²⁵

The average score is calculated by dividing the total score by nine.²¹ People with depression alone score approximately 4.5.²⁴

Mean Detectable Change. The MDC_{95} was calculated based on data from an FSS test-retest evaluation involving 11 individuals with systemic lupus erythematosus or multiple sclerosis.²¹

$FSS\ MDC_{95} = 1.44$. This means that a patient’s pre-post score would need to change by 1.44 for the FSS score to be 95% confident that true change occurred (rather than measurement error).

Reliability Estimates

Internal Consistency. Good internal consistency (Cronbach’s alpha = 0.88–0.95)²¹

Test-Retest. Eleven subjects (five with systemic lupus erythematosus, six with multiple sclerosis) were retested after an average of 10 weeks, in which no change in fatigue was clinically anticipated. Paired *t* test differences were not significant; correlation coefficient was 0.84.²¹

Validity Estimates

Convergent. FSS scores are correlated with other measures of fatigue, including the Multidimensional Assessment of Fatigue and Rhoten Fatigue Scale.²³

MEDICATION MANAGEMENT

Many individuals with c/mTBI report forgetfulness and organization problems. As a result and for a variety of reasons, patients with c/mTBI may have difficulty keeping track of their medications

and remembering to take them as prescribed. For example, patients may be taking medications prescribed by more than one physician or have received instructions about medication at a time

FORM 9-1

MEDICATION MANAGEMENT PERFORMANCE OBSERVATION

Instructions

The following observation checklist may be used to help the therapist determine what aspect of medication management is problematic for a given patient. Ideally, this observation may occur in the patient's room (as an inpatient setting), during a home visit, or if the patient brings his or her medications to an outpatient session.

Identifying Medications

- Can the patient locate all of his or her medication bottles? Are they stored together in the same place? Does the patient keep medications in a specific place in the house or on his or her person?
- Can the patient identify the names of the pills, what they look like, and their purpose?

Organizing Medications

- Does the patient have a written schedule of his or her medications?
- How are the medications organized (eg, day, time of day, both)?
- Does the patient use a pill box?

Opening Medication Containers

- Can the patient open bottles with childproof caps?
- Can the patient open bottles with regular caps?

Using Vision to Read Labels and Recognize Medications

- Can the patient identify what the medication looks like and distinguish the differences between medications?
- Can the patient read the prescriptions on the bottles?
- Does the patient understand what the prescriptions mean?

Memory Strategies and Medication Schedules

- Does the patient use a pill box?
- Can the patient fill his or her pill box accurately?
- Does the patient have a written schedule for taking medications?
- Does the patient use a checklist?
- Does the patient remember when to take the medications?
- Does the patient have a system for remembering to take the medications? If so, what (eg, alarms, reminders from someone else, etc)? Does the patient take his or her medications around meals and or bedtime?

Refilling Medications

- Does the patient know the name of his or her prescribing physician? Does the patient know the doctor's telephone number?
- Can the patient recognize when medications need to be refilled?
- Does the patient know how to refill the medication?
- Can the patient report or find the name and number of the pharmacy?
- Does the patient remember to pick up refills after ordering them?
- If the patient took too much medication, would he or she know what to do?
- If the patient took too little medication, would he or she know what to do?

Adapted with permission from Marsey Waller Devoto, MSOT, OTD; Assistant Professor and Fieldwork Coordinator, Brenau University, School of Occupational Therapy College of Health Sciences, 500 Washington St Southeast, Gainesville, GA 30501; 2013.

when they have been less able to attend to or remember the information. Because medication management is an extremely important component of any patient's recovery, especially for those with brain injury, it is important to assess the extent to which patients with c/mTBI are adhering to their medication regimen.

If clients are not managing their medications well, they may present with drowsiness, decreased attention skills, and overall inability to efficiently manage pain and stress. If a client is taking medications regularly and as prescribed, the treatment team is better able to understand the client's baseline and potential. It is also helpful to collaborate with nursing staff and doctors to determine whether a client's medications should be changed.

Assessment will be optimally effective in this realm if an interdisciplinary approach, involving but not limited to nursing, physical therapy, and speech language pathology, is used to understand this and other problems associated with c/mTBI.

Strength of Recommendation: Practice Option

There are no standardized or validated methods described in the literature for assessing the extent to which individuals with c/mTBI understand and are able to manage their medications. However, assessment in this area is consistent with standard occupational therapy practices and reported as valuable by occupational therapists working with individuals with c/mTBI.

Assessment

Screen all patients with c/mTBI for any issues that they may have with medication management. The first screen may be done during the client's initial interview, during which it is important to determine the following:

- whether the client understands the medications he or she takes,
- what the doses and schedules are,
- whether or not the client remembers to take his or her medications,
- who prescribed the medication,
- the purpose of the medications, and
- the extent to which the client follows his or her medication regimen as prescribed.

If the interview indicates that the patient has difficulties with some aspect (or several aspects) of medication management, use more formal methods for determining where the performance breakdown lies. Use a self-report questionnaire with additional follow-up questions and observe functional performance (see Patient Handout: Medication Management Self-Report Questionnaire and Form 9-1).

Determine how the client manages his or her medication and whether or not the management system is effective. Define the organization systems he or she uses (pill organizer, medication list, spouse), memory aids (checklist reminders, alarms, etc), and strategies for identifying medications and dosages (medication list). Once the areas of breakdown are identified, you can address each area individually.

INTERVENTION: FATIGUE AND SLEEP ISSUES AFTER CONCUSSION/MILD TRAUMATIC BRAIN INJURY

Patients report both physical and mental fatigue that affects their ability to efficiently perform daily and weekly ADLs, IADLs, and work responsibilities. Fatigue can be minimized or restored with rest and fatigue management strategies. It is important that individuals understand the best methods of managing fatigue while simultaneously working on increasing their activity tolerance. Therefore, occupational therapists provide education about fatigue and sleep hygiene and help patients employ strategies that maximize energy and productivity as they regain their activity tolerance.

Many of the strategies described in this section

of the toolkit require the service member to "work smarter, not harder." This means making decisions about how to manage one's workload and tasks and when to take breaks, strategies that may appear to be at odds with some aspects of military culture. Therapists should prepare for service member rebuttals such as, "I can't take breaks whenever I want to." Therapists help patients appreciate that their command is supportive of their recovery process and that even if some strategies are not feasible on the job, they may be helpful for aspects of life that are under service members' control.

Intervention Methods

1. Provide patient education regarding fatigue and contributing factors (see Patient Handout and Clinician Tip Sheet: Fatigue Management and Factor Awareness; also www.nhlbi.nih.gov/health/public/sleep/healthy_sleep.pdf).
2. Help the patient identify and implement individualized fatigue management and sleep hygiene strategies (see Patient Handout and Clinician Tip Sheet: Taking Breaks, Pacing; also www.helpguide.org/mental/stress_relief_meditation_yoga_relaxation.htm).

3. Remind patients and therapists of executive and attention strategies that apply to fatigue management, such as pausing and compensatory cognitive strategies (see Chapter 7: Cognition Assessment and Intervention).

Strength of Recommendation: Practice Standard

Recommendations for fatigue management and sleep hygiene are supported by the VA/DoD Clinical Practice Guideline for Management of Concussion/Mild Traumatic Brain Injury.¹⁹

INTERVENTION: MEDICATION MANAGEMENT

It is important for clients to take their medication regularly and as prescribed to increase independence and maximize rehabilitation potential. It is also important for patients to establish accountability and competency in managing their own medication.

Strength of Recommendation: Practice Option

There is no empirical evidence to guide practice in this area; however, intervention is consistent with standard occupational therapy practices and reported as valuable by occupational therapists working with individuals with c/mTBI.

Intervention Methods

- Address barriers to medication management (as identified during assessment) in a systematic fashion (see Clinician Tip Sheet: Intervention Planning for Medication Management).
- Develop a comprehensive list of medications, coordinating with nursing staff if possible (see Exhibits 9-4 and 9-5).
- Determine which strategies will best facilitate consistent adherence to the medication regimen (see Strategies to Improve Medication Management Clinician Tip Sheets: Pill Organizers, Checklists and Routines, and Alarms and Reminders).

EXHIBIT 9-4

EXAMPLE MEDICATION SUMMARY

Medicine	Dose	Time (s)	Reason	Prescribing Doctor
Zoloft	40 mg 3x/day	0800 & 1800	Depression	Dr. Smith
Nexium	40 mg	0800	Stomach pain	Dr. Jones
Zanaflex	4 mg	0800	Headache	Dr. Hope

EXHIBIT 9-5
EXAMPLE MEDICATION SCHEDULE

Morning

Medicine	Dose/Route	Time	Reason
Nexium	40 mg by mouth	0800	Stomach pain
Zanaflex	4 mg by mouth	0800	Headache

After Lunch/Midday

Medicine	Dose/Route	Time	Reason
Zanaflex	4 mg by mouth	1400	Muscle pain

Bedtime

Medicine	Dose/Route	Time	Reason
Prazosin	1 mg / 1–2 tabs by mouth	At bedtime	Sleep/PTSD/BP
Zanaflex	4 mg by mouth	At bedtime	Muscle pain
Seroquel	400 mg by mouth	2200	Sleep

As Needed

Medicine	Dose/Route	Time	Reason
Midrin	2 tabs by mouth	At onset of headache & 2 tabs every 6 hours as needed	Headaches
Motrin	200 mg (6 tabs)	Once a day as needed	Pain

BP: blood pressure
 PTSD: posttraumatic stress disorder

INTERVENTION: BILL PAYING AND MONEY MANAGEMENT

Purpose/Background

Brain injury, including c/mTBI, may affect how a person feels, processes information, and executes functional tasks, including those related to bill paying and money management. Injury-related symptoms (decreased attention, memory, or executive functions), changes in routine, fatigue, and accompanying mood disorders sometimes make it difficult for patients to pay bills on time, organize personal paperwork, and effectively manage their money. Occupational therapists help patients employ strategies and techniques to reestablish competence in this important area of self-management.

Intervention will be optimally effective in this realm if:

- the patient understands that performance problems in this area do not reflect personal incompetence. Rather, the temporary after-effects of c/mTBI combined with per-

sonal (eg, pain, headache) and situational (eg, distracting environment) factors make the task more challenging at present.

- the patient has implemented some form of memory back-up system (such as a day planner) that can be used to address personal financial tasks.

Strength of Recommendation: Practice Option

There is no empirical evidence to guide practice in this area. Intervention is consistent with standard occupational therapy practice and reported as valuable by occupational therapists working with individuals with c/mTBI.

Intervention Methods

- Talk with the patient to figure out the specific symptoms or factors that contribute to problems with money management. Also,

ask the patient to describe in detail his or her current processes for task performance as well as those used in the past when, presumably, he or she had fewer problems. For example, find out answers to questions of this nature:

- What happens to the bills when they arrive in the mail?
- When do you tend to pay bills? At a routine time during the week or month? On weekends or after work?
- Where in the home is the activity performed?
- How and where are financial records stored?

- Use this information to identify processes or strategies that may improve task performance. Effective processes or strategies may involve modifying daily routines (ie, sorting mail to avoid disorder, confusion, and worry associated with losing bills amid junk mail) or using checklists or worksheets to organize bill-paying procedures to ensure accuracy (see the following Patient Handouts and Clinician Tip Sheets: Organizing the Mail, Establishing a Budget, Bill Paying, Using a Smartphone or Planner to Manage Money, and AAA Worksheet; and Patient Handouts: Budget Planning Worksheet, Budget Tracking Worksheet, and Money Management [packet]).

CLINICIAN TIP SHEET: FATIGUE MANAGEMENT—FACTOR AND STRATEGY AWARENESS

Purpose/Background

Occupational therapists help patients address problems with fatigue by:

- providing education on healthy living, including information related to managing fatigue;
- helping the patient identify strategies to improve sleep and address fatigue; and
- supporting and reinforcing the process of implementing new strategies and habits through structure and reinforcement.

Patient Handout: Fatigue Management—Factor and Strategy Awareness summarizes four key avenues for addressing fatigue by establishing and maintaining 1) good sleep hygiene practices, 2) good nutrition and hydration, 3) regular exercise or activity, and 4) stress-reduction practices.

Instructions

The handout incorporates information and opportunities for a patient's self-reflection. The patient and therapist discuss these reflections and together identify new strategies that might help (the therapist may also refer the patient to other professionals). For example:

- If a patient reports difficulty falling asleep due to ongoing issues with pain, a referral to his or her primary doctor may be indicated to investigate the source of the pain

or the medications the individual is taking.

- If the patient reports difficulty falling asleep and also reports excessive caffeine use or napping behaviors, these areas may need to be changed.
- If the patient reports falling asleep readily but waking up often with nightmares, the recommendation may be a referral to a psychologist or physician.

Occupational therapists support implementation of fatigue management and sleep strategies by incorporating them into homework assignments and reinforcing behaviors that optimize the patient's energy level and rest. Occupational therapists also support fatigue management and improved sleep patterns by helping patients learn and then implement appropriate stress-relief skills. This might include learning relaxation techniques such as deep breathing, progressive muscle relaxation, mindfulness meditation, and guided imagery (see www.helpguide.org/mental/stress_relief_meditation_yoga_relaxation.htm). During clinic sessions, therapists help patients select and learn techniques then provide homework assignments that support implementation on a routine basis.

Remember, occupational therapists use in-depth conversation with the patient about his or her fatigue, activity, and sleep patterns to inform referrals to other providers. Occupational therapy intervention that emphasizes education and implementation of sleep and fatigue management strategies contributes to interdisciplinary efforts to address this important aspect of functioning.

CLINICIAN TIP SHEET: HELPING PATIENTS LEARN AND IMPLEMENT FATIGUE MANAGEMENT STRATEGIES

Purpose/Background

Many individuals view fatigue management strategies (such as taking breaks or pacing) as forms of laziness or weakness. It is important that therapists help patients see these techniques as means by which they perform at their optimum level.

The patient handouts on these topics are designed to facilitate discussions that help patients reflect on their physical and mental responses to fatigue. Once they identify their symptoms and current patterns, patients need assistance exploring and implementing alternative strategies, including taking preemptive breaks that can give them greater staying power, pacing, and managing personal and situational factors (see Chapter 7, *Cognitive Assessment and Intervention*).

In general, implementing fatigue management strategies in daily life involves effective use of compensatory cognitive strategies, self-reflection, and self-awareness.

Effective Use of Compensatory Cognitive Strategies

As is the case whenever people are engaged in changing patterns of behavior, it is easy to forget one's best intentions amid the challenges and distractions of everyday life. Therefore, occupational therapists help patients build on their skills with compensatory cognitive strategies to optimize the likelihood that they will remember to use fatigue management strategies in the course of their everyday activities. This includes the following:

- Using stop notes. Taking a moment to leave yourself a written note as to where you left off and what to do next (after a break or when the task is resumed the next day) can be a useful compensatory strategy. Many patients report reluctance to take breaks because they will forget where they were; stop notes help eliminate that concern.
- Preplanning fatigue management strategies. Generative thinking can be taxing and very difficult, especially when an individual is fatigued. That is why it is very important that patients plan for fatigue

in advance, when they are not tired. This may involve generating a possible "break" list in therapy and having numerous options for breaks when at home or work, or spreading essential or desired tasks throughout the week.

- Using alarm prompts for starting and stopping breaks or initiating scheduled tasks. Sometimes patients get so engaged in the task at hand that they simply forget to monitor symptoms that might otherwise indicate the need for a break. As a result, they do not stop until it is simply too late. Setting an hourly alarm for a fatigue status check might encourage a brief preemptive break and increase staying power for the work session. Similarly, setting an alarm for 10 minutes could signal a return to the task after a brief break or initiate a scheduled task.

Self-Reflection and Self-Awareness

Self-reflection and self-awareness are essential to the successful use of fatigue management strategies. Patients need to be mindful of their daily to-do lists, priorities, and activity tolerance.

They need to know:

- when to take a break,
- how long the break needs to be, and
- what to do during a break or if stopping for the day and trying again another time is a better option. For example, simply stopping for the day may be the best option if headache pain is out of control and continued effort is likely to both exacerbate pain and result in error-laden output.

Remember, therapists can contribute to improved patient self-awareness in this realm by providing simulated work tasks at therapy sessions in which the patient practices implementing these strategies and analyzes his or her performance afterwards (see AAA Worksheet in Chapter 7, *Cognitive Assessment and Intervention*).

CLINICIAN TIP SHEET: INTERVENTION PLANNING FOR MEDICATION MANAGEMENT

General Guidelines

Identify one area to work on at a time. Start with a compiled, comprehensive list of medications. If

the patient is taking several medications, use a pill organizer. Establish daily and weekly routines as they relate to medication. Link assessment findings with intervention plans (Table 9-1).

TABLE 9-1
INTERVENTION PLANNING

Assessment Issue	Yes	No
Can patient open the medication bottle?	Nothing needs to be addressed	Request easy-open bottles from the pharmacy. Use adaptive equipment like a rubber bottle opener.
Can patient read the prescription?	Nothing needs to be addressed	Type prescription in large print and tape to outside of the bottle. Use adaptive equipment, such as a magnifier. If the above suggestions are ineffective, color code the medication and link the coding to a comprehensive medication list.
Can patient identify medications, dosages, and purpose of medication?	Even if the client has a good handle on his/her medication, it is recommended that he/she develop a wallet list of medications (and laminate it, if possible).	Develop a list of medications for the wallet (and laminate if possible). Review the medications list with the patient to make sure he/she understands.
Does the patient understand how to follow the directions of the prescribed medications?	Even if the client has a good handle on his/her medication, it is recommended that he/she develop a medication schedule. This can be posted at home (on the refrigerator).	Develop a medication schedule that can be posted at home. It is important to review the schedule with the client and have the client use it to fill his/her pill box. Emphasize to the patient and family the importance of keeping the medication schedule updated and double check to make sure the schedule matches the prescription guidelines on the bottles.
Can patient develop a schedule to follow to take all of his/her medications?	Use a medication schedule comprised of all medications from all doctors.	Use medication schedule comprised of all medications from all doctors. In addition, it may be helpful to consider using a pill box divided into different times of the day and days of the week.
Can patient organize his/her medications (ie, does he/she have a pill box, etc)?	This is usually the case if someone takes fewer than three medications. Nothing needs to be addressed.	Use some form of medication box or organizer. When determining which pill box is the best fit for your patient, it is important to remember the simplest option that meets all of your client's needs is usually the best option. If you cannot find the ideal pill box, adapt a similar one. When deciding on the right pill box, consider the following: <ul style="list-style-type: none"> • How often does patient take medications (once a day, twice a day, etc)? • How many pills does the patient take? • Does patient have PRN meds? If so, how often can he/she take them, and is there a maximum amount? • Will he/she need to take some of the medications when away from home?

(Table 9-1 continues)

Table 9-1 *continued*

<p>Can patient follow a schedule and take medications on time?</p>	<p>Post a medication schedule as a back-up.</p>	<p>Help the patient develop a medication schedule and routine. It is helpful to anchor these routines to routines that are already in place in a client’s daily schedule (such as eating meals). In addition, it is important to determine what types of cues would be effective for the client. Just as there are many types of pill boxes, there are also many different strategies and devices. When determining the best cuing system for your client, it is important to determine what systems your client already uses and what has been successful. For example, some clients like to use alarms on their cell phones, whereas other people use CATs or watch reminders. Again, try the simplest options first. Types of cuing systems may include: cell phone alarms, CAT alarms/schedules, day planner schedule check-lists, and watch alarms. Your client should practice these strategies at home as well as in the clinic. Initially, the client may need additional cuing from family members. However, as the client develops a medication routine, less cuing may be needed.</p>
<p>Does patient know when and how to refill his/her medication?</p>	<p>Nothing needs to be addressed</p>	<p>Have the client fill the pill box at the same scheduled time every week (eg, Sunday evenings). At this time, have patient check to see if any refills are needed. When the client determines what medications need to be refilled, make a list with the name of the medication, prescription number, prescribing doctor, name of pharmacy, and telephone number of the pharmacy. Then, with the clinician or family member, the client can practice calling in a prescription or taking the prescription to the pharmacy to be refilled.</p>

CAT: cognitive assistive technology
 PRN: pro re nata (as needed)

**CLINICIAN TIP SHEET: STRATEGIES TO IMPROVE
 MEDICATION MANAGEMENT—MEDICATION LIST**

Start intervention by helping the patient compile a comprehensive list of medications (see Exhibit 9-4). It is important that patients know what medications they are taking for several reasons. Patients often see several doctors, all of whom may prescribe medications. It is help-

ful for these doctors to know what medications a patient is taking to provide the best care. It is also important for patients to take ownership of their care, knowing what medications they take and why.

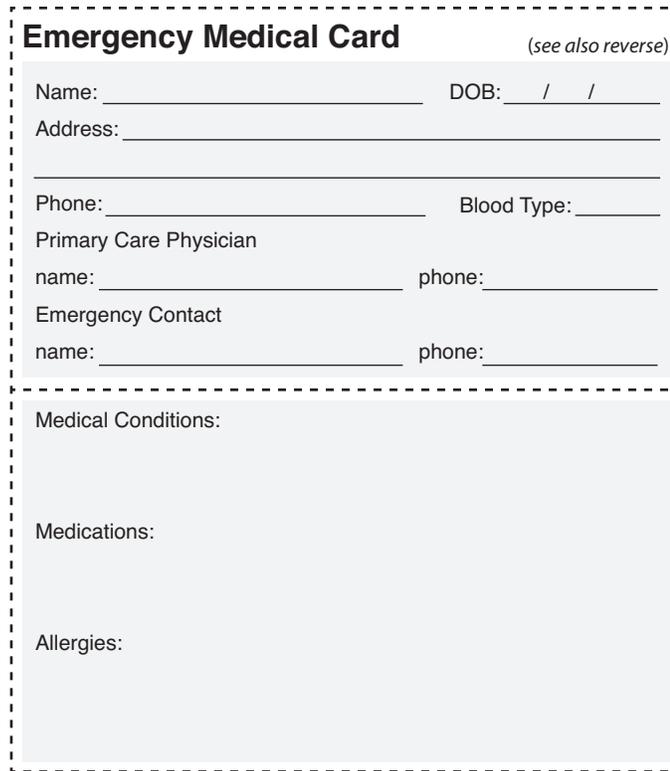
**CLINICIAN TIP SHEET: STRATEGIES TO IMPROVE
 MEDICATION MANAGEMENT—MEDICATION SCHEDULE**

Develop a medication schedule to help clients fill their pill organizers (see Exhibit 9-5). Divide the

schedule into the different times the medications should be taken.

CLINICIAN TIP SHEET: STRATEGIES TO IMPROVE MEDICATION MANAGEMENT—EMERGENCY CARD

An emergency card is another helpful resource to develop for your client (Figure 9-1; a free card template is available at: www.medids.com/free-id.php).



Emergency Medical Card *(see also reverse)*

Name: _____ DOB: ____ / ____ / ____

Address: _____

Phone: _____ Blood Type: _____

Primary Care Physician
name: _____ phone: _____

Emergency Contact
name: _____ phone: _____

Medical Conditions:

Medications:

Allergies:

Figure 9-1. Emergency wallet medical card.

CLINICIAN TIP SHEET: STRATEGIES TO IMPROVE MEDICATION MANAGEMENT—DAILY CHECKLIST

It is important to anchor medication times to a patient's current routines (ie, morning medications taken at breakfast, midday medications taken with lunch, evening medications taken at dinner). It is recommended that clients schedule times to refill their medications pillbox, preferably at the same

time every week using a medication sheet. To help develop these medication routines, it may be important to develop checklists as reminders (Exhibit 9-6). These checklists should be posted in a visible area, such as the bathroom mirror.

CLINICIAN TIP SHEET: STRATEGIES TO IMPROVE MEDICATION MANAGEMENT—MEMORY AIDS

Patients may be able to identify medications and organize them in a pill organizer, but if they cannot remember to take them as scheduled, the organization system is useless. Therefore, memory aids are

important components to the success of medication management.

Occupational therapy intervention incorporates selecting a memory aid based on the patient's needs

EXHIBIT 9-6

SAMPLE CHECKLIST

Morning Checklist	Afternoon Checklist	Evening Checklist
1. Brush teeth	1.	1.
2. Take shower	2.	2.
3. Get dressed	3.	3.
4. Eat breakfast	4.	4.
5. Take meds	5.	5.
6. Get keys, wallet, planner	6.	6.

and abilities and training the patient to use it (see also Chapter 7, Cognitive Assessment and Intervention). Because there are a multitude of memory aids, from checklists to cell phones to watches, it is necessary to match the client’s needs and abilities to the appropriate memory aids (eg, smart watch, cell phone, watch with alarms, checklist, day planner, spouse or loved one calling or reminding client to take medications during scheduled time). Try the simplest option that meets your client’s needs first and progress from there. Many electronic devices and other aids can be explored through a simple Internet search.

Discuss or observe the following:

- What systems does the client already have in place and use? Does the client often use a cell phone for reminders? Does the client use a day planner?
- Does the client already have a structured schedule and home environment?
- What is the client’s current cognitive level? Can he or she follow one-step, two-step, or multistep directions? Does the client get confused handling multiple applications? Can the client tolerate multiple alarms, or will that just be confusing? Can the client follow and understand the alarms if he or she cannot set them?
- Is the client able to solve basic functional problems?
- Does the client understand written, pictorial, and verbal directions?
- Does the client initiate participating in ADLs?
- Does the client prefer high technology or low technology?
- Does the client respond to external cues?

Does the client hear the alarm, not notice it, or just turn it off and forget what it is for?

- Did the client wear a watch before experiencing cognitive difficulties?
- How simple is the equipment to use? Which equipment functions are important and which would lead to greater confusion? Is one type or brand of watch better than another for the specific client? Therapists should test the equipment and be able to operate it before asking the patient to do so.
- Does the client have vision impairments? Can he or she read, including complex materials?
- Does the client need multiple alarms?
- Is cost a factor?

In addition to anchoring medication times to patients’ current routines, it is also important to educate clients and their families on storing the pill organizer (as well as the pill boxes) in the same place; that way clients do not get confused or frustrated every time they fill their pill box.

Adequately train patients to operate the memory aids and provide opportunities to practice on a regular basis. Several high-tech memory aids may be complex to operate; however, with good instruction, repetition, and practice, it is possible for someone to learn to operate the equipment effectively. Provide simple, written out, step-by-step directions to set the device (these instructions can be given to all clients who use the same device), then have the client follow the directions step by step with you. You may need to use chaining techniques to help the patient learn this new information. **Remember**, memory devices may get lost or break, so patients with problems managing medication may need back-up from a spouse or another source.

CLINICIAN TIP SHEET: ORGANIZING THE MAIL

Purpose/Background

Establish a strategy with the patient on how to organize mail to stay on top of paying bills on time; provide simulated activity so the patient gains experience with the process (Table 9-2).

Directions

1. Talk with the patient to figure out what specific symptoms and factors contribute to problems with organizing the mail.
2. Review Patient Handout: Organizing the Mail, adapting recommended procedures for the individual patient's circumstances.
3. If the patient indicates a willingness to try this strategy at home, have him or her complete the simulated work task described below.
4. After providing instructions, ask the patient to complete the AAA worksheet before, during, and after task performance (see also Techniques to Promote Engagement and Learning in Chapter 7, Cognitive Assessment and Intervention).
5. Based on simulation performance, modify strategy recommendations as needed.

6. Assign homework to implement some or all aspects of the recommended strategy.

Task: Organizing the Mail

1. Provide the patient with the following: an "Incoming Mail" box filled with junk mail and important mail items; sticky notes.
2. Ask the patient to perform steps 2, 4, 5, and 6 as specified on the corresponding patient handout.
3. Observe performance as described below.

Performance Measures (Evaluate the Following)

1. Ability to prioritize and organize mail
2. Length of time to complete the task before becoming frustrated and fatigued
3. Effect of task modifications on performance
4. Extent to which patient can employ other strategies for managing personal and situational factors during task performance
5. Amount of assistance needed to complete task (eg, independent, requires supervision [specify why], needs cues [specify the nature and frequency of cues], or needs hands-on assistance [specify the nature of the assistance and amount])

TABLE 9-2

TASK ANALYSIS FOR THE SIMULATED WORK TASK: ORGANIZING MAIL

Skills Targeted	Task Analysis
Attention	Ability to complete task without interruptions due to distractions
Memory	Ability to follow instructions
Problem solving	Ability to plan and then modify the plan as needed
Organization/self-structuring	Appropriate and effective use of office supplies and materials

CLINICIAN TIP SHEET: ESTABLISHING A BUDGET

Purpose/Background

The purpose of this task is to establish a budget, allow clients to make appropriate payments on time, and become better organized (Table 9-3).

Directions

Develop a spreadsheet with the client to break down his or her budget (involve the client's spouse, if applicable) based on income, bills that need to be

TABLE 9-3
TASK ANALYSIS FOR SIMULATED WORK TASK: BUDGETING

Skills Targeted	Task Analysis
Attention	Ability to complete task without interruptions
Memory	Ability to follow recall information about income and other details provided
Problem solving	Ability to plan and then modify the plan as needed
Organization/self-structuring	Appropriate and effective ways to use budget sheet

paid, and other expenses. Structure the task according to the client’s needs.

Task Description

1. Assist the patient in identifying monthly income and expenses. If the patient is unable to organize a budget, ask a family member for assistance (see Patient Handout: Budget Planning Worksheet).
2. Ask the patient to fill out the budget tracking worksheet (see Patient Handout: Budget Tracking Worksheet and completed example).
3. Observe performance as described below.

Performance Measures (Evaluate the Following)

1. Ability to identify income and expenses
2. Length of time to complete the task before becoming frustrated and fatigued
3. Effect of task modifications on performance
4. Extent to which the patient can employ other strategies for managing personal and situational factors during task performance
5. Amount of assistance needed to complete the task (eg, independent, requires supervision [specify why], needs cues [specify the nature and frequency of cues], or needs hands-on assistance [specify the nature of the assistance and amount])

CLINICIAN TIP SHEET: BILL-PAYING ACTIVITY

Purpose

The purpose of this task is to assess and improve the client’s sustained attention during money management and promote correct task completion (Table 9-4).

ment and Learning” in Chapter 7, Cognitive Assessment and Intervention).

5. Based on simulation performance, modify strategy recommendations as needed.
6. Assign homework to implement some or all aspects of the recommended strategy.

Directions

1. Talk with the patient to figure out the specific symptoms or other factors that contribute to problems with bill paying.
2. Review Patient Handout: Bill Paying, adapting recommended procedures for the individual patient’s circumstances.
3. If the patient indicates a willingness to try this strategy at home, have him or her complete the simulated work task (described below).
4. After providing instructions, ask the patient to complete the AAA Worksheet before, during, and after task performance (see also “Techniques to Promote Engage-

Task Description

1. Provide the money management packet to the client and ask him or her to complete the task by reading the instructions (see procedure on patient handout). Explain to the client that you are trying to assess his or her ability to follow instructions and complete a basic money management task.

Performance Measure (Evaluate the Following)

1. Ability to write a check properly
2. Ability to calculate the account
3. Ability to use prompts or cues from the therapist to adjust task performance

TABLE 9-4
SIMULATED WORK TASK: BILL PAYING

Skills Targeted	Task Analysis
Attention	Ability to complete task without interruptions due to distractions Ability to write a check and balance the account by alternating attention between the two tasks
Working memory	Ability to do math without using a calculator
Problem solving	Ability to identify errors with task, fix the problem when it arises

- | | |
|--|--|
| <ul style="list-style-type: none"> 4. Ability to manage personal and situational factors during task performance 5. Amount of assistance needed to complete the task (eg, independent, requires super- | <ul style="list-style-type: none"> vision [specify why], needs cues [specify the nature and frequency of cues], or needs hands-on assistance [specify the nature of the assistance and amount]) |
|--|--|

CLINICIAN TIP SHEET: USING A SMARTPHONE OR PLANNER TO HELP MANAGE MONEY

Purpose

The purpose of this task is to improve the efficiency and accuracy of the client’s ability to perform financial management tasks by using memory back-ups (Table 9-5).

identify strategies for inputting prompts into the tools or devices; have the patient demonstrate back the proper techniques.

Performance Measure (Evaluate the Following)

Directions

Talk with the client about his or her ability to recall and retain information during complex everyday tasks associated with money management. Talk about devices that can help the client complete tasks without relying on others for help (eg, a daily organizer or cognitive assistive technology [CAT]).

1. Ability to attend to the task
2. Ability to follow two- to four-step instructions
3. Ability to use prompts or cues from therapist to adjust task performance
4. Ability to manage personal and situational factors during task performance
5. Amount of assistance needed to complete the task (eg, independent, requires supervision [specify why], needs cues [specify the nature and frequency of cues] or needs hands-on assistance [specify the nature of the assistance and amount])

Task Description

Provide the patient with a CAT or memory aid tool, such as a daily organizer with a calendar, and

TABLE 9-5
TASK ANALYSIS REGARDING MEMORY AID TO MANAGE MONEY

Skills Targeted	Task Analysis
Sustained and alternating attention	Ability to complete task without interruptions due to distractions Ability to put information into a CAT and go between two different programs to complete task
Memory	Ability to remember the steps to use a CAT appropriately

CAT: cognitive assistive technology

SECTION 2: SOCIAL ROLES

REENGAGING WITH SPOUSES, CHILDREN, AND FRIENDS

Activity engagement associated with the roles of friend, spouse, and parent changes as service members go on lengthy and often serial deployments. Once commonplace, everyday interactions turn into long-distance communications through letters, telephone and video calls, and emails. Role strains are common throughout and following deployment. The challenges of reintegration with family and friends may be exacerbated by symptoms related to c/mTBI and the associated psychosocial strain.²⁷ Awareness and insight into specific interpersonal stressors, role shifts, and the needs of others may provide a foundation for healthy reengagement with family and friends. Stressors with family and friends may influence overall perceptions of well-being and affect performance in areas such as work, school, and social settings. Occupational therapists explore service members’ social and family roles to help them successfully reenter their home communities.

While this section of the toolkit summarizes occupational therapy evaluation tools and methods that may enable the therapist to better understand patients’ challenges with role resumption and social interaction, it is important for occupational therapists to be mindful of their scope of practice and confine services to their areas of expertise

associated with activities, occupations, and roles. Evaluations by and referrals to other professionals, such as social workers, psychologists, chaplains, and counselors may also be needed. All professionals involved in helping a service member reestablish family and social roles should be committed to team communication and to reinforcing interdisciplinary strategies that advance carry-over and minimize frustration and confusion for all involved.

Recommended Instrument Use

The following assessments may be used in service members who have returned home with c/mTBI and present challenges of reengagement with spouses, children, or friends (Table 9-6). These may have been identified by the service members themselves or by another interested party.

Note: The COPM is described in the self-management section of the toolkit. The COPM may be used to assess childcare concerns and to inform the intervention plan. However, even if service members with children do not identify parenting issues among their top five priorities, the occupational therapist should explore this area of functioning with the patient.

TABLE 9-6
EVALUATION OPTIONS BASED ON KEY SOCIAL RELATIONSHIPS

Evaluation	Spouse	Children	Friends
Canadian Occupational Performance Measure ¹	X	X	X
Assessment of Communication and Interaction Skills ²	X	X	X
Activity Co-engagement Self-assessment ³	X	X	X
The Dyadic Adjustment ⁴	X		

1) Law M, Baptise S, McColl MA, Carswell A, Polatajko H, Pollock N. *Canadian Occupational Performance Measure*. 2nd ed. Toronto, ON: Canadian Association of Occupational Therapists–Association Canadienne d’Éducation Publications; 1994. 2) Kielhofner G. *A Model of Human Occupation: Theory and Application*. 3rd ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2002. 3) Davidson LF. *Activity Co-engagement Self-assessment*. Winchester, VA: Shenandoah University; 2009. 4) Spanier GB. Measuring dyadic adjustment: new scales for assessing the equality of marriage and similar dyads. *J Marriage Fam*. 1976;38:15–28.

ASSESSMENT OF COMMUNICATION AND INTERACTION SKILLS

The Assessment of Communication and Interaction Skills (ACIS)²⁸ is a structured observation rating scale that explores the interaction of an individual during occupational engagement or in a group set-

ting (Exhibit 9-7). This tool addresses the domains of physicality, information exchange, and relations; observations of competencies and deficiencies inform treatment planning (Exhibit 9-8).

EXHIBIT 9-7

ASSESSMENT OF COMMUNICATION AND INTERACTION SKILLS

The Assessment of Communication and Interaction Skills is available from:

Model of Human Occupation Clearinghouse
Department of Occupational Therapy
University of Illinois at Chicago
1919 West Taylor Street
Chicago, IL 60612
www.moho.uic.edu

Recommended Instrument Use: Practice Option

This test may be a helpful inclusion in an occupational therapy evaluation when the patient or others indicate that communication and social functioning interfere with task performance.

This assessment must be conducted in an environment and with a task that has been specifically chosen for and by the client and concerned loved one (spouse, child, etc). The task must have structured and unstructured elements, a moderate to high risk of unpredictability or challenges, and require the dyad to engage in activities both in a parallel (eg, both cutting their own vegetables) and cooperative format (they are serving dinner from one central dish and must negotiate how to share resources). Spouse-patient activities could include cooking and eating dinner, paying bills and reviewing finances, playing with the children, or planning a trip. Parent-child activities might include structured play (eg, a board game), unstructured play (eg, playing make believe), storytelling, or assisting with homework.

Administration Protocol/Equipment/Time

Clinicians should refer to the administration manual for detailed instructions specific to administration and scoring. It takes 20 to 60 minutes to administer the ACIS, depending on the task. The manual, score sheet, and a pencil are all the equipment that is required.

As the patient engages in an individual or group activity, the therapist observes three aspects of so-

cial functioning (physicality, information exchange, and relations). Skills related to each domain (20 verbs) are rated using a four-point scale (competent, questionable, ineffective, deficit). In the case of a dyad activity, the therapist may rate the performance of both individuals simultaneously.

Groups Tested With This Measure

The test was developed for adults with psychiatric illness, but version 4.0 can be used to assess communication and interaction issues associated with any condition or illness.²⁹

Interpretability

Norms

No norms are reported.

Scoring

As the patient engages in an individual or group activity, the therapist observes three aspects of social functioning: 1) physicality, 2) information exchange, and 3) relations. Skills related to each domain (20 verbs) are rated using a four-point scale (competent, questionable, ineffective, or deficit).

Mean Detectable Change

No information reported.

Reliability Estimates

Internal Consistency/Interrater and Intrarater Reliability

Rasch analysis was used to evaluate internal consistency and rater reliability. Authors described good internal consistency and evidence of intrarater and interrater reliability.²⁸

Validity Estimate

Construct

Using Rasch analysis, the ACIS discriminated between varying levels of communication and interaction skill as reported by Asher.²⁹

ACTIVITY CO-ENGAGEMENT SELF-ASSESSMENT

The Activity Co-Engagement Self-Assessment (ACeS) is designed to help the occupational therapist better understand the patient's engagement in

activities with loved ones, including types of activities performed together, potential barriers to activity engagement, and perceived self characteristics

EXHIBIT 9-8

ACIS SUMMARY SHEET

Client:					Examiner:					
Observation situation:										
Age:		Sex:		Diagnosis:						
Adaptations:				Inpatient:			Outpatient:			
Ethnicity:		White		Black		Hispanic		Asian		Native American
<p>Competent (4): Competent performance that supports communication/interaction and yields good interpersonal/group outcomes. Examiner observes no evidence of a deficit.</p> <p>Questionable (3): Questionable performance that places at risk communication/interaction and yields uncertain/interpersonal group outcomes. Examiner questions the presence of a deficit.</p> <p>Ineffective (2): Ineffective performance that interferes with communication/interaction and yields undesirable interpersonal/group outcomes. Examiner observes a mild to moderate deficit.</p> <p>Deficit (1): Deficit performance that impedes communication/interaction and yields unacceptable group outcomes. Examiner observes a severe deficit (risk of damage, danger, provocation, or breakdown of interpersonal group relations).</p>										
Physicality					Comments:					
Contacts	4	3	2	1						
Gazes	4	3	2	1						
Gestures	4	3	2	1						
Maneuvers	4	3	2	1						
Orients	4	3	2	1						
Postures	4	3	2	1						
Information Exchange					Comments:					
Articulates	4	3	2	1						
Asserts	4	3	2	1						
Asks	4	3	2	1						
Engages	4	3	2	1						
Expresses	4	3	2	1						
Modulates	4	3	2	1						
Stares	4	3	2	1						
Speaks	4	3	2	1						
Relations					Comments:					
Collaborates	4	3	2	1						
Conforms	4	3	2	1						
Focuses	4	3	2	1						
Relates	4	3	2	1						
Respects	4	3	2	1						
Comments:										

Reproduced with permission from: Forsyth L, Salamy M, Simon S, Kielhofner G. *The Assessment of Communication and Interaction Skill (ACIS) (OSA)*, Version 4.0. University of Illinois at Chicago: Chicago, IL; 2006: 48.

as they relate to engaging in activities with others (Form 9-2). In addition, the patient is asked to identify areas of strength and areas for improvement. This tool can be used for self-evaluation and reflection (when used in conjunction with a video observation and analysis). Goal setting and strategy implementation may also be incorporated after ACeS administration.²⁷

Recommended Instrument Use: Practice Option

The ACeS may be used when concerns about communication or interaction between the patient and his or her children, spouse (or significant other), siblings, or close friends have been identified. If patients have not had opportunities to engage in activities with their loved ones, this assessment will not be useful. The therapist may administer all sections or individual sections, based on the patient's circumstances. Findings from the assessment and self-reflections may be used for goal writing, family activity treatment sessions, and to help guide education and strategy adoption. **Note:** The patient identifies a particular loved one (eg, daughter, son, or spouse) and fills out the questionnaire with that *single individual* in mind.

Groups Tested with this Measure

These methods have not been formally tested on any groups.

Interpretability

Supplemented by findings from standardized assessments, the results from the ACeS will pro-

vide the occupational therapist with information that can be used throughout the occupational therapy process. For the purpose of goal setting, the ACeS will provide a subjective comparison of preinjury/postinjury coactivity engagement, self-perceived relationship traits, and patient priorities regarding traits and resumption of activities with loved ones. This information allows for a client-centered focus when developing treatment goals and interventions. In addition, subjectively reporting participation barriers may provide the therapist with insights into deficits not identified through standardized measures or observation. Patient responses can be used as a source for making treatment decisions, including environmental modification recommendations and strategy adoption. Additionally, the relationship trait questionnaire can be used for goal setting, self-reflection through video self-observation, and self-monitoring across the continuum of treatment.

Norms

There are no established norms for this self-report tool.

Mean Detectable Change

MDC is not established.

Responsiveness, Reliability, and Validity Estimates

Responsiveness, reliability, and validity estimates are not established.

DYADIC ADJUSTMENT SCALE

The Dyadic Adjustment Scale (DAS)³⁰ is a 32-question self-report questionnaire exploring adjustments in partner relationships. The DAS measures four areas associated with marital or relationship adjustment: (1) consensus on issues important to marital functioning, (2) dyadic satisfaction, (3) dyadic cohesion, and (4) expression of affection.

Partners are asked to rate the extent of agreement or disagreement in fifteen areas (eg, religion, leisure interests and activities, family finances, household tasks). Respondents are asked to indicate how often they engage in behaviors relating to marriage (eg, confiding in mate, quarreling with mate), how often they engage in activities together and how they feel about where the relationship is going.

Recommended Instrument Use: Practice Option

The DAS can be used with any couple, married or unmarried.³⁰ For the purpose of service members with c/mTBI, it may be used when resumption of spousal roles and associated activities has been identified as a concern. This evaluation should be done in conjunction with other assessment tools designed to gain an understanding of activity engagement, self-perception of parenting, and goals.

Administration Protocol/Equipment/Time

The DAS is given to married or partnered couples and can be administered as a paper-and-pencil task or in the course of an interview. Although the

FORM 9-2

ACTIVITY CO-ENGAGEMENT SELF-ASSESSMENT

Background

Spending time engaged in enjoyable activities with loved ones is one way of reestablishing relationships as you return home. The following questions have been designed to help your occupational therapist understand more about the activities you do with your loved ones (children, spouse, significant other [SO], etc) as well as the challenges you may face when spending time together. Please make an effort to answer questions as honestly as you are able. This information will help us set goals and plan treatment for your occupational therapy.

I am answering the questions that follow based on spending time and sharing activities with my (select **one**):

- child / children
- spouse or significant other
- close friend(s) or sibling(s)
- other (specify):

Here is more information about my loved ones (as identified above).

Child/children	Spouse/SO	Friend(s) or siblings(s)	Other
Name(s):	Name:	Name:	Name:
Age(s):	Age:	Age:	
	# of years together:	Nature of relationship:	Nature of relationship:

PART I: SPENDING TIME TOGETHER

This assessment describes my relationship with my (choose one): child/children spouse friend

- 1) List the activities you and your loved one(s) routinely did together prior to your last deployment and injury and how often you did them (ie, going to the movies twice a month; going to the park every Saturday).
- 2) List the activities you and your loved one are currently doing together.
- 3) List the activities you would like to engage in with your loved one on a routine or more frequent basis.
- 4) What activities have you and your loved one done together within the past week?
- 5) Which of the following issues are barriers that make it difficult for you to enjoy activities with your loved one? **Circle the response that best applies to you.**

	Yes	No	Sometimes
I have pain during activities.	Y	N	S
I have headaches during activities.	Y	N	S
I get dizzy during activities.	Y	N	S
I get angry during activities.	Y	N	S
I can't tolerate bright lights.	Y	N	S
I experience feelings of nausea.	Y	N	S
I become frustrated.	Y	N	S
I don't like to be touched.	Y	N	S

(Form 9-2 continues)

Form 9-2 continued

I can't pay attention to the game or activity.	Y	N	S
I feel like a bad person.	Y	N	S
I don't have enough time.	Y	N	S
No one listens to me.	Y	N	S
I get tired during activities.	Y	N	S
I have no transportation.	Y	N	S
The noise level bothers me.	Y	N	S
I don't know what to do with my loved one(s).	Y	N	S
I don't share the same interests with my loved one(s).	Y	N	S

PART II: HOW I CURRENTLY SEE MYSELF

Circle the appropriate response to how you see yourself as a **(circle one)** parent/spouse/friend.

My loved one would describe me as:	Never	Occasionally	Usually
Kind	N	O	U
Strict	N	O	U
Patient	N	O	U
Lazy	N	O	U
Selfish	N	O	U
Loving	N	O	U
Fair	N	O	U
Mean	N	O	U
Supportive	N	O	U
Unreliable	N	O	U
Caring	N	O	U
Encouraging	N	O	U
Nervous	N	O	U
Absent	N	O	U
Moody	N	O	U
Easygoing	N	O	U
Tolerant	N	O	U
Generous	N	O	U
Funny	N	O	U
Flexible	N	O	U
Forgiving	N	O	U
Committed	N	O	U
Respectful	N	O	U
Trustworthy	N	O	U
Bossy	N	O	U
Cooperative	N	O	U

(Form 9-2 continues)

Form 9-2 continued

1) The things I do best as a parent/spouse/friend are:

2) The things I would like to be better at as a parent/spouse/friend are:

amount of time it takes to complete the assessment is not indicated, the author suggests that it takes only a few minutes. The evaluation may be given to both partners independently or individual partners at any given time.³⁰

Groups Tested With This Measure

The scale has been used to evaluate partner adjustment across the demographic continuum since its development in 1976. It has not been used with couples where one has sustained TBI.

Interpretability

Scoring

Responses to the 32 items each carry a number value that can be summed to determine subscale scores and a total score. The scale ranges from 0 to 151.³⁰ Occupational therapists will likely gain more insight regarding patient-spouse relationships by reviewing subscale scores and patients' responses to individual items rather than trying to interpret a total score.

Mean Detectable Change

MDC is not available.

Responsiveness Estimates

Responsiveness estimates are not available.

Reliability Estimates

Internal consistency. Internal consistency reliability was determined for the DAS as well as the component subscales. This included 0.96 for the DAS; 0.90 for the dyadic consensus subscale; 0.94 for the dyadic satisfaction subscale; 0.86 for the dyadic cohesion subscale; and 0.73 for the affectional expression subscale.³⁰

Validity Estimates

Content validity. The 32 items were selected from an initial pool of approximately 300 items based on consensus among three judges that the item was indicative of marital adjustment.³⁰

Criterion validity. The scale was administered to 218 married people and a sample of 94 individuals who were divorced. Each of the 32 items in the scale correlated significantly with the external criterion of marital status.³⁰

Construct validity. The DAS is significantly correlated with other published marital adjustment scales (0.86 among married respondents; 0.88 among divorced respondents).³⁰

INTERVENTION: REENGAGING WITH SPOUSES, CHILDREN, FRIENDS

Professionals involved in helping service members reestablish family and social roles should be committed to team communication and reinforcing

interdisciplinary strategies that advance carry-over and minimize frustration and confusion for all involved.

The following evaluation and interventions strategies are based on the behavioral/cognitive-behavioral conceptual frame of reference. This frame of reference is based on the premise that cognitive processes are responsible for behaviors. In addition, adaptive responses are behavior based; feedback from adaptive responses change our cognitive processes as well as our behavior (Figure 9-2). For example, say your patient is a mechanic and has recently had a difficult time attending to his work tasks at the end of the day. This is typically when he cleans up his workstation, puts all of his tools away, and completes his paperwork for all the activities done throughout his shift. His problems with attention at the end of the shift have led to numerous errors in paperwork and organization of his workspace. His poor attention (cognitive processes) has led to behavior issues (poor organization and errors), which have led to “maladaptive responses,” including increased anxiety in the workplace, avoiding work activities, and general performance issues.

To turn this around, the therapist can provide assistance in structuring paperwork and returning tools and items to their storage places throughout the day. That way, his final tasks of the day (sweeping, general cleaning) require less attention and are better matches for his abilities at that time of day. Changing the structure and organization of the workday (cognitive processes) leads to better performance, which leads to habit formation, increased performance, and reinforcement of the new way of doing things.

If therapists suggest strategies that provide pa-

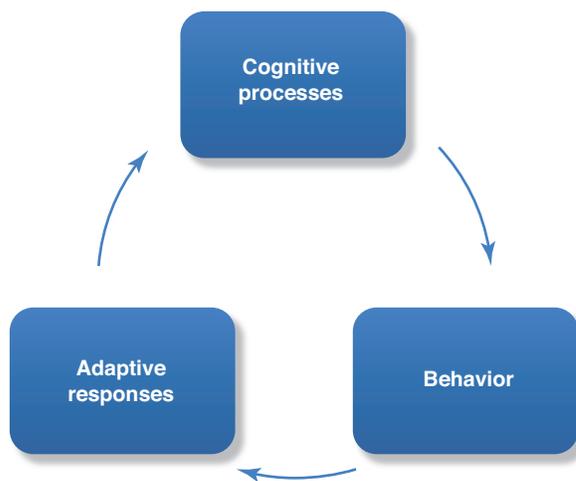


Figure 9-2. Behavioral/cognitive behavioral conceptual frame of reference.

tients with adaptive responses, they must provide therapy, reinforcement, and feedback that shapes behavior.³¹ In addition to the environment and context, it is assumed a number of inherent capacities will influence the feedback loop. These may include attention, memory, orientation, processing skills, perception, and interpretation. According to the behavioral/cognitive-behavioral conceptual model of practice, a therapist can affect change in three ways:

1. by working with the client to adopt adaptive behaviors in the context of relationships and abandon maladaptive ones,
2. by facilitating adaptive skill development, and
3. by working to change unsubstantiated perceptions of performance that may impair productive activity role resumption.

The strategies and interventions suggested for reengagement with friends, spouses, and children are based on these principles.

Recommended Use

The following may be used with service members who have returned home with c/mTBI and present challenges of reengagement with spouses, children, or friends. These challenges may have been identified by the service members themselves or by another interested party. Family members or friends must be available and committed to implement the following recommendations.

Strength of Recommendation: Practice Option

There is little empirical evidence to guide practice in this area; however, intervention is consistent with standard occupational therapy practices and reported as valuable by occupational therapists working with individuals with c/mTBI.

Intervention Methods

Reengaging as a Parent

Therapists will choose appropriate interventions based on their experience and knowledge of an individual patient’s needs. It is strongly recommended the therapist work with the patient and child during sessions to provide feedback and modeling.

1. Provide education regarding parenting skills (see Patient Handout: Understanding Your Child’s World—Toddler).
2. Help the patient understand and assess the demands of various child play activities and cognitive demands (see Patient Handout and Clinician Tip Sheet: Understanding the Structure of Play and Parent-Child Activities, and Patient Handout: Understanding the Environment of Play and the Role of Cooperation in Child-Related Activities).
3. Help the patient identify and use multiple resources for post-deployment family support (see Clinician Tip Sheet: Utilizing Resources for Family Reengagement).
4. Help the patient understand how and why c/mTBI may impact parenting (see Chapter 7, Cognitive Assessment and Impairment, “Multifactor Model Explaining Performance Declines after mTBI” and “Understanding Human Information Processing”).

Reengaging With a Spouse

1. Provide education regarding common issues for spouses after deployment (see Patient Handout: Reconnecting with Your Spouse or Significant Other).
2. Help the patient understand and assess the demands of various roles his or her spouse has adopted during deployment and assist in role reengagement (see Patient Handout and Clinician Tip Sheet: Reengaging in Household Roles and Activities, and Patient Handout: Dividing Roles With Your Spouse).
3. Help the patient understand how and why c/mTBI may impact his or her relationship with his or her spouse (see Chapter 7, Cognitive Assessment and Impairment, “Multifactor Model Explaining Performance Declines After mTBI” and “Understanding Human Information Processing”).

CLINICIAN TIP SHEET: UNDERSTANDING THE STRUCTURE OF PLAY, ROLES OF ENVIRONMENT, AND COOPERATION IN PARENT-CHILD ACTIVITIES

Background

Service members who return from lengthy and serial deployments will often find that returning to family roles presents a challenge. Symptoms associated with c/mTBI may only exacerbate these challenges. Potential issues associated with parenting should be discussed before patients return home or after they have returned and issues have been identified.

The role of the occupational therapist is to gain an understanding of the patient’s parental role performance anxieties and concerns, and provide education and strategies to facilitate role resumption. To do this effectively, the therapist must be aware of the cognitive and social-emotional issues that may place barriers between the patient and effective role performance, as well as with task elements, such as levels of structure and the cooperative continuum in parent-child play. It is also important that the therapist have a grasp on child developmental play so as to suggest and present appropriate activities.

Therapy Approaches to Improving Resumption of Parent Roles

1. Goals associated with parent-child interaction should be developed in

collaboration with the patient (and spouse if appropriate).

2. Evaluation tools, such as the COPM and ACeS, and observation should be used to discuss strengths and areas of concern.
3. If possible, evaluation and interventions should include a large observation component; the therapy clinic should have a number of developmentally appropriate toys as well as a “safe and private” play space.
4. When choosing play activities for the clinic, use those that span the continuum of structure to provide opportunities to rehearse and adopt strategies and skills.
5. Provide education about play and structure (Table 9-7).
6. Parent-child clinic work should be planned in advance, with the patient generating activity ideas. Facilitate identification of activities that are unstructured, semistructured, and structured, and plan on at least one activity in each area.
7. Have the patient predict his or her performance. Use predications based on previously generated goals.
8. The parent-child session will include a brief overview of the session and, if appropriate,

TABLE 9-7
GUIDE FOR PROVISION OF STRUCTURE

Level of Structure	Examples of Activities	Cognitive Demands Associated With Level of Structure
Structured (typically this level of structure is not tolerated by infants and toddlers. At the age of 5, children begin to successfully engage in more structured play)	Model building, some cooking activities (eg, baking, construction tasks, board games, video game, many sports)	Organization and planning, sequencing, error detection and correction, attention to detail, memory, time management, ability to shift focus, ability to understand and follow rules and directions
Semi-structured (toddlers to adult-aged kids)	Puzzles, arts and crafts, pretend play, some sports, some video games	Task initiation, organization and planning, error detection and correction, flexibility, time management, attention
Unstructured (all ages)	Some arts and crafts, such as free drawing and play dough, sand play, water play, dancing	Task initiation, creative thinking, planning and organization, flexibility, time management

- the child's predication of how the session may go based on the activities chosen.
9. The therapist will provide added or decreased structure, grade task materials for increased or decreased collaboration, and cue for strategy implementation.
 10. A reflection will be done immediately after the session. If the activity was videotaped, the therapist and the patient should review the tape.
 11. If indicated, the therapist will provide modeling behaviors for parent-child interaction.
 12. Help the patient identify how much structure is needed in play activities to op-

- timely interact with his or her children at home (see Table 9-7). Therapists can have some control over the level of structure by changing game rules, adding directions, or modifying activity-based play goals.
13. Help the patient determine what types of cognitive strategies might improve his or her ability to satisfactorily engage with his or her children during play. Provide opportunities (via homework or in-clinic activities with children) for the patient to practice these strategies.
14. The patient will keep a parent-child activity log to review with the therapist in person or by email.

CLINICIAN TIP SHEET: REENGAGING IN HOUSEHOLD ROLES AND ACTIVITIES

Background

Role conflict is a source of marital stress following deployment even in healthy service members³²; the addition of potential inefficiencies associated with c/mTBI can increase the conflict surrounding role reengagement and negotiation. Role participation, performance, and satisfaction can be evaluated through interview, the COPM, and the ACeS (spouse version). In addition, the associated patient handout can be used as an evaluative and therapeutic tool in the clinic.

Therapists may also help patients resume home roles and responsibilities in the following ways.

- Help partners realistically prioritize. When working with patients and their partners on role negotiation, it is important to evaluate the skills necessary to perform identified roles and the context in which they are going to be done. For example, if a patient wants to resume the role of money management (banking, bill paying, and budgeting), the therapist must explore the subtasks the patient must do successfully to fully complete those tasks. In addition, performance evaluation must be consistent with the context. Are money management activities done online only, offline only, or

a combination of the two? Using the strategies introduced in Chapter 7 (Cognitive Assessment and Intervention) can help when dividing role tasks and activities needed to fully participate in areas that are a priority.

- Work with both partners during treatment sessions. Address role resumption in a partnership between the patient and the spouse. Provide strategies and skills to facilitate negotiation and successful collaboration.
- Include information about cognitive task demands. Incorporate an education dimension to therapy; provide information about cognitive task demands as related to role activities and assist in determining appropriate levels of performance.
- Engage in real-life activities as they relate to roles. Create budgets based on the couple's income and expenses, make sandwiches, do laundry, plan vacations. Observe com-

munication styles and points of conflict during these tasks and provide feedback and suggestions to improve performance.

- Become a partner in scheduling role activities (see calendar example located in associated patient handout). This can be done face to face or through email. The journal entries completed individually by the patient and spouse will help you better understand barriers to optimal performance.
- Reflect with the couple. Consider videotaping observations of co-occupational engagement. You may want to employ the ASIS to structure activity negotiation and engagement. The ASIS can also be used by the couple to evaluate performance during video reflections.

Remember, as a rehabilitation specialist, your job is to work with the couple to help them successfully divide and conquer.

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SECTION 3: RETURN TO SCHOOL

RETURNING TO SCHOOL

Service members who have sustained c/mTBI are typically younger adults acquiring vocational skills or training to qualify for promotion, or veterans returning to school to pursue new careers. Persisting cognitive and psychosocial difficulties present as significant barriers to successful classroom participation and learning.^{33,34} Students with a history of TBI report studying longer and with more effort, and require greater use of study strategies than they did prior to sustaining their injuries.³⁵ Moreover, they have greater difficulties with memory, executive functions, socialization, and academic skills than students without TBI.^{36,37} While the majority of research investigating return to school has focused on students with moderate to severe TBI, subtle challenges have been reported by students with c/mTBI. Cognitive symptoms (eg, memory, attention) and psychosocial problems (eg, aggression, depression, reduced frus-

tration tolerance) impact their transition to college.³⁸

Because psychosocial factors appear to impact academic performance for students with c/mTBI,³⁶ the clinician should consider comorbidities that may be associated with postdeployment, such as hypervigilance, irritability, low frustration tolerance, depressed mood, fatigue, sleep dysfunction, headache, dizziness, balance, vision and hearing problems, and pain (see Clinician Tip Sheet: Postdeployment Factors and Academic Performance). Facilitating return to school involves assessing skills specific to academic performance (see Clinician Tip Sheet: Needs Assessment–Return to School), and teaching compensatory strategies (see clinician tip sheets and patient handouts in this section, and in Chapter 7, Cognitive Assessment and Intervention). The initial assessment identifies the service member's current academic status or plan, performance level, and goals to guide the intervention plan. In addition

to instruction on strategies to enhance academic performance, service members may benefit from guidance applying for admission, facilitating success by matching their performance level with academic program demands, and advocating for accommodation services (see Clinician Tip Sheet: College Accommodations for Students With Cognitive Disabilities).

Strength of Recommendation: Practice Option

Although empirical guidelines for return to school after TBI do not exist, the literature indicates that cognitive and psychosocial challenges associated with TBI are strongly correlated with the difficulties people experience as they return to school. There are numerous practice guidelines for treating cognitive and psychosocial sequelae of TBI.^{36,39-43} This knowledge can be used to develop rehabilitation models that go beyond standard academic accommodations and provide effective cognitive and behavioral strategies that support successful return to school after c/TBI.

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Intervention Methods

1. Complete a needs assessment (see Clinician Tip Sheet: Return to School Needs Assessment, and Patient Handout: Return to School Needs Assessment / Essential Skills for College Success).
2. Provide patient education (see Clinician Tip Sheet: Postdeployment Factors and Academic Performance and Clinician Tip Sheet: College Accommodations for Students With Cognitive Disabilities).
3. Teach strategies to improve reading comprehension (see Patient Handout: Study Reading Systems and Clinician Tip Sheet: Reading Strategies).
4. Teach strategies to improve note taking (see Clinician Tip Sheet and Patient Handout: Note-Taking Strategies).
5. Teach test-taking strategies (see Clinician Tip Sheet and Patient Handout: Test-Taking Strategies).

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CLINICIAN TIP SHEET: RETURN-TO-SCHOOL NEEDS ASSESSMENT

Background

Assessing changes in cognitive function and self-awareness and identifying strengths and weaknesses and barriers to learning is critical when designing an intervention plan to facilitate a service member's return to school. The Essential Skills for College Success⁴⁴ survey helps identify potential challenges in returning to school that can be used in conjunction with other assessment tools to evaluate cognitive deficits. It is a self-assessment scale for students who have been deployed to rate their level of difficulty in academic skills and predict their success in college. Survey areas include listening, note taking, reading, remembering, organizing, writing papers, working in groups, and making presentations. Periodic reassessment using this tool provides

a way to quantify outcome measures (see Patient Handout: Return to School Needs Assessment / Essential Skills for College Success Handout).

Ongoing assessment of the service member's school performance enables interdisciplinary team members (eg, vocational rehabilitation counselors, mental health providers, social workers) to identify and address needs, as they arise, to facilitate school success. Assessment results also provide support for the clinician to advocate for appropriate adaptations, modifications, and accommodations for the service members (see College Accommodations for Students With Cognitive Disabilities; also see Clinician Tip Sheet: Electronic Memory and Organization Aids—Smartphone and Mobile Applications in Chapter 7, Cognition Assessment and Intervention).

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CLINICIAN TIP SHEET: POSTDEPLOYMENT SYMPTOMS THAT CAN INFLUENCE ACADEMIC PERFORMANCE

Background

The return-to-school transition for service members with c/mTBI can be complicated by psychosocial comorbidities.³⁶ Postdeployment symptoms may include hypervigilance,⁴⁵ irritability and low frustration tolerance, anxiety, sleep dysfunction and fatigue, physical symptoms (eg, pain, headache, dizziness, balance, and vision and hearing problems), medication side effects, depressed mood, memory deficits, and attention and concentration difficulties.⁴⁶

Clinicians should consider the influence of these deployment-related symptoms on the student's ability to attend to and comprehend lectures, take notes, recall information, write papers, comprehend and retain reading material, and study for and take tests. The following postdeployment symptoms and suggestions are intended to help clinicians understand the potential influence of symptoms

and provide strategies to decrease their impact on academic performance.

- **Hypervigilance** is a symptom associated with the constant need to monitor the environment for potential danger.⁴⁵ In the school setting, this may divide the student's attention and interfere with the ability to process information presented in the classroom and while studying or taking tests. Service members often manage hypervigilance by acclimating to the campus environment and classroom prior to the start of the classes, and by sitting in a location within a classroom that allows them to monitor all individuals in the room, with their back against a wall or facing the door, ready for rapid evacuation.
- **Irritability and low frustration tolerance** may be triggered by disrespectful behaviors

of classmates that do not align with military standards of conduct. This may include classmates talking during a lecture, not completing work in a timely manner, or challenging authority figures. Additionally, service members may become frustrated by the increased time and effort involved in learning new information. Self-regulation and behavioral management strategies can facilitate successful reintegration into the academic setting. Promote understanding that learning requires time and effort, and that effective behavior- and time-management strategies can help reduce the frustration and anxiety associated with returning to school.

- **Fatigue and sleep dysfunction** are common postdeployment symptoms^{47,48} that may interfere with attention and concentration and impact reading efficiency and lecture understanding. For management strategies, refer to Patient Handout: Fatigue Management—Factor and Strategy Awareness.
- **Medications** for pain, sleep, and mental health conditions may have side effects that impact alertness and interfere with attention, concentration, and the ability to retain information. Providing feedback to prescribing physicians regarding negative side effects will assist in efficient medication management.
- **Physical symptoms** associated with postdeployment, such as pain, headache, dizziness, balance, vision, and hearing

problems^{49,50} can interfere with receiving and interpreting written and spoken information. Pain tends to command attention and may compromise the ability to dedicate full attention to lectures and course work, as well as influence class attendance. Physician consultation to manage physical symptoms that interfere with school performance is important.

- **Anxiety, worry, and stress** may result in thoughts that interfere with the ability to attend to, concentrate on, process, and retrieve information. Anxiety may divert concentration during class and increase vulnerability to thought intrusions. Anxiety may also interfere with test taking and make it difficult to initiate assignments when feeling overwhelmed, which contributes to procrastination. Behavioral, organizational, and time-management strategies can assist with initiating and accomplishing assignments, managing anxiety, stress, and feeling overwhelmed.
- **Unrealistic expectations** can interfere with return to school after deployment. Military training provides service members with skills to successfully execute their education plan, including the ability to focus and perform under pressure. Encourage service members to approach college as their next mission, realizing that success is possible with the use of compensatory strategies. Patience, perseverance, and realistic expectations are important to their school success.

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CLINICIAN TIP SHEET: READING STRATEGIES

Background

Reading strategies can be passive or active. Active strategies are more effective because they require purposeful effort to increase meaning by developing relationships between information presented and previous knowledge and experiences, making judgments and predictions about the information, and creating connections between different ideas. College-level reading requires active participation on the part of the reader to facilitate recall of information.⁵²

Three Components of Reading Strategies

To optimize the use of reading strategies, preparation involves controlling internal conditions (eg, pain, stress, fatigue) and the external study environment (eg, noise, distractions), and employing strategies that can assist with redirecting attention focus. For information on strategies to manage personal and environmental factors that may distract or prevent optimal studying, refer to Clinician Tip Sheet: Understanding the Multifactor Model of Functioning After Concussion in Chapter 7, Cognitive Assessment and Intervention). Effective reading strategies have components that address organization, isolation, and elaboration.⁵³

Organization Strategies

Organization strategies activate the readers' attention before they begin to read by cueing their awareness regarding their knowledge on the topic and connections to new information. Strategies include:

- **Previewing.** Previewing or scanning material prior to reading for comprehension activates previous knowledge about the topic, aids in organization, and establishes the purpose for reading the text. This step is similar to looking at the picture on a jigsaw puzzle box prior to putting the pieces together or knowing the scope of a mission before planning (see Patient Handout: Study Reading Systems).
- **Graphic or concept mapping.** This may be used as a pre- or postreading strategy to process and organize information in a

visual format. This is done while reading by creating timelines, tree diagrams, or web-shaped diagrams that connect main ideas with supporting details and requires the ability to identify relationships between and among ideas. Concept mapping software is available that can help with this tactic (eg, Inspiration 9, which can be downloaded from www.inspiration.com/).

Isolation Strategies

Isolation strategies include underlining, highlighting, and note taking. Selecting key points from a text reduces the amount of information to retain.

- **Underlining and highlighting** are passive methods that can help focus attention on the text being read and require the reader to identify the main idea of passages or paragraphs and discriminate between important and unimportant information.
- **Note taking** while reading is an active strategy that involves transforming written text into information that is meaningful to the reader. By organizing information into main points and supporting details, readers are able to self-monitor how well they understand the information, relate new information to previous knowledge, and make judgments and predictions. Note taking is effective only when notes are in the reader's own words and are reviewed after they are written.⁵²

Elaboration Strategies

Elaboration strategies include self-questioning and rehearsing information aloud. These strategies facilitate an awareness of relationships between new information with prior knowledge and information that is inferred.

- **Self-questioning strategy** requires the reader to ask *who, what, when, where, how*, and, more importantly, *why* questions while reading. Self-questioning focuses attention, prompts retrieval of information, helps readers self-monitor their

comprehension, encourages prediction of test questions, and fosters a deeper processing of information.

- **Rehearsing information aloud** is a strategy in which readers “teach” themselves new information by restating it in their own words. Rewording new information requires readers to associate new concepts

with prior knowledge, summarize key ideas, and reflect on personal reactions.

These strategies are effective with regular information review. Rereading information is a passive review technique that does not result in the same degree of retention that can be achieved through actively retrieving information multiple times.⁵⁴

Selected References

Holschuh JP, Aultman LP. Comprehension Development. In: Flippo RF, Caverly DC, eds. *Handbook of College Reading and Study Strategy Research*. 2nd ed. New York, NY: Routledge; 2009: 121–144.

Hooper CH. *Practicing College Learning Strategies*. 5th ed. Belmont, CA: Wadsworth, Cengage Learning; 2010.

Mulcahy-Ernt PI, Caverly DC. Strategic Study-Reading. In: Flippo RF, Caverly DC, eds. *Handbook of College Reading and Study Strategy Research*. 2nd ed. New York, NY: Routledge; 2009: 177–198.

CLINICIAN TIP SHEET: NOTE TAKING

Background

Note taking is a critical aspect of achieving academic success and is required in multiple contexts and formats, including when listening to lectures, briefings, or instructions, and while reading textbooks, articles, or onscreen text. Although college students spend approximately 80% of class time listening to lectures,⁵⁵ they typically record incomplete notes, including only 20% to 40% of the important lecture ideas.^{56,57}

Note taking is a complex and demanding cognitive activity involving attending to oral instructions or written text, selecting important facts and concepts, manipulating information in working memory, interpreting information, deciding what to record, and writing or typing the information. These almost simultaneous demands are made on multiple cognitive processes.

- During lectures, the time urgency of selecting and recording key points while comprehending new information places significant demands on executive functioning and memory. Although the typical speaking speed is approximately two to three words per second, the average writing speed is approximately 0.2 to 0.3 words per second.⁵⁸
- Postdeployment factors that may impede the complex task of note taking include difficulty with attention, reduced speed of processing, decreased working memory,

and problems with executive functioning (see Clinician Tip Sheet: Deployment Related Factors That Can Influence Academic Performance).

Methods to Improve Note Taking

Methods to improve note taking and facilitate learning from lectures based on generative theories of learning include improving the completeness of notes, making relationships among lecture ideas, and making relationships between lecture ideas and prior knowledge. Self-questioning and summarizing are more effective strategies than taking and reviewing notes because they require a student to construct their own meaning of the lecture. This underscores the importance of summarizing and revising notes after classes.⁵⁹

Instructors can improve note taking in lectures by providing students with a list of main ideas or topics and subtopics to improve selective attention and guide note taking on the most important information.⁶⁰

Methods to Organize Notes

Methods to organize notes include the Cornell method, two-column method, margin notes, outlining, mapping, charting, topic and concept cards (flashcards), side notes for onscreen text, and intentional reading for written text (see Patient Handout: Memory Strategy–Intentional Reading).

Additional resources on note-taking methods include the following:

- Academic Skills Center, Dartmouth College. www.dartmouth.edu/~acskills/success/notes.html.
- California Polytechnic State University Student Academic Services, Academic Skills Center. www.sas.calpoly.edu/asc/ssl/notetakingsystems.html.
- Penn State University Center for Academic Achievement. www.sl.psu.edu/Documents/Note_Taking_Strategies.pdf.
- Stanford University Office of Accessible Education, Strategies for Academic Success, Suggestions for Note Taking. www.stanford.edu/dept/undergrad/cgi-bin/drupal_ual/sites/default/files/common/docs/ctl_notetaking.pdf.
- Princeton University, The McGraw Center for Teaching & Learning. www.princeton.edu/mcgraw/library/for-students/.

Assistive Technology Aids

Assistive technology aids may improve note taking, provided they do not serve as a distraction. The following are common aids for note taking:

- digital audio/voice recorders that record spoken information for future reference to reconcile with written notes.
- smart pens that provide simultaneous audio recording of lecture and visual recording of notes that can be downloaded onto a computer.
- laptop computers and tablets for taking notes in lectures.
- text-to-speech software that converts text to audio.
- applications for note taking on computers and tablets.
- software applications for taking notes on electronic text that allow side-by-side on-screen note taking and editable portable document format (PDF) files.

Selected References

- Armbruster BB. Taking notes from lectures. In: Flippo RF, Caverly DC, eds. *Handbook of College Reading and Study Strategy Research*. 2nd ed. New York, NY: Routledge; 2009:220–248.
- Cohn E, Cohn S, Bradley J. Notetaking, working memory, and learning principles of economics. *J Econ Educ*. 1995;26:291–307.
- Kiewra KA. A review of note taking: the encoding-storage paradigm and beyond. *Educ Psychol Rev*. 1989;1:147–172.
- Kiewra KA. Students' note-taking behaviors and the efficacy of providing the instructor's notes for review. *Contemp Educ Psychol*. 1985;10:378–386.
- O'Donnell A, Dansereau DF. Learning from lectures: effects of cooperative review. *J Exp Educ*. 1993;61:116–125.
- Piolat A, Olive T, Kellogg RT. Cognitive effort during notetaking. *Appl Cogn Psychol*. 2005;19:291–312.

CLINICIAN TIP SHEET: TEST-TAKING STRATEGIES

Meeting assignment deadlines and having adequate time to study for tests is dependent upon efficient organization and prioritization. The key to managing time is developing a study schedule based on accurate judgments of the time required to learn and retain new information, complete reading and writing assignments, and review and study for tests. Although schedules are modified according to pain, fatigue, and mood levels, a study schedule will provide the structure that supports motivation, enhances efficiency, and helps avoid procrastination.

A realistic study schedule will also help reduce anxiety by providing a visual timeline for completing course assignments and preparing for tests. This is critical for service members whose educational benefits depend on them passing college courses. In military service, service members are required to develop clearly defined goals, adhere to stringent deadlines, and fulfill duty responsibilities. Course syllabi offer this same structure. The following are suggestions that will promote success in time management and preparing for tests.

- Based on the patient's strengths and preferences, select a planner system (eg, paper planner or calendar, smartphone, tablet computer, dry-erase board) to consolidate school, study, and personal commitments, including exam dates from course syllabi. This will provide a visual overview and engage the patient in planning and prioritizing tasks.
- Assist the patient in establishing realistic timelines by estimating time needed to complete tasks (eg, reading and creating a study guide for each chapter). Have the patient predict, then compare the actual time required to complete tasks to increase self-awareness and time management.
- Guide the patient to use the planner to track daily task progress and review, reorganize, and reprioritize to-do lists as needed to allow adequate time to prepare and study for tests.
- Inform the patient of accommodation services for test taking available through the school.
- Reinforce strategies that enhance retention, such as making associations with prior knowledge and experiences, generating questions about the information, and creating visual tools, such as concept maps, timelines, notes, or webs. These strategies increase the meaningfulness of information and enhance recall.
- Help the patient identify and minimize or eliminate distracters that interfere with concentration and learning. Distracters may be internal or personal (eg, hunger, fatigue, pain, medication effects, depression, anxiety, anger, irritability) or external or environmental (eg, poor lighting, noise, uncomfortable chair, cluttered desk, incoming phone calls, text or email messages).
- Develop redirection strategies to lengthen the time of effective studying (eg, positive self-talk, standing and stretching, getting a drink of water to get back on track).
- Teach strategies to improve recall and retention of information (eg, distributed across multiple sessions rather than "cramming" in a mass practice session).⁶¹

Selected References

Baddeley AD, Eysenck M, Anderson M. *Memory*. New York, NY: Psychological Press; 2009.

University Seminar at Middle Tennessee State University, Study Skills Help Page, Learning Strategies for Success, <http://frank.mtsu.edu/~studskl/>.

CLINICIAN TIP SHEET: COLLEGE ACCOMMODATIONS FOR STUDENTS WITH COGNITIVE DISABILITIES

Americans With Disabilities Act Amendments Act of 2008

In accordance with the Americans with Disabilities Act Amendments Act of 2008, students with TBI or PTSD are entitled to receive services and accommodations for symptoms that may affect their academic performance.⁶² Colleges and universities have adopted nondiscrimination policies and procedures to support the full participation of students requesting accommodation services, programs, and activities (Exhibit 9-9).

All colleges and universities have some kind of office for students with disabilities that provides reasonable accommodations and support for students with documented disabilities at no charge. Confidential information is shared with classroom instructors only with the student's permission.

To initiate services and accommodations, documentation from a qualified professional is needed

to verify the presence of a disability and potential impact within an academic setting. To ensure timely service, a request for services should be submitted several weeks prior to the start of the semester. Check with each college for its specific requirements. Guidelines for disability documentation are available through the Association on Higher Education and Disabilities (www.ahead.org/resources/best-practices-resources/elements).

Although resources vary among colleges, types of accommodations may include:

- early class registration and registration assistance
- academic counseling
- extended time to take exams
- extended time to complete projects, papers,

EXHIBIT 9-9

AMERICANS WITH DISABILITIES ACT AMENDMENTS ACT OF 2008

The Americans With Disabilities Act Amendments Act (ADAAA) of 2008 defines a disability as “a physical or mental impairment that substantially limits one or more major life activities.” It states that “an individual would be substantially limited in a major life activity if the individual’s major life activity or activities are materially restricted as to the condition, manner or duration under which he or she performs the activity as compared to most people.”

According to the ADAAA, major life activities include: “seeing, hearing, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working.” An impairment may be substantially limiting even if its impact is only episodic. Prescribed medications may further impair academic performance.

The invisible nature of postdeployment symptoms makes it necessary for the student to self-identify. In the college setting, nondisclosure of limitations is a significant issue, in part because individuals do not want to be considered as disabled by either themselves or others.¹ Additionally, career fields (eg, security, criminal justice, law enforcement) may require background checks in which certain disability history may not be favorable.²

1) Church TE. Helping student-veterans poses unique challenges. *Disability Compliance in Higher Education*. 2008;13(4). 2) Burnett SE, Segoria J. Collaboration for military transition students from combat to college: it takes a community. *J Postsecondary Educ Disabil*. 2009;22(1):233–238.

- and assignments
- exams in a distraction-reduced area
- note-taking assistance
- tutoring (also available through campus learning centers)
- lecture notes prior to class, if available
- being allowed to stand during class to relieve body pain
- use of recording devices during class (digital recorders)
- assistive technology to convert speech to text, digital text to speech, or documents to alternative formats or sizes
- alternate format exams

Additional accommodation resources may be available through the following sources:

- **Tutorial Assistance Program:** Tutorial assistance is available through the Veterans Affairs Post 9-11 GI Bill for students “receiving VA educational assistance at the half time or more rate and who have a deficiency in a subject making tutoring necessary.” Toll free number: 1-888-442-4551.
- **Computer/Electronic Accommodations Program:** The Computer/Electronic Accommodations Program (www.tricare.mil/cap) serves active duty service members and federal employees with disabilities to ensure they receive appropriate accommodations (eg, assistive technology) and services to support their recovery, rehabilitation, and reintegration.

Selected References

Burnett SE, Segoria J. Collaboration for military transition students from combat to college: it takes a community. *J Postsecondary Educ Disabil*. 2009;22(1):233–238.

Church TE. Helping student-veterans poses unique challenges. *Disability Compliance Higher Educ*. 2008;13.

Additional Resources

Montgomery College, Maryland. <http://cms.montgomerycollege.edu/EDU/Plain.aspx?id=10283>. Accessed September 13, 2013.

US Department of Veteran’s Affairs. http://www.GIBILL.va.gov/resources/education%5Fresources/programs/tutorial_assistance_program.html. Accessed September 13, 2013.

US Equal Employment Opportunity Commission. <http://www.eeoc.gov/laws/statutes/adaaa.cfm>. Accessed September 13, 2013.

SECTION 4: RETURN TO DUTY

INTERVENTION: PERFORMING WORK ROLES AND RETURN TO DUTY

In addition to impacting performance in self-care, home management, and family- and community-based activities, c/mTBI can significantly disrupt an individual's ability to function in job roles. Perceived inadequacy in one's occupation can undercut personal competency and self-efficacy, which may, in turn, have a detrimental effect on productivity and work quality.

Recent research on return to work following head injury has attempted to answer questions such as the following:

- What are the rates of return to work?
- What factors are indicators of successful return to work?
- What interventions are effective in enhancing return to work?

Answers to these questions can be complicated by variables including injury severity, variations in the definition of return to work, and availability of vocational rehabilitation services.

A review by Shames, Treger, Ring, and Giaquinto suggests that injury severity and lack of self-awareness may be the most significant indicators of failure to return to work.⁶³ Specifically, a strong correlation was found between self-awareness and favorable employment outcome.⁶⁴ Associations have also been made between failure to return to work and psychiatric history, violent mechanism of injury, and prior alcohol or drug use.⁶⁵ Impaired cognition, including inattention, impaired memory, slower processing speed, and decreased verbal skills seem to interfere with return to work as well.⁶⁶

Civilian literature focusing on c/mTBI reveals that only 12% of patients with c/mTBI following motor vehicle accidents were able to return to full pre-morbid level of employment, with 30% able to return to modified work.⁶⁷

Occupational therapy intervention in this realm embodies two complementary approaches: 1) instruction in compensatory cognitive strategies that is functionally compatible with the service member's job requirements (see Cognitive Assessment and Intervention for more information

about compensatory cognitive strategies); and 2) completion of simulated work tasks of increasing realism to evoke an adaptive response to challenges. Simulated work tasks may incorporate implementation, rehearsal, and refinement of compensatory strategies.

When addressing issues related to return to work, it is important to consider the following:

- When instructing service members in the use of cognitive compensatory strategies, be sure to discuss their implementation in the work environment. Brainstorm with the service member about what types of adaptive equipment and strategies will be feasible in training and combat.
- Consider the impact of stress on job performance. Rehabilitation clinicians often instruct patients to learn to control their environments and approaches to limit stress when possible. However, it is unrealistic to think that stress will be controllable in combat. It is important to allow real-world time constraints, environmental distractions, activity complexities, multitasking demands, and anxiety-provoking stimuli to be present during some therapeutic activities when preparing service members to return to work.
- Ensure therapy moves from static to dynamic, structured to unstructured, controlled to uncontrolled, and predictable to unpredictable. By placing service members in realistic situations, occupational therapists can facilitate adaptive responses, both neuroplastic and compensatory. The desired outcome is that when the conditions of performance are stressed, the functional impact of identified deficits will be diminished or remediated.
- Note that traditional cognitive testing may not fully reveal deficits, which may only be evident under real-world demands. When setting goals, combine testing results with observations during functional vocational simulations to pinpoint specific areas of deficiency.

Strength of Recommendation: Practice Option

There is little empirical evidence to guide practice in this area; however, intervention is consistent with standard rehabilitation practices and reported as valuable by clinicians working with individuals with c/mTBI.

Intervention Methods

Intervention methods include the following tasks.

- Remedial activities based on Soldier's Manual of Common Tasks⁶⁸ (see related patient handouts and clinician tip sheets), including the following:
 - locating topographical symbols on a military map,

- determining the grid coordinates of a point on a military map, and
- performing first aid for bleeding of an extremity.
- Vocational simulations of moderate complexity (see related patient handout and therapist tool), such as:
 - administrative tasks, and
 - job-specific tactical simulations.
- Return-to-duty performance validation (see related patient handout and clinician tip sheet).

Note: The remedial and simulated return-to-duty tasks described in this toolkit are designed for service members who have demonstrated at least basic competency using compensatory motor, visual, or cognitive strategies.

RETURN-TO-DUTY PERFORMANCE VALIDATION PROGRAM

The following is a **practice option** that has been adopted at Fort Campbell, Kentucky. It is continually being developed and refined, and it is understood that this program may be difficult to replicate at other locations due to the variable availability of and cooperation among the many parties involved. However, the concept of "performance validation" is central to occupational therapy intervention related to determining a service member's readiness to return to duty.

The Return-to-Duty Performance Validation Program is a multidisciplinary, functional assessment that takes place over 10 treatment sessions. It is the last step in the TBI treatment process and incorporates a "top down" evaluative approach.

During the program, service members participate in both didactic and real-life, application-based training activities. Many of the training activities are those that are supported by the installation and regularly used by units for training. During the activities, service members are evaluated based on overall performance and independence. Team members from several therapeutic disciplines are involved, including occupational therapy, physical therapy, and mental health. Each provider assesses behavior according to his or her scope of practice. Specifically, occupational therapists comment on visual, cognitive, and fine motor skills; physical therapists comment on balance and vestibular reactions; and mental health providers comment on managing psychological

stress and anxiety (Form 9-3).⁶⁹

The performance validation sessions are arranged to present service members with gradually increasing task complexity and psychological demand. In doing so, occupational therapists can assess the service member's ability to generalize strategies learned and implemented in the clinic to approximations of real-world situations. Service members are monitored closely by mental health providers and participate in weekly biofeedback sessions to learn to actively control adverse reactions to stress. If service members display balance deficits that impact task performance, they then participate in physical therapy sessions targeting compensatory strategies.

The "critical tasks" involved in Fort Campbell's Return-to-Duty Performance Validation Program are outlined below. This progression may not be possible to replicate everywhere based on the availability of the required training and equipment; however, this task list may be modified to incorporate other common tasks that are deemed appropriate and for which resources are more readily available.

Task 1: Didactic Review of Eagle First Responder Skills, Followed by Practice Exercise

Review the principles of tactical combat casualty care via slideshow presentation and discussion. Practical exercises consist of basic casualty simulations to rehearse applying tourniquets, pressure

dressings, and occlusive dressings for an open chest wound. Environmental distractions and stressors should be minimized to facilitate learning. The service member should:

- Verbalize understanding the difference among the three levels of care (care under fire, tactical field care, and casualty evacuation).
- Demonstrate manual carries for casualty evacuation.
- Be able to call up a 9-line medical evacuation (MEDEVAC) request based on a given scenario (radio use).
- Evaluate a casualty using “CBA” (check circulation, breathing, and airway).
- Demonstrate appropriate hemorrhage control (apply a tourniquet and a pressure dressing).
- Check for an exit wound.
- Seal an open chest wound.
- Open and maintain an airway (head tilt, chin lift [when appropriate], jaw thrust, insert a nasopharyngeal tube).
- Address tension pneumothorax (be able to identify tension pneumothorax and accurately simulate needle decompression).^{68,70}

Task 2: Rollover Training Using High-Mobility Multipurpose Wheeled Vehicle Egress Assistance Trainer

High-Mobility Multipurpose Wheeled Vehicle (HMMWV) Egress Assistance Trainer (HEAT) instructors present a 20- to 30-minute class on HMMWV rollover safety. Service members then complete three rollover simulations (basic egress, egress with limited visibility [blindfolded], and egress out the turret). On the final simulation, service members must extract a simulated casualty, perform Eagle First Responder (EFR) treatment, and call up a 9-line MEDEVAC request. The service member must:

- Yell “rollover” at critical rollover angle (30 degrees).
- Demonstrate appropriate HMMWV egress techniques (speed of egress; egress under variable conditions, such as reduced vision or in water; egress out the turret).
- Demonstrate appropriate response for various roles (tank commander, driver, back seat, gunner).
- Demonstrate appropriate extraction of a casualty (may use mannequin).
- Perform EFR skills to treat casualty.

- Call up a 9-line MEDEVAC request.^{68,70-72}

Task 3: Required Physical Tasks and Drill and Ceremony Review

These are physical tasks completed at various stations and supervised by participating clinicians. They may require the service member to:

- Don gas mask per Army standard (under 9 seconds).
- Don mission-oriented protective posture (MOPP) suit per Army standard.
- Describe the five levels of MOPP (0 through 4).
- Simulate casualty evacuation using combat litter.
- Complete physically demanding activities to bring heart rate to 85% of maximum heart rate without requiring intervention due to increased headache, dizziness, imbalance, or nausea. Activities may include 3- to 5-second rushes, combat rolls, push-ups, sit-ups, and the like.
- Demonstrate ability to lead and follow drill and ceremony commands according to rank or experience. The following commands are required: facing movements, forward march, column left/right, and rear march.⁶⁸

Task 4: Zero and Qualify Weapon Using Engagement Skills Trainer

For this task, the service member must:

- Demonstrate understanding of basic marksmanship skills (steady position, aiming, breath control, and trigger squeeze).
- Zero and qualify with the assigned weapon (primarily M-4).
- Identify all parts of the weapon.
- Perform function check on weapon.
- Clear weapon.
- Demonstrate adequate visual skills, including visual recognition, accommodative facility / flexibility, visual processing speed, fixation, and hand-eye coordination.⁶⁸

Task 5: Combat Scenarios Using Virtual Combat Convoy Trainer

In this task, service members complete two or three predetermined combat scenarios embedded with selected entities (improvised explosive devices

FORM 9-3
OCCUPATIONAL THERAPY GRADING SHEET

Return to Duty Activity: _____ Date: _____

Name	Pass/Fail*	Go/No Go	IL	Pain	Comments (judgment/safety, memory, visual skills, problem solving, planning, organization, attention, motor planning, sequencing, processing speed)
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*An IL score of 1, 2, or 3 indicates a pass; an IL score of 4 or 5 indicates a fail.
 IL: independence level

Independence Levels

1. Independent, no adaptations. Service member (SM) is able to complete all the tasks in the activity safely, without modification or compensations, within reasonable time. No cues are required.
2. Independent with adaptations or modifications. SM requires increased time to complete tasks, use of compensatory strategies and techniques, indirect verbal guidance or gestural guidance.
3. Acceptable level of assistance. SM requires no more help than direct verbal assistance or physical assistance. SM performs at a level that is acceptable based on rank or experience. SM will benefit from additional training.
4. Unacceptable level of assistance. SM requires that a part of the task (< 25%) be completed for them by the clinician or SM performs at a level that is unacceptable based on his or her rank or experience.
5. Dependent. SM requires that 25% or more of activity be done for them by the clinician. SM requires psychological intervention. SM unable to complete task due to physical restrictions or limitations.

Cueing Descriptions

Cueing descriptions are based on those found in the Executive Function Performing Test.¹

No Cues Required

The SM does not require help or reassurance. Self-cueing (speaking to oneself) is acceptable.

Indirect Verbal Guidance

The SM requires verbal prompting, such as an open-ended question or an affirmation that will help him or her move on. Indirect verbal guidance should come in the form of a question, not direct instruction (eg, "What should you do now?" "What is the next step?" "What else do you need?").

Gestural Guidance

The SM requires gestural prompting. At this level, you are not physically involved with any portion of the task. Instead, you should make a gesticulation that mimics the action necessary to complete the task, or make a movement that guides the SM. You may not physically participate (eg, by handing the SM an item).

Direct Verbal Assistance

You are required to deliver a one-step command, so that you are cueing the SM to take an action.

(Form 9-3 continues)

Form 9-3 *continued*

Physical Assistance

You are physically assisting the SM with the step, but you are not doing it for him or her. You may hold/steady/prepare an item, but the SM is still attending to and participating in the task.

Do for the Service Member

You are required to do a portion of the task for the participant.

Cueing Guidelines

- If the SM has difficulty with any aspect of any of the tasks, you must wait at least 10 seconds (to observe processing) before giving a cue.
- Give two cues of each kind before progressing to the next cueing level.
- Give cues progressively in the order listed above.
- Do not initiate conversation during the task, and do not “cheerlead” (ie, do not give positive or negative feedback).

1) Baum CM, Connor LT, Morrison T, Hahn M, Dromerick AW, Edwards DF. Reliability, validity, and clinical utility of the Executive Function Performance Test: a measure of executive function in a sample of people with stroke. *Am J Occup Ther.* Jul–Aug 2008;62(4):446–455.

[IEDs], rocket-propelled grenades, noncombatants, friendly forces, etc). The service member must:

- Demonstrate appropriate radio use.
- Demonstrate adequate visual scanning and attention to visible threats, such as IEDs, rocket-propelled grenades, and snipers.
- Demonstrate adequate safety and judgment.
- Navigate through a virtual scenario (laterally and directionally) using a map and given route.
- Demonstrate adequate communication within the team.
- Perform respective role (driver, tank commander, gunner, etc) without assistance.⁶⁸

Task 6: Care Under Fire Scenario at Medical Skills Training Center Using Simulation Mannequins

Service members complete three medical training scenarios of escalating psychological demand and cognitive complexity. The first iteration involves caring for a mannequin on a litter with the lights on and loud music playing. The second iteration involves caring for a mannequin on the floor with the lights on, combat sounds (low), strobe flashing (low), and simulated smoke. The third iteration involves caring for a mannequin on the floor with debris (simulating explosion), lights out, combat sounds (high), strobe flashing (high), and simulated smoke. Service members must:

- Demonstrate understanding of the difference between the three levels of care (care under fire, tactical field care, and casualty evacuation).
- Demonstrate appropriate radio use by calling up a 9-line MEDEVAC request based on the given scenario.
- Evaluate the casualty using “CBA” (check circulation, breathing, and airway).
- Control hemorrhage by applying a tourniquet or pressure dressing.
- Check for an exit wound.
- Seal an open chest wound.
- Open and maintain an airway (head tilt, chin lift [when appropriate], jaw thrust, insert a nasopharyngeal tube).
- Address tension pneumothorax (identify tension pneumothorax and accurately simulate needle decompression).
- Demonstrate acceptable level of independence when under stressful conditions (combat sounds, reduced vision, strobe light, fog, visually distressing images).⁶⁸

Task 7: Didactic Review of Land Navigation Followed by Practical Exercise

This activity involves a classroom-style presentation of basic land navigation skills, followed by a practical exercise in which 8-digit grid coordinates are used to locate three specific features on

a map and determine the distance and azimuth between the three points. The service member must:

- Demonstrate appropriate protractor use and be able to determine 8-digit grid coordinates.
- Correctly identify topographical symbols on a military map.
- Correctly identify colors on a military map.
- Correctly identify marginal information on a military map.
- Correctly identify terrain features.
- Calculate distance between two points.
- Correctly determine azimuth between two points.
- Verbalize understanding the use of a pace count.
- Demonstrate appropriate use of compass to shoot azimuth.⁶⁸

Task 8: Completion of Judgmental Shooting Scenarios Using Engagement Skills Trainer

Service members work as a team to complete five to seven preselected “collective” shooting scenarios, followed by 5 to 10 “shoot/no-shoot” scenarios. Scenarios are selected based on increasing realism and the complexity of the skills required. Service members must:

- Demonstrate adequate visual and perceptual skills, including visual recognition, accommodation, visual fields, contrast sensitivity, visual attention and scanning of sector of fire, visual processing speed, fixation, and hand-eye coordination.
- Demonstrate adequate communication within the team.
- Respond accurately and efficiently to weapon malfunction.
- Demonstrate good judgment and follow the rules of engagement.
- Lack impulsivity.
- Demonstrate weapon safety at all times.⁶⁸

Task 9: Three- To Five-Point Land Navigation Course

In this activity, the service member completes land navigation tasks individually under supervision of participating providers (maximum distance between points of 350 m). The service member must:

- Demonstrate appropriate protractor use and determine 8-digit grid coordinates.
- Correctly identify topographical symbols on a military map.
- Correctly identify colors on a military map.
- Correctly identify marginal information on a military map.
- Correctly identify terrain features.
- Calculate distance between two points.
- Correctly determine azimuth between two points.
- Demonstrate appropriate use of pace count (able to track pace count while navigating).
- Demonstrate appropriate compass use.
- Use terrain association when possible.
- Demonstrate adequate visual scanning and awareness of surroundings.
- Demonstrate problem-solving capabilities if point cannot be located.
- Demonstrate cognitive flexibility.⁶⁸

Task 10: Combat Simulation/Improvised Explosive Device Lane in a Squad-Sized Element

The mission during this activity is to keep from being “mortally” wounded while evaluating, treating, and evacuating a casualty following a simulated IED attack. The team is provided with paintball guns and is opposed by two or three training personnel acting as the opposing force. The service member must:

- Independently perform assigned role (eg, squad leader, medical provider, additional personnel assigned to establish security).
- Demonstrate appropriate “reaction to contact.”
- Establish a perimeter.
- Move casualty to a covered position if necessary.
- Perform EFR skills (care under fire) to evaluate and treat casualty.
- Demonstrate appropriate radio use to call up situation reports (SITREPS) and 9-line MEDEVAC request.
- Demonstrate appropriate “break from contact.”
- Use combat litter to evacuate casualty to collection point.
- Perform tactical field care once casualty is out of enemy fire.
- Demonstrate good judgment and overall safety.
- Demonstrate adequate awareness of surroundings.

- Demonstrate appropriate communication within team.⁶⁸

Activity Preparation

Setup

Recommended equipment for the above-mentioned tasks includes clipboards, stopwatches, compasses, protractors, military maps, training aids, mannequins, moulage, a small-arms generator and simulated IEDs from the training support center, water cooler, sunscreen, bug spray, smoke machine, night vision goggles, flashlights, two-way radios, paintball guns, modular integrated communications helmets, body armor, face shields, gas masks, and Joint Service Lightweight Integrated Suit Technology suits (“J-List” suits that provide protection against chemical attack). Access to the following training entities is also recommended: HEAT, Engagement Skills Trainer, Virtual Combat Convoy Simulator, and Medical Skills Training Center.

Brief Soldier

Tell the service member the following:

You have been selected to participate in a therapeutic program designed to assess your readiness to return to duty. This program will serve as the capstone of your therapy and will incorporate all elements of your rehabilitation thus far. The multidisciplinary assessment team includes professionals from occupational therapy, physical therapy, and mental health. The physicians involved in your care will use input from participating therapists to customize your treatment and discharge plans, which may include returning you to duty or initiating a military occupational specialty medical retention board or medical evaluation board.

Performance Measures

An occupational therapy grading sheet was developed specifically for the Return-to-Duty Performance Validation Program at Fort Campbell (see Form 9-3). It is not yet validated and is merely a proposed option for performance assessment. Physical therapy and mental health providers may wish to design a similar grading sheet for use during return-to-duty program sessions. Overall “go/no go” status for each session is based on collaboration among providers. At the conclusion of the program, all involved providers meet to discuss patient performance and discharge recommendations. Each participant is then invited to meet with the team to go over the recommendations.

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CLINICIAN TIP SHEET: TOPOGRAPHICAL SYMBOLS ON A MILITARY MAP

Purpose/Background

This activity requires obtaining a 1:50,000-scale military map (these may be available through a military post’s training and support center, or the service member may be able to bring one to treatment). Use the associated patient handout to go over the topographical symbols with the service member. If you do not have a military background, take this opportunity to allow the patient to instruct you; this will give you an idea of the service member’s level of functional performance in this area. Challenging the patient’s teaching skills is also beneficial from an occupational standpoint, as nearly all service members will be faced with the responsibility to train others in their jobs at some time during their career.

Activity Preparation

Setup

- On a 1:50,000-scale military map, circle each item of marginal information (Table 9-8) found on the map.

- Randomly letter the circled items A through J.
- Circle 10 items or features on the map itself, which are indicated by color. Choose two of each color (red, blue, green, red-brown, etc).
- Randomly number each colored item 1 through 10. The potential items are listed below.
- Have a sheet of paper and a pencil available for the service member.

Brief Soldier

Tell the service member to letter the paper A through J and 1 through 10. Tell the service member to write down the name of the item contained in each lettered and numbered circle on the map.

Success or failure for each item is rated as “Go” or “No Go,” respectively.

Skills Addressed

Static visual attention, visual identification, working memory, and figure ground are all addressed with this activity.

TABLE 9-8

PERFORMANCE MEASURES FOR TOPOGRAPHICAL SYMBOLS ON A MILITARY MAP

Measure	Go	No Go
Identified the sheet name		
Identified the sheet number		
Identified the contour interval		
Identified the grid-magnetic angle (mils or degrees)		
Identified the legend		
Identified the bar scales		
Identified the declination diagram		
Identified the grid reference box		
Identified the adjoining map sheets diagram		
Identified the elevation guide		
Identified 2 of 2 specific human-made features (shown in black on the map)		
Identified 2 of 2 water features (blue on the map)		
Identified 2 of 2 vegetation features (green on the map)		
Identified 2 of 2 human-made features (eg, main roads or build-up areas; shown in brown or red-brown on the map)		
Identified 2 of 2 contour lines (shown in brown or red-brown on the map)		

CLINICIAN TIP SHEET: DETERMINE GRID COORDINATES OF A POINT ON A MILITARY MAP

Purpose/Instructions

This activity requires a 1:50,000-scale military map and a protractor (these may be available through a military post's training and support center, or the service member may be able to bring one to treatment). You will also need a copy of *The Soldier's Manual of Common Tasks*.⁶⁸ Use the associated patient handout to review how to determine grid coordinates with the service member. If you do not have a military background, take this opportunity to allow the patient to instruct you; this will give you an idea of the service member's level of functional performance in this area. Challenging the patient's teaching skills is also beneficial from an occupational standpoint, as nearly all service members will be faced with responsibility to train others in their jobs at some time during their career.

Note, the patient handout instructs service members how to determine 6-digit grid coordinates.⁶⁸ You may find that service members are more familiar with using 8-digit grid coordinates, as this method is preferable for use during actual land navigation. Therefore, the following activity has been designed to use 8-digit grid coordinates.

Activity Preparation

Setup

Provide the service member with a 1:50,000-scale military map, protractor, paper, and pen or pencil.

Brief the Soldier

Instruct the service member to find the 8-digit grid for a specific human-made object or terrain feature of the therapist's choice. Pick an object using the legend at bottom of map, such as a church, windmill, mine, building, or route marker. Alternatively, provide the exact coordinates and ask the service member to find what object is at that location.

Performance Measures

Observe for the following abilities and use your observations to measure performance. See how the patient:

- uses the correct protractor according to map's scale (1/50,000 m).
- looks for the correct symbol or coordinates.
- uses the protractor appropriately (moving it along the map from left to right and from bottom to top).
- places protractor correctly (horizontal line of protractor is lined up with the horizontal line of the map and vertical line of the protractor is lined up with the vertical lines of the map, going straight over top of the object).
- places the zone identifiers in front of coordinates.
- identifies correct object or grid coordinates.
- uses appropriate strategies to remember objects or coordinates while working.
- completes task in a functional time limit.
- completes task with no verbal cues.

Skills Addressed

This activity assesses static visual attention, figure ground, procedural memory, sequencing, precision, and hand-eye coordination.

To Make the Activity Harder

- List several objects or coordinates at a time for the service member to locate.
- Pick objects that are more difficult to locate or are in busy locations.
- Give the service member a time limit.
- Have the service member complete another task simultaneously (scanning) or add background noise for additional stimulation.

To Make the Activity Easier

- Have the service member locate just one object or coordinate at a time.
- Pick objects that are more easily seen.

CLINICIAN TIP SHEET: PERFORM FIRST AID FOR BLEEDING OF AN EXTREMITY

Instructions

This activity could be performed in a small-group setting. Review techniques then divide patients into groups of two for practical rehearsal. Observe speed, problem-solving, fine-motor coordination, response to stress, and procedural memory. Activity can be graded up or down for complexity, stress, required speed, and the like.

Activity Preparation

Setup

Use the same field dressing repeatedly. Have materials available for a pressure dressing (wadding and cravat or a strip of cloth). Have one service member play the part of the casualty and another apply the field and pressure dressing. Use moulage or mark a place on the casualty’s arm or leg to simulate a wound. For applying a tourniquet, use a mannequin or simulated arm or leg (padded length of 2-by-4-inch wood with a glove or boot on one end) with a field dressing appropriately placed on the arm or leg. **Under no circumstances will a live simulated casualty be used to evaluate the application of a tourniquet.** Place the tourniquet materials (a stick and one or two pieces of cloth) nearby.

Brief Soldier

Tell the service member to take the first aid steps

TABLE 9-9

**PERFORMANCE MEASURES FOR ACTIVITY:
PERFORM FIRST AID FOR EXTREMITY
BLEEDING**

Step	Go	No Go
1. Uncovered the wound		
2. Applied a field dressing		
3. Applied manual pressure and elevated the arm or leg, if necessary		
4. Applied a pressure dressing, if necessary		
5. Applied a tourniquet, if necessary		
6. Performed steps 1–5, as necessary, in sequence		

required to put on a field dressing and, if necessary, apply a pressure dressing on the casualty’s wound (Table 9-9). When testing the first step (uncovering the wound), you can vary the test by telling the service member that clothing is stuck to the wound or that a chemical environment exists. After steps two and three (applying a field dressing and applying manual pressure to the extremity), tell the service member that the bleeding has not stopped. After step four, tell the service member the bleeding is continuing and ask him or her to describe the wound and perform first aid.

**CLINICIAN TIP SHEET: JOB-SPECIFIC TACTICAL SIMULATION 1–
DYNAMIC VISUAL SCANNING ACTIVITY**

Purpose/Instructions

These types of activities will vary based on the service member’s military occupational specialty. Simulations can be modified to target specific skill areas.

- A forward observer can complete a visual scavenger hunt using a spotting scope and scanning for specific landmarks at a distance of 100 to 300 meters.
- A medic can complete tactical casualty combat care simulations.
- A combat engineer may calculate breaching charges based on given scenarios.
- An upper-enlisted member may prepare and execute briefings.

Keep in mind that creativity is the key when creating these activities. Also, feel free to rely on the individual service member to guide your approach. The knowledge and experience of your patients can be a valuable resource in developing occupational therapy return-to-work programming.

Activity Preparation

Setup

There are many variations to this activity. The goal, however, is always the same: challenge the patient to adequately attend to specific visual stimuli in a dynamic, real-world environment. The activity can take place in the hospital, post

exchange, commissary, or outside. Desired stimuli can range from large items, such as car makes and models, to small items, such as wedding bands. Provide yourself and the patient with a pen or pencil and a small notepad.

Brief Soldier

Instruct the patient that he or she will be required to scan for desired stimuli while walking through a busy environment. Reiterate the importance of staying alert and focused while using effective search patterns.

Performance Measures

To determine accuracy, divide the patient's scanning totals by your own. For example, if the patient spotted 15 soldiers wearing Army combat uniforms and you spotted 21, his or her accuracy would be 71%.

Skills Addressed

This activity addresses selective, divided, and alternating visual attention, dynamic visual acuity, and working memory.

To Make the Activity Harder

The activity can be made more difficult by adding additional dual-task elements, such as having the patient keep track of one or both of the totals internally, or having the patient complete a secondary task while performing visual scanning (ie, locate items on a grocery list).

To Make the Activity Easier

The task can be simplified by reducing the number of required stimuli, completing the task in a less distracting environment, and removing dual-task elements.

CLINICIAN TIP SHEET: JOB-SPECIFIC TACTICAL SIMULATION 2– TARGET DETECTION VISUAL SCANNING ACTIVITY

Activity Preparation

Setup

This activity mimics a tactical training task performed by many service members. The activity requires advanced set-up and a large, relatively flat outdoor space. Select 10 small (3 to 5 inch) military items (eg, a pin, badge, compass, and protractor). Scatter the items on the ground in a lane that is approximately 20 to 30 meters wide. Have the patient use binoculars or a spotting scope to locate and identify the items from approximately 25 to 75 meters away. Materials include a scope or binoculars, 10 military items, pen or pencil, and a small notepad.

Brief Soldier

Instruct the service member that he or she will be required to scan for desired stimuli scattered within a designated lane. Upon locating each target, the patient attempts to identify it and write a detailed description of the item on the notepad.

Performance Measures

To determine accuracy, divide the patient's scanning totals by 10. If the patient spotted 7 out of the 10 items, accuracy would be 70%.

Skills Addressed

Visual discrimination, visual closure, figure ground, selective attention, and accommodation are addressed in this activity.

To Make the Activity Harder

To make the activity harder, increase difficulty by partially obscuring some of the items from view, choosing smaller items, and enforcing a time constraint.

To Make the Activity Easier

To make the activity easier, simplify the task by using larger items and reducing distance.

CLINICIAN TIP SHEET: DUTY ROSTER ACTIVITY

Activity Preparation

Setup

Provide the service member with the handout, a blank Duty Roster Activity form (Department of the Army 6 [DA-6]), calendar, and a pencil.

Brief Soldier

Instruct the service member to use given information and the previous month's DA-6 form to complete the following month's schedule. If the patient requires cues, follow these 10 general rules:

1. Write out all the days of the month across the top.
2. Highlight vertically the weekends and holidays (these are the "weekend" duty cycle).
3. Place a lower case "a" in the upper right hand corner of the days that certain service members will be absent.
4. Based on the last weekday and weekend from the previous month (given), begin filling in the numbers from left to right, keeping in mind that there are two simultaneous duty cycles: weekday and weekend. For example, an individual could be in the fourth duty slot for weekdays, but the nineteenth duty slot for weekends.
5. When you get to number 20 in either duty cycle, fill in the lower right hand corner of the square to signify "duty" for a service member on that particular day.
6. When a duty day falls on a day a service member will be on leave, duty goes to the next highest-ranking service member (#19).
7. The service member who misses duty because of leave performs duty the next day that he or she is back for that particular duty cycle. The following day after that, he or she becomes number 1.
8. The person who does duty in the stead of someone who is on leave cycles back to number 1 the day after completing substitute duty (staying in the same duty cycle).
9. A service member will never pull duty two days in a row. If the two duty cycles (weekend and weekday) coincide so that a person will have two duty days in a row, follow the same process described in numbers 7 and 8.

Performance Measures

Assess service members based on the level of cueing required, organization of approach, attention to details, cognitive flexibility, and problem solving. To determine the accuracy of the service member's response, you must correct by hand because there are multiple correct responses for the duty roster.

Skills Addressed

Organizational skills, planning, sequencing, executive functions, following written instructions, working memory, and attention to detail are all addressed with this activity.

To Make the Activity Harder

To make the activity harder, increase the number of fictional sergeants on the duty roster, increase the number of accommodations required, provide a time limit, increase distractions, or introduce a second task to complete simultaneously.

To Make the Activity Easier

Decrease the number of sergeants on the duty roster, decrease the number of accommodations required, allot more time for completion, and set up the activity in a controlled environment with few distractions to make the activity easier.

CLINICIAN TIP SHEET: TRAINING SCHEDULE

Activity Preparation

Setup

Provide the service member with the handout, a blank weekly calendar, and a pencil.

Brief the Soldier

Instruct the service member to complete the training schedule following the guidelines on the handout.

Skills Addressed

This activity addresses organizational skills, planning, sequencing, following written instructions, attention to detail, working memory, and executive functions.

To Make the Activity Harder

To make the activity harder, increase the number of activities to schedule, decrease flexibility by requiring training activities to take place at certain times, provide a time limit, increase environmental distractions, or introduce a second task to complete simultaneously.

To Make the Activity Easier

To make the activity easier, decrease the number of scheduled activities, increase flexibility by removing assigned times, or limit environmental distractions.

Definition of Terms From Patient Handout

- NCOER: Noncommissioned Officer Evaluation Report
- EO class: Equal Opportunity class
- NCODP: Noncommissioned Officer Development Program

CLINICIAN TIP SHEET: DRESS UNIFORM ERROR DETECTION

Instructions

Incorrectly place 5 to 10 badges on the Army Service Uniform jacket. Score the number of inappropriately placed badges the service member is able to identify and correct. The total score will be factored out of the number of badges initially put on the jacket. For correct placements, refer to Army Regulation 670-1 or the US Army Uniform Guide.^{69,70}

Activity Preparation

Setup

Provide service members with the handout, the dress uniform jacket, a ruler, and a US Army Uniform Guide.⁷⁰

Brief Soldier

Explain to the service member that some or all of the badges on the dress jacket are not correctly placed and it is his or her job to pin them in the correct locations.

Skills Addressed

This activity addresses skills such as visual scanning, memory, fine motor skills, attention to detail, and following directions.

To Make the Activity Harder

To make this activity harder, increase the number of badges on the jacket and make initial (incorrect) placement of badges similar to the correct placement, simulate interruptions (set a timer to go off, set up a phone to ring, add an additional task to complete), give the service member a time limit for completion, or have the service member complete the activity in a distracting environment.

To Make the Activity Easier

Decrease the number of badges on the jacket and make initial (incorrect) placement of badges obvious, complete activity in a controlled environment with little noise or distraction, or allot more time for completion to make the task easier.

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SECTION 5: PATIENT HANDOUTS

PATIENT HANDOUT: MEDICATION MANAGEMENT SELF-REPORT QUESTIONNAIRE

Instructions

Your answers to these questions will help us ensure you take the medications prescribed by your doctor. Please select or provide the answer to each question that best fits your situation or circumstances.

1. Do you know the names of your medications and what they look like? If yes, please list them.

- Yes, all of them.
- Yes, some of them.
- No, none of them.

2. Do you know the purpose and dosages of your medications? If so, please list below.

- Yes, all of them.
- Yes, some of them.
- No, none of them.

3. Do you keep a current list of your medications?

- Yes No

4. Do you have a schedule for taking your medications (ie, morning, lunch, evening)?

- Yes, I do for all medications I take.
- Yes, I do, but only for some medications I take.
- No, I do not have a schedule.

5. Do you know when to take your medication(s)?

- Yes No

6. Can you open the containers?

- Yes No

7. Can you read the prescription on the bottle?

- Yes No

8. Do you understand how to follow the prescription?

- Yes No

9. How do you organize your medications? Do you use a pill box or do you take the pills directly out of the bottles?

10. How do you remember to take your medications?

11. Do you know how to refill your medications? Do you know who to call? Do you know who and when to call and how to pick up your refills?

- Yes No

Example: _____

12. Do you carry your doctor's name and telephone number with you?

- Yes No

PATIENT HANDOUT: FATIGUE MANAGEMENT–FACTOR AND STRATEGY AWARENESS

Background

After concussion, you may find that you tire more readily during both physical and mental tasks. It is important to actively work on managing your fatigue to avoid unnecessary errors and frustrations and to put your effort into regaining your previous level of activity tolerance.

You can manage fatigue by maintaining:

1. good sleep hygiene practices,
2. good nutrition and hydration,
3. regular exercise / activity, and
4. stress reduction practices.

Maximizing Your Energy as You Recover

This handout is designed to help you explore each of the four factors that comprise fatigue management so you and your therapist can identify strategies that might help you improve your energy and activity tolerance. Read each section and answer questions about your current habits, then discuss your answers with your occupational therapist and together identify possible strategies that you can evaluate in your daily life.

Sleep Hygiene

- Sleep hygiene pertains to all behavioral and environmental factors that precede **sleep** and may interfere with **sleep**.
- The following practices help people establish restful and satisfying sleep patterns.
 - Wake up and go to bed at consistent times.
 - Avoid stimulants, such as caffeinated beverages and nicotine, after 2:00 pm.
 - Avoid alcoholic drinks before bed.
 - Minimize distractions in your bedroom (this includes television).
 - Relax before bed so you can unwind before sleep.
 - Limit naps to no longer than 30 minutes; avoid napping after 3:00 pm.
 - Exercise and stay active during the day. Try to exercise every day, but not within 5 hours of bedtime.

Components of Your Sleep Routine	Your Current Habits	Strategy (N/A if no problems are reported)
What time do you awake/ get up?		
What time do you go to bed?		
What do you typically do right before going to bed at night (read, watch TV, etc)?		
Do you nap during the day?		
If yes, how often and how long?		

Sleep Characteristics	Your Current Habits	Strategy (N/A if no problems are reported)
Do you fall asleep readily?		
Do you stay asleep?		
Do you wake up feeling rested?		
Other:		

Nutrition and Hydration

Your body needs well-balanced meals and consistent hydration to heal optimally. If you do not know what good nutrition entails, it may benefit you to meet with a nutritionist to review guidelines and options.

Nutrition Characteristics (how would you describe your nutrition at the following meals)	Your Current Habits	Strategy (N/A if no problems are reported)
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Other:		

Regular Exercise

If cleared by your medical doctor, it is important to resume physical activities. Exercise helps brain function and builds activity tolerance. Consult with your therapist to assure an effective exercise regimen.

Exercise Characteristics	Current Habits	Strategy (N/A if no problems are reported)
What is your current routine in terms of endurance or aerobic exercise (frequency, time of day, and nature of the exercise)?		
What is your current routine in terms of strengthening exercise (frequency, time of day, and nature of the exercise)?		

Stress Reduction

It is important to resume or develop stress-reduction skills. These skills vary from individual to individual, and include regularly engaging in activities that help you reduce your stress level.

Stress-Reduction Activities	Current Habits	Strategy (N/A if no problems are reported)
What kinds of everyday activities help you reduce stress?		
How often do you engage in these activities? Daily, weekly, monthly?		

FURTHER RESOURCES

- Additional information on sleep hygiene can be found at: http://www.nhlbi.nih.gov/health/public/sleep/healthy_sleep.pdf.
- Detailed stress-relief techniques can be found at: http://helpguide.org/mental/stress_relief_meditation_yoga_relaxation.htm.

PATIENT HANDOUT: TAKING BREAKS

Overview

As you recover from concussion/mild traumatic brain injury (c/mTBI), you can manage fatigue and optimize performance by knowing how to pace yourself. Sometimes this means stepping away from your work for a few moments to regroup so you can continue to perform at your best.

Managing fatigue involves knowing:

- 1) when to take a brief break, and
- 2) what to do during a brief break that will rejuvenate you.

Steps you can take:

- 1) Pre-plan what to do during a brief break that will refresh you.
- 2) Come up with some additional things to do when you need a brief break (see example below).

WHAT TO DO WHEN YOU NEED A BREAK

- | | |
|-----------------------------|-----|
| 1. Take a brief walk. | 6. |
| 2. Do stretching exercises. | 7. |
| 3. Get a drink of water. | 8. |
| 4. | 9. |
| 5. | 10. |
-

Recognizing When You Need to Take a Break

Be aware of any **physical symptoms** that indicate you may need a break, including:

- headache or tension
- irritability
- eye strain
- increased fatigue
- increased frustration
- decreased ability to concentrate
- other:

Be aware of cognitive inefficiencies that impede task performance, such as:

- increasing number of errors
- increasing need to start over or not remembering what you did last
- inability to see the big picture, understand the whole of the task
- task feels harder than it should be
- other:

An increase in physical symptoms or cognitive inefficiencies signals you to stop and reflect on what to do next.

Options:

- Determine if you need a break, should shift to another task, or if you are done for the day.
- Leave yourself a “stop note,” which allows you to resume where you left off when you come back.
- Determine approximately how long a break you need to resume the task refreshed. Set an alarm if needed.

- Return to the task. Read your stop note and seamlessly resume the task.

REMEMBER: Sometimes the goal is to work smarter rather than harder!

PATIENT HANDOUT: PACING

Activity tolerance refers to your capacity for physical output and stamina on a given day. After concussion or other injuries, people work to regain their activity tolerance by doing as much as they are able without under- or over-doing.

In the early stages of recovery (or any time you feel busy or overwhelmed), it can be helpful to view your activity tolerance as a limited resource that needs to be budgeted. Much like a checking account, if your activity tolerance is not well managed, there can be penalties and it can take a long time to recover.

Pacing is a strategy that enables you to maximize your activity tolerance and thereby manage fatigue.

How Pacing Works

Consider the activities that you need to perform throughout a week:

- personal tasks,
- home-management tasks,
- care of others/social tasks,
- medical appointments, and
- work and community tasks.

Pacing yourself involves scheduling these tasks throughout the course of the week (with rest breaks scheduled as well) so your activity tolerance can be used wisely and restored to functional levels with rest. If an event or project requires you to use all of your activity tolerance in one fell swoop, you will need to plan to rest before and after to help restore that budget.

Begin by tracking the areas that you are primarily responsible for on the grid below. Choose days of the week on which you will try to perform these tasks; make sure you are spreading them out throughout the week and not over-taxing yourself on any particular day. Here’s an example of part of a completed grid; fill out your own on the next page.

EXAMPLE RESPONSIBILITIES GRID

Task	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
<i>Personal</i>							
Physical therapy appointments			X		X		
Physical therapy home exercises		X		X		X	
<i>Household</i>							
Grocery shopping							X
Home repair tasks							X
<i>Work</i>							
Duty assignment		X	X	X	X	X	

RESPONSIBILITIES GRID

Task	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
------	-----	-----	------	-----	-------	-----	-----

Personal

Household

Care of others

Medical

Social

Work/Community

REMEMBER: Meeting your task responsibilities as you recover does not involve an all-or-none phenomenon. Pacing allows you to continue to perform essential or desired tasks as you thoughtfully schedule them over the course of the week.

PATIENT HANDOUT: MEDICATION SUMMARY

Medicine	Dose	Time(s)	Reason	Prescribing Doctor
	mg/day			Dr.

PATIENT HANDOUT: MEDICATION SCHEDULE

Morning

Medicine	Dose/Route	Time	Reason
----------	------------	------	--------

After Lunch/Mid Day

Medicine	Dose/Route	Time	Reason
----------	------------	------	--------

Bedtime

Medicine	Dose/Route	Time	Reason
----------	------------	------	--------

As Needed

Medicine	Dose/Route	Time	Reason
----------	------------	------	--------

PATIENT HANDOUT: ORGANIZING THE MAIL

Receiving mail on a daily basis can be overwhelming at times, especially because getting junk mail is inevitable. Having a systemized method of mail management can reduce irritation and allow better awareness of necessities when it comes to paying bills.

Here are some ideas for how you can get organized:

1. Set up a system and game plan.
 - Obtain the supplies needed to get organized: a box for incoming mail, a shredder, a filing cabinet or file box, file folders, marker, and a calendar, cognitive assistive technology (CAT), or day planner.
 - Talk with your significant other and establish a specific place in which to put all incoming mail as it arrives. For example, use the kitchen, bedroom, or home office.
 - Purchase a 13-by-10-inch box, label it “Incoming Mail,” and put it in the designated place (as above). Consider purchasing a clear plastic bin for this purpose.
2. Sort the contents of the Incoming Mail box once per week.
 - Once a week, with your significant other, go through the mail and sort it into two piles: junk mail and important mail.
 - Junk mail: any mail that is not important to you (such as credit offers, advertisements, newsletters)
 - Important mail: any mail that you need (such as utility bills, credit card bills, mortgage bill / statement, car payment, tax information, receipts)
3. To prevent identity theft, shred all junk mail. If you do not want to shred all junk mail, at least shred your name and address before recycling the rest.
4. Further sort your important mail pile.
 - Create a temporary sorting space. Clear off a table top surface or floor space.
 - Use sticky notes to help you sort. Create a sticky note for each category of important mail that you observed when you separated out the junk mail, such as utility bills, credit card bills, mortgage bill / statement, car payment, tax information, receipts.
 - Place the sticky notes around the table and sort important mail accordingly. After sorting, return the sticky notes to the Incoming Mail box for reuse.
5. File your important mail by categories.
 - Label file folders based on the categories above.
 - Make sure one folder is labeled “Unpaid Bills.”
6. Put papers into their respective file folders and store in the file or file box.
7. Examine each bill in the Unpaid Bills folder; write the due date on the outside of each envelope.
8. Make reminders for yourself in your CAT, day planner, or calendar on the days on which you actually intend to write checks or pay the bill or bills.

REMEMBER: If you set up and maintain a mail-sorting procedure on a weekly basis, you will reduce the stress of going through mail and be more organized when it comes to paying your bills.

PATIENT HANDOUT: ESTABLISHING A BUDGET

Keeping a budget is difficult for most people, even those without concussion. Having consistent and simple methods for keeping track of your money (to avoid over- or underpayment of bills) can be particularly helpful as people recover from the aftereffects of concussion.

Staying on top of your finances involves three key steps:

1. Estimating your monthly expenses
2. Tracking your actual monthly income and expenses
3. Maintaining bank account balances

Improving Your Budgeting and Financial Management

1. Determine why your financial management process breaks down.
2. Do you have a good handle on what your actual expenses are each month?
3. Are you spending more each month than you estimate?
4. Are you keeping records of what you actually spend each month?
5. Do you have an effective accounting system in place?
6. Set up your own record-keeping systems (see Patient Handout: Budget Planning Worksheet).
7. Use a calculator to make sure your records are accurate.
8. Work with your spouse (or other family members) to set joint financial management goals and work as a team to achieve them. Decide on who is responsible for what based on each person's strengths. Set aside a time each week to log expenses and bank transactions and to problem solve together.

REMEMBER: Learning good financial management habits takes time and practice; be patient with yourself if your first (second or third) efforts are not perfect.

FURTHER RESOURCES

There are several Internet sources that can help you with budget planning, such as:

- <http://www.womens-finance.com/monthlybudget.shtml>
- <http://www.docstoc.com/docs/7923811/Budget-Planner-Worksheets>
- <http://www.free-financial-advice.net/create-budget.html>

PATIENT HANDOUT: BUDGET PLANNING WORKSHEET

Step 1: Estimate your typical income and expenses for each month. Fill in the “Estimated Amounts” column below.

Income and Expense Categories		Estimated amounts
Estimated monthly income	Your monthly take-home pay	
	Your spouse’s monthly take-home pay	
	Other work income	
	Financial gifts	
	Investment income	

Estimated Income Total

Estimated monthly expenses	Rent or mortgage	
	Utility: electricity or gas	
	Utility: water	
	Telephone / cell phone / Internet	
	Garbage	
	Groceries	
	Car payment	
	Clothing	
	Gasoline	
	Leisure / eating out	
	Childcare	
	Other:	
	Other:	

Income and Expense Categories

	Other:	
--	--------	--

Estimated Expense Total

--	--

Step 2: Compare your estimated expense total to your income total.

- If your estimated expenses are greater than your estimated income, determine what expenses you might pare down.
- If your estimated expenses are greater than your estimated income, determine how you might generate more income or if you can afford to dip into your savings.

Step 3: Examine the actual amounts of money available in your bank account(s).

Actual Amount in Checking Account

Actual Amount in Savings Account

PATIENT HANDOUT: BUDGET TRACKING WORKSHEET

- Step 1:* Transfer your income and expense estimates from the Budget Planning Worksheet.
- Step 2:* Record your starting bank balances at the beginning of the month.
- Step 3:* Work with your family members to keep track of what you actually spend this month.
- Step 4:* At the end of the month, record bank balances and compare estimated to actual monthly expenses.
- Step 5:* Adjust budget as needed.

Example

Income and Expense Categories		Estimated amounts	Actual amounts for the month of:
Monthly income	Your monthly take-home pay	\$2,322.32	\$2,322.32
	Your spouse's monthly take-home pay	\$1,543.65	\$1,543.65
	Other work income		
	Financial gifts		
	Investment income		
Income Total			
Monthly expenses	Rent or mortgage	\$950.56	\$950.56
	Utility: electricity or gas	\$130	\$120.76
	Utility: gas/water	\$60-70	\$57.90
	Telephone/cell phone/internet	\$136.10	\$136.10
	Garbage/trash	\$40.34	\$40.34
	Groceries	\$110-130	\$122.42
	Car payment	\$428	\$428
	Clothing		\$0
	Gasoline	\$110-\$140	\$129.90
	Leisure/eating out	\$100-\$140	\$132
	Childcare		
	Other:		
	Other:		
	Other:		
Expense Total		\$2,065.44-\$2,165.44	\$2,117.98

Checking account balance at beginning of month	Savings account balance at beginning of month
\$2,342.40	\$3,245.89

Analysis

- Did I meet my financial goals this month?
Yes
- What, if anything, do I want to change to better manage my budget next month?
Eat out less.

PATIENT HANDOUT: BUDGET TRACKING WORKSHEET

Income and Expense Categories		Estimated amounts	Actual amounts for the month of:
Monthly income	Your monthly take-home pay		
	Your spouse’s monthly take-home pay		
	Other work income		
	Financial gifts		
	Investment income		
Income Total			
Monthly expenses	Rent or mortgage		
	Utility: electricity or gas		
	Utility: water		
	Telephone / cell phone / Internet		
	Garbage / trash		
	Groceries		
	Car payment		
	Clothing		
	Gasoline		
	Leisure / eating out		
	Childcare		
	Other:		
	Other:		
	Other:		
Expense Total			

Account	Balance at beginning of month	Balance at end of month
Checking		
Savings		

Analysis

- Did I meet my financial goals this month?

- What, if anything, do I want to change to better manage my budget next month?

PATIENT HANDOUT: BILL PAYING

People can minimize the stress and effort involved in bill paying by setting up monthly routines and procedures for this activity. This is particularly helpful as people recover after concussion.

The following are two examples of bill-paying procedures that you may consider when optimizing your own efficiency in this area.

1. Set up automatic withdrawal/bill-paying with your bank, vendors, and utilities.
 - Several banks and service companies try to make it more convenient for clients to pay their monthly bills by offering to take owed money directly out of a client's bank account.
 - As a consumer, you can call vendors and set up a day for the merchant to take the money out of your account. You will need an email account to receive confirmations and notices from your bank.
 - You can schedule payments to go out of your account in the beginning or towards the end of the month, which reduces the stress of paying a bill every week or so.
 - Use a spreadsheet to keep track of your payments and how much money is due monthly.
 - Balance your account to make sure you have enough money to be withdrawn. Your bank should also send you a new electronic statement to review after any change occurs to your account.
2. Pay your bill by writing a check, mailing the bill, and maintaining the balance of your account.
 - Set up your work space, removing as many distractions as possible.
 - Collect the supplies and materials you need for the task (eg, checkbook, pen, calculator, stamps, checkbook register, deposit slips, notepaper).
 - Make a list of the bills that need to be paid.
 - Write the check for the first bill on your list.
 - Record the check number (top right corner) on the checkbook register.
 - Fill in the appropriate details (eg, date, payee, amount).
 - Write the amount paid in your checkbook register and subtract from your bank balance.
 - Put the check and bill stub in the envelope and seal the envelope. Stamp and add your return address.
 - Cross the bill off your list.
 - Move on to the next bill.
 - Repeat the above steps until all bills are crossed off your list.
 - Put all the bills in the mail.

BALANCING YOUR ACCOUNT (EXAMPLE)

Date	Check No.	Payment type and details (check, credit, deposit; payee)	Amount paid	Deposit	Balance
<i>Example</i> 1/10/14		Credit card payment: Groceries at Kroger's	\$156.43	00	Before trans: \$1,342.30 After: \$1,185.87 Before trans: \$1,185.87 After: Before trans: After: Before trans:

PATIENT HANDOUT PACKET: MONEY MANAGEMENT

The goal of this task is to perform financial transactions in which you come up with the correct account balance at the end.

1. Start with a balance of **\$1,233.45** in your account.
2. Use the sample blank checks (Figure 9-3) provided to pay the following bills in this order:
 - Wayne's Lawn Care (Figure 9-4)
 - Gas and water bill (Figure 9-5)
 - Charter Cable bill (Figure 9-6)
3. Deposit the following using the sample deposit slip (Figure 9-7):
 - Refund from Wal-Mart: \$53.24
 - Check from Calvin Smith: \$476.57
4. Calculate your new account balance.

John Doe 387 Wilson Road Clarksville, TN 34973	Date: _____	101
Pay to the order of _____	\$ _____	
		Dollars
<i>FundTrust</i>		
Memo _____		
John Doe 387 Wilson Road Clarksville, TN 34973	Date: _____	102
Pay to the order of _____	\$ _____	
		Dollars
<i>FundTrust</i>		
Memo _____		
John Doe 387 Wilson Road Clarksville, TN 34973	Date: _____	103
Pay to the order of _____	\$ _____	
		Dollars
<i>FundTrust</i>		
Memo _____		

Figure 9-3. Sample blank checks.



Customer:	Account #	984928
John Doe	Invoice #	3865
387 Wilson Road	Invoice Date	14 September 2013
Clarksville, TN 34973		

Terms:		
Item	Invoice subtotal	\$80.00
Aerate Lawn	Tax	\$0.00
	Invoice total	\$80.00
	Total payments for this invoice	\$0.00
	Balance due for this invoice	\$80.00
	Balance dues from previous invoices	\$0
	Total amount owed	\$80.00

Figure 9-4. Sample lawn care bill.



Clarksville Gas & Water
 2123 Madison St
 Clarksville, TN 37043

Account # 358762987
Billing cycle 4 Dec 2012 – 3 Jan 2013
Payment due by 4 Feb 2013

Customer Information: John Doe
 387 Wilson Rd
 Clarksville, TN 37043

Meter Location: 387 Wilson Rd
 Clarksville, TN 37043

Billing Statement

Payments Received

2 Jan 2013 - \$90.14

Outstanding Balance

\$0.00

Charges this period

Gas	\$11.65	Reading 2000–2011
Water	\$30.61	Reading 73383–73777
Sewer	\$43.65	
Tax	\$2.91	
Total	\$88.82	

<i>Usage History</i>	Previous	Type	Usage	Charge
<i>Account # 358762987</i>	Nov	Water	2100 Gallons	0
<i>Water meter #</i>	Nov	Gas	900 Cubic Feet	0
<i>Gas meter #</i>	Oct	Water	1200 Gallons	0
	Oct	Gas	2700 Cubic feet	0

Important message

Effective July 13th customer acct number will be changing. Please notify bank or payment services you used to pay your bill.
 Look for new numbers on bill after July 13th. Go to CGW website or call 931-098-9786.

Make checks payable to: Clarksville Gas and Water

Figure 9-5. Sample gas and water bill.



P.O. Box 31269
Clarksville, TN 34243

Security code
14th of Next Month

John Doe
387 Wilson Road
Clarksville, TN 34973

Account # 20497992875
Phone # (931)386-9873
Contact us: for billing or questions
visit us @ www.charter.com, or call 1-888-Get Charter

Account Information:

Thank you for choosing Charter Communications. We appreciate your prompt payment and value you as a customer. Charter brings your home to life.

Summary:	
Previous Balance	\$80.19
Payment Received	\$80.19
Balance Forward	\$0
Charter Cable Services	\$44.99
Charter Internet Services	\$29.99
Adjustments, Taxes and Fees	\$5.21
Total Due	\$80.19

Charter Communications • P.O. Box 31269 • Clarksville, TN 34243

Figure 9-6. Sample cable bill.

CHECKBOOK REGISTER ACTIVITY

Date	Check #	Payment Type (Check, Credit, Deposit)	Amount Paid	Deposit	Balance: \$1,233.45
					Before trans:
					After:
					Before trans:
					After:
					Before trans:
					After:
					Before trans:
					After:
					Before trans:
					After:
					Before trans:
					After:
					Before trans:
					After:
					Before trans:
					After:
					Before trans:
					After:

PATIENT HANDOUT: USING A SMARTPHONE OR PLANNER TO MANAGE MONEY

The calendar on your cell phone, organizer, or day planner comes in handy for keeping track of your money and making sure you pay your bills on time. By using the calendar feature, you can input specific times and dates to remind you of when you intend to pay certain bills.

Using a Cell Phone to Create Reminders

- Go to the calendar setting and select a date.
- Type “pay bills” in the subject line.
- Set a reminder alarm for 3 days prior to due date.
- When the phone reminder goes off, make sure you write a check, post the envelope, and mail the payment.
- Consider adding a reminder note to your planner just in case your alarm doesn’t go off as planned.

Using a Planner or Organizer to Manage Money

- When you receive a bill, open it and write the due date on the outside of the envelope.
- Decide by what date you must pay and mail the bill so it will be paid on time.
- Make a note on the calendar prompting you to pay a given bill on the date specified. If your budget allows, try to specify one or two days each month to pay all your bills.
- Establish a daily routine for reviewing your planner; that way you will see bill-paying prompts on the days you specified.

PATIENT HANDOUT: UNDERSTANDING YOUR CHILD’S WORLD—INFANT (0–1 YEAR OLD)

Age-Appropriate Behaviors

Infants’ understanding of the world around them is based on their age and their life experiences. We would not expect a 3-year-old to be able to sit for a 30-minute conversation, but we would not think twice about asking a 17-year-old to do the same. Successful engagement with your child is somewhat dependent on your ability to understand the world in which they live. This handout is designed to help you identify age-appropriate play activities that the two of you can do successfully.

How Does My Child Play?

Infants learn through play. During the first year of life, infants’ play is exploratory and we are often unable to identify their activity as play. They do this through contact with others, playing with their hands and feet, and engaging in the world around them; remember, their world is only what they see in front of them at any given moment. Babies are interested in others who talk, sing, and explore their world. Infants will seek out parents or siblings as their first choice for play “toys.”

What Games Does My Infant Play?

Games such as peek-a-boo, dancing with the child in your arms, floor play, and singing games are all effective ways to engage infants and help them learn about the world around them. Looking at picture books and listening to music are wonderful ways to share time with your infant. As your baby grows and begins to roll and crawl, toys that move, such as trucks and trains, will provide turn-taking activities.

Activities for Infants 0 to 6 Months Old

- Talk and sing when you are doing activities like changing, bathing, or feeding the child.
- Play with your child’s toes and fingers, and say the names of body parts.
- Place high contrast and colorful objects where the baby can see and begin to reach for them.
- Walk with the infant and rock, sing songs, and bounce.
- Engage in floor time as well as other positions during play.
- Play with toys that make sounds (soothing) and play music.¹

Activities for Infants 6 to 12 Months Old

- Play peek-a-boo and other hiding games.
- Promote crawling and pulling up in safe places.
- Promote playing with toys that react when they are touched or squeezed.
- Provide teething toys.
- When your child is upset, console by rocking and holding.
- Let your child fill containers and dump them out.
- Provide your child with pots, pans, and a wooden spoon.
- Change toys often when babies get bored with them.¹

What are Typical Infant Behaviors?

Don’t be surprised if your infant seems to be enjoying your time together one minute and is screaming the next. Infants are not able to understand subtle changes in their bodies, so they may be content and happy while the two of you play, only to realize they are hungry, wet, and unhappy about it. This quick turn of events will require you to quickly change your behavior as well. The “turn on a dime” behaviors seen in infants, although frustrating, are a normal part of the developmental process.

Parenting an Infant After Sustaining Concussion

- Infants are exhausting not only because of their sleep patterns but because they require constant attention. This becomes more evident once they are mobile. Be aware of your level of fatigue as this can influence your thinking skills and overall performance.
- You will have to be attentive to your child or be aware of what he or she is doing almost all of the time. Dual tasking, like watching television, playing video games, or talking with/ texting friends while watching your infant may be unsafe.
- If you have issues with memory, double check the safety of your surroundings; close doors, latch safety gates, and keep hot or sharp items out of reach.
- Ask for help when you need it. If you need a brief break, place your infant in a safe place (such as a crib) and leave the room. Your child will be fine for a few minutes while you reset.
- Never leave your child alone in the home without supervision by an adult or child older than 14.
- Incorporate cognitive strategies you have used for other activities, such as work and school, to the home and your role as a parent.
- Most of all, have fun!

Takeaways

Use this space to list three activities you will do with your infant.

1.

2.

3.

1. National Network for Child Care. Helping infants learn. In: Lopes M, ed. *CareGiver News*. 1993:4. Amherst, MA: University of Massachusetts Cooperative Extension.

PATIENT HANDOUT: UNDERSTANDING YOUR CHILD'S WORLD— TODDLER (1–3 YEARS OLD)

Age-Appropriate Behaviors

A child's understanding of the world around them is based on his or her age and his or her life experiences. We wouldn't expect a 3-year-old to be able to sit for a 30-minute conversation but we wouldn't think twice about asking a 17-year-old to do the same. Successful engagement with your child is somewhat dependent on your ability to understand the world in which they live. This handout is designed to help you identify age-appropriate play activities that the two of you can do successfully.

How Does My Child Play?

Toddlers are active learners who are continuing to develop the fine and gross motor skills they will need as they get older. At this age, they are becoming more interested in other children and will begin to play alongside them. Younger toddlers will have difficulty sharing and cooperating, so it is a good idea to have enough materials for you and your child to complete an activity. That being said, encourage turn-taking while speaking and playing. Language development is on the rise during these years. In addition, your toddler may look to you to model play behavior and copy what you have done.

What Does My Toddler Play?

Children this age will spend hours putting things in containers and dumping them out. They will begin building with sand, play dough, and clay. They become increasingly interested in music and dance. These gross motor activities also include outdoor playgrounds, walks, and throwing and chasing balls. Toddlers will put things in their mouth as a means of exploration, so be sure to watch these children carefully.

Toddlers love to play with a variety of household objects and will often toss a fancy doll for a 99-cent kitchen spoon. Activities and toys encourage the child's imagination, and as you play with your toddler, promote imaginative and dramatic play. Some toys the two of you can enjoy together include blocks, riding toys, dolls, pots and pans, stuffed animals, dress-up clothes, cars/trucks/trains, books, some arts and crafts, and music.

Activities for Toddlers

- Fill and dump containers.
- Make play dough.
- Sink or water table play (be sure the child is supervised at all times).
- Pretend play and building. Ask your local appliance shop for a cardboard box from a refrigerator or other large appliance. Cut doors and windows in the box to make a playhouse.
- Draw with different-sized crayons. Different sizes help with toddlers' fine motor skills and hand muscle development.
- Messy play. Finger paint with shaving cream mixed with food coloring.
- Jumping. Place pillows, cushions, or a mattress on the floor and let your toddler bounce and jump.
- Playground play. Some swings, climbing equipment, and low slides are appropriate for this age group.
- Go for lots of walks. Encourage your toddler to practice walking and running.
- Help your toddler practice climbing stairs.
- Play house with dolls and housekeeping props, such as plastic dishes and spoons.¹

What are Typical Toddler Behaviors?

Because their language skills are just beginning to emerge, toddlers have a difficult time expressing their needs and feelings. This is often the source of the toddler "meltdown." Be aware of the pre-meltdown signs during play. These may include physically changing their space, decreased eye contact, increased laughter, or sudden fatigue.

Toddlers are movers who constantly run from one activity to another. Although they need structure to predict what comes next, highly structured activities like board games and play with numerous rules are difficult and can become a source of frustration for the child and the caregiver.

Interacting With a Toddler

- Provide choices; if the parent or caregiver provides two choices for an activity, the child feels in control of their environment and activities. Instead of saying, "It's time to read a book," say, "Would you like to read a book and then brush your teeth or would you like to brush your teeth first and then read a book?"
- Acknowledge the toddler's feelings. Instead of saying, "There's no reason to be upset that you spilled the bubbles," say "I can see you're sad about spilling that container of bubbles. Would you like to make more?"
- Avoid environments that require the child to stay still and quiet for long periods of time.
- Be flexible in your activities and the time you spend with each one.
- Set limits to help the child understand what is expected.
- Provide positive reinforcements during games and activities.
- Let the child know how much you enjoy playing with him/her.
- Position yourself at eye level with the child during games and activities, when possible.
- Most of all, have fun!

Takeaways

In the space below, list three activities you will do with your toddler.

1.

2.

3.

1. National Network for Child Care; Miller L. Play activities for children birth to nine years. *Family Day Care Facts*. Amherst, MA: University of Massachusetts. 1991.

PATIENT HANDOUT: UNDERSTANDING THE STRUCTURE OF PLAY AND PARENT-CHILD ACTIVITIES

Background

The elements of play may seem routine on the surface. Games such as patty-cake, building with Legos (Lego Systems, Inc, Enfield, CT), imaginary pirates, or a backyard game of basketball, despite their familiarity, are complex and fall within a continuum of structure and cooperation.

Throughout the therapy process, an emphasis has been placed on your ability to identify skills that are strengths and some that present a challenge. Self-reflections on task demands and the strategies you have adopted can easily be translated into the activities you do with your children. If needed, effective planning and strategy implementation can make the wonderful and challenging job of parenting a positive experience for you and your children. This handout provides some suggestions that may help you understand which, if any, strategies you may use when spending time with your child (**Figure 9-8**).

What are the Structures of Play?

All activities and play have some type of structure. They typically fall into three categories: structured, semi-structured, and unstructured.

“Structure” refers to the level of variability that an activity allows in order to successfully complete it. For example, in the areas of play, a **structured** activity may be building a model. To complete an airplane model correctly, you must perform the steps in a specific order (eg, you would not put the wings on without first having a stable body). Successful completion of one step is based on successful completion of previous ones.

A **semi-structured** task is an activity that presents with a logical sequence, but there are a number of different ways to reach the end (eg, constructing a puzzle). You are given the materials to complete the task and you know exactly what the final product will look like, but there is an infinite number of ways you can go from the first step (eg, opening the box and pouring out the puzzle pieces) to the final step (eg, fitting the last piece).

An **unstructured** activity is one in which the directions and rules are minimal. An unstructured play activity you may engage in with your child is sand play; you have the materials (sand) but there are few rules or outcome expectations identified. As the two of you play together, unstructured play may quickly become semi-structured as you negotiate what you may build, how to go about it, and what it may look like in the end.

The Importance of Understanding Activity and Play Structure After Concussion

The various levels of structure in play activities will require you to use different cognitive skill sets. These skill sets become even more critical when engaging in an activity with another person, especially a child. Because various levels of structure, as related to play, will tax different cognitive skills, you may use various cognitive strategies to make the activities easier for you.

Level of Structure	Examples of Activities	Cognitive Demands Associated with Level of Structure
Structured (typically this level of structure is not tolerated by infants and toddlers. At the age of 5, children begin to engage in more structured play successfully).	Model building, some cooking activities (eg, baking), construction tasks, board games, video games, many sports	Organization and planning, sequencing, error detection and correction, attention to detail, memory, time management, ability to shift focus, ability to understand and follow rules and directions
Semi-structured (toddlers to adult-age children)	Puzzles, arts and crafts, pretend play, some sports, some video-games	Task initiation, organization and planning, error detection and correction, flexibility, time management, attention
Unstructured (all ages)	Some arts and crafts, such as free drawing and play dough, sand play, water play, dancing	Task initiation, creative thinking, planning and organization, flexibility, time management

REMEMBER: When choosing play activities to do with your children, be sure to consider the level of structure in the activity and how the structure may present cognitive demands; being aware of potential challenges can greatly increase the success and enjoyment of the activities you choose to do with your child.

Takeaways

Consider the following questions as you plan activity time with your children.

- Currently, what level of structure works best for you as you play with your children?
- What cognitive strategies might make fun time with your children more satisfying and enjoyable for you and them?

PATIENT HANDOUT: UNDERSTANDING THE ENVIRONMENT OF PLAY AND THE ROLE OF COOPERATION IN CHILD-RELATED ACTIVITIES

Environment of Play

We spend time with our families in every environment imaginable: home, grocery store, places of worship, parks, friends’ homes, schools, libraries, and others. Each of these settings presents different environmental conditions that may influence your ability to engage with your child.

Take a moment to review the following list of environmental characteristics. For each environmental characteristic, rate the extent to which it helps or detracts from “fun time” with your child by placing a checkmark in the appropriate column.

Environmental Characteristic	Helps me enjoy my time with my child	Detracts from my time with my child	Neither – No effect on my time with my child
Crowds			
Light and glare			
Noise (volume)			
Noise (in the background)			
Temperature (hot or cold)			
Time of day			
Colors in a room			
How the environment is organized			
Physical space (too large or too small)			
Knowledge of exits			
Other:			
Other:			

When planning activities with the family, be aware of how these environmental factors may influence your ability to make this a successful experience for you and your children. Here are some suggestions.

- Go to the playground early in the day or later in the evening when it will be less crowded and you will be less distracted. If you have light sensitivity, the early morning and evening hours will make it a more pleasant experience for you.
- During shopping activities, avoid big stores if possible. Go to a smaller local store where there are fewer distractions for you and your child.
- Plan family activities around the time of day you feel most able to participate. This may be early in the morning or later in the afternoon.
- If you have concerns about public places, be sure to spend some time exploring the space to alleviate those concerns. This will help you better engage with your family members.
- Be aware of the environmental demands and use the strategies you have learned with your therapist to successfully engage with your family members.

Takeaways

In the space below, list two things that, based on this information, you will do next time you take your children out for a fun activity in the community.

- 1.
- 2.

Activities and Collaboration

Similar to a continuum of structure, when engaging in activities with your child, the activity you choose has an element of collaboration and cooperation. Often the amount of cooperation can be modified by providing more materials or taking away materials. In general, activities that require cooperation tend to involve greater levels of communication and satisfaction. Consider how you can orchestrate the cooperation and interaction characteristics of an activity by how you set up a simple family meal.

If you are having a family dinner and each person is given a plate of food that comes from the kitchen, there is little need to ask for things on the table. All the family members have what they need at every given time during the meal, but there are fewer requirements for communication. This situation places low demand on family cooperation. Conversely, if you sit down at the table with the food in the middle and family members are expected to serve themselves (family style), the situation is conducive to more collaboration and discussion. This situation places high demand on family cooperation, but provides the opportunity to practice healthy cooperation and negotiation.

The nature of participating in activities with your child, be it a family dinner or a play task, is basically the same. Think about the activity ahead of time and consider how you are feeling as you begin the activity with your child. Make choices about just how much cooperation you want to build into the activity. For example, if one or both of you are tired, you may decide to work in parallel on your model airplane. Minimize the conversation or sharing by working on separate task components. If you are interested in increasing the likelihood of working cooperatively together, work together on one component of the model airplane or limit the availability of tools and materials so that you need to share.

Insight into how various activities influence collaboration between you and your child is important when choosing activities that will promote a healthy reengagement after your injury. Remember that children younger than 3 will have a hard time sharing and collaborating on a project, so have materials for both of you to use.

REMEMBER: Sharing supplies and materials during an activity generally leads to greater levels of communication and cooperation.

Takeaways

Think of one activity that you enjoy with your child or children. List three things you can change about how you organize or perform this activity to increase the cooperation and communication involved.

1.

2.

3.

PATIENT HANDOUT: RECONNECTING WITH YOUR SPOUSE OR SIGNIFICANT OTHER

Background

Returning to a loved one after deployment can fill you with anticipation and excitement as well as apprehension. The emotions are even more complex if you are coming home with injuries. This handout provides some basic information to prepare you for the process of reconnecting with your spouse or significant other; we encourage you to seek out other resources that are available to you as well.

Points to Keep in Mind

After your return home, the “new normal” may take weeks to months to establish. It is normal for things to be awkward between you and your spouse at first. Be open to communication, be flexible, share your experiences, and listen to your loved one’s concerns.

Remember that you may continue to experience issues associated with your concussion after returning home. Sometimes people experience symptoms as they encounter new challenges or try to function in the less-structured environments of home. Despite the possibility of physical and cognitive consequences of your injuries, returning to the role of “present spouse” after a long absence is both exciting and anxiety provoking for you and your loved one. Be patient with yourself and your spouse during the first 6 months to year; the process of reengaging takes time.

Share

Share your feelings with your spouse about what is going on and what has happened to you. Encourage your loved one to share his or her feelings as well. Listen to what your loved one shares and validate his or her feelings; both of you have gone through a number of changes and have experienced quite a bit on your own. The best way for the two of you to reengage is to communicate and spend time talking and sharing.

Educate

Educate your spouse about mTBI, what it is, and behaviors often associated with this diagnosis. Your partner may not understand why you are sleeping so much, avoiding bright lights, having constant headaches, or failing to pay attention. Let your loved one know how the injury has impacted you and what you have done during the rehabilitation process to decrease the associated symptoms. Help him or her become part of your recovery process.

Ask

Ask questions about how the household was managed while you were gone. Your loved one had to adopt a new routine, which may have included taking care of kids, assisting other military spouses and providing support, paying bills, dealing with family-related health issues, and doing yard work and home maintenance, to name a few. Do not be critical of those tasks that may have fallen to the bottom of the priority list and be sure to acknowledge the significant amount of work your loved one did during your absence. Your partner may love to return many of these duties to you. Discuss this with your loved one and work on slowly resuming “normal” household and partner duties.

Communicate

Communicate your needs and let your partner know why you ask for things. Your spouse may have planned a full schedule with friends and family upon your return home. If you feel as though you are unable to tolerate a busy schedule, ask to begin slowly and work with your spouse on scheduling events and activities.

Use Resources

Use the resources available to members of the military who are returning home with or without an injury. Reconnecting can be difficult for both you and your partner, and support may be needed. Bring your spouse to your rehabilitation sessions so treatments and goal setting can include his or her concerns as well as your own.

Teach

Teach your partner many of the strategies you have adopted to ensure success in different areas; he or she can act as a reinforcer or reminder for strategy use. If needed, incorporate these into home and family routines.

FURTHER RESOURCES

The following are additional places where you can find help returning to family life after deployment.

- Beyond The Yellow Ribbon: Bringing Soldiers and Their Families All the Way Home. <http://www.beyondtheyellowribbon.org/home>. A website of the Minnesota National Guard. Accessed October 25, 2013.
- Reintegrating into Family Life After Deployment. A website provided by the Defense Centers of Excellence. <http://www.realwarriors.net/active/afterdeployment/familylife.php>. Accessed October 25, 2013.

PATIENT HANDOUT: REENGAGING IN HOUSEHOLD ROLES AND ACTIVITIES

Background

During your absence, your loved one became responsible for running the home and all the responsibilities related to the household. At times, the additional responsibility was welcome. Success may have generated a sense of accomplishment and contribution not felt before. At the same time, the additional responsibilities may have become burdensome and presented unwelcome challenges.

Resuming the traditional roles each of you had prior to your deployment and injury may be difficult; however, assuming your partner will continue with all he or she had taken on is unrealistic. This handout and the worksheet that follows are designed to help you and your partner identify ways in which you can work together at home. Use the worksheet as a way to negotiate role resumption and develop new routines together.

Considerations for Discussion Between You and Your Partner as You Reestablish Household Roles

- Am I limited by any deficits or problems (physical, cognitive, visual, social, emotional) that will prevent me from successfully resuming a role?
- Do I currently have any activity restrictions that may prevent me from successfully resuming a role (ie, driving)?
- Are there any other barriers that prevent me from resuming a role (ie, motivation, interest, time, lack of competence)?
- What roles are most important for me to resume and what roles are most important for my partner to maintain?
- What roles do I not wish to resume or take on, and what roles does my partner hope to relinquish?
- Do my partner and I argue over any of the identified roles and associated activities? If so, what is the source of the argument (we both want to do it, neither of us wants to do it, being critical of the other’s performance or style)?

Once you and your spouse have determined how to reassign home and family responsibilities, it is important to develop a plan and reflect on role negotiation and performance as a team. Set aside a time each week to coordinate your household family activities for the upcoming week. Use daily planners and calendars to help organize and develop these together.

Example

Week of 12/20	Laundry	Yard Work	Cooking	Take Kids to School	Pick up Kids	Pay Bills
Monday			Joe	Joe	Jane	Jane
Tuesday			Jane	Jane	Joe	
Wednesday	Jane		Joe	Joe	Jane	
Thursday			Jane	Jane	Joe	
Friday			Joe	Joe	Jane	
Saturday	Jane		Eat out			
Sunday		Joe	Together			

Keep a journal and identify when role conflict occurred between you and your spouse and what was done to resolve the conflict. Talk together about the conflict to gain the other’s perspective. Bring the journal entries and calendars to therapy and use these as a source of discussion and reflection on performance.

REMEMBER: Communication with your partner is key to successful role negotiation.

PATIENT HANDOUT: DIVIDING UP ROLES WITH YOUR SPOUSE

This handout is to be completed by the patient’s spouse. An alternative version may be developed to explore predeployment roles and desire to resume.

PART A:

The purpose of this worksheet is to explore roles you participated in before, during, and after your partner’s deployment. Roles in the areas of home management, finances, parenting, future planning, and work distribution are considered.

Role	Before Deployment	During Deployment	After Deployment	Desire to Continue (Yes or No)
Home Management				
Shopping				
Cleaning				
Home repair				
Yard work				
Laundry				
Pet care				
Cooking				
Finances				
Budgeting				
Bill paying				
Banking				
Insurance				
Wills				
Credit cards				
Mortgage				
Parenting				
Discipline				
Transportation				
Scheduling				
Medical issues				

Help with school				
Volunteering for kid activity				
Morning routine				
Bedtime routine				
Gift buying				
Other				
Auto repair				
Vacation plans				
Moving-related activity				
Visitors				
Retirement planning				
Other				

PART B:

- List those roles you want to relinquish:

- List those roles you want to maintain:

- Which roles are areas of conflict with your partner?

- Which roles are you willing to negotiate on?

Data source: Gambardella LC. Role-exit theory and marital discord following extended military deployment. *Perspect Psychiatr Care*. Jul 2008;44(3):169-174.

**PATIENT HANDOUT: RETURN TO SCHOOL NEEDS ASSESSMENT—
ESSENTIAL SKILLS FOR COLLEGE SUCCESS**

Name: _____ Date _____

Check all that apply:

- I am enrolled in school this semester.
- I am planning on enrolling in school within the year.
- I am a part-time student.
- I am a full-time student.

Directions: Using the scale below each item, please rate how difficult is it (or if you are not in school at present, how concerned you are regarding the items below) for you to:

1. Listen to instructor and take notes at the same time
0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely
2. Pay attention to the instructor because you are distracted by people or situations that seem threatening
0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely
3. Stay awake in class
0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely
4. Pay attention to the instructor because your mind wanders
0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely
5. Ask the instructor a question or for clarification and additional explanation
0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely
6. Focus while reading at home
0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely
7. Focus while reading at work or school
0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely
8. Remember what you have learned when taking a test
0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely
9. Organize notes from lectures
0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely
10. Decide what to write about in a paper
0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = extremely

11. Write a paper (including locating, collecting, and organizing the information needed to write the paper)
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely
12. Finish homework projects, assignments, and papers on time
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely
13. Remember to bring completed assignments to class
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely
14. Start working on a project or assignment (paper) so you have plenty of time to complete (not starting at the last minute)
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely
15. Remember verbal instructions for complex projects
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely
16. Complete assigned reading material
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely
17. Work with others on group assignments
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely
18. Write so others can read and understand what you have written
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely
19. Make oral presentations in class
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely
20. Stay motivated to put your best effort into school for the entire semester
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely
21. Keep a balance between school and other things going on in your life (eg, family, job, health, etc)
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely
22. Keep your emotions (anger, frustration) toward instructors and fellow classmates under control
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely
23. How hopeful are you that you will succeed in school?
0 = not at all 1= a little bit 2 = moderately 3 = quite a bit 4 = extremely

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PATIENT HANDOUT: STUDY-READING SYSTEMS

SURVEY, **Q**UESTION, **R**EAD, **R**ECORD, **R**ECITE, **R**EVUE

This handout outlines “SQ4R,” a system designed to assist your comprehension and retention of material while reading.

SURVEY*

Preview the entire book

- Survey the introduction or preface
- Survey the table of contents
- Survey appendices, glossaries, and references
- Flip through the pages to see how the information is organized

Preview the chapter

- Read the introductory section and make predictions about the content
- Read the headings and subheadings
- Look for pictures, graphs, charts, and tables
- Read the summary at the end of the chapter

QUESTION†

- Read the questions at the end of the chapter for main concepts and important details
- Develop your own who, what, how, when, where, which, and why questions about the information
- Compare the information with your opinions and previous knowledge
- Understand the main ideas of pictures, graphs, charts, and tables
- Look up unfamiliar words

READ/RECORD‡

- Read the text in a systematic manner from start to end
- Take notes either in the book or on notepaper
- Summarize the information in your own words; if you are having difficulty, implement a strategy to overcome barriers (eg, reduce the demands, shorten your study time, eliminate distractions, or take a break)

RECITE§

- Recite answers to questions aloud in your own words, check your notes or the text for accuracy, ask for clarification if you don't understand the information
- Provide examples cited in the text or from your own knowledge or experiences

REVIEW¶

- Review your notes and test yourself frequently to retain information for the test
 - Define new vocabulary
 - Write a summary of the chapter using your own words
-

*Similar to briefing or overview of mission.

†Similar to operational guidelines.

‡Similar to perform duties, carry out mission, record.

§Similar to debriefing.

¶Similar to after-action report.

FURTHER RESOURCES

- Holschuh JP, Aultman LP. Comprehension development. In: Flippo RF, Caverly DC, eds. *Handbook of College Reading and Study Strategy Research*. 2nd ed. New York, NY: Routledge; 2009:121–144.
- Robinson FP. *Effective Study*. New York, NY: Harper & Brothers; 1946.

PATIENT HANDOUT: NOTE-TAKING STRATEGIES

Note taking plays a critical role in academic success and is required in multiple contexts and formats, including listening to lectures or instructions and taking notes while reading textbooks, articles, or on-screen electronic text. Note taking during lectures requires you to attend to and process information, select key details, and write or type notes while simultaneously processing incoming information. A second major aspect of note taking comes after the lecture, when you revise your notes to summarize, fill in, or clarify information.

Invest the time to implement the following suggestions before, during, and after the lecture.

Before the Lecture

Prepare yourself to learn by^{1,2}:

- Arriving early to class to select a seat where you will not be distracted.
- Checking the course syllabus or purpose of the briefing to anticipate what the instructor is likely to present.
- Reading assignments before class to understand main ideas, formulate questions, and become familiar with terminology.
- Doing a quick review of previous lecture notes.

During the Lecture

Listen actively by¹:

- Developing the intention to learn in the lecture and getting involved in the ideas being presented.
- Developing notes that will allow quick review of key concepts that are likely to be on the test.
- Asking or answering questions and seeking clarification while the information is fresh in your mind.
- Generating questions and formulating answers of information that might be on the test.

If you lose concentration¹:

- Use “self-talk” to manage attention lapses (eg, “I will relax, breathe, and refocus on what I am doing”).
- Leave space between points and paragraphs if you miss information so you can fill in blanks later.
- Keep a notecard in view to remind you to focus.
- Write down cues to help remind you of the topic.
- Use a smartpen or audio recorder to retrieve missed information.

How to take notes and what to write down¹⁻³:

- Take notes consistently, but do not try to write down every word; focus on facts, definitions, or formulas
- Translate ideas into your own words.
- If the instructor is using slides, write down the main idea from each slide.
- Write main ideas with a few supporting details. Organize as you write:
 - Leave space to elaborate (eg, information from your textbook that complements the lecture).
 - Use indentation to distinguish major from minor supporting points.
 - Develop a system of abbreviations and symbols.
 - Draw pictures or diagrams to help visualize information (mapping).
- Be aware of the following cues that may signal the importance of topics or details and highlight them in your notes:
 - Information reviewed from past classes.

- Information repeated or restated during class, recapped at the end of class, or written on the board.
- Amount of time spent on a point and number of examples provided.
- Word hints, such as, “This is key information,” “Make sure you understand this,” “These are the key points,” “Got it?”
- Nonverbal cues from the lecturer, such as pauses, change in intonation, and gestures.

After the Lecture^{1,3}

- Take 5 minutes to review your notes after class to change, organize, add, delete, summarize, or clarify information.
- Review and revise your notes to fill in missing information, highlight key information, or link new information to your existing knowledge base.
- Write down key words to cue your recall of important information.
- Formulate questions that may be asked on a quiz.
- If you do not understand information presented during the lecture, check your textbook, or request clarification from the instructor after class or during office hours.
- Review your notes at regular intervals to keep the information in your memory.

REMINDER: Test preparation starts the first day of class with note taking and developing a study schedule.

FURTHER RESOURCES

- Penn State University, Center for Academic Achievement. http://www.sl.psu.edu/Documents/Note_Taking_Strategies.pdf. Accessed October 28, 2013.
- James Madison University. Learning Toolbox. <http://coe.jmu.edu/LearningToolbox/index.html>. Accessed October 28, 2013.
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PATIENT HANDOUT: TEST-TAKING STRATEGIES

Before the Test

- Develop a schedule to review notes and study guides, and self-test.
- Make sure that you attend the class meeting before the exam. The teacher often provides information about the material that will be on the test or other information that may be helpful.
- Request accommodations through the Office for Students With Disabilities (or similar) on campus if needed (eg, taking the test in a nondistracting environment).
- Arrive early to allow yourself time to prepare your mind and body to perform optimally and secure a preferred seat in the classroom.

During the Test

- Survey the test to quickly develop a “plan of attack.”
 - Allocate your time accordingly (eg, you may need more time to answer essay questions).
 - Consider answering the easy questions first.
- Read instructions and questions. Underline key points to consider when responding. Ask for clarification if you don’t understand.
- For multiple-choice questions:
 - Think of the answer before you read the choices.
 - Eliminate obvious wrong answers.
 - Consider that technically worded choices are not always the correct answer.
- For true-or-false questions, attend to qualifiers and keywords (eg, usually, sometimes, generally, always, or never).
- For essay questions:
 - Make an outline before writing the essay to organize your thoughts.
 - Answer the questions completely. Some may have multiple components.
 - Avoid long introductions or conclusions.
 - If the question asks for facts, don’t provide opinions.
- Mark difficult questions. Revisit these later if you have time.
- Answer all questions if there is not a penalty for guessing.
- Proofread your work to correct errors (eg, spelling, grammar, and punctuation) that may lower your grade.

FURTHER REFERENCES

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PATIENT HANDOUT: TOPOGRAPHICAL SYMBOLS ON A MILITARY MAP**Conditions**

You are given a standard 1:50,000-scale military map.

Standards

Identify topographic symbols, colors, and marginal information on a military map with 100% accuracy.

Performance Steps

1. Identify the colors on a military map.
 - Ideally, every feature on the portion of the earth being mapped is shown on the map in its true shape and size. Unfortunately, that is impossible.
 - The amount of detail shown on a map increases or decreases, depending on its scale; for example, on a map with a scale of 1:250,000, 1 inch shows 4 miles.
 - Details are shown by topographic symbols. These symbols are shown using six basic colors (see Table 1 below).

TABLE 1
COLORS ON TOPOGRAPHIC MAPS

Colors	Symbols
Black	Cultural (human-made) features (other than roads)
Blue	Water
Brown	All relief features (contour lines on old maps, cultivated land on red-light readable maps)
Green	Vegetation
Red	Major roads, built-up areas, special features on old maps
Red-Brown	All relief features and main roads on red-light readable maps

2. Identify the symbols used on a military map to represent physical features, such as physical surroundings or objects, as shown in Table 2.

TABLE 2
FEATURES ON TOPOGRAPHIC MAPS

Features	Colors	Description
Drainage	Blue	These symbols include lakes, streams, rivers, marshes, swamps, and coastal waters.
Relief	Brown	These features are normally shown by contour lines, intermediate contour lines, and form lines. In addition to contour lines, there are relief symbols to show cuts, levees, sand, sand dunes, ice fields, strip mines, and glaciers.
Vegetation	Green	These symbols include woods, scrub, orchards, vineyards, tropical grass, mangrove and marshy areas or tundra.
Roads	Red, Black, or Red-brown	These symbols are hard-surface, heavy-duty roads; hard-surface medium-duty roads; improved light-duty roads; unimproved dirt roads; and trails. On foreign road maps, symbols may differ slightly. Check the map legend for proper identification of roads.
Railroads	Black	These symbols show single-track railroads in operation; single-track railroads not in operation; double- or multiple-track railroads.
Buildings	Black, Yellow, Red, or Pink	These symbols show built-up areas, schools, churches, ruins, light-houses, windmills, and cemeteries.

- The shape of an object on the map usually tells what it is. For example, a black, solid square is a building or a house; a round or irregular blue item is a lake or pond.
 - Use both logic and color coding to determine a map feature. For example, blue represents water.
 - If you see a symbol that is blue and has clumps of grass, it's a swamp.
 - The size of the symbol shows the approximate size of an object. Most symbols are enlarged 6 to 10 times so that you can see them under dim light.
 - Use the legend; it identifies most of the symbols used on the map.
3. Identify the marginal information found on the legend.
- Marginal information found at the top of the map sheet:
 - The top left corner contains the geographic location of the map area and the scale of the map.
 - The top center shows the name of the map sheet.
 - The top right corner contains the map edition, map series, and the map sheet number.
 - Marginal information at the bottom of the map sheet:
 - The lower left corner of the map contains the legend, the name of the agency that prepared the map, the map sheet number, and the map sheet name.
 - The bottom center contains the bar scales in meters, yards, miles, and nautical miles; the contour interval of the contour lines; the grid reference box; the declination diagram; and the G-M angle (mils or degrees).
 - The lower right corner contains the elevation guide, the adjoining map sheet diagram, and the boundaries box, which shows any boundaries that may be on the map.

PATIENT HANDOUT: DETERMINE GRID COORDINATES OF A POINT ON A MILITARY MAP

Conditions

Given a standard 1:50,000 scale military map, a 1:50,000 grid coordinate scale, pencil, paper, and a point on the map for which coordinates must be determined.

Standards

Determine the six-digit grid coordinates for the point on the map with a 100-meter tolerance (grid coordinates must contain the correct two-letter 100,000 meter-square identifier).

Training and Evaluation

Training information outline:

1. To keep from getting lost, a soldier must know how to determine his or her location. A combat area has no street addresses, but a military map can help you identify a location accurately. The map has vertical lines (top to bottom) and horizontal lines (left to right). These lines form small squares 1,000 meters on each side called "grid squares."
2. The lines that form grid squares are numbered along the outside edge of the map picture. No two grid squares have the same number.
3. The precision of a point location is shown by the number of digits in the coordinates: the more digits, the more precise the location.
 - 1996: a 1,000-meter grid square.
 - 192961: to the nearest 100 meters.
 - 19269614: to the nearest 10 meters.

Exercise

1. Use the figures in *The Soldier's Manual of Common Tasks* to complete this exercise. Your address is grid square 1181. How do you know this? Start from the left and read right until you come to 11, the first half of your address. Then read up to 81, the other half. Your address is somewhere in grid square 1181.
2. Grid square 1181 gives your general neighborhood, but there is a lot of ground inside that grid square. To make your address more accurate, just add another number to the first half and another number to the second half so your address has six numbers instead of four.
 - To get those extra numbers, pretend that each grid square has 10 lines inside it running north and south, and another 10 running east and west. This makes 100 smaller squares. You can estimate where these imaginary lines are.
 - Suppose you are halfway between grid line 11 and grid line 12. Then the next number is 5, and the first half of your address is 115. Now suppose you are also 3/10 of the way between grid line 81 and grid line 82. Then the second half of your address is 813. (If you were exactly on line 81, the second part would be 810). Your address is 115813.
 - The most accurate way to determine the coordinates of a point on a map is to use a coordinate scale. You do not have to use imaginary lines; you can find the exact coordinates using a coordinate scale and protractor (Graphic Training Aid 5-2-12) or a plotting scale. Each device has two coordinating scales, 1:25,000 meters and 1:50,000 meters. Make sure you use the correct scale.
3. Locate the grid square in which the point is located (the point should already be plotted on the map, for example, Point A).
 - The number of the vertical grid line on the left (west) side of the grid square is the first and second digits of the coordinates.
 - The number of the horizontal grid line on the bottom (south) side of the grid square is the fourth and fifth digits of the coordinates.

4. To determine the third and sixth digits of the coordinates, place the coordinate scale on the bottom horizontal grid line of the grid square containing Point A.
5. Check to see that the zeroes of the coordinate scale are in the lower left (southwest) corner of the map grid square.
6. Slide the scale to the right, keeping the bottom of the scale on the bottom grid line until Point A is under the vertical (right hand) scale. On the bottom scale, the 100-meter mark nearest the vertical grid line provides the third digit, 5. On the vertical scale, the 100-meter mark nearest Point A provides the sixth digit, 3. Therefore, the six-digit grid coordinate is 115813.
7. To determine the correct two-letter 100,000-meter square identifier, look at the grid reference box in the margin of the map.
8. Place the 100,000-meter square identifier in front of the coordinate, GL 11508133.

PATIENT HANDOUT: PERFORM FIRST AID FOR BLEEDING OF AN EXTREMITY

Conditions

You have a casualty who has a bleeding wound of the arm or leg. The casualty is breathing. Necessary equipment and materials include the casualty's first aid packet, materials to improvise a pressure dressing (wadding and cravat or strip of cloth), materials to elevate the extremity (blanket, shelter half, poncho, log, or any available material), rigid object (stick, tent peg, or similar object), and a strip of cloth.

Standards

Control bleeding from the wound following the correct sequence. Place a field dressing over the wound with the sides of the dressing sealed so it does not slip. Check to ensure the field and pressure dressing does not have a tourniquet-like effect. Apply a tourniquet to stop profuse bleeding not stopped by the dressings, or for missing arms and legs.

Performance Standards

1. Uncover the wound, unless clothing is stuck to the wound or if you are in a chemical environment. **Do not remove protective clothing in a chemical environment;** apply dressings over the protective clothing.

Note: *If an arm or leg has been cut off, go to step 5.*

2. Apply the casualty's field dressing.
 - Apply the dressing, white side down, directly over the wound.
 - Wrap each tail, one at a time, in opposite directions around the wound so the dressing is covered and both sides are sealed.
 - Tie the tails into a nonslip knot over the outer edge of the dressing, not over the wound.

Warning

Field and pressure dressings should not have a tourniquet-like effect. The dressing must be loosened if the skin beyond the injury becomes cool, blue, or numb.

- Check the dressing to make sure it is tied firmly enough to prevent slipping without causing a tourniquet-like effect.
3. Apply manual pressure and elevate the arm or leg to reduce bleeding, if necessary.
 - Apply firm manual pressure over the dressing for 5 to 10 minutes.
 - Elevate the injured part above the level of the heart unless a fracture is suspected and has not been splinted.
4. Apply a pressure dressing if the bleeding continues.
 - Keep the arm or leg elevated.
 - Place a wad of padding directly over the wound.
 - Place an improvised dressing over the wad of padding and wrap it tightly around the limb.
 - Tie the ends in a nonslip knot directly over the wound.
 - Check the dressing to make sure it does not have a tourniquet-like effect.

Note: *If the bleeding stops, watch the casualty closely, and check for other injuries. If heavy bleeding continues, apply a tourniquet.*

Warning

The only time a tourniquet should be applied is when an arm or leg has been cut off, or when heavy bleeding cannot be stopped by a pressure dressing. If only part of a hand or foot has been cut off, the bleeding should be stopped using a pressure dressing.

5. Apply a tourniquet.
 - Make a tourniquet at least 2 inches wide.
 - Position the tourniquet.
 - Place the tourniquet over the smoothed sleeve or trouser leg if possible.
 - Place the tourniquet around the limb 2 to 4 inches above the wound, between the wound and the heart but not on a joint or directly over a wound or a fracture.
 - Place the tourniquet just above and as close as possible to the joint when wounds are just below a joint.
 - Apply the tourniquet.
 - Tie a half knot.
 - Place a stick (or similar object) on top of the half knot.
 - Tie a full knot over the stick.
 - Twist the stick until the tourniquet is tight around the limb and bright red bleeding has stopped.

Note: *In case of an amputation, dark oozing blood may continue for a short time.*

- Secure the tourniquet. The tourniquet can be secured using the ends of the tourniquet band or with another piece of cloth as long as the stick does not unwind.

Note: *If a limb is completely amputated, the stump should be padded and bandaged (do not cover the tourniquet). If possible, severed limbs or body parts should be saved and transported with, but out of sight of, the casualty. The body parts should be wrapped in dry, sterile dressing; placed in a dry plastic bag; and placed in a cool container (do not soak in water or saline or allow to freeze). If your location in the field or during combat does not allow for the correct preserving of parts, do what you can to keep it sterile and prepare it to be transferred.*

- Do not loosen or release a tourniquet once it has been applied.
 - Mark the casualty's forehead with a letter *T* using a pen, mud, the casualty's blood, or whatever is available.
6. Watch the casualty closely for life-threatening conditions, check for other injuries (if necessary), and treat for shock.

**PATIENT HANDOUT: JOB-SPECIFIC TACTICAL SIMULATION 1—
DYNAMIC VISUAL SCANNING ACTIVITY**

Visual scanning and attention to detail are critical skills for any service member. In this task, you will be challenged to scan your environment for two specific visual stimuli:

1. People wearing glasses
2. People wearing hats

To keep track of your accuracy, you will be asked to keep a tally of the number of people you see that meet the descriptions above. Your totals will be compared with your therapist's.

People wearing hats

People wearing glasses

**PATIENT HANDOUT: JOB-SPECIFIC TACTICAL SIMULATION 2—
TARGET DETECTION ON VISUAL SCANNING ACTIVITY**

Visual scanning and attention to detail are critical skills for any service member. In this task, you will be challenged to hone your visual skills to locate and identify specific static visual targets. Use the scope and/or binoculars to locate and describe as many military items as you can.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PATIENT HANDOUT: DA-6/DUTY ROSTER ACTIVITY

Instructions

Using January's duty roster (DA-6), fill out the February duty roster. The last weekday and last weekend have been given to you. Be sure you always have someone on duty during a week and weekend. Weekday duty and weekend duty are considered two separate duty times; weekday duty numbers carry over to the next weekday, and weekend numbers carry over to the next weekend.

- All weekends and holidays are to be highlighted; holidays are considered weekends.
- If you have a service member who wants time off (pass or leave) a lowercase "a" should be placed in the days that service member wants off.
- The numbers will continue to increase while the service member is on pass or leave.

You must accommodate for the following special circumstances:

- 15 FEB 10 is President's Day and is a federal holiday for the division.
- SGT Foxtrot wants 22, 23, 24 FEB off to take his sick mother to the hospital.
- SGT Charlie wants 3 FEB off to take care of his kids.
- SGT Kilo wants 6 FEB off for hunting because it is rabbit season.
- SGT Alpha wants 26 FEB off because he is moving into his new apartment.

PATIENT HANDOUT

DUTY ROSTER		NATURE OF DUTY	ORGANIZATION	FROM (Date)	TO (Date)																												
GRADE	NAME	Month Day	JAN		FEB																												
		Day	29	30	31	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
SGT	ALPHA	15	1	2																													
SGT	BRAVO	16	2	3																													
SGT	CHARLIE	17	3	4																													
SGT	DELTA	18	4	5																													
SGT	ECHO	19	5	6																													
SGT	FOXTROT	6	7																														
SGT	GOLF	1	7	8																													
SGT	HOTEL	2	8	9																													
SGT	INDIGO	3	9	10																													
SGT	JULIET	4	10	11																													
SGT	KILO	5	11	12																													
SGT	LIMA	6	12	13																													
SGT	MIKE	7	13	14																													
SGT	NOVEMBER	8	14	15																													
SGT	OSCAR	9	15	16																													
SGT	PAPA	10	16	17																													
SGT	QUEBEC	11	17	18																													
SGT	ROMEO	12	18	19																													
SGT	SIERRA	13	19																														
SGT	TANGO	14	20	1																													

DA FORM 6, JUL 1974

PREVIOUS EDITIONS OF THIS FORM WILL BE USED UNTIL EXHAUSTED.

For use of this form, see AR 220-45; the proponent agency is DCSPER.

APD PE v1.00

ANSWER KEY

DUTY ROSTER		NATURE OF DUTY		ORGANIZATION		FROM (Date)		TO (Date)																										
GRADE	NAME	Month	JAN														FEB																	
		Day	29	30	31	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	
SGT	Alpha		15	1	2	16	17	18	19	3	4	1	2	3	4	5	5	6	7	6	7	8	9	8	9	10	11	12	13	14	10	11		
SGT	Bravo		16	2	3	17	18	1	2	4	5	3	4	5	6	7	6	7	8	8	9	9	11	9	10	12	13	14	15	16	11	12		
SGT	Charlie		17	3	4	18	19	20	1	5	6	2	3	4	5	6	7	8	9	7	8	10	10	11	11	12	13	14	15	12	13			
SGT	Delta		18	4	5	19	1	2	3	6	7	4	5	6	7	8	8	9	10	9	10	11	12	11	12	13	14	15	16	17	13	14		
SGT	Echo		19	5	6	1	2	3	4	7	8	5	6	7	8	9	9	10	11	10	11	12	11	12	13	12	13	14	15	16	17	14	15	
SGT	Foxtrot		1	6	7	1	2	3	4	5	8	9	6	7	8	9	10	10	11	12	11	12	13	14	13	14	15	16	17	18	19	15	16	
SGT	Golf		1	7	8	2	3	4	5	6	9	10	7	8	9	10	11	11	12	13	12	13	14	15	14	15	16	17	18	19	16	17		
SGT	Hotel		2	8	9	3	4	5	6	7	10	11	8	9	10	11	12	12	13	14	13	14	15	16	15	16	17	18	19	1	17	18		
SGT	Indigo		3	9	10	4	5	6	7	8	11	12	9	10	11	12	13	13	14	15	14	15	16	17	16	17	18	19	1	2	18	19		
SGT	Juliet		4	10	11	5	6	7	8	9	12	13	10	11	12	13	14	14	15	16	15	16	17	18	17	18	19	1	2	3	19	1		
SGT	Kilo		5	11	12	6	7	8	9	10	13	14	11	12	13	14	15	15	16	17	16	17	18	19	18	19	1	2	3	4	1	1		
SGT	Lima		6	12	13	7	8	9	10	11	14	15	12	13	14	15	16	16	17	18	17	18	19	1	19	1	2	3	4	5	1	2		
SGT	Mike		7	13	14	8	9	10	11	12	15	16	13	14	15	16	17	17	18	19	18	19	1	1	1	2	3	4	5	6	2	3		
SGT	November		8	14	15	9	10	11	12	13	16	17	14	15	16	17	18	18	19	1	19	1	2	1	2	3	4	5	6	7	3	4		
SGT	Oscar		9	15	16	10	11	12	13	14	17	18	15	16	17	18	19	1	2	1	2	3	3	4	4	5	6	7	8	5	6			
SGT	Papa		10	16	17	11	12	13	14	15	18	19	16	17	18	19	1	20	1	1	2	3	4	2	3	5	6	7	8	9	4	5		
SGT	Quebec		11	17	18	12	13	14	15	16	19	17	18	19	1	1	2	3	2	3	4	5	4	5	6	7	8	9	10	6	7			
SGT	Romeo		12	18	19	13	14	15	16	17	1	18	19	1	2	2	3	4	3	4	5	6	5	6	7	8	9	10	11	7	8			
SGT	Sierra		13	19	1	14	15	16	17	18	1	2	19	1	2	3	3	4	5	4	5	6	7	6	7	8	9	10	11	12	8	9		
SGT	Tango		14	1	15	16	17	18	19	2	3	1	2	3	4	4	5	6	5	6	7	8	7	8	9	10	11	12	13	9	10			

DA FORM 6, JUL 1974

PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE.

For use of this form, see AR 220-45; the proponent agency is DCS, G-1.

APD LF v1.02

PATIENT HANDOUT: TRAINING SCHEDULE

Instructions

You are in charge of creating a weekly training schedule for your platoon. The following activities need to take place every day: physical training, first and final formations, accountability, personal hygiene, breakfast, and lunch. Lunch must be an hour and a half.

The following activities do not need to be every day, but need to be scheduled into the week's events with no gaps or overlaps:

- weapons management
- complete Department of the Army (DA) Form 2404
- warrior skill training
- counseling / noncommissioned officer evaluation reports (NCOERs)
- equal opportunity class
- noncommissioned officer development plans (NCODPs)
- preventative medicine class
- training meeting
- suicide prevention meeting

Weapons management can only take place on Tuesdays and Thursdays. Counseling / NCOERs need to be completed after 1500. Please use the attached calendar to create a weekly training schedule.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
0500							
0530							
0600							
0630							
0700							
0730							
0800							
0830							
0900							
0930							
1000							
1030							
1100							
1130							
1200							
1230							
1300							
1330							
1400							
1430							
1500							
1530							
1600							
1630							
1700							
1730							
1800							

PATIENT HANDOUT: ARMY DRESS UNIFORM ERROR DETECTION

Instructions

Your job is to correct the Army dress uniform jacket in front of you. None, some, or all of the badges on the jacket are incorrectly placed. Use your knowledge and other available resources to correct the badges so the jacket is wearable.