

Vocational Implications of Psychiatric Disabilities: Introduction to Mental Illness – Transcript

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Powerpoint Presentation:
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Kat Oertle, Facilitator: Welcome everyone to the monthly RSA Region V CRP-RCEP teleconference. I'm Kat Oertle here at the University of Illinois and we have David Strauser on today. Dr. Strauser will be talking about vocational implications of psychiatric disabilities. I'll let you get started David.

David Strauser, Presenter: Thanks Kat. What I want to talk about today is psychiatric disabilities in the workplace and introduce you to some basic concepts and issues regarding psychiatric disabilities in the workplace, using major depressive disorder as an example. I'm going to assume, and Kat maybe you can correct me if I'm wrong on this, that everybody has access either via computer or has printed out the PowerPoint slides.

Kat Oertle, Facilitator: They should.

David Strauser, Presenter: Okay, that is what I'm going to be using as my foundation for my discussion. I've also provided some background information that is in addition to the PowerPoints. I believe that has been disseminated as well. Those are the two documents that we're going to be working with today, primarily focusing in on the PowerPoints. I'm starting off on slide two now, which is entitled "Overview." I think it's really important how the labor market is configured and how the labor market is currently changing and how that might impact people with psychiatric disabilities. It's important to understand that work is changing. There are more lay offs, more downsizing, and different skill sets that are needed.

We're going to go over some key terminology that will be relevant to us as we talk about psychiatric disabilities, particularly in how we would use that from a work perspective and how we're going to operationalize work-related impairment. I'm going to go over the diagnostic criteria using major

depressive disorders. My purpose here again is not to teach you how to diagnose, but to help you become aware of how a diagnosis is established so that you understand it and can work with it more effectively. I'm not going to talk today as much about treatment options. We will certainly discuss some of those things from a vocational perspective, but really today I want to try to give you the "nuts and bolts" of how work is changing, how it impacts people with psychiatric disabilities, and how we can operationalize vocational impairment or impediment as a result of psychiatric disabilities.

On slide three I have an overview of mood disorders. I don't want to pay too much attention to that today. I am going to use major depressive disorders or depression as our example today for diagnosis. On slide four and I want to spend a little bit of time on the changing nature of work. If you come to any of our workshops this summer or you've been to our workshops in the past, we always talk about the changing nature of work. I think this is a really important starting point for variety of reasons. One – the world and the economy and the labor market distribution are becoming more global in nature. It's a global economy. Today with our US economy not doing very well, there has been more emphasis on the global economy, on foreign currencies, exports of labor, exports of goods and people exporting labor to the US.

It's a changing nature, and that unfortunately has a great impact for individuals with mental health impairments or mental disabilities, psychiatric disabilities specifically. Many times some of the characteristics that are associated with psychiatric disabilities, problems with attention, concentration, getting along with others, supervision, not being able to handle lack of structure very well, those are problems for people with psychiatric disabilities and yet those are pretty inherent and pretty imbedded in the global economy. Technology has been a great access and improvement for people with physical disabilities. Technology and globalization, virtual offices, different things like that have not been necessarily good for people with psychiatric disabilities. Because of the globalization of the economy and how things have changed and how things have become more spread out, more diffuse, some ways less structured, there tends to be career development issues for people with psychiatric disabilities. For those of you who work with people with psychiatric disabilities, my guess is you've encountered these issues quite a bit. There's a lot of stress related to the work environment, there's a lot of stress associated with low paying jobs, entry level jobs, and unskilled jobs. A lot of stress has been created by lack of structure and ambiguity in the workplace. Ambiguity meaning not necessarily fixed ways to do things, things are always changing.

So those are things that are happening as a result of the global economy that tend to be negatively impacting people with psychiatric disabilities. On the other hand, it's really important for us to keep in mind that a sizable amount of research shows that work is very beneficial to people with psychiatric disabilities. It tends to reduce the severity and frequency of symptoms. It tends to provide that needed structure to help manage daily lives and manage symptoms. It certainly creates some financial freedom and some financial capability to be more empowered in the environment. It also provides a very valuable social network. We're trying to manage both the negatives and the positives and create a situation in which people with psychiatric disabilities are able to manage the work environment. Work is changing, work is becoming more global, work in many ways is becoming less structured, more diffuse. People are having to deal with a lot of different types of people in the labor market compared to what they had to deal with twenty years ago. On the other hand, we know there are a lot of positives as far as structure, social networking, potential economic independence potentially, and economic contribution that are all very positive for people with psychiatric disabilities.

If you look at the supplementary handout that I gave to you, there is a lot more detail about the new global economy and the impact on work and why it's important to people with disabilities and particularly people with psychiatric disabilities. Let me mention something that I think is important too before I get into the diagnostic criteria on slide five. This is not on any overhead, so if you have the ability to take notes you might want to do that. Career development issues for people with psychiatric disabilities are significant because many times people with psychiatric disabilities lack work experience. So part of their problem in interfacing with the work world is they don't have a lot of experience doing that. Many times the experience they do have is failure. They have not succeeded. With that they also have a fragmented work history. They might have worked for a period of time and then they've been off and then back onto work, and etc. So then there is this very scattered, checkered work history. Within that checkered work history is often combinations of failure and very limited success.

The onset of their illness or their condition oftentimes occurs or impacts their ability to be trained and develop skills. Schizophrenia is a good example of that. We know that the onset of schizophrenia tends to be in the early college years and interrupts the formalized education process quite a bit. I think that's true for a lot of other psychiatric disabilities as well. The onset can often interrupt the development of skills and associated training programs. Oftentimes, people with psychiatric disabilities have limited work experience. They also tend to have a very narrow view of the labor market, and as a result of that narrow view of the labor market they tend to not really conceptualize or not understand the wide array of jobs that are available to them in the economy. So that's very important.

Finally the last point I want to make here before we move onto the diagnostic criteria is one characteristic that tends to span across all of them is the impairment of attention, concentration, and persistence. Attention, concentration, and persistence – being able to attend to something, being able to then focus on it in some detail, and be able to persist at that activity tends to be problems for people with psychiatric disabilities. As a result, that does not allow them to effectively meet the demands of the contemporary labor market. So those are important issues.

Let me move on now to slide five and look at the diagnostic criteria. What I want to introduce to you as a basis for understanding psychiatric disabilities is the Diagnostic Statistical Manual, often referred to as the DSM, the criteria and process for establishing diagnostic criteria. I think it's important for rehab professionals to understand the multi-axis system, what it is, how it was intended to be used, and what information you can glean from this multi-axis system. Under the multi-axis diagnostic scheme there are five axis that are used to fully operationalize the understanding of how a psychiatric condition is impacting a person's ability and functioning.

The first axis is clinical disorders. If you're looking at the PowerPoint you will see that on slide five, all five axis. You can also look into that handout and you'll see descriptions of each axis. So if you have access to that, you might want to flip to it in that separate handout. If you do not right now, you might want to go back and look at and fill in your notes for a little bit of clarity. Axis one shows what we term clinical disorders, and these are disorders that are usually diagnosed in infancy, childhood, adolescence, or adulthood. Disorders that are commonly included on axis one would be things like major depressive disorder, anxiety disorders, dementia, substance abuse, schizophrenia, and eating disorders. Personality

disorders and mental retardation are not included on axis one. That is because they are considered to be axis two diagnoses.

Axis two is exclusively reserved for personality disorders and mental retardation. So one question that somebody might have is, “Do you have to have an axis one diagnosis in order to get an axis two diagnosis?” No. You can have an axis two diagnosis, like mental retardation, with no axis one diagnosis. That’s a very important concept. You can have a personality disorder without an axis one diagnosis. You can have mental retardation without an axis one diagnosis. So it’s important to understand the role of axis one and axis two. Axis one includes clinical disorders such as depression, anxiety, schizophrenia, eating disorders, alcohol and substance abuse. Axis two is exclusively reserved for mental retardation and personality disorders. Axis three is reserved for the documentation of general medical conditions. General medical conditions are conditions that would be physical ailments, such as heart condition, amputation, diabetes. Things like that would be medical conditions that would need to be documented that could certainly impact both physical functioning and also may have some impact on psychiatric functioning as well. As our understanding of mind and body interaction grows, we’re seeing more and more of that. But general medical conditions are again medical conditions: amputations, diabetes, sinus infections, colds, heart conditions. They would be identified there.

Axis four is a really important axis for us in that axis four deals primarily with psychosocial issues and environmental problems. What this allows the clinician to do is to identify particular environmental stressors that might be negatively impacting the person’s ability to function. For example, you might see things related to problems with the primary support group and to the social environment. You might see things known as educational or work-related problems, family problems, economic problem, access to healthcare. These are all environmentally based psychosocial problems that could be negatively impacting diagnosis or, more importantly than a diagnosis, a person’s ability to function.

The last axis would be axis five which is a global assessment of functioning scale. The global assessment of functioning scale, I think, is extremely important from a vocational perspective because this is where it gives overview for the clinician working with the individual, and provides a number or a range of where they think the person is currently functioning based on their psychiatric state. This scale has a range from zero to one hundred or one to one hundred. This scale does provide us with really good information about where the person is functioning. I want to point out a couple key numbers on this scale and talk to you briefly about them.

First, if you look at slide six the number, the third row down, seventy-one to eighty, you might want to put a little mark right there and note that that would be what most psychologists and psychiatrists would consider to be normal functioning. A person who has a GAF above seventy is considered to be in the normal range of functioning. So I don’t want to make this a medical-model type activity. You’ll see in a minute that I’m not for the medical model necessarily, but I think it is important that you understand what this means so that you can be a better consumer of information. So a GAF of seventy or higher is considered to be in the normal range.

People who are scoring seventy-five, seventy-seven, eighty are going to be able to function in the normal environment for the most part. They might have some idiosyncrasies and problems that create some tension for them, but they’re not things they can’t manage and overcome.

Now the second block that I want you to note is between fifty and seventy. This is where we start to experience some decline in functioning that is significant, causing occupational and social dysfunction and causing some significant stress for this individual and their family. So somebody in the sixty to sixty-five range is going to have some symptoms that are significantly impacting them. Somebody closer to fifty is going to be more problematic than somebody closer to seventy. What's important to understand here is that this range, theoretically, between fifty-five and seventy, are people who might be struggling, might be having some significant personal issues that are impacting their ability to function daily, but despite those difficulties they are still able to function well enough. They can probably engage in some work-related activities with appropriate support, appropriate counseling and guidance, appropriate supportive employment, peer group support, mentoring, putting them into the right work environment. All of those things that are done there might be things that would be available to this person to help them maintain a job despite their more significant level of functioning or lack of functioning.

The last one that I want to talk to you about and the last marker that I want you to mark is that of fifty, and you can draw from fifty and arrow downward, meaning people whose GAF is below fifty are going to have some significant impairments that are producing some pretty negative, work-related problems and social problems. People in this category, people who have a GAF below fifty are going to need an intensive amount of support, guidance, and structure from rehabilitation professionals in attempting to return to work. It could mean something like a very intensive, supportive employment program. It could mean something like a very intensive peer support, peer guidance type program. It might involve some other type of counseling and therapy to help individuals sustain their level of psychological functioning or reduce the negative impact. So again, it's important to know people below fifty are going to have more significant limitations in the workforce that need to be overcome. I'm not going to tell you they can't work, but I will tell you that if they are going to work, they're going to need extensive support. As you move down that ladder from fifty to forty and moving on down you're going to need more and more support as you go along. So the GAF axis five is what I would consider in many ways one of the most important axis of our multi-level axis diagnosis as far as giving us information that can be used by rehabilitation providers in developing an effective plan for their work with individuals.

Real quickly before I move on—I've gone over the diagnostic criteria used by the DSM. There are five axis. Axis one provides clinical diagnoses. Axis two is mental retardation and personality disorders. It's important to understand that you can have an axis two diagnosis without having an axis one diagnosis. It's also important to understand that you can have both axis one and an axis two diagnoses. Your third axis is general medical condition. Axis four is your psychosocial environmental stressors and axis five is the global assessment of functioning (GAF), which goes on a scale of zero to one hundred. Important points there again: seventy or higher considered to be normal range – a person would need minimal support if any support at all, fifty to seventy – person is going to need some fairly intensive support, below fifty – person will need a lot of support.

Let me say this too. You probably, as consumers of psychological reports, might not be getting as many reports as you need to have a full multi-axis system outlined, the multi-axis diagnosis. I think it is certainly well within your right if you are paying for or requesting a psychological examination that the provider give you a multi-axis diagnosis covering all five of those axis areas. That should not be difficult for them. They should have enough foresight and insight to be able to address that issue. So, keeping in

mind that you are a consumer yourself, you are purchasing these types of services in many cases, and what you can do is you can request that those services be at a certain level and a certain standard, a multi-axis diagnosis. Some people might say, “You know, Dr. Strauser, my psychologist will never do that,” or, “My psychiatrist will never do that.” I have actually found in our work that actually they’re fairly receptive to doing this.

I want to talk real quickly about the categorical model as an alternative to the medical model. What we teach at the University of Illinois and what we taught at the University of Memphis when I was there is not a categorical model, but more of a dimensional model where you look at the level of functioning. Not a diagnosis, but the person’s level of functioning. For those of you who are able to attend our trainings this summer we, Deidre O’Sullivan and I, have spent a lot of time talking about the differences between a categorical model and dimensional model. The major difference that impacts you is certainly related to eligibility. Unfortunately the way the state federal vocational rehabilitation system is set up, it’s an eligibility-based system in which an individual has to be diagnosed, for example, with a mental health impairment to get services. You have to have a disability documented and many times documentation means that they have to meet the criteria. What we would argue is that’s not the best way to necessarily provide treatment and that people who have symptoms, but may not meet the full criteria still are going to have problematic areas and problematic functioning. You might see this in the dual diagnosis context where a person might have a physical impairment or a neurological impairment and also have symptoms related to a mental health impairment that might not meet the full diagnosis but might be causing functional impairment. For those of you who attend this summer, you will get a lot more detail about categorical, which will mean you meet all of the criteria – no services are provided until a diagnosis is achieved vs. a dimensional model, which is more of a continuum.

Let’s talk about slide eight now. We’re moving to conceptualizing vocational impairment. There are four areas that I think are really important when we talk about vocational functioning for people with psychiatric disabilities. First one being understanding and memory. People need to understand and they need to follow directions and memorize. They need to make performance adjustments. They need to make personal and social adjustments. They need to be able to meet the physical demands of the work environment for the most part, in terms of working eight hours a day or four hours a day. We’re going to break each one of those down a little bit in more detail. For example, on the next slide you’ll see understanding and memory. We talked about understanding and memory. You’ll see that we have these areas here that tend to be related to understanding and memory, things like being able to follow work rules, relate to co-workers, deal with the public, use judgment, interact with supervisors, deal with work stress, function independently, and maintain attention and concentration. These are areas that tend to congregate around understanding and memory.

Slide ten—Performance adjustments are another major domain area. What we’re talking about here is basically being able to follow directions from complex job instructions all the way down to very simple. Complex would be multi-step directions that might be delayed in their implementation. For example, I want you to take the trash out, get the car washed, and then go to the drugstore and pick up some bubble gum. That would be what I would consider a complex job instruction. A detailed job instruction would be a multi-step instruction that wouldn’t involve any type of delay. It would be simple like empty the dishwasher and put the spoons in the drawer. Simple job instructions are just simple one-step job instructions. That’s what we talk about related to performance adjustments.

Slide eleven – Making personal and social adjustments. These are things related to a person’s actual appearance and social performance on a job, such as maintaining personal appearance, behaving in an emotionally stable manner, relating predictably in social situations, and demonstrating reliability. The last one is work adjustment, and this is the old-school work adjustment term where we’re looking at things such as you can work eight hours a day, five days a week. More importantly – can you work without excessive breaks? And many times for people with psychiatric disabilities this is a lot harder than what it sounds. And can you maintain regular attendance? And my guess is for a lot of you, the concept of maintaining regular attendance can be very challenging as can working without excessive breaks.

I’m going to move into the diagnostic criteria and how we establish diagnosis. Characteristic of psychiatric disorders—there are really four major components of every psychiatric disorder. This will help you understand how clinicians go about making diagnoses and this will also give you some idea about how this might impact your ability to work with them. Every diagnosis has what I call a temporal requirement or a time requirement. For example, depression has a two-week time requirement. The symptoms need to be present for at least two-weeks before you can make a diagnosis. Bipolar disorder is one week, and schizophrenia is thirty days, I believe. So there’s a certain length or time requirement—that often goes with every diagnosis. It can vary depending on the diagnosis, it can vary depending on the disorder. But every one has a time requirement. Every one has a symptom cluster requirement. There needs to be a certain cluster or grouping of symptoms co-occurring together for there to be an established diagnosis. Symptom intensity is the third one, meaning that these symptoms, although they can exist in a group which would be the symptom cluster, they also need to be intense enough to be causing problems and impairment. And then fourth and final is that any of these symptoms or clusters or conditions cannot be explained by another type of diagnosis. For example, you might have a memory problem or some symptoms associated with dementia, but if you have been diagnosed with a traumatic brain injury you’re not going to meet the criteria for dementia. Basically if we have another medical condition that can offer an explanation for those psychiatric symptoms, we would defer to the other medical condition.

Let’s move onto slides fourteen, fifteen, and sixteen, and I’m going to take you through depression as an example diagnosis. For example, let’s take a look at depression and our overall criteria. So if we look at that criteria, you will see several things related to the characteristics. Five or more of the following symptoms, so that would be our symptom clusters. What this diagnosis is showing is that five or more of these symptoms need to be present together. So that’s our symptom cluster, and they need to be present during the same two week period. That two week period is our temporal requirement. So these symptoms need to exist together, at least five of them together, and they need to be present for at least the same two weeks. They also represent a change from previous functioning. That is an emerging intensity issue. Something has changed significantly that is noticeable. So we don’t have all of our characteristics explained in that initial criteria statement, but you’ll see as we go along that they do. The criteria from a cluster perspective is at least five or more symptoms need to be present. If you’re wondering what symptoms we’re referring to, if you peek ahead to slide fifteen you’ll see those symptoms. But there’s a qualifier in here. Out of those five symptoms, meaning five have to be present, one of those five present has to be either a depressed mood or loss of interest and pleasure. If you do not have depressed mood or loss of interest and pleasure as one of those five symptoms, then you are not going to meet the full criteria for major depressive disorder.

On slide fifteen you'll see that I have a couple stars next to depressed mood and diminished interest or pleasure, and then you'll see there that I have the remaining symptoms. There are nine symptoms criteria listed. Out of those nine, five have to be present. Of those five that are present, one of them needs to be at least depressed mood or diminished interest and pleasure. So if a person had recurrent thoughts of death, diminished ability to concentrate, feeling of worthlessness, fatigue, psychomotor agitation, they would have five symptoms that would meet the qualification of a cluster of five symptoms. Because one of those is not depressed mood, one of those is not diminished interest or pleasure then we don't meet the full criteria for depression. Another thing here with our symptoms is that these five symptoms, at least five of these need to be together and if they are together they have to be together for at least two weeks. That's our time qualification.

Let's move onto a couple of other criteria that we need to establish before we can say that we have a diagnosis. Symptom intensity—we talked about it being a marked change. That's one indicator of symptom intensity. If you go down to slide sixteen and you look at point two, it says causes clinically significant stress or impairment in social or occupational function. The last couple things here are relevant. Symptoms do not meet criteria for mixed episode—not related to substance abuse or another medical condition and it's not related to bereavement. Just real quickly again, what we have for depression is an example of our characteristics of the disorder. If I go back and say, "Well, what are my time requirements?" Symptoms have to be present for at least two weeks. What is my symptom cluster requirement? Out of the nine symptoms that are associated with depression, five of them need to be co-occurring together for me to have a necessary amount of symptoms. Important qualifier is of those five symptoms, one of them needs to be either a depressed mood or a loss of interest in pleasurable activities. My symptom intensity is identified by two things. It represents a change from the previous level of functioning and more importantly what you will see is that the symptoms cause a clinically significant distress or impairment in social and occupational functioning. Then finally, not explained by any other condition. You see the qualifiers there that it can't be bereavement, it can't be a mixed episode, and it can't be explained by substance abuse or a medical condition.

I reviewed the steps of establishing a categorical diagnosis as outlined by the Diagnostic Statistical Manual. That is what clinicians do to establish a diagnosis. They might do it for you for eligibility. You might see this in terms of psychological reports that you get. You might see this in terms of medical records that are reviewed, psychological records that have been part of the school file or something along those lines. We believe that really to provide good effective rehabilitation services you need to understand how a diagnosis is established. You might be like us where we don't necessarily like the categorical model. We prefer more of the dimensional model, but despite that, I think there is still some merit in understanding how a categorical diagnosis is made.

I'm going to focus on slides now eighteen, nineteen, twenty, and twenty-one. What I've given you here is a way to operationalize how a person is currently functioning based on psychiatric impairment. What I provided you on slide eighteen through twenty-one is a benchmark, a gauge of how depression might be impacting these major vocational areas. This is not to say that everybody with depression is impacted this way. This is strictly to give you a starting point, a guideline for you to be able to work with people who might have major depressive disorder. If you remember, one of our first areas is making occupational adjustments. You can see we have a scale here that goes basically from one to

four with one being not very good, which would be poor to none meaning that they have no ability. Fair, they have some ability to do it, but they have some limitations. Good, that they're able to function in that area pretty well, and then very good, unlimited, they have no problems.

Let me clarify—don't get caught up in what I just said about the one to four. This will be something I can explain to you this summer if you attend our sessions, but what you'll see here is for depression, in the areas of making occupational adjustments typically, a person with depression has good ability to follow basic work rules and use basic judgment. However, they tend to have fair ability, meaning that they're seriously limited but not precluded from doing that, relating to co-workers, dealing with the public, interacting with a supervisor, dealing with work stress, functioning independently, and maintaining attention and concentration. When it comes to making performance adjustments, over on slide nineteen, you can see that the person has a good ability to remember the simple job instructions. As the job gets more complex, and requires more steps, multiple steps, you see that they start to have diminished ability in that area. It tends to only be fair, seriously limited but not precluded. Performance adjustments, slide twenty, you'll see the same kind of thing. They can carry out simple job instructions.

Slide 21—Work adjustment. Typically people with major depressive disorders who have a GAF below seventy tend to have problems with working eight hours a day, five days a week, working without excessive breaks, and maintaining regular attendance.

Now I want to end there because of the time. We talked briefly about the changing nature of work and how it tends to impact people with psychiatric disabilities. I've given you a structure on how to categorize work-related activities and I've also given you an overview of the categorical model of diagnosis as used in the DSM and used depression as an example of how a diagnosis is established, what the clinicians would use to establish a diagnosis, and how it can be of some help to you as a rehab professional if you understand the five axis. So at this point, I'm going to end.

Caller: I have a question as far as redirecting someone who has mental illness versus a different type of disability. What techniques work better?

David Strauser, Presenter: What kind of techniques do we use as far as redirecting people?

Caller: Yes.

David Strauser, Presenter: Could you clarify what you mean for me as far as redirecting?

Caller: This individual has a hard time dealing directly with a supervisor, so we put a job coach in place to kind of be the middle person and try to problem solve.

David Strauser, Presenter: Okay.

Caller: But he does not seem to be very open to redirection from the job coach either. We don't know if it's the style of the person. Do you pull the person to the side or do you deal with it right then and there?

David Strauser, Presenter: The first place I would start is to look at the interaction and what is going on. If you're hearing it from a third party, meaning you're hearing it from the individual, you're hearing it from the job coach, my guess is you're not getting real good information. It'd be good for you to go and observe that dialogue if you have not done that. If you have done that, great! I think that's the first place to start. You need to observe what is actually going on. If you've done that and you see that this person is having a hard time taking supervision or getting feedback, I would try to find out what the issues are. Is it feedback regarding grooming and hygiene, for example, or feedback whenever the person's dealing with a female supervisor or something along those lines. You might want to start reinforcing appropriate behavior and extinguishing the negative behavior. Reinforcing the behavior would be starting now with a fairly straight forward oftenly administered reinforcement system, "That was a good job!" When they do act appropriately, catch them being good, talk to them and give them that verbal reinforcement. When they're not acting appropriately, extinguish that behavior through either ignoring them or, as you mentioned, redirecting them by getting them to focus on something else at that time by saying, "I understand what you're saying, but let's talk about this instead. Let's talk about what you were doing over here." Does that make sense?

Caller: Yes.

David Strauser, Presenter: I would not get into a protracted, long dialogue with this person about what they're doing wrong. Instead, I would teach more proactive activities/responses and reinforce their use of that, and ignore, if you can possibly, their negative behaviors.

Kat Oertle, Facilitator: Are there other questions for Dr. Strauser? Okay, well at this point, Dr. Strauser, could you give your e-mail address in case folks do have questions for you?

David Strauser, Presenter: Sure. My e-mail address is strauser@uiuc.edu.

Kat Oertle, Facilitator: Thank you very much and thank you all for joining us today for the teleconference. We'll be back again next month with Joe Lewis on May 6th at 2PM, talking about traumatic brain injury and employment success. Also, I want to direct you again to our website because we have trainings coming up including our week-long Simulation training in Madison, WI. We also have a number of online courses that will be beginning here in this next month. So I hope you'll join us. Thank you again, Dr. Strauser. This was very informative and we appreciate your time. I hope everyone has a great day. Don't forget to fill out the evaluation form on our website if you're wanting CEU or CRC credit. Thank you again.

David Strauser, Presenter: Thank you for having me.

Kat Oertle, Facilitator: Bye everyone.