Ohio Domestic Violence Network
ODVN

Partner-Inflicted Brain Injury: Promising Practices for Domestic Violence Programs

An Overview of Brain Injury Caused by Violence

The Center on Partner-Inflicted Brain Injury

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Introduction

> Do the best you can until you know better. When you know better, you do better.
> -Maya Angelou

Since the beginning of the domestic violence response movement, it has been known that people who use violence often intentionally target their victim's head, neck and face. The most iconic representation of domestic violence is the face of a battered woman with a black eye—a head injury. Understanding head injury in the context of domestic violence has the potential to transform your advocacy, your organization, and the survivors you serve.

The presence of head injury related to partner-inflicted violence should alert service providers to the possibility of brain injury. Brain injury is damage and/or trauma to the brain caused by blows to the head, decreased oxygen available to the brain, or a combination of both. For decades, brain injury has not been addressed by domestic violence survivors and/or their advocates. Poor outcomes for many survivors could be linked to this gap in understanding. Brain injury in the context of domestic violence is complicated. This document consists of three important components to help you better serve survivors of domestic violence impacted by head trauma. The first section provides you with an overview of partner-inflicted brain injury. It will assist your advocacy efforts by raising your awareness on the subject, informing you of how survivors may present or speak of potential brain injury, and increasing your empathy for those who may have endured brain injury and better understanding the complications it can cause. The second section describes the CARE (Connect, Acknowledge, Respond, Evaluate) framework and provides you with promising practices and strategies for integrating CARE into your work. Finally, section three consists of CARE organizational practices, policies and procedures to address brain injury within domestic violence organizations.

How the Brain Works

The brain is known as "the last frontier" in medicine for its intricate nature and depth of complexity. The brain is composed of four sections, or lobes. Each lobe is made up of neurons, nerves, and a variety of helper cells. The neurons connect with each other and through a series of electrical impulses, control our body, our thoughts, and our emotions. Our brains control voluntary decision-making as well as involuntary actions such as breathing. The lobes must work together in order for our bodies and minds to function. In addition, the brain needs oxygen in order to perform all of the tasks necessary to live.

The frontal lobe of the brain, located just behind the forehead is critically important for many "executive" functions, such as making decisions, planning, prioritizing, and controlling impulses. Just like an air traffic control system at a busy airport safely manages the arrival and departures of many airplanes on multiple runways, so the frontal lobe manages the detailed and complex executive functions essential for successful daily living.

If the ability to complete executive functions is compromised through brain injury, carrying on with daily life can become impossible. Mental/emotional health issues, substance use, maintaining employment or housing, and countless other difficulties can occur, further compounding the initial brain injury.

What is Brain Injury?

Brain injury is damage to the neurons in the brain that interferes with normal function of those neurons and their connections. The injury occurs in one of two ways: traumatic injury and acquired injury.

Traumatic brain injury (TBI) occurs after an external force is applied to the head in a way that causes the brain to collide with the skull. This collision results in damage to the brain region directly impacted (a coup injury) and possibly a contrecoup injury, an injury on the other side of the brain due to a whiplash effect. Examples of common TBIs in domestic violence include punches, blows to the head by an

object, slams, and kicks to the head and neck. Sometimes these injuries can be seen on medical imaging, such as CT scans or MRIs, but these are the exception. Acquired brain injury (ABI) results from oxygen deprivation to neurons. ABI can further be divided into hypoxic brain injury and anoxic brain injury. Hypoxic injury occurs when oxygen levels in the brain decrease to low enough levels to cause damage. Anoxic injury occurs when no oxygen is available to the brain; the consequence of prolonged hypoxic injury. Strangulation is the most lethal form of ABI and oftentimes causes no obvious signs of injury[1]. The brain is incredibly sensitive to changes in oxygen levels. Even the slightest decrease in oxygen can cause hypoxic injury.

Someone can become unconscious within seconds, have permanent brain damage in under a minute, and die within a few minutes if oxygen to the brain is not restored[1].

Strangulation prevents blood and oxygen from entering the brain leading to hypoxic injury, and sometimes anoxic injury. Other causes of ABI in domestic violence include suffocation, gagging, and chokeholds.

Regardless of the type of injury the brain suffers, there are many symptoms of brain injury. These range from mild to severe depending on the type of injury. Some symptoms include memory lapses, memory problems, visual disturbances, balance issues, hearing problems, difficulty comprehending written or spoken words, trouble concentrating, and others.

The symptoms involving executive functions can be particularly challenging for survivors and advocates to identify if not aware of their possibility.

Brain Injury in the Context of Domestic Violence

Both research and practice have identified that the head, neck and face are the most common areas of a person's body that a partner and/or abuser targets with physical violence that cause TBIs. Physical violence directed towards these vulnerable regions include slaps, punches, kicks, severe shaking, and direct object impact. Potential causes of ABIs in the context of domestic violence include strangulation (choking), chokeholds, being sat on, and gagged. TBI and/or ABI can be the result of one or multiple assaults.

Partner-inflicted brain injury is uniquely traumatic and devastating. Working within the context of domestic violence, it is clear that there are many mechanisms that could result in brain injury. Unfortunately, partner-inflicted brain injury is also unique in that there is almost always a clear intention to harm. There can be multiple types of traumatic blows to the head within quick succession coupled with strangulation.

The repeated nature of these damaging assaults to the head and neck also complicate the understanding of brain injury in survivors. In addition, the likely emotional connections between survivors and abusers tend to confound the story of the assault making it more difficult to identify potential brain injury.

Abusers who strangle are particularly dangerous. The Training Institute on Strangulation Prevention describes strangulation as "the last warning shot," often a last escalation of terrible violence that precedes homicides[1]. Victims who have been strangled are 7 times more likely to be killed by their partner[1]. Strangulation is terrifying and traumatic. Over 70% of strangulation survivors believed they were going to die[1]. Survivors are more likely to struggle with post-traumatic stress disorder (PTSD) as well.[1]

After an assault, there are distinct challenges to receiving medical care for survivors. Many injuries go unidentified and untreated. Advocates and providers often approach domestic violence survivors without an awareness of possible brain injury.

This can also lead to poor outcomes for survivors. There has been much more research in some settings of brain injury, such as accidents, sports, or military service, but understanding the complex mechanisms and consequences of partner-inflicted brain injuries has long been neglected.

Unique Characteristics of Partner-Inflicted Brain Injury

- Both TBI and ABI could be present together often repeated
- Inflicted by a known and trusted person
- Caused by domestic violence, which is a stigmatized issue that is difficult to talk about and disclose
- Occurs in a private setting without bystanders or others who can assist with

identification
- Safety concerns when seeking medical evaluation

Brain Injury as a Chronic Health Issue

While the injuries described previously are hallmarks of the acute presentation of potential brain injury in domestic violence survivors, there can be long-term consequences for survivors as well. Long after the initial trauma occurs survivors may experience symptoms of brain injury.

Oftentimes these symptoms can seem unrelated to past trauma making it difficult to identify and treat. Survivors who have brain injury identified soon after their assault could also suffer from long-term brain injury symptoms. It is important in practice to recognize the impacts of brain injury on survivors no matter the time frame after their assault.

[1]https://www.familyjusticecenter.org/downloads/traininginstitute-on-strangulation-prevention/

Section 2 • CARE Promising Practices for Addressing Brain Injury Caused By Domestic Violence

A comprehensive, survivor-based understanding of trauma, partner-inflicted violence, and brain injury must form the foundation of domestic violence (DV) survivor advocacy.

Partner-inflicted brain injury is damage to the brain caused by partner violence directed at the head, neck and face, including blunt force trauma and strangulation. Domestic violence, psychological trauma, and brain injury are separate public health problems, but intertwined when in the context of partner-inflicted head injury. Service professionals working with domestic violence victims often lack understanding regarding domestic violence as a mechanism of brain injury.

Psychological trauma impacts brain function and stress response systems; brain injury is connected with these issues. The ODVN Trauma-Informed Approaches manual will help you become familiar with the trauma-informed framework of DV advocacy.

We must integrate trauma-informed principles into all work with survivors of abuse impacted by brain injury. A trauma-informed service provision approach means having a basic understanding of trauma and how it impacts survivors by understanding trauma triggers, unique vulnerabilities of survivors, and designing services that acknowledge the impact of violence in people's lives. A trauma-informed approach is sensitive and respectful; advocates seek to respond to traumatized individuals in a way to consciously avoid re-traumatization. It is critically important for trauma-informed services to strive to do no harm.

The Center for Mental Health Services (CMHS) and the National Center for Trauma-Informed Care (NCTIC) report that a trauma-informed approach is based on the recognition that many behaviors and responses expressed by survivors are directly related to traumatic experiences. This approach recognizes the complex experiences of traumatic stress as a core component of domestic violence, as well as the impact on survivor's histories.

Advocates must make every effort to develop a complete picture of a survivor's life situation—past and present—in order to provide effective service and understand behaviors, feelings, and responses. A survivor's experience with domestic violence most often includes head trauma that could cause brain injuries, and it is the domestic violence program's responsibility to intentionally address this reality using practices and approaches in this document.

Integrate a Brain Injury-Informed Approach Into Trauma-Informed Frameworks

A brain injury-informed approach highlights the significance of developing a relationship with survivors that helps the advocate understand the survivor's strengths, priorities, and values. It also includes raising awareness of the consequences of head trauma and identifying the unique impact that head injuries might have on a survivor's life.

Professionals working with survivors should receive training on intersections of domestic violence, brain injury and trauma. They should learn about partner-inflicted brain injury, signs and symptoms of partner-inflicted head trauma, and strategies to raise awareness of these injuries.

Consequently, they use the components of CARE as well as CARE tools to meet the needs of survivors with potential brain injuries accessing domestic violence services.

Use CARE (Connect, Acknowledge, Respond, Evaluate) to Raise Awareness and Address Partner-Inflicted Brain Injury

The CARE framework offers advocates specific tools and strategies for working with survivors who may have experienced head trauma or brain injury that affect their ability to access services and resources they might need. Survivors may have physical, cognitive, emotional, and/or behavioral issues resulting from the traumatic brain injury(s) or oxygen deprivation. Other components like physical or mental health challenges, substance use, other traumatic circumstances, or a combination of these may also complicate healing. In light of these realities, survivors might find it difficult to access support within DV services that truly meet their needs.

At the same time, domestic violence programs may find they are ill equipped to meet the complex needs of survivors who have suffered injuries to their head, neck, and face. However, head trauma and subsequent brain injury are part of survivor's experiences and must be addressed by advocates.

CARE contains strategies that allow domestic violence program services to address these issues. Raising awareness, education, training, accommodations, referrals, and core approaches that engage survivors are all included in the CARE framework. Advocates using CARE believe that domestic violence survivors deserve brain injury-informed services. CARE offers practical, brain injury-informed practices for survivors, staff, and other community partners.

CARE (Connect, Acknowledge, Respond, Evaluate) Strategies and Practices

CONNECT

Before addressing potential head injuries, focus on building genuine relationships and connections. Establishing a trusting relationship is the foundation for effective advocacy. This is true even when survivors find making connections difficult, upsetting, or challenging, often as a result of their experiences involving trauma.

Sometimes called survivor-defined advocacy, services involve a person-centered approach. A person-centered approach is where the person is placed at the center of the service and treated with respect and dignity, and their perspectives, needs, and priorities are of primary importance. The focus is on the person and what they can do, want to do, and need from you and your services--not on their situation, condition or disability. It requires flexible support in order to suit the person's needs and unique circumstances.

The CARE framework offers ideas for building connections with survivors who may have difficulty relating to others. The survivor may begin to feel more connected when an advocate checks in regularly and seeks them out by offering to talk with them in their spaces. Advocates might show genuine interest in the survivor's children or other things important to them, celebrate their victories and sit with them when they experience difficulties. Asking about a survivor's children or playing with them, or eating a meal with a survivor also encourages

support and creates a safe space for them to be themselves. Strong connections help people begin healing from trauma and break down the feeling of isolation that abusers create. Effective advocacy is connection.

ACKNOWLEDGE

Provide information on head injury and strangulation to all survivors. This could be through conversations between survivors and CARE-trained advocates or through the brain injury-informed CARE written materials.

In addition to providing information about partner-inflicted brain injury, ask directly about head injuries. Incorporate these questions as part of a larger discussion about the impact of head injuries if possible. Sample questions can be found on the CARE tool, CHATS.

Use the term "head injuries" to discuss possible brain injuries. Ensure that you are NOT telling a survivor they have a brain injury. Brain injury is a medical condition only diagnosed by a doctor. Tell them that like all other injuries, head injuries can heal and be managed with the proper treatment and support. There are many things that the survivor can do, and you can do together, to help them get what they need.

When talking with survivors about head trauma, share the common symptoms of brain injury. Share that many symptoms have been misunderstood by both professionals and survivors as signs and symptoms of mental health or a personal deficit or failing. Also include that symptoms have significant overlap. Many survivors have blamed themselves and many professionals have not yet developed a brain injury-informed understanding of trauma in domestic violence. Brain injury can play a significant role in a survivor's life, but can easily go unnoticed.

Using an individualized approach, work collaboratively to identify a survivor's unique experiences, strengths, and perspectives. Also explore challenges that are impacting their lives and/or ability to fully access your services. What matters to them the most, and what challenges are bothering them the most? Continue to use survivor-defined advocacy.

Effective advocacy is to acknowledge the reality of head trauma and strangulation resulting in potential brain injury.

RESPOND

Accommodations are a modification or adjustment to how you or your agency usually provides services that take into consideration the unique needs of the person you are working with. Work together with the survivor to identify accommodations and put them into practice to improve their access to services. Sample accommodations include writing down more information than normal, checking in more frequently on a survivor, or scheduling shorter and more frequent meetings. The CHATS tool helps to identify possible accommodations and should be made available to staff to assist in this process, though a formal process such as CHATS might not always be practical and there are other different strategies that can be used.

Environmental accommodations, or changes to the environment or setting, can be enormously helpful for healing. The survivor's home, work and family as well as the shelter or service provision setting can be sources of stress that interfere with their ability to heal. While there are unique barriers to this for survivors of domestic violence, explore with the survivor how making small changes can reduce stress. Examples include identifying ways to improve sleep, adjusting lights and noise, having a quiet space or quiet time, or forming routines like returning items back to where they belong.

Identify possible referrals to medical care, behavioral health care, evaluation for additional issues, and/or other types of services that address individualized survivor needs. There are resources outside of your agency that can be beneficial to the survivor. If head trauma is part of a person's experience, incorporate medical providers and primary health care as possible referrals, particularly for physical problems such as headaches, vision issues, balance problems, or seizures.

Effective advocacy is responding to potential brain injury in an informed and empathetic way.

EVALUATE

Regularly check in with survivors for feedback on services, accommodations, referrals, case planning, or advocacy strategies. Survivor feedback not only helps them receive the necessary services and identify what is helping and what isn't, but also supports identifying strategies that may help others.

Adjust advocacy strategies, referrals, case plans, etc. to reflect changing situations. It is critical for advocates to be flexible with the healing process as circumstances change, survivors improve, and new issues emerge. Effective advocacy is evaluating how current efforts are working and how to improve healing for all survivors.

Training and Education for Staff

1. Ensure that education on brain injury in the context of domestic violence is a priority. This could include scheduling in-services on brain injury, encouraging staff to attend conferences, webinars, and/or other training related to brain injury and DV.
2. New advocate education. Use ODVN's CARE Brain Injury and Domestic Violence online learning series to educate new advocates about CARE, available at www.odvn.org.
3. Inform all advocates and staff that ODVN's Center on Partner-Inflicted Brain Injury is available to assist with brainstorming ways to connect a survivor to community resources and discussing specific situations.

Policies and Procedures

1. Review existing policies and procedures that your agency has regarding survivors with head injuries. If your agency does not have these policies, consider what policies and procedures should be added to meet the needs of survivors with head injuries.
2. Make sure every survivor has access to CARE educational materials and information about brain injury caused by domestic violence.
3. Develop a strategy for addressing potential head injuries with all survivors. Some examples include adding questions to hotline or intake forms, providing CARE educational materials in paperwork, and using the CHATS tool.
4. Make all paperwork and forms that survivors use as simple and straightforward as possible, using plain language. Offer to provide assistance with forms and acknowledge that brain injury can make reading, writing, and communication difficult.
5. Consider an environmental assessment of your agency. Think through what it would be like to experience your agency's services while healing from a brain injury. Begin with assessing the survivor's surroundings and the most recent events the survivor has been through.
6. Due to the widespread lack of awareness on brain injury, consider

including educational opportunities on brain injury and brain health as a part of the available programming and services for survivors. This could include incorporating information on brain injury and ways to support brain health during meeting and support groups, in individual advocacy, and by providing written information.

7. Ask about recent injuries and critical health concerns at arrival to the agency. Include the following: recent violence directed at the head, neck, and face, blows to the head and strangulation or other violence that impedes breathing, as well as recent unprotected sex that could warrant emergency contraception if desired.
8. If advocates and staff learn of or observe signs of a recent head injury, ask about current symptoms. Assess for dangerous symptoms related to both head trauma and strangulation. Express concerns you might have. Offer to assist with accessing medical evaluation, care or clearance. If a survivor wants medical care, facilitate access to medical services.
9. Provide survivors with information on warning signs that indicate a need for medical attention and encourage survivors to alert an advocate if they experience any of them.
10. Check regularly on the survivor for at least 72 hours. Offer to assist with recording symptoms or encourage survivors to record symptoms on their own. Ask about dangerous symptoms during these routine check-ins.
11. If the survivor is having symptoms that necessitate immediate medical care (for example, a survivor is struggling to breathe after a strangulation), follow your agency's policies regarding medical emergencies.