

Traumatic Brain Injury and

Domestic Violence

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BLANCA KLING: Good afternoon. Welcome to Traumatic Brain Injury and Domestic Violence on the third series of national webcasts presented by the national association of the state head injury with collaboration with the Traumatic Brain Injury at the United States, Department of Health and human services. Maternal and Child Health Bureau. At this time we are experiencing technical difficulties so there will be audio only and we apologize-- apologize with that. I am Blanca Kling, the moderator today. NASHIA's mission is to assist state government and build assistance to meet the needs of individuals with brain injury and their families. This webcast was presented -- traumatic injury and the reverse. Please watch NASHIA's website for more information.

Tuning in today are approximately 100 other locations, with some who have one individual watching and others who have more. Today's webcast from the U.S. Department of Health and human services from Maryland. I offer a special welcome to David, director of Maternal and Child Health Bureau. This webcast was made possible today in partnership and communication with an agreement with NASHIA. The audience may pose questions at any time during the webcast. Simply type your questions in the white message window on the right of the computer screen. Select questions for a speaker. From the drop down me -- menu and hit send. Please include the state or organization in the message so we know the location you are participating.

We will have two designated question and answer times, but we invite you to submit the questions at any time during this webcast. Our power point slides will appear in the central window and will advance automatically. The slide changes are synchronized with the presentation. You do not need to do anything to advance the slides. You may need to match the timing of the slide changes to match the audio by using the slide change. On the left is the video window, you can adjust the volume of the audio using the volume control slider. You can access by clicking the loud speaker icon. Those of you who select the disabilities features will see text captioning underneath the video window. At the end of the broadcast, the interface will close automatically.

You will have the opportunity to fill out online evaluations. Please take a couple of minutes to do so. You will help us to plan future broadcasts in this series and improve our technical support. The webcast will archive on NASHIA's website after September 1st for future replay at your convenience. Today's topic is Traumatic Brain Injury and Domestic Violence. Joining with me are Susan Vaughn, director of public policy for national association of sustained head injury administrator. There are many state and national state conference trainings, hundreds of providers throughout the state of New York. Before coming to the New York office for prevention of New York violence, she was a therapist and teacher for 25 years in various colleges and Universities. Susan Vaughn has nearly 30 years of experience in the disability field, and in state government. She retired from the state government two years ago, served for 17 years as a director of the advisory council.

Under her leadership, they obtained legislation to create or expand newer programs for people with brain injury and their families. She also served as a co-program director for the federal traumatic brain injury grants, and now public policy articles in the journal of head trauma rehabilitation. She earned her masters of education, NASHIA's founder and first volunteer president. I'm Blanca Kling, Montgomery County. I have been work for the past 24 years, advocating mainly for the Hispanic community in issues of domestic violence, rape, and different types of crime. Now let's talk about Traumatic Brain Injury and Domestic Violence. We will discuss what traumatic brain injury services providers need to know about domestic violence. Sue.

SUE PARRY: Thanks, Blanca. Listening to the presentation this afternoon are people from the brain injury field and domestic violence service providers. We will try to address the questions that both of them will have. In this presentation domestic violence, we will learn about what it is, and recognize it when you see it and a little bit about intervention techniques, available services and resources and where to find more information. When Susan Vaughn talks about brain injury, the domestic violence providers in the audience will learn screening techniques, strategies to use to help brain injured victims cope with their situation, and again, intervention, services, support, and resources. And we will both be talking about some of the challenges that victims of domestic violence who have head injuries are faced in trying to overcome the situation, and both of us are going to stress the importance of collaborative approaches between domestic violence providers and brain injury providers.

Why are we talking about these two topics together? Domestic violence, particularly for women, is a major cause of brain injury. I became very aware of this at a conference on brain injury in the late 1980s, the whole thing turned out to be on domestic violence. As speaker after speaker told about brain injury caused by intentional assaults by a partner. And in assaults by intimate partners, the head is the major target, along with the neck, other, other parts of the torso. But the head is a major focus. Individuals struggling with domestic violence and brain injury also meets similar challenges. For one thing, both problems frequently go unidentified, and that's really one of the things that we are seeking to address today, to make us better able to identify what's happening. Both often lead to behaviors that other people misinterpret, although this happens for somewhat different reasons in these two areas.

As a result of that, both can lead to interventions that either are not helpful or actively endanger the individual. While their real needs go unmet. Finally, both victims of domestic violence and individuals with head injuries often find difficulties assessing the services that do exist, making use of them, and with domestic violence victims in particular, there can be safety issues in using services which we'll talk about later. Our two fields share a number of perspectives in common in the work in a we do. One is a big push to help our clients with self-determination, to make sure that their the ones making the decision about their lives. We both rely very heavily on the power of peer support networks and peer advocacy, and we both rely very heavily on coordinating with other services to meet our clients' needs.

I'm going to start out talking about what service providers in the traumatic brain injury field need to know about domestic violence. And I want to start with just a few statistics, I promise you this is the only time I will talk about statistics. First of all, at least 85% of the victims of domestic violence, according to many years of federal statistics, are women. And most of these are women abused by male partners. I'm going to refer to victims of domestic violence as she, I'm going to refer to batterers as he, recognizing that there are also some other forms that this takes. Some men are battered by female partners. Lesbians and gay men also experience domestic violence we think at about the same rate as heterosexual women. Most of the people that you are going to see, though, who are victims of domestic violence are going to be women abused by male partners, that's who I'm going to focus on today.

We also know that a fairly substantial proportion of men who are violent towards their partner are also abusive toward their children, and that children can suffer a number of negative consequences as a result of their mothers being abused. We know that domestic violence occurs in all economic classes, all religious groups, all ethnic groups, without distinction. It occurs in all age groups. Teenagers, we are starting to learn are abused about as often as older married women. So that when we are talking about screening for domestic violence, we are often talking about screening quite young girls, anyone who might conceivably be dating. On the other end, elderly women are also abused, and this sometimes will not be recognized, sometimes what we have come to call elder abuse is actually very long standing abuse by a partner, times in a marriage that has lasted 30 to 40 years. When we say domestic violence, I want to give a definition so that

we are all on the same page. Most domestic violence advocates will use a definition somewhat similar to this one. We say domestic violence, we mean a pattern of coercive tactics that includes physical, psychological, sexual, economic, and emotional abuse. I'll break that down a little more in a minute. Perpetrated by one person against their adult intimate partner with a goal of establishing and maintaining power and control over that victim. Let me just take a minute to break down this definition, because there are about four parts of this that I want to make sure to highlight. First of all, when we are talking about domestic violence, not just talking about violent incidents. That's what people tend to think of. Somebody gets beaten up, the paramedics show up, channel whatever shows up with a satellite truck, and it's on the 11:00 news.

But domestic violence really is better thought of as something that victims experience on a 24-7 basis. It's something that never really goes away, and many of the behaviors that we know that victims experience at the hands of their partners are not happening during violent incidents. So if we only look at the incidents, we are going to miss 90% of what's going on. Around the incidents we have economic controls, we have emotional abuse, we have verbal abuse, we have sexual assault, which may not be experienced as violence, per se. Second thing about this definition is that this is a one-sided thing. One person perpetrates violence against another. It's not mutual, it's not two-sided. There is a perpetrator and there is a victim. And lastly, this is behavior that has a goal. That goal is control, domination, power. Having your partner put all of her energy, her attention, into anticipating your needs, doing what you want, jumping when you say jump.

So let me break this down a little bit some of the ways that abusers gain control, and the physical abuse is of course the most obvious one. Hitting, kicking, hair pulling, we could all make our own lists, and we probably still would not come up with everything that happens. Sexual abuse, which can range from negative comments, nasty words, emotional assaults of that kind, all the way up to rape, use of objects, use of weapons, forcing women into prostitution, very serious criminal activity. Economic control is a big part of it, and part of why it's such a powerful part of it is because economically women in this country are still at a disadvantage, being paid less, in lesser jobs, vulnerable to a partner who seeks to control their educational opportunities, their work opportunities, their contacts with colleagues, so batterers will commonly require accounting of the money, run up debts in their partner's name, forbid them from working and going to school, show up at their work site, make a nuisance of themselves and get them fired, okay, and economic controls are by the accounts of many victims, one of the things that keeps them trapped in relationships with an abusive partner.

They rely heavily on intimidation and threats, sometimes vague, sometimes very specific. Not just threats against their partner, but threats against the children, threats against other family members, against pets, occasionally against co-workers, in other words, threats against anybody that the victim feels close to or who is important to the victim. We have begun to learn that stalking is often a part of domestic violence, and it may surprise you to know that stalking is something that sometimes people do to people that they live with. This can include things like following her to work, following her around town, showing up at places where you have no reason to be but where you know she's going to be, and this

is part of what will keep a victim of domestic violence on edge and watchful and intimidated. Another big piece of domestic violence is the emotional and psychological abuse that goes on. Often this is verbal put-downs, isolation, destroying her relationships, putting restrictions on how she can come and go, who she can see, destroying her relationships. Control of her through her children. Very often after a relationship breaks up, what will happen is a very long and nasty custody fight perpetrated by the batterer to try and get that victim still under his control. Now I want to say a couple things about what domestic violence is not, okay. For one thing, it's not conflict. Conflict is a two-sided kind of thing. And it can happen in a relationship of relative equality.

But really what we have got in domestic violence is a relationship where the batterer has made a concerted effort to put into place a one up, one down relationship. And certainly those relationships have conflicts like anyone else does. But conflict is a separate thing from abuse. Abuse is something one person does to another. We are not talking about dysfunctional relationships, we are not talking about mutual battering, although the victim may fight back to defend herself, and we are also not talking about behavior that the victim causes. Because one thing that we have learned about batterers, they often batter one partner after another, and those partners may be very different from each other.

Domestic violence is chosen behavior. We are talking about behavior that abusers engage in intentionally. Not by what you see on the screen, anger, lack of ability to communicate, insecurity, alcohol, or the abuser's own head injury, although he may try to get you to attribute it to that. I want to spend a minute to how we can tell the difference

between a violent behavior that is related to domestic violence and whether it may be related to a brain injury. Okay? Is it intentional or is it impulsive? Is there a goal of control or isn't there? Okay. Is it specifically targeted, and this is particularly important. Batterers will tend to target just their partner or partner and their kids. If a person's violent behavior is related to a head injury, it's going to look much more random. Not going to have that targeting of one person. And the fact that an abuser chooses specific targets really speaks to the extent to which the violence is under his control. It's something that he feels entitled to engage in, most abusers see their behavior as actually pretty ordinary and justifiable. And if you ask about it, what you'll hear is rationalization, and well, it's not so bad anyway.

Abuse has a number of effects on the victims. We don't really have time to go into these in detail, but the obvious, of course, are the injuries, the bruises, the black eyes, the broken bones. Stress-related illnesses commonly will go along with domestic violence, headaches, stomach upset, backaches, all sorts of symptoms that are often difficult for health care providers to pin down. Disability commonly results from domestic violence, head injury is one of them, but we also know of women who lose the use of their eyes, lose their hearing, become paralyzed, a number of disabilities that can follow from experiencing this sort of victimization. Also find that women who already are ill or already have disabilities are particularly vulnerable to being abused, and that what is wrong with them actually may get worse as a result.

Think, for instance, of a woman with asthma, who under stress gets worse. And then think of the stress that living with a dangerous partner puts on that woman. Battered women often experience health problems as a result of their partner's behavior. Most common one, post traumatic stress disorder, depression, anxiety disorders, chemical dependency. Any woman that you see who is talking about any of these sorts of issues should be asked if she is being abused by her partner. And I want to mention that frequently domestic violence results in death. We know that in this country every year somewhere between 1,000 and 2,000 women die as a result of assaults by their partners. Some children also are killed. Now these numbers have gone down as we have more services in place, more help available, better law enforcement, but the numbers are still way too high.

Other effects of abuse, pregnancy, problems during a wanted pregnancy, frequently when a woman becomes pregnant the assaults will shift to the abdomen. She is threatened with loss of her children, economic difficulty, and then her ability to be a parent may be a target of her partner's abuse. He wants to interrupt that. And for most women, getting at them through their children is a very successful tactic of control. Victims have a lot of reasons to stay with an abusive partner and if you ask the victims themselves why they stay, either or both of two reasons. One is just flat out fear. Fear of what he will do if she tries to leave him. And in fact, we know most victims of domestic violence who do get killed by the abuser are somewhere in the process of trying to leave him when they get killed. It's not the women who stay who tend to get murdered by their partners.

The other main reason that victims stay with abusive partners is finances. Lack of education, lack of a job, lack of money, and a difficulty of pulling enough money together to allow them to leave. The other main thing that keeps victims with abusive partners is our failure to help them. This can happen at any level, from law enforcement to health care, to mental health therapists, to child protective services. If we don't do what we can do to recognize what's happening to them and reach out to them, we may miss opportunities to make it possible for them to get free. And for women with illnesses and disabilities, you may have the additional incentive to stay because the abuser may be the only caregiver that they have. Not only is he the one making their life difficult but he also may be providing essential services and persuading her, rightly or wrongly, that nobody else is going to help her if she leaves him.

Having said that, I want to say that it's a myth that most victims of domestic violence just simply stay with the abuser. There are lots of incentives to leave. These are some of the ones that victims talk about in terms of helping them out. The violence has escalated to where she says to herself he'll kill me if I stay, or sees how it's affecting her and her kids, particularly affecting her kids, or somebody reaches out. So victims who stay with a partner, okay, these may be the ones that you will most easily identify, have lots of strategies that they will use to try and cope with the situation. They'll try and do -- do what they can to provide incidents, by appeasing him, walks on egg shell, saying I'm fine, I can cope, this doesn't bother me, it's not so bad. In order to keep herself calm enough to cope. She may take various steps to involve other people to try and protect herself and protect her kids, and she may try over and over to escape.

One thing that's important to know is that victims often try many times to escape before they successfully do so. Sometimes five, six, eight, ten times, and you never know if the service provider, whether your intervention this time might be what actually enables her to get free. Here is a little scenario. For those of you in the brain injury field, let's just talk about how you might identify whether this woman is a victim of domestic violence. Mary is applying for services for TBI and says she fell down and hit her head. She had been to rehabilitation, she needs a job. And in taking the personal history and looking for information the service provider learns that she's been injured more than once and is currently married.

So how might you ask her about domestic violence? Now if you just say are you a victim of domestic violence, she's likely to say no. And she may do this for a couple of reasons. Stigmatizing, people hate to admit it. It may be dangerous to admit it if she has to go home to her abusive partner, and may not really understand the question. Because if you are thinking, as I hope you are by this time about this pattern of controlling and abusive behavior, and she's thinking just of violent incidents, she may say well, real domestic violence is something worse than what happens to her. So here are some more, some questions that are more likely to get at it, and still fairly simple questions.

Acknowledge that you encounter domestic violence, that you encounter people who are being abused, and let her know I ask everybody about this, and you should ask everybody about it. Okay. Is this happening to you? We know people are being hurt. Is this happening to you? Is anybody you live with hitting you, kicking you, hurting you, making

you do things that you don't like to do, controlling you in other ways. In other words, ask about abusive behaviors. Don't just ask the general are you being abused question, but put some meat to it. And then ask about what her partner does in the situations that maybe she has identified as problematic. Okay. When he's drunk, when he's angry, when he's jealous. Does he ever get physically violent, and ask her to describe incidents to you. When was the last time this happened. What was the worst it ever got. Tell me about the worst incident. I will be particularly concerned in this scenario of Mary that we just looked at in the previous slide, she's been injured more than once and she says she fell down and she hit her head.

Many victims of domestic violence will tell us something like that. I fell. I was in a car accident. And yet what you may be seeing is injuries that don't seem to quite fit how she says they came about. So routine screening is always the easiest. If you can say we ask everybody about it, then you don't leave your clients worried what does she see in me, what does she think is going on with me that makes them ask that question. Take a little bit of the stigma out of it. So let me finish up by just talking about a few strategies that TBI providers can use with women who identify themselves as victims, anybody that identifies themselves as a victim. Listen, listen some more, and listen some more. This is something that takes a while to get out, and you are not going to get the whole story right from the get-go. They have to be willing to put some time into it.

It's also important to let her know that her feelings are understandable, that it's not her fault, and that you'll do what you can to hook her up with options. One thing we

mentioned, self-determination at the beginning and it's important not to tell her what she ought to do. An awful lot of people when they encounter a victim of domestic violence will say something along the lines you have to get out of there, or why don't you leave. And when we ask that sort of question, I encourage you not to ask that question. Because what that says to a victim is you don't really understand her situation because if you knew how bad it was, you would understand the factors that make it impossible for her to leave. It also says to a victim, well if I was in your situation, I would leave, and then that says to her you know, I'm better than you are. I have it more together than you do. So we take away nothing else from this, take away don't just ask her why don't you leave. Far better to say how can I help you make some decisions that can help increase your safety?

That can help maybe make it a little more possible for you to get out if you are trying to get out the next time. But the goal really is empowerment, not leaving. To be an advocate for her and to help her make the decisions for herself that are going to lead to greater safety for herself and for kids. When we talk about that, we usually call it safety planning. And I think you will see, as we go into talking about the brain injury side of this, how that can be problematic for a victim of domestic violence who has a brain injury. And Susan will talk in a few minutes about some strategies to use to help make that more possible. A couple other strategies. Process everything you think about doing with her through the lens of does this have any possibility to endanger her. That means any referrals that you make, any phone calls that you make, any suggestions that you make, any contacts that you try to make for her, talk to her about it first. And talk about any safety implications. And that includes, incidentally, how you contact her. So is it safe for me to contact you at home,

can I call you? If I call you, are there certain times I shouldn't call you because he's likely to be there. If I can't call you, is there a neighbor I can call and have you call me back that I can leave a message with, can I send you mail? You never know with a given victim what might be the things that will endanger her, and the only person that can tell you that is that victim herself. You need to not just think about this inside your own head but need to talk about it with her. To help her mobilize her support system because the batterer is likely to have destroyed it. She may not have seen her mother, her brother, her sister, her friends, because he may have made a concerted effort to separate her from them, to make it too costly for her to spend any time with them.

But if you can help her find ways to reconnect with the people who probably are out there that would offer her some support, you do her a real favor. And then help her contact domestic violence service providers. Now I've given you a couple of numbers, this is the national domestic violence hotline, and both the audio line and the TTY line. They will help to hook her up with state coalitions against domestic violence which exist in most states, which are usually coalitions of service providers. Most states also have their own domestic violence hot lines, which you can usually find in the front of your phone book in the emergency number section. In most areas now I would say I know in New York where I live, it's organized by county, it's probably similar in other states, that almost every county will have at least one domestic violence service provider, not just a shelter.

Some of these are non-residential service providers. Support groups, counseling, help with housing, services like that. Women don't have to go into shelter to access those

services. And they need to know that. Women often don't. They think they have to go to shelter before anyone will help them. So if you've got a woman who is a victim of domestic violence, call the national hotline, get the numbers for local services, help her to contact them. Remember that they are going to want, they put confidentiality very highly, and they are going to want releases of information before they will talk with you about her specifically, but you can always call them for advice and ask about a case for consultation.

BLANCA KLING: Thank you very, very much for such good information and important information for domestic violence. We are going to go ahead now and have a period of questions and answers so please feel free to send your questions and we have wonderful experts who will answer your questions. The first we have, thank so much, thank you so much, are there any reliable studies on TBI and domestic violence?

SUE PARRY: Not that I know of. There has not been very much done in the area of this overlap at all. The one study that I am aware of, a study by O'Leary and Monahan, we can provide the reference for that afterwards, looked at victims in domestic violence, and some level had head injury which they could attribute directly to the violence that they had experienced. We also know that batterers will tend, as I said, to target the head and neck and torso for a couple of different reasons. Batterers who target the torso will often be wanting the injuries to be covered by clothing so they can go to work. And target the head, make her look so bad she'll stay home and will not be contacting the outside world. Victims whose abuser target the head, may get hit, shaken, bashed into a wall, shoved

down stairs, lots of ways in the course of domestic violence assaults a woman can incur a head injury.

BLANCA KLING: Thank you so much, Marilyn from Virginia, wonderful question. Go to another question now, power point presentation be available later, and of course the answer is yes, and it will be after September 1st. So keep an eye on your website. Thank you very much for your questions, and now we are going to go ahead and have another presentation.

SUSAN VAUGHN: Okay. My side of the presentation is to talk about what domestic violence providers need to know about traumatic brain injury and we recognize that individuals who do contact domestic violence providers may only have a believe encounter with people, or they may actually be in a shelter for a period of time, 30, 40 days. So the time the person may be in contact may be very limited. But at any rate, what we were trying to do is at least give some awareness about what a traumatic brain injury is, something you might be able to pick up if you are doing some kind of intake and assessment, or if the person is continuing to reside in the shelter, what kind of compensatory strategies may need to be put in place to help that person live there.

The first slide you'll see is an incident slide we use, statistics come from Centers for Disease Control who gathers information from the states and data to determine how many people each year are injured with a traumatic brain injury. And this is the figures that is now reported that we do have, at least 1.5 million Americans sustain a traumatic brain

injury each year, and this comes from hospitalization records. Many other folks who may receive a brain injury who do not go to an emergency room, may not be in that number. 75% of them will fall in the category of mild brain injury. And we know that today, that at least 5.3 million Americans do live with a traumatic brain injury-related disability. In terms of the cause of brain injury, most are attributed to motor vehicle crashes, sporting events, and violence. There is CDC on violence-related injury, and CDC does gather information on domestic violence, on the website, but it may not be to the degree the questioner was asking earlier. Next slide tells you what a traumatic brain injury is. This is the definition that CDC use to say define brain injury.

Mainly what that is talking about, Sue gave you a couple examples, is if somebody shoves somebody's head against a wall. The head is going to strike the wall, but inside that head is a brain that will tend to hit in the front, and then will continue to move to the back, and some to the sides. That creates further damage. And that can lead to damage, as you can imagine, from striking the skull on the inside, but also bruising can take place, swelling can take place, and with like a shaken brain injury as you describe, like shaken baby syndrome, or somebody grabbing somebody and shaking their head severely enough, you can have bleeding in the brain. Another kind is a gunshot wound, somebody that would be shooting someone, or if there is some kind of a weapon that actually Pierces the skull.

And those two type of injuries describe the types of traumatic brain injury as we categorize them, that being one, the open or penetrating brain injury, and makes sense that the gunshot wound or if a weapon of some sort penetrates the skull, that would be considered

an open injury. And then an example I gave you of somebody's head being slammed against the wall will be considered a closed brain injury. In that you will, might hear the term focal damage and diffuse damage, what that means is as the focal damage is the point of impact, and that's the damage that takes place there, and the diffused damage refers to the other part of the brain that may be damaged as a result of that blow to the head. Injuries are generally classified as severe, moderate and mild. Severe injuries will generally be hospitalized, those are folks hospitalized, acute care. Sometimes rehabilitation after the injury. Most moderate brain injuries are also hospitalized initially, receive medical care. But mild is not life-threatening at the time, and they are often then not in a hospital situation.

Mild injury is what we now most commonly refer to as concussion. Those injuries are often treated in emergency room or emergency department setting. They may not be visible on a CAT scan or MRI. The symptoms of a mild brain injury may not show up 'til later, maybe initially there might be some physical symptoms such as headache, etcetera. But then it's not until later when people get back into a situation that's stressful they may have difficulty managing that stress and their environment that the symptoms might appear. The last term, repetitive concussions on the slide, we hear a lot now among the sporting world. I think the American Medical Association has been a done a good job over the last couple of years trying to point out to people sporting events, like soccer in particular, produce competitive concussion, and football injuries, and hockey injuries.

The same thing can happen with domestic violence people. Someone that is a victim of domestic violence. If the head is slammed against the wall or knocked around over and over again so the concussions appear each time, that means there is more damage that starts accumulating, so it becomes a repetitive concussion. Maybe the first injury or first sign does not demonstrate a lot of damage, but if you have that happening over and over again, it's going to accumulate. There are some guidelines CDC put out with regard to what to do. So somebody comes to a shelter and talking to you tells you that they just had their head bashed or something, and they are complaining about headaches, or stiff and nauseous or whatever, the guidelines are they probably need to see a physician.

And of course if the symptoms are more severe, and the person all of a sudden starts falling asleep, cannot be awakened, seizures, speech, they're confused, restless, etcetera, then the guidelines indicates that person probably needs to go to the emergency room. Okay. We talked a little bit about what causes brain injury. So what are some of the problems that are frequently associated with brain injury. And these kind of fall out in these areas, big one we talk about is cognition. It affects the ability to think. Cognition also is needed to communicate effectively, and as we talk about some of these areas of problems you'll see how they all kind of connect or relate to each other. And of course that falls into judgment issues. People may also have problems with emotional, behavioral, psychosocial issues, and physical functioning.

Person after brain injury may have a combination of these problems. A lot of it will depend on how severe the injury was, where the damage took place in the brain. And so then

because of these kinds of issues they will then create problems in terms of what we call activities of daily living. So obviously if the person is having trouble organizing their thought processes and figuring out what to do in a sequential order, they may have trouble getting dressed in the morning, may have trouble initiation, remember to get dressed, or what order the articles of clothing should be they put on. So these kinds of problems associated with brain injury can affect all these areas. Ability to go to work, pay bills, look for a job, all the things you do living from day-to-day. Cognitive problems I'll talk a little bit more in-depth. One of the areas frequently associated with brain injury is in the area of memory. People will often have a good long-term memory, but they may not remember what took place before the injury or after injury.

And so short-term, intermediate. Problem solving, figuring out how to analyze tasks, what are the steps necessary to complete that, to solve that problem, how to break that down, what's first, what's second, what's third. People may be confused, attention span may be shortened. They have trouble understanding abstract concepts. Sometimes people do not understand when you use certain phrases that we have that are kind of abstract, they may take that as very concrete rather than that it's just a phrase or like go jump in the lake. They may not understand jokes or the subtlety of jokes, humor. Trouble with complex direction, sense of time and space, and may not have a good awareness of themselves or others. As I said earlier, cognition also affects the ability to communicate.

Certainly if a person has a brain injury, it can affect their ability to articulate. That would be your expressive language-ability. Also the ability to understand language. But if you

are having trouble organizing thought processes, then you may also have trouble communicating those thought processes. The cognition communication goes hand-in-hand. People, if they have trouble with memory, they may have trouble identifying objects and words, they may be better apt at describing an object as opposed to being able to come up with a name for something. All of those communication problems. Sometimes people say the same thing over and over, and then they are not able to shift as the topic shifts with them. So communication problems are a big problem for people with brain injury. For judgment, we have talked a little bit about judgment earlier in Sue's presentation, that I think the ability again to understand what the long-term consequences of an action is.

If you don't show up at work tomorrow, sometimes they don't realize the long-term consequences, they may not have a job. May not be able to pay bills. So that judgment issue, that lack of insight of their own behavior, lack of insight on what their decision is going to, what's going to happen when they make that decision. Sue talked about the inability for safety planning, that their judgment may not be there to figure out what makes this to do safety planning. And Sue, I think you were going to comment a little bit about the need to differentiate between poor judgment resulting from TBI, from decisions of victims that don't make sense to others. That was something she did not include in the slide -- I said you can expand on that.

SUE PARRY: Okay. Very often the victims of domestic violence, because they are trying so hard to cope with danger on an ongoing basis, will make decisions that other people

see as irrational. Other people who have not lived in their situation may see their decisions as irrational. In particular, as I said before, the decision to stay with an abusive partner. If her best judgment is she's actually safer staying there rather than trying to leave, or keeping her kids with him where she can keep an eye on him, or if she really thinks because he's threatened her that he will kill her if she tries to leave, because he's made threats before and he's followed through on them, she may decide to stay and then others look at that as if there's something wrong with her psychologically, for deciding to do that. So that's what I mean about the importance of sorting that out is are there some real factors in her situation that you as a service provider don't have insight into or don't understand, not that she's functioning badly. But how much of it is in the situation and how much it is in her for other reasons.

SUSAN VAUGHN: Right. Right. It's that keeping out of the information, and sometimes it's very difficult to do, especially if you are seeing somebody in a brief period of time. What we are hoping we can give is enough awareness things we can keep it up as we go along with people that may be in the shelter or people served by case management. Emotional, behavioral issues, I touched on earlier, that often depression may follow a brain injury. Sometimes it's depression because of the actual injury that took place. Other times depression may be associated with the brain being damaged that creates that. People may have mood swings, low self-esteem, they may be the inability to initiate or complete tasks, they have impulsive behavior, and they may have a changed personality.

And often times family members or close friends or others will say this important is not the same person as before. Physical problems, I'll run through briefly. They may be associated with seizures, fatigue is a big one. People may be, tire very easily, affect their ability to work. Maybe a half day of working is all someone can do because they just are too, they tire too easily to complete a full day of work. And then certainly hearing, vision and speech, all can be affected. And you can see why, because if the brain is being injured, and hitting different places within the skull, all of that can affect the kinds of things that can, that are, that take place after brain injury.

The next few slides are something that Sue provided me and I thought were very interesting, and that is what do domestic violence victims with TBI report, and you will see it is kind of in line with what we have been talking about. They do report having headaches, and this, by the way, came from a study that Sue had and she will be able to give that information at a later time, or we'll post it on the website. But it is headache, dizziness, no initiation, can't retain information, can't concentrate, irritability, apathy, and others. The next slide continues with the line of thinking, blurred vision, problems with hearing, can't sleep, depression, all of those things quite match up with what we know about brain injury and the study.

So if we move on to slide 45, we talk about what are some of the issues, then, for people who are domestic violence victims but also have brain injury? Sometimes it's just a matter, it's not a just, maybe the first issue is getting them medical care as a result of the brain injury. Or rehabilitation. And what I'll talk about after this slide are some resources

that might point you in that direction. It may be the person really does need to go see a physician or somebody experienced with brain injury that can help either diagnose or help see what's going on with this individual to know what needs to take place to compensate for that, or help that individual cope with those issues. Financial dependence, I think that really plays into what Sue is talking about, somebody is trying to leave a situation, then how are they going to be able to do that financially, especially if they have kids to take care of, how are they going to do that. She touch on the deciding to stay or leave, caring for the kids, symptoms that overlap crisis reactions, all these can be issues for people with traumatic brain injury. Okay.

We have kind of a little scenario, similar to what Sue had presented. She presented it from the viewpoint of somebody coming into a case, to a TBI case management system or provider. This is the flip side of that. Somebody coming in to domestic violence provider, and in that intake, here is a scenario of what might be, information that might be gathered. In this one it says during her shelter intake, Julia says she was living with her mother who threw her out after Julia went ballistic following a phone call from her husband. She left her husband a month ago almost after he killed her. He has been following her and harassing her wherever she goes. She needs to find an apartment and a job but feels overwhelmed by the process of looking.

What are key phrases or words that might make you want to explore further what took place. Okay. Julia went ballistic. That might be something you want to explore. If somebody is reacting inappropriately, having anger, they are frustrated, acting out, as we

talked about earlier, that is a symptom of traumatic brain injury. So that might be a little key word that you might make you want to explore things a little further. The other thing is he almost killed her. How was that, what did he do to her, did he choke her, slam her against the wall, push her down the stairs, whatever. And then she's having trouble finding a job, overwhelmed by the prospects of looking. That's another little tid bit that might make you want to look a little further what took place with Julia. In fact, I looked at some other kinds of intake information that has our true scenario, actually intake that people have written down about people, and some of the other things that I saw in there also are key little phrases like I lost consciousness, I passed out, I don't remember, or he choked me until I almost passed out.

All those should be ticklers to explore a little further. We have also devised some TBI screening questions that might be necessary to ask, to gather more information of what took place. Did he hit you in the head, slam the head into an object, suffocate you, shake you, did he do these things more than once. And then next, did you lose consciousness, did you feel dazed or confused, did you get medical attention, if you got medical attention, what did they tell you, what did you tell them. And finally, are you experiencing trouble concentrating, are you interesting trouble organizing, remembering things, do you find yourself to be irritable, are you having headaches, loss of balance, those are all kinds of prodding questions that you can ask to gain further information.

So, after that, then, what are some of the strategies to help you as a provider to be communicating and working with a person that you may suspect, after all you may not

have medical verification, but the signs may be there that this person is struggling a little, so what would help you in terms of communicating with that individual? Well, first of all, have some structure. People with brain injury have difficulty when there are multiple things going on sometimes. Having different stimulation that's going on when there's a lot of noise. So if you can try to minimize distractions, keep it focused and have some structure. Take your time, repeat as you need to, stick to the main points, don't go off in different directions but stay focused so you can help them stay focused. Check that information has been received, write things down.

So you are really trying to organize even in the assessment process if you are feeling that you are, this person is struggling with giving you some information, you may take a deep breath, as I need to do, take a deep breath and try to structure it in such a way it's more organized for the person so they can then follow along and give you the information you need. Other strategies for TBI providers, I would assume most providers work with other community agencies, state agencies and federal agencies and programs, as you try to find employment for people, child care for people, transportation to services. Well, these kinds of services are also in place for people with disabilities. What you may want to do, though, you look at some of these agencies, whether it's Medicaid, if you are looking at Medicaid for health care or Medicaid to pay for rehab, see if they have programs or eligibility requirements that would fit a person that has a disability.

In most instances, the state and federal programs they will want medical documentation with regards to brain injury. Think of the things you can explore as you find out

information from the agencies, and then you will need to convey that to the person in such a way they will understand that. If you are saying you know I think there's a vocational rehabilitation program that can be for job training, that has programs in place to help you accommodate for your problems and your needs to help you get a job, then explain that and write it down. One of the confusing things for people with brain injury is that with state programs, local programs, they all tend to have case managers or an intake coordinator or service coordinator or some kind of front line staff that interacts with individuals or families. And it gets very difficult to track who's who tan -- and what their role is.

When somebody calls them, you will know who the person is. Write down what the name is, what they are calling about, whether it's employment, medical assistance, child care or transportation, that might help that person stay on task and know when that person is calling why they are calling. Also explain confidentiality and writing so they understand about confidentiality because you will maybe be intervening on their behalf to other agencies, and I think you want to make sure that everybody understands the confidential information is either allowed or not allowed to be released. And really, as you help her communicate with others, and if you are providing her with information about phone numbers to call or agencies to call, you may want to not only write that down but double back and check with her.

She may not remember to do that, or remember how to do that, or be able to follow through with that process. So just assuming somebody is going to make the call doesn't always work. Page 52 are compensatory strategies. Most of these are around the issues

of memory. If somebody is residing in a shelter for a period of time and you are finding out that they are not quite fitting in with the routine of others in that she -- shelter, you may need to make accommodations, what the schedule is, what time to get up, make their beds, take a shower, keep checklists, note pads by the phone. Writing things down really do help. The amazing thing now is so many things have timers to them, you can help to cue people to certain things. If it's a timer on a watch to remind them to call somebody or take medication, a lot of devices we get now have that already built in. Just use that to help cue people in. The next slide is on social judgment strategies. Again, we talked about being concrete, helping people to have appropriate judgment and the right situation.

You may want to discuss and go over that with that person. Help set priorities. Make sure there's clear and consistent feedback. And as Sue has said, build these kinds of issues into your safety planning. In terms of natural -- in terms of other strategies, Sue talked a lot about natural support. Sometimes with brain injury the family is the natural support. They may not be involved with domestic violence situations, but they may actually have been the caretaker before. And it may be appropriate to contact them partly to learn more information about the individual, help them with their day-to-day activities, and transportation, and kind of being back into the community. And the last one I have on there is know your local brain injury service provider.

Sue talked about that, the brain injured community about knowing the domestic violence provider, and many of the state we have state agencies or contact people that know about brain injury. We also know that we have brain injury associations that will have the phone

number on the last slide of this presentation, these can be resources for you. They can be resources in terms if you want further training to your staff about brain injury, they may be resources in terms of knowing what are available, what kinds of services are available in your community. So nice to kind of add them to your list of the other kinds of providers that you may already have at your fingertips. The state, the resources on the next slide I alluded to in terms of the state TBI programs. Your disability resources. Often they are located in state agencies of mental health, vocational rehabilitation, departments of health. They will either have a brain injury program or they may have a disability program that will lend itself well to the needs of that individual.

I'm going to shift my focus now into the system aspect of it, of what's happening around the country in these two fields. We do have what we call the TBI grant program, a federal program that awards grants to states to do innovative projects, and change systems, and that has taken place in a few states around the country who have chosen this issue as something to further study. There are some states that are looking into both educating domestic violence providers about brain injury, much what we are doing now but more in depth, and also educating the TBI providers about domestic violence. Incorporating the screening questions that we have both given you, there are some states who are trying to do that as a routine in the domestic violence screening, questions about brain injury, and as a routine question with those who are serving people on the brain injury side about domestic violence.

They are looking at identifying resources, learning about each of the lingo, what the programs and services look like. And in fact, one program also has a brochure that is geared specifically to the person with the brain injury, and that then can be given to them so that if they suspect a brain injury, what can they need to know about, kind of their own self-assessment tool. In terms of these resources, how do I find out about the national resources or the state resources, on slide 57 there are organizational names, technical assistance center, can be accessed on that website. Information about brain injury that can be printed off, overviews on brain injuries, services, that any, anybody is welcome to use. Some versions in Spanish, but most are in English versions. Feel free to copy those. We also have information about safe programs.

I've also added on our website information about domestic violence. Under the resource center, or on this presentation as you scroll down you probably saw where you can click on this site for more information about domestic violence. And what I did is I included all the names and contact people of the state domestic violence coordinators that Sue talked about, as well as other information. So if the people in the brain injury community want to know how to contact someone in their state that is there. And those of you in the domestic violence community, if you want to know about brain injury, it is there for you as well on that site. And then I mentioned a brain injury association of America, but we have state affiliates, most of them have offices in the states that might have information at support groups at a local level, something that might be helpful with people's brain injury to hook up with a support group with other people of brain injuries.

They will also have information about informational referral services. And as I said earlier, they would know about brain injury if you want further information or training. And then as Sue gave you, the last address was the national coalition against domestic violence. And that is the WWW site right there. So in summary, I have listed some areas that we have tried to bring together for this presentation. That there are cognitive and executive problems that typically follow TBI that could cause extra problems for people who are domestic violence victims, that domestic violence victims of TBI may have difficulty with planning and self-determination, and coordination understanding service providers are very crucial.

BLANCA KLING: Thank you so much for the wonderful presentation. Very informative. We would like to remind the audience to include your name or the name of your group or the state where you are calling from when you ask the questions because we really wanted to know where you are calling from. We are going to go ahead and ask you some questions of the panel, and we would like to know, Carol wants to know how is the testing for TBI differs from regular medical or psychiatric exams.

SUSAN VAUGHN: Okay. The question is, how does testing for TBI differ from regular medical or psychiatric exams? Well, if somebody knows on the medical side they can do CAT scans and MRI's and physical test that might be able to capture brain injuries, although for mild brain injury -- on the other side of it, different for psychiatric examinations, usually in brain injury a neuropsychological evaluation is used that kind of have been outlines with what the strengths and weaknesses are, people can see where

they are having cognitive, memory skills, sequencing skills, looking at it more how a person is able to think and communicate and be able to identify what the problems are so that you can then turn that around to strategies for how you accommodate that. Anything you want to add?

BLANCA KLING: Okay. The other question. Brain injury tests and imaging and neurophysical exams are expensive. How can women with little resources get the resources they need.

SUSAN VAUGHN: We all know health care is expensive and everyone is struggling how to pay for it. And it is an issue that I know Sue brought up early in our discussions that women who are trying to leave their husbands, for example, I guess it could be the other way around, often it's the husbands that have the health insurance policy so that may not follow the individual if she makes the break from the husband. If there is not any insurance, sometimes you can contact Medicaid, the state Medicaid programs to see if there is any kind of health evaluation that might be considered an eligible service provided the individual herself is Medicaid eligible, or you might, what I would suggest, really contacting, if you can, your state TBI program person. They often know who is local that conducts those kind of evaluations, and how they might be able to get those paid or absorbed by that provider. So the best thing to do is to contact somebody locally. Different answer state to state.

BLANCA KLING: The state differs.

SUSAN VAUGHN: Right. Eligibility requirements are different.

SUE PARRY: I want to add to that, this really illustrates the importance of collaboration between services. Not just because we offer different services, but because we know about different services and that domestic violence programs need to contact their local brain injury association and they're the ones that are going to have the knowledge about what's available in this area. One thing I want to add to that, though, is that very common tactic of abusers is to keep their partner from getting health care in the first place, and to make it very difficult for her to tell the truth when she does seek health care. So she may need some talking and assistance to figure out how she can safely access those services, even if she can get ahold of the money. On the positive side, it may be very difficult for her to seek domestic violence services. She may not feel free to do that. If she's able to seek other services, then that can be a start for somebody to reach out to her.

BLANCA KLING: Right. Right. Will persons with brain injury benefit from the use of medications to change the behavior without any other treatment?

SUSAN VAUGHN: That's kind of clinical question. The question is will persons with brain injury benefit from use of medication to treat their behavior without using other treatment modalities in concert with medications, and to me that's a medical question that somebody needs to be referred to a professional to do that. Certainly there have been uses of medication that's been very good to deal with behaviors. But that's such an individual case by case situation, and really needs to be, somebody who knows brain injury as a

physician or medical provider that can assess and know how the medications are going to respond to somebody who has had an injured brain.

BLANCA KLING: Thank you so much. Are batterers themselves victims of TBI or domestic violence, and does TBI encourage violent behavior?

SUE PARRY: I think this is an area where we need to be careful how we think about it. And really the question, okay. The question is are batterers themselves victims of domestic violence or TBI. Two-part question here. And then does the TBI encourage violent behavior. What we know from research is that some batterers have been exposed to, have grown up with a father who battered their mother. But many did not. And many have never had in their growing up any exposure to domestic violence. And we also, we also know pretty clearly by this point that simply being exposed to domestic violence does not turn you into a batterer, unless you have some underlying beliefs that says it's okay for me to act this way. I'm entitled to act that way. And in sorting out those domestic violence versus the brain injury, I think the question really to ask is which came first. If he was battering his partner before he got head injured, what you are going to see is that pattern of controlling behavior that I talked about, you are going to see him only hitting certain people. And you can ask questions like, well, how do you act towards other people, have you ever been violent towards anybody besides your partner, and if the answer is no you are not really looking at behavior caused by a TBI. What you are looking at intentionally chosen behavior, and then if he's trying to tell you well, yeah, but I have a head injury and that's why I act this way, that's a rationalization. An attempt to pull the wool over your

eyes, basically. Batterers will sometimes try and do that with police officer, probation officers, others trying to intervene as a way to get themselves off the hook. How we know that battering behavior is intentional and is not caused by a brain injury is we look at the choices that batterers make about who they hit, when they hit, what they do in between times, where on the body they hit, and we see patterns that you don't see when you have behavior that's other reasons caused. They don't normally hit the neighbors, the Boss, the cop writing them a ticket, they know there is consequences if they do that, and that their partner is in a much weaker position to impose consequences. The important thing really when you are dealing with somebody who may be a batterer, try and sort that out so we don't accept a brain injury as an excuse for intentional abusive behavior.

BLANCA KLING: That's very important. How many wives murderers are men with TBI, Mark hacking, does he have a brain injury, and also O.J. Simpson, what is the response to that?

SUSAN VAUGHN: I think the response to that is pretty much the response to the previous question. If he's only been violent toward her and not toward other people, and if in between times, in between episodes of violence he does all these other things that we talked about to try and control her, he may have a, he may have a TBI. Okay. But that's not what's causing the behavior. And it should not be a reason for us to say take him --

BLANCA KLING: Absolutely. Absolutely. Another very important question. Power and control are factors in domestic violence. What advice do you have for helping victims and survivors feel more controlled and regain their power.

SUE PARRY: You know, that's the \$64,000 question, and that's really what domestic violence service providers do is to try and help victims, survivors, find ways to regain power. A lot of that is a safety planning process that maybe we could just talk about that for a minute. When we talk about safety planning, we are talking about figuring out what the victim can do, whether she leaves her abusive partner or not, what she can do to make herself safer. We might talk about different things with different victims, but things that we might typically include would have to do with figuring out where you go when you think an incident is about to occur. Staying out of places if you can, like the kitchen, the garage, things that are full of items that can be used as weapons, like carving knives and hammers and stuff like that.

Planning an escape route out of your house if you need to get out in an emergency. Maybe having a code word with your children to tell them leave now and go to aunt Mary's house, maybe a signal with a neighbor that says call 911, a lamp turned on, or a window shade pulled all the way down the neighbor understands as a signal that something is happening. Other things you might talk about in terms of safety planning has to do with planning escape routes, getting things together that you need. Money, clothing, documents, paperwork. Driver's license and health insurance cards and green cards and school records for the kids, and birth certificates and all the kinds of things that a person

needs to get out on their own and to be able to access services. And I think you can see from what Susan was talking about that for a person with a TBI, dealing with those details might be difficult. And so as much as domestic violence service providers we focus on the details, we may need to take that extra step of making sure that things are written down, and then kept in a safe place, incidentally. Because you don't know what might happen if the safety plan that you so carefully wrote down to help the person with the TBI falls into the hands of the abuser.

BLANCA KLING: I think after that, I think it's important as far as documents, documents are very, very important, to have, make copies of Social Security, birth certificates and maybe putting other things, give it to a neighbor, somebody who is close by that if you can't necessarily take it if you are rushing out of the house, somebody will have the information so they can be helped in filling out the documents later on.

SUE PARRY: Women with a TBI are more likely to experience domestic violence, I don't think we know. We know women with disabilities have a high rate of interpersonal violence, by partners, caregivers, other family members. So it's possible. But as far as I'm aware, that's not research that has been done. The other thing I want to say about that, we don't really, we are not really ever able to quite know the true extent of domestic violence because like most other crimes, it's very much underreported. Victims may not recognize themselves as victims, they may not know who to call, they may be afraid to call. They may not be comfortable using police as a resource. As a result, there are lots

and lots of victims of domestic violence that don't make it into any statistics. So it makes these kinds of, answering these kinds of questions really difficult. And --

BLANCA KLING: Working with victims of domestic violence, Hispanic community, due to the language barriers and the barriers of immigration, they are usually not reporting cases of domestic violence and I had a chance to work with a victim which was, I was very sad, I met her at the funeral home. She died and she, the family tried to get help for her but she never could call the police. Okay. If a person sees many times in the emergency room, is a police report required?

SUE PARRY: That's going to vary by state. In most states there is not -- mandatory reporting of child abuse, in most states there is not going to be mandatory reporting of domestic violence, but in some there is. So you would have to check your own state laws.

BLANCA KLING: Yeah. Montgomery County, for instance, domestic violence is taken very, very seriously, the police also have to write a report and not only write a report, but have to send information immediately to the domestic violence unit so we can work on it. What percentage of women with TBI have experienced domestic violence and vice versa.

SUSAN VAUGHN: Again, the question we had before. We don't know.

BLANCA KLING: Can the abuse victims get a court order requiring anger management classes?

SUE PARRY: I guess I don't want to answer that question directly because I want to say anger management classes are a very problematic intervention in domestic violence cases. Batterers abuse their partners both when they are angry and when they are not. And they use their anger as a weapon of control. They are not out of control of their anger. So when they go to anger management classes, unfortunately usually they have been not given any criminal justice sanctions along with that. What they are maybe likely to learn is better ways to use their anger to control their partners without getting arrested. So from our point of view in the domestic violence arena, we don't really see anger management as an appropriate response to a domestic violence case. We see it as a response that can be dangerous, and that basically takes the abuser off the hook. Now the kinds of court orders that victims typically will seek are orders of protection or restraining orders that ban the abuser from the residence or from coming within X amount of distance of the victim, or that order him to refrain from specified abusive behaviors in the presence of the victim, and usually of the children.

BLANCA KLING: Also a protective order to have the husband ordered to go to anger management classes. Okay. Can the abuse victim get a court order requiring anger, I'm sorry, this is so interesting I didn't switch my story. How do you differ between the two of them?

SUE PARRY: What was the question?

SUSAN VAUGHN: Psychologist resident psychologist.

SUE PARRY: We may have to answer this between the two of us, actually. Post traumatic stress symptoms, usually -- first of all, we talk about post traumatic stress, it's always against the background of what has happened to this person that they are responding to. And what you may see with post traumatic stress disorder is usually things like a certain amount of numbness, a certain amount of withdrawal, maybe from relationships, a loss of interest in things that used to give them pleasure. You are likely to see nightmares, you may see difficulty concentrating, which I suppose could be a point of confusion. I think what you have to evaluate is what's going on with this person across the board. You know, is there, is there inability to concentrate a reflection of what they have experienced emotionally, or is it reflecting what's happened to them physically. And that would be a matter to be assessed by a professional.

BLANCA KLING: If you have a victim and suspect a brain injury, where do you refer to confirm?

SUSAN VAUGHN: I figure that followed her question, I thought we would get to this part as kind of a second part to her question. The thing about referring people to brain injury, the whole health care delivery system is difficult. Some people are operating under managed care systems, insurance plans, obviously people have to go through the insurance plans and maybe get referred to an appropriate psychologist or neurologist or somebody who can assess both a medical view point and assess from where the person is performing. Another way to do that, if you are looking at public resources to do that, is

to contact people I gave you earlier, contact your state program or contact your brain injury association. The reason I say that is they generally will know which kind of rehab provider or facilities that have expertise in brain injury, not all medical communities have experts in brain injury. There are certain kinds of professionals that can assess brain injury and there are certain kinds of professionals that also work with rehabilitation to assess brain injuries. So just referring somebody to the hospital or to a doctor's office or to any speech and language therapist or psychologist isn't going to catch it. You really want to find out if those disciplines have background and expertise in brain injury so they can do the proper evaluation.

So again, I would, you know, either, you can either have the person referred to their local physician but might also, if you are able to, go ahead and go the extra mile and see in your community if there is expertise around brain injury. If not, go to the website and find the state person or the brain injury association to help you direct that person to get the appropriate care or assessment.

BLANCA KLING: How do you build TBI into safety planning, can you give me briefly some examples? I think we did that, but if you want to review it quickly.

SUE PARRY: A couple things, some may be how you approach the safety planning. Obviously this also comes back to before you can build a TBI issue in, you have to identify. So if you know that somebody has been hit in the head, bashed against the wall, attempted strangulation, something like that, to try and identify the TBI first so that you

know that it's necessary to attend to these issues in safety planning. Again, you have to be careful that the compensatory strategies, the writing things down and all that, doesn't put them in any danger. So they know, so the safety stuff does not get written down and put in a place where the abuser can find it. Safety planning in this case may have to involve helping her build not just the supports that she needs to cope with the domestic violence, but the supports that she needs to cope with the TBI, so she has access to people who can help her with that, aside from her partner. Remember, her partner who abused her may be the partner now taking care of her.

That is not an uncommon pattern. The other thing I would say is that a lot of times as I understand it that women with head injuries are going to have more trouble when they get into situations where they're under a lot of stress, and where they are expected to perform kind of rapidly and take in information rapidly and respond rapidly. Primary example of that situation is having to go to court, and sitting there in court with the batterer sitting across the courtroom staring at you and glaring at you and the judge wanting to move things along and wanting quick responses from you. That person is going to need a fair amount of support going through that. So in talking about safety planning, we often talk about the woman's need to use the court to get an order of protection, to get custody of her kids, to get child support, to get a divorce, and there may be a criminal case. That woman is likely to need a fairly knowledgeable advocate to go through that process with her. Knowledgeable not just about the DV, but about the TBI as well. So that when they're, she is sitting there in court they can plan for how to deal with that.

SUSAN VAUGHN: I might add that the family member that the person close to might be the kind of person to help you figure out what is the best safety plan for that person. Because they are going to know what, how that person is going to function or who they are likely to call or what might be more appropriate for that individual. So you might get some really good insight from the family member or good friend in terms of safety planning that would make more sense to the person with the brain injury.

SUE PARRY: Can I just say one thing, that is be careful when you are accessing family members to make sure that victim of domestic violence knows that that particular family member.

SUSAN VAUGHN: Right.

SUSAN PARRY: Is a safe support person and is not allied with her partner.

SUSAN VAUGHN: That's right.

SUE PARRY: It has to go through her.

BLANCA KLING: Right. Clarification, in Maryland emergency staff at the hospitals are only required for injury due to gunshots or moving vehicles.

SUE PARRY: In New York it's gunshot or stab wounds or burn injuries. The cause of the injury doesn't get reported.

BLANCA KLING: Police report is required, how should this be handled -- handled with the victim?

SUE PARRY: First thing, don't make a report without telling her about it first. There should be no additional surprises for victims of domestic violence coming from service providers. Because if they know that you are going to have to make a report, and this is also true if there is a suspicion of child abuse by the abuser, and you have to make a child abuse report, if you can tell her about that, and tell her about what will happen, and prepare her for that, then that's a window of opportunity for her to do some safety planning. If it comes, the first time she hears about it is when child protective services shows up at the door, that's not good.

BLANCA KLING: That's right. Mild TBI go away? If --

SUSAN VAUGHN: After we added to the session, it's nice to -- nice to end on a question because mild TBI's seem like a little bit pregnant. A brain is injured, it's going to be injured. The symptoms, the person may not be showing any symptoms or able to accommodate them, but if a brain is injured, it has been injured. I always remembered that little phrase after he said that.

BLANCA KLING: Great. We are going to go to one more question. What documentation or diagnostic documentation will be needed for rehabilitation services?

SUSAN VAUGHN: Usually what a person needs is a medical documentation. Most of the state and federal programs, if that's the side you are looking at for rehab services, will want medical documentation. And even for rehabilitation itself, you know, in terms of therapy, physical therapy, speech therapy, will be doctor ordered or verification that the brain injury took place and that's what's needed, in order to make progress. Usually rehab is not in order for people unless they think there is significant progress made. You need somebody to make the assessment that there was a brain injury and that the therapies are going to help that person. And then if you are in programs like vocational rehabilitation or state programs, most of those programs will want some kind of medical documentation that the event took place.

BLANCA KLING: We'll attempt to answer questions at the national site to please keep an eye on it. An online evaluation form will be appearing at the end of the broadcast. Please take a few minutes to complete the evaluation to help us to plan future webcasts. If you need a certificate for continuing education units or credits, please send an email message to NASHIA at NASHIA.ORG, or click on the website. On behalf of NASHIA I would like to thank the presenters, Sue and Susan for an informative session, and the Maternal and Child Health for making this webcast possible. We thank our audience, and hope that you will join us in future webcasts. I am Blanca Kling, thank you so much for participating.