

Concussion Symptoms Quiz

Please check the symptoms someone may experience in the days following a concussion:

- Dizziness
- Disorientation
- Amnesia
- Headaches
- Loss of Consciousness (LOC)
- Confusion
- Nausea
- Vomiting
- Unusual or prolonged sleepiness
- Emotional instability
- Fatigue
- Pica (craving non-edible things to eat)
- Depression
- Anxiety
- Uncontrollable urge to dance
- Visual Disturbance
- Noise Sensitivity
- Vertigo
- Diabetes
- Altered gait
- Attention deficits
- Poor memory
- Poor concentration
- Constipation
- Slow Thought Process
- Neurologic Deficits
- Slowed processing in general
- Fatigue
- Sensitivity to lights
- Drowsiness



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[Back to Home Page](#)

[Living with TBI](#)

[About Brain Injury](#)

[Diagnosis](#)

[Treatment](#)

[Community](#)

[Children](#)

[Mild Brain Injury](#)

[Family & Caregivers](#)

[Brain Injury FAQs](#)

[Personal Stories](#)

[Contact Consumer Services Staff](#)



[BIAA HOME](#) : [LIVING WITH BRAIN INJURY](#) : [ABOUT BRAIN INJURY](#)

About Brain Injury

The Brain Injury Association of America and its state affiliates strive to connect people with useful, accurate information and resources in their area. If you or a family member are struggling with the effects of a brain injury, or think you may have sustained a brain injury, there is help. Here are some useful first steps:

- [Contact your State Brain Injury Association](#). The Brain Injury Association state offices will have information about Programs, support groups, and resources that could be helpful to you. They understand brain injury, and understand the resources available. Use that resource!
- Use this website as a starting point. Brain injury can be complex and overwhelming. We are here to help. Use the navigation menu to the left to find information that might be useful to you. [Contact us](#) if you can't find it!
- Find a [list of common issues](#) and suggested publications on our "[community](#)" page.
- Find some personal stories in our [Marketplace](#). Read about other people's experiences with recovery from a brain injury.
- Remember that not all the information you read will be relevant to you. Take what you need and leave the rest.
- Understand that recovery after a brain injury is a journey. You do not have to go it alone. Come back to the website or contact us for different information as you move along your journey.

This page offers helpful definitions and terms you might hear used. Use this page to help you understand brain injury a little better. Use the resources on other pages as well.

[Definitions](#)
[Types of brain injury](#)
[Causes](#)
[Outcomes](#)
[Severity of brain injury](#)
[Tips for recovery](#)

Brain Injury Definitions

Traumatic Brain Injury (TBI)

TBI is defined as an alteration in brain function, or other evidence of brain pathology, caused by an external force.

Adopted by the Brain Injury Association Board of Directors in 2011. This definition is not intended as an exclusive statement of the population served by the Brain Injury Association of America.

Acquired Brain Injury

An acquired brain injury is an injury to the brain, which is not hereditary, congenital, degenerative, or induced by birth trauma. An acquired brain injury is an injury to the brain that has occurred after birth.

There is sometimes confusion about what is considered an acquired brain injury. By definition, any traumatic brain injury (eg, from a motor vehicle accident, or assault) could be considered an acquired brain injury. In the field of brain injury, acquired brain injuries are typically considered any injury that is non traumatic. Examples of acquired brain injury include stroke, near drowning, hypoxic or anoxic brain injury, tumor, neurotoxins, electric shock or lightning strike.

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Types of Brain Injury

[Diffuse Axonal Injury \(TBI\)](#)

[Concussion \(TBI\)](#)

[Contusion \(TBI\)](#)

[Coup-contre coup injury \(TBI\)](#)

[Second Impact Syndrome \(TBI\)](#)

[Open and Closed Head Injuries](#)

[Penetrating Injury \(TBI\)](#)

[Shaken Baby Syndrome \(TBI\)](#)

[Locked in Syndrome \(TBI\)](#)

[Anoxic brain injury \(ABI\)](#)

[Hypoxic brain injury \(ABI\)](#)

Diffuse Axonal Injury

- A Diffuse Axonal Injury can be caused by shaking or strong rotation of the head, as with Shaken Baby Syndrome, or by rotational forces, such as with a car accident.
- Injury occurs because the unmoving brain lags behind the movement of the skull, causing brain structures to tear.
- There is extensive tearing of nerve tissue throughout the brain. This can cause brain chemicals to be released, causing additional injury.
- The tearing of the nerve tissue disrupts the brain's regular communication and chemical processes.
- This disturbance in the brain can produce temporary or permanent widespread brain damage, coma, or death.
- A person with a diffuse axonal injury could present a variety of functional impairments depending on where the shearing (tears) occurred in the brain.

Concussion

- A concussion can be caused by direct blows to the head, gunshot wounds, violent shaking of the head, or force from a whiplash type injury.
- Both closed and open head injuries can produce a concussion. A concussion is the most common type of traumatic brain injury.
- A concussion is caused when the brain receives trauma from an impact or a sudden momentum or movement change. The blood vessels in the brain may stretch and cranial nerves may be damaged.
- A person may or may not experience a brief loss of consciousness (not exceeding 20 minutes). A person may remain conscious, but feel "dazed" or "punch drunk".
- A concussion may or may not show up on a diagnostic imaging test, such as a CAT Scan.
- Skull fracture, brain bleeding, or swelling may or may not be present. Therefore, concussion is sometimes defined by exclusion and is considered a complex neurobehavioral syndrome.
- A concussion can cause diffuse axonal type injury resulting in permanent or temporary damage.
- It may take a few months to a few years for a concussion to heal.

Contusion

- A contusion can be the result of a direct impact to the head.
- A contusion is a bruise (bleeding) on the brain.
- Large contusions may need to be surgically removed.

Coup-Contrecoup Injury

- Coup-Contrecoup Injury describes contusions that are both at the site of the impact and on the complete opposite side of the brain.
- This occurs when the force impacting the head is not only great enough to cause a contusion at the site of impact, but also is able to move the brain and cause it to slam into the opposite side of the skull, which causes the additional contusion.

Second Impact Syndrome "Recurrent Traumatic Brain Injury"

- Second Impact Syndrome, also termed "recurrent traumatic brain injury," can occur when a person sustains a second traumatic brain injury before the symptoms of the first traumatic brain injury have healed. The second injury may occur from days to weeks following the first. Loss of consciousness is not required. The second impact is more likely to cause brain swelling and widespread damage.
- Because death can occur rapidly, emergency medical treatment is needed as soon as possible.
- The long-term effects of recurrent brain injury can be muscle spasms, increased muscle tone, rapidly changing emotions, hallucinations, and difficulty thinking and learning.

Penetrating Injury

- Penetrating injury to the brain occurs from the impact of a bullet, knife or other sharp object that forces hair, skin, bone and fragments from the object into the brain.
- Objects traveling at a low rate of speed through the skull and brain can ricochet within the skull, which widens the area of damage.
- A "through-and-through" injury occurs if an object enters the skull, goes through the brain, and exits the skull. Through-and-through traumatic brain injuries include the effects of penetration injuries, plus additional shearing, stretching and rupture of brain tissue.
- The devastating traumatic brain injuries caused by bullet wounds result in a 91% firearm-related death rate overall.
- Firearms are the single largest cause of death from traumatic brain injury.

Sources: Brumback R. Oklahoma Notes: Neurology and Clinical Neuroscience. (2nd ed.). New York: Springer;

2006. and [Center for Disease Control and Injury Prevention](#).

Shaken Baby Syndrome

- Shaken Baby Syndrome is a violent criminal act that causes traumatic brain injury. Shaken Baby Syndrome occurs when the perpetrator aggressively shakes a baby or young child. The forceful whiplash-like motion causes the brain to be injured.
- Blood vessels between the brain and skull rupture and bleed.
- The accumulation of blood causes the brain tissue to compress while the injury causes the brain to swell. This damages the brain cells.
- Shaken Baby Syndrome can cause seizures, lifelong disability, coma, and death.
- Irritability, changes in eating patterns, tiredness, difficulty breathing, dilated pupils, seizures, and vomiting are signs of Shaken Baby Syndrome. A baby experiencing such symptoms needs immediate emergency medical attention.

Source: [National Center on Shaken Baby Syndrome](#)

Locked in Syndrome

- Locked in Syndrome is a rare neurological condition in which a person cannot physically move any part of the body except the eyes.
- The person is conscious and able to think.
- Vertical eye movements and eye blinking can be used to communicate with others and operate environmental controls.

Anoxic Brain Injury

- Anoxic Brain Injury occurs when the brain does not receive oxygen. Cells in the brain need oxygen to survive and function. Types of Anoxic Brain Injury:
 - Anoxic Anoxia - Brain injury from no oxygen supplied to the brain
 - Anemic Anoxia - Brain injury from blood that does not carry enough oxygen
 - Toxic Anoxia - Brain injury from toxins or metabolites that block oxygen in the blood from being used

Source: Zasler, N. Brain Injury Source, Volume 3, Issue 3, Ask the Doctor

Hypoxic Brain Injury

- Hypoxic Brain Injury results when the brain receives some, but not enough, oxygen. A Hypoxic Ischemic Brain Injury, also called Stagnant Hypoxia or Ischemic Insult, occurs because of a critical reduction in blood flow or low blood pressure leading to a lack of blood flow to the brain.

Source: Zasler, N. Brain Injury Source, [Volume 3, Issue 3, Ask the Doctor](#)

Open Head Injury

The following are terms used to describe types of skull fractures that can occur with open head injuries:

- Depressed Skull Fracture - The broken piece of skull bone moves in towards the brain.
- Compound Skull Fracture - The scalp is cut and the skull is fractured.
- Basilar Skull Fracture:
 - The skull fracture is located at the base of the skull (neck area) and may include the opening at the base of the skull.
 - Can cause damage to the nerves and blood vessels that pass through the opening at the base of the skull.
- Battle's Sign
 - The skull fracture is located at the ear's petrous bone.
 - This produces large "black and blue mark" looking areas below the ear, on the jaw and neck.
 - It may include damage to the nerve for hearing.
 - Blood or cerebral spinal fluid may leak out of the ear. This is termed "CSF Oterrhea."
- Raccoon Eyes
 - The skull fracture is located in the anterior cranial fossa.
 - This produces "black and blue" mark looking areas around the eyes.
 - Cerebral spinal fluid may leak into the sinuses. This is termed "CSF Rhinorrhea."
 - Nerve damage for the sense of smell or eye functions may occur.
- Diastatic Skull Fracture
 - The skull of infants and children are not completely solid until they grow older.
 - The skull is composed of jigsaw-like segments (cranial fissures) which are connected together by cranial sutures.
 - Skull fractures that separate the cranial sutures in children prior to the closing of the cranial fissures are termed "diastatic skull fractures."
- Cribiform Plate Fracture
 - The cribiform plate is a thin structure located behind the nose area.
 - If the cribiform plate is fractured, cerebral spinal fluid can leak from the brain area out the nose

Closed Head Injury

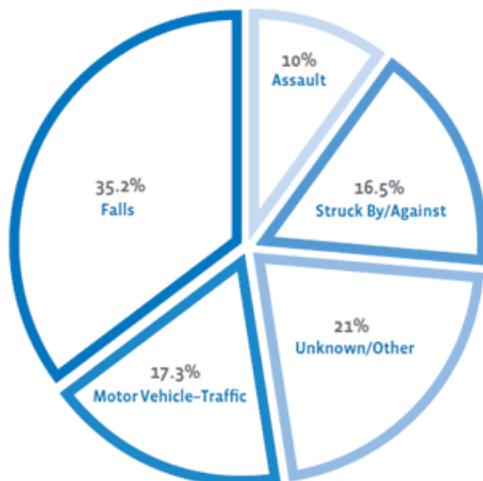
When a person receives an impact to the head from an outside force, but the skull does not fracture or displace this condition is termed a "closed head injury". Again, separate terminology is added to describe the brain injury. For example, a person may have a closed head injury with a severe traumatic brain injury.

- With a closed head injury, when the brain swells, the brain has no place to expand. This can cause an increase in intracranial pressure, which is the pressure within the skull.
- If the brain swells and has no place to expand, this can cause brain tissues to compress, causing further injury.

- As the brain swells, it may expand through any available opening in the skull, including the eye sockets. When the brain expands through the eye sockets, it can compress and impair the functions of the eye nerves. For instance, if an eye nerve, Cranial Nerve III, is compressed, a person's pupil (the dark center part of the eye) will appear dilated (big). This is one reason why medical personal may monitor a person's pupil size and intracranial pressure.

Causes

According to the [Centers for Disease and Control Injury Prevention Center](#), the leading causes of traumatic brain injury are:



- Falls: 35.2%
- Unknown/Other: 21%
- Motor Vehicle: 17.3%
- Struck by/Against: 16.5%
- Assault: 10%

Outcomes After Brain Injury

Brain injury can result in a range of outcomes:

- 52,000 die;
- 275,000 are hospitalized; and
- 1,365,000 are treated and released from an emergency department.

Among children ages 0 to 14 years, TBI results in an estimated

- 2,685 deaths;
- 37,000 hospitalizations; and
- 435,000 emergency department visits.

The number of people with TBI who are not seen in an emergency department or who receive no care is unknown.

Source: [Centers for Disease Control and Injury Prevention](#)

Severity of Brain Injury

Emergency personnel typically determine the severity of a brain injury by using an assessment called the Glasgow Coma Scale (GCS). The terms Mild Brain Injury, Moderate Brain Injury, and Severe Brain Injury are used to describe the level of initial injury in relation to the neurological severity caused to the brain. **There may be no correlation between the initial Glasgow Coma Scale score and the initial level of brain injury and a person's short or long term recovery, or functional abilities.** Keep in mind that there is nothing "Mild" about a brain injury—the term "Mild" Brain injury is used to describe a level of neurological injury. Any injury to the brain is a real and serious medical condition. There is additional information about mild brain injury on our [mild brain injury page](#).

Glasgow Coma Scale (GCS)

| Glasgow Coma Score | | |
|----------------------|----------------------------|-----------------------|
| Eye Opening (E) | Verbal Response (V) | Motor Response (M) |
| 4=Spontaneous | 5=Normal conversation | 6=Normal |
| 3=To voice | 4=Disoriented conversation | 5=Localizes to pain |
| 2=To pain | 3=Words, but not coherent | 4=Withdraws to pain |
| 1=None | 2=No words.....only sounds | 3=Decorticate posture |
| | 1=None | 2=Decerebrate |
| | | 1=None |
| Total = E+V+M | | |

The scale comprises three tests: eye, verbal and motor responses. The three values separately as well as their sum are considered. The lowest possible GCS (the sum) is 3 (deep coma or death), while the highest is 15 (fully awake person). A GCS score of 13-15 is considered a "mild" injury; a score of 9-12 is considered a moderate injury; and 8 or below is considered a severe brain injury.

Mild Traumatic Brain Injury (GCS of 13-15)

Some symptoms of mild TBI include:

- Headache
- Fatigue
- Sleep disturbance
- Irritability
- Sensitivity to noise or light
- Balance problems
- Decreased concentration and attention span
- Decreased speed of thinking
- Memory problems
- Nausea
- Depression and anxiety
- Emotional mood swings

This information is not intended to be a substitute for medical advice or examination. A person with a suspected brain injury should contact a physician immediately, go to the emergency room, or call 911 in the case of an emergency. Symptoms of mild TBI can be temporary. The majority of people with mild TBI recover, though the timetable for recovery can vary significantly from person to person.

Moderate Brain Injury (GCS of 8-12)

A moderate TBI occurs when there is a loss of consciousness that lasts from a few minutes to a few hours, when confusion lasts from days to weeks, or when physical, cognitive, and/or behavioral impairments last for months or are permanent. Persons with moderate TBI generally can make a good recovery with treatment and successfully learn to compensate for their deficits.

Source: Defense and Veterans Head Injury Program & Brain Injury Association. Brain Injury and You. 1996.

Severe Brain Injury (GCS Below 8)

Severe brain injury occurs when a prolonged unconscious state or coma lasts days, weeks, or months. Severe brain injury is further categorized into subgroups with separate features:

- Coma
- Vegetative State
- Persistent Vegetative State
- Minimally Responsive State
- Akinetic Mutism
- Locked-in Syndrome

Tips to Aid Recovery

- Get lots of rest. Don't rush back to daily activities such as work or school.
- Avoid doing anything that could cause another blow or jolt to the head.
- Ask your doctor when it's safe to drive a car, ride a bike, or use heavy equipment, because your ability to react may be slower after a brain injury.
- Take only the medications your doctor has approved, and don't drink alcohol until your doctor says it's OK.
- Write things down if you have a hard time remembering.
- You may need help to re-learn skills that were lost. Contact the [Brain Injury Association](#) in your state to learn more about the programs, supports and services available to people with brain injury and their families.



Services & Resources on this site reflect the best practices in the field of Traumatic Brain Injury



Providing wealth of information, creative solutions and leadership on issues related to brain injury since
1985
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IF YOU ARE EXPERIENCING LOSSES OR CHANGES WITH YOUR **Memory**
From The Ashes and the Super Bowl XXXIV Connection — Author Constance Miller



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nationally recognized horse expert
Alpharetta, GA
01/07/54 - 02/20/03

In memory of
16-year-old, football player
Scott Wehnes, 1982 - 1998

Let's hear it for
TBI survivor Colleen Edwards
Tacoma, WA

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Brain Injury In Sports

Sports-Related Recurrent Brain Injuries - United States

An estimated 300,000 sports related traumatic brain injuries, **TBIs**, of mild to moderate severity , most of which can be classified as **concussions**, (i.e., conditions of temporary altered mental status as a result of head trauma, occur in the United States each year. The proportion of these concussions that are repeat injuries is unknown; however, there is an **increased risk** for subsequent **TBI** among persons who have had at least one previous **TBI** . Repeated mild brain injuries occurring over an extended period (i.e., months or years can result in **cumulative neurologic and cognitive deficits**, but repeated mild brain injuries occurring within a short period (i.e., hours, days, weeks) can be **catastrophic or fatal**. The latter phenomenon, termed "**second impact syndrome**" has been reported more frequently since it was first characterized in 1984. This page describes two cases of second impact syndrome and presents recommendations developed by the American Academy of Neurology to prevent recurrent brain injuries in sports and their adverse consequences.

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In memory of
17-year-old, football player
Matt Colby, 1984 - 2001
Costa Mesa High School,
Costa Mesa, CA

In memory of
24-year-old, football player
Curtis Williams, 1978 - 2002
University of Washington "Husky"
Seattle, WA

Visualize

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Life after brain injury

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[Personal Safety Net](#)

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[Denial](#)

[When I Grow up](#)

[Daily Journal](#)

Case Reports:

Case 1. During October 1991, a 17-year-old high school football player was tackled on the last day of the first half of a varsity game and struck his head on the ground. During half-time intermission, he told a teammate that he felt ill and had a headache; he did not tell his coach. He played again during the third quarter and received several routine blows to his helmet during blocks and tackles. He then collapsed on the field and was taken to a local hospital in a coma. A computerized tomography (CT-Scan) brain scan revealed diffuse swelling of the brain and a small subdural hematoma. He was transferred to a regional trauma center, where attempts to reduce elevated intracranial pressure were unsuccessful, and he was pronounced dead 4 days later. Autopsy revealed diffuse brain swelling focal areas of subcortical ischemia, and a small sub dural hematoma. [TBI Glossary](#)

Case 2. During August 1993, a 19-year-old college football player reported headache to family members after a full contact-practice during summer training. During practice the following day he collapsed on the field approximately 2 minutes after engaging in a tackle. He was transported to a nearby trauma center where a CT scan of the head showed diffuse brain swelling and a thin subdural hematoma. Attempts to control the elevated intracranial pressure failed, and he was pronounced brain dead 3 days later. Autopsy revealed the brain to be diffusely swollen with evidence of cerebrovascular congestion and features of temporal lobe herniation.

Second Impact Syndrome. The two cases described above involved repeated head trauma with probable concussions that separately might be considered mild but in additive effect were fatal. The risk for catastrophic effects from successive seemingly mild concussions sustained within a short period is not yet widely recognized. Second Impact Syndrome results from acute, usually fatal, brain swelling that occurs when a second concussion is sustained before complete

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recovery from a previous concussion that causes vascular congestion and increased intracranial pressure, which may be difficult or impossible to control.

The Dangers of Concussion

"...during the minutes to few days after concussion injury, brain cells that are not irreversibly destroyed remain alive but exist in a vulnerable state. This concept of injury-induced vulnerability has been put forth to describe the fact that patients suffering from head injury are extremely vulnerable to the consequences of even minor changes in cerebral blood flow and/or increases in intracranial pressure and apnea...."

"Experimental studies have identified metabolic dysfunction as the key postconcussion physiologic event that produces and maintains this state of vulnerability. This period of enhanced vulnerability is characterized by both an increase in the demand for glucose (fuel) and an inexplicable reduction in cerebral blood flow (fuel delivery).⁵⁸ The result is an inability of the neurovascular system to respond to increasing demands for energy to reestablish its normal chemical and ionic environments. This is dangerous because these altered environments can kill brain cells." --

The American Orthopaedic Society for Sports Medicine - url: <http://www.intelli.com/vhosts/aossm-isite/html/main.cgi?sub=151>

Relative Risk. The risk for second impact syndrome should be considered in a variety of sports associated with likelihood of blows to the head, including boxing, football, ice or roller hockey, soccer, baseball, basketball, and snow skiing.

Neurologists say **once a person suffers a**

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concussion, he is as much as four times more likely to sustain a second one. Moreover, after several concussions, it takes less of a blow to cause the injury and requires more time to recover. Troy Aikman sustained 8 concussions that he publicly admits to, the last two occurred since January 1, 2000. According to league officials there are about 160 concussions in the N.F.L. and 70 in the NHL each year.

Sideline Guidelines. The American Academy of Neurology has adopted recommendations for the management of concussion in sports that are designed to prevent second impact syndrome and to reduce the frequency of other cumulative brain injuries related to sports. These recommendations define symptoms and signs of concussion of varying severity and indicate intervals during which athletes should refrain from sports activity following a concussion. Following head impact athletes with any alteration in mental status, including transient confusion or amnesia with or without loss of consciousness, should not return to activity until examined by a health -care provider familiar with these guidelines.

The popularity of contact sports in the United States exposes a large number of participants to risk for brain injury. Recurrent brain injuries can be serious or fatal and may not respond to medical treatment. However, recurrent brain injuries and second impact syndrome are highly preventable. Physicians, health and physical education instructors, athletic coaches and trainers parents of children participating in contact sports and the general public should become familiar with these recommendations.

Source: Centers for Disease Control and Prevention, Dept. of Health and Human Services, USA. 1997

More than just a bump on the head! Though not always visible and sometimes seemingly minor, head injury is complex. It can cause physical, cognitive, social, and vocational changes. In many cases recovery becomes a lifelong process of adjustments and accommodations for the individual and the family.

Depending on the extent and location of the injury, impairments caused by a head injury can vary widely. The irony of mild head injuries is that often, such injuries do not even require a hospital stay, yet they result in changes so profound that lives are forever changed.

Some common impairments include difficulties with memory, mood, and concentration.

Others include significant deficits in organizational and reasoning skills, learning, cognitive, and executive functions.

Recovery from a head injury can be inconsistent. In many cases gains may be closely followed by setbacks and plateaus. A "plateau" is not evidence that functional improvement has ended. Typically plateaus are followed by gains.

Changes in memory and organizational skills after a brain injury makes it difficult to function in complex environments. The resources on this page will provide answers and guidance concerning many of the most puzzling aspects of traumatic brain injury.

The family and friends feel the psychic repercussions of the head injury acutely as well. Caring for an injured family member can be very demanding and result in economic loss and emotional burdens.

It can change the very nature of their family life; the resultant emotional difficulties can affect the cohesiveness of the family unit. Typically, the emotional damage is intense, affecting family and friends for years afterward and sometimes leading to the breakup of previously stable family units.

Summary of Recommendations of Management of Concussion in Sports

A concussion is defined a head-trauma-induced alteration in mental status that may or may not involve loss of consciousness. Concussions are graded in three categories. Definitions and treatment recommendations for each category are presented below.

Grade 1 Concussion

Definition: Transient Confusion, no loss of consciousness, and a duration of mental status abnormalities of less than 15 minutes.

Management: The athlete should be removed from sports activity, examined immediately and at 5 minute intervals, and allowed to return that day to the sports activity only if post concussive symptoms resolve within 15 minutes. Any athlete who incurs a second Grade 1 concussion on the same day should be removed from sports activity until asymptomatic for 1 week.

Grade 2 Concussion:

Definition: Transient confusion, no loss of consciousness, and a duration of mental status abnormalities of more than 15 minutes.

Management: The athlete should be removed from sports activity, examined immediately and frequently to assess the evolution of symptoms, with more extensive diagnostic evaluation if the symptoms worsen or persist for more than 1 week. The should return to sports activity only after asymptomatic for 1full week. Any athlete who incurs a Grade 2 concussion subsequent to a Grade 1 concussion on the same day should be removed from sports activity until asymptomatic for 2 weeks.

Grade 3 Concussion:

Definition: Loss of consciousness, either brief (seconds) or prolonged (minutes or longer).

Management: The athlete should be removed from sports activity for 1 full week without symptoms if the loss of consciousness is brief, or 2 full weeks without symptoms if the loss of consciousness is prolonged. If still unconscious, or if abnormal neurologic signs are present at the time of initial evaluation, the athlete should be transported by ambulance to the nearest hospital emergency department. An athlete who suffers a second Grade 3 concussion should be removed from sports activity until asymptomatic for 1 month. Any athlete with an abnormality on computed tomography or magnetic resonance imaging brain scan consistent with brain swelling, contusion, or other intracranial pathology should be removed from sports activities for the season and discouraged from future return to participation in contact sports.

Features of Concussion Frequently Observed:

1. Vacant stare (befuddled facial expression)
2. Delayed verbal and motor responses (slow to answer questions or follow instructions)
3. Confusion and inability to focus attention (easily distracted and unable to follow through with normal activities)
4. Disorientation (walking in the wrong direction; unaware of time, date and place)
5. Slurred or incoherent speech (making disjointed or incomprehensible statements)
6. Gross observable incoordination (stumbling, inability to walk tandem/straight line)
7. Emotions out of proportion to circumstances (distracted, crying for no apparent reason)
8. Memory deficits (exhibited by the athlete repeatedly asking the same question that has already been answered, or inability to memorize and recall 3 of 3 words, or 3 of 3 objects in 5 minutes)
9. Any period of loss of consciousness (paralytic coma, unresponsiveness to arousal)

Additional Resources:

Roberts, William, MD "Who Plays? Who Sits?", The Physician in Sports Medicine, 6/92, Vol 20, No. 6, pp. 66-72.

Kelly, James P. "Concussion," Current Therapy in Sports Medicine. Mosby - Year Book, Inc. 1995, pp 21 - 24.

Saunders, R. and Harbaugh, R., "The Second Impact in Catastrophic Contact-

Also see our [Coma](#) page

Additional Resources

[Campaign Safe & Sober](#) - Safe Driving Tips Motorcycle Helmets: The Facts of Life Safe Communities Success Stories Tribal Communities NHTSA s Kid s HomePage Contact Lists Materials Catalog Reply Card President's Letter The...**url:**

<http://www.nhtsa.dot.gov/people/outreach/safesobr/OPlanner/protection/safecomm.html>

Injury Related Web Sites - [National Center for Injury Prevention and Control](#) Search NCIPC Links to organizations found at this site are provided solely as a service.

url:<http://www.cdc.gov/ncipc/injweb/websites.htm>

[SafeUSA](#) -- Information and fact sheets for the general public and health consumers.

url: <http://www.cdc.gov/safeusa/siteindex.htm>

Protective Gear:

[Plum Enterprises](#) -- 500 Freedom View Lane, PO Box 85, Valley Forge, PA 19481-- Manufacturers of protective headgear for head protection around the house after head injury, surgery, during epileptic seizures, etc. These protective caps are not designed for the heavy impacts seen in most sports. Sizes available from toddlers to adults. **Telephone:** 800-321-PLUMB; **Fax:** 610-783-7577 -- **url:** <http://www.plument.com/>
email: lynn@plument.com

[WIPSS Jaw-Joint Protector](#), a custom fit mouthpiece that prevents jaw joint, head, and mouth injuries. Jaw Joint Injuries occur at an alarming rate in soccer. According to [Bill Whitney](#), Olympic Development Soccer Coach, the primary reasons for injury are:

getting hit in the jaw by the ball,
the aggressive action of the opponent,
heading the ball

The amount of force calculated the moment a soccer ball hits the head of a player is 208 joules. Since the jaw is not attached to the skull, and knowing that every force produces equal and opposite directional components of force, the impact causes the lower jaw to slam against the base of the skull. These forces account for a large percentage of the damage found in the jaw joints of soccer players.

WIPSS Products, Inc.- email: wwhitney@voicenet.com -- **URL:** <http://www.wipss.com/>

[SoccerDocs](#) -- During the summer of 1994 one of SoccerDocs' founders, like many soccer parents across the nation, was enjoying his seven-year-old son Charles' soccer game. While Charles was goalkeeping an uncontested shot found its way through the defenders and struck him directly in the forehead before Charles could put up his hands. The shot caused a concussion, resulting in headaches and dizziness.

This incident motivated his father to find head protection but he soon realized that no practical product existed. He was surprised to learn from a review of the scientific literature

that there was a potential for long-term effects even from non-catastrophic head injuries (when the player does not lose consciousness). While concerned about his son's safety, he also knew that Charles wanted to continue to play the game he loved. This is what led him to co-found SoccerDocs. **url:** <http://www.soccerdocs.com/>

Telephones : 1-877-HEADER-1 -- 1-877-432-3371 -- 612- 823-2426

Head Blast -- The inventor of a so-called "shinguard for your head" is bracing for jeers from world-class soccer players when his product hits the market next month. Zatin conceived the idea when his 12-year-old son Ben complained of dizziness after heading a fast-moving clearance pass back to the other side of the field. He took Ben straight to a local sporting goods store in search of protection. Zatin, who owns a small printing press and hat-binding company, has begun production of a laminated foam headband he says softens the impact of headers by 30 to 50 percent. By design, the ball would go no farther or shorter than if it struck a player's forehead.

Dr. David Janda, director of the Institute for Preventative Sports Medicine, said he plans to test Zatin's headband at his Ann Arbor, Mich., lab. But he expressed concern it would protect children only from the headers they do correctly, leaving the most tender spot at the top of the head exposed.

"When you watch kids learn to head the ball, they'll hit it off the front of their head, the back of their head, the side of the head, their shoulder -- they're all over the map," Janda said. "A headband type of approach still leaves the head vulnerable." **telephone:** 314- 652-2700 -- **url:** <http://www.headblast.com/>

Bicycle Helmet Safety Institute -- A helmet advocacy program of the Washington, DC Area Bicyclist Association. They are a small, active, non-profit consumer-funded program acting as a clearinghouse and a technical resource for bicycle helmet information. Their volunteers serve on the ASTM and ANSI bicycle helmet standard committees and are active in commenting on actions of the Consumer Product Safety Commission. They provide a documentation service and a number of helmet publications.

url: <http://www.helmets.org> -- **email:** webmaster@helmets.org

National Safe Kids Campaign -- 1301 Pennsylvania Ave NW, Ste 1000, Washington, DC 20004-1707

Telephone: 202-662-0600; **Fax:** 202-393-2072 -- **url:** <http://www.safekids.org/> **email:**

International Inline Skating Association -- 201 N. Front St. #306, Wilmington, NC 28401

Telephone: 910-762-7004 -- **email:** director@iisa.org

American National Standards Institute ANSI -- 11 W 42 Street, 13th fl, NY 10036,

Telephone: (212) 642-4900; **Fax:** 212- 302-1286 -- **url:** <http://www.ansi.org>

U.S. Consumer Product Safety Commission - CPSC -- Washington, DC 20207

Telephone: 301-504-0424; **Fax:** 301-504-0124 -- **url:** www.cpsc.gov -- **email:** info@cpsc.gov

American Society For Testing And Materials - ASTM -- 100 Barr Harbor Drive
Conshohocken, PA 19428-2959 -- **Telephone:** 610-832-9500; **Fax:** 610- 832-9555

World Health Organization - WHO -- **Helmet Initiative and Helmet Resource Center** -- Look at what people are doing worldwide to reduce injuries and deaths through the use of helmets. Included is a link to "Headlines", the quarterly newsletter of the WHO Helmet Initiative. **url:** <http://www.sph.emory.edu/Helmets>

World Health Organization - WHO - OMS -- Department of Health Promotion (HPR),
 1211 Geneva 27
 Switzerland -- **Fax:** 41-22-791-4186 -- **url:** <http://www.who.org/> -- **email:**
 mainesa@who.org

Snell Memorial Foundation -- 3628 Madison Ave, Ste 11-- North Highlands, CA 95660 --
 A not-for-profit organization dedicated to research, education, testing and development of
 helmet safety standards. Since its founding in 1957, Snell has been a leader in the frontier of
 helmet safety in the United States and around the world. **Telephone:** 916- 331-5073; **Fax:**
 916-331-0359 --
url <http://www.smf.org/> -- **email:** info@smf.org

Centers for Disease Control -- Washington, DC -- **url:** <http://www.cdc.gov>

Bureau of Transportation Statistics -- This DOT site links to transportation data from
 government and other public sources. **url:** <http://www.bts.gov>

Sports Organizations

| | |
|--|--|
| <p><u>US Youth Soccer</u> http://www.usysa.org/</p> | <p><u>Women's National Basketball Assoc.</u> - WNBA http://www.wnba.com</p> |
| <p><u>Nat'l Soccer Coaches Assoc of America</u> 800-458-0678 http://www.nscac.com/</p> | <p><u>Women's Boxing</u> http://www.geocities.com/Colosseum/Field/6251</p> |
| <p><u>International Rugby Football Board</u> Dublin Ireland Telephone: 3531-662-5444 http://www.irfb.com/ email: irb@irb.ie</p> | <p><u>Sports Illustrated for Women</u> http://CNNSI.com/siforwomen/index.html</p> |
| <p><u>League of American Bicyclists</u> 1612 K Street NW, Ste 401 Washington, DC 20006- 2082 Telephone: 202-822-1333 Fax: 202-822-1334 URL: http://www.bikeleague.org email: bikeleague@bikeleague.org</p> | <p><u>Special Olympics Inc.</u> 1325 G Street, NW / Suite 500 Washington, DC 20005 Telephone: 202-628-3630 Fax: 202-824-0200 URL: http://www.specialolympics.org/ email: webmasteso@aol.com</p> |
| <p><u>Ride Safe Home Page</u> email:</p> | <p><u>Womens Sports Foundation</u> 305-315 Hither Green Lane Lewisham, London, SE13 6TJ</p> |

rsdkl@ix.netcom.com

URL:

<http://ridesafeinc.com>

Tel/fax: 0181-697 5370

URL: <http://www.wsf.org.uk/>

Email: info@wsf.u-net.com

[Global Cycling Network](#)

URL:

<http://www.cycling.org>

[The International Olympic Committee Women and Sport Working Group](#)

RETIRED BOXERS

FOUNDATION

3359 Bryan Avenue

Simi Valley, CA 93063

Phone (805) 583-5890

Fax (805) 306-1663

www.retiredboxers.org

JaxFacts@ix.netcom.com

For more information concerning the Management of Consciousness in Sports Public Education Campaign. please contact: Head Injury Hotline -- <http://www.headinjury.com> -
email: brain@headinjury.com

Head Injury Hotline: Providing Difficult to Find Information About Head Injury Since 1985



[Back to Top](#)



brain@headinjury.com

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NYSCADV

*Over 30 Years of Building Coalition
and Promoting Social Change*

**NEW YORK STATE COALITION
AGAINST DOMESTIC VIOLENCE**

**TECHNICAL ASSISTANCE
FOUNDATIONS**

THE INTERSECTION OF BRAIN INJURY AND DOMESTIC VIOLENCE

The use of physical violence to establish and maintain power and control over an intimate partner is a widely recognized form of domestic violence. Survivors often report horrific acts of abuse, including (but not limited to) repeated hits to the head, neck and face, strangulation, smothering, shaking, and penetrating head wounds. Domestic violence advocates witness the devastating psychological and physical effects of these attacks upon survivors. It is within the past ten years, through collaboration with brain injury service providers, that the intersection between such intimate partner violence and brain injury (BI) has been acknowledged.

Service provision to survivors who are living with a brain injury is unique and nuanced, as the advocate must balance the privileging of safety and confidentiality with the need for coordination of services and accommodation of brain injury related challenges. This short guide provides foundational information about brain injury and the possible complications that this disability can provide to domestic violence survivors. Furthermore, this guide includes suggestions for providing informed services to domestic violence survivors living with a brain injury, and further resources to access for more information.

Women with disabilities experience the highest rate of personal violence...of any group in our society today. Yet, they are often invisible in crime statistics, find domestic and sexual violence programs inadequately prepared to fully understand and meet their needs...and are all too commonly devalued and unsupported because of societal prejudice.

(University of Minnesota, 2000)

Special thanks to *Judy Avner, Executive Director* of the Brain Injury Association of New York State for her collaboration on this project and willingness to share her vast knowledge on this topic!

This technical assistance publication was developed by Sarah DeWard, M.S. at NYSCADV.

For more information, contact NYSCADV.

NYSCADV

**NEW YORK STATE COALITION
AGAINST DOMESTIC VIOLENCE**

350 New Scotland Ave
Albany, NY 12208

p 518.482.5465
f 518.482.3807

nyscadv@nyscadv.org
www.nyscadv.org

Brain Injury: The Basics

An acquired brain injury is a type of injury to the brain that is not hereditary or degenerative. Included in this category are injuries obtained through anoxia, or deprivation of oxygen (for example, strangulation). Traumatic Brain Injury (TBI) is a type of damage to the brain which results when the head:

- hits a stationary object (for example, slammed into a wall or table)
- is hit (for example, struck with a blunt object, like a baseball bat or lamp)
- is penetrated (for example, gunshot or knife wound)
- is violently shaken (for example, severe whiplash)

Domestic violence service providers recognize that these acts of physical violence are frequently perpetrated against survivors. There is a known cumulative effect of brain injuries. Research indicates that a history of brain injuries exponentially increases the likelihood of further brain injuries. In fact, the effects of repeat brain injuries often compound, resulting in more serious disabilities. A domestic violence victim may not know that she has a brain injury, especially if she was denied access to medical care, or refused treatment. Unfortunately, many brain injuries are undiagnosed or misdiagnosed.

Common Challenges Associated with Brain Injury

Remember that each person is different, and each brain injury is different. Not all people will exhibit the same combination of problems or concerns related to the brain injury. As is common practice with domestic violence service provision, each survivor living with a brain injury should be treated individually from a strengths-based, empowerment approach. Remember that people’s needs can change across time, and that recovery from a brain injury is not sequential. Below is a snapshot of the most common problems associated with brain injury, and should not be seen as a comprehensive listing.

Possible Physical Disabilities

- Balance and visual difficulties
- Slurring of speech
- Fatigue
- Sleep

Possible Cognitive Disabilities

- Short term memory loss
- Difficulty with concentration and attention
- Difficulty with abstraction and conceptualization
- Heightened distractibility

Possible Executive Functioning Disabilities

- Problems with long term goal setting
- Difficulty with task completion
- Issues with long term planning
- Problems with self-monitoring

Possible Behavioral and Affective Disabilities

- Increased impulsivity
- Increased tension and anxiety
- Depression
- Decreased frustration tolerance

Possible Psychosocial Disabilities

- Educational/vocational problems
- Interpersonal difficulties (intimacy, dependency, substance abuse)

Leading Causes of TBI

- 28% - Falls**
- 20% - Motor Vehicle or Traffic**
- 19% - Struck By or Against**
- 11% - Assault**
- 9% - Unknown**
- 7% - Other**
- 3% - Pedal Cycle**
- 2% - Other Transport**
- 1% - Suicide**

(CDC, 2007)

Brain Injury and Domestic Violence

A domestic violence survivor living with a brain injury must negotiate a very complex set of life circumstances. The brain injury is a temporary or permanent disability that serves as a constant and inescapable reminder of her batterer and the abuse suffered. In addition to the other physical and emotional consequences of the abuse, the survivor must also integrate a new set of challenges related to the brain injury. Along with navigating the real concerns for safety, autonomy, and independence, domestic violence survivors living with a brain injury may also cope with additional employment and economic concerns related to the BI.

Consider other challenges that domestic violence survivors face, for example, child custody proceeding or criminal court testimony. Successful utilization of the justice system often requires the ability to communicate incidences of abuse from memory using detailed, sequential, rapid, clear communication. These functions may be compromised by the brain injury. These challenges may diminish the survivor's credibility in the courtroom, and have dire outcomes to the survivor's life.

Batterers will use every life circumstance to their advantage to further manipulate and control victims. The presence of a brain injury provides new opportunities for tactics of power and control. For example, new forms of manipulation may include making the victim doubt her own perceptions and memory of the abuse, using statements such as: "That never happened," or "You're crazy." The BI may also be used as a further tool of isolation, explaining away her accounts of abuse and subsequent need for support and help as a symptom of the brain injury.

Finally, we know that survivors must combat many forms of oppression, including sexism, racism, classism, and heterosexism. In addition, ableism (the privileging of the experiences of the able-bodied, and the subsequent discrimination and devaluing of those who are differently-abled) is another form of oppression experienced by domestic violence survivors living with a brain injury. Ignorance, prejudice, and active discrimination provide more barriers for survivors seeking safety, support, and help from service providers and systems.

*Of women reporting to emergency rooms for injuries associated with domestic violence, **30%** reported a loss of consciousness at least once.*

***67%** reported residual problems that were potentially head-injury related.*

(Corrigan, 2003)

Providing Services to Survivors with Brain Injury

Revisit Survivor-Centered Advocacy and Empowerment Philosophy
Domestic violence service providers should revisit the core concepts of empowering survivor-centered advocacy when working with a survivor living with a brain injury. Every individual comes for services with unique challenges and strengths, and it is imperative for advocates to truly understand and accommodate this uniqueness. Do not assume that a survivor diagnosed with a BI will have certain deficits. Similarly, do not assume that a survivor does not have a BI because there is no formal diagnosis. Remember that a diagnosis is simply a label—it is a formality and not central to our work as advocates. As always, it is the role of the advocate to truly listen to what the survivor living with a BI is expressing, focus on strengths, and provide feedback in a respectful and positive way.

Build Organizational Capacity and Policies

Commit to learning more about the realities of brain injury, as well as other disabilities that may be affecting domestic violence survivors. Seek out technical assistance and training from organizations that are known experts in this field. Spend time during staff meetings discussing organizational policies and procedures for women with disabilities seeking services.

Re-evaluate Shelter Rules

Be careful about misunderstanding with shelter rules or other behavioral concerns as willful non-compliance. This behavior may have an underlying link to a brain injury. Perhaps the survivor with a brain injury will require special advocacy or case management within the shelter itself—for example, being respectfully and consistently reminded of communal living responsibilities, or being provided a date book, planner, or post-it notes to help in with her memory. Ask the survivor what accommodations help her most. As per the Americans with Disabilities Act, shelters are required to provide such accommodations for those with a disability—including a brain injury.

Advocate and Educate Against Oppression

As you learn about the realities of traumatic brain injury, and its intersection with domestic violence, commit to educating others. Systems advocacy is oftentimes a core function of domestic violence advocates, and this generally includes an educational component. Consider incorporating traumatic brain injury into these discussions with other professionals in a respectful way.

For a survivor with a TBI, it may be harder to...

- *Assess danger*
- *Make safety plans*
- *Hold a job*
- *Leave an abusive partner*
- *Live independently*
- *Remember appointments*
- *Live in shelter*
- *Access services*
- *Navigate the criminal justice system*
- *Care for children*

(NYS OPDV, 2009)

Providing Services to Survivors with Brain Injury (continued)

Re-format Safety Planning

Abstract thought may be hard for those living with a brain injury, and a safety planning discussion is full of hypothetical scenarios and theoretical circumstances. For example, advocates may ask a survivor to predict the batterer's actions and reactions, hide emergency items and remember where to retrieve them, and envision an emergency escape plan to be remembered and executed in crisis. Advocates have discussions like these with survivors everyday, but these crucial safety planning discussions framed in this way may be very challenging for a survivor living with a brain injury.

To help facilitate a more productive safety planning discussion, minimize outside distractions (phone, interruptions, noise, fluorescent lighting) during safety planning discussions. Keep your meetings short, and understand that these abbreviated meetings may need to take place more frequently. Keep the meetings focused on a single topic, and direct the conversation to stay on the one task. Make all discussions and future action items concrete, and simplify information into small, manageable pieces. Finally, summarize the information at the end of your discussion, and check that she understands.

Develop New Community Partnerships

Make community connections to further provide access to survivors living with a brain injury. Consider building collaborations with your state brain injury association and local brain injury service providers.

Learn more about:

- Traumatic Brain Injury Medicaid waiver programs
- Community-based rehabilitation programs
- Return-to-Work vocational planning programs
- Independent living centers

Consider Screening

The HELPS tool is often used to quickly screen for brain injury. Consider asking survivors the following questions to help determine the likelihood of a brain injury. "Yes" answers to any of the following questions should prompt outreach for evaluation for a brain injury. *Please remember that this screening tool is simply a quick guide, and does not determine or diagnose a brain injury. Please seek a brain injury service provider for more information.*

- H- Were you ever HIT on the head?
- E- Did you ever seek EMERGENCY room treatment?
- L- Did you ever LOSE consciousness?
- P- Are you having PROBLEMS with concentration or memory?
- S- Did you experience SICKNESS or other problems following the injury?

The entire HELPS screening tool, including the complete scoring system, can be found in the NRCDV Special Collection: TBI and DV at www.vawnet.org.

Our Collaboration:

***The Brain Injury Association of New York State and
the New York State Coalition Against Domestic Violence***

The Brain Injury Association of New York State (BIANYS) and the New York State Coalition Against Domestic Violence (NYSCADV) continue their two-year collaboration to educate others about the intersection of brain injury and domestic violence. They provide cross training and educational handouts to both brain injury and domestic violence service providers, including material packets distributed during both Brain Injury Awareness month (March) and Domestic Violence Awareness month (October). BIANYS and NYSCADV have presented numerous trainings about the intersection of traumatic brain injury and domestic violence, including two webinars hosted by the National Resource Center on Domestic Violence. For more information about this nationally recognized collaboration, please contact the BIANYS or NYSCADV at the information listed below.

Resources

Brain Injury Association of New York State. Judith Avner, Executive Director, 10 Colvin Avenue, Albany, NY 12206, javner@bianys.org, www.bianys.org, 518-459-7911, 800-228-8201.

National Resource Center on Domestic Violence. 2010. *Special Collection: Traumatic Brain Injury and Domestic Violence: Understanding the Intersections*, Accessed June 4, 2010: http://new.vawnet.org/category/index_pages.php?category_id=1075 .

New York State Coalition Against Domestic Violence. Sarah DeWard, Training and Membership Services, 350 New Scotland Avenue, Albany, NY 12208, sdeward@nyscadv.org, www.nyscadv.org, 518-482-5465.

Sources

Avner, J. and S. DeWard. 2010. "Domestic Violence and Traumatic Brain Injury: Understanding the Intersections." Accessed June 15, 2010: http://new.vawnet.org/Assoc_Files_VAWnet/TBIandDVWebinarSlides.pdf .

Corrigan, J. D., Wolfe, M., Mysiw, J., Jackson, R. D., & Bogner, J. A. Early identification of mild traumatic brain injury in female victims of domestic violence. *American Journal of Obstetrics and Gynecology*, 188(5), S71-S76.

National Center for Injury Prevention and Control, Centers for Disease Control. 2010. "Traumatic Brain Injury." Accessed June 15, 2010: <http://www.cdc.gov/ncipc/factsheets/tbi.htm> .

New York State Office for the Prevention of Domestic Violence. 2009. "Traumatic Brain Injury and Domestic Violence." Accessed June 4, 2010: <http://www.opdv.state.ny.us/professionals/tbi/index.html> .

University of Minnesota, *Impact Magazine*, Fall 2000, Available at: <http://ici.umn.edu/products/impact/133/133.pdf>

When Your Child's Head Has Been Hurt:



Many children who hurt their heads get well and have no long-term problems. Some children have problems that may not be noticed right away. You may see changes in your child over the next several months that concern you. This card lists some common signs that your child may have a mild brain injury. If your child has any of the problems on this list — AND THEY DON'T GO AWAY — see the "What to Do" box on the back of this sheet.

HEALTH PROBLEMS

Headaches

Including:

- headache that keeps coming back
- pain in head muscle
- pain in head bone (skull)
- pain below the ear
- pain in the jaw
- pain in or around eyes

Balance Problems

- dizziness
- trouble with balance

Sensory Changes

- bothered by smells
- changes in taste or smell
- appetite changes



- ringing in the ears
- hearing loss
- bothered by noises
- can't handle normal background noise



- feels too hot
- feels too cold
- doesn't feel temperature at all

- blurry vision
- seeing double
- hard to see clearly (hard to focus)
- bothered by light



Sleep Problems

- can't sleep through the night
- sleeps too much
- days and nights get mixed up

Pain Problems

- neck & shoulder pain that happens a lot
- other unexplained body pain



These problems don't happen often. If your child has any of them, see your doctor right away.

- ▲ severe headache that does not go away or get better
- ▲ seizures: eyes fluttering, body going stiff, staring into space
- ▲ child forgets everything, amnesia
- ▲ hands shake, tremors, muscles get weak, loss of muscle tone
- ▲ nausea or vomiting that returns

Continued on Back

BEHAVIOR and FEELINGS

Changes in personality, mood or behavior

- is irritable, anxious, restless
- gets upset or frustrated easily
- overreacts, cries or laughs too easily
- has mood swings

- wants to be alone or away from people
- is afraid of others, blames others
- wants to be taken care of
- does not know how to act with people
- takes risks without thinking first

- is sad, depressed
- doesn't want to do anything, can't "get started"
- is tired, drowsy
- is slow to respond
- trips, falls, drops things, is awkward

- eats too little, eats all the time, or eats things that aren't food
- has different sexual behavior (older children)
- starts using or has a different reaction to alcohol or drugs
- takes off clothes in public

THINKING PROBLEMS

- has trouble remembering things
- has trouble paying attention
- reacts slowly
- thinks slowly
- takes things too literally, doesn't get jokes
- understands words but not their meaning
- thinks about the same thing over and over
- has trouble learning new things

- has trouble putting things in order (desk, room, papers)
- has trouble making decisions
- has trouble planning, starting, doing, and finishing a task
- has trouble remembering to do things on time
- makes poor choices (loss of common sense)

TROUBLE COMMUNICATING

- changes the subject, has trouble staying on topic
- has trouble thinking of the right word
- has trouble listening
- has trouble paying attention, can't have long conversations
- does not say things clearly
- has trouble reading
- talks too much

WHAT TO DO:

If your child has any of the problems on this list, and they don't go away:

- ▲ Ask your child's doctor to have your child seen by a specialist in head injury who can help your child learn skills (rehabilitation).
- ▲ Ask your child's doctor to have your child seen by a Board-certified Neuropsychologist. This specialist can help you understand and deal with your child's behavior and feeling changes.
- ▲ Call the Brain Injury Association of Arizona for more information:

(602) 323-9165 Phoenix Helpline

1-888-500-9165 Toll-Free Statewide Helpline

We have only listed the problems we see most often when a child's brain is hurt. Not every problem that could happen is on this list.



ARIZONA GOVERNOR'S COUNCIL
ON SPINAL AND HEAD INJURIES

For additional copies of this publication, or to obtain this information in an alternative format, contact the Arizona Governor's Council on Spinal & Head Injuries at: Voice/(602) 863-0484 or through the AZ Relay Service.

THE HELPPS TOOL

(Adapted from the International Center for the Disabled 1992.)

| Question | Yes | No | Comments |
|--|-----|----|----------|
| <p>H = Was your head ever hit, jarred, or slammed?</p> <p>Were you ever injured in the head or neck area, including being bruised, strangled, suffocated, nearly drowned or having bones broken?</p> | | | |
| <p>E = Have you ever gone to an Emergency Room or sought medical attention due to an action from another person, including an intimate partner or relative?</p> <p>How long ago? How often did you go?</p> <p>Have you ever felt that you needed such attention but did not seek it out?</p> | | | |
| <p>L = Did you ever lose consciousness?</p> <p>For how long? How long ago? For what reason?</p> | | | |
| <p>P = Do you have any problems in the head or neck area?</p> <p>If so, do you know why?</p> | | | |
| <p>P = Are you or could you be pregnant?</p> | | | |
| <p>S = Have you noticed any outstanding symptoms after an injury to your head or neck area?</p> | | | |



Advocacy Tip: Upon interviewing a patient, the final question, “S,” is not necessary if the patient answered negative to the first five questions.

: i bXYX`VmiDYbbgmj Ub]U8 Ydh`cZ< YUH `UbX`H YI G`8 Ydh`cZ< YUH `UbX`<i a Ub`GYfj]Wgž
[fUbh`_< &%A 7 %+& &`

Sample B: TBI Medical Screening Guideline (MSG)

PCADV Adaptation 2011†

Sample B, The TBI Medical Screening Guideline (MSG), is intended for use in a medical appointment setting:

- During a medical advocacy session
- After domestic violence has been disclosed at intake

After domestic violence disclosure at the hospital intake:

- A survivor is usually asked if she would like to meet with a medical advocate

Confidentiality must remain a priority.

- Intake providers can be made aware that survivors must sign a “release of information” form to share their domestic violence assessment information with a medical advocate
- In turn, medical advocates can ask intake providers to inquire about written permission from the survivor to share the domestic violence screening information with a medical advocate, including the HELPPS Tool answers
- As a result, a medical advocate will have concrete information to guide the screening conversation during the advocacy and counseling session

Medical advocates must remember:

- The screening guidelines are not for the purpose of making any medical diagnoses.
- A survivor may refuse to answer the screening questions and/or may bypass making or attending any medical appointment.
- Program staff may not set conditions on the delivery of domestic violence services based on a survivor’s refusal to participate in a TBI screening or go for further medical assessment.

*Adapted from the screening tool developed by the Alabama Head Injury Council, see note 15.

SAMPLE B: MEDICAL SCREENING GUIDELINES (MSG)

To help alleviate possible subjective barriers in screening for abuse, service providers should initiate:

A **conversation** that allows the survivor and advocate to discuss the survivor's abuse experiences, keeping differences of families, religions and cultures in mind.

How to initiate and continue a conversational screening is explained below.

Having a Conversation

To conduct a conversational Traumatic Brain Injury screening with someone who has disclosed abuse, medical advocates may choose to first initiate a conversation beginning with informing the survivor about confidentiality, and clarifying the exception of child abuse disclosure and mandatory reporting.

Ask about and address any questions or concerns. Then, begin with the usual pleasantries:

*Please sit down and make yourself comfortable.
How are you doing?*

Continue the conversation by asking the survivor about facts that someone without a brain injury would easily remember:

*Have you eaten today? Are you hungry?
What did you have to eat?
Are you thirsty? Did you have much to drink today?*



Advocacy Tip: The above questions may tell the advocate if the survivor's blood sugar is low or if she is dehydrated. Low blood sugar or dehydration may influence the manner in which someone answers questions. Provide a snack and water to help prevent such factors that may cause interference during the conversation.

*Do you have any children?
How about pets?
What are their names?
How are they cared for while you are here?*

Continue to let the conversation naturally unfold, responding to the survivor's answers. The questions should not be asked as though you are using a checklist.

*Let's talk about your day for a minute...
How did you come to need medical care today?
Who brought you to the hospital?
Can you tell me who you spent time with today?*

As the survivor and advocate become acquainted:

What happened before you came to the hospital?

What was going on before the incident with your boyfriend/ girlfriend/ partner/ family member?



Advocacy Tip: Be sensitive to how someone identifies an abuser; the person facilitating the screening should refer to an abuser in the same way a survivor refers to an abuser.

If a medical advocate has obtained permission to reference the survivor's HELPPS Tool answers from the intake provider, she can reference those answers as she continues talking more specifically about the abuse.

At the medical intake a bit ago, you said...

Can you tell me about that situation?

If an advocate does not have the completed HELPPS Tool copy from the intake provider in hand, she can continue **conversationally** with the questions below. (Screeners will notice that some of the questions are directly from the original HELPPS tool.)

Let's talk about things that have gone on or may be going on in your life. In remembering times with a [boyfriend, girlfriend, date, relative, or caregiver], were you ever:

Hit on the head, mouth, or other places on your face?

Pushed so hard you fell and hit your head on a hard or firm surface?

Shaken or jarred in any way?

Injured in the head or neck area, including strangled/choked or suffocated.

Restricted in your breathing?

Nearly drowned, electrocuted, or purposely given something you are allergic to?



Advocacy Tip: PCADV recommends that advocates avoid discussing perceived differences between choking and strangulation when engaging in this screening conversation. Such a discussion may distract the survivor and cause the disclosure part of the process to be compromised due to semantics. If a survivor discloses being "choked," simply ask how they were "choked" and about the circumstances which followed.

Continue referencing the following questions through your conversation:

Have you ever gone to an emergency room or sought medical attention because of something a boyfriend, girlfriend, relative, or caregiver did to you?

Have you ever felt that you needed medical attention, but did not get it or were prevented from getting it?

(If yes)

Will you share why you did not get medical care?

Have you ever been told you had a concussion or other type of head or brain injury?

Did you ever have a time when you lost consciousness or blacked out?

Do you remember for how long or the reason?

Do you have any problems in the head or neck area? If so, do you know why?

If the survivor discloses a head, neck or brain injury, ask:

You mentioned an injury to your [head, neck, brain]; do you have any problems since your injury(ies)?

Allow the person time to consider, listen carefully and circle symptoms below from the answer. When the survivor is finished considering the answer, ask about symptoms not mentioned by the survivor.

Since the incident(s), do you experience:

| | |
|--|--|
| Headaches | Depression |
| Anxiety | Sore throat |
| Fatigue | Petechiae |
| Difficulty concentrating | Swollen tongue |
| Difficulty remembering | Bodily function loss |
| Difficulty reading, writing or calculating | Pupil dilation |
| Difficulty performing job or school work | Broken collarbone |
| Changes in behavior or attitude | Difficulty completing things |
| Changes in relationships | Difficulty in usual activities |
| Difficulty solving problems | Uncontrollable mood changes |
| Changes in vision, hearing, smelling or tasting | Difficulty managing stress |
| Breathing difficulties | Comments or criticism that “you’ve changed” |
| Dizziness | Drowsiness |
| Problems with balance | |

If a survivor discloses symptoms that may indicate TBI and the medical service providers have not considered TBI:

- Have a gentle conversation about your concerns with the survivor
- Obtain permission to discuss your concerns with a nurse

If disclosure happens in continued counseling beyond the initial medical visit:

- Gently review your concern about her symptoms
- Suggest that next time the survivor visits a health care provider, that she brings her symptoms to that provider’s attention and find out how to be screened further, or see Appendix B to obtain list of additional resources

Sample B: TBI Domestic Violence Program Screening Guideline (PSG)

PCADV Adaptation 2011†

Sample B, The Domestic Violence Program Screening Guideline (PSG) is intended for use:

- In a conversational format by domestic violence program advocates
- In a program setting
- During a counseling or advocacy session, once the survivor is determined to be safe or has entered shelter

Engaging in a TBI screening conversation during a counseling or advocacy session allows a service provider to:

- Help a survivor consider symptoms possibly associated with TBI
- Refer for a follow up medical appointment, if needed

The tool is to be used as a way to:

- Review a survivor’s abuse history to listen for symptoms that may be associated with TBI
- Help the survivor decide if she may benefit from medical attention and rehabilitation

After the conversational TBI screening, the survivor may:

- Feel that immediate medical attention is not needed, but opt to be observed by others and see how she feels for a week or so and, in particular, the first 36 hours post-incident

Ask the survivor if she is agreeable to her situation being shared with:

- Other shelter advocates and line staff to be made aware of what may be transpiring if symptoms surface over the next few days, as there can be swelling and hemorrhage for a time post-incident

Having secured a survivor’s permission, the program can:

- Identify procedures to indicate a person has reported events that can result in symptoms associated with TBI
- Non-invasively but closely observe the resident over the next week

† Adapted from the National Center for Traumatic Brain Injury (NCTBI) and the National Center for Post-Traumatic Stress Disorder (PTSD) (2008). *TBI Screening for Domestic Violence Survivors: A Manual for Health Care Providers*. Washington, DC: NCTBI.

Domestic violence program advocates must remember that the screening guidelines are not for the purpose of making any medical diagnoses. A survivor retains the legal right to refuse to answer the screening questions and/or bypass making or attending any medical appointment.

To help alleviate possible subjective barriers in screening for abuse, advocates should initiate:

A **conversation** that allows the survivor and advocate to discuss the survivor's abuse experiences, keeping differences of families, religions and cultures in mind.

Having a Conversation

To conduct a conversational TBI screening with a program participant, advocates may choose to first initiate a conversation beginning with informing the survivor about counselor and advocate confidentiality, and clarifying the exception of child abuse disclosure and mandatory reporting.

Ask about and address any questions or concerns. Then, begin with the usual pleasantries:

Please sit down and make yourself comfortable.

How are you doing?

Continue the conversation by asking the survivor about facts that someone without a brain injury would easily remember:

Have you eaten today? Are you hungry?

What did you have to eat?

Are you thirsty? Did you have much to drink today?



Advocacy Tip: The above questions may tell the advocate if the survivor's blood sugar is low or if she is dehydrated. Low blood sugar or dehydration may influence the manner in which someone answers questions. Provide a snack and water to help prevent such factors that may cause interference during the conversation].

Do you have any children?

How about pets?

What are their names?

How are they cared for while you are here?

Continue to let the conversation naturally unfold, responding to the survivor's answers. The questions should not be asked as though you are using a checklist.

Let's talk about your day for a minute...

How did you come here today?

Who brought you here?

Can you tell me who you spent time with today?

As the client and advocate become acquainted:

What happened before you came to the program?

What was going on before the incident with your boyfriend/ girlfriend/ partner/ family member?



Advocacy Tip: Be sensitive to how someone identifies an abuser; the person facilitating the screening should reference an abuser in the same way a survivor references an abuser.

Advocates can become familiar with the HELPPS Tool answers noted by the intake provider and reference the answers as she continues talking more specifically about the abuse.

When you met with [name] during your intake, you said...

Can you tell me about that situation?

If an advocate does not have a completed HELPPS Tool copy from the intake provider in hand, she can continue **conversationally** with the questions below¹⁸.

Let's talk about things that have gone on or may be going on in your life. In remembering times with a boyfriend, girlfriend, date, relative, or caregiver, were you ever:

Hit on the head, mouth or other places on your face?

Pushed so hard you fell and hit your head on a hard or firm surface?

Shaken or jarred in any way?

Injured in the head or neck area, including strangled/choked or suffocated.

Restricted in your breathing?

Nearly drowned, electrocuted, or purposely given something you are allergic to?



Advocacy Tip: PCADV recommends that advocates avoid discussing perceived differences between choking and strangulation when engaging in this screening conversation. Such a discussion may distract the survivor and cause the disclosure part of the process to be compromised due to semantics. If a survivor discloses being "choked," simply ask how they were "choked" and about the circumstances that followed.

Continue referencing the following questions through your conversation:

Have you ever gone to an emergency room or sought medical attention because of something a boyfriend, girlfriend, relative, or caregiver did to you?

Have you ever felt that you needed medical attention, but did not get it or were prevented from getting it?

(If yes)

Will you share why you did not get medical care?

Have you ever been told you had a concussion or other type of head or brain injury?

Did you ever have a time when you lost consciousness or blacked out?

Do you remember for how long or the reason?

Do you have any problems in the head or neck area? If so, do you know why?

If the survivor discloses a head, neck or brain injury, ask:

You mentioned an injury to your [head, neck, brain]; do you have any problems since your injury(ies)?

Allow the person time to consider, listen carefully and circle symptoms below from their answer. When the survivor is finished considering their answer, ask about symptoms not mentioned by the survivor.

Since the incident(s), do you experience:

| | |
|---|---|
| Headaches | Depression |
| Anxiety | Sore throat |
| Fatigue | Petechiae |
| Difficulty concentrating | Swollen tongue |
| Difficulty remembering | Bodily function loss |
| Difficulty reading, writing, or calculating | Pupil dilation |
| Difficulty performing job or school work | Broken collarbone |
| Changes in behavior or attitude | Difficulty completing things |
| Changes in relationships | Difficulty in usual activities |
| Difficulty solving problems | Uncontrollable mood changes |
| Changes in vision, hearing, smelling or tasting | Difficulty managing stress |
| Breathing difficulties | Comments or criticism that “you’ve changed” |
| Dizziness | Drowsiness |
| Problems with balance | |

If a domestic violence advocate is concerned about possible TBI:

- Have a gentle conversation about your concerns with the survivor.
- Suggest that next time the survivor visits a health care provider, that she bring her symptoms to that provider's attention and find out how to be screened further, or see Appendix B: Additional Resources.

Exercise and Discussion: Screening Role Plays

Medical Screening Exercise

One partner acts as a nurse while the other partner acts as an emergency room patient.

Scenario: A 66-year old patient, with use of a wheelchair, comes to the emergency room for pain in her ribs and a headache. She says her husband became violent with her and she thinks she needs to be checked out. Her blood pressure is high, she has red spots around her eyes and bruising on her ribs. Also, she reports nausea. Given this general information, how would you conduct a TBI screening and referral?

Participant Notes:

Domestic Violence Program Screening Exercise

One partner acts as shelter staff while the other partner acts as new program participant.

Scenario: A 21-year old woman and her four-year-old come to the program where you work. She says her partner psychologically tormented her night and day, not ever leaving her alone or to have a moment of peace. She escaped by the back door while at a doctor's appointment and her abuser was in the waiting room. She reports that she suffers from migraines. You observe that she talks in circles often repeating her words and does not seem to be able to follow through with guiding her child in appropriate behavior. She expresses the need for cigarette breaks often, speaks quickly and seems very anxious.

Participant Notes:

Accommodations for Individuals with Brain Injury

Staff Completing Checklist: _____ Client Name: _____ Date: _____

| <p>Challenges:</p> | <p>Suggested Accommodations</p> |
|---|---|
| <p>Problems with Attention</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Work only on one task at a time. <input type="checkbox"/> Have client participate in discussion and development of plan. <input type="checkbox"/> Limit distractions (both visual and verbal). <input type="checkbox"/> Meet in a quiet environment. |
| <p>Problems with Processing Information Quickly</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Allow additional time to answer questions. <input type="checkbox"/> Speak slowly, making sure client understands. <input type="checkbox"/> Offer assistance with completing written forms. <input type="checkbox"/> Allow additional time to complete forms. |
| <p>Problems with Memory</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Provide written documentation, when possible, to supplement verbal discussions. <input type="checkbox"/> Present new information in small, concise chunks. <input type="checkbox"/> Encourage client to write down instructions/information. <input type="checkbox"/> Check client's understanding by asking for a restatement of information provided. <input type="checkbox"/> Provide cues to help client recall information. <input type="checkbox"/> Do not assume she will remember information you provided in earlier meetings. Review previous goals/meetings. Inconsistency is the hall-mark in brain injury. |
| <p>Problems with Planning, Organizing and Self-Control</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Present information in a factual manner, avoiding abstract concepts where possible. <input type="checkbox"/> Provide several solutions to a problem and encourage client to make the best choice. Engage in problem solving. "What would happen if..?" <input type="checkbox"/> Provide written direction that summarizes steps to be followed in the plan. |
| <p>Problems with Communication</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Limit use of open-ended questions. Use <u>yes/no</u> format, structured, or multiple choice where possible. <input type="checkbox"/> If client wanders off topic, redirect to topic at hand. <input type="checkbox"/> Cue client with beginning sounds of word if client has word-finding difficulties. |
| <p>Emotional Changes</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Don't interpret a lack of emotion as a sign of lack of interest. <input type="checkbox"/> Minimize anxiety with reassurance, education, and structure. <input type="checkbox"/> Provide neutral, but direct, feedback if client behaves inappropriately. <input type="checkbox"/> Suggest breaks or other activities if client becomes irritable or agitated. <input type="checkbox"/> Don't interpret poor follow-through or forgetfulness as resistance. |

If you need additional assistance in accommodating the individual with whom you are working, contact either the Alabama Head Injury Foundation Helpline at 1-800-433-8002 or TBI/SCI Helpline at 1-888-879-4706.

Exercise and Discussion: Culture and Cultural Competency

Trainer: Cut and paste these words/phrases onto index cards

Family structure and authority

Birthplace

Food

Sense of place/home

Religion and spirituality

Dis/abilities

Race

Communication

Heritage

Clothing/hair choices

Gender (male, female, intersex)

Hygiene

Socio/economic class

Power and control

Nationality

Relationships to animals

Language

Children/childraising

Age

Expressions of abuse

Sexual orientation/identity (lesbian, gay, bisexual, transgender, queer, questioning, pansexual and androgynous)

Medical preferences (holistic and/or technological/ pharmaceutical modalities)

Challenging differences that may affect service provider decisions through unhelpful assumptions within a provider's cultural belief system

Recognizing that layers of abuse may seem complex due to cultural differences between some people offering medical care or domestic violence advocacy and some survivors in need of care⁹

Recognizing that strong cultural competency skills will benefit service provision as advocates and survivors navigate an individual's circumstances

Asking service providers to become comfortable with questions and accommodations that may conflict with their personal preferences, values and social training⁹

Providing written materials and other accommodations, such as interpreters or translators, which are sensitive to cultural groups, sexualities and ubiquitous community languages

Providing Braille materials¹⁰ and other supports for persons with limited or no vision

Providing interpreters, signers and equipment for those who identify as D/deaf/hard of hearing

Collaborating with a community or hospital-based diversity caucus willing to provide feedback on the screenings, policies and procedures as they are relevant to serving the whole community

Providing services that are based on community-identified needs

Exercise and Discussion: Sexual Assault Medical Consent Form Exercise

Domestic violence survivors with a newly acquired TBI or pre-existing TBI may visit a hospital emergency room for evidence collection purposes due to sexual assault. As with any sexual assault examination, a medical consent form will be offered to the survivor by a SANE (Sexual Assault Nurse Examiner) nurse.

The purpose of this exercise is to better inform advocates, who may accompany survivors to a sexual assault examination, in order to help empower survivors to ask medical staff to further explain medical language that may seem inaccessible.

The information is for informational purposes only. The context is not meant to entitle the advocate to explain medical terminology to the survivor.

Note: Consent form contents are not to be reproduced or adapted in any way. The form sections are samples for the use of this training curriculum only.

Scenario

Roger N. has come to the Brookville Hospital emergency department within one hour after a sexual assault. Roger reports that his head was hit on a wooden nightstand during the assault. His abuser took photos of him with his cell phone, from the time during and after the assault, and sent those photos to his friends. Roger has agreed to a sexual assault examination. Roger's SANE nurse is Shauna R. and emergency room doctor is Dr. Lang.

Instructions:

- Fill in the blanks for Roger.
- Cross out any procedure that Roger has a right to refuse
- Circle words or phrases that some survivors may have trouble understanding.

Medical Consent Form Sample

I, _____, freely consent to allow _____, and his/her medical and nursing associates to conduct a forensic examination, which includes the collection of evidence. This procedure has been fully explained to me and I understand that I may refuse any part of the examination. Clinical observation for physical evidence of both penetration and injury to my person will be done. Collection of other specimens and blood samples for laboratory analysis may be done per the events reported.

Patient Information

- I understand that hospitals and health care facilities must report certain crimes to law enforcement authorities in cases where a survivor seeks medical care.
- I have been informed that Pennsylvania law provides that a survivor of a sexual offense shall not be charged for the costs of a forensic rape examination.
- I understand that “I” do not need to talk to law enforcement authorities directly if I choose not to, however I understand the health care facility will provide the evidence of the forensic rape examination to law enforcement authorities.

Patient Consent to Examination

- I understand that a forensic examination to collect evidence from the sexual assault may be conducted, with my consent, by a health care professional(s), to discover and preserve evidence of the assault. If conducted, the report of the examination and any evidence will be provided to law enforcement authorities.
- I understand that I may withdraw consent at any time for any portion of the examination.

Patient Consent to Photographs

- I understand that collection of evidence may include photographing injuries and that these photographs may include the genital area.

General Information

- I understand that evidence including photographs may be collected from this report for health and forensic purposes and provided to health authorities and other qualified persons with a valid educational or scientific interest for demographic and/or epidemiological purposes.
- I fully understand the nature of the examination and the fact that medical information gathered by this means may be used as evidence in a court of law or in connection with enforcement of public health rules and law.

Copy 1-Medical Records
Initials _____ Date _____

Copy 2-Law Enforcement

Copy 3-Forensic Laboratory

Exercise and Discussion: Medical Consent Word Match Exercise

Match the Word to the Definition

- | | |
|---|---|
| A. Laboratory analysis | 1. Referring to environmental, social or biological factors present in the assault. |
| B. Forensic | 2. Those who study the assault evidence with professional and valid interest in the situation. |
| C. Valid educational or scientific interest | 3. Nurses, doctors, other medical staff, forensic scientists, police officers, legal representatives and data collection analysts. |
| D. Demographic | 4. The survivor should not bathe, douche, urinate, drink, wash hands, brush teeth or change clothes. |
| E. Health authorities and other qualified persons | 5. Collected evidence and documentation submitted to [an internal or] crime lab. |
| F. Discover and preserve evidence | 6. Doctors, nurses and allied health workers compile notes that document the conditions they encounter, the treatments provided and the outcomes of those treatments. |
| G. Epidemiological | 7. Collection of semen, blood, vaginal secretions, saliva, vaginal epithelial cells, and other biological evidence. |
| H. Clinical Observation | 8. Official record of classifications such as age, race, marital status, income and gender. |
| I. Collection of Evidence | 9. Having to do with the law. |



Advocacy Tip: An advocate's role can include talking with a survivor about the right to ask questions before and during procedures, refuse certain procedures, and select which sections of the consent forms are agreeable or not agreeable to the survivor.

Medical Vocabulary List

The following words and phrases may seem confusing or irrelevant to anyone not trained in medical language, particularly survivors in crisis who may have TBI.

Forensic: The term simply means “having to do with the law”.¹

- In the case of an assault-based medical forensic examination, “forensic” implies using medical procedures to help legally support survivors of sexual assault.

Collection of evidence:

- Evidence is described as semen, blood, vaginal secretions, saliva, vaginal epithelial cells, and other biological evidence that may be [tested], identified and genetically typed by a crime lab.²
- Photographs are considered as evidence collection.
- Clothing worn during the assault may be collected.³

Clinical observation:

- Doctors, nurses and allied health workers compile notes that document the conditions they encounter, the treatments provided and the outcomes of those treatments.⁴

Laboratory analysis:

- Collected evidence and documentation are submitted to [a medical and/or] crime lab.⁵

Discover and preserve evidence of the assault:

- In order to discover, gather and preserve the most effective evidence, the survivor should not bathe, douche, urinate, drink, wash her/his hands, brush her/his teeth or change her/his clothes. If urination is urgent, this should be caught in a container.
- If oral sex was part of the assault, a survivor must not eat, drink, or smoke.⁶

Health authorities and other qualified persons:

- The list may include: Nurses, doctors, other medical staff, forensic scientists, police officers, legal representatives and data collection analysts.

Valid educational or scientific interest:

- May mean those who study the assault evidence with professional and valid interest in the situation.

Demographic:

- Official record of classifications such as age, race, marital status, income and gender.

Epidemiological:

- Referring to environmental, social or biological factors present in the assault.
 - Examples may include: Were alcohol or drugs part of the situation? Did anyone have a disability? Was the offender a boyfriend/girlfriend? Where did the assault occur? Was there an injury to the head?

-
1. Southeastern Association of Forensic Document Examiners. (n.d.). What is forensic Document examination? Retrieved from <http://www.safde.org/whatwedo.htm>.
 2. U.S Department of Justice Office of Violence Against Women. (2004.). A national protocol for sexual assault medical forensic examinations: Adults/adolescents. September. P. 90. Retrieved from <http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf>.
 3. U.S Department of Justice Office of Violence Against Women. (2004.). A national protocol for sexual assault medical forensic examinations: Adults/adolescents. September. P. 93. Retrieved from <http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf>.
 4. National Institutes of Health. (2008.). Clinical observation. U.S. National Library of Medicine. Retrieved from http://www.nlm.nih.gov/nichsr/usestats/clinical_observation.html.
 5. President's DNA Initiative. (n.d.). Evidence to submit to the crime lab for analysis. Sexual assault medical forensic examinations. Retrieved from http://samfe.dna.gov/examination_process/exam_evidence_collection_procedures/submit.
 6. The University at Arlington, Texas. (n.d.). Relationship violence & sexual assault prevention program. Division of student affairs. Retrieved from <http://www.uta.edu/studentaffairs/rvsp/howtohelp.htm>.

Patient Reminder Cards

Advocates can make and distribute their own Patient Reminder Cards:

- These cards may be handed to survivors who plan to follow up for medical care for a head or neck injury.
- After discussing the domestic violence and TBI screening results, if a survivor agrees for a follow-up medical appointment, and it is established by the survivor that it is safe for her to carry a Patient Reminder Card, then a shelter or medical advocate hands the survivor a card for an examiner to complete. The survivor may carry the card as an appointment reminder.
- The card font should be large, bold and easy to read for accessibility. A domestic violence services reference is intentionally exempt from the card wording for safety purposes.
- Advocates can discuss with survivors if they are able to keep the card from an abuser, relatives or friends working on his behalf.

Patient Reminder Card Sample

REMINDER CARD

You have been examined at _____ for a head injury.

Be sure to let a trusted family member or friend know about your injury. They may notice symptoms before you do and can help you.

Take time off from work or school for _____ day(s) or until you and your doctor think you are able to return to your usual routine.

Your next appointment with _____ is on

_____.

REMINDER CARD

You have been examined at _____ for a head injury.

Be sure to let a trusted family member or friend know about your injury. They may notice symptoms before you do and can help you.

Take time off from work or school for _____ day(s) or until you and your doctor think you are able to return to your usual routine.

Your next appointment with _____ is on

_____.

REMINDER CARD

You have been examined at _____ for a head injury.

Be sure to let a trusted family member or friend know about your injury. They may notice symptoms before you do and can help you.

Take time off from work or school for _____ day(s) or until you and your doctor think you are able to return to your usual routine.

Your next appointment with _____ is on

_____.

TBI and Personal Goals List

1. How might a survivor's reduced ability to perceive, remember or understand risky situations lead to physical or sexual violence?¹⁷
2. How might risky drinking or drug use place people with TBI in situations or relationships that could lead to victimization¹⁷ or re-victimization?
3. How might uninhibited behaviors on the part of a survivor with TBI lead to risky sexual exchanges, possibly exposing her to HIV/AIDS or other sexually transmitted diseases?¹⁷
4. How might uninhibited sexual behaviors, on the part of a survivor with TBI, lead to unintended pregnancy?
5. Epilepsy and an increase in the risk for conditions such as Alzheimer's disease, Parkinson's disease, and other brain disorders can become prevalent with age. How might these affect an advocate's perception of what may be going on for an older survivor who has TBI?¹⁸
6. How might difficulty with anger or other behavioral management on the part of the survivor with TBI prompt others to use undue physical force, prescribe inappropriate medication¹⁹ or administer unhelpful or harsh consequences? Include implications for domestic violence services in your discussion.
7. How might the effects of TBI on someone result in demeaning or abusive treatment from others?¹⁹
- 8a. How might a survivor with TBI might experience judgment or ostracism from others?
- 8b. How might uninformed responses from advocates result in a shelter experience that is difficult or unproductive (may include decisions about intake or exit from shelter)?
9. How might real or perceived problems with a person's ability to honestly and accurately report an incident of victimization affect the quality of the advocacy relationship?¹⁹
- 10a. How might an advocate's lack of awareness about TBI affect or result in denying a problem associated with possible TBI?
- 10b. How might a lack of awareness about TBI affect the survivor's perception of her situation or needs?

Exercise and Discussion: Build A Wall

Domestic violence survivors must deal with and dismantle barriers in their every day lives. The wall in this exercise is a metaphorical barrier for types of abuse and abuse techniques, while the safety planning measures show ways that advocates can work with survivors to address barriers that may be more present for those with TBI.

Write on your index cards (as these are relevant to TBI):

- First card: A type of abuse;
- Second card: corresponding abuse tactics for those who have TBI
- Third card: safety planning measures that may benefit someone with TBI who is confronting those abuse types and tactics.

Cards must be kept in relevant groups of three.

After several minutes, appoint a spokesperson to present ideas to the group and tape cards to the newsprint attached to the wall. (See example chart.)

Example:

| Type of Abuse | Abuse Tactics | Suggested Safety Planning Measures |
|----------------------|---|---|
| Medical | Hiding medication | Always keep medications in reach or sight, such as in a purse, when abuser is around. |
| Physical | Hitting on the head | Protecting the head when abuse happens. Seek out medical help immediately upon injury. |
| Psychological | Telling her he will report neglect for her forgetting to pick up kids from school | Tell school about survivor's medical issue. Set a cell phone timer to let you know when to pick up kids, Arrange a trusted support person to pick up kids if you forget or are not able. |
| Economic | Abuser keeps disability checks | Hide away as much money as possible at every safe opportunity. |
| Sexual | Abuser takes advantage of decreased sexual inhibitions | Become aware of signs leading up to abuse and try to circumvent the situation. |
| Mental | Abuser tells her she is dumb because she cannot do things like she used to | Try to remember why things may be different now. Be kind to yourself. Try to find a counselor educated in TBI and domestic violence and/or a rehabilitation facility to work on skills. |
| Emotional | Abuser tells her he will leave her with nothing | Try to find someone who can assist with legal options. Apply for disability benefits/ government assistance. Connect with TBI rehabilitation services that will help reinstate job and survival skills. |

❧ Safety Planning for Victims with TBI ❧

Safety planning is a very concrete, specific process, but you may need to break plans down into very small steps when working with a victim who has a TBI. Questions about specific TBI-related issues may be useful.

❧ Protecting her head

- Are there any steps she can take to protect her head from future assaults?
- Are there steps she can take to protect her head from accidental re-injury? Ideas may include:
 - Removing tripping hazards such as throw rugs.
 - Keeping hallways, stairs and doorways free of clutter.
 - Putting a nonslip mat in the bathtub or shower floor.
 - Installing grab bars next to the toilet and in the tub or shower.
 - Installing handrails on both sides of stairways.
 - Improving lighting inside and outside her home.
 - Always wearing a helmet when bike riding, rollerblading, skiing, etc.

❧ Accessing services

- Is she aware of, and able to access, TBI-related medical care, rehabilitation and support services?
- Does she depend on her abusive partner for any disability or health-related assistance?
- Does the abuser exploit barriers created by her TBI?
- What assistive devices does she use? Some people with TBI use wheelchairs, but most do not. Many use memory aids, such as voice recorders, timers and blackberries.
- Is it safe for her to take notes or keep notepads by the phone?
- Does she have a way to keep her service animal safe, if she has one?

❧ Managing her mood and energy

- Is she short-tempered, irritable or aggressive? If so:
 - Does she pick fights with her partner that he uses as an excuse to become abusive?
 - Has it strained her relationships with family and friends, depriving her of needed support?
- Has she been depressed? Depression may be related to the TBI, the abuse, or both. Remind her of her strengths, which depressed people tend to forget.
- Is she tired all the time? Fatigue is common, and may be related to the TBI, the depression, or both. Be realistic about how much – or how little – she may be able to do in a given day.

Financial independence

- Is she able to work? If so, how supportive is her employer in terms of both the domestic violence and the TBI?
- Does she have difficulty holding a job?
- Is she getting whatever benefits she might be entitled to?
- Has she filed an application for state crime victims compensation? It may pay for services if the TBI was caused by a criminal act. Help her fill out an application and compile needed documentation.

Leaving

- Does she have a plan to take her service animal and assistive devices with her?
- Is she able to drive or use public transportation on her own? If not, how will she access transportation?
- Does her emergency escape bag include (as needed):
 - Spare batteries for assistive devices?
 - Back-up assistive devices, and specific information on how and where to get replacements or repairs?
 - Instructions for use of technical equipment?
 - Medications, medical information, and medic alert systems?
 - Contact information for medical personnel, TBI advocates and other service providers?
 - Social Security award letter, payee information and benefit information?
 - Supplies for her service animal – food, medications, leashes, vet’s contact information, etc.?¹



Hints to Remember

- Safety plans should be reviewed frequently and in detail, to help compensate for problems with memory, motivation, initiative and follow-through.
- An action plan that involves several steps should be sequenced: first do A, then B, then C.
- A victim who has a TBI may not be aware of how it is affecting her, and may think she is functioning better than she is. Provide respectful feedback on problem areas that affect her safety.

¹ Empire Justice Center, Building Bridges: A Cross-Systems Training Manual for Domestic Violence Programs and Disability Service Providers in New York, 2006

Domestic Violence & Traumatic Brain Injury

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