Traumatic Brain Injuries among Domestic Violence Victims: An Unrecognized Public Health Issue

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Many domestic violence victims suffer substantial physical injuries resulting in brain injuries that remain undetected and have severe health consequences. Of particular concern are concussions and traumatic brain injuries caused by assaults to the head, being shaken, and losing oxygen to the brain (anoxia) through strangulation. While there are times that these injuries are identified in emergency medical services, many victims report that more often than not, they do not receive medical care for their injuries or they do not reveal the extent of their injuries when they do.

In 2015, a large domestic violence program in Arizona called the Sojourner Center began a ground-breaking collaborative effort to study and address traumatic brain injuries for domestic violence victims. According to a survey of women in domestic violence shelters, 92% of the women had been hit in the head by their abusive partner. 83% of these women had been hit in the head and severely shaken. Alarmingly, 8% of these women reported being hit in the head over 20 times in the last year. In the fall of 2016, a Kent County, Delaware domestic violence shelter completed an informal review of their resident's Danger Assessment data, finding similar results. Of the 27 women in the shelter during the quarter, 20 of them reported having been strangled (73%).

Through the Sojourner Centers work on this project, it is expected that a new awareness of the risks for victims will be clear and standards of care will be established, including better pathways for screening, assessment, and medical intervention.

Brain injuries have extensive health and life consequences for victims and survivors. The impact of head injuries and loss of oxygen can be quite varied, but may include damage such as memory loss, difficulty concentrating, hearing loss, headaches, vertigo, ringing in the ears, irritability and anxiety. Brain injuries may also cause impairments in physical functions, cognition, use of language, speech, perception, or ability to reason or think abstractly and problem solve.

These extensive and varied symptoms can make it difficult for a victim of domestic violence to be able to assess how much danger they are in or to be able to make and remember a safety plan. Additionally, these injuries can make it challenging to receive help and to access services, including medical care. It can make it problematic to live in a shelter, as victims may be increasingly stressed, confused or disruptive, or have trouble remembering and following shelter procedures. It can also make it difficult to near impossible to go to school or hold a job, making victims even more financially dependent on their abuser.

It is important to note that the domestic violence service community's ongoing efforts to provide trauma-informed and trauma-responsive services are helpful in mitigating some of the barriers those with brain injuries experience when trying to access services. A domestic violence advocate's experience in being able to provide non-judgmental, empathetic services with the understanding that victims may be experiencing problems with concentration, memory, problem solving, and emotional dysregulation is significant in assuring that victims have access to services. This approach is effective for all types of trauma, including brain injuries.

Domestic violence victims face many obstacles to receiving an evaluation and treatment for a traumatic brain injury. Victims may be hesitant or fearful to talk with medical professionals about what is occurring. They may not be aware that they lost consciousness or what the medical implications of doing so are. They may have poor recollections of the incidents. Often times, medical providers are not asking screening questions that lead to a brain injury assessment.

When concerns are identified, the process to receive a formal diagnosis may be cumbersome, often including numerous appointments, multiple doctors, and expenses that make it inaccessible to many victims. Financial barriers, lack of transportation, as well as challenges with having to continue to navigate the violence may all contribute to victims not seeking or receiving the consistent medical care needed to formulate a traumatic brain injury diagnosis and participate in treatment.

While medical settings strive for universal screenings for domestic violence, research informs that screening within primary care settings or ob/gyns does not occur regularly. Rates of screening tends to be higher in Emergency Departments, especially when injuries or obvious signs of domestic violence are present, but they still may not be asking specific questions about loss of oxygen and injuries to the head unless it is obvious or the victim informs them of what happened. Victims may not present with symptoms and may actively attempt to conceal what they experience at home due to fear, shame, or uncertainty around how the physician will respond.

As domestic violence service providers, we can ask questions and help direct survivors to medical professionals. We, as a domestic violence community, need to reach out to the medical community to build collaborations that help to address these specific and substantial needs of victims. Collaborative projects that address the barriers to screening for domestic violence universally and traumatic brain injuries specifically are essential to being able to create the medical pathways needed to assure that victims are assessed and treated for these types of injuries as standard practice.

Working together to reduce victim's barriers to medical care, assuring that medical professionals know how to access safety services when victims are identified, and providing supports that enable victims to follow through with appointments and procedures are all essential.

The HELPS screening tool was designed for responders who are not experts in traumatic brain injuries. These questions can be asked of everyone who seeks services in a domestic violence or victim services program.
HELPS is an acronym for the most important questions to ask:
H = Were you **hit** in the head?
E = Did you seek **emergency** room treatment?
L = Did you **lose** consciousness? (Not everyone who suffers a TBI loses consciousness.)
P = Are you having **problems** with concentration and memory?
S = Did you experience **sickness** or other physical problems following the injury?

If a victim answers "yes" to any of these questions, it is important to help assure that the victim has an evaluation by a medical or neuropsychological professional, especially if repeated incidents are reported.