Great Lakes (HHS Region 5)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Transcript: Part 2: Invisible Injuries: The Complex Intersection of Domestic Violence, Behavioral Health, Traumatic Brain Injury and Strangulation

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Recorded on March 15, 2023

PRESENTER: Well welcome everyone, we're going to let folks get into the Zoom room. And we'll begin in just a moment. Well welcome again everyone to today's webinar part two, "Invisible injuries: the complex interaction of behavioral health, domestic violence, traumatic brain injury, and strangulation" with our presenter, Rachel Ramirez.

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A few housekeeping items, if you're having any technical issues, please individually message me, Jen Winslow, or Rebecca Buller in the chat section at the bottom of your screen, and we will be happy to assist you. If you have any questions for today's speaker, please put those in the Q&A section in your Zoom's screen or Zoom toolbar, excuse me. It helps us keep them organized outside of the chat if the chat moves quickly. If captions or live transcript would be helpful, please use your Zoom toolbar to enable them by going into the More section, Select Captions, Show Captions.

At the end of this session, you will be automatically redirected to a very brief survey. Certificates of attendance will be sent out to everyone who attended the session in full. The recording of this presentation and the presentation materials will be available on the Great Lakes MHTTC website within a week. I will also be emailing you a PDF of the slides and the handout following the presentation.

And let me again welcome our presenter. Rachel Ramirez is the director of health and disability programs and the founder of the Center on Partner-Inflicted Brain Injury at the Ohio Domestic Violence Network. In this role, she oversees several initiatives on the intersection of domestic violence, disability, and health access with a focus on trauma-informed services and partner-inflicted brain injury. She also provides extensive statewide, national, and international training, consultation, technical assistance, and program support.

Rachel has been with ODVN for 15 years and has co-authored several peer reviewed journal articles as well as been featured on National Public Radio, The New York Times Magazine, and The Washington Post discussing brain injury and domestic violence. So welcome everybody, and I will turn it over to you, Rachel.

RACHEL RAMIREZ: Hello, everybody. Thank you all so much for joining us today. I know we're getting some hellos from people and where they are from. And it's always fun to see and fun to be able to connect kind of across spaces and places.

I am joining you from Columbus, Ohio, very excited. If any of you live in the Midwest, we have this thing today. It's called the sun. It has not made its appearance very often in the past I don't know how long. But it comes back to visit, even though we also had snow on the ground until the sun came out.

So welcome to March in Ohio. We are all very, very, very tired of this weather but hope you're having a beautiful day wherever you are. And thank you all so much. I know how valuable your time is. I know how important your time is, so I appreciate you dedicating the time that you have to spend with me today learning about these things.

I know Lisa said in Cape Cod, Massachusetts you have no sun for months. It's amazing, Lisa. Someday there will be some sun. I don't know if it happens like this in Massachusetts again where you have a couple of-- everybody has weird weather. But you have a couple of nice days, and you think it's almost spring. And then it's like 19 degrees again when you wake up the next morning. And you're like, Oh, it's not spring yet. But it's coming. It's around the corner, so looking forward to being with you all today.

I am going to just go ahead and share my screen. And we're going to get started. I will talk a little bit more about the things that we're talking about today. I know today is a part two of some of our presentation. Oh, hold on, we just did this earlier-- part two of some of our presentation.

And we had our first session that we did on this that was two weeks ago. And I wanted to see if maybe we could do our first poll question would be if you were here for the first session-- very, very easy answers, kind of a yes and a no, because we're going to do a brief overview.

Even though-- I know we had a great time two weeks ago. I do assume you all might have had just a little bit of something else between the past two weeks and have done something else. So we're going to kind of try to reorient you, do a brief overview. And then we'll move on.

But we're going to give people like-- we'll start with five more seconds, four, three, two, one. And we can go ahead. Wow, we literally have of people who answered half of the people came to the first section and half of the people who didn't.

So thank you so much to my old friends who came back for more. I appreciate you not only making time for me today but two weeks ago. And welcome to my new friends. And I'm so glad that you're here.

I wanted to see just to kind of get us started, as I will kind of go over real quickly a few review slides that we talked about just to kind of place some context of the work that we're doing and kind of help us start off where we're starting off, but I wanted to see if anybody-- and I think people are able to. I'm not sure if we're in like, kind of with a Zoom webinar or whatever, if anybody wants to raise their hand and say something, which I know nobody likes to do. And I don't know if we're actually allowed to do this, [INAUDIBLE] depending on the settings.

But if anybody who was here for the last session would be willing to share something that they learned or something that they remembered or something that they can put in the chat box-- or like again, if that's possible, raise their hand and just let us know, something you remembered or that stuck out to you-- this is also what I like.

I used to close my eyes and cross my fingers and say, please tell me that somebody out there just remembers something about what we talked about from a couple of weeks ago. I do remember that the group had a lot of thoughts. And we talked about a lot of really important things.

So Lisa said-- thank you so much, Lisa, woo-- how much the brain is impacted by domestic violence. Hannah said, "I was surprised how DV was connected to mental health," so talking about those relationships between domestic violence and mental health. Kimberly says, "I never really thought about things being an invisible wound and domestic violence."

So we talked about how one of the things with brain injury, brain injury is something people can continue to live with for years and years. But there often are-- even in an initial assault where people might get a brain injury, they might not have physical signs or visible signs. And it could be impacted by the brain injury for many, many years later. But they look fine. We don't see anything.

Deanna said, "The mind explosion of how DV can cause brain injury, I never considered it." I know. And that was one of the things for many of us it was kind of the first time, even though it's not that head trauma and domestic violence is new. But domestic violence and brain injuries are really a new thought.

Nicole says, "Please remember brain impacts by physical abuse and uncommon side effects and mental triggers from DV, the brain is impacted by physical abuse." Very true.

"I was struck by how common brain injuries are with DV but hasn't been recognized by and large."

Jennifer said, "I was struck by the impact on reading and comprehension," so thinking of reading and comprehension as one of those brain functions. Stephanie says, "These thoughts people are bringing up remind me of the same thing I was having about the subject here in-- the same thoughts I was having during the subject"-- sorry about that, "about this subject during the last session."

So thank you again, all of you, for sharing. Catherine said how TBI may be misinterpreted as a substance use disorder. Yep, some of those signs and symptoms of a possible TBI people might see it. People might think, Oh, this person might be slurring their speech, because again, speech is a brain function. Maybe they're drunk. This person might not be making a lot of sense, so thinking about often we see the misinterpretation or other causes that are attributed to brain injury.

So thank you, everybody, for sharing that. It warms my heart. I have many, many times been to a webinar that was two weeks ago and not remembered anything about it. So thank you all so much for giving me, just helping me. It means a lot to me that you all still remember that.

So those are a bunch of things that we talked about. And what we're going to do is we're just going to spend, like I said, just a few brief minutes kind of reviewing that for some of the new people and then kind of hitting home on some of these points again.

I did want to acknowledge and we know that on this webinar domestic violence is a hard topic. Domestic violence and brain injury and being hit or hurt in the head is a particularly difficult topic to talk about, a particularly nasty form of violence, a particularly damaging form of violence, a particularly traumatic form of violence. And we know that we have people that are on this webinar that are also doing domestic violence work or doing other types of behavioral health worker working with domestic violence victims in some capacity and have their own personal experience with domestic violence.

So I just want to first of all applaud all of the survivors that are on this webinar with us. Thank you so much for your bravery and the work that you do. And we acknowledge what an amazing act of courage it takes just to survive domestic violence.

But did just want to let you know that some of these things might be new and might pertain to some people's personal situations. So I'm in imploring all of you to have your good or great self-care skills that we've developed doing this work with hard topics and make sure that you use those. And feel free to take a break, kind of do whatever you need to do. I'm not going to be sharing any graphic pictures or anything that I think is particularly triggering, although we might hear a little bit from some survivors about their experiences.

But again, I just wanted to kind of acknowledge that. And what we have learned is from survivors, whether survivors who later on become advocates in their career or get into helping professions because of those experiences, we know that this can have both a personal and a professional impact. But the vast majority, almost everyone-- actually everyone that I've talked about that has had a personal experience with head trauma has been really, really glad to have some of this information.

So and I know we did my introduction, so big picture of my first job in domestic violence in a domestic violence shelter. 18-- oh, not 18 years ago, I've been doing this work for almost 20 years and had no knowledge, no injury, no context of brain injury until we got a grant, which we talked about a grant, some of the research. And we'll review that real briefly.

About six years ago, brain injury wasn't anything that was on our radar. At the Ohio Domestic Violence Network, we have 76 member programs across the state, an extensive training program that we do for our DB programs and other professionals who work with domestic violence that spans three decades, and before we started this project had never considered or done any kind of training or really done any kind of thinking or even pondering on the role that brain injury could play in the lives of domestic violence survivors.

We spent many, many years working on trauma informed care and trauma informed approaches without any, again, any acknowledgment or inclusion of the role brain injury could play in the lives of survivors, and then had the opportunity to do this work and totally had the opportunity to get a grant, started looking at this issue.

And it totally revolutionized and really changed my whole perception of thinking about services, any type of services that we're providing when working with domestic violence victims that could be impacted by head trauma, as well as a lot of other real kind of tricky issues that are also impacted by trauma, that are impacted by mental health and substance use and behavioral health and all of those pieces, that are impacted by problems with access to services, that are impacted by challenges, structural barriers, impacted by systemic oppression, all of those pieces.

But one of the things that we had never talked about was brain injury. And I think the reason-- I'm going to give a quick overview of just kind of last session, like I said, just a few minutes to reorient ourselves. But it really came to-- I came to very much believe deeply, and this might not be the only missing piece, but brain injury just being this missing piece of working with domestic violence survivors that needs to be taken into consideration as one of the contributors or one of the ways that domestic violence survivors could be impacted or affected. So we talked a little bit about that.

We're going to provide really quickly, just go over the research and what we learn when we're talking to domestic violence programs, when talking to survivors who are accessing domestic violence services, and what survivors' experiences are and what

their programs' experiences are. We then talk about brain functions and executive functions. And that's kind of where we left off for this session.

So the first-- I think that the kind of-- and some of you, those of you who have seen this have seen these slides really quickly. But I do just want to show these again to you just to realize I think that take away number one, when we went to domestic violence programs and started talking to survivors and asking about simple questions like, have you ever been hit or hurt in the head, we got responses that 86% of the survivors that we worked with said they had been hit or hurt in the head, which is an absolutely astronomical number when you think about it.

I think for some of you who do domestic violence work-- I mean, I think for me having been a domestic violence advocate, that's all I've ever done in my career, if you were to ask me does head trauma occur pretty often, I would have said, oh, yeah. But really, that lack of connection to there being brain impacts that can impact a survivor's overall well-being, that can impact their daily activities, that can impact things like holding a job, things like accessing domestic violence services, even things like escaping and planning for escaping an abusive relationship were impacted by this head trauma, that was just not a thought I had ever had even 12, 13 years into providing domestic violence services.

Particularly-- I don't know if "startling" is the word, but that almost half of the survivors said when we asked how many times they'd been hit in the head, they said, I don't even know. I can't put a number on it. And one of the things that we know about head trauma and one of the reasons why there's such a big discussion in sports circles and football circles in the NFL is repetitive head injuries. Just like any kind of repetitive injury we have in any type of our bodies, they're really, really bad for you.

So we had so many survivors say that I just couldn't even put a number on how many times I've been hurt in the head. When we asked about if someone had ever been choked or strangled-- these were the same survivors we talked to, so the 86% that had been hit in the head-- 83% had been choked or strangled. And you'll see kind of 51% had been choked or strangled a few times. One fifth of the survivors we worked with had been choked or strangled more times than they know.

It's just one of those things that it just is so much-- and I know Dena said, "I experienced it many times. My head was almost regularly a targeted area of my body." Dena, thank you for being here. Thank you for sharing that with us. And we're really sorry that that's something that you experienced and not something that you ever deserve to have happen to you.

But I think the more and more we're learning about physical abuse-- we don't know a lot about this, because these again are questions that we haven't even asked-- is that when people are physically abused and physically hurt, it is very regular that the head is

one of the places in which they're hurt, you know? And Dena says, "A lot of providers forgot to ask directly, and direct questions help individuals like me answer honestly."

Jennifer talked about another thing from last session, using the language the client's use-- choke, throttle, strangle, hold by the neck, et cetera. So we'll talk some more about those things. But I think again, you know, I think talking about part of the importance of providing information and asking some of these direct questions is the number of survivors that I have worked with-- survivors have a lot going on when they're coming into services with us. Even the physical violence they've experienced is one piece of a whole array of things that they're dealing with.

And I think that was the thing that we learned about this whole concept of partner-inflicted brain injury, which you'll see the definition here is not only were providers or professionals or people working with domestic violence victims largely unaware of this issue, survivors themselves were. And survivors themselves had never really connected their head injury or the trauma that they had experienced to their head with that having any impact on them.

The vast majority had never gotten medical care, had never seen a doctor, that had never-- you think about all of the concussion protocols we have in sports and in other areas and in schools. None of that stuff had ever happened in domestic violence survivors, and really thinking about, really recognizing that this whole concept of partner-inflicted brain injury, which puts together these-- the brain injury that is caused by oxygen deprivation and the brain injury that's caused by blunt force head trauma caused by things like shaking, even caused by things-- domestic violence victims being chased and falling and hitting their head, that is happening intentionally.

And it's happening to survivors. Most survivors have experienced both these different types of insults to the brain with very, very little acknowledgment and almost no treatment, or no rehabilitation, or no way of addressing, no real opportunities to heal from this.

And I know this is-- for those of us who saw this last time, this is just-- and we're not going to go over each part of it. But it's really recognizing that different parts of our brain are responsible for different things. And I'm going to try to insert some of these nuggets. I don't know if they're nuggets. I think they're nuggets for me. But you take whatever nugget you like.

But some of the things that I think are most important for me to remember and one of my biggest takeaways from going from doing this training with you, from starting at like-- if you were to ask me like, what are signs of a brain injury, I was like, I have no idea. I don't know why we're talking about this. I work in domestic violence. What does that have to do with brain injury?

From going to that spot to going where I am now is just really recognizing that a lot of things we just take for granted for being able to do our brain functions. And reasoning and judgment and learning and recalling information, so being able to learn something-- the reason that you all were able to get on this Zoom, and you are able to see me, and you're able to unmute yourself, and you're able to put things in the chat box is because your brain can recall the information about the last time you were on Zoom. You know how to do this. You didn't have to totally learn from newness.

We have different-- again, different parts of our area. We have a part of our brain that really integrates our senses, that makes our senses into kind of a thought. We have parts of our brains that coordinate new movement, parts of our brains that are responsible for sight, parts of our brains that are responsible for language, hearing, and comprehension, talking about some of that reading and just even being able to do that stuff.

And this is what-- I just think one of the things that I really, really want us to remember is a lot of things we just assume people can do are brain functions. I know Dena said in the chat that there's financial, emotional, and then TBI symptoms make it hard to be clear mentally, then the stigma and shame, not just self-shame but the social shame. What did you do? They didn't mean to. It takes two.

So again, and I think that that's one of the things-- Dena, your sharing with us is so helpful and so powerful. But you know, I think it's one of those things. The other thing that we know about when we think about access and we think about why we need to figure out how to answer these questions and ask these questions in a sensitive way is that it is not the same to share.

We do not have the same response when somebody shares about I was hurt in a sports accident, or I slipped and fell. We don't have anybody say, well, why were you walking outside? I mean, it was icy. You slipped and fell. It was icy. What did you think was going to happen?

And I'm sure you've heard on the news or how people slip and fall all the time. And wasn't there a weather alert out? And then you went outside and you slipped? And of course you have a brain injury.

No, we never say that. But there's so much-- again, the stigma and shame that is connected to domestic violence, that disclosing abuse is very, very different from saying you were in a car accident. I mean, nobody who was ever in a car accident has been hurt is-- their judgment is questioned, because why did they get in a car? Because they know that cars-- cars get in accidents all the time. But you know somebody who's been in a car accident. You still got in a car? No, there's a lot of that blame and a lot of that shame.

And this is kind of getting into kind of where we left off as really thinking about executive functioning. And this frontal part of our brain, the frontal lobe right here, it's a part of our brain that really makes us different from all other animals and allows us to do. These are all things that, as you can see, if you think about those in the animal kingdoms can't do so well and don't do so well, because they don't have this part of their brain.

These executive functions are really, really important for us to live our daily lives. And they include these mental skills that include those things like again, working memory. So you're able to do something yesterday, see where you left off, come back into work today, continue on that, have something you haven't done for a long time and be able to pull that information to be able to do it now, flexible thinking, which is being able to approach problems from different areas, and self control. And these are really essential for everyday tasks.

So this is a little bit different. I actually found this between the last training and this training. We talked about this a little bit. And I like this a little bit more. But really, thinking about the executive functions being things like self control, like the ability to stop and think before acting-- and this is what I say want you to remember a lot of us just assume that these are things people can do.

These are all brain functions. These are all functions of our brain that when our heads are hurt again and again become more challenging, just like when we hurt our ankles again and again, it becomes more difficult to walk. Emotional control, being able to manage feelings to achieve goals and complete tasks, to be able to start tasks, to be able to figure out what the first step of something is in a task, the working memory, to again-- we talked about that a little bit, to use information held in memory to complete a task, self monitoring, the ability to be able to view and evaluate somebody, flexibility is ability to adapt to changing conditions by revising plans or changing strategies, to be able to do things differently, our organization and then planning and time management, these are all again brain functions.

You know, it's one of those things-- I know Elizabeth says TBI can also negatively affect personality, which can impact relationships with providers, yeah, and personality and also self awareness. And then talking about impulse control problems with Dena, aggression and mood swings, the way in which brain injuries can exacerbate or kind of exacerbate mental health conditions.

So I think what we want to recognize is that when your brain has been hurt-- and there are lots of ways in which people's-- it's almost impossible to list all the ways in which people's brains have been hurt in the context of domestic violence. All of this stuff becomes harder. It becomes harder for me to plan and manage my time. It becomes harder for me to start a task, you know what I mean, to be able to start and finish tasks without procrastinating.

That is not-- and I think that this is something that has really, really shifted my view. Sometimes we think people coming into our services just need to try harder. And if they tried harder or if they cared more, they would be able to do things the way that we wanted them to or the way we set up our systems for. What we're learning about brains and our brain functions and how it is that that works is more complicated.

The ability-- when we talk about working memory, the ability for us to meet week after week, and we're working on a case plan, and we had these tasks last week, and we were going to do these things-- the ability to break things down into smaller pieces, those are all brain function, even the ability to prioritize when we wake up and we have 30,000 things to do when we have an hour. What needs to be done today? What can wait? What do we need to do? Our brain is involved with all of that.

And I think one of the reasons why I feel like this information is so critical for people who work with domestic violence survivors and for domestic violence survivors themselves is I think it adds onto-- I know Dena has talked about some of the shame and the stigma and the self-blame. We have survivors who are having challenges with this stuff. They're having a hard time in our services. They're having a hard time getting the supports that they need.

They're having a hard time on their jobs. They're having a hard time in all these areas in their lives. And guess what they think? They think they're stupid. They think they're crazy. They think it's their fault.

And it makes sense, because a lot of times they've been told that by their abusive partners, right, that you're not going to be good at this stuff. And nobody else is going to love you when you're crazy. And you don't see things right. And all of this, and then people really having these functional challenges in their lives.

And it feels like-- I know somebody talked about earlier about the reading and the comprehension. Has anybody ever disclosed to you, adults are supposed to be able to read, right? And I do want to acknowledge Nicole said the brain has to be rewired and healing can begin. Yes, the brain can absolutely heal. And the brain can absolutely learn to do new things. And this stuff can happen.

I always say another example of a brain injury is a stroke, right? If anybody knows anybody who's had a stroke, there are people who have strokes and lose their ability to talk, lose their ability to move, lose the ability to use a certain side of their body, and with the proper identification and rehabilitation are able to do all of those things again.

But somebody doesn't sit at home and get better from a stroke on their own. That has to be identified. There are services and there are people who are specially trained that can help people learn to walk again, learn to talk again, learn to do all of these things again. It's not something that a stroke victim can want to, just want to get better enough, like I just want to be good at walking again. And if I use motivational interviewing strategies

and could figure out the right way to get you motivated enough to walk again-- it's not that simple.

I know Elizabeth says we ask people to fill out a lot of complicated paperwork. Absolutely, I think that this makes us think about our paperwork and think about what that is and what that looks like. Nicole says even developing conditions because of trauma from DV. Yep, there are that interrelationship and intersection of trauma is absolutely critical to understanding this, because like I said, when your head is hurt, your head is hurt and you have altered consciousness-- you know, we'll talk about that a little bit later-- from a traumatic event, being hit or hurt in the head or being choked or strangled or having something done to you that made it hard to breathe—

I know somebody talked about language. And we know that a lot of times, if we're asking people have you ever been strangled, a lot of people say no. A lot of people don't resonate with that language. If we ask people, have you ever had anything done to you that made it hard to breathe, has anyone ever put their hands around their neck, has anybody ever made it difficult for you to be able to talk, those kind of things will get us different answers.

And then we can talk about what executive dysfunction is and talk about-- it's kind of like the opposite of an executive function. It's where it just disrupts your ability to manage your thoughts, emotions, and actions. We know a lot of things to contribute to this. And it can turn into being hyper-focused on something.

And I think you might see this in many of the survivors you work with. Being easily distractible or daydreaming and spacing out when you shouldn't be, not being able to switch between tasks, so that's something-- as someone who tends to be pretty distractible and has challenges and problems with attention, that ability to be able to do one thing, do another thing, come back on to this thing, those are brain functions.

Talking about impulse control, it is this frontal lobe in our brain. The impulse control is which, again, grows and develops as we grow. One of the things that makes humans humans is the ability-- we have this frontal lobe that helps us decide, like all right, there's something that we really want to do right now. But we're not going to do it, because it'll work out for us later.

And you can think when you were-- again, if you ever had something, some friends call you and want to go out late, but you have an important event the next morning or you have to work the morning, you want to go out. But you know it's not good for you. You know tomorrow morning you'll be glad you didn't go out.

Thinking about that ability, even thinking about how much we talk about even in the substance use issue being able-- people really, really are having a craving or want to use. And we just kind of assume that that's something that people's brains have the

capacity to recognize that and then bring in those strategies to help kind of manage that.

But I think even trouble starting difficult or boring tasks, like that's something that we talk about. Like things that are tricky, things that are hard to do, those are just some examples of what happens with this executive dysfunction that can end up happening due to-- once again, mental health and trauma can impact this. Addiction can impact this. And absolutely brain injury can impact this.

So one of the things that we're going to talk about-- and I'm going to get-- transfer a little bit more over into talking some more and digging more deeply into some of these areas. As I interrupt myself-- if anybody does have any comments, questions, or thoughts, please don't hesitate to put them in the chat box. We will make sure to address them. And I know Jennifer and the whole staff has my total permission to interrupt me if something comes in and I don't see it. But it really is about providing support in a way that takes into account a person's unique needs.

Accommodations is this concept that we use in education, we use with people who have disabilities, we use a lot of different settings. But it's just really recognizing that our support might need to look different for different people depending on how they're impacted by brain injury, depending on how they're impacted by trauma, depending on what it is that that looks like. And what it really does is it creates opportunities to address potential barriers to success.

So one of the challenges-- I remember working with people. One of the big challenges related to brain injury are things around memory. I don't know how many times in my career when I was working in a shelter, like I'd just give people the name and time of an appointment. And I just expect them to be there. I expect them to remember it. I expect them to be able to figure out transportation. I expect them to be able to do all of these things.

And if somebody can't-- and I think that this is one of the shifts, too, as we think about this. Thinking about if somebody won't-- I think a lot of times I had a framework that was like, if people cared enough, or if people would do the work that they need to do, they just would be able to do this stuff, that they were things that they wouldn't do, not maybe things that they couldn't do, that they couldn't do the way that they were asking them.

So if somebody has a memory problem, doesn't it make sense that it would really help us to know about that? It would really help us to be able to take that into account when we're working with them. And we might need to remind them for things in different ways. We might need to work on them on calendars. We might need to help them program things into their phone.

We might need to help them think about how they can use reminders. I don't know if anybody has a Google Voice or a Siri or all of those things. I've worked with many

survivors who use Siri for so many things. And we'll say-- you know, I have a survivor who's flooded her kitchen two or three times, because she'll turn on the water. She'll be doing dishes, turn on the water, go run and grab something-- remember multitasking?

Oh, here comes somebody at the door. I'm running multitasking, but I'm going to remember. Oh look, memory, I'm going to remember that my water is on. So I'd run off to the door and then come back to the task I was doing. She'd flood her kitchen, because by the time she gets to the door she just totally forgets what she was doing.

I want to say-- I want to check on these questions. I know Nicole says creating a plan of action required reminders and encouragement. Deanna asks, "Can brain injury from DV cause seizures later in life?" There's every reason to think possibly.

Yeah, absolutely, I mean, I think that brain injuries can cause seizures. I think that's the other thing to understand about what we know about-- there's still a ton we don't know about brain injury and domestic violence, because again, a part of-- in order for us to learn and have some of this research, this is an issue that has to be identified.

We didn't know anything about breast cancer until breast cancer had a name and was identified. Somebody discovered it. So I think that that's one of those things. But one of the issues that we were having-- and actually, we're probably going to hear from a survivor who's going to talk a little bit about her experience, which is just again, like having these seizures and nobody knew why. And nobody thought about her past history of abuse. And nobody asked about the head trauma.

Sometimes we know that the way that these brain injuries-- when we think about brain injuries, a really want to think about brain injuries as more of a chronic condition as opposed to an acute condition. A chronic condition-- I might have this later. So if we see this later in the slide, I just gave it to you a little bit earlier.

But brain injury can impact people for a long time, even after the injury. Thinking about an acute condition could be something like a broken arm, where usually for most people-- I mean, there are some people who have long-term problems due to the breaks in their arm.

But most of us if we break our arm, we get a cast. We get it fixed. And then it's like better, you know what I mean? Our broken arm from when-- my daughter broke her leg when she was two. She's eight. She has no long-term impacts for that. She doesn't remember her leg being broken. It doesn't impact her daily life.

Other health conditions like chronic health conditions could be things that are more-- like asthma, diabetes, high blood pressure are things that can continue to impact you across your life, can obviously be controlled and can be managed. We think about how important it is also for us to know about some of the health conditions and know about

what our challenges are and knowing about one of our-- what our limitations are, so we're able to better plan for that.

But it's just essential. It is impossible to get your diabetes under control if you don't know you're dia-- you don't know-- well, I guess you could eat super healthy and get diabetes under control that you didn't know you had. But thinking about how important that information and education and support is from other people, that's kind of parallels the idea of accommodations and really thinks about how it's recognizing that we're not going to be able to support everyone in the same way, that people are going to need different types of supports in different ways and in different contexts.

So we'll be talking kind of about this accommodations framework. You know, I think that the other thing that's really, really critical for us to understand when we talk about brain injury and the role of brain injury in the clients and survivors that we work with is that this absolutely impacts a person's access to our own services. This is not necessarily something—

And I wish it was as easy as-- and like I said, this is the difference with a chronic condition. I wish it was as easy as oh, somebody has a brain injury. You send it over to them to that doctor. They fix it, and then they're all good. You know, this isn't strep throat. This isn't like, you get your penicillin and in 10 days you're good. There's this really obvious thing that you can do.

This impacts us. I think that the other piece-- I know that we have people who work in substance use and work in addictions. I think the other piece we've been talking about a lot-- I'm thinking about people who have co-occurring substance use and mental health and domestic violence and trauma and all of those things. If you're working with people who have overdosed or many people have overdosed multiple times, often what happens when people overdose is that they stop breathing, right? So they have a short period of time or sometimes a longer period of time where their brains are deprived of oxygen, very similar to being strangled.

And often when people overdose-- very rarely, sometimes-- I mean, if it's an emergency situation and the emergency squad is called, people get medical care. A lot of times people don't get medical care. A lot of times it's never told to anybody. So thinking about even people who have a history of overdose, that being one of those things could very, very much-- could very, very much be a piece that could be impacting the survivors, for survivors and what it looks like.

I know Dena's sharing that they don't have forensic nurses in every position. "That's where it gets hard. The hardest part was finding a medical team that worked together and communicated openly about what was happening to me. And her professionalism was huge for my healing. Things like this training will be lifesaving. Please network with colleagues to create a team that you can case communicate with.

Second big thing, we are not stupid or children. I know that some providers they are just talking caring but watch your tone. There's a way you talk to a child. And there is a way you talk to a hurt adult. It personally took time to find a provider I felt safe with, because it took me time to get a provider that was a survivor. Survivors hide what happens for many reasons. Development, social beliefs, and environment all have an impact on victims actually talking about things."

So again, I think that that's very true. When we talk about sometimes people having challenges with things, talking to survivors in a way that's empowering and in ways that are respectful and really building that trust are so essential. And I think even Dena's talking about some of those accommodations that she needed and some of those supports that she needed. She needed people working together for her. She needed people to talk to her in a way that was respectful but also kind of acknowledged what some of those limitations are.

And I think that this is also-- this brain injury piece is, like I said, one of the missing pieces. We've talked a lot about trauma and trauma informed approach. A trauma informed approach is based on the recognition that many behaviors and responses expressed by survivors are directly related to traumatic experiences.

They are. They're also-- some of the things, behaviors and responses, can also be related to brain injury and to experiences and some of those cognitive impairments or functional limitations that result from brain injury. So we really are taking this trauma informed approach with domestic violence survivors but really expanding that.

Like I said, I spent seven or eight years doing a statewide training on trauma informed care and trauma informed approaches and never once mentioned brain injury ever. It just was not a part of the function. So when we think about-- and we can't divorce or separate trauma from brain injuries caused by physical violence. It's not possible.

And we need to be looking at how are we looking at brain injury and trauma together. How are we looking at how treating trauma needs to take brain injury into account? How are we looking at treating brain injury and needs to take the traumatic roots of that brain injury into account?

And that's something I wish I could tell you that I had all of the answers and had this all figured out. I very, very much don't. I feel like-- I don't know if you've ever seen those pictures where there's this mountain. And you're standing at the bottom of the mountain and you're like, oh my gosh, it's so big.
But I do think that-- I didn't even know there was a mountain five or six years ago. And now we do. And that's a start. And there's going to be a lot of work we're all going to need to do together to think about this.

So what I'm going to do now, I'm actually going to-- give me just one minute. I am going to show off my incredibly high-tech abilities, which I totally shouldn't say that now. And

we're going to watch a very short video of survivors, three survivors, all of whom I know personally. I'm kind of sharing about their experiences with head trauma.

Let me stop this share and start a new share. So I will let you know, these are survivors that, again, are sharing how their heads were hurt in domestic violence. So it is words from survivors, hard to listen to, hard to listen to because it's real.

But I think it's really-- one of the things that we have to understand is kind of the breadth and depth of what it is that this looks like. So I'm going to introduce you to my friends, Nina, Rebecca, and Paula. They are-- this video is only a couple of minutes long. But we'll hear from them a couple of times here in this training.

OK, Jen, thank you. Jen gave me a-- I'm sorry if there were black boxes on there. Sometimes these work well. Please-- I was afraid to check your message, Jen, because I was like, there's going to be a black box.

Let me try sharing this real quick in the right way that I think maybe has helped with that before. So please feel free if anybody wants to share in the chat box kind of what stuck out for them. Ooh, hold on, look at this. I am feeling very high tech with some of these things. And I'm not on video anymore, sorry about that, too many things at the same time.

But really talking about what that violence looked like, I think Paula really talks about that integration of psychological trauma and neurological trauma. But it just again, the vast majority of this is kind of what that looks like. And we're going to spend, like I said, just a few brief minutes.

I think one of the things-- we can't take the context out of this issue. Again, sorry-- sorry, just got to keep [INAUDIBLE]. We can't take the context out of this issue, and really recognizing that this violence is occurring in the context of-- this violence is occurring in the context of this dynamic of coercive control and this pattern of assaultive and coercive behaviors that includes all these different types of behaviors.

I know when we talk about violence, physical and sexual violence, many of you might be familiar with this. This is called the power and control wheel. Intimidation, emotional abuse, isolation, there's lots of different ways in which this pattern of coercion and control happens and what it is and what it looks like. So I think that that's the other thing is we're really recognizing that there's financial abuse and financial manipulation.

There's emotional abuse. There's all of these different things. There's threats and there's intimidation. And there's also a part of what we say, that manipulation that involves people apologizing and saying they're sorry and they're going to change and it's never going to be like that again, really thinking that is being just another form of manipulation and another form of control.

But you know, I want to spend just a couple of minutes talking about a couple of other pieces when we talk about mental health and substance use coercion. And coercion is such a key part of domestic violence. I would almost encourage you, if I were to pick one word to connect with domestic violence, it would probably be coercion, because then what coercion really involves is somebody really kind of forcing you to do something or abstain from doing something against their will.

So I think it's funny when people say, well, people choose to stay. There's not a lot of choices in domestic violence. And if you're in a relationship where you can just leave and nothing bad happens, then you're not in an abusive relationship. But it really is that whole being prevented from doing something that you want, not being allowed to do something that you want, and using force as an equation in that. Sometimes that's physical force. Sometimes that's—

I think one of the other things I wish people understood about domestic violence that they often don't, and I think many survivors also share this, is that the only way force is used-- it's not always like, oh my gosh, it's scary. And it's awful. And it's terrible. And I'm going to beat you up.

Sometimes it's very manipulative and very sweet and very like, oh well, if you care more about your friends than me, I totally understand. I'm so glad that they love you so much. And I'm sorry that I can't do a good job as they can.

That's two sides to the same coin as someone being like, I'll beat you up if you go out. I think it's just a different tactic. And different people use that effectively in such a different way. And that's one of the ways that keeps domestic violence victims so kind of off balance.

We talk about substance use coercion. And for those who are behavioral health professionals, that substance use coercion, which is where-- we often see many domestic violence victims who are impacted by substance use. One of the things that we've learned more and more is sometimes this is a very intentional tactic, because if you are-- it's very, very easy to control somebody who has an addiction. And it's an incredibly powerful tool of control.

So substance use coercion, talking with survivors who have been-- that their partner introduced substances or forced the survivors to use more than they want worked with survivors who are working in or they're trying to get in recovery. They're trying to get help for their substance use. They are trying to undermine their sobriety. They won't come home. They discourage meetings. They do that kind of stuff.

When you think about that dependency and debility, like really-- I've worked with survivors who have had substances, like gotten unknowing to them addicted to substances, because their partners were giving them things that they didn't know about.

Really thinking about controlling access to treatment and services and undermining some of those relationships, substitutes can be a very powerful tool.

When we think about if somebody wants to reach out to the police or reach out to-- needs help, needs protection, it might be using something that's illegal. So I just-- I think that's one of the things that's thinking about sometimes people's behavioral health is very intentionally a target of abusers. And when we think again how substance use, mental health, all of that coercion, those dynamics of domestic violence can play and can kind of line up with brain injury, I think that that's one of the things that's just really, really critical for us to think about and talk about with survivors and really address that.

I know I'm looking at some of the questions. I know somebody said, "Can you speak about the effects of children who witnessed this at home?" Yes, and then two questions, I'm going to read both these questions. And then maybe I'll address both of these.

Let me talk about that one first, the effect of children who witnessed this at home. I think it's obviously not good. I think that one of the things-- I think there's a couple of pieces. There are children who-- sometimes we've actually moved away from using terminology, children who witness domestic violence, because a lot of times people are kind of talking-- I don't know if exposure is a better word.

But sometimes children are also very directly get involved in the domestic violence. Children are hurt when parents are hurt. Children try to get in the middle of abuse to protect their parent that's being hurt. Children try to stop fights.

Children see the aftermath of-- even if they don't physically witness the abuse, they see their victim, parent, being hurt or being upset. They see things being broken. They see all of those kind of things.

So it's a whole other training. And I can absolutely point you towards-- I encourage you, if you want to follow up with me, I'll make sure you have my email address. We do have somebody who specially works with children, kind of issues related to children in domestic violence.

It's going to be very individual. It's going to depend on a ton of things. It's going to depend on a kid's age. It's going to depend on what other protective factors, what other supports they have in their lives. What are their strengths? What are their assets? It's going to depend on what the response has been. It's going to depend on how the victim parents is impacted and how the abuser or the person who's hurting the other parent, kind of what those relationships are.

So I think one thing that's very-- one of the things that we do know is-- and again, most often we know that domestic violence victims can be men and can be women, can occur in same sex relationships, can occur among LGBTQ communities, occur at all racial and ethnic groups, occur among all ages. We know that women, particularly

talking about women who experience head trauma and head injury, survivors of abuse who experience severe physical violence, including head trauma and strangulation, are almost overwhelmingly women.

What we also do know is one of the most important protective factors or things that help buffer the impact of abuse is strong relationships with adults who care about them. So in some cases, one of the worst things that can happen is a domestic violence victim or a child being removed or not having access to their parent who has been victimized in abuse. So it's really, really complicated.

But one of the things that I encourage us to think about and I encourage us to recognize is a lot of times what happens-- I'm going to go back for two seconds. And then we're going to-- we're going to go back for two seconds and look at this power and control wheel where we talk about one of the chunks of this power and control wheel is on using children.

I think that we are fooling ourselves, that we're lying to ourselves if we say, if we think that leaving an abusive relationship or escaping an abusive relationship again, which I think is probably a better word to describe it, means things are automatically going to get better with children. Somebody who you have children with, you're connected with. You can be connected with for life.

Often we see sometimes that use of children around that power and control can get worse when a survivor leaves before it gets better, because that's still my access to you. And I remember when I worked in shelter and we would have kids that had to go on visitation and just would come back, and it would be such a terrible adjustment to come back to shelter, and the kids often get very intentionally put in the middle. Abusers often very intentionally try to sabotage kids' relationships with their mothers, again, because that gives them more control.

But I think that that piece is really, really important. And please follow up with me. And I'll connect you with-- there's lots of good resources. And I might actually try to get a couple of those and maybe I'll get those to Jennifer or Isa just to help think through that.

But it is also going to be very, very individualized. And I think again, like I think kids, they need to be-- their hurts and their harms need to be acknowledged. I think one of the things we don't even know about brain injury and children, and we didn't figure out a way to kind of collect this research in the research that we did, was I mean, there are children whose heads are hurt during an abusive incident, that I've worked with children-- many mothers have been assaulted when they're holding small children.

There's a huge number of individuals of kids who get in the middle of an abusive relationship, of abuse, and try to protect someone. And their heads end up getting hurt, which again can have long term consequences, particularly when people's brains are still growing and changing.

I know the other question asked, "Have you noticed any link between the frequency and level of violence as violent pornography has become more normal and easily accessible?" Absolutely, both of these questions could be total other trainings, but really thinking about the whole issue of particularly strangulation and sex—

I actually worked for many years with a sociologist who actually studies porn. I know that sounds weird. But just kind of-- and again, from a perspective of-- porn is so much more accessible and so much more incredibly violent than it was for decades and decades and decades. And one of the things that's really doing is that's teaching our younger generation about what sex is and what it looks like and what consent is and how normal people have sex.

So in thinking about that whole role of strangulation, oxygen deprivation, and head injuries, and thinking about what consent looks like that, there are actually states that have laws that like when you talk about consensual relationships, that you can't consent to something that is deadly. So there are states that have kind of penal codes, that strangulation, like you can't consent to it. You can't consent to somebody burning you. That that's just not really possible, if it's a deadly act.

So I think that that's another thing, even if those were-- you know, I'm going to date myself. I'm older. I will be 44 this year. But like when I was a kid, I couldn't just have my phone and type in "porn" and like get a bunch of stuff, you know, very, very different. So I think that that's another issue that is important for us to think about.

And thank you for everybody who's putting comments in the chat box. And I will make sure to connect some of the DV and kids information. And there are some links on our website, too, that I can point you all toward.

All right, thank you all for your questions. Please feel free to keep them coming. I think what-- sorry, clicked on the wrong thing. I think what we're going to do now is really transfer into talking for just a few minutes about thinking about concussions or traumatic brain injuries and what causes them.

And I think for a long time we've had a few different causes that most of you-- if anybody, if you want to put it in the chat box, feel free. But most of us when we hear concussions-- concussions is just you know, another term for a mild traumatic brain injury. Concussions mean mild traumatic brain injuries. We'll talk about defining traumatic brain injuries in just a minute.

But most people-- I think the first place I usually get when people say-- what's the first thing you think about when you think of concussions? People say "football." We've talked a lot about sports concussions, particularly this past year in the NFL. And thanks, Jeff, for putting my email address in there.

But people have thought about concussions in the context of car accidents, in the context of military service. If any of you are old enough to remember when the United States had a large over sea presence in the Middle East, there was lots of talk about a blast explosions from IED, improvised electronic devices. And people are wearing helmets and there's a blast explosion. And their brain kind of rattles around in their helmet.

We don't have good data on domestic violence and brain injury. But the best estimates-- we're just starting to figure out even how to collect that data, that for every one NHL player or hockey player, another source of concussions, around 5,500 survivors of domestic violence sustain a brain injury every year.

So just when we're talking about sheer numbers, well, we don't have them. And I mean, you're never going to have exact numbers for something like this. It's astronomical. How many more women and people will be hurt in violent relationships, their heads will be hurt, than any of these other causes?

So when we talk about what is head injury look like-- and we'll talk about some of these ways to talk about it, some of these questions we can ask, some of the ways it's important to just also provide information. I think that the other piece I want us to be thinking about when we're talking about approaching how we talk about-- another thing in how we talk about brain injury, how we address possible brain injury within our services, is talking about it is one way. Also providing access to information and resources for survivors without them having to talk about it with you is also very important.

As we said, some of the stigma, some of the shame, some of the very, very real reasons that survivors have to not trust us and not share all of the information with you, but it's things like, have you ever been hit or hurt in the head. You've been hit in the head with something. You've been pushed. Somebody's been pushed into furniture or walls.

You've been made to fall, even violent shaking-- we'll talk about it. I know we talked about in the last session what happened when you're violently shaken. And your brain is made out of jello-like material, packed very tightly. And it's got kind of some liquid and tissue around it that keeps it nice and tight within our skull.

What happens when somebody shakes you real hard-- I don't know if any of you remember shaken baby syndrome? Shaken baby syndrome is actually the old terminology right now. Shaken baby syndrome is no longer called shaken baby syndrome. It's called abusive head trauma.

So we talk about abusive head trauma. What happens is the baby's brain really jiggles around in its head and bangs up against the skull and gets hurt. When someone is-- they would put your hand up or your head's around their neck, slammed your head into

something, or done something that made it hard to breathe, those are ways in which people's brains can be hurt or impacted.

We talked a little bit about how overdose can cause brain injuries. I know Dena is talking about chronic traumatic encephalopathy, which is kind of a-- I don't know if any of you have heard of CTE, very much connected to a degenerative brain disease, very much connected to football players, only diagnosable upon autopsy, upon death, but very, very high levels. It's got different ways in which the brain has been impacted. We're not at the point where that's something that could be diagnosed in a living person, but lots of different impacts of that.

We want to also acknowledge that brain injury changes how survivors think, feel, and act. And we are going to once again take just a couple of minutes to listen to Rebecca, Nina, and Paula teach us a little bit about and share with us their personal experiences. The question that-- I don't even think I actually asked them any questions. We just talked.

But one of the things that we talked about was what were some of the things that in hindsight you might have noticed when-- what does it look like to be living with an undiagnosed brain injury? So I'm going to pull this up. And it's just a couple of minutes. And we're going to watch this here.

So I know that kind of thinking about that, we've heard some of these things mentioned. And if anybody wants to share in the chat box, I'm going to get back to-- I'm going to get back to the PowerPoint. But please share in the chat box what stuck out to you.

But I just think if you think about that list of things that people were seeing, I know we've talked about how sometimes this stuff can look like substance use. Sometimes this stuff can look like
-- these are just these really, really difficult survivors who can't get their act together.

I think one of the things that always sticks out to me, and I've watched that video several times, when Rebecca says, this is what people were saying about me that I didn't necessarily notice myself. Everybody talked about aggression. And you just think about how many survivors I have worked with in my life-- I'm just like, why are you so freaking angry? You know what I mean? What did I do to you? And how that gets portrayed, how that gets played, what it is that that looks like—

So I just think that if you think of somebody, if you think of somebody who has come to get your services and has had some of these symptoms-- I'm sorry, I just have to-- [INAUDIBLE]. Let me share this again one more time real quick. So I forget to take things off. And then we can see things weird, things in certain ways.

But people could have challenges. If they come in to our services looking like what Nina-- or this is how they show up at every appointment, those are, again, can be very

challenging for us. And sometimes we think, again, people just need to get their emotions under control. People just need to pay better attention.

We even think about Nina talking about how she's bumping into things and her balance is all bad. That's a problem with her vestibular system, the vestibular system in our system, in our body, that makes us be able to walk all right and our spatial orientation, so we can walk around the room and not bump into things.

Those kind of things, when we don't start bringing the stuff up-- dizziness and those kind of-- the problems with orientation, it doesn't matter. So many of them talk about how these things get misdiagnosed as other things or get misattributed to mental health to other things. Best therapist in the world is not going to help your balance problems. And thinking about that, how that could be impacting her life-- so thinking about some of the physical symptoms, the sleep problems, and there is absolutely an overlap between trauma and brain injury for lots of reasons, but especially because this is a traumatic cause of brain injury.

There are some of these symptoms, and we'll talk about that a little later, that might lean towards more trauma based, others more brain injury based. When we're seeing people who are having sleep problems, problems with eyesight or hearing-- the survivors I remember who used to come to my shelter and walking around in sunglasses, that should have been something I should have picked up on.

And I think, again, when we talk about the intersection between-- there's something different to somebody being triggered, like when we talk about a trauma trigger, like I'm triggered by a sound, which kind of evokes a traumatic memory. There's also people who sounds gives them headaches, like I just can't handle and process sounds. Or I'm wearing sunglasses, because I'm sensitive to light because light hurts my eyes.

Trauma usually does not make light hurt your eyes. That is a brain injury problem. That is a problem connected to, again, the occipital lobe, which is the part of our brain that is responsible for our vision. So these are just some examples of what some of those physical symptoms are. And I think that these are things in domestic violence we've asked less about.

One of the reasons I think that these are really, really important is if you are not feeling good, if anybody's ever had a problem and they are-- again, you're having vision problems, you're having headaches, you are feeling tired, you're nauseous, you can't sleep, your mood is not great, and you don't think great-- I mean, like that's just when you're sick or when you're not feeling well. Those really contribute to more difficult emotional issues and more difficult cognitive issues.

So this is what some of the emotional symptoms might look like. People becoming easily frustrated, upset, or agitated. We heard everyone talk about that aggressive,

those mood fluctuations, those impulsive decisions. Again, a part of that is-- there's trauma basis in some of this stuff.

But that's also the brain's job, part of our frontal lobe's job is to be like, wait, wait, wait, wait, wait, wait, wait. I know you want this. But we had a survivor, I remember, at shelter who got her monthly disability check and spent all of it on steak for everybody. And we were just like-- again, thinking about trauma and trauma informed approaches, we shouldn't have asked what's wrong with her. We should have asked how is this connected with what happened to her.

But it's like-- how many survivors I've worked with who have even done things like that and have been very, very upset and very frustrated with themselves, because they're like, I knew better. I should have made a better decision. And but just thinking like, I can think myself, helping survivors acknowledge and be aware that sometimes one of the things my brain's job is to do is to help us control our impulses, and if we're having challenges doing that, let's plan about it. Let's think about it.

I work with survivors-- Paula talks about when she is going to make a big purchase, she has somebody that she consults with on it. She's like, I just buy all these things impulsively. That part of the brain that helps me control that is just not working well.

But these are what some emotional symptoms can look like. And then I think these cognitive symptoms are so important. When we talk about people who have cognitive deficits or cognitive problems, we often take this for granted when we're providing services. We assume that people can really think clearly, plan clearly.

If we see somebody who's saying that they're taking longer to think or find words, somebody who speaks very slowly, this is another thing that sometimes can get confused with addictions or substance or mental health. Somebody has a really hard time expressing their thoughts. Again, that's a part of our brain that turns thoughts into words. That's a brain function.

Being able to get started on tasks and following through-- so we're supposed to get a job. We're supposed to find housing. What is the very first thing you do when you need to find housing? The very first task, think about that. My brain is what helps me figure that out.

Thinking about those risk assessment or judgment-- many survivors who have been like, I don't know why I was dating that person, because I kind of knew that was not good for me. But I did it. Judgment is a brain function. So that's what some of these things may look like, not starting through or following through on plan, which is obviously very, very frustrating for people who work in domestic violence.

What I'm going to do now is I'm actually going to switch gears just a little bit, because I want to get to talking about some of the hands on stuff, about thinking about addressing

head injuries within your organization. You will see some extra slides that will get sent out, and it's because I knew that-- I knew that we weren't going to get through everything. But I wanted you to have some of that information hoping to do more.

I want to have-- Emile, and I'm sorry if I didn't say your name right, it says, "This has been so eye opening and a good experience for me. Thank you so much for putting this together. I am a survivor who is now a DV advocate. And I myself have been through a journey with thinking I am dumb or why am I so unintelligent all of a sudden and questioning my capacity at all, and thinking maybe I was in a dream where I thought I was capable but I'm really not, just questioning my entire existence. So I am so thankful to have heard other stories that link closely with mine.

No one ever told me the three years of ongoing, weekly strangulation was slowly killing my brain. To some it's common sense. But to me I thought we were just trying to make a family work. So just thank you so much, you have no idea how much I needed this. I have balance, eye, and cognitive issues. And I finally have answers."

Thank you, thank you so much for sharing that for me, Emile. And again, this is why-- I think that it's not about we are not trying to diagnose brain injuries for people. We are not trying to do any of that stuff. But what we are trying to do is really help put this on the table and so Emile and Nicole and Dena and all of the survivors that we work with aren't thinking, this is me, this is a problem, I'm stupid, I'm crazy.

Like maybe I thought I could do things, and I can't. Maybe I've always been like this. But I know I haven't always been like this. A part of this is what I think-- and there was a video, another video that I played last time that Paula, who you've heard from a couple of times, says, had the right person had the right knowledge, this all could have been avoided. And I think you are the right people with the right knowledge around this, kind of really thinking about that.

So how do we do this? And I think it's recognizing that head injury really impacts survivors' daily activities. It impacts things that we do on a daily basis and can make it difficult for survivors to take care of themselves and those that they care about.

I encourage you to listen to Dena, who told us to make sure that we talk to adults and we talk to children different. This can take us to a very paternalistic place. And that's not where we want to go. But what we want to acknowledge that some of these things might be harder for survivors to do, and we might need to support them and accommodate for these needs in a different way and help them get the education and information that they need, so they can be empowered, so they can know where some of those—

I think all of us have-- I always say, like if anybody on here doesn't have any weaknesses, we all have strengths and we all have weaknesses. We all-- I always like to say, I'm a social worker. So I like to say opportunities for growth. We all have opportunities for growth.

But it's helpful for me to know where my holes are. I am somebody who gets lost everywhere. So if you get lost everywhere and you know you get lost everywhere, you have a lot of ways in which you navigate that. So I always get my directions where if anybody is like, you turn right at the gas station then turn at the green house, like I'm not one of those people. Don't ever tell me to go East somewhere. I'm like, who freak knows where East is.

But having that information, having that knowledge, knowing that sometimes remembering things is hard, knowing I have a hard time figuring out what the first thing I need to do is-- and we can help them with that. And I can think about how I can integrate that into my life and how we can also help that get better. But these things that can be harder, things like self care and education, and even managing health and managing appointments-- I mean, you think about that list of cognitive issues, being able to remember to go to a doctor and get there and take the medication and all of those kind of things are so important.

You know, I know Nicole says, "giving yourself grace and learning to recognize that." We all-- there is no lack of grace. And none of us are supposed to be perfect. But I think it really can help and it's very empowering for us to know this thing is challenging for me. And I need this help with that. And then that can help me live my life better and for me to know it's not me, it's not because I'm crazy.

It's not because I'm stupid. It's because somebody hurt me. And that wasn't my fault. And I didn't do anything to deserve that. Even that message can help so many survivors.

Also, I think that just starting to mention these things, starting to provide information even as simple as saying, do you know that when your head is hurt, your brain can be impacted? Oh my gosh, that feels so obvious, doesn't it? It's so obvious after the fact.

But that's not things-- we have so many survivors reach out to me. It's been 10 years. And they're like, I've done a lot of emotional healing. And I'm in a new relationship. I'm happily married. But I'm still having problems at my job. And I have to read everything. I read three times. And that's like-- could this be related to that? Absolutely it could be.

So what we have done-- I think we're always want to ask a couple of questions when we see anything. It might be asking like, if we're having any problems, what might have happened from the client's perspective? And what might help?

And what I want to do is introduce them-- my last few minutes introducing you to this framework we developed called CARE. We have lots of information and materials and resources around CARE on our website that I will take you to and show you to in just a minute that all are free, are available in English.

[SPEAKING SPANISH]

I was just saying, we have them available in Spanish, too.

But it's really this framework to help us and a toolbox. So I want you to think about this as a toolbox. I don't want you to think about I have this one form and this one set of questions that you ask everybody the first time you meet them, and that's going to work.

No, this is an approach, because we know people need individualized services. We know people are different. So this is a flexible framework with a toolbox. Sometimes you need a hammer. Sometimes you need nails. Sometimes you need a saw. And providing you with some of those options—

And CARE is an acronym based on-- CARE is an acronym that the C stands for Connect. And it really starts by that relationship and rapport building and building that trust. That is an essential foundation and framework. I know Dena talked about that, how important was that connection in that relationships. If we do not build that foundation, everything that we do, we are going to be building a house on a basement that wasn't done right. And the house is just not going to work.

So we have to connect with survivors and that rapport building and that relationship building and get to know them outside of their abuse. Domestic violence survivors have experienced domestic violence. They have lots of other things that they are and that they do and that are important to them and that they enjoy.

We want to acknowledge that head trauma and mental health challenges are common. We want to give information and education to survivors. We want to give them information about this. We want to ask questions about head trauma.

If somebody is sharing with you about physical abuse or we know they have been physically abused, asking about head trauma, asking about health issues. We know there's issues related to recent head trauma and also long term head trauma. If people have health issues, how sometimes their brain injuries can be contributing to other health issues is just a really, really important connection to help survivors make.

And then we talked about identifying for this person what are the physical, cognitive, and emotional challenges. How have this impacted them physically and cognitively and emotionally? And that's going to look different from everyone.

We talked about accommodations earlier. But our response is really around accommodations within our services, about again providing support in a way that survivors can get what they need. So we're accommodating needs related to traumatic brain injury, strangulation, and mental health challenges and thinking about what kind of additional, accessible referrals and advocacy for individuals who might need additional care, might need to connected to the medical system, might need to be connected to a

therapist, might need to be connected to assistance and seeking some of these additional services, might need to be connected to disability services, kind of thinking about how are we providing those referrals. And again, remembering when people have cognitive issues, it might not be as easy as, oh, here's the phone number. Go figure that out yourself.

And then the E comes back to Evaluating these accommodations. One of the things that we can do, if any of you work in shelters, is how do we help people sleep? That's one of the most impactful things, one of the best things you can do for your brain is sleep.

And if people are having problems sleeping, we've had shelters who have done things like provide eye masks and earplugs, and helping people wake up when they need to be waked up, and helping people kind of set that sleep schedule. How do we figure that out? How are we supporting people?

And we're evaluating these accommodations and referrals and seeing how they're working. And guess what? Like I said, we all need to have grace with ourselves. Even as advocates and as professionals, we're not going to get this right first shot.

We have to try lots of things. This is a trial and error game. This is not like, again, that you can do the same thing for everybody and then everybody does this and then everybody's all good. That's not what it looks like. It looks like well, let's see, if we provide a referral to a medical provider, were they able to get in to get an appointment? Were they able to have their concerns addressed?

Did we even talk to them about what might be some of the things that they should be sharing with their medical professional, even thinking about are we helping them by writing down some of the concerns? I don't know if any of you ever choke when you go to a doctor. I sometimes do. Or I forget the one question that I wanted to ask.

How are we sharing some of that information? We have some tools to assist with that. We do have a promising of-- about 15 pages of guide, a promising practices guide, that I will connect you all to about this. But this is our CARE framework. And we talked about accommodations, really thinking about all those different accommodations.

I did want to show you-- I'm going to check the chat box real quick. I did want to show you some of these CARE tools that we have available. We have availability-- I'm sorry, that we-- I got myself too distracted. I will get in chat box again in just a minute.

But these are some of the CARE tools that we've developed that are available at odvn.org. I am going to actually get out of here and go to our website, just so we're able to see. Jen, thank you so much. I'm going to pull these up. But I'm just going to navigate.

I like to think-- again, this is a part of what might be different. And I'm not saying everybody here-- this is like probably not the best brain injury analogy. But I could just give you all the website and you all find it, right? You all can figure it out.

Our website-- I like to think it's pretty easy to figure out everything, but not always. I think it's instinctual. But if you go here to Our Work-- this might, again, be the difference between just being like, well, go to odvn. Google me, figure it out.

But go to Our Work. Click on Brain Injury right here. You see there's a whole page on the Center on Partner-Inflicted Brain Injury. There's a link to a short video. There's a couple-- I had to-- I have to update this and put a couple of-- Here's a link to a recording. I was actually on a national NPR-- National Public Radio has a show called On Point talking about this.

And down here we have more information. We have brain injury materials. These are our brain injury materials. We have educational materials up here and then some service provider materials down here.

So I would just give you an example of one of them. [INAUDIBLE] the Invisible Injuries booklet. We have a booklet that's about what happens when your head is hurt. It has topics in it like what is a head injury and what does it look like. When there is a change to how your brain normally works due to [INAUDIBLE] to the head, what causes the head injury, right after your head has been hurt, what can you expect, what are some of the warning signs—

Here's a log, a symptom log that people can use. We have a whole page on strangulation. We very intentionally don't have separate strangulation and TBI materials, because most survivors experience both of them. Common problems after a head injury and what you can do to help-- this is kind of like a workbook, an educational workbook for survivors.

We also have tips for anyone with a head injury, what can help you, some planners and calendars. So that's just one resource. I did want to point you towards a couple of other things.

You'll see right here we have-- this is what I was talking about, some promising practices. I feel like-- I don't know if you ever heard of kind of best practice framework. I always am just like, who's the best judge? Who gets appointed to decide what's best? But these are really some promising practices that we have that talks through our CARE framework, about an overview of partner inflicted brain injury, just about three or four pages, and then some policies and procedures that you can consider including.

We have some accommodations. We talked about accommodations. Here's an accommodations checklist about how you can think of accommodations if people are having problems making connections. Here are some ideas to help with that.

If people are having physical health problems, here are some ideas and thoughts. We talk about emotional challenges here. We have challenges related to getting things started or figuring out what to do next, understanding things, paying attention. So please feel free to download and look at those.

We also have a tool called chats that has some direct questions about brain injury, about possible brain injury, questions like has anyone ever put their hands around your neck, put something over your mouth, or done anything else that made you feel choked, strangled, suffocated, or like you couldn't breathe? This is just-- sometimes like I said, sometimes having a series of very direct questions will be helpful.

Depending on and your services, I don't think-- I'm not like, everybody should use [INAUDIBLE] chats within three days of somebody coming in to shelter. You have to figure out what's best for each person. You have to figure out what's best for your services and what makes the most sense.

But chats does come with a guide. It has a little section for referrals, in case anybody wants to take this to another appointment, a medical appointment or a behavioral health appointment or whatever. It also has a guide on how to use that.

And we have some more, again, educational materials. We also have a course. It's an online-- it's an e-learning course. It's a seven-part series, that you'll hear some more from Paula and Nina and Rebecca in there. Each module is-- what do they call it? Modules is about 10 or 15 minutes each, so made for advocates.

So please feel free to check all of these out with more information. I'll put it in the chat box again. It has been evaluated by Ohio State, the Ohio State University, as an evidence-based based practice and has really shown to increase trauma informed practices.

I know it is 3:29. And I'm supposed to save a minute for Jen. But I'd like to thank you to all of you for your participation, particularly to the survivors who shared with us, who shared this with us. I just thank you. You all have made such an impact on me and on each other. Thank you for trusting us with your stories. And we're very proud to know you all.

I'm going to put my chat box. I'm going to put my email address-- I know it's been in there-- in the chat box, in case anybody wants to follow up with me. Please don't hesitate to do so. And I'm hoping to see you again at an event soon.

So thank you so much, everybody. I hope you have a wonderful rest of the day and a wonderful rest of the week. Everybody, just keeps swimming, just keep plugging along and know the amazing power you have to really help survivors learn to think about this and help our agencies be more accessible to everybody who needs them.

PRESENTER: Thank you so much, everybody, for being here. A couple minor things, we put a link in the chat for a very brief survey. These surveys allow us to continue to provide free trainings to you all. So they're very important to us. They just take a quick moment. You will also be automatically redirected as we close out this session. So thank you so much for taking that.

As I said that, we will email you-- it'll probably be tomorrow-- with a PDF of those slides. And Rachel has put together a great fact sheet for us.

RACHEL RAMIREZ: I forgot. We have a fact sheet that's super cool. I totally forgot. I remembered that at the beginning. I'm glad you said something, Jen.

PRESENTER: Yes, so I will include that in the email as well. And all of this will be on our website as well. So please share the fact sheet, share the slides, share the recording to any and all of your networks and people, and direct them to our website for those documents and those resources.

And yeah, we hope that we can-- yes, Melanie, you can rewatch it. I'll put the link in that email, so you will receive that email tomorrow. And all of the recordings will be on our website.

So we hope to see you again at a future training. But I will be in touch via email. And I have all of your emails through your registration.

RACHEL RAMIREZ: You'll get my email, too. Thank you all so much. Have a great rest of the day. And if there were any questions anybody had or anything comes up, please don't hesitate to reach out.

PRESENTER: Thanks everyone, have a great day. Bye bye.