‘SAFER WHEN, SAFER HOW?’

TRAUMATIC BRAIN INJURY AND INTIMATE PARTNER VIOLENCE IN AOTEAROA

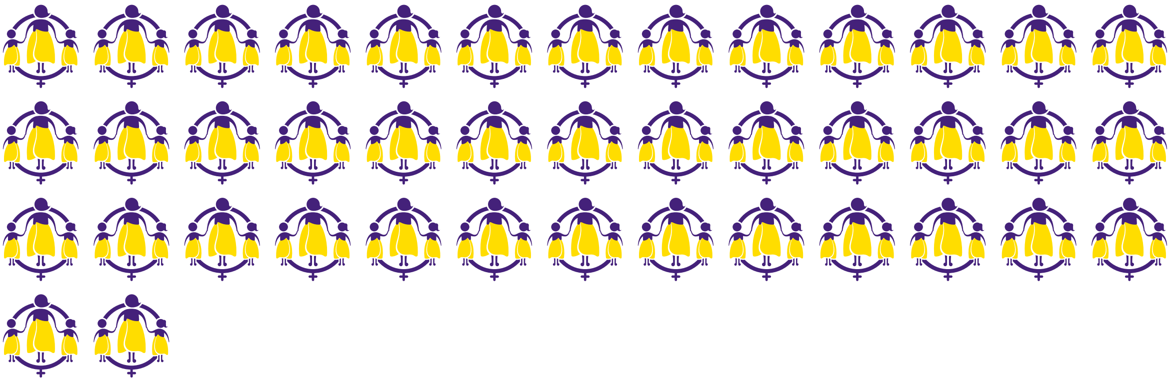
2025

WOMEN’S REFUGE

Women’s Refuge

The National Collective of Independent Women’s Refuges - Ngā Whare Whakaruruhau o Aotearoa (NCIWR), has been providing support to women, children, and whānau impacted by family violence for over 50 years.

Our vision is for all women and children in Aotearoa to live free from family violence.



NCIWR comprises **41** affiliated Women’s Refuges and is the largest nationwide organisation providing immediate crisis and long-term family violence specialist advocacy to women in Aotearoa.

Thank you

A huge thank you to everyone who took part in this research. You are the source of knowledge for this topic and have directly contributed to what is known about traumatic brain injury inflicted by intimate partner violence. This report is dedicated to you, and was only possible because of you.

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Suggested citation: Thorburn, N., Arathoon, C., Beaumont, S., & Jury, A. (2025). Traumatic brain injury and intimate partner violence in Aotearoa. National Collective of Independent Women’s Refuges Ngā Whare Whakaruruhau o Aotearoa.

> *“Within te ao Māori, the head has always been referred to and treated as the most tapu part of the body as it holds a person’s defining features, particularly the brain which possesses the skills, attributes, characteristics, and personality of that person.”[1]*

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Introduction

The image most often conjured when hearing the words ‘intimate partner violence’ (IPV) is of a woman being hit by her partner. An estimated 94 percent of the injuries that victims present to hospital with are to the neck or higher.[2] The media frequently and graphically describes women’s experiences of how their partners used external (and potentially lethal) force against them with phrases like “punched”, “hit with a bat”, “knocked out”, “serious assault”, “multiple head injuries”, “beaten”, “boot marks on her face”, and “broken jaw”.

Traumatic brain injury (TBI) refers to the changes to brain function caused by these kinds of external force. Despite the obvious connection, research into how TBI manifests in women (as a consequence of violence) is still very much in its infancy.[3]

Traumatic brain injury is commonly understood and acknowledged as something sustained through contact sport or serious accidents, and as mostly impacting men. It makes sense that most of what is known about TBI comes from research into sporting, combat, or crash injuries[4] – contexts in which injury is expected, screened for, and proactively treated, and where those suffering from it are supported to heal and recover. In contrast, it is seldom recognised as a possible – or indeed, probable – consequence of violent offending against a woman partner.

The prevalence of TBI amongst IPV victims is undeniably high, although under-identification of it complicates prevalence estimates. Studies elsewhere have found that 13 to 93 percent of IPV victims have a TBI inflicted by their abusive partners.[5] A recent review of such studies concluded that up to 75 percent of victims sustain a TBI,[6] but that only 25 percent seek medical care for it, and that even fewer receive an assessment, diagnosis, or treatment for it.[7]

Brain injuries may also be acquired (ABI) rather than traumatic. The most common mechanism of ABI in IPV is hypoxia, or the restriction of blood flow to the brain caused by strangulation or suffocation.[8] However, this report focuses predominately on TBI.

Perpetrators of IPV often target and injure victims’ heads, faces, necks, and spines. When abuse involves blows to the head, shoving, violently shaking, or being thrown onto hard surfaces, it can result in a traumatic brain injury (TBI).[9] TBI is sometimes labelled an ‘invisible disability’ because its symptoms are not apparent to others and are commonly misunderstood.[10]

Women’s Refuge data* show that of women accessing support for IPV:

77.5% are physically assaulted by their abusers,

57.0% are hit or punched in the head by their abusers

69.8% are pushed or shoved by their abusers, and

39.8% are strangled or suffocated.

Of those hit or punched in the head,

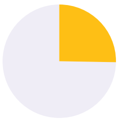
26.7% lost consciousness,

36.7% experienced physical symptoms like head/neck pain, fatigue, unsteadiness, or problems hearing or seeing in the days afterwards, and

30.4% experienced new difficulties with concentration, memory, or emotion regulation in the days afterwards.

*Of 1250 risk assessments completed with new Women’s Refuge clients in 2024.

Women's Refuge data* show that of women accessing support for IPV:



25.5% were stopped from accessing medical services.

*Of 1250 risk assessments completed with new Women's Refuge clients in 2024.

Traumatic brain injuries may present as:

- Fatigue,
- light-headedness or dizziness;
- headaches, neck pain, and decreased physical wellbeing,
- balance problems or light sensitivity;
- changes to mood (e.g. fear, anxiety, or depression),
- changes to emotion regulation (e.g. easily frustrated/angry)
- memory loss, taking longer to think, difficulty with reasoning or problem-solving, and poor concentration; and
- changes to sleep patterns.[11,12]

Women tend to experience more intense symptoms, and for more prolonged periods.[13]

The experience of TBI from IPV is distinct from other experiences of brain injuries. Rather than a one-off incident that is treated immediately, victims often experience repetitive head injuries that alone may seem inconsequential, but which cause cumulative damage to brain tissue.[14] These repetitive head injuries are particularly difficult to quantify and classify as TBI.[15]

Health practitioners are often less aware of the conditions in which TBI is likely to occur when associated with IPV, so even when victims do access health services, the TBI may not be identified.[16] Similarly, IPV advocates are not specifically trained to identify TBI, so accessing specialist services may not guarantee support with, and referral for, TBI treatment.[17] In addition, when women show symptoms of TBI, these are frequently misattributed to their mental health or to their character, while the TBI gets overlooked. This may be because their symptoms differ from men's; research shows women are more likely to report symptoms like fear or anxiety and are more likely to have PTSD at the same time as a TBI.[18] As a result, many victims – and the people supporting them – are unaware that they have a brain injury.

A further compounding factor (and one specific to victims of IPV) is the active role of their abusers, who influence victims' opportunities for safety, treatment, and recovery in several ways.

1. When an abuser inflicts a TBI on their partner, it is not accidental. They do so with an intention to cause harm.[19] The resulting TBI seldom spells the end of their relationship or of their abuse. Many victims with a TBI are at intensified risk of further assaults that cause additional (and at times lethal) trauma to their brains.[20]
2. Abusers may restrict victims' opportunities to disclose injuries (including potential TBI) and seek medical help. When victims' capacity to do so is already restricted by the symptoms of the TBI, these factors, in combination, effectively prevent their access to timely treatment.[21]
3. Abusers' behaviour toward their victims typically creates barriers to healing from a TBI, whether the relationship is ongoing or not. Generic advice for recovery emphasises rest, relaxation, avoidance of stress, and a gradual return to normal activities. For IPV victims, these conditions for recovery may be unfeasible because of both the risk of ongoing violence and the burdens and hardships engendered by past violence.[22]
4. Abusers often isolate their victims, so they may not have the same level of social support that is available to many people living with a TBI.[23]

In sum, victims of IPV who sustain a TBI are not simply restricted by the physical, cognitive, and emotional consequences of the TBI itself, but also by their abusers' use of violence in their pasts, presents, and futures.

Women who sustain a TBI because of their partners' use of violence are frequently overlooked within mainstream approaches to screening, diagnosis, treatment, and service provision.[24] As a result, they do not simply contend with TBI as an invisible disability, but the severity of impacts (as well as the critical risks to their lives), are made equally invisible.

About The Report

This report is part of a wider project that Women's Refuge is carrying out with the generous support of Contact Energy. This project aims to build on knowledge about the risks and impacts associated with intimate partner violence.

In December 2024, the Women's Refuge[1] research team conducted research into the impacts of IPV on victims and their experiences of help seeking. **We heard from 1707 women and non-binary victims.** While most reported that they were no longer experiencing violence, 21 percent (375) reported that it was ongoing. The majority (1328) had been physically assaulted by their partners, **10 percent (138) of whom reported having a (known) TBI** caused by their partners' use of violence. Given IPV-inflicted TBI is often undiagnosed, the actual prevalence amongst this sample is likely far higher.

To explore how those with a TBI experienced risk, support, and safety, we analysed the data based on two groups of respondents:

- The **138** respondents who reported that they had an IPV-inflicted TBI, who are referred to throughout as **'victims with a TBI' or 'respondents with a TBI',** and
- The **1707** total respondents, who are referred to throughout as '**overall respondents**' or '**overall victims'.**

Rates of TBI sustained through IPV were slightly higher for wāhine Māori, women who had children under the age of 18 at the time of the abuse, women who were still in relationships with their abusers, and women who had sought help from Women's Refuge.

These results offer insight into how the conditions of IPV complicate TBI recovery, and how the symptoms of TBI complicate pathways to safety from IPV. They show how victims' needs for safety and support can be better met by considering IPV and TBI in tandem.

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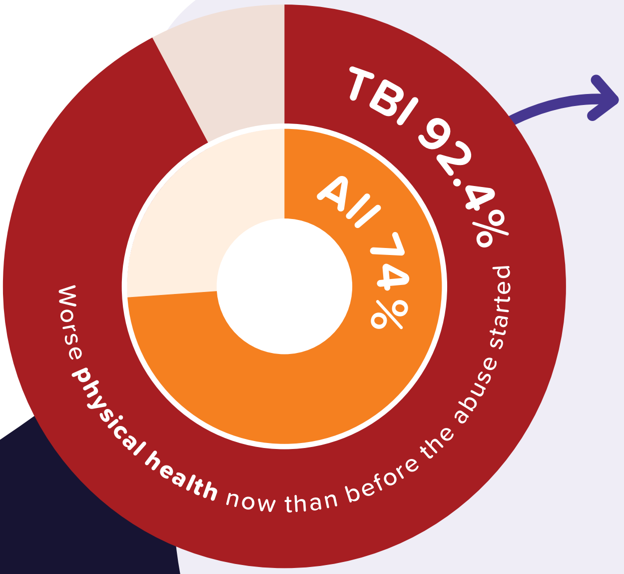
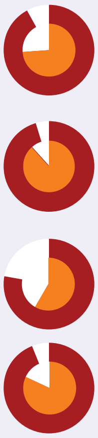
[1] National Collective of Independent Women's Refuges | Nga Whare Whakaruruhau o Aotearoa

A Threat to Long-term Health, Wellbeing, and Everyday Functioning

Unlike many other kinds of injury, TBI is associated with long-term (sometimes permanent) consequences that span every aspect of people's lives. The longevity of these impacts are particularly debilitating in the context of IPV.[25] Accordingly, victims with a TBI were much more likely than overall respondents to report the following changes to their current everyday lives – even though many of them had been separated from their abuser for years.





92.4%
My **physical health** is much worse than it was before the abuse started

95.5%
My **mental health** is much worse than it was before the abuse started abuse started

78.2%
I constantly **fear for my safety**

94.0%
Managing my **everyday life** is still much harder because of the impacts of the abuse

● % of respondents with a TBI

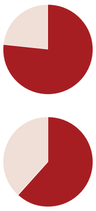
● % of all respondents

Nearly 80 percent of victims with a TBI reported that they still 'constantly fear for their safety', compared to just under 60 percent of overall respondents. This finding reflects the unique contextual influence of IPV on how women experience TBI. Intimate partner violence understandably gives rise to fear for personal safety, and fear and anxiety are also (especially for women) commonly caused by a brain injury.

Victims with TBI were similarly more likely to report that their 'physical health is much worse than before the abuse started' (92.4%) than overall respondents (74%). Given the physical symptoms associated with TBI, and the ubiquity of fatigue as a TBI symptom for women in particular, this difference is unsurprising. However, it again underlines the importance of considering both IPV and TBI as vital context for how a victim is able to navigate and recover from either.

In addition, just as IPV is known to restrict women's opportunities for seeking help with a TBI, TBI may also restrict their opportunities (or capacity) to seek help for IPV, as is evidenced throughout this report.

Wāhine Māori with a TBI reported feeling less connected to whānau, whakapapa, reo, tikanga, and/or culture than they did before the abuse started, at higher rates than overall Māori respondents:



76.7%
I feel much **less connected** to my whānau and/or whakapapa

61.7%
I feel much **less connected** to my reo, tikanga, or culture

We recommend reading the research by Dr Hinemoa Elder and colleagues to understand more about TBI and the significance and sacredness of the brain from a te ao Māori perspective.[26]

The Toll It Takes to Live With Both IPV and a TBI

Implications For Health and Wellbeing

All respondents were asked to think about when the violence and abuse from their (ex) partner was **at its worst** and to identify the impacts on their physical health and wellbeing. Those with a TBI reported greater impacts than overall respondents in every domain.

Respondents with a TBI were **twice as likely to report daily pain** from a physical injury caused by the violence (63.8% with TBI; 25.5% overall respondents). They were also more likely to suffer daily headaches, to feel unwell or get sick often, have difficulty remembering or concentrating on tasks, to find everyday tasks harder or more overwhelming, and to report changes to appetite and a loss of energy.

> *"I have really, really bad memory problems."*

In addition to these physical impacts, respondents with a TBI reported losing more sleep and rest time because of their partners' abuse each day. The reduction of usual sleep and/or rest has multiple implications for their safety and wellbeing, such as:

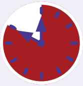
- Exacerbating the impacts of the TBI and preventing recovery,
- Further detracting from overall physical and emotional wellbeing and resilience, and
- Complicating or restricting their opportunities to access support for either TBI or for IPV.

How many hours of rest and sleep time did you lose each day because of the violence?

TBI: 12 hours a day - 3 of which are hours of lost sleep

Overall respondents: 9 hours a day

How many hours per day did you worry about, anticipate, or try to manage your partner's abusive behaviour?



TBI: 10 hours a day

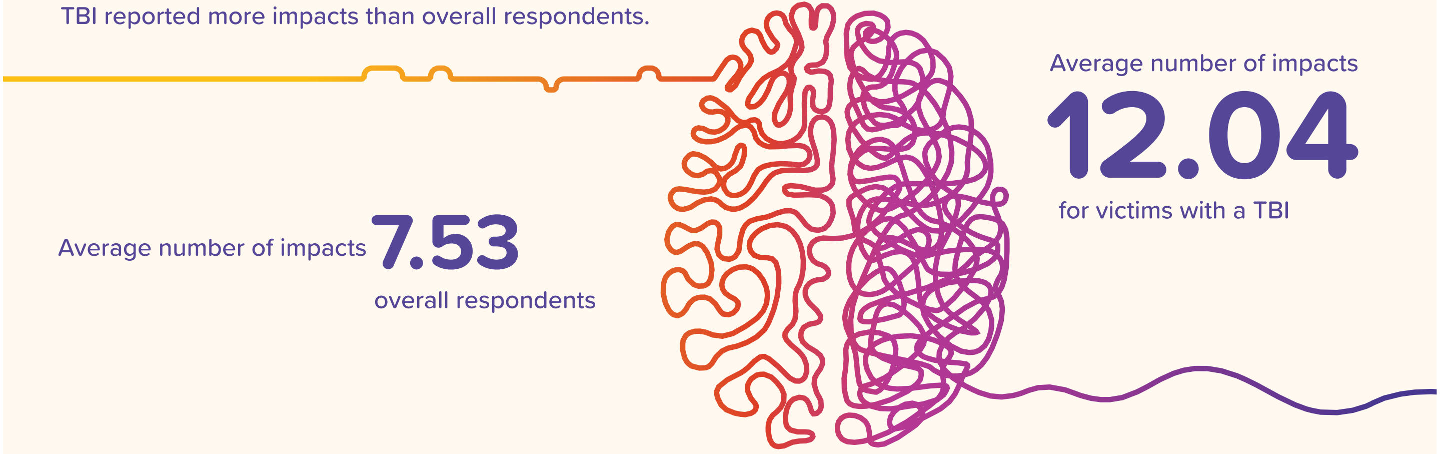
Overall respondents: 7 hours a day

The impacts on their physical, emotional, and social wellbeing did not typically end when their safety from IPV increased.

> *"I don't feel normal anymore. I'm never happy, never feel excited or interested in anything. Constant feeling of anxiety. Never sleep. No motivation for life in general."*

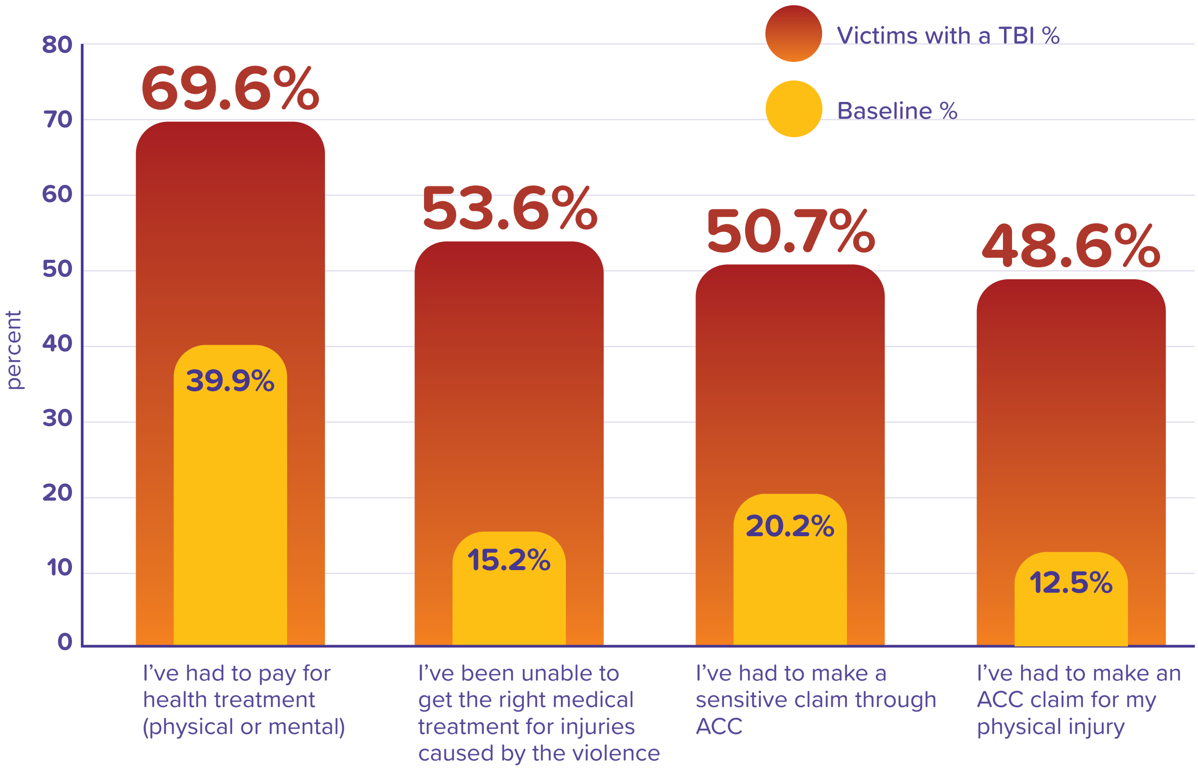
> *"I feel weird around people, unable to relax and paranoid that they look and find fault, it's hard to ignore these thoughts I often feel less than human."*

Respondents were also asked about the long-term impacts of IPV that they experienced. Victims with a TBI reported more impacts than overall respondents.



Average number of impacts **7.53** overall respondents

Average number of impacts **12.04** for victims with a TBI



The **biggest differences** for those who had a TBI were related to access to support for physical, sexual, and mental health.

As the above shows, victims with a TBI disproportionately struggled to get medical treatment. They were more likely to need to make a claim for a physical injury, or to make a sensitive claim, and they were burdened more with the costs of physical or mental health treatment that was needed as a result of IPV.

> *"ACC paid for his foot getting broken from kicking my head in but not for the damage it caused me."*

Some respondents with a TBI also alluded to the extreme difficulty they had navigating these services while struggling with TBI symptoms.

When asked to select which impact of IPV took the biggest toll on their lives, the main option selected by respondents was 'a traumatic brain injury'.

We also asked all respondents what they found hardest to get help with. In addition to struggling to get useful support for the TBI itself, respondents with a TBI identified 'ending up in debt' (both as a consequence of abuse tactics and from the financial burden of injury) and 'making a sensitive claim through ACC' as most difficult to get help with. While debt was universally acknowledged as difficult to get support for, TBI-specific support and support with making a sensitive claim stood out as crucial gaps in how the needs of victims with a TBI are currently responded to.

> *"My doctor was asked to write a letter regarding physical abuse resulting in my needing dental work. Apparently 'her ex smacked her around' IS NOT an appropriate comment. The doctor saw us all for years and never gave me help to leave, no info, no reporting of the violence, just tried giving me anti-depressants 'cos this must be so hard'. I wasn't depressed, I was being beaten, and concussed."*

In sum, the physical health and social wellbeing impacts were worse and more prolonged for victims with a TBI. When their partners inflicted a TBI, they are not simply harmed severely in that moment. The severity of the harm they experienced was prolonged (and at times permanent) and spanned multiple domains of their lives. The impacts of abuse therefore disabled many of their immediate and longer-term life prospects, including the extent to which safety, stability, wellbeing, and fulfilment became viable possibilities in their futures.

> *"It took me two years to be brave enough for, and to get access to, trauma counselling. Before that it was PTSD symptoms every day, which made daily functioning very hard. After trauma counselling, I could focus on the future, have dreams and set ambitious but realistic goals with career, friendships, relationships, identity, finances, hobbies/adventures, and have hope for the future."*

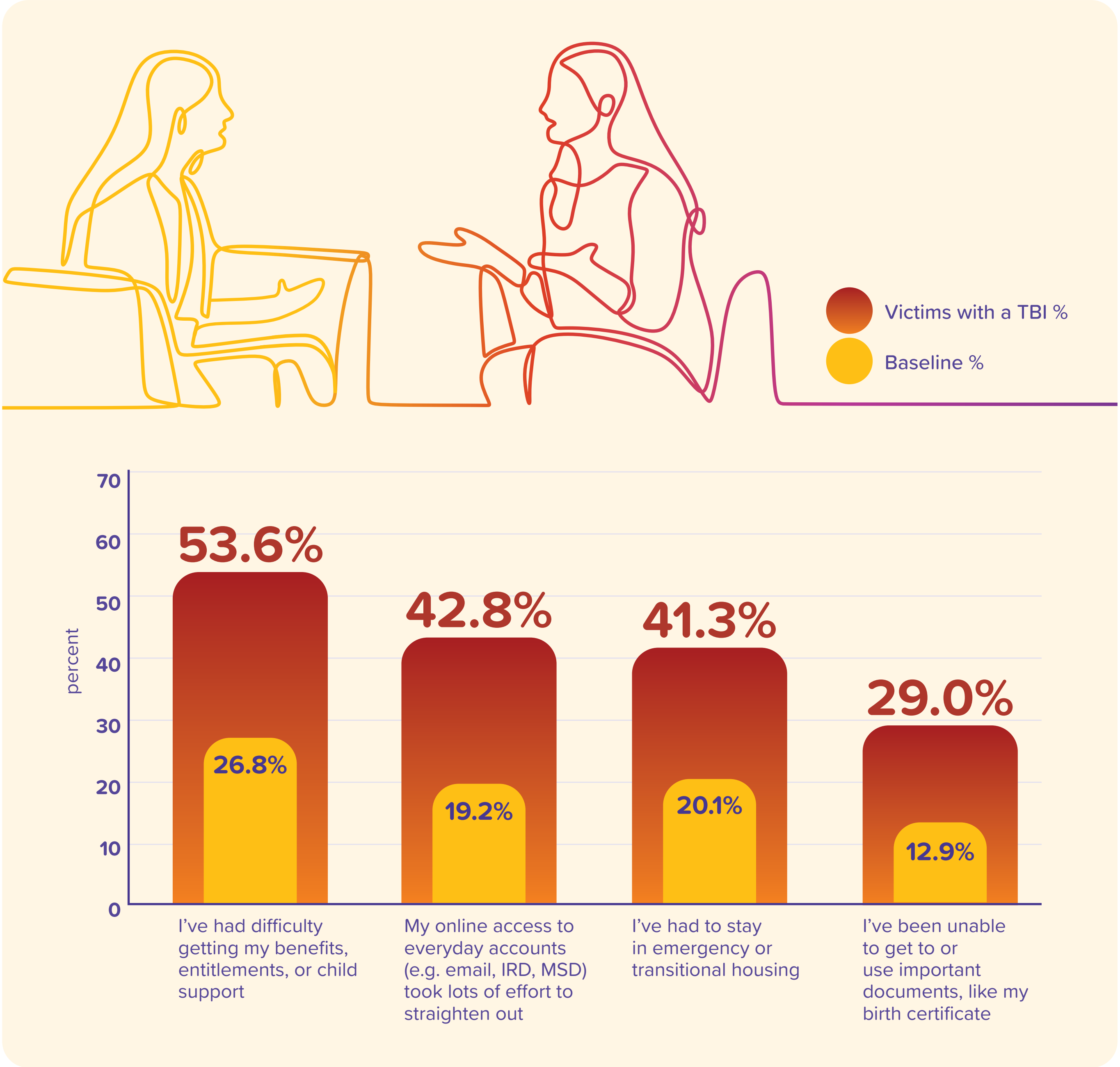
Implications For Practical and Necessary Tasks

All respondents reported a range of adverse impacts from the IPV they experienced. However, victims with a TBI reported four specific impacts at **double** the rate of overall respondents.

These specific impacts all involve bureaucratic requirements, such as appointments, completion of forms, document retrieval, and participation in online systems. Navigating these systems absorbs victims' time and energy, and relies on their capacity to concentrate, complete multiple or sequential tasks, retain information, recall events, communicate in whatever format and pace is required, and regulate their responses.

Put simply, while an abuser's IPV tactics may give rise to these difficulties in a variety of ways, inflicting a TBI puts victims at a significant disadvantage. It can limit their capacity and functioning, and make it much harder to fulfil the bureaucratic requirements that stand between them and pathways to safety or wellbeing.

> *"I can't drive due to double vision. I struggle with video and phone calls. I have engaged support to do the banking to pay the debts cos I can't see well enough to ensure the account number is entered correctly!"*



Implications For Life Prospects

Respondents with a TBI reported every single impact at a higher rate than overall respondents, including:

55.1% I've had difficulty finding permanent and affordable housing

78.3% I've had difficulty getting enough food or groceries

60.1% I've had a new mental health diagnosis

61.6% I've had difficulty with getting, keeping, or moving forwards in my job

83.3% My reputation has been damaged or harmful stories about me have been shared with others

78.3% I've had to work hard to rebuild my connections with my whānau or my community

76.8% I've had to move house

50.7% I've had to move towns

78.3% I've ended up in debt that I would not have otherwise had

60.1% I've struggled to balance coping and parenting my children

36.2% I've had to rearrange childcare options or schooling for my kids

● Respondents with a TBI % ● Baseline %

These impacts have far-reaching implications for victims over their lifespan. For many, the key ingredients for social wellbeing, such as housing, day-to-day access to essentials, and maintaining connections with others, were grossly impeded by the mutually reinforcing impacts of IPV and TBI.

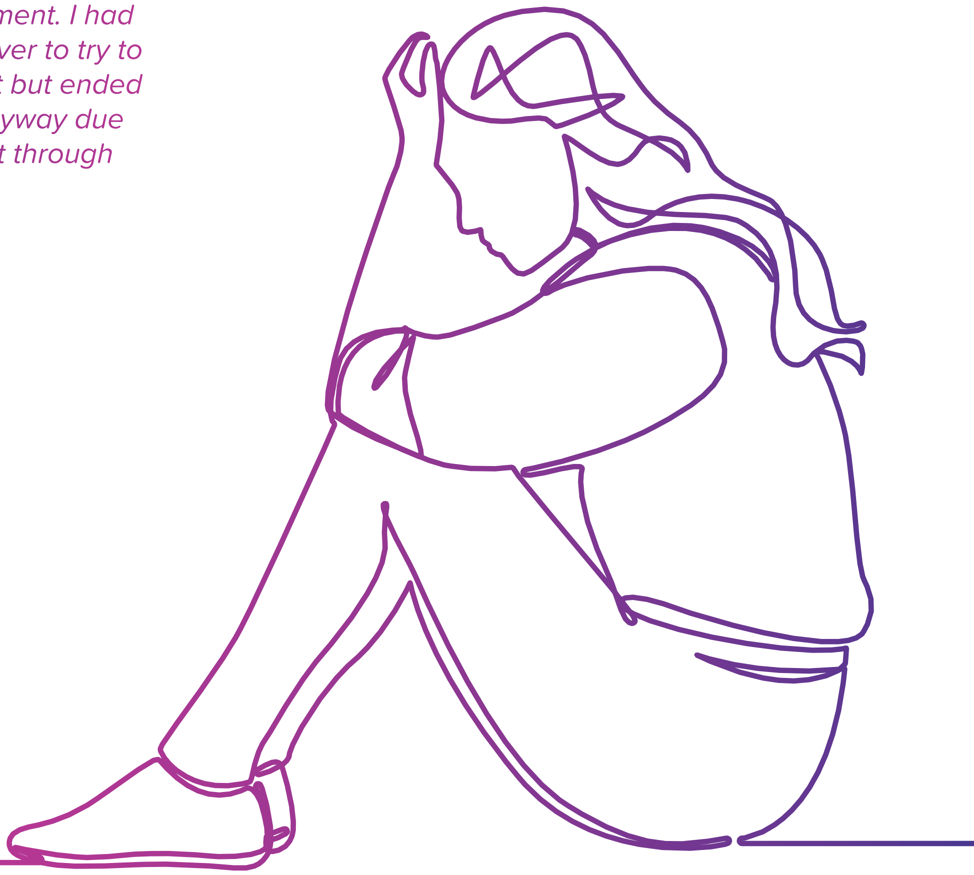
Equally important however, are what these impacts represent for victims' prospects for meaningful recovery. Generic recovery advice for TBI is predicated on the assumption that rest and respite from stress and the usual rigour of everyday demands is a viable possibility. Instead, victims with a TBI faced additional, urgent, and stressful responsibilities that undermined their opportunities for recovery, such as:

- having to navigate multiple bureaucratic systems (compounded by TBI-related limitations);
- worrying about, moving to, and trying to secure suitable housing;
- coping with parenting in the aftermath of abuse and/or separation;
- organising new schooling or childcare options;
- dealing with debt;
- struggling to find the means to get groceries; and
- losing friends, whānau, and reputation/standing/security in employment.

> *"I was declined a sensitive ACC claim as abuse started outside New Zealand. I have had to stop working 2 years ago so I'm currently on supported living payment. I had to access mental health support for eldest child [because of my] ex-partner. I had to access legal support with parenting agreement. I had to withdraw money from my KiwiSaver to try to reduce my portion of marriage debt but ended up accessing budgeting support anyway due to not initially claiming child support through IRD for safety reasons."*

Finally, victims also alluded to the role a TBI played in making safety from ongoing violence seem untenable, commenting that when they were most impacted by the TBI, they simply could not undertake the tasks and burdens required to leave the abuser or seek safety. **Abusers therefore effectively entrapped victims in relationships with them by inflicting a TBI, thus rendering their victims unable to leave.**

> *"I've since had significant periods of trauma counselling, but when I finally left the PTSD symptoms were massive. The hypervigilance, insomnia, nightmares, flashbacks, avoidance of hobbies previously enjoyed, spiritual confusion, financial poverty, and suicidal ideation at times were just as horrific as being abused was. Also, [there were] lingering beliefs of community who haven't experienced domestic violence toward victim blaming - e.g.* ***"Why didn't you just leave?",*** *as if I deserved it for being so stupid to stay. Lots of people also still believed my ex-partner to be a lovely man, [but] in private he often strangled/choked and beat me where bruises could be covered up. When he told them I was crazy/lying, they usually believed him until they got to know me - this included Police."*



Experience With Services

Victims with a TBI each **accessed an average of six support agencies** (such as social services, counsellors, Women's Refuges, and Work and Income) while experiencing IPV. This is significantly more than overall respondents, who accessed four services on average. They also spent **20 hours per month** (twice as many hours as overall respondents) engaging with services, and they had to continue engaging with services for an **average of 12 months.**

Despite the time and effort victims with a TBI put into seeking help, only 12.5 percent said engaging with services put an end to their partners' abuse. In other words, services worked more effectively for overall respondents (23.3% reported that services made the violence 'stop for good') than for those with a TBI.

Few services can realistically enact complete safety by forcing the abuse to stop. On the other hand, services have immense potential to make victims' lives safer and easier, and to positively contribute to victims' recovery, wellbeing, access to resources, and opportunities to live the lives they want for themselves, even without 'solving' the IPV.

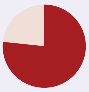
For some victims, this was indeed the result of accessing services. **Victims with a TBI were slightly more likely than overall respondents to report that any service made them better off or safer.** Many attributed this gain in safety or wellbeing to services doing something for them they would have been unable to do themselves, and proactively providing support. However, nearly half did not feel safer or better off after accessing services.

TBI victims were asked:

Did any of the services/organisations you were involved with make your partner's/ex-partner's abuse stop for good?

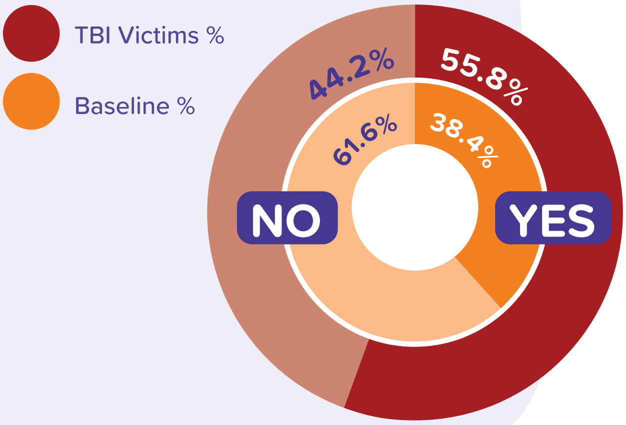
12.5%
said 'yes, it stopped for good'

10.7%
said 'yes, it stopped for a few months or more'



76.8%
said 'no, none of them made the abuse stop'

Were there things that services did that were unhelpful or made your situation worse?



> *"They helped me work out my safety plan and revised it often, gave me a personal safety alarm, wrote letters of support for everything, GP, workplaces, schools, family court, creditors etc.* ***Having these professionals representing me in writing got me places/support I was otherwise denied on my own merit due to my vulnerability… I am thankful I am alive, and I put that down*** *to the safety planning I did with [a refuge], and constantly reviewing it wherever I go, whenever things change. It's a working document and it's been a really good tool for me to help offload my worries about that stuff, [because] I have a written record, I don't need to THINK about my safety ALL THE TIME now, which means my mental and physical health can begin to improve.*

In fact, victims with a TBI were also far more likely to report that accessing services made things worse or harder for them, and some explained that the adverse impacts of both IPV and TBI were amplified by harmful actions taken by services. Given the quantified time and energy per month that these victims put into help-seeking, this demonstrates the risk that **seeking help may be a negative investment** for many victims.

> *"[Services had] bad attitudes towards me, a lack of consideration for my well explained disability/special needs, having those conditions minimised, being gaslit on my lived experience, mumbling, sarcasm, ambiguous communication, lack of follow through."*

Research into TBI consistently shows the association between a lack of understanding of TBI inflicted by IPV and victims' poor experiences of services, with multiple mechanisms through which victims experience inadvertent harm. First, when providers overlook the possibility of a TBI or fail to apply an understanding of it, they are more likely to label the victim as 'difficult' or 'uncooperative'. Second, if support is offered and then withdrawn from a victim because of her TBI symptoms, it exacerbates her sense of isolation and gives her perpetrator further opportunities to control her. Finally, if services do not cater to the specific (and often greater) needs of victims with a TBI, they are much less likely to derive any benefits from accessing them.[27]

> *"I felt supported until help suddenly stopped because I didn't feel able to make [a] police statement as [I was] too physically unwell."*

These findings suggest that there is extensive scope for improvement in how services support victims who have a TBI.

Meeting Victims’ Needs

Many respondents articulated what services did that that worked well for them. Some expressed appreciation that a service **“didn’t judge me”**, or **“didn’t pressure me”,** and said **“**I **appreciated so much the non-judgemental, open mindedness of the** [staff]**.”**

> *“They were gentle and patient with me… I was a scared little mouse back then. I couldn’t make eye contact with anyone, couldn’t understand why it kept happening to me. It was very confusing. If someone was judgemental or careless it would have made it so much worse.”*

Given that many victims will be unaware that they have a TBI, efforts to support them must not be predicated on diagnosis. Equally, supporting victims’ access to health practitioners who can facilitate a diagnosis, or at a minimum record the potential injury, can protect their access to treatment later on.

Two women without a (known) TBI commented:

> *“Although I haven’t made medical ACC claims I probably should have, and I am likely entitled too. I have suffered head trauma which I believe has impacted my memory.”*

> *“I believe that I’ve got a TBI, but I’ve never had it diagnosed as it’s been many years, and I never knew how or who to approach about it.”*

The support people offer victims is beneficial regardless of whether they have a TBI. However, for those with a TBI, this support is both **more necessary** for and **more instrumental** to their safety and wellbeing.

What works:

Understand that IPV happens because an abuser chooses to behave abusively, and that only an abuser can choose to stop the violence.

⊕ *"Women's Refuge made me feel safe and told me that nothing I did was deserving of the beating and choking my ex did to me."*

⊖ *"The other service was the hospital. They seemed to not care much about my injuries, like 'I made my bed, I have to sleep in it' type vibe. Only one nurse was helpful. She slipped me a Women's Refuge card. That night I ended up using it. She saved my life."*

Recognise that victims only need help because of someone else's violent actions, which they are now suffering the consequences of.

⊖ *"WINZ declined my family food so many times even after I provided 4+ weeks' worth of bank statement which showed my entire spending went on bills."*

⊖ *"The police contacted me to begin the criminal investigation (sexual violence/ non-fatal strangulation) and have given me a HUGE list of data to collect for them."*

Actively ask about (and support assessment and treatment for) the potential for a TBI.

Explain the process for treatment, follow up to make sure it is provided, and proactively communicate to ensure it is meeting victims' needs.

⊖ *"ACC had all evidence of massive TBI and even though I begged and begged and rang and rang no one would help no one cared - we were pushed away from any service and no support whatsoever was offered."*

Acknowledge the immense impacts IPV has on physical and mental health, believe them when they talk about it, and treat them with warmth, care, and respect.

⊕ *"Listened with genuine vibes, heard me, believed me, asked me if I'd like help and listened assiduously to my answers, and especially to the unsaid things, the pauses, the catches in my breath. I was treated with kindness."*

Assume that victims are doing their best, and that the impacts of violence (including potential brain injury) prevent them from being able to do more.

Tailor support to victims' specific needs – for both the TBI and for the IPV. Offer options, solutions, and workarounds.

⊖ *"My lawyer didn't understand PTSD, refused to believe I couldn't hear/ understand her over the phone (sensory processing disorder) and constantly mocked my lived experience."*

⊖ *"[I had] difficulty connecting with the service due to poor accessibility, [they] wouldn't give me a paper copy of the info put in the protection order today because [they said] 'we've got to save the trees'."*

Unburden victims from their everyday (and at times impossible) workload and obligations by organising practical support for victims and their children – like childcare, meals, and transport.

⊕ *"[My worker] gave and organised practical and helpful support for my kids, she made sure we had food."*

Take the administrative workload off them. Ensuring they have everything they are entitled to and getting them what they need as soon as they need it can limit the magnitude and longevity of these consequences.

Offer to speak to other agencies or services, act on their behalf, communicate their needs to others in writing, or go with victims to appointments to explain the violence and its impacts so they don't have to.

⊕ *"My social worker was a wonderful, calm and kind support person who came to WINZ appointments with me and actually spoke!"*

⊕ *"She talked on my behalf as I was having difficulties talking due to trauma."*

⊕ *"Social worker made calls to debtors and explained to people about why I was struggling."*

Conclusions

Experiencing IPV and TBI In Tandem

Not all victims survive intimate partner violence. Many victims who do survive find that their partners' use of it (and the impacts of it) takes valuable parts of their lives from them: their physical resilience and wellness, their emotional stability, their economic security, their connectedness with people around them, and their dignity, reputations, and freedom to live as they would like to.

These findings show that for victims with a TBI, the risks and harms associated with IPV are amplified and extended – even in their abusers' absence. Victims with a TBI reported worse impacts and worse outcomes in every measurable way within this questionnaire, and their comments underlined the immense toll that IPV-induced TBI took on their health, lives, and future prospects.

When abusers inflict a TBI, they threaten their victims' very means of survival.

Respondents' quotes signal the difficulties they faced in surviving and coping with the impacts of IPV because of the way TBI symptoms limited what they were capable of. Equally, their quotes signal how the context of violence and the range of (often debilitating) impacts from IPV complicated and confounded the symptoms, stressors, and adverse outcomes associated with TBI. From these, we can infer that if they sustained their TBI through another means, in an otherwise safe social context, many of the contributors to prolonged adverse impacts would cease to exist for them.

In these victims' lives, TBI and IPV do not simply co-exist; they are mechanised by one another and ultimately service abusers' interests. It is therefore essential to name the abuser as the origin point for both, and as the instigator of the costs and consequences that IPV and TBI in tandem accrue within the victim's life.

Effective Support Must Account for Both IPV and TBI

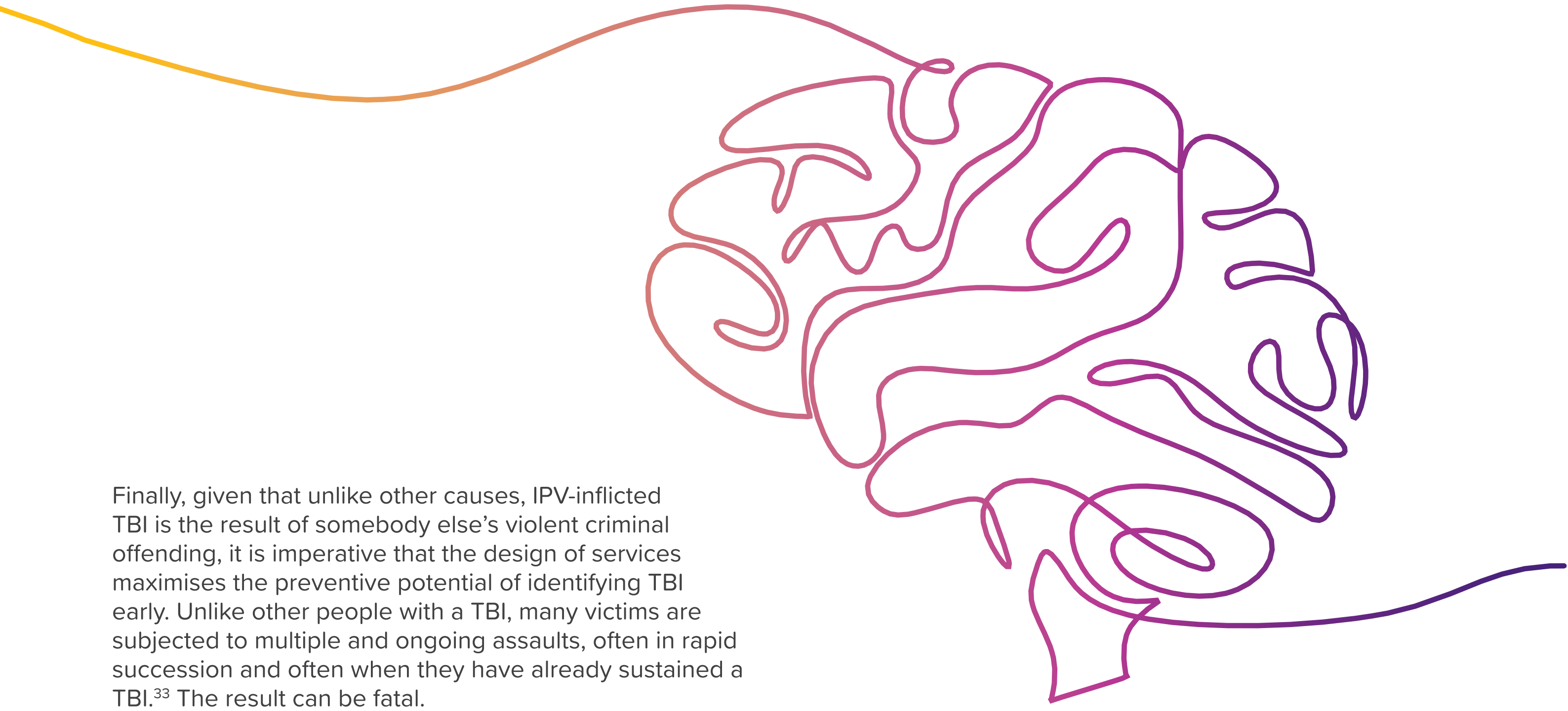
The findings show that **IPV, as the context for TBI, is a salient consideration for how treatment is designed and presumed to work**. When IPV victims sustain a head injury, it is never the only challenge they are facing: IPV causes immense hardship and upheaval, and catalyses a range of distressing or difficult burdens. Support may consequently need to be more intensive and comprehensive to achieve a comparative state of recovery.

Moreover, the symptoms of TBI are often nested within a constellation of hardships in victims' lives, rather than easily attributable to one discrete injury. The onus must therefore be on healthcare providers to proactively enquire about head injury even when it is not the main concern victims are presenting with, and on those responding to the violence to facilitate timely healthcare access after the disclosure of any assault involving the head, face, neck, or spine.

The recent proliferation of research and knowledge, both in Aotearoa and internationally, about the prevalence and risks of strangulation[28] show the positive effects that a galvanised response to specific IPV risks can have. Knowledge, intervention, and support for IPV victims with a TBI has not yet seen such a response despite the arguably equivalent risk.

The result is many victims missing out on the correct diagnoses, treatment, support, and resources.

Failing to attend to the sociocultural context in which TBI is often sustained for women perpetuates the gendered inequity[29] of treatment and resource provision for TBI. At present, men are 40 percent more likely to be diagnosed with (and receive treatment for) a TBI, mainly caused by falls, recreational sports, and motor vehicle accidents – in other words, single, standalone incidents after which medical treatment is often sought.[30] In contrast, the leading cause of TBI in women is IPV.[31] Moreover, women's access to medical assessment after an injury is often dictated by a partner and/or by opportunities for relief from caregiving, domestic, and other obligations. Even if they do eventually present to health services, their symptoms are more likely to be misattributed, with TBI overlooked as an underlying cause.[32] In short, the current landscape of TBI identification and treatment in Aotearoa, and internationally, appears oriented to the context of men's TBI.



Finally, given that unlike other causes, IPV-inflicted TBI is the result of somebody else's violent criminal offending, it is imperative that the design of services maximises the preventive potential of identifying TBI early. Unlike other people with a TBI, many victims are subjected to multiple and ongoing assaults, often in rapid succession and often when they have already sustained a TBI.[33] The result can be fatal.

Raising knowledge, capability, and capacity to respond to IPV-inflicted TBI can mitigate the risk of subsequent and cumulative head injury, as well as mitigating the extent of service burdens victims of violent crime are currently forced to carry.

Brain Trauma-Informed Support: What Works?

The last decade has seen a rapid uptake of discourse and practices with a locus of 'trauma-informed care', which is "based on the recognition that many behaviours and responses expressed by survivors are directly related to traumatic experiences."[34] But for many victims, 'trauma' is not only a psychological imprint of IPV, it is also (or even primarily) a physical one. Specialist services supporting IPV victims often use principles of trauma-informed care alongside the more expansive framework of violence-informed care, which utilises a stronger analysis of an abuser's pattern of behaviour and the global and continuous threat they pose to their victim.[35]

However, relying on practices that are 'trauma-informed' or 'violence-informed' but do not account for traumatic brain injury can cause more harm to victims, such as by disregarding, ignoring, or misinterpreting the physical, cognitive, emotional, and behavioural implications. Becoming brain injury-informed, as well as trauma- and/or violence-informed, requires greater awareness of how a TBI might manifest and the range of impacts it may have on every part of a victim's life. It also requires this knowledge to be acted on in service of the victim's safety, health, and wellbeing.[36]

The findings in this report indicate that TBI victims engage with more support services, more frequently, and for longer durations. Unfortunately, they also report having a more negative experience overall. This is not an inevitable story of support-seeking.

Services can work better for women with IPV-inflicted TBI.

Specialist agencies involved because of IPV can ask about head injury, name it as a risk, talk about common symptoms or difficulties associated with it, and help the victim access (and explain the backdrop of IPV to) healthcare providers. They can also acknowledge the greater need for functional support that victims with TBI are likely to have, and reserve capacity for this.[37]

Health services can ask about assault and injury directly, removing the onus on the patient to raise them, when they notice emotional and/or physical symptoms that may be consistent with TBI – even when there are multiple other possible explanations.[38]

Services that determine and enable access to resources after an injury – such as compensation, in-home support, funding for childcare, and rehabilitative pathways – can be alert to the likelihood that women with TBI may be victims of IPV, and tailor their contact, service delivery, and expectations of them accordingly.[39]

Finally, and crucially, all services involved with a victim can help by listening to how they describe their symptoms, and modifying their approach to make it as feasible, easy, and sustainable for them as possible. Similarly, all services can advocate for victims by working to overcome any bureaucratic barriers and administrative burdens they encounter, and by communicating with other services to ensure that victims get what they need and what they are entitled to.

Support For People with An IPV-Inflicted TBI

If you (or someone you know) have experienced IPV or had any injury to your head, face, neck, or spine, even if it seems minor, it is important to see your doctor as soon as possible, especially if you experience any of the following:

- fatigue,
- light-headedness or dizziness,
- headaches, neck pain, or decreased physical wellbeing,
- balance problems or light sensitivity,
- memory loss or taking longer to think,
- difficulty with reasoning or problem-solving,
- poor concentration,
- changes to mood (e.g. fear, anxiety, depression),
- changes to emotion regulation (e.g. easily upset, frustrated, or angry), or
- changes to sleep patterns.[40]

A doctor can:

- provide immediate care
- make a record of how it happened (which is crucial for keeping future pathways to treatment open for you, such as by making an ACC claim),
- support assessment for TBI,
- make referrals for treatment, and
- give you information on TBI.

Consider taking a trusted support person along to appointments with you so they can advocate on your behalf and share the workload associated with ongoing medical care.

Could someone you know have a TBI caused by IPV?

- Notice it! They may not know
- Link them up with medical support and assessment
- Advocate for TBI support and for safety from IPV
- Do the practical work for them – even everyday things like covering any domestic and caregiving responsibilities, or tasks that have to do with safety or setting up support
- Think about other ways you can proactively unburden them and share the extra workload associated with IPV and TBI
- Check in regularly and offer different kinds of help based on what they need.

"My neighbour who I saw often, but not every day, was actually the one who got the ball rolling for me. Bless him, he's an older guy, but he was noticing like me being more forgetful and having trouble keeping on top of appointments and things. Him and his wife knew about my ex-partner and the abuse. He said to me one day 'have you thought about having someone check to see there's not something more going on for you'. So, I went to the doctor and my GP took it seriously and now I'm on the path to getting proper help for this brain injury that I never knew I had been living with!"

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