

DOWNLOAD PDF COPING WITH HEAD INJURY: INTRODUCTION AND OVERVIEW

Chapter 1 : Brain Injury | Family Caregiver Alliance

Complete with traditional, complementary, and alternative treatment options, suggestions for overcoming obstacles, and advice on financial matters, Coping with Concussion and Mild Traumatic Brain Injury is a lifeline for patients, families, and other caregivers.

Tips and suggestions for using the resources on the site as part of workplace learning. It occurs as the result of some external force being applied to the brain. People in the 14 to 24 age group are more likely than people of other ages to get a TBI. Men are more likely than women to get a TBI. Road traffic accidents are the most common cause of TBI. A second peak in incidence is after 75 years of age. The main cause for the elderly is falls. About the site This site supports learning for working with people with traumatic brain injury TBI. The content on the site uses materials developed by a wide range of practitioners working in brain injury units in NSW, Australia. People with brain injuries and their family members have also generously shared their stories of living with brain injury in order to help people learn about working with people with TBI. The site is managed by Paul Bullen. Self study modules Study at your own pace. Modules take 1 to 3 hours. There are currently 12 Modules. Modules are being updated and new ones added during Communication This module provides information about the range of communication problems that may result following a traumatic brain injury TBI , as well as strategies for dealing with some of these deficits. Promoting skills for independence The module is for support workers who provide direct care and assistance to people who have had traumatic brain injury TBI. It offers practical strategies that can help individuals with a TBI to increase their independence. Understanding and managing behaviour changes following a TBI This module explores the behavioural changes that occur following a Traumatic Brain Injury TBI and offers a framework for effective behaviour management.. Working with Families after Traumatic injury: An Introduction This module provides staff members with an introduction to working with families after traumatic injury based on a strengths based approach. Gabby and her mother talk about their experiences. He had an extensive stay in hospital. He needs 24 hour support in his own home. Andrew left and worker.

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Chapter 2 : Injury and Violence Prevention | Healthy People

Traumatic brain injury, also called brain injury or head injury, occurs when a blow or jolt to the head results in damage to the brain. TBIs range in severity from mild to severe. The most common type of brain injury, a concussion, is classified as a mild traumatic brain injury.

Worksheet Plan We recommend that each individual session or group work follow the structure suggested by the format of the workbook. Sessions should begin with a review of the goals, followed by the presentation of information, self assessment and personal goal-setting. In most chapters, information is brief enough that it can be reviewed with the client in a single session. However, there are some topic areas that are more complex and may take several sessions to review. A recovery checklist is included in the Forms for reproduction section. Completing this form, or a similar plan at the end of each session, will help to keep clients focused on their particular goals. Getting in the habit of reviewing these each week will assist clients in organizing their thoughts, problem-solving, and follow-through. A structured self-assessment is provided in most chapters. Worksheets and plans are provided to assist the client in applying the new information to their own plan of action. The order of the chapters provides a logical sequence for the introduction of information. However, this order can be altered to fit the needs of a particular client or the structure of the program in which it is being used. Please note that not all chapters contain all sections. Worksheets can be taken out of the workbook and used as handouts for groups. This workbook is designed to be a resource for the following user groups: Counsellors with little experience in substance use should find enough information and examples in each chapter to have meaningful conversations with their clients about substance use and its effects. However, the workbook is not intended to be a replacement for consultation with counsellors in substance abuse. Counsellors with little experience in acquired brain injury should find that the structured, written presentation and concrete examples will help clients to compensate for memory impairments and other cognitive difficulties. However, consultation with an acquired brain injury professional is strongly recommended. The multiple choice and checklist format of self-assessments is designed to facilitate self-assessment for persons whose cognitive difficulties make answering open-ended questions difficult. Please [click here](#) to download the rest of the guide. A Provider Manual can be obtained by registering at [www](#). The manual is not available directly for download, but once you have registered, you will receive the pdf. Posted on BrainLine October 16, Use of this material for profit is prohibited.

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Chapter 3 : Brain Injury Resource Center - blog.quintoapp.com

Closed head injury: which results from any trauma that causes the brain to be violently shaken inside of the skull such as a "blast" injury. Penetrating injury: which results when object goes through the skull and enters the brain.

This article has been cited by other articles in PMC. Abstract Traumatic brain injury TBI is among the significant causes of morbidity and mortality in the present world. This literature review assesses the current knowledge of various cognitive rehabilitation training strategies. The entire spectrum of TBI severity; mild to severe, is associated with cognitive deficits of varying degree. Cognitive insufficiency is more prevalent and longer lasting in TBI persons than in the general population. A multidisciplinary approach with neuropsychiatric evaluation is warranted. Attention process training and tasks for attention deficits, compensatory strategies and errorless learning training for memory deficits, pragmatic language skills and social behavior guidance for cognitive-communication disorder, meta-cognitive strategy, and problem-solving training for executive disorder are the mainstay of therapy for cognitive deficits in persons with TBI. Cognitive impairments following TBI are common and vary widely. Different cognitive rehabilitation techniques and combinations in addition to pharmacotherapy are helpful in addressing various cognitive deficits. As India continues to progress to greater urbanization with rapid development in terms of motorization, incidence of TBIs will increase significantly. Cognitive deficits can significantly impair activities of daily living ADL , employment, social relationships, recreation, and active participation in the community. TBI is classified as mild, moderate, and severe depending on the level of consciousness, particularly duration of coma and posttraumatic amnesia PTA. Hence, it is necessary to have a proper guideline for the cognitive rehabilitation of traumatic brain injured persons with multiple cognitive impairments. This article has been adapted from various literatures and outlines briefly the commonly encountered cognitive deficits following TBI. It also provides a summary of effective rehabilitation strategies for the cognitively impaired persons. A total of 99 studies on cognitive rehabilitation were assessed and evaluated. Common cognitive impairments TBI can cause a plethora of cognitive impairments. Table 1 shows the common cognitive impairments following TBI. Attention and memory deficits may exacerbate or cause additional disturbances in executive function, interpersonal communication skill, and other complex cognitive functions. Table 1 Open in a separate window Cognitive assessment A detailed neuropsychiatric assessment, to assess the residual cognitive abilities and inabilities of the TBI person, is necessary before starting of cognitive rehabilitation. In addition, repeat neuropsychological assessments, at a regular interval, are necessary to evaluate the effectiveness of ongoing treatment. Table 2 shows the commonly used standardized assessment scales for neuropsychological assessments for cognitive function. Table 2 Open in a separate window As a caveat, an improvement in the neuropsychological test does not necessarily mean that the patient has improved in functional ADL contemporaneously. Hence, assessment for functional outcome measurement tools functional independence measure [FIM], Disability Rating Scale [DRS] to live independently and to return to work, should be considered when attempting to plan appropriate cognitive rehabilitation programs for survivors of TBI. It is evident from literature[15 , 16 , 17] that the neuropsychological test results, as measures of cognitive ability, have been found to correlate significantly with functional outcome measures e. Similarly, Neese et al. Multidisciplinary team approach encompasses physician, neuropsychologists, speech-language pathologists, occupational therapists, physical therapist, and social workers. Cognitive rehabilitation consists of diverse interventions; however, there is a consensus in literature that cognitive rehabilitation has to be tailored to individual needs. Restorative and compensatory approach. It includes the repeated exercise of standardized cognitive tests of increasing difficulty, targeting specific cognitive domains e. Compensatory approach teaches ways of bypassing or compensating for the impaired function. Pharmacotherapy based on two principles, catecholaminergic and cholinergic augmentation has been found to be a useful adjunct in cognitive rehabilitation. APT targets five components of attention: Focused attention,

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sustained attention, selective attention, alternating attention, and divided attention. The training program consists of tasks with a hierarchical progression of increasing attention demands, graduating from simple to complex distracters. Compared to the control group, the treatment group showed significantly improved emotional functioning, reduced psychological distress. Cognitive remediation program included direct attention training and compensatory strategy training with memory notebook and problem-solving strategies. A comprehensive review article by Cicerone et al. Metacognitive training targets the development of the compensatory strategy. However it is noteworthy, that there is not enough evidence to differentiate the effectiveness of specific attention training during the acute stage versus gains that occur from spontaneous recovery or general cognitive interventions. Similarly, few studies[28 , 29 , 30] have reported that methylphenidate may improve hypoarousal, attention and processing speed, and general cognitive function. Although methylphenidate was found to improve cognitive functions in several studies the results were conflicting, which until date does not have enough evidence to support its usage among moderate to severe brain injury patients. Memory Memory impairment is one of the most common cognitive impairments after TBI. Cognitive rehabilitation therapy interventions aim either to restore or compensate the memory deficits. Though, computer-assisted strategies have been found to be useful to improve overall general cognitive functioning, attention, memory, and executive skills as a whole. There is strong evidence supporting the use of external memory aids in compensating the memory impairments in TBI persons. Compensatory strategy training, including internalized strategy training e. EL technique facilitates compensatory strategies training targeting personally relevant memory problems, such as taking medications at meal time, or keeping keys in a consistent location. Computer assisted training is useful for improving general cognitive functioning. It has been found to have several benefits such as allowing flexibility in retraining procedures, programs that can be customized for individuals, and finally it reduces the direct time a therapist needs to be with a patient. Several studies have shown computer-assisted strategies to improve attention, memory, and executive skills. However, Levin[44] in his study reported that citicholine may reduce postconcussive symptoms and improve cognition memory during the early period after mild to moderate TBI. In contrast, Zafonte et al. Similarly, Tj et al. Visuospatial perception Visuospatial perception changes such as unilateral neglect, impairments of body scheme, and constructional skills are common in severe TBI persons. When such deficits combine with cognitive impairments, they have a significant impact in rehabilitation participation and ADL along with posing as a safety concern. Using visuospatial cues to direct attention to the areas of residual vision, in vision restoration therapy VRT , some improvement in vision in persons with visual field defect has been documented. It has the potential to enhance neural plasticity and ultimately increase conscious visual perception. A study by Cicerone et al. Likewise, prism adaptation has also been found to be useful in gaze abnormalities. Anosognosia impaired self-awareness or denial is a very common and serious consequence of brain injury. Brain-injured persons with anosognosia face difficulties in the adoption of compensatory strategies, which ultimately comes in the way of rehabilitation. However, pharmacotherapy has not found to be any role for visual perceptual impairments. Language and communication Communication is very complex and involves processing of both verbal and nonverbal information. Language and communication disorder in the TBI can be categorized into four main groups: Apraxia, aphasia, dysarthria, and cognitive communication disorder. Apraxia is the inability to carry out a motor act despite intact motor and sensory pathways. Ideomotor, ideational, and constructional apraxia. They find difficulty specially in word finding[61] and language processing. The principle behind CIAT is massed practice, with language tasks of increasing difficulty and using constraint of compensatory nonverbal communication strategies. Studies[25 , 77 , 78] have reported that pragmatic language skills, social behaviors, and cognitive training along with psychotherapy for emotional adjustment, can significantly improve the social communication skill of the traumatic brain injured persons. Similar results were reported by McDonald et al. Group-based interventions[25] and specialized computer and internet training material[20 , 79] were found to be additional useful methods of rehabilitating social communication skills after TBI. Bornhofen and McDonald[80] suggested

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that EL and self-instruction training both can improve in emotional perception abilities of TBI persons and indirectly can improve communication with the general population. For those with apraxia, studied by Smania et al. Impairments in executive functions may include an inability to perform these cognitive processes and impede daily activities. A number of studies [84 , 85] have reported metacognitive strategy training directed at improving self-monitoring and self-regulation are more effective compared to conventional rehabilitation in improving posttraumatic executive dysfunction. Complex tasks can be broken into smaller steps and directly teaching individuals using step-by-step procedures. Besides the metacognitive training, problem-solving training PST [87] and goal management training [88] have shown favorable outcome in posttraumatic executive function. Pharmacotherapy Dopaminergic agents bromocriptine and amantadine have been found to improve executive function of brain injured persons. Persons who were taking a low dose of bromocriptine 2. Amantadine is also an N-methyl D-aspartate glutamate receptor antagonist, protect neural cells against excitotoxicity. Primary caregivers of persons with TBI undergo a lot of emotional stress and burden. A study done by Sinnakarupan et al. Behavioral changes, very common after traumatic brain injuries, usually include anger, depression, agitation, and verbal or physical aggression. Emotional stability is primarily necessary, otherwise the person with TBI is unable to attend to participate and benefit from the cognitive rehabilitation processes. Psychotherapy individual, as well as group psychotherapy stresses on emotional, and behavioral therapy, which ultimately facilitate the training of cognition-specific interventions. Studies have shown some benefit of coping skills training and anger management in reducing aggression. Pharmacotherapy also aids in the management of behavioral issues, although discussion of this in details is beyond the scope of this article. Noninvasive brain stimulation Demirtas-Tatlidede et al. However, they caution that this evidence is mainly theoretical and recommend further studies for establishing definitive role of NBS in TBI. Comprehensive holistic rehabilitation program Cicerone et al. Comprehensive holistic rehabilitation programme CHRP , a combination of therapeutic services, includes individual and group therapies, psychotherapy, psychoeducation, and family therapy. The holistic neuropsychological intervention stress on metacognitive and emotional regulation technique for cognitive deficits, emotional difficulties. CHRPs facilitate skill transfer and generalization, behavioral and affective regulation, and community integration. Our review study highlights the effectiveness of rehabilitation in reducing the impact of brain injury related cognitive impairments. Novel techniques have emerged and are further evolving. On the other hand, it must be kept in mind that rehabilitation not only encompasses cognitive limitations but also physical and psychosocial issues. Although evidence regarding the efficacy of pharmacotherapy in persons with cognitive and behavioral deficits due to TBI is scarce, they may be used to support recovery.

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Chapter 4 : Severe head injury - NHS

Coping with head injury: introduction and overview --How the brain works and how it is damaged --Treatment and recovery after head injury --Changes in physical functioning --Changes in thinking skills --Changes in speech, language, and communication --Changes in emotions and behaviour --Changes in sexual functioning --Family issues after head.

Depending on the part of the brain affected and the severity of the injury, the result on any one individual can vary greatly. Personality changes, memory and judgement deficits, lack of impulse control, and poor concentration are all common. Behavioral changes can be stressful for families and caregivers who must learn to adapt their communication techniques, established relationships, and expectations of what the impaired person can or cannot do. In some cases, extended cognitive and behavioral rehabilitation in a residential or outpatient setting will be necessary to regain certain skills. A neuropsychologist also may be helpful in assessing cognitive deficits. However, over the long term both the survivor and any involved family members will need to explore what combination of strategies work best to improve the functional and behavioral skills of the impaired individual. Some changes can be quite striking. It may be, for example, that the head injury survivor used to be easygoing, energetic, and thoughtful and now seems easily angered, self-absorbed, and unable to show enthusiasm for anything. This is sure to make the person feel frustrated, angry, or embarrassed. Generally, new learning presents the greatest challenge to memory or remembering. In contrast, pre-injury knowledge is more easily retained. The ability to focus and concentrate are keys to addressing some short-term memory problems. Whenever possible, have the person write down key information e. Keep household objects in the same place. Use the same route to walk to the mailbox or bus stop. If getting lost is a problem, you can label doors or color code doors inside the house, or hang arrows to indicate directions. When going out, the person should be accompanied initially to ensure the route is understood. A simple map can be sketched from the bus stop to the house. Establishing Structure A structured environment can be essential in helping a head injury survivor relearn basic skills. Lack of Emotion After a head injury, a person may lack emotional responses such as smiling, laughing, crying, anger, or enthusiasm, or their responses may be inappropriate. This may be especially present during the earlier stages of recovery. Recognize that this is part of the injury. Try not to take it personally if the person does not show an appropriate response. Encourage the person to recognize your smile at a humorous situation or tears if you are sad , and to take note of the proper response. Emotional Lability In some cases, neurological damage after a head injury may cause emotional volatility intense mood swings or extreme reactions to everyday situations. Such overreactions could be sudden tears, angry outbursts, or laughter. It is important to understand that the person has lost some degree of control over emotional responses. The key to handling lability is recognizing that the behavior is unintentional. Caregivers should model calm behavior and try not to provoke further stress by being overly critical. Aggressive Behaviors Provided a situation does not present a physical threat, various approaches may be used to diffuse hostile behavior: Remain as calm as you can; ignore the behavior. Show extra affection and support to address underlying frustrations. Validate the emotion by identifying the feelings and letting the person know these feelings are legitimate. Do not challenge or confront the person. Offer alternative ways to express anger e. Try to understand the source of the anger. Isolate the disruptive impaired person. Treat each incident as an isolated occurrence, as the survivor may not remember having acted this way before or may need to be prompted to remember. Seek support for yourself as a caregiver. Support groups, professional counselors, and, if necessary, protective services or law enforcement may be contacted. Self-Centered Attitude The person who has survived a head injury may lack empathy. The result can be thoughtless or hurtful remarks or unreasonable, demanding requests. This behavior stems from a lack of abstract thinking. Help cue the person to recognize thoughtlessness. Remember that this is a part of the neurological damage and not just obstinance. Demonstrate that you can do the task easily. Inappropriate Sexual Behavior After a head injury, a person may experience either increased or decreased interest in sex. The causes could be a result of brain regulation of

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hormonal activity or an emotional response to the injury. Sexual disinterest from a head injured spouse should not be taken personally. Avoiding sexual contact could stem from fear or embarrassment about potential performance. Increased sexual interest can be particularly stressful and embarrassing to families and caregivers. Without good impulse control, the survivor may make crude remarks out in public, make a pass at a married friend, try to touch someone in an inappropriate setting, or demand sexual attention from a spouse or significant other. It is important to remind the person that the behavior is not acceptable. A sexually aggressive person may need to be isolated from others where inappropriate behavior is not controlled. A call for help may be necessary, if physical threats are made. Support groups may be useful in helping the person realize the consequences of inappropriate sexual behaviors. A comprehensive neuropsychological assessment is recommended. This may help both the survivor and the family to better understand neurological and cognitive deficits. In some cases, it may be easier for the family caregiver to recognize personality changes than to resolve the problem behavior. Targeted strategies may be used to deal with specific behavioral issues. Finally, it is critical that family members seek and receive support family, friends, support group, counselor in dealing with their own emotional responses to caring for a head injured loved one.

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Chapter 5 : Substance Abuse/Brain Injury Client Workbook | BrainLine

Besides coping with your physical injury, you may worry about other things what this has done to your family, money worries, your future, dreams that may never be fulfilled.

Efforts to prevent violence may focus on: Changing social norms about the acceptability of violence and the willingness to intervene Improving skills and competencies for example, communication, impulse control, parenting, conflict resolution, coping Fostering safe, stable, nurturing relationships and environments for children and families Changing policies to address the social and economic conditions that often give rise to violence Emerging Issues in Injury and Violence Prevention While not included as objectives in Healthy People , there are several emerging issues in injury and violence prevention that need further research, analysis, and monitoring. For unintentional injuries, there is a need to better understand the trends, causes, and prevention strategies for: Prescription drug overdose deaths Motor vehicle crashes due to distracted driving Traumatic Brain Injury In the area of violence, there is a need to better understand the trends, causes, and prevention strategies related to: Bullying, dating violence, and sexual violence among youth Elder maltreatment, particularly with respect to quantifying and understanding the problem Overlapping causes of violence and the strategies that can prevent multiple forms of violence References 1 Centers for Disease Control and Prevention CDC , National Center for Injury Prevention and Control. Journal of Safety Research 43 4: Estimated lifetime medical and work-loss costs of fatal injuries-United States, Morbidity and mortality weekly report, 64 38 , Estimated lifetime medical and work-loss costs of emergency department-treated nonfatal injuries-United States, The ecology of human development: Experiments by nature and design. Advancing injury and violence prevention in the United States. Handbook of injury and violence prevention. Chapter 14, Changing the built environment to prevent injury; p. A difference-in-differences analysis of health, safety, and greening vacant urban space. American Journal of Epidemiology, 11 , Changing the social environment to prevent injuries. Chapter 15 in Handbook of injury and violence prevention pp Injury prevention and behavior: Chapter 1 in Injury and violence prevention: Behavioral science theories, methods, and applications pp

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Chapter 6 : Cognitive Impairment and Rehabilitation Strategies After Traumatic Brain Injury

Coping with head injury: introduction and overview -- How the brain works and how it is damaged -- Treatment and recovery after head injury -- Changes in physical functioning -- Changes in thinking skills -- Changes in speech, language, and communication -- Changes in emotions and behaviour -- Changes in sexual functioning -- Family issues.

Overview This website contains a thesis that was completed in The research component of the thesis involved a year long study of people with traumatic brain injuries. The subject matter of the thesis included a theoretical analysis of certain topics of interest that the author surmised would be of interest to the brain injury survivor community, a community that included the author. The study was undertaken between and The author sustained a tbi in It was a slow process, eventually achieved. Ultimately the topic was allowed, the work commenced, and the faculty advisors were incredibly supportive and knowledgeable about how to conduct a research project. Many others were also helpful with their special insights. Most praiseworthy of all were the study participants who happened to be people with traumatic brain injuries TBI. They shared their knowledge and personal situations in order that the study go forward. This thesis, which actually came from the perspectives of persons with brain injuries, resulted. For people with TBI and other kinds of acquired brain injuries, brain injury can bring on great life challenges and changes. There are never enough resources for survivors and their families to cope with numerous struggles on many fronts that can result from brain injury. The issues faced are not just medical, but economic, cognitive, interpersonal, political, legal and spiritual. In the ensuing years, the author came to realize that the brain injury survivor community included many others besides persons with traumatic brain injuries. It included persons with other forms of acquired brain injury abi including people with strokes, brain illnesses and other abi conditions. Although orginally designed as a commentary on the perspectives of persons with traumatic brain injuries, the thesis also can extend in many respects to the issues of the larger acquired brain injury community. In conclusion, we survivors with any kind of acquired brain injury must continue to communicate to get our viewpoint on things out into the public arena. Some survivors are affiliated with the Brain Injury Network <http://www.braininjury.org>: We continue to develop and disseminate a public policy agenda that will benefit our survivor community, that is to say, people with acquired brain injuries. The author of this thesis and web site is pleased to announce the publication of her book entitled Brain Injury Advocates: This book is available for purchase.

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Chapter 7 : Head injury the facts - ECU Libraries Catalog

TBI and PTSD can affect the whole family. Whether you're caring for a partner, a spouse, a parent, or a child, family dynamics will change. We've gathered basic information about family relationships and some hard-earned wisdom from caregivers sharing their stories.

Summary Acquired brain injury refers to any type of brain damage that happens after birth. Causes of ABI include disease, blows to the head, alcohol and drug use, or oxygen deprivation. Coping with the consequences of acquired brain injury can be difficult for everyone, including family members. Acquired brain injury ABI refers to any type of brain damage that occurs after birth. It can include damage sustained by infection, disease, lack of oxygen or a blow to the head. Two thirds of all people with an ABI who have their activity limited or restricted are over the age of 65. One third of those are over the age of 75. The largest age group is between 40 and 49 and, at all ages except for those aged 80 and over, rates for males are higher than for females. How brain injury occurs Brain injury can occur through: Causes of acquired brain injury ABI Acquired brain injury is any damage to the brain that happens after birth. The specific symptoms or losses of functioning depend on which brain areas are affected. Some of the causes include: How ABI affects a person The long-term effects of brain injury are difficult to predict. They will be different for each person and can range from mild to profound. It is common for many people with ABI to experience increased fatigue mental and physical and some slowing down in how fast they can process information, plan and solve problems. They may experience changes to their behaviour and personality, physical and sensory abilities, or thinking and learning. This soft, jelly-like organ has countless billions of neural cross-connections. It functions using a combination of electrical and chemical means. The brain oversees the workings of the body, and gives us consciousness and personality. It is divided into two halves; the left hemisphere and the right hemisphere. Each hemisphere is further subdivided into lobes. This fluid nourishes the brain and serves as a shock absorber. The brain is connected to the rest of the body through the spinal cord. Together, the brain and spinal cord make up the central nervous system. Traumatic brain injury Traumatic brain injury TBI is not the same as head injury, since a person can sustain damage to the face, scalp and skull without necessarily injuring their brain. TBI is considered a form of acquired brain injury, and refers to brain damage caused by an impact to the head. When the head is struck hard, the brain slams against the inside of the skull, causing physical injuries such as bruising, swelling, bleeding, twisting or tearing of tissue. There are degrees of injury, ranging from a momentary loss of consciousness which can happen from a punch to the face, for example to a long-term bout of unconsciousness or coma. Treatment for brain injury A range of tests, including x-rays and CT brain scans, can help pinpoint the exact areas of damage. In some cases, surgery may be needed. Recovery depends on the extent and location of the brain damage, the age and general health of the person, the speed of first aid received and the quality of treatment. The consequences of a person having an ABI are far reaching. Coping with any loss of functioning and going through rehabilitation can be difficult. The person with an ABI will have great distress. Family, friends and partners will also experience difficulties as they deal with emotional and practical challenges, interruptions to family life and role changes. An ABI can affect intimate relationships, friendships, social networks, recreational and vocational activities. It may force the person and their immediate family to adapt to a completely new way of life and new kinds of relationships. Caring for someone who has had a brain injury may bond a family closer together. It can also mean enormous burdens for the family, which may tear it apart. It will help if family members: For carers to cope with the situation, it helps to: Where to get help.

Chapter 8 : Head Injury : Audrey Daisley :

Coping with the impact of a family member's head injury is one of the most difficult tasks that can confront a family. In this

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article, an overview of head injury etiology and sequelae is presented, along with the impact on blog.quintoapp.comines for counseling families of persons with headinjuries and suggestions forfuture research are provided.

Chapter 9 : Acquired brain injury - Better Health Channel

INTRODUCTION. Traumatic brain injury (TBI) is a steadily rising public health concern and one of the significant causes of morbidity and mortality in India.[.] Around 10 million people sustain TBI worldwide annually.[.]