Exposing an Invisible Crisis

Building Holistic, Integrated Care Pathways for Intimate Partner Violence Survivors with Traumatic Brain Injury through Multi-Sector Partnerships in Manitoba

Literature Review

University of Manitoba

Research and Education for Solutions to Violence and Abuse
RESOLVE
MANITOBA

Social Sciences and Humanities Research Council of Canada

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Citation for this document: Charles, A., Arthurs, A., Leverick, K., Hill, G., Kisil, S., Holwell, G., Stewart-Tufescu, A., Nixon, K. (2026). *Exposing an Invisible Crisis: Building holistic, integrated care pathways for intimate partner violence survivors with traumatic brain injury through multi-sector partnerships in Manitoba: Literature Review*. RESOLVE, University of Manitoba.

This project is supported by funding from the Social Sciences and Humanities Research Council of Canada (File Number 890-2024-0163).

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Literature Review: Intimate Partner Violence and Traumatic Brain Injury

Introduction

Intimate partner violence (IPV) is a public health and social issue that disproportionately impacts women, girls, and gender-diverse individuals (Women and Gender Equality Canada, 2024). In Canada, the federal government has labelled IPV an epidemic (Hayes, 2023). Traumatic brain injury (TBI) is another public health and social issue that has serious and long-lasting consequences for Canadians (Brain Injury Canada, 2023). On their own, IPV and TBI are significant concerns. Together, in the case of IPV-inflicted TBI (IPV-TBI)[1], they are compounded and profound. Estimates show that 75% (Valera & Berenbaum, 2003) or between 60-92% (St. Ivany & Schminkey, 2016) of IPV survivors are likely to have sustained a brain injury from their partner's (or ex-partner's) violence. Yet, there is limited diagnostic criteria and a lack of awareness, training, and coordination across help-seeking sectors, resulting in IPV-TBI going unrecognized and untreated (Clarke et al., 2024; Nicol et al., 2021). Consequently, IPV-TBI survivors' may experience higher risks of unemployment, income instability, substance use, job loss, and loss of child custody (Boyle et al., 2022; Lamontagne & Ben Miloud, 2023); be deterred from disclosing IPV-TBI and engaging with care systems (St. Ivany, Bullock, et al., 2018); and experience worsening symptoms, chronic impairments, and sometimes premature death (Brain Injury Canada, 2023).

Evidently, there is a need to expose and address the invisible crisis of IPV-TBI. RESOLVE Manitoba, in collaboration with a multidisciplinary Advisory Circle and Partnership Network,

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[1] This paper will use the term IPV-inflicted TBI to refer to brain injuries that occur as the result of violence perpetrated by an intimate partner. This language is intentional, leading with the cause of the injury and explicitly recognizing the perpetrator of that violence. Too often, passive language obfuscates perpetrators and erases the cause of the violence.

has developed a research project[2] that explores the intersection of IPV and TBI for the purpose of developing holistic pathways of care in Manitoba. This review is intended to help readers better understand the intersection of IPV and TBI, as well as the diverse and cross-sectoral impacts. As such, a wide range of topics relevant to the topic of IPV-TBI and goals of the project are covered. To begin, two issues central to the project—IPV and TBI—are explained. The following section provides a general overview of IPV and TBI in Canada and, when available, the Prairies. Next, the developing field of research investigating the intersection of IPV-inflicted TBI is described. The definition and development of IPV-TBI pathways of care are discussed in the following section. Next, specific populations and their vulnerabilities to IPV-TBI, including, Indigenous survivors, 2SLGBTQQIA+ and queer populations, newcomers to Canada, and mothers, are outlined. Community and public responses to IPV-TBI, including policing and emergency responses, shelter services, legal implications, and child protection services, are described next. The final section discusses IPV-TBI in relation to the social issues of mental health, substance use and addictions, and disability.

Methodology

The setting of the Canadian prairies (Manitoba, Saskatchewan, and Alberta) and the goals of this project were key considerations in the approach and scope of this review. Subject areas were identified by a combination of academic, community, and student team members, all of whom are working and researching in areas connected to the project. Before beginning the initial literature search, the larger team developed various keywords to clarify scope.[3] Various words

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[2] RESOLVE Manitoba was awarded a Partnership Development Grant (PDG) from the Social Sciences and Humanities Research Council (SSHRC), *Exposing an Invisible Crisis — Building Holistic, Integrated Care Pathways for Intimate Partner Violence Survivors with Traumatic Brain Injury through Multi-Sector Partnerships in Manitoba*. This project will run from 2025-2028.

[3] Various BSW, MSW, and PhD students, the project coordinator, the social work subject librarian, and the principal investigator (PI) were involved in this round-table discussion.

and language were discussed for each subject area to ensure the comprehensiveness of the search, and team collaboration was an ongoing part of the research process. Several databases were selected for initial searches (Social Work Abstracts, Sociological Abstracts, Social Services Abstracts, Psych Info, Web of Science), as well as databases for grey literature (e.g., Policy Commons, Canada Commons, Google Scholar, Statistics Canada reports). Following these initial searches, the reference list of relevant articles, as well as additional databases, was used as needed. Initial searches and identified literature were reviewed by the project coordinator at various stages of the research process to ensure continuity with other students and the larger project.

An Introduction to IPV and TBI

Intimate Partner Violence[4]

IPV is a type of gender-based violence that occurs within the context of an intimate relationship and can include coercive control, criminal harassment, stalking, emotional/psychological abuse, economic abuse, physical abuse, reproductive coercion, sexual violence, spiritual abuse, and technology-facilitated violence (also referred to as cyberviolence) (Women and Gender Equality Canada, 2024). The World Health Organization (WHO) estimates that one in three women worldwide will be victimized by IPV in their lifetime (WHO, 2021). In Canada, 44% of women and 36% of men report experiencing IPV in their lifetime (Cotter, 2021).

The Gendered Nature of IPV

While many prevalence estimates in Canada show similar rates of IPV between men and women, these epidemiological studies cannot account for important contextual information to better understand associated impacts and mechanisms. Research consistently shows that it is

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[4] This chapter was written by AmyAnne Charles.

women compared to men and other gender-diverse people who sustain the most serious and severe physical forms of IPV—they are more often strangled, assaulted, threatened with a weapon, or sexually assaulted (Burczycka, 2016; Cotter, 2021). While the majority of instances of IPV are not reported to police, the vast majority of survivors who do report are women (Burczycka, 2016). Additionally, crime data consistently shows that women are more likely to be killed by an intimate partner than by any other kind of perpetrator. In 2019, 47% of women in cases of solved homicides were killed by their intimate partner, while the same was true in only 6% of men (Cotter, 2021). IPV is a component of more than a quarter of all police-reported violent crime in Canada and is a leading cause of non-fatal injury to women, with the most common sites of injury being the head, neck, and face (ABI Research Lab, 2025; Sheridan & Nash, 2007). In the most recent data available from 2023, there were 123,319 victims of police-reported IPV (or 354 victims per 100,000 individuals) in this single year alone (Statistics Canada, 2024a).

Geographic Differences in IPV

The Prairie Provinces have higher rates of IPV than other parts of Canada. In 2022, Saskatchewan and Manitoba had the highest rates of police-reported IPV (732 per 100,000 and 633 per 100,000 respectively (Statistics Canada, 2024b). These provinces also had the highest rate of homicide of women and girls (Statistics Canada, 2024b). This violence is more frequent and severe for Indigenous women and girls, with almost 60% reporting some form of IPV in their lifetime (Heidinger, 2021). Given that the Canadian prairies are the traditional territories of many Indigenous Peoples in urban centres and on-reserve, this crisis must be met with an increased urgency (Statistics Canada, 2017).

Traumatic Brain Injury[5]

In the most general sense, a brain injury is defined as a sudden alteration in brain function that disrupts normal functioning (Menon et al., 2010) and effects how the brain works (Centers for Disease Control and Prevention, 2025). An acquired brain injury is a more specific injury defined as damage to the brain that occurred after birth, not related to congenital or degenerative diseases (Brain Injury Canada, 2020). There are two different types of acquired brain injuries: 1) traumatic brain injury (TBI) and 2) non-traumatic brain injury. TBI is a type of acquired brain injury caused by something outside of the body (e.g., blow to the head), while a non-traumatic brain injury is caused by a health issue within the body (e.g., stroke) (Brain Injury Canada, 2020). Traumatic brain injuries can be the result of a number of different sources, including (but not limited to): combat injuries, motor vehicle accidents, sports injuries, falls, shaken baby syndrome, and IPV (Public Health Agency of Canada, 2024).

Pathophysiology

There are three categories used by medical professionals to classify traumatic brain injuries, representing different mechanisms of injury: closed head; penetrating; and explosive blast. Closed head TBI are typically caused by a blunt impact, which result in immediate damage to brain vasculature (arteries, veins, capillaries) and neuronal cells (or neurons/nerve cells) under impact site (Ng & Lee, 2019). The vibrations from the impact in a closed head TBI can also result in brain displacement—the brain to shift out of its normal position—which can subsequently result in the compression of brain tissue and reduction of blood flow (Ng & Lee, 2019). Penetrative TBI are caused by an object penetrating the skull (bone) and dura (protective membrane) into the brain tissue (Ng & Lee, 2019). Finally, explosive TBI and subsequent

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[5] This chapter was written by AmyAnne Charles.

injuries are the result of shock waves and the energy they produce (Ng & Lee, 2019). Symptoms of TBI are varied and include neck pain, loss of consciousness, confusion, headache, vomiting, unusual behavioural changes, seizures, double vision, weakness/tingling in limbs, coma, anxiety, aggression, and memory issues/amnesia (Pennsylvania Coalitioni Against Domestic Violence, 2024).

Prevalence

TBI is a leading cause of disability worldwide and is more prevalent than breast cancer, spinal cord injury, HIV/AIDS, and multiple sclerosis combined (Haag, Sokoloff, et al., 2019). In Canada, approximately 20 percent of the population lives with a TBI (Brain Injury Canada, 2023). Between 2018 and 2023, there were approximately 823,884 visits to emergency departments in Canada that were related to a TBI (Public Health Agency of Canada, 2020).[6] In an analysis of various health surveillance systems published in 2020,[7] the Public Health Agency of Canada (PHAC) found that there were 53,200 injury deaths associated with a TBI diagnosis (PHAC, 2020). Additionally, concussions—which are defined as a mild form of TBI (PHAC, 2020)—are one of the most common diagnostic categories assigned by health professionals. Currently, there is no data on the prevalence of TBI that is specific to Manitoba or the prairies. This is a gap that the larger project seeks to address through the analysis of administrative data housed at the Manitoba Repository for Health Research (MCHP, 2025). While there is a significant body of literature on brain injuries, very little of this work is devoted to (or even mentions) IPV-TBI.

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[6] This data was collected using the National Ambulatory Care Reporting System, gathered by the Canadian Institute for Health Information, which has data from Emergency Departments, day surgery, and other ambulatory care visits (Public Health Agency of Canada, 2024)

[7] Vital statistics, Hospital Morbidity Database, Discharge Abstract Database, Canadian Institute of Health Information, National Ambulatory Care Reporting System, and electronic Canadian Hospitals Injury Reporting and Prevention Program (eCHIRPP).

Intersection of IPV and TBI

The type of violence and mechanism of injury involved in abuse against women makes them more likely to sustain a TBI. Male partners perpetrate violence repeatedly against their female partners and over a sustained period of time (Cotter, 2021), and they often strike women's heads, necks, and faces (Adhikari, Maldonado-Rodriguez, et al., 2024). Men also strangle their partners—manually or using a ligature—which increases the likelihood of a brain injury (Adhikari, Stranges, et al., 2024; St. Ivany & Schminkey, 2016). Women with IPV-TBI experience a myriad of physical symptoms, including blurry vision, migraines, fatigue, tinnitus, body aches, insomnia, permanent disability, and visible long-lasting injuries such as scars and broken teeth (Kwako et al., 2011; St. Ivany, Bullock, et al., 2018; Toccalino et al., 2023).

Diagnosis of IPV-TBI

While severe to moderate TBI can be diagnosed with tools available in medical facilities, such as a CT scan, mild TBI requires subjective evaluation by a healthcare provider (Public Health Agency of Canada, 2020). The guidelines for assessing and diagnosing mild TBI is well documented (Children's Safety Network, 2020; Deaconess Regional Trauma Center, 2023; Gillette Children's Specialty Healthcare, 2024), but are not designed with IPV-specific injuries in mind. In Manitoba, Dr. Michael Ellis and the Pan Am clinic have developed a pilot clinical pathway for IPV-TBI (Pan Am Clinic, 2025); however, as of June 3, 2025, this project has been discontinued and will no longer be accepting new referrals. There are IPV-TBI toolkits available through the Acquired Brain Injury Research Lab (ABI Research Lab, 2025) and the Supporting Survivors of Abuse and Brain Injury through Research (SOAR) program (SOAR, 2025). Additionally, Bill C-277, legislation to establish a national strategy on brain injuries, is currently moving through parliament (*National Strategy on Brain Injuries Ac*t, 2025).[8] These efforts are important steps in addressing IPV-TBI, but are either in-progress, underfunded, or absent across much of Canada. While some types of brain injuries have clearly defined clinical pathways, the criteria for assessing partner-inflicted brain injuries continues to be extremely limited.

Pathways of Care[9]

A pathway of care is a structured, coordinated approach that guides individuals through essential treatment and support steps, ensuring appropriate care at each stage (Schrijvers et al., 2012). In the context of IPV-TBI, a pathway of care is a comprehensive, integrated and trauma-informed network of services addressing both the physical and psychological impacts to support survivors' recovery, safety, and well-being. Coordinated, cross-sector protocols that bridge healthcare, community, and legal systems are crucial for responding to IPV-TBI (Rajaram et al., 2024; Ramesh et al., 2024; Toccalino et al., 2022). Early detection, streamlined referrals, and continuity of care are critical for reducing harm and enhancing recovery trajectories (Rajaram et al., 2024; Ramesh et al., 2024; Toccalino et al., 2022). As elaborated in the following discussion, current care pathways present numerous barriers for IPV-TBI survivors. Reimagined pathways will improve survivor outcomes, strengthen social service and healthcare systems, and advance survivor-centered, equity driven, justice-oriented care.

Barriers and Determinants of Care

Systemic Fragmentation

Disconnected sectors—including legal, healthcare, housing, and social services—operate in silos, governed by jurisdictional mandates that rarely communicate or coordinate effectively

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[8] This bill was first introduced to parliament in a first reading in 2022. In 2024, Bill C-277 passed in the House of Commons with a unanimous vote and went on to pass the Standing Committee in the fall of 2024 (National Strategy on Brain Injuries Act, 2025).

[9] This chapter was written by Gary Hill.

(Adhikari, Stranges, et al., 2024; V. Chan et al., 2022; Grewal et al., 2024). This systemic disconnection places the burden of coordination on survivors themselves, forcing them to coordinate their own care while coping with the cognitive and emotional impacts of brain injury. For those navigating the impacts of colonization, racism, geographic isolation, and poverty, these failures amount to what many survivors describe as systemic abandonment (Haag, Biscardi, et al., 2019). This fragmentation extends beyond initial points of contact. Survivors seeking longer-term supports such as housing, rehabilitation, or mental health services encounter systems that remain disjointed and unresponsive to the cognitive realities of brain injury. Many programs lack the training, resources, or structural design needed to accommodate survivors' neurocognitive needs (Clarke et al., 2024; Gill, 2023). The result is a deep erosion of trust, repeated traumatization, and missed opportunities for recovery. National data further underscore these failures: in a multi-jurisdictional review of Canadian and American research, Bell et al. (2024) document systemic breakdowns in IPV-TBI screening, documentation, and follow-up across health systems. These are not isolated oversights, but are patterned, structural, and entirely preventable.

The Invisibility of TBI

The literature overwhelmingly illustrates that IPV-TBI is not only underrecognized but systemically erased. Most media and medical attention on TBI focuses on sports-related injury, even though TBI resulting from IPV is much more common (St. Ivany & Schminkey, 2016). There is a lack of standardized IPV-TBI screening protocols and widespread gaps in provider training across sectors (Clarke et al., 2024; Nicol et al., 2021). Despite growing neurobiological evidence of the cognitive, emotional, and behavioural effects of IPV-TBI (Valera & Kucyi, 2017), most frontline practitioners remain ill-equipped to ask the right questions or interpret the subtle ways survivors communicate distress (Haag, Sokoloff, et al., 2019).

Consequently, systems, and professionals within them, often fail to recognize or respond to the neurological and psychosocial impacts of IPV-TBI (Costello & Greenwald, 2022; Heidinger, 2021). At critical first points of contact—such as emergency departments, women's shelters, and primary care settings—survivors' injuries are frequently misdiagnosed, minimized, or completely overlooked (Murray et al., 2015; Nemeth et al., 2023; Valera, 2020). Symptoms are frequently misunderstood and misinterpreted, especially when injuries are invisible (Hendrix et al., 2025; Mahood, 2025; Valera & Kucyi, 2017).). Forgetfulness, irritability, and confusion are often pathologized as defiance, mental instability, or poor mothering/parenting (Gill, 2023; Mahood, 2025). Memory lapses, disorientation, affect dysregulation, or cognitive fatigue are frequently pathologized and attributed to mental illness, noncompliance, or substance use, rather than recognized as signs of neurological trauma (Nemeth et al., 2019; Valera et al., 2019; Valera & Kucyi, 2017). In such cases, survivors are not only denied validation but are placed at further risk of being excluded from services, discredited in legal proceedings, or retraumatized by inappropriate care. Without expertise, tools, time, or trauma-informed frameworks, providers miss the chance to intervene in meaningful, life-altering ways (Clarke et al., 2024; Grewal et al., 2024).

The Need for Screening and Documentation

Emerging models of screening offer promising alternatives to harmful norms. Research by Pebole et al. (2024) demonstrate that brief, trauma-informed IPV-TBI screenings embedded in primary care can significantly improve survivors' safety outcomes, bolster social support, and reduce future exposure to violence. These interventions succeed not just because they detect injury, but because they acknowledge survivors as experts in their own experience, placing relational care at the forefront. Other toolkits that focus on identification, education, intervention, and ongoing care have been developed for use in healthcare and community settings (Montgomery & Ramirex, n.d.; Pennsylvania Coalitioni Against Domestic Violence, 2024). Epidemiological analysis by Ramesh et al. (2024) confirms that IPV-TBI is far more prevalent than current data suggests, and that they affect survivors of all genders, ages, and backgrounds. However, a consistent failure to document the IPV context of these injuries in medical records leads to systemic erasure, undermining both prevalence estimates and intervention opportunities.

The rationale offered by some providers for avoiding screening, such as fears of re-traumatization, legal complications, or discomfort, must be critically examined. Nicol et al. (2021) note that while these concerns may be valid, they are often used as justification for inaction. The absence of inquiry itself can also be profoundly re-traumatizing for individuals. When survivors are not asked, not believed, or not taken seriously, they are left to carry the invisible weight of their trauma alone. This invisibility fosters emotional exhaustion, self-doubt, and repeated storytelling—none of which advance safety or healing (Mahood, 2025; St. Ivany, Kools, et al., 2018).

Addressing these concerns requires a paradigm shift. IPV-TBI screening must evolve from a rare intervention to a routine expectation. Screening should not be treated as a procedural task but as a doorway to care that validates lived experience and creates space for healing When done well, IPV-TBI screening not only identifies injury but also signals to survivors that their stories matter, their symptoms are real, and their futures are worthy of investment (Clarke et al., 2024; Rajaram et al., 2024). In a system too often defined by silence, disbelief, and neglect, relational, survivor-centered inquiry is essential. As elaborated in the following section, this is not just clinical—it is a political and ethical imperative.

Trauma-Informed and Survivor-Centered Practices

Trauma-informed, survivor-centered practices depart sharply from traditional systems (such as child protection, healthcare, legal, and shelter services) that seek to assess, manage, or discipline survivors. Instead, it moves toward frameworks grounded in autonomy, relational accountability, and the legitimacy of lived experience. Care is reconceptualized not as something done to survivors, but developed with them, anchored in trust, choice, and cultural responsiveness (Mahood, 2025). Survivors consistently express the need to be believed, actively involved, and supported in ways that reflect their cognitive, emotional, social, and cultural realities (Hendrix et al., 2025; Iverson et al., 2019). Crucially, survivor-centered care is not static or prescriptive; it demands flexibility, humility, and a sustained commitment to listening, learning, and adapting. It is both a philosophy and a practice—one that must be embedded at every level of service delivery. A truly survivor-centered approach requires providers to not only recognize brain injury as a legitimate health concern, but also to respond with intersectional awareness, cultural humility, and practical accommodations (Omar et al., 2023; Toccalino et al., 2024).

Trauma-informed care offers a pathway to operationalize this shift. Among the most promising models is CARE (Connect, Acknowledge, Respond, Evaluate), which aims to enhance provider empathy, build trust, and address the cognitive, psychological, and relational effects of IPV-TBI (Nemeth et al., 2019; Sucaldito et al., 2025). Rather than viewing survivors through a deficit lens, CARE supports strengths-based, survivor-led decision-making. Sucaldito et al. (2025) found that the implementation of CARE tools improved providers' ability to recognize cognitive symptoms and offer tangible supports, such as slowing intake processes, adjusting communication styles, or allowing for sensory breaks. Though seemingly minor, these accommodations help restore dignity, safety, and relational connection. Similarly, Kemble et al. (2022) demonstrate that organizational integration of CARE results in greater survivor confidence, improved access to mental health resources, and stronger advocacy relationships.

However, even the most promising tools are insufficient without systems that support their use. The literature calls for broad-based change, where trauma-informed, interdisciplinary responses become standard practice. Monahan (2018) challenges social work and allied fields to reject narrow biomedical frameworks and instead recognize the intersecting impacts of trauma, poverty, racism, colonization, and brain injury. Women must be seen not as isolated individuals, but as members of communities with layered histories, navigating systems that too often pathologize their pain while denying its roots. What is needed are collaborative models that integrate legal, health, and social supports through equity-driven, culturally safe practices. These approaches dismantle hierarchy and foster true interdependence, bridging gaps that survivors are too often left to traverse alone (Toccalino, Haag, Nalder, Chan, Moore, Wickens, et al., 2024).

At the heart of this transformation is the integration of survivor voice; not as an afterthought or mere consultation, but as foundational expertise. Across multiple studies, the most effective models are co-created with those who live the realities of IPV-TBI. Survivors' experiential knowledge offers insights that cannot be replicated through professional training alone (Adhikari, Stranges, et al., 2024; Gill, 2023; Macy et al., 2018; Pebole et al., 2024). When survivor wisdom informs design, evaluation, and leadership, systems become more transparent, responsive, and accountable. This co-creation is a necessity for ethical and effective practice. Only by centering those most impacted can we begin to build systems that heal, rather than harm.

Models for Integration and Policy Reform

A growing body of literature offers tangible, survivor-informed solutions to the systemic failures that have long defined IPV-TBI response. These works move beyond critique to offer blueprints for building coordinated, trauma-informed, and equity-centered systems of care. Central to these strategies is the call for fully integrated service models. For example, these approaches must dissolve institutional silos and link healthcare, shelter, legal aid, housing, and community supports within a cohesive, survivor-led continuum (V. Chan et al., 2022; SOAR, 2025). These models recognize that survivors' needs rarely align with bureaucratic categories, and that fragmented service delivery often replicates the chaos, control, and confusion of abuse itself.

Building on this foundation, the literature highlights the effectiveness of co-located and interdisciplinary service delivery. For example, Pebole et al. (2024) and Haag et al. (2019) show that when survivors can access trauma-informed clinicians, legal advocates, and brain injury specialists under one roof, outcomes improve across domains including safety, housing stability, neurorehabilitation, and emotional well-being. These wraparound supports are especially critical for women experiencing cognitive impairments, who are often excluded from services due to stigma, systemic fatigue, or logistical barriers. However, the sustainability of these models relies on more than frontline innovation; they require durable policy infrastructure. To move from isolated success to systemic transformation, researchers stress the need for cross-sector education, shared information systems, stable funding, and governance mechanisms that hold systems accountable to survivors (V. Chan et al., 2022; Pebole et al., 2024; Toccalino et al., 2022; Toccalino, Haag, Nalder, Chan, Moore, Wickens, et al., 2024). Without these structural supports, integration risks becoming a temporary project rather than a long-term norm.

Extending this focus, Toccalino et al. (2024) emphasize that sustainable change must be rooted in survivor-defined metrics, feminist principles of care, and culturally safe programming. These commitments are especially vital in rural and remote regions. Kardashevskaya et al. (2022) underscore the importance of place-based frameworks in these settings, where survivors face elevated risks of isolation, service scarcity, and transportation barriers. Without tailored policies responsive to geographic and cultural realities, integration remains an urban-centric ideal rather than a truly equitable standard.

In tandem with policy reform, health system innovations are helping to translate vision into practice. Rosenblatt et al. (2019) call for trauma-informed, hospital-anchored interventions that extend into community settings, fostering continuity of care from triage through rehabilitation. The Pan Am Clinic (2025) IPV-TBI pilot pathway embedded screening, referral, and follow-up directly into clinical workflows. Developed through collaboration with community advocates and organizations, the model reflected a broader shift toward relational accountability, survivor-led design, and coordinated system change. However, this project has since been discontinued.

To support the success of such innovations, frontline practitioners require tools that foster care that is both trauma-informed and underpinned by knowledge of brain injuries and their impacts. Survivor-informed toolkits that translate complex research into accessible strategies for frontline use are a good example of these innovations (ABI Research Lab, 2025; Campbell et al., 2020). These resources enhance provider capacity, promote interdisciplinary collaboration, and disrupt traditional hierarchies by positioning survivor expertise as foundational rather than supplemental. Building on this, the SOAR (2025) offers a medical provider resource specifically designed to embed IPV-TBI awareness into daily clinical routines. The resource includes documentation guidelines, trauma-informed referral protocols, and strategies for responding to the broader social and systemic realities survivors face.

Taken together, these examples illustrate that meaningful change is not only possible, but also already unfolding across Canada. However, the sustainability and reach of these efforts depend on whether they are scaled and embedded within long-term, coordinated strategies. Transformation requires structural redesign rooted in trauma-informed values, survivor-led leadership, and equity-driven policy. The ongoing invisibility of IPV-TBI, particularly at first points of contact like emergency rooms and shelters, results in widespread misdiagnosis, disbelief, and systemic neglect. However, as seen in much of the existing literature, when care is trauma-informed, survivor-led, and culturally grounded, it can restore safety, dignity, and hope. Integrated, equity-based models—particularly those shaped by Indigenous knowledges, intersectional analysis, and survivor expertise—offer concrete, replicable strategies for system transformation. Initiatives like the CARE model, co-located service hubs, and place-based interventions in rural areas show that change is attainable. To build on these foundations, systems must move beyond pilot projects and rhetorical commitments towards a structural redesign that embeds survivor-defined metrics, sustainable funding, intersectoral governance, and accountability at every level. Survivors, communities, and frontline practitioners have already outlined the way forward. Their expertise—grounded in lived experience and sustained resistance—has produced a growing body of models, practices, and policies that are ready to be scaled. The challenge now is not a lack of evidence or innovation, but a lack of political will and coordinated investment. If systems are serious about supporting survivors of IPV-TBI, they must begin by listening—and then act with sustained courage, clarity, and care

Specific Populations

Certain populations are increasingly and uniquely impacted by IPV. Compared to their non-marginalized counterparts, rates of IPV are higher in younger women and girls (29% vs 10%), Indigenous women (61% vs 44%), and women with disabilities (55% vs 37%) (Women and Gender Equality Canada, 2024). Survivors who are racialized, newcomers, or living in rural and remote regions, also face adverse risks and consequences (Costello & Greenwald, 2022; Heidinger, 2021). Macy et al. (2018) emphasize that recognizing survivors' intersecting identities is essential to delivering trauma-informed, equitable care; yet most systems remain unequipped to operationalize this understanding, resulting in continued suffering and exclusion (Grewal et al., 2024). This portion of the literature review examines IPV and TBI from an intersectional lens, highlighting the experiences of Indigenous survivors, 2SLGBTQQIA+ survivors, newcomers, and mothers.

Indigenous Survivors[10]

The intersection of IPV, TBI, colonialism, and Indigeneity is underexplored in academic literature, policy frameworks, and clinical practice. As noted earlier, Indigenous women in Canada, along with Two-Spirit and Indigenous trans, and gender-diverse people, are disproportionately affected by IPV (Cotter, 2021). Indigenous women are estimated to be three times more likely than non-Indigenous women to experience IPV (Heidinger, 2021), and six times more likely to be victims of homicide (MMIWG, 2019). Among Two-Spirit, Indigenous trans and non-binary people in Canada, 73% report experiencing IPV in their lifetime (Merasty et al., 2021). These patterns are the outcomes of layered colonial harms, including the residential school system, the Sixties Scoop, systemic racism, and chronic underfunding of Indigenous

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[10] This chapter was written by Katherine Leverick.

health and social services (Hunt, 2016; MMIWG, 2019). Indigeneity and the impacts of colonial violence have received little focused attention in TBI research. This section draws together sources that, while varied in scope and method, help illustrate both the persistent barriers to diagnosis and care and the possibilities for more just, culturally grounded responses.

Social Determinants of TBI and IPV

The social and structural conditions that contribute to TBI among Indigenous populations are well-documented. In a systematic review, Zeiler and Zeiler (2017) identified 10 studies that discussed the social determinants of TBI among Indigenous populations in Canada and the United States. Across these studies, six recurrent social determinants emerged: rurality, gender, substance use, interpersonal violence, limited access to rehabilitation, and lack of familial support in care settings. While gender was identified as a significant social determinant of TBI in Indigenous Peoples, studies disproportionately linked TBI to males, often attributing this to risk-taking behaviours and substance use (Coronado et al., 2011; Zeiler & Zeiler, 2017). In contrast, female gender was only noted in one study as a risk factor, and only in the context of interpersonal or family violence 2026-05-14 11:32:00 AM. This suggests a potential gap in recognition of the disproportionate impact of IPV on Indigenous women and gender-diverse people, and thus, the underrepresentation of health impacts such as TBI (Zeiler & Zeiler, 2017). Additionally, approximately 35% of Indigenous Peoples in Manitoba live on a reservation (Zeiler & Zeiler, 2017). Zeiler and Zeiler (2017) note that people living in reservation-based rural communities face an increased risk of acquiring injuries—including brain injuries. There are several causes of this increased vulnerability to injury, including a lack of infrastructure, decreased access to health services, and higher rates of substance use (Zeiler & Zeiler, 2017). Interpersonal violence, particularly in Indigenous women, was also found to lead to injuries at higher rates; women victimized by this type of violence were more likely to sustain a TBI (Zeiler & Zeiler, 2017). The lack of focused attention to these intersections may help explain why many female and gender-diverse Indigenous survivors face additional barriers to both diagnosis and disclosure of IPV-related TBI, as explored in the following section.

Barriers to Disclosure and Diagnosis

Across global contexts, researchers are beginning to name and document the barriers which Indigenous women face in accessing support and care after IPV-related TBI. Recent qualitative studies from outside of Canada (Fitts et al., 2025; Souza, 2021) examine the lived experiences of Indigenous women who have sustained brain injuries through family violence or IPV. Fitts et al. (2025) highlight how emergency department staff in Australia frequently lack the training, specifically regarding cultural safety, to respond to TBI in Aboriginal and Torres Strait Islander women.[11] Like most survivors of partner-inflicted brain injuries, the absence of visible injuries, combined with the lack of standardized screening tools, negatively impact the care that Aboriginal and Torres Strait Islander women receive. These issues are compounded by self-reports from Aboriginal and Torres Strait Islander women, who say they feel excluded from discussions concerning their injuries, they experience direct racism and micro-aggressions from service providers, and they encounter barriers that emerge from the inter-generational experience of settler colonialism (Fitts et al., 2025).

Research on Indigeneity and IPV in Canada supports these international findings. In a qualitative study of primary care providers serving rural First Nations communities in northern Ontario, Rizkalla et al. (2020) found many practitioners felt unprepared to address IPV.

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[11] The term *Aboriginal and Torres Strait Islander* is used in this context as it reflects the language commonly used in Australia to refer to the First Peoples of the continent. This term differs from usage in Canada, where *Indigenous* is currently the preferred umbrella term for First Nations, Métis, and Inuit peoples.

Providers expressed uncertainty on initiating conversations and making appropriate referrals and were under-equipped to respond in trauma- or culturally-informed ways. Female survivors reported a lack of trust in providers, fears of child apprehension, and difficulty accessing services across jurisdictions. These findings echo those in a provincial report published by the Saskatchewan Alliance for Sexual and Reproductive Health (SASS)[12] in collaboration with the Community-University Institute for Social Research (CUISR) (Umereweneza et al., 2020a).[13] This report identified racism, institutional betrayal, long waitlists, and geographic and emotional isolation as persistent barriers to disclosing sexual and gender-based violence (Umereweneza et al., 2020). Similar themes emerge in *Gwayakwaajimowin: Truth Telling*, a report from the Ontario Federation of Indigenous Friendship Centres (OFIFC) [14] (2017) that documents the experiences of urban Indigenous women with police responses to sexual violence in Ontario. Survivors described police and service systems as dismissive, fragmented, and fundamentally unsafe. Brassard et al. (2015) analyze how racism, gender, geography, and colonial histories interact in four remote Quebec communities. Their study involved both IPV survivors and service providers, illustrating how geographic and social isolation create a ‘law of silence’ that suppresses disclosure and support-seeking (Brassard et al., 2015). While TBI is not explicitly named, the dynamics described offer a useful lens for understanding how IPV-related head trauma may go unrecognized within tight-knit or resource-constrained communities.

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[12] The Saskatchewan Alliance for Sexual and Reproductive Health (SASS) is a provincial network of organizations working to improve supports and services for survivors of sexual violence in Saskatchewan.

[13] The Community-University Institute for Social Research (CUISR) is a collaborative research institute based at the University of Saskatchewan, focused on community-engaged research to address social issues in the province.

[14] The Ontario Federation of Indigenous Friendship Centres (OFIFC) is a provincial organization that represents and supports Friendship Centres across Ontario, which provide culturally based programs and services to urban Indigenous communities.

Colonial Legacies and Indigenous-Led Healing

There is a growing call for culturally safe, community-rooted responses for Indigenous survivors of IPV. Working in collaboration with Blackfoot community members, Jackson et al. (2015) advocate for moving beyond settler-centric case management models towards relational, land-based, and ceremony-informed approaches grounded in Blackfoot ways of knowing. Collaborators used storytelling and shawl-making to reconnect survivors with kinship, culture, and Blackfoot knowledge (Jackson et al., 2015). Their work exemplifies Community-Based Participatory Research (CBPR),[15] and centers community leadership, shared decision-making, and reciprocal knowledge exchange between researchers and participants. The project embodies a culturally grounded approach to mainstream IPV survivor care that is led by Indigenous knowledge systems and practices of healing.

Allice et al. (2022) expand on this approach through a complete a systematic review of 34 peer-reviewed studies on Indigenous cultural safety in family violence contexts across Canada, the United States, Australia, and Aotearoa New Zealand. Their findings echo Jackson et al. (2015) recommendation to transform not only frontline care practices but also the broader systems in which care is delivered in relational, community-led, and contextually grounded models of support that address the impacts of colonization and systemic inequity. Both studies challenge the notion that cultural ‘competency’ is sufficient; what is needed is cultural humility and Indigenous leadership in designing care models (Allice et al., 2022; Jackson et al., 2015).

In Australia, Wills and Fitts (2024) and Fitts et al. (2025) offer insight into the everyday realities of Aboriginal and Torres Strait Islander women living with the cumulative effects of repeated brain injuries caused by IPV. Their work documents how women navigate daily life

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[15] CBPR is a collaborative research approach that equitably involves community members, organizational representatives, and researchers in all aspects of the research process.

with cognitive symptoms, limited formal diagnosis, and minimal support, often relying instead on informal strategies and deep personal resilience. These authors argue that trauma-informed care on its own is insufficient and call for neurologically-informed and culturally co-designed models of care. The absence of specialized clinics, long-term follow up, and standardized screening practices reinforce harm, a pattern mirrored in the Canadian context of emergency care (Fitts et al., 2025) and neurological services (Salaheen et al., 2022).

Across these studies, the gaps are persistent and structurally embedded. Survivors are not routinely screened for TBI (Fitts et al., 2025; Salaheen et al., 2022), providers lack the training and time to respond meaningfully (Jackson et al., 2015; Rizkalla et al., 2020), and health and social systems often alienate the very people they are intended to serve (Brassard et al., 2015; OFIFC, 2017; Umereweneza et al., 2020). These failures have material consequences for Indigenous women, who are frequently left to manage cognitive symptoms without validation, diagnosis, or coordinated care. Still, the literature also surfaces important points of strength: survivor resilience, community-led innovations, and the clarity with which Indigenous scholars and practitioners articulate what culturally safe care could look like. Whether through culturally grounded healing practices (Maranzan et al., 2018), integrated primary care (Rizkalla et al., 2020), or participatory models rooted in ceremony and community (Jackson et al., 2015), the path forward takes shape.

Recommendations: Building Better Pathways to Care

Pathways to care must be relational, flexible, and place-based. For Indigenous people living in urban settings, this might mean building trusted, wraparound support teams that center cultural safety and continuity of care. These teams could include Indigenous health workers, IPV counsellors, TBI specialists, and Elders, and would not only address medical needs but also emotional, cultural, and familial dimensions of healing (Allice et al., 2022). In rural and remote communities, emerging models such as mobile concussion clinics and outreach-based care models led by Indigenous practitioners could bridge geographic and jurisdictional gaps, particularly in areas where formal services are scarce (Fitts & Soldatić, 2024). Services should integrate land-based practices and ceremonial knowledge to create holistic healing environments (Fitts & Soldatić, 2024; Jackson et al., 2015). Elder-led programming, while under-documented in the context of TBI and IPV, remains a promising and culturally resonant approach to care that reflects longstanding Indigenous practices of wellness and relational accountability (Jackson et al., 2015; OFIFC, 2017).

The compounded harms of IPV and TBI for Indigenous survivors reflect more than individual trauma; they signal systemic gaps in diagnosis, care, and accountability. The silences in literature, policy, and practice are rooted in colonial structures that have long devalued Indigenous knowledge systems, underfunded Indigenous health care, and failed to prioritize gendered violence as a critical determinant of neurological health. The continued absence of attention to IPV-TBI in Indigenous contexts is not simply a research gap but is an extension of epistemic injustice. However, the work of Indigenous scholars, survivors, and community leaders offers a way forward, and that is one that is relational, self-determined, and rooted in place, language, and kinship. These shifts are necessary to reimagine systems of care capable of addressing violence and injury in ways that honour both the body and the spirit.

2SLGBTQQIA+ Survivors[16]

Although 2SLGBTQQIA+ survivors face similar IPV experiences as cisgender and heterosexual survivors, they remain vulnerable to unique identity-specific abuse, barriers, and

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[16] This chapter was written by Grace Holwell.

challenges (Haller et al., 2021). This section will review 2SLGBTQQIA+ terminology, examine the experiences of queer and trans survivors of IPV, and address the exclusion of 2SLGBTQQIA+ identities and experiences within IPV-TBI literature.

Definitions

The 2SLGBTQQIA+ community is continuously evolving, much like the language used to describe it (Thelwall et al., 2023). Frequently used terms within 2SLGBTQQIA+ research have historically been homosexual and homosexuality; however, since 1990, research has shifted towards more inclusive language that includes a range of identities, such as the acronym 2SLGBTQQIA+ (Thelwall et al., 2023). Due to the rapid evolution of language used within the 2SLGBTQQIA+ community, there is currently no single dominant terminology, and some sources still include outdated terms (Thelwall et al., 2023). The term *queer,* which was previously used as a derogatory slur towards the 2SLGBTQQIA+ community, has recently been reclaimed and is now used by many activists and community members as a non-pathologizing term to describe the diversity within their community (Thelwall et al., 2023). Thus, the acronym (i.e., 2SLGBTQQIA+) and the term queer and trans will be used interchangeably throughout this section to promote inclusivity and to use language more frequently used by community members.

Experiences of IPV Among the 2SLGBTQQIA+ Community

Members of the 2SLGBTQQIA+ community face higher rates of IPV compared to their heterosexual cisgendered counterparts (WAGE, 2024); this data is consistent across population-based self-reporting surveys, as well as reports to law enforcement (Jaffray, 2021). Lesbian, gay, and bisexual (LGB)+ women are nearly twice as likely to report IPV compared to heterosexual women (WAGE, 2024). These results are similar for LGB+ men, with 54% of LGB+ men reporting IPV compared to 36% of heterosexual men (WAGE, 2024). Transgender and gender-diverse individuals are 1.7 times more likely to face IPV and 2.2 times more likely to encounter physical abuse compared to cisgender people (WAGE, 2024).

Barriers

Despite a clear need for IPV supports and services, barriers prevent queer and trans people from accessing support (Haller et al., 2021). IPV support services often operate with a cisheteronormative[17] lens that assumes a cisgender woman as the victim and a cisgender man as the perpetrator (Haller et al., 2021). Since 2SLGBTQQIA+ people do not fit into these norms or assumptions, they often avoid IPV support services (Haller et al., 2021). Reasons for avoidance include a lack of understanding and knowledge from service providers, fear of stigma and/or discrimination (i.e., minority stress), concerns around confidentiality, lack of tailored safe and affirming services, and previous negative experiences (Haller et al., 2021).

Intersection of IPV and TBI Among Queer and Trans Individuals

Queer and trans people experience the same kinds of physical abuse associated with TBI in cisgender and heterosexual populations—pushing, grabbing, slapping, punching, throwing items, forcible confinement, including strangulation, and repeated patterns of physical abuse (Haller et al., 2021; Kurbatfinski et al., 2023; Messing et al., 2021)—yet there is little work examining the effects of this violence on this unique group. Existing and emerging literature on IPV-TBI often focuses only on the experiences of cisgendered straight women (J. Chan et al., 2024; Stranges et al., 2025). Research by Stranges et al. (2025) is an exception. This study gathered survey data from 2,391 respondents, with inclusion criteria requiring self-identification

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[17] Cisheteronormativity combines cisnormativity, the belief that being cisgender (people who identify with their sex assigned at birth) is the norm, and heteronormativity, the belief that heterosexuality (attraction to the opposite gender) is the norm. Those who do not fit these assumptions often encounter prejudice and discrimination.

as part of the 2SLGBTQQIA+ community, residency in British Columbia, English language proficiency, and being over 18 years old. Participants were presented with questions surrounding their lifetime history of IPV, brain injury symptom history, and classification of abuse. Results indicated that 98% of participants indirectly screened positive for a history of IPV, and a large number of participants reported high rates of symptoms (approximately 70%) indicative of a IPV-TBI (Stranges et al., 2025). The prevalence of IPV-TBI symptoms within the queer and trans community is comparable to the findings of similar studies that only examined the experiences of heterosexual and cisgender women (Stranges et al., 2025).

The queer and trans community is not a monolith. Participants ‘experiences of IPV-TBI reflect this diversity, as they differed according to sexual orientation and gender identity (Stranges et al., 2025). Trans women and queer individuals were more likely to encounter IPV episodes that could potentially result in TBI. In contrast, trans men and bisexual people were less likely to experience IPV episodes that could lead to TBI. These findings indicate that individuals, regardless of sexual orientation and gender identity, can experience episodes of IPV that can cause TBI (Stranges et al., 2025). Although Stranges et al. (2025) provide information on the prevalence of IPV-TBI within the 2SLGBTQQIA+ population, questions regarding how queer and trans survivors of IPV-TBI navigate care pathways (if at all), and the specific barriers, challenges, and experiences they may face, remain unanswered.

Overall, 2SLGBTQQIA+ people face higher rates of IPV and similar rates of IPV-TBI compared to their heterosexual and cisgender counterparts. However, research on the specific intersection of IPV-TBI among 2SLGBTQQIA+ survivors is limited and fails to examine the way queer and trans people navigate pathways to care. More research is needed to verify current findings and to understand the experiences of 2SLGBTQQIA+ survivors, so that IPV-TBI services and pathways to care can be better tailored to meet their unique needs.

Newcomers[18]

Although awareness of IPV-inflicted TBI is gradually increasing, there remains little research focused specifically on newcomer women. For the purposes of this literature review, “newcomers” is used to refer to people who have arrived in Canada in the past 5 years, including immigrants, refugees, permanent residents, and international students. Also included in the search criteria were terms commonly used outside of Canada such as asylee, asylum seeker, and migrant. While there is consensus among larger studies and literature reviews that newcomer women face elevated risks of IPV (Costello & Greenwald, 2022; Toccalino et al., 2023), research looking at their specific experiences is sparse. Currently, there is no literature that examines IPV, TBI, and newcomer populations together.

Intersectionality

An intersectional approach must be applied to recognize and understand the multiple factors that shape newcomer women’s experiences of IPV, TBI, and access to care. Rather than acting independently, these overlapping forms of oppression, such as racism, classism, sexism, xenophobia, ableism, and colonialism, interact and reinforce one another, shaping survivors’ experiences in complex ways (Giesbrecht et al., 2023). These intersecting systems of power contribute to unique issues such as immigration-related precarity, healthcare inequities, and social isolation, all of which can exacerbate violence (Ahmad et al., 2013; Giesbrecht et al., 2023; Kikulwe et al., 2025; Njie-Carr et al., 2021). Structural violence shows up in how services are both offered and withheld. Newcomer women may face discrimination within healthcare,

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[18] This chapter was written by Katherine Leverick.

legal, and social service systems, reflecting the colonial legacies of their creation and provision (Giesbrecht et al., 2023).

Newcomer populations are highly diverse in religion, education, language, ethnicity, and more, yet dominant institutions frequently treat them as culturally homogenous (Giesbrecht et al., 2023). These one-size-fits-all approaches often fail to address the specific needs and risks newcomer women face when living with both IPV and head injury. The cumulative impact of these layered inequities can contribute to survivor isolation, mistrust of services, and barriers to support that may go unrecognized by systems focused solely on either safety or resettlement. Given what is known about systemic barriers, intersecting oppressions, and the complexity of brain injury, it is likely that IPV-TBI has specific and underrecognized impacts on help-seeking, resettlement, and access to care among this population.

Barriers to Accessing Care

Newcomer women face a variety of intersecting barriers to accessing care. These challenges are not only logistical, but deeply rooted in systemic inequities shaped by race, gender, class, immigration status, and language. These barriers can be linguistic (language differences, lack of trained interpreters), cultural (stigma around disclosing abuse), or systemic (immigration-related fears, limited access to culturally responsive and trauma-informed services (Giesbrecht et al., 2023; Njie-Carr et al., 2021). A regional study by Giesbrecht et al. (2023) identified specific barriers voiced by newcomer women living in Saskatchewan, including difficulty accessing transportation, economic dependence on abusive partners, long waitlists, childcare challenges, and social pressure to keep families intact. These constraints were not experienced in isolation but layered atop systemic racism and institutional inflexibility. Similarly, Njie-Carr et al. (2021) found that women's fears of deportation, child apprehension, or not being believed often kept them from disclosing abuse or seeking help. These fears were intensified by prior experiences of dismissal or discrimination by police, health care providers, and immigration officials.

Even when services are physically present in a community, they may remain inaccessible in practice. Survivors frequently encounter providers who lack the cultural competence or trauma-informed training to respond appropriately. Ahmad et al. (2013) note that language interpretation is often unavailable or unreliable, leading to miscommunication and mistrust. Some women report fear of being shamed or ostracized within their cultural or faith communities, especially when disclosure of abuse is seen as a betrayal of the family or a threat to immigration security (Njie-Carr et al., 2021). These dynamics can leave survivors technically within the scope of services, but effectively shut out from them due to stigma, fear, and structural exclusion.

The presence of TBI introduces additional complexity. Symptoms such as memory loss, difficulty concentrating, irritability, and communication impairments may interfere with survivors' ability to navigate services, follow up on referrals, or explain their needs. McPherson (2019) highlights how cognitive impairments linked to head trauma can disrupt both formal and informal help-seeking. The disruption becomes particularly evident in systems that demand self-advocacy and bureaucratic navigation. McPherson (2019) also notes that survivor narratives are often fragmented or inconsistent due to injury, which can lead to credibility being questioned, further silencing those already at risk of being disbelieved due to their newcomer status. When systems are rigid or unfamiliar with the neurocognitive consequences of TBI, women may be retraumatized by their interactions with care providers or labelled as non-compliant or deficient

(McPherson, 2019). Access to care is already constrained for many newcomer women, and one can extrapolate how service chasms deepen when IPV-related brain injury is present.

Barriers to Naming and Diagnosing TBI

While this review did not locate any literature to examine IPV-TBI in newcomer women, inferences from literature available on TBI in newcomers can be drawn. In general, newcomers are frequently underdiagnosed with TBI, or their symptoms misattributed due to the overlap between physical, psychological, and trauma-related symptoms (Jahan et al., 2025; McPherson, 2019). Providers often report challenges in distinguishing TBI from mental health conditions like PTSD and depression, especially when survivors present with memory loss, cognitive disruptions, or emotional dysregulation (Jahan et al., 2025). Additionally, migration-related trauma such as torture, displacement, and war-related violence can mask or complicate the identification of IPV-TBI, as clinicians may not be trained to ask about head injury or may not consider TBI when focusing on mental health or resettlement concerns (Jahan et al., 2025; McPherson, 2019). These diagnostic gaps matter and without improved pathways to care, TBI in newcomer survivors will remain untreated. The long-term effects of TBI, including depression, anxiety, difficulty parenting, and chronic pain, may be also misunderstood or medicalized inappropriately. When compounded with structural violence and cultural stigma, the failure to recognize IPV-TBI risks deepening harm rather than alleviating it.

Recommendations: Building Better Pathways to Care

Considering the compounding impacts of racism, sexism, xenophobia, and ableism, service systems must adopt more intersectional and culturally responsive frameworks and pathways of care that reflect the complex realities of newcomer women’s lives (Ahmad et al., 2013; Giesbrecht et al., 2023; Kikulwe et al., 2025; Njie-Carr et al., 2021). One way in which newcomers can be better accommodated is through the provision of language-accessible materials and translation services to support access to care (Tabibi et al., 2018). Programs should be grounded in anti-racist and anti-oppressive principles in both service and design, while actively avoiding cultural stereotyping or overgeneralization. Hiring diverse staff is important but must be done with care to avoid assumptions about cultural alignment. Technology-based interventions may offer safer and more accessible alternatives for newcomer women, particularly when developed with culturally adapted and trauma-informed frameworks (Emezue & Bloom, 2021). In addition, service providers should consider if they can provide flexible intake policies as strict identification or citizenship requirements can create barriers to service (Njie-Carr et al., 2021). A truly accessible and survivor-centred approach must consider not only what services are offered, but how, where, and by whom they are delivered. Without research that explicitly ties IPV, TBI, and newcomer populations together, the needs of many survivors will continue to be unmet, signalling not only a gap in the literature, but a gap in care.

Mothers[19]

Despite the global prevalence of IPV against women and its effects on survivors' mental and physical health, the impact of IPV on mothering/parenting is often overlooked in IPV research. Considering that most women of reproductive age (15-49 years old) are likely to have children (World Health Organization, 2025), many women who experience IPV are likely to be mothers. Motherhood is an important factor to consider in IPV research as caring for children presents unique challenges and responsibilities that can make navigating and coping with an IPV situation even more difficult.

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[19] This chapter was written by Breanna Amoyaw.

IPV and TBI in Mothers

A mother interviewed by St. Ivany, Bullock et al. (2018) detailed the night she fled to a shelter with her children after being abused by her partner, graphically describing how he stomped on her head until she lost consciousness. This story highlights the severity of the violence and obvious brain injuries that mothers experience. Yet, research on IPV-TBI in mothers is fairly limited (Fitts et al., 2023; Glecia & Moffitt, 2024; St. Ivany & Schminkey, 2016; Toccalino et al., 2023; Wills & Fitts, 2024). Existing research suggests that the emotional and physical outcomes of IPV-TBI influence mothers' wellbeing and parenting. A mother interviewed by Glecia and Moffitt (2024) described how she was unable to bathe her children as she was recovering from a debilitating neck injury that she sustained from IPV. Concern about how exposure to partner abuse will affect their children's perceptions of intimate relationships has also been expressed by mothers with IPV-TBI (Glecia & Moffitt, 2024). One mother interviewed by Glecia and Moffitt (2024) described her fear that her son would grow up to perpetuate IPV and that her daughter would think it is normal to be abused by an intimate partner. A fear of child apprehension is also common amongst mothers with IPV-TBI (Fitts et al., 2023; St. Ivany & Schminkey, 2016). In many cases, these women grew up in unstable environments or had past negative experiences with child protection agencies, whether they had been through foster care themselves or had their children previously removed from their custody for other reasons (Fitts et al., 2023; St. Ivany & Schminkey, 2016).

Barriers to Care

The fear of child apprehension may cause mothers to avoid reporting or seeking help for IPV (Fitts et al., 2023; St. Ivany & Schminkey, 2016). Concern about the safety of their children may prevent IPV-TBI survivors from seeking or receiving medical intervention. Mothers may stay home to prevent the abuser from harming the children, or flee with the children to a domestic violence shelter (St Ivany et al., 2021). Isolation also prevents IPV-TBI survivors from seeking or receiving care. Perpetrators of IPV will deliberately isolate mothers from their support networks, leaving them without family members nearby to provide support (St. Ivany, Bullock, et al., 2018; Wills & Fitts, 2024). For example, a woman interviewed by Wills and Fitts (2024) discussed how her partner hit her just days after their son was born. The couple was living in the father's home country where the mother had never lived before, her family was not around to support her, and she did not feel safe reporting the IPV incident to authorities. In other cases, mothers will intentionally isolate themselves to manage their TBI symptoms or to protect themselves from being abused again (Wills & Fitts, 2024). Overall, parenting, child protection, isolation, and social support are important factors to consider when addressing IPV and TBI in mothers.

Indigenous Mothers with IPV-TBI

In the studies by Fitts et al. (2023), Glecia and Moffitt (2024), and Wills and Fitts (2024), the participants were all Indigenous mothers. A whole-population data linked study conducted in Australia found that 58.5% of mothers who were admitted to the hospital for IPV-related injuries were Indigenous women (Bulsara et al., 2021). Furthermore, this study found that Indigenous mothers were admitted to the hospital more than 2.5 times on average compared to non-Indigenous mothers during the same period (Bulsara et al., 2021). This overrepresentation is another factor to consider when responding to incidences of IPV-related TBI, as Indigenous mothers may not be receiving culturally appropriate care when disclosing an IPV situation or seeking help for their injuries. This overrepresentation is evident in Canada as well—particularly in the Canadian prairie provinces (Statistics Canada, 2024b).

Ethical and Legal Considerations of Screening for IPV-related TBI in Mothers

Researchers and other professionals must consider the ethical and legal consequences of screening for, and diagnosing, TBIs in mothers. Mothers with IPV-TBI fear that a disability diagnosis will be used to undermine their parenting ability and justify the apprehension of their children (Tsu et al., 2025). This concern is not unwarranted. Mothers deal with unequal expectations in court and are placed under greater scrutiny for mental health issues compared to fathers (Boyle et al., 2022). Research suggests that 40-50% of children with cognitively disabled parents are placed permanently in foster care, despite the lack of evidence for a link between cognitive disability and child maltreatment (DisAbled Women's Network of Canada, 2019). With the appropriate tools and support to accommodate their psychological and physical needs, mothers with IPV-TBI can still parent safely and effectively.

Interventions and Community Responses

The following section outlines the ways that community organizations, first responders, shelters, and other social sectors interact with survivors with partner-inflicted brain injuries, as well as the types of supports that exist and the current gaps and missed opportunities.

Law Enforcement and First Responders[20]

Law enforcement and emergency responders are often among the first professionals to encounter survivors of IPV, which makes them critical actors in the early identification of TBI. Despite the frequency and severity of IPV-related head trauma, TBIs remain vastly under-recognized and under-documented within policing and emergency care protocols, where survivors' symptoms are often overlooked or misinterpreted (Gagnon & DePrince, 2017; Haller et al., 2021; Meyer et al., 2022; Valera et al., 2019; Zieman et al., 2017). Emerging research

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[20] This chapter was written by Katherine Leverick.

indicates that many survivors never receive a formal diagnosis for concussions or brain injury, even when emergency services are involved (Meyer et al., 2022; Zieman et al., 2017). This section critically examines both the systemic limitations and the potential of law enforcement and emergency responders in recognizing and responding to IPV-TBI. Highlighted in this portion of the literature review are survivor-reported experiences, practice gaps, and the policy frameworks that shape the Canadian context, particularly in Manitoba, while also drawing on comparative insights from other jurisdictions.

Missed Opportunities and Systemic Blind Spots

Across multiple studies, a consistent theme emerges: first responders often miss or minimize IPV-TBI, even in cases where physical violence is evident. In a sample from a neurology clinic, Zieman et al. (2017) found that, although 81% of IPV survivors in the sample presented with symptoms consistent with TBI, only 20% had a formal diagnosis prior to clinical referral. Similarly, Meyer et al. (2022) found that only 25% of survivors sought medical care, and none were formally diagnosed with TBI, despite 65% reporting head injuries, 44% reporting repeated head trauma, and 24% experiencing loss of consciousness. These findings suggest that police and emergency services are either unequipped or untrained to recognize the symptoms of TBI in IPV contexts.

Research completed by both St Ivany et al. (2021) and King et al. (2025) further reinforce these blind spots, confirming that survivors frequently experience dismissal, disbelief, or superficial documentation during police or emergency contact. Without comprehensive training and reflection, law enforcement officers can have difficulty understanding the complexity of IPV and may struggle to identify abusive behaviour, resulting in officers blaming victims for remaining with abusive partners (Richards et al., 2021). The absence of visible injury following strangulation is especially relevant to discussions about police and EMS misidentifying survivors as uncooperative, intoxicated, or aggressive (Valera et al., 2022). These neurological symptoms, including confusion, dizziness, aggression, may be interpreted through a lens of bias if responders are not trained in IPV-related brain injury Misinterpretation of neurological TBI symptoms can occur in first responders without proper training, with cognitive symptoms and emotional blunting being mistaken for evasiveness (Valera et al., 2022). In some cases, cognitive symptoms like disorientation or memory loss are interpreted by police or court systems as instability or unreliability, reinforcing systemic biases that disadvantage survivors with invisible injuries (Haller et al., 2023). These oversights are more than just procedural gaps, and they have real, lasting consequences for survivor credibility, legal outcomes, and access to support.

Survivor Mistrust and Barriers to Reporting IPV

The low rate of police reporting among survivors is a recurring theme in the literature (Klinic Community Health, 2025b; Rudzinski et al., 2025; St Ivany et al., 2021). Klinic Community Health's Hummingbird Program in Manitoba provides services for survivors of IPV and sexual violence. Of those survivors who accessed this program,[21] only 15% chose to report to police in its first year, despite most accessing care within 24 hours of an incident (Klinic Community Health, 2025a). Nationally, a Statistics Canada report found that nearly 8 in 10 survivors (79%) of spousal violence did not report the incident to police, with the most common reasons being fear of retaliation, shame, a belief that the incident was not serious enough, and distrust in the criminal justice system (Conroy, 2021). Most survivors are unaware that they could have a potential head injury. Further, data from Women and Gender Equality Canada

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[21] The Hummingbird Program is a trauma-informed, community-based response initiative for survivors of recent sexual assault and intimate partner violence. These statistics are drawn from Klinic Community Health's one-year update on the program, published in January 2025. See: https://klinic.mb.ca/2025/01/one-year-of-hummingbird/.

(2024) show that police-reported rates of IPV have increased since 2014, including a 163% rise in sexual assault and a 14% rise in physical assault, suggesting that police contact may reflect increasing violence but not necessarily improved survivor safety. However, while reporting rates may have increased, many survivors will still choose not to report to police because they are not aware that they have a serious injury. Survivors have also cited prior negative experiences with police and emergency services, fear of not being believed, and lack of control over the process as primary reasons for non-engagement (Deutsch et al., 2017; St Ivany et al., 2021). These existing patterns reveal a system where survivors often choose silence over seeking help, especially when the first point of contact is expected to be law enforcement.

For survivors with intersecting areas of identity and victimization, these barriers are compounded by systemic harm. As Lundy (2022) notes, colonial and patriarchal policing structures have historically criminalized rather than protected Indigenous women. Survivors from racialized and immigrant communities may also avoid police due to past trauma with law enforcement in their home country, fear of deportation, or the possibility of child apprehension—especially for those with uncertain immigration status or who face linguistic barriers in navigating the justice system (Gagnon & DePrince, 2017; Haller et al., 2023; St. Ivany, Bullock, et al., 2018). These intersecting barriers manifest in harmful ways during survivors' real-world encounters with first responders. Survivors frequently report feeling dismissed or not believed by police or emergency personnel due to communication challenges, language barriers, or cultural stereotypes. These assumptions, often shaped by language barriers, cultural misunderstanding, and racial bias, contributed to survivors being misidentified as perpetrators or flagged for child protection involvement. These dynamics point to a broader pattern of mistrust and harm experienced by marginalized communities in their interactions with law enforcement and emergency systems. Police and EMS responders may also carry implicit biases that affect how survivor testimony is documented, particularly when symptoms such as confusion, flat affect, or disorientation (all common with brain injury) are misunderstood or minimized (Monahan, 2019).

Gaps in Protocol, Screening, and Training

Despite growing awareness of IPV-TBI, most law enforcement agencies and emergency services continue to operate without standardized screening tools or protocols. Gagnon and DePrince (2017) showed that more than half of IPV survivors screened positive for head injuries, yet they had never been diagnosed. This finding highlights the potential of simple screening tools in non-clinical settings, but also shows the importance of follow up and developed care pathways to encourage both diagnosis and engagement. Higbee et al. (2019) piloted a concussion awareness training with police officers responding to domestic violence calls and found that, prior to training, officers lacked even basic understanding of TBI symptoms. However, after this training, officers showed greater confidence in identifying signs and referring survivors for medical evaluation. These findings show how screening and response protocols are not only feasible within police systems, but necessary. While dominant concussion frameworks prioritize athletes and military personnel, it is crucial to reconceptualize this issue. Service providers must not render IPV survivors (particularly women, Indigenous people, and racialized communities) invisible within the concussion crisis.

National and Provincial Policy Gaps

The lack of standardized screening and training protocols within emergency response systems is mirrored by incomplete national and provincial policy frameworks that fail to recognize the neurological impacts of IPV. The Royal Canadian Mounted Police (2024) and Manitoba Justice (2024) both encourage survivors to report IPV and emphasize offender accountability. However, both institutions fail to mention TBI, concussion, or cognitive symptoms in their protocols or public-facing education. The Manitoba family law guidance on contacting police promotes mandatory charge policies without consideration for survivors' autonomy, neurological symptoms, or barriers to coherent self-advocacy (Family Law Manitoba, 2024). While the Canadian Association of Chiefs of Police (2016) calls for trauma-informed, collaborative, and victim-centred policing, it fails to include specific directives around brain injury, neurological assessment, or partnerships with healthcare providers. These documents illustrate a well-intentioned but incomplete policy landscape—one that continues to overlook the very neurological consequences of IPV.

Integrated Manitoba Models and Community Partnerships

Manitoba is home to several community organizations and professional bodies that offer models or infrastructure to support a more integrated, trauma-informed, and TBI-aware emergency response system. The Hummingbird Program at Klinic Community Health offers a promising low-barrier alternative for IPV survivors (Klinic Community Health, 2025a). Clients can access medical, emotional, and forensic support without requiring police involvement, creating a rare but vital model of survivor-led, TBI-aware care. The program illustrates what a trauma-informed, health-anchored response can look like—particularly for those who have experienced systemic mistrust, institutional betrayal, or fear of criminalization. The Manitoba Association of Women's Shelters (MAWS) provides IPV-focused education, including safety assessment tools and prevention training (MAWS, 2025). These organizations could play a central role in developing first responder training modules that prioritize survivor autonomy, equity, and neurological literacy.

Manitoba’s Domestic Violence Support Service (DVSS), operated by Manitoba Justice, provides safety planning, legal support, and advocacy for survivors with open police files (Haller et al., 2021; Rudzinski et al., 2025). However, this service is contingent on police contact, and without formal partnerships or referral pathways between DVSS and community health providers, survivors with TBI who avoid law enforcement may be left unsupported. Finally, WAGE Manitoba and the province’s Family Violence Prevention Program provide funding and coordination frameworks that could anchor systemic reform. These infrastructures could offer a natural starting point for cross-sector collaboration, particularly around standardized screening tools, interagency referrals, and province-wide training that centers survivor experience and medical realities like TBI (WAGE, 2024).

Considering emergency medical services, the College of Paramedics of Manitoba and the Manitoba Emergency Services College oversee education and licensing for paramedics across the province (College of Paramedics of Manitoba, 2025). Within the capital, Winnipeg Fire Paramedic Service (WFPS) delivers urban emergency care (City of Winnipeg, 2025). WFPS also operates a community paramedicine program, Emergency Paramedic in the Community (EPIC), which focuses on preventative care, home visits, and addressing the social determinants of health (City of Winnipeg, 2025). EPIC aims to reduce emergency department visits and prevent repeat 911 calls through early health assessments and intervention planning. This existing infrastructure could present a valuable opportunity to embed IPV and TBI screening into EPIC’s holistic approach, and first responders may be able to identify survivors in need of care sooner.

Taken together, the above organizations demonstrate that Manitoba has the core ingredients necessary to build a survivor-centered, brain-injury-informed response to IPV. The challenge now lies in political commitment, interprofessional collaboration, and funding structures that elevate survivor expertise and community care above carceral logic.

Recommendations

Improving outcomes for survivors with IPV-related TBI will require fundamental changes in how first responders and law enforcement professionals are trained, supported, and held accountable. Training initiatives should prioritize routine screening for head injuries using simple, evidence-informed tools, as studies have demonstrated the feasibility and utility of brief TBI screeners in IPV contexts (Gagnon & DePrince, 2017; Higbee et al., 2019). Police and paramedics must be equipped to identify not only physical symptoms, but also the more subtle signs of cognitive impairment, which may affect a survivor's ability to remember, articulate, or respond during a crisis. These are symptoms that are often misinterpreted due to lack of neurological awareness (Meyer et al., 2022).

Institutional protocols must shift from reactive enforcement to trauma-informed, survivor-centred practices—an approach supported by research showing that trauma-uninformed policing leads to re-traumatization, especially for marginalized survivors (Haller et al., 2023; Rudzinski et al., 2025). For example, Rudzinski et al. (2025) found that 29.3% of IPV survivors were referred to child protection services, yet fewer than 1% were assessed or referred for possible brain injury or strangulation, despite significant self-reports of head trauma and symptoms of altered consciousness. The authors attribute this disparity to a systemic lack of awareness about IPV-related brain injuries and a tendency among service providers to misinterpret neurological symptoms as behavioral or parenting concerns (Rudzinski et al., 2025)—these same patterns of misinterpretation are evidenced in the work St Ivany et al. (2021). These findings illustrate how institutional responses can pathologize survivors with cognitive injuries, exacerbating harm rather than offering support. Mandatory charging policies should be re-evaluated to provide greater flexibility for survivors and systems should allow for nuanced, context-sensitive assessments that centre survivor safety and agency, in line with broader calls for decolonial, anti-racist, and neuro-informed reforms in first response systems (Henne & Ventresca, 2025; Sereno et al., 2024).

A growing body of research confirms that bias-reduction training can improve professional responses to IPV survivors. In a systematic review of 17 empirical studies across health, legal, and community-based sectors, Sereno et al. (2024) found that all training programs evaluated led to statistically significant reductions in practitioner bias towards IPV survivors. However, the review also noted a lack of consistency in training structure, duration, and content, raising concerns about sustainability and generalizability. Most interventions focused on IPV broadly, with few addressing neurocognitive symptoms, intersectional marginalization, or trauma rooted in systemic harm (Sereno et al., 2024). These findings reinforce Haller et al.'s (2023) observation that many police and court systems lack protocols that accommodate survivors with brain injuries, often resulting in re-traumatization or credibility challenges. Similarly, Gagnon and DePrince (2017) found that simple head injury screening tools could be easily implemented yet are rarely used in practice, reflecting a missed opportunity for early intervention. Taken together, these sources support calls for standardized interdisciplinary training programs that move beyond abstract trauma-informed principles and offer concrete tools for recognizing IPV-TBI, mitigating bias, and supporting diverse survivor experiences in emergency contexts.

The structural barriers that prevent appropriate law enforcement and first responder responses to IPV-TBI are magnified for survivors from Indigenous, immigrant, and racialized communities. These groups are disproportionately impacted by IPV (Costello & Greenwald, 2022; Toccalino et al., 2023) and face increased risk of brain injury alongside heightened surveillance, dismissal, and mistrust in emergency and justice systems (Lundy, 2022; Rudzinski et al., 2025; St Ivany et al., 2021). When first responders are untrained in recognizing the effects of brain injury and unresponsive to the cultural and structural realities that shape help-seeking, these gaps compound survivors' trauma and risk of harm. A meaningful commitment to equity must guide future reform efforts. Protocols must be evaluated through an anti-racist, decolonial, and disability-informed lens to ensure they respond to the lived experiences of Indigenous women, newcomers, 2SLGBTQQIA+ survivors, as well as others who face compounded barriers to safety and care (Henne & Ventresca, 2025; Lundy, 2022). This includes not only equitable representation and intersectional training, but also the dismantling of policies that structurally disadvantage those already most at risk—an approach echoed in emerging frameworks for systemic change across health, policing, and legal sectors (Costello & Greenwald, 2022; Sereno et al., 2024).

Law enforcement and first responders are uniquely positioned to intervene in the early stages of IPV-related TBI, yet current practices fall far short of this potential. Despite repeated calls for trauma-informed policing, survivor experiences and empirical research reveal systemic blind spots that prevent timely diagnosis, support, and justice. By integrating TBI awareness into emergency protocols, prioritizing survivor autonomy, and building community-based alternatives, a more equitable and effective response to IPV can begin to take shape.

Legal Implications[22]

The intersection of TBI and IPV presents a complex and underacknowledged challenge for the legal system. These barriers are compounded by the invisibility of TBI symptoms, the stigma associated with cognitive impairments, and the legal system's lack of trauma-informed practices. Legal recognition and response to IPV-TBI remains fragmented and inadequate. Drawing on interdisciplinary and Canadian-focused literature, this section explores the legal implications of IPV-TBI, emphasizing how cognitive, psychological, and institutional dynamics intersect to affect survivor safety, credibility, and access to justice.

Legal Misrecognition and the Question of Survivor Credibility

Cognitive symptoms caused by TBI are frequently misunderstood in legal settings. Research highlights that these symptoms may be interpreted by judges, lawyers, or child protection workers as evidence of emotional instability or parental unfitness, rather than as medical consequences of abuse (Boyle et al., 2022; Haller et al., 2021). Banks (2007) and Baxter and Hellewell, (2019) argue that the lack of professional training on IPV-TBI contributes to systemic disbelief, especially in cases involving custody and access. This misrecognition compromises survivor credibility in courtrooms, where composure and consistency are often misused as proxies for truthfulness and competence. In family law cases, these types of assumptions have profound implications. TBI diagnoses may inadvertently be weaponized against women in parenting disputes, with neurological impairments used to question their caregiving capacity (Boyle et al., 2022). Boyle et al. (2022) further emphasize the ethical risks of screening in these contexts, cautioning that without informed consent and proper safeguards,

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[22] This chapter was written by Gary Hill.

screening outcomes may be misused in legal proceedings, ultimately disempowering the survivor.

Fragmentation Across Legal Systems and Institutional Harm

Survivors navigating multiple legal systems such as family, criminal, and child protection, often face conflicting processes and standards, resulting in disjointed protection and support. Linda Neilson's federal bench books (2013, 2020) offer insight into legal fragmentation in IPV cases in Canada. She outlines how family, criminal, and child protection systems operate in isolation, issuing conflicting orders and failing to share vital information. While TBI is not the focus, Neilson describes how trauma symptoms, many of which overlap with TBI, are misinterpreted in court, especially against mothers. Survivors are reframed as "unprotective" or emotionally unstable, leading to custody loss or over-intervention by child welfare systems (Neilson, 2020).

Douglas (2018) and Wilde et al. (2024) highlight how survivors with trauma-induced mental health challenges are often pathologized during legal proceedings. Rather than viewing these effects as consequences of violence, courts may perceive them as personal deficits—leading to discriminatory custody decisions and further trauma. This institutional harm is intensified by legal cultures that prioritize adversarialism over empathy, structure over flexibility, and composure over lived experience. Wilde and colleagues (2024) emphasize how mothers frequently experience the family court process as re-traumatizing, particularly when their safety concerns are dismissed or minimized. Survivors reported feeling disbelieved and emotionally exhausted, with distress responses interpreted as instability. The expectation for survivors to remain composed reinforces systemic disbelief and disadvantages those most impacted by violence (Wilde et al., 2024)

Screening Dilemmas and the Ethics of Legal Intervention

The prospect of introducing standardized TBI screening into legal contexts raises significant ethical concerns. Boyle et al. (2022) caution that while screening may enable earlier identification of injury, it also poses risks when systems lack the infrastructure to respond safely. Survivors may fear that revealing a diagnosis will result in custody loss or legal disempowerment. These fears are supported by findings from Boyle et al. (2022) and Lamontagne and Ben Miloud (2023), who describe how TBI evidence can be weaponized in court. Without trauma-informed frameworks and survivor-led protocols, mandatory screening may replicate existing power imbalances. As Lamontagne and Ben Miloud (2023) explain, legal professionals must understand that a TBI diagnosis can serve as both a pathway to support and a source of stigma, particularly when courts misinterpret symptoms like memory lapses, emotional dysregulation, the inability to remember sequences of events, and changes in testimony as indicators of ‘unfitness’. Many survivors lack formal diagnosis due to systemic gaps in services, while those who are diagnosed can find the information used against them in custody disputes (Lamontagne & Miloud, 2023). Survivor autonomy, informed consent, and medical-legal collaboration are critical to avoiding re-traumatization and secondary victimization (Boyle et al., 2022).

Custody Proceedings, Trauma, and Judicial Inconsistency

Family court systems, particularly in custody and access hearings, are often hostile spaces for survivors of IPV. Coy et al. (2015) and Wilde et al. (2024) document how the process of pursuing parenting rights can retraumatize women, especially when courts disregard histories of violence or prioritize formal neutrality over safety. Courts may privilege the calm demeanor of abusers while viewing survivors’ trauma responses as instability or alienation (Coy et al., 2015).

This judicial inconsistency is further compounded in TBI-related cases, where cognitive symptoms are unfamiliar or invisible to legal professionals (Haller et al., 2023). The adversarial nature of family court, combined with a lack of standardized knowledge on IPV-TBI, creates legal environments where survivors are misunderstood, discredited, and disadvantaged (Haller et al., 2021).

Recommendations for Reform and Advocacy

Legal reforms must be rooted in interdisciplinary, trauma-informed practices that recognize the complexity of IPV-related TBI. Neilson (2020) and Cross et al. (2018) recommend integrated case management, coordinated legal systems, and specialized training for legal practitioners. These reforms should prioritize survivor safety and credibility while reducing institutional bias and harm. Professional education is also critical. As Haller et al. (2023) argue, increasing legal professionals' understanding of cognitive impairment, trauma, and IPV will promote more equitable outcomes. Screening tools, if implemented, must be voluntary, accompanied by legal protections and embedded within survivor-centered services (Boyle et al., 2022; Lamontagne & Ben Miloud, 2023). Legal systems must shift from discrediting survivors to supporting them—ensuring that TBI does not become another barrier to justice, but a recognized factor in their healing and safety.

The current Canadian legal landscape lacks clear precedent or frameworks to handle IPV-related TBI. Survivors are navigating systems that are neither trauma-informed nor equipped to interpret cognitive injury. As the literature shows, transformative change is needed: interdisciplinary legal training, courtroom accommodations, trauma-informed assessments, and formal pathways for introducing TBI evidence must all be prioritized. Without these reforms, legal systems will continue to re-enact the harm they are meant to prevent.

Child Protection[23]

The intersection of IPV, TBI, and child protection responses reveals deep systemic challenges and critical opportunities for integrated practice. Exposure to IPV remains a primary reason for child welfare involvement, yet the neurobiological impacts of family violence (especially head trauma) on both caregivers and children are often poorly understood, under-assessed, and inconsistently addressed. The following section synthesizes current research exploring how IPV-TBI manifests within child protection systems, highlighting diagnostic gaps, interagency fragmentation, and the need for trauma-informed, brain-injury-aware interventions.

Exposure to IPV as a Driver of Child Welfare Involvement

Across the literature, children's exposure to IPV emerges as one of the most consistent predictors of child protection involvement. Black et al. (2024) analyze 25 years of administrative data from Ontario, revealing that exposure to IPV is both highly prevalent and unevenly addressed across regions, with substantial gaps in trauma-informed risk assessment and service delivery. Ravi (2021) further links this exposure to heightened emotional-behavioral disability diagnoses in children, especially when maternal mental health support is lacking. Both studies call for enhanced maternal support and cross-sector coordination to interrupt cycles of intergenerational trauma. These findings underscore the need for child protection agencies to explicitly address the neurological and psychological fallout of IPV on children—not merely their physical safety. Children's exposure to IPV is one of the most frequent drivers of child welfare involvement in Canada. National statistics highlight ongoing underreporting and systemic barriers, particularly for Indigenous children (Conroy et al. 2021). These concerns extend beyond TBI to broader patterns of missed diagnostic and intervention opportunities.

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[23] This chapter was written by Gary Hill.

Interagency Fragmentation and Systemic Barriers

Service fragmentation is a dominant theme across studies, many of which describe structural “silos” between domestic violence, child protection, and legal systems (Hale et al., 2024; Laing et al., 2018; Langenderfer-Magruder et al., 2019). These silos produce contradictory mandates, uncoordinated safety planning, and re-traumatization of survivors, particularly when protective parenting is undermined by legal proceedings (Hale et al., 2024; Laing et al., 2018). Ayton et al. (2021) also emphasize widespread underreporting, misdiagnosis, and the disproportionate impact of IPV-related brain injuries on women and children, especially in marginalized populations such as Indigenous communities. Drawing from an international analysis of 29 studies, Ayton et al. (2021) highlight that brain injuries in a family context are frequently overlooked or misinterpreted due to gendered assumptions, inadequate screening protocols, and lack of integrated care. Their review underscores that children and women, particularly those facing socioeconomic disadvantage or systemic oppression, are routinely missed in medical and legal systems—leading to significant gaps in protection, treatment, and justice (Ayton et al., 2021).

Recommendations Toward Integrated, Trauma-Informed Practice

What emerges across the literature is an urgent need for integrated, trauma-informed, and brain-injury-literate approaches within child protection. Promising practices include co-located service teams (Hale et al., 2024), shared language and cross-training (Laing et al., 2018), and formal multidisciplinary protocols for early intervention. Professionals from child protection, IPV, and mental health services are physically housed together in co-located service team. This approach is highlighted by Hale and colleagues (2024) as a promising model that fosters real-time collaboration, reduces communication barriers, and enables more survivor-centered responses. Additionally, Sayrs et al. (2022) highlight the importance of screening for both IPV and neurocognitive concerns in caregivers and children as part of standard intake. The Gabe et al. (2018) Australian-based report provides actionable policy recommendations to support these approaches, including screening for brain injury in both survivors and perpetrators.

The literature consistently demonstrates that IPV-related TBI is a blind spot in child protection systems. Children's exposure to violence is well-documented, yet its neurological and intergenerational impacts are under-addressed (Jaffe et al., 1990; Lefebvre et al., 2013). Bridging the divide between IPV services, pediatric health care, family courts, and child protection is essential. Trauma-informed, and coordinated responses are not only possible but necessary to improve outcomes for vulnerable children and families.

Shelter Services[24]

Shelters for survivors of IPV have long served as critical frontline supports, offering protection, emergency housing, and crisis intervention. Yet, these settings often remain under-equipped to recognize or respond to TBI. Many shelter environments lack the structural capacity, expertise, training, or resources to identify and support survivors experiencing these invisible or "unseen injuries." The following section synthesizes Canadian and international research to examine the systemic gaps, survivor experiences.

Shelter Readiness and Staff Capacity

Shelters are often the first and only service point for female survivors following violent and traumatic experiences. However, research continues to highlight that shelter workers are often unprepared to recognize or respond to TBI, particularly when symptoms such as memory lapses, irritability, confusion, or fatigue are misread as emotional instability or resistance to

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[24] This chapter was written by Gary Hill.

services (Campbell et al., 2024; Maki, 2019). Campbell et al. (2024) found that while many shelter staff had basic knowledge of IPV-TBI (with 94% answering at least 75% of knowledge questions correctly), only a small percentage actively screened for brain injury or felt confident in providing tailored support. In a Canadian study, Nicol et al. (2021) similarly documented that service providers, though motivated to help, frequently felt constrained by a lack of training, organizational tools, and post-screening support protocols. Unlike Campbell (2024), Nicol and colleagues (2021) did not find Canadian shelter staff to report strong baseline knowledge, instead emphasizing structural and systemic challenges to implementation. These limitations prevent staff from identifying and responding to the unseen injuries that survivors may be carrying with them into shelter environments.

Survivor Experience and Environmental Challenges

Survivors living with brain injuries often encounter environments that inadvertently worsen their symptoms. For those navigating post-traumatic and neurological impacts, shelters can sometimes feel overwhelming. Bright fluorescent lighting, high noise levels, strict rules, and shared spaces can exacerbate TBI-related sensitivities such as light and sound intolerance, emotional dysregulation, and cognitive fatigue. These conditions may lead survivors to feel unsafe or misunderstood, further reinforcing isolation and discouraging continued engagement with services (Maki, 2019; Nicol et al., 2021). Tutty et al. (2025)found that women valued the protection and community shelters offer, yet many described shelters as emotionally draining spaces lacking in privacy, flexibility, and tailored support. Oakley et al. (2021) reported that, among a cohort of women in shelter, over 77.8% had a probable TBI. Using the HELPS (Head injury, Emergency room treatment, Loss of consciousness, Problems with memory or consciousness, and Sickness) tool, the majority reported daily symptoms such as depression, anxiety, and headaches and disclosed histories of head injury. Despite symptoms consistent with brain injury, most participants never received a formal diagnosis or medical attention, highlighting critical gaps in healthcare access and the invisibility of IPV-related TBI's in shelter populations (Oakley et al., 2021). Without proper accommodations or trauma-informed practices, survivors are at risk of being labeled "non-compliant," "difficult," or "uncooperative", when their reactions may be rooted in neurological trauma.

Screening, Training, and the Recognition of Unseen Injuries

Recognizing and responding to TBI in shelter settings requires a commitment to trauma-informed, low-barrier screening and education. The HELPS screening tool has shown promise in shelter contexts, offering a simple, accessible way to identify possible TBI without requiring clinical diagnosis (Oakley et al., 2021). The HELPS screening tool is a brief, 5-question instrument designed to identify potential histories of TBI; it is especially useful in shelter settings due to its simplicity, ease of use, and ability to flag invisible injuries that often go undetected in survivors of IPV (Oakley et al., 2021). However, implementation remains limited. Staff are often unsure how to interpret or act on results and may worry that identifying a brain injury could trigger unintended consequences for survivors, such as child welfare involvement or loss of autonomy. As a response to training deficits, Nicol et al. (2023) evaluated the Concussion Awareness Training Tool for Women's Support Workers (CATT-WSW), a free online module, and found significant improvements in staff knowledge and confidence. Participants in this study reported feeling better equipped to recognize signs of TBI and offer meaningful support after taking this training. These types of tools are critical in bridging the gap between knowledge and practice, especially when shelters operate with constrained resources.

Structural and Policy Barriers

Even with staff willingness and growing awareness, many shelters operate within systems that limit their capacity to implement trauma-informed and disability-responsive models of care. Chronic underfunding, staff burnout, and a lack of coordinated national standards prevent shelters from consistently identifying or addressing the unseen injuries of IPV survivors. Maki (2019) and Mendoza and Hoogendam (2025) document how women's shelters across Canada continue to face funding instability and uneven policy support, particularly in their ability to serve survivors with complex health and neurocognitive needs. Women's Shelters Canada (2023) similarly highlights the increasing demand for services amid national housing insecurity and dwindling resources, noting that shelters are being forced to extend stays and stretch capacity far beyond their intended design.

These challenges are even more pronounced for survivors from marginalized communities. Maxwell (2024) found that Indigenous-operated shelters frequently experience capacity challenges and face systemic barriers to culturally grounded, trauma-informed service delivery. Many shelters report difficulties hiring and retaining trained Indigenous staff or accessing tools and partnerships necessary for recognizing and responding to brain injury (Maxwell, 2024). Beattie and Hutchins (2015) also underscore how women living in rural or northern areas may face especially limited access to TBI-sensitive services—supports that include routine screening for brain injury, staff trained to recognize IPV-related head trauma, and accommodations such as quiet spaces, memory aids, and trauma-informed communication. Wathen et al. (2015) further point out that most shelter evaluation frameworks fail to account for the long-term impacts of trauma. While funders often demand measurable outcomes, the success metrics rarely capture the invisible and enduring impacts of TBI (Wathen et al., 2015). This tension between administrative expectations and survivor-centered realities creates further disconnects in how services are delivered and assessed.

Recommendations

The literature emphasizes the urgent need for shelters to evolve into spaces that are not only safe but also responsive to the full range of injuries survivors may carry, including those that cannot be seen. This includes implementing trauma-informed, culturally safe, and neuro-aware practices at every level of service delivery. If adopted more broadly, training and educational initiatives such as CATT-WSW can ensure that all frontline staff have a foundational understanding of brain injury, how it presents, and how to respond in a supportive and empowering manner. Screening tools like HELPS should be integrated into shelter protocols in a way that preserves survivor autonomy and dignity, with clear referral pathways that connect clients to health and legal supports when desired.

However, staff education alone is not sufficient. Shelters need structural supports to enact meaningful change. This includes increased and stable funding to hire and retain staff, modified sensory-friendly physical environments , and partnerships with neurologists, mental health workers, and culturally relevant service providers. National standards and coordinated policies are essential to ensure that survivors receive equitable care regardless of geography, identity, or ability. Marginalized communities must be centered in these reforms with services designed in partnership with the populations they intend to serve. Shelters must be supported in transforming from emergency havens into comprehensive healing spaces that can recognize and respond to the visible and invisible injuries of IPV.

Social Issues

The final section of this literature review explores various social issues that intersect with intimate partner violence and brain injury. IPV-TBI has several complex and contextual intersections with mental health, substance use, and disability that will be explored in this final portion of the review.

Mental Health[25]

Emerging evidence illustrates a complex and deeply interwoven relationship between TBI, IPV, and mental health conditions. The existing literature reveals both the frequency of these intersecting issues and the limitations of current research in capturing their full scope. Many studies explore IPV and mental health or TBI and mental health separately, but few look at all three together. This intersection is under-researched in general, and particularly so in Canadian contexts (Toccalino, 2024a). This section will cover several topics that emerged in existing research on Indigenous survivors of IPV and TBI, including the high rates of co-occurrence of IPV, TBI and mental health conditions, the unique profile of PTSD in women who have sustained IPV-TBI, barriers survivors face in obtaining diagnosis and care, and critical structural gaps. Further discussed are the impacts of intersectionality, with an important focus on Indigenous survivors, culminating in the recommendations for effective pathways of care for mental health conditions within the context of IPV-TBI.

High Rates of Co-occurrence

IPV-TBI related injury increases vulnerability to mental health conditions such as depression, anxiety, and PTSD (Toccalino et al., 2023; Valera, 2020). In the limited literature, there has been a clear correlation between IPV survivors and their experiences of anxiety,

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[25] This chapter was written by Katherine Leverick.

depression, and PTSD (White et al., 2024). White et al. (2024) conducted a meta-analysis of IPV and mental health outcomes globally, confirming high prevalence rates of PTSD, depression, and anxiety among survivors. However, most of the studies included in this work did not focus on neurocognitive symptoms or explore brain injury explicitly. Where the overlap has been studied, results are concerning.

Several studies demonstrate that IPV survivors with TBI are more likely to experience co-occurring mental health challenges than those without brain injuries. In Karr et al.'s study (2024) women with IPV-TBI screened positive for depression at higher rates than their non-TBI counterparts. Anxiety symptoms were also assessed in the study and elevated scores were observed, though not all differences reached statistical significance. These findings align with broader trends reported in large-scale population datasets Drawing on data from the Canadian Community Health Survey, Kureshi et al. (2023) found that individuals (not specifically IPV survivors) with a history of TBI were more likely to use mental health services. This association held true even after controlling for sociodemographic factors and pre-existing diagnoses.

Building on these findings, recent research has begun to explore how co-occurring conditions such as TBI, PTSD, and chronic pain intersect in the lives of IPV survivors. Known as the polytrauma clinical triad, this constellation of symptoms was originally identified in military populations but is now being applied in civilian contexts. In a recent study, Leong et al. (2025) examined this triad among women with IPV-related TBI and found that participants who screened positive for all three conditions reported significantly poorer cognitive functioning and mental health outcomes. These finding reinforce the need for more nuanced, trauma-informed diagnostic frameworks capable of capturing the complex interplay between physical, psychological, and neurological harm in IPV contexts (Leong et al., 2025). By adopting clinical models originally developed for combat veterans, researchers are beginning to acknowledge the severity and complexity of IPV-related trauma. This shift opens the door for deeper investigation into specific conditions like PTSD, which remains one of the most pervasive, yet under-addressed, outcomes of TBI in the context of IPV.

Post-Traumatic Stress Disorder: A Distinct Focus

PTSD is among the most frequently studied mental health outcomes in the context of IPV-TBI. This emphasis may reflect the field's reliance on frameworks developed in military and veteran populations, where the co-occurrence of PTSD and TBI is well established (Leong et al., 2025). However, while some symptom patterns overlap, studies show that the social and structural contexts for IPV survivors differ significantly from those in military settings, particularly in relation to ongoing exposure to violence, gendered power dynamics, and systemic barriers to care (Toccalino et al., 2023; Valera, 2020). Research suggests that women with IPV-related brain injuries screen positive for PTSD at higher rates than those without (32.1% compared to 22.6%) (Karr et al., 2024). Although this difference did not reach statistical significance across all models, symptom severity scores for PTSD were significantly elevated across all subscales—re-experiencing, avoidance, negative mood and cognition, and hyperarousal—for women with TBI. These findings align with earlier work by Valera (2020), who emphasized the link between repeated head trauma and persistent PTSD symptoms in survivors of IPV. Drawing on both clinical research and survivor narratives, Valera (2020) argues that IPV-related TBIs are often cumulative and chronic, leading to long-term neuropsychological consequences that heighten vulnerability to PTSD and complicate trajectories for recovery.

Despite this growing evidence, most therapeutic models for PTSD do not account for co-occurring brain injury. Toccalino (2024) notes that common screening tools for PTSD among IPV survivors rarely include questions that assess for potential head trauma, resulting in misattribution or neglect of symptoms such as memory loss, attention deficits, or emotional dysregulation. This disjuncture is particularly important, as unaddressed TBI may affect treatment efficacy and limit survivors' ability to engage with traditional trauma therapies (Toccalino, Haag, Nalder, Chan, Moore, Colantonio, et al., 2024). Additionally, symptoms like memory loss or hyperarousal may be misattributed or go unsupported (Toccalino, Haag, Nalder, Chan, Moore, Colantonio, et al., 2024). Taken together, these findings underscore a critical gap; despite high rates of symptomology, the literature consistently notes that IPV survivors, as well as the service providers interacting with them, may not recognize their injuries as TBIs, limiting opportunities for accurate diagnosis, appropriate care, and long-term recovery (Toccalino, 2024a; Toccalino, Haag, Nalder, Chan, Moore, Colantonio, et al., 2024; Valera, 2020).

Barriers to Diagnosis and Recognition

TBI can mimic, amplify, or complicate mental health symptoms, often making diagnosis and treatment more difficult (Toccalino et al., 2023; Toccalino, 2024a). Toccalino's doctoral research emphasized that many survivors only came to understand their symptoms as indicative of a brain injury well after their experiences of violence (Toccalino, 2024b). The invisibility of TBI symptoms, particularly when they overlap with psychological distress, can delay access to appropriate care and reinforce stigma. Shame, systemic neglect, and the siloing of physical and psychological health systems often result in survivors being "bounced" between providers without coordinated treatment plans (Toccalino, 2024b). The overlap between mental health and TBI symptoms creates unique challenges to receiving care.

The lack of standardized tools and integrated assessment protocols remains a critical gap. Research by Smirl et al. (2019) compared the use of Sport Concussion Assessment Tool 5 (SCAT5), a tool developed for sports-related concussion, with the Brain Injury Severity Assessment (BISA), designed for IPV survivors. The study found that BISA identified more injuries and aligned more closely with survivors' reported symptoms, yet BISA remains underutilized in frontline healthcare settings (Smirl et al., 2019). Without appropriate diagnostic tools, survivors may be dismissed or misdiagnosed, especially when presenting with symptoms such as fatigue, anxiety, or memory problems, which are symptoms that are neurologically rooted but often interpreted solely as psychological.

Critical Gaps and Intersectionality

While the body of literature on the intersection of IPV, TBI, and mental health is growing, it remains fragmented. Toccalino et al. (2023) conducted a scoping review and identified only 28 articles that met inclusion criteria for examining all three components together. The included studies varied widely in methodology, with many relying on small samples and using inconsistent definitions or assessment tools for both TBI and mental health outcomes. This lack of standardization made comparisons across studies difficult (Toccalino et al., 2023). Notably, few studies addressed healthcare access or system-level responses, despite mounting evidence that the cognitive and psychological symptoms of TBI may interfere with survivors' ability to navigate complex health and social service systems (Toccalino et al., 2023; Tutty et al., 2021). The review highlighted an urgent need for research that not only captures the lived experiences of survivors but also evaluates how service systems do (or do not) account for the compounded effects of brain injury and trauma in IPV contexts (Toccalino et al., 2023).

Indigenous Survivors: Mental Health, TBI, and IPV

Intersectionality is often absent or underdeveloped in the existing literature on these topics. Even when demographic data is collected, few studies analyze how multiple systems of oppression such as racism, colonialism, and ableism interact to shape survivors' experiences of violence and care. Toccalino et al. (2024) notes the need for inclusive research frameworks that attend to survivors across the gender spectrum and meaningfully incorporate racialized and Indigenous perspectives. Without these lenses, research risks obscuring the experiences of the most marginalized survivors and reinforcing patterns of exclusion under the guise of neutrality.

Research on the intersection of TBI, mental health, and IPV in Indigenous communities remains limited, but what exists clearly points to unmet need and systemic neglect. The burden of mental health concerns among Indigenous women who have experienced IPV is disproportionately high, and brain injuries are likely under-recognized and under-treated in these contexts (Tutty et al., 2020). In their Canadian study, Tutty et al. (2020) found that Indigenous women reported higher rates of PTSD and depression symptoms compared to White and other visible minority women who had experienced IPV. This disparity reflects the layered impacts of cumulative trauma, including high rates of childhood abuse, the intergenerational effects of residential schools, forced disconnection from family and land, and the ongoing legacy of the Sixties Scoop (MMIWG, 2019). Hunt (2016) argues that these harms are not historical but embedded in present-day structures through systemic racism, surveillance, jurisdictional neglect, and the chronic underfunding of Indigenous health and social services. Colonization, intergenerational trauma, and institutional violence continue to shape the conditions under which Indigenous survivors experience IPV and contribute to the under-recognition of brain injury and psychological distress. Despite this, Indigenous-specific data remain sparse, and most studies fail to account for how these structural factors shape both the risk and outcomes of IPV-related TBI and mental health concerns (Toccalino et al., 2024; Tutty et al., 2021).

There is an absence of detailed studies exploring how systemic barriers, such as jurisdictional healthcare disputes, remote geography, and mistrust of colonial institutions, impact diagnosis and treatment for Indigenous survivors with TBI and mental health concerns. Kureshi et al. (2023) note that while TBI is linked to increased mental health care utilization in general, access patterns are uneven and may obscure the experiences of marginalized populations. Indigenous survivors described systems that failed to recognize their needs, misinterpreted symptoms, or retraumatized them through institutional barriers and bureaucratic indifference (Kureshi et al., 2023). As Toccalino et al. (2023) scoping review indicates, Indigenous identity is rarely explored as a meaningful variable in studies on IPV-related BI and mental health, despite clear relevance. Given the unique and layered histories of trauma in Indigenous communities, future research must move beyond inclusion-as-diversity and build frameworks that acknowledge colonial harm and support community-led solutions.

Recommendations

The literature supports a shift toward trauma- and brain-injury-informed service models that acknowledge the combined effects of TBI and mental health conditions in the context of IPV (Smirl et al., 2019; Toccalino, 2024b, 2024a; Valera, 2020). Collaboration across sectors, including mental health, neurology, IPV services, and housing, can help address the wide-ranging impacts of IPV-TBI. The integration of mental health screening into emergency departments and IPV-specific services is also supported by national data showing increased mental health service use following TBI (Kureshi et al., 2023). Flexible, survivor-led care models should be prioritized. These models acknowledge that care-seeking is often nonlinear and influenced by shame, system fragmentation, and prior experiences of discrimination (Toccalino, 2024a). Research and policy conducted to further this topic should center intersectionality as a guiding framework, as existing studies overwhelmingly reflect non-diverse samples, limiting their applicability. Including Indigenous, racialized, and gender-diverse survivors is essential to building equitable systems of care (Toccalino, Haag, Nalder, Chan, Moore, Colantonio, et al., 2024; Tutty et al., 2021). Studies should prioritize lived experience and community-led perspectives while addressing systemic barriers to care. Only then can we begin to understand how these interwoven harms unfold, and how to intervene in ways that are meaningful, equitable, and effective.

Substance Use[26]

Substance use, IPV, and TBI are interdependent issues that can be the cause or result of one another. There is very little literature that considers substance use, IPV, and TBI together. Literature on substance use and IPV remains extensive, while literature on substance use and TBI is limited. This section outlines research concerning the relationship between substance-using behaviours and IPV, substance use, and TBIs. Speculation on the implications for IPV-TBI and substance use are drawn from these findings.

Substance Use and IPV: Prevalence

Substances may be used within the context of IPV by the perpetrator, victim, or both, for a multitude of different reasons (St. Ivany, Kools, et al., 2018). The use of substances can put victims at risk in a variety of ways: they can increase the risk of assaults by incapacitation, increase anger and agitation among perpetrators, increase the severity of violence and injury, negatively interact with mental illnesses, cause financial struggles, and cause many personal

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[26] This chapter was written by Sam Kisil.

health issues or even death (Monahan & O'Leary, 1999). Evidently, substance use and IPV are largely intertwined and both substance use and IPV may perpetuate one another for a multitude of reasons (Monahan & O'Leary, 1999). Substance use is highly prevalent among IPV cases and can affect the severity of IPV (Stover et al., 2022). Among sexual assaults, alcohol is involved in roughly 30-60% of cases, and among IPV cases, the perpetrator may be under the influence of alcohol nearly 44% of the time (Karr et al., 2024; McCormack et al., 2022). Additionally, substances such as prescription painkillers, cannabis, heroin, cocaine, and crystal methamphetamine are also common in many IPV cases (McCormack et al., 2022; St. Ivany, Kools, et al., 2018). Among a sample of 37 IPV-TBI female survivors, substance use in the household persisted for an average of approximately 16 years (with a confidence interval of 9.84 years), illuminating the effects that the presence and history of substances in the household have on IPV (Rojczyk et al., 2024). The presence of a lifetime history of household substance use and IPV affects IPV susceptibilities, as roughly 40% of individuals who experience(d) IPV have a family member with an alcohol use disorder, and 27% have a family member with a drug-use problem (McCormack et al., 2022). Clearly, substances are heavily involved in IPV cases and attention is warranted toward the issue.

Substance Use as a Predictor for IPV

Substance use is prevalent following a traumatic IPV-related event, though it is also exceedingly prevalent prior to or during an IPV-related event (Ullman et al., 2019). Due to the disinhibiting and sedating effects of many substances, intoxicated individuals may be targets for assaults (Ullman et al., 2019). Even worse, these victims are often blamed for consuming substances prior to the assault or violent event, while the perpetrator is typically excused for the actions because they were intoxicated (Ullman et al., 2019). Crane and Easton (2017) highlight the aggressive and disinhibiting effects that substances can have on the perpetrator, facilitating irregular behaviours like anger and violence. Individuals who become dependent on substances also display symptoms of depression, irritability, agitation, low tolerance for frustration, and cravings, which are highly associated with IPV (Monahan & O'Leary, 1999). Perpetrators also commonly pressure their partners into using substances. For example, in an interview with St. Ivany, Kools, et al. (2018), a survivor stated, "he started hitting me for not wanting to do meth with him" (p. 201). There are also many financial strains coupled to the common emotional strains of IPV, as monthly paychecks are typically spent on substances, inducing stress and emotional instability for family providers and their children (St. Ivany, Kools, et al., 2018). This added emotional tension further perpetuates IPV (St. Ivany, Kools, et al., 2018).

Substance Use to Self-Medicate and Treat Pain

IPV episodes induce major physical and psychological trauma, causing many victims to turn to substances as a form of self-medicating (Mehr et al., 2023). Substances with analgesic or inhibiting effects on the body are commonly used, as IPV survivors experience chronic pain (Karr et al., 2024). Karr et al. (2024) found that high alcohol consumption among IPV-involved individuals could likely be attributed to both physical and psychological pain. Mehr et al. (2023) raised concerns from a legal perspective, as they found alcohol only causes pain-relieving symptoms once blood alcohol concentrations exceed legal limits, putting this demographic at risk of legal charges, car accidents, and subsequent TBIs, among other consequences. Moreover, continually increased alcohol intake is required for these pain-relieving symptoms to stay effective, increasing the risk of developing an alcohol use disorder (AUD) (Mehr et al., 2023).

Mental Health, IPV, and Substance Use

Unsurprisingly, AUDs are coupled with high rates of PTSD, TBIs, depression, and anxiety (Karr et al., 2024). These mental health disorders can induce instability and increase an individual's susceptibility to using substances. Using substances can also disrupt mental disorders (Murphy et al., 2009). Cannabis is another substance that is typically used to cope with the psychological aspects of trauma; however, regular use can increase the risk of substance use disorder, depression, and anxiety, especially among the younger populations (Copeland et al., 2013). Cannabis is also associated with polysubstance use, increasing susceptibility to assaults and revictimization (Mehr et al., 2023). Rojczyk et al. (2024) found that veterans who have PTSD, mood-related disorders, and substance use disorders had a higher risk of IPV, and that both mental health and SUDs can perpetuate one another.

Substance Use and Indigenous Peoples

Indigenous Peoples in Canada experience several intergenerational effects of colonialism, such as discrimination and trauma, and subsequent SUDs (Murphy et al., 2009). Sullivan and National Native Addictions Partnership Foundation (2012) found that Indigenous communities with above average rates of substance use also saw higher rates of suicide, violence, illegal activity, and many forms of abuse. High rates of substance use are also seen among Indigenous youth compared to non-Indigenous youth, meaning they are likely more susceptible to violence, abuse, and illegal activity at a younger age (Chiefs of Ontario, 2010). Opiate epidemics exist among 43-85% of First Nations communities in Canada, which are presumably coupled with high rates of IPV (Chiefs of Ontario, 2010).The demands for additional support could not be more evident, yet they are still failing to be met.

Brain Injury and Substance Use

TBIs can both lead to a substance use disorder, and substance use can also make one susceptible to TBIs (Mehr et al., 2023). Mehr et al. (2023) found that, among those with a brain injury, substance use typically increases following the brain injury though it can be dependent on injury severity. Similarly, West (2011) found that substance use might increase eventually after sustaining a TBI, though dips are observed in use immediately after sustaining the injury. TBIs can also further exacerbate symptoms of mental health disorders like depression and substance-using behaviours, as noted in more detail in another section of this review (Ullman et al., 2019). It is important to note that TBIs may cause physical pain, but further setbacks caused by acquired mental disabilities can negatively affect a survivor's well-being and encourage substance-using behaviours (Ullman et al., 2019). West (2011) stated that 50-60% of those with a TBI have problems with drugs or alcohol, and of the 50-60%, 33-75% of them reported having problems with drugs and/or alcohol before sustaining the head injury. Moreover, an average of 61% of individuals with a brain injury report having an alcohol use disorder prior to the injury, whereas an average of 30% of individuals with a TBI report having a drug abuse problem prior to the injury (West, 2011). West (2011) found that about half of all TBI cases occurred while the individual was under the influence of alcohol, as it impairs coordination and motor skills, which increases the risk of falls, car accidents, and violence.

IPV, TBI, and Substance Use

There is currently a lack of literature on the relationship between IPV, TBI, and substance use. Therefore, the relationship between IPV, TBI, and substance use is speculatory. Crane and Easton (2017) found that BI increased the odds of IPV, and that impaired functioning due to BI is likely coupled with substance-using behaviours, self-medicating, and prescription drug-use.

Gibson et al. (2024) also found that, when a group of survivors of IPV were compared to a non-IPV group, the IPV group had higher rates of TBI (17.3% vs 3.9%) and substance use disorders (38.5% vs 11.4%). These studies highlight the relationship between IPV, TBI, and substance use, though the temporal relationship remains uncertain. There is likely a vast number of causes and effects among IPV, TBI, and substance use, and the direction of the relationship between each of these three areas is currently unknown. For example, one could have a substance use disorder, leading to a violent event that results in a brain injury, or someone could have sustained a brain injury at a young age, leading to substance use habits, and then engage in IPV. More importantly, recognition of the interconnected relationship between IPV, TBI, and substance use, and the implications that follow each one is crucial for future research, health care provision, and community support.

Complications with Treatment, the Courts, and Data Collection

Required abstinence is a common issue among many treatment centers for TBIs, complicating the treatment process for those who also have a substance use disorder (Mehr et al., 2023). The combination of substance use and TBI makes it difficult for individuals to seek treatment, particularly because facilities will refuse entry for those who have a substance use disorder (Mehr et al., 2023). Furthermore, symptoms of brain injury and intoxication via substances may sometimes appear similar, leading to misclassifications (Mehr et al., 2023). Individuals with substance use disorders also struggle with treatment follow-up, often failing to attend appointments or take medications (Mehr et al., 2023).

As this review has demonstrated, TBIs are commonly sustained by IPV, and many of these disputes end up in the courts (Ullman et al., 2019). Within the criminal justice system, many victims struggle to recall events, and both judges and lawyers quickly attribute their lapse in memory to their substance-using habits (Ullman et al., 2019). Many legal officials fail to acknowledge the effect that TBIs have on memory, and if substances were present during the offence, any evidence from the victim will often be excused as faulty .There is also a growing narrative that the victim should be blamed for consuming substances prior to an assault or violent event, compared to the perpetrator who is typically excused for their actions because they were intoxicated (Ullman et al., 2019). This narrative, from a legal perspective, tends to be biased towards the perpetrator and results in weaker legal punishments (Ullman et al., 2019).

There are currently shortcomings in the data collection of IPV events involving intoxication. Some researchers classify intoxication using three categories: unimpaired (substances do not affect decision-making), impaired (conscious, though decision-making is altered by substances), and incapacitated (unconscious due to substance-use) (Ullman et al., 2019). While these categories might appear useful, there is often cross-over and confusion between categories. For example, many assault cases involve someone who is asleep, but may not be intoxicated, and many researchers classify these cases differently, with some under “impaired” and some under “incapacitated”. There are also cases where victims and perpetrators could have been unimpaired, then became impaired, then incapacitated, which makes it difficult to classify the case into one category. Moreover, there is often doubt in the victims’ ability to recall events if they were ever incapacitated throughout the event (Ulman et al., 2019). While there is no current solution to this issue, it is noteworthy to acknowledge the shortcomings associated with this method of data collection, as it could have further implications if the data is used in the courts.

Disability[27]

Women with IPV-TBI face disability-specific IPV risks, experiences, and barriers. TBI often results in a combination of cognitive and mental health disabilities , which may increase the likelihood of further victimization. Elevated rates of victimization occur for women who experience two or more types of disabilities, and women with cognitive and mental health disabilities experience violent victimization at a rate four times that of nondisabled women (DisAbled Women's Network of Canada, 2019).

Conceptualizing TBI as a Disability

Definitions and understandings of disability are innumerable and constantly in-flux, making it a difficult concept to concretely define. A disability may be categorized into multiple subgroups or analyzed according to multiple models and therefore cannot be neatly conceptualized nor wholly understood within one category or analytical lens. TBI is no exception. TBI is referred to as an injury (Stocchetti & Zanier, 2016; Toccalino et al., 2023) a chronic disease (Dams-O'Connor et al., 2023; Engström et al., 2025), a chronic disability (Engström et al., 2025), and a cognitive disability (Lalonde & Baker, 2019). It has also been conceptualized as an invisible disability, to denote how it is often not visually nor systemically perceived as a disability (Engström et al., 2025).

TBI may also be analyzed according to various models, the most common being the medical model of disability. The medical model frames disability as a medical phenomenon, asserting that it is a natural result of an individual's flawed pathology (Withers, 2024). Accordingly, TBI is a disability because it causes permanent and chronic impairment to a person's physical, mental, and/or cognitive functioning. Conversely, the social model frames

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[27] This section was written by Alexandra Arthurs.

disability as a social phenomenon, asserting that it is a constructed outcome of society's inaccessible social and built environments (Withers, 2024). Rather than seeing impairment as inherently disabling, the social model recognizes that impairment is *made* disabling in a society that does not value or accommodate non-normative difference (Withers, 2024). From this perspective, TBI is a disability because TBI-related impairments are devalued and unaccommodated in an ableist society. A medical lens yields reductionist and depoliticized examinations of disability, as sociopolitical influences are ignored and systemic problems are individualized (Grue, 2024; Withers, 2024). To underscore both the biophysiological and sociopolitical implications of TBI-related disability, it is important to understand it from a medical and a social lens.

Disability and IPV

Women often acquire disabilities due to IPV, which then increases their risk of further victimization (DisAbled Women's Network of Canada, 2019; Munson, 2016). Findings from the 2018 Statistics Canada *Survey of Safety in Public and Private Spaces* (SSPPS) suggest that the likelihood of experiencing sexual or physical assault by an intimate partner is nearly doubled amongst women with disabilities (Savage, 2021). More than half of respondents disclosed a type of IPV, and nearly half have feared an intimate partner (Savage, 2021). Women with disabilities are also subjected to additional disability-specific forms of abuse. Examples of disability specific abuse include withholding or damaging assistive devices, harming service animals, threatening institutionalization, neglecting caregiving duties, and weaponizing ableist stereotypes to undermine a disabled person's self-esteem, voice, and intelligence (D'Costa, 2025; Lalonde & Baker, 2019). These acts jeopardize the livelihood and agency of disabled people, resulting in further marginalization and disenfranchisement, and consequently more susceptibility to victimization.

Various kinds of ableism also contribute to the increased rates of victimization for disabled people. For example, internalized ableism may cause a disabled woman to believe she is unattractive or unlovable and consequently reduce her relationship standards (D’Costa, 2025). Attitudinal ableism may allow perpetrators to frame themselves as a heroes or victims, as they are seen as self-sacrificing for “dating crips” (Munson, 2016). Structural ableism may make IPV supports and services inaccessible to people with disabilities, as they are not designed to accommodate non-normative differences (D’Costa, 2025). Institutional ableism may force a disabled person to stay with their abuser, as bureaucratic barriers impede their ability to build financial capital or access an alternative caregiver (D’Costa, 2025; Munson, 2016). Increased experiences of IPV may also be attributed to the heightened discrepancies in vulnerability, power, and control between a nondisabled abuser and disabled victim (Hao, 2023; Munson, 2016; Muster, 2021). The tendency for people with disabilities to be socially excluded and isolated is also a contributing factor (D’Costa, 2025; DisAbled Women’s Network of Canada, 2019; Muster, 2021). Evidently, disabled women face amplified and distinct IPV experiences and barriers due to their diminished social location and the impacts of ableism.

Barriers to Care

Though they are clearly in need of supports and services, survivors with IPV-TBI may go without for a variety of reasons. One reason is bias. “Disability hierarchy” and “disease prestige” are terms used to denote how disabilities and diseases are differentially ranked and responded to according to their perceived legitimacy (Grue, 2024; Meyers et al., 2023). Disabilities or diseases that are clearly visible, are acute, and have “moral” causes are perceived and treated as most legitimate and important (Grue, 2024). Considering that IPV-TBI related disability is often invisible, chronic, and the result of circumstances that could (erroneously) imply personal responsibility and moral failure (for example, the inability to leave an abusive relationship), it may be perceived and treated as illegitimate or unimportant. In addition to disability bias, gender bias may also influence the dismissal or misdiagnosis of women with IPV-TBI. A combination of IPV and TBI-related symptoms may cause women to appear aggressive, emotionally unstable, restless, or expressionless, and consequently be misdiagnosed with a psychiatric or behavioral condition (Costello & Greenwald, 2022). These misdiagnoses may be influenced by sexism, founded on the stereotype that women are hysterical and neurotic. Gender bias in the perceptions and treatments of chronic and invisible disabilities is well documented (Oldfield, 2013; Rice et al., 2024; Samulowitz et al., 2018; Yee, 2013).

The demand and inaccessibility of both IPV and disability supports is another barrier to seeking and receiving help. When accessing IPV services, survivors are expected to complete paperwork, make phone calls, remember appointments, recall detailed recollections of past events, answer questions, and navigate systems and services that are often complex and fragmented (Hao, 2023; Namatovu & Ineland, 2024). Access to disability services is often predicated on one’s ability to verify their disability via official diagnosis and supportive medical documentation, which may be expensive and/or time-consuming to obtain. In addition to general life admin and IPV admin, people with IPV-TBI are also burdened with disability admin. Disability admin refers to the additional physical, mental, emotional, and logistical work involved in maintaining one’s livelihood, ‘proving’ one’s disability through disclosure and documentation, and trying to ‘pass’ as nondisabled (Grue, 2024). Essentially, accessing services requires abundant time, energy, and mental, emotional, cognitive and financial resources—all of which are depleted in IPV-TBI survivors. People with TBI often experience impairments in attention, memory, processing speed, and executive functioning (Stocchetti & Zanier, 2016). They may also be more likely to experience poverty due to increased medical expenses, barriers to gainful employment, and bureaucracy surrounding disability payments and social welfare provisions (DisAbled Women's Network of Canada, 2019).

Complex experiences of shame and discrimination is another barrier to accessing IPV-TBI supports and services. IPV-TBI survivors report that the intersecting shame of having a brain injury and being an IPV survivor has caused them to avoid intervention services (Toccalino et al., 2023). Women may avoid seeking healthcare to prevent the shame and discrimination that can accompany a permanent disability diagnosis (Tsu et al., 2025). A diagnosis of a mental health or cognitive disability could also be used to "legitimize" the dismissal of a woman's IPV report, as she is deemed too crazy, forgetful, or incoherent to provide an honest and reliable recollection (Cole, 2020).

Evidently, the intersection of having three devalued identities—being a woman, being disabled, and being an IPV survivor—creates complex barriers and confounding experiences of oppression. These barriers and oppressive experiences are further amplified when an IPV-TBI survivor has additional devalued identities, such as being a gender and/or sexual minority, or a racialized person.

Conclusion

Partner-inflicted brain injuries are a significant social and public health issue with impacts that are pervasive across various sectors, demographics, and social institutions. The prevalence of IPV in Canada, as well as the increasingly well-documented comorbidity of IPV and TBI, emphasizes the need for interventions and care pathways that meet the needs of this diverse group of survivors. This review has highlighted the existing research on specific populations, community responses, and social issues, as well as the glaring gaps in both the scholarship and knowledge of those working with survivors of partner-inflicted TBI. Ultimately, this review highlights the importance of developing specific care pathways that serve the complex identities, lived experiences, and needs of survivors.

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