Mental Health and ABI

There is hope, there is help!

Your clients cannot afford to compromise on their recovery, even when insurance limits are capped. We fight to ensure that your clients get funding for the care and treatment that they need.
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Loss of community, loss of connection and, at times, loss of relationships, can have a profound impact on one’s mental health and well-being.

By Ruth Wilcock
Executive Director, OBIA

RUTH’S DESK

Connection, Caring and the Impact on Mental Health

To be loved, cared for, and to belong is an inherent and fundamental need that crosses all boundaries of age, gender, nationality, and ethnicity. Some may say that it is as essential as food and water. Inevitably, when we come into this world as infants we seek connection to our primary caregivers, as we must have this bond in order to survive physically, emotionally and psychologically. Furthermore, research demonstrates that we are shaped by our environment and communities in which we are located. Certainly, for children, when bonds to their primary caregivers are threatened, severed through abandonment, abuse or other circumstances, it can lead to emotional and psychological difficulties.

As human beings, we all have the need to feel connected to someone or something. Furthermore, belonging to a group or community helps define and shape who we are and makes us feel a part of something larger than ourselves.

Connection to community powerful, as it is within our community that we find strength and inspiration.

Our community is the fertile soil by which we all grown and thrive. True community also provides a safe and comfortable space where people meet, share their thoughts, concerns, render, and receive support from one another. Within true community, fundamental elements such as connection, caring, development of quality relationships, collaboration, and celebration of diversity are present.

For many who have sustained brain injuries one of the first major losses they experience is the connection to their communities. Due to the impairments from their injuries, many survivors cannot return to work or their volunteer activities in the community. Furthermore, brain injury can have a profound impact on personality. This sudden change in personality combined with limitations in day-to-day functioning is not only difficult for the survivor to cope with, but for their family and friends as well.

Loss of community, loss of connection, and at times loss of relationships can have a profound impact on one’s mental health.
health and well-being. According to Julianne Holt-Lustand, a professor of psychology and neuroscience, a lack of social connection may heighten health risks as much as smoking 15 cigarettes per day or having an alcohol use disorder. She has also found that loneliness and social isolation are twice as harmful to physical and mental health as obesity (Perspectives on Psychological Science, Vol. 10, No. 2, 2015).

The good news is there is widespread consensus in public health and epidemiology literature that social connectedness causally protects and promotes mental health (Kawachi and Berkman, 2001; Perkins et al., 2015).

This is why it is so important that supports are in place for not only those who have sustained brain injuries, but also their families and loved ones. In Ontario we are so fortunate to have twenty one local affiliated brain injury community associations across the province that are there to help the survivor navigate through the murky waters of assessing who they are “now” and where they belong. Moreover, the associations provide an environment, which encourages a survivor just to “be” without the pressure of trying to portray the person they were prior to their injury.

OBIA is also responding to the need for connection and caring through our Online Concussion Support Group and through a pilot program for an Online Caregiver Conversations Group. To date we have supported close to 300 individuals through these programs. The feedback we often hear is that participants feel less isolated, and more connected and supported, which research has shown to positively impact one’s mental health.

To be a part of one of our groups please visit our website at obia.ca, call 1-800-263-5404 or email support@obia.on.ca. If you wish to connect with someone from a local brain injury association in your area you can find their information on page 46 of the OBIA Review. ◊◊◊

1 Retrieved from https://www.apa.org/monitor/2019/05/ce-corner-isolation
Throughout the last eight years, the Ontario Brain Injury Association (OBIA) has been hosting a longitudinal project, titled the OBIA Research Questionnaire (RQ). The purpose of this project was to explore the impact of brain injury on those living in Ontario. The RQ has provided powerful information about those living with brain injury and their caregivers across the lifespan.

Since the development of the original RQ, the landscape of brain injury has changed. As a result, in October 2018, the Ontario Neurotrauma Foundation (ONF) granted funding to OBIA to refine the existing project.

The goal of this revision is to make the questions more relevant to those living with a brain injury and their family members. The new questionnaire contains more specific and concrete questions about changes to one’s life following a brain injury. It also strives to apply to the many individuals in Ontario who have sustained a concussion.

Family members and caregivers are vital to the recovery of individuals who have sustained a brain injury. The updated project now includes a separate and more extensive questionnaire for family members and caregivers. Information collected from this project will be instrumental in the goal of developing new programs and supports for those caring for loved one’s with a brain injury.

Look for the updated questionnaire in your mailbox this spring! Your participation will enhance our ability to provide a unified voice on behalf of people affected by brain injury in Ontario.
We are all hoping to live as much of the good life as we can, but modern life with its stresses and distractions is hard. When brain injury turns your world upside down, the challenge is even greater. It’s easy to get stuck thinking about how life was in the past, and wanting to get back to the way things were. There are a few reasons why looking to the past is not the best way to build a good life now. The first is that research suggests that we tend to remember the “good old days” as better than they actually were. The second is that somethings may be so different now, that looking back is mainly a source of pain and loss. The relatively new field of Positive Psychology offers some evidence-based guidance about how to capitalize on what is working in the present to live a better life now.

What is Positive Psychology?

Martin Seligman, generally regarded as the founding father of the Positive Psychology movement describes this branch of behavioural science as “The study of what constitutes the pleasant life, the engaged life, and the meaningful life.” During his term as President of the American Psychological Association, Seligman inspired his colleagues to explore happiness and the positive aspects of human nature rather than focusing on abnormal behaviour or mental illness. Some of the topics that researchers from around the world have addressed include what happiness actually is, how optimism develops and what it does for us, character strengths and virtues, and emotional resilience. After more than 20 years research there is a robust body of knowledge that we can use to understand what really leads to happiness, and what we can do to improve the quality of our own lives.

There are a few important findings from Positive Psychology research that probably confirm what the wise elders in your life may have told you:

- Wealth or money isn’t correlated with happiness. In fact, windfalls of money can have the opposite effect. Spending money on yourself might feel good in the moment, but more lasting satisfaction is actually felt when we spend money on others.
- Our best resources in getting through hard times include social relationships and character strengths.
- Work is very important to wellbeing—but that isn’t tied to money. Rather, we need something that is meaningful and purposeful to do.
- Happiness is actually influenced by genetics, but people can learn to feel happier by developing optimism, practicing gratitude and helping others.
- It is important to have a clear sense of what your strengths are, and have ways to use your strengths every day.

The PERMA model (see diagram on page 8) helps to define what well-being or happiness is made up of. When we pay attention to all aspects of PERMA we are flourishing!

Another very important concept in Positive Psychology was contributed by Mihaly Csikszentmihalyi, called flow. Flow is the state of mind that occurs when a person has the right amount of skills to meet a challenge. You know you’re in a state of flow when you are so engrossed in what’s happening you don’t know
that time is passing (Csikszentmihalyi, 2008). Happy people have a way to enter that state of flow regularly. Of course if your skills have changed as the result of an injury, and challenges always feel too great, you’re more likely to feel anxious than to achieve a state of flow. On the other hand, if you have no challenges, boredom takes over. One key to living the good life after injury is to figure out where you can find your flow.

There are eight essential characteristics of flow:

1. You have focus on the task
2. You have clear goals and rewards, along with immediate feedback
3. That feeling of time slowing down (or maybe speeding up)
4. You find the activity rewarding in some way
5. You feel at ease while you’re engaged in the task
6. Skills and challenges are balanced
7. You are doing things without thinking too much about the process
8. You feel that you have control.

For some, it’s easier to find flow in a group by doing something that’s meaningful, like volunteering, or working on a project together. Putting aside the hustle and bustle of daily life (and your electronics) and giving what you are doing your full attention is essential to finding flow. Just cooking dinner or playing a quick game of cards with your full focus can induce a state of flow.

How can we apply Positive Psychology to life after brain injury?

At Community Head Injury Resource Services of Toronto (CHIRS) we’ve made a point of considering how we can support the pursuit of PERMA. These are a few key concepts and skills that are particularly helpful for our community.

Mindfulness Practice: Even brief types of mindfulness practice can be very helpful. Joy and happiness are available to us if we can be present to enjoy it. So practicing mindfulness—learning to focus our attention in the moment without judgement—becomes very important. It takes practice, and using the techniques of mindful meditation, mindful movement, and other activities, we practice focusing our attention on the current moment. The practice of mindfulness can open our eyes to new sources of enjoyment and joy. Mindfulness is built into many of the activities and groups we do at CHIRS. Usually the practice is brief at the beginning of a group or activity, and may include a moment of gratitude, following controlled breathing or an imagined body scan.

Finding Flow: The CHIRS program is designed to maximize personal choice, and the opportunity to shape activities by serving as a leader or mentor, usually in partnership with a staff member. Often activities are geared toward something rewarding, like helping others, having a nice meal, or a final product that can be shared. Care is taken to allow for entry into activities with the amount of support that allows a client to do something they find meaningful, with the right amount of challenge. As a community we celebrate being together often. Having a lot of variety in the program makes it possible for a person to experiment with how to find their flow, and when they do, how to plan for finding flow wherever they are outside of the program.

Practicing Gratitude: This is one of those very simple things that we often don’t do enough of. Research has shown happy people are better at recognizing and talking about what’s going right. Just noticing what’s going well may seem like an obvious thing, but too often we take the good stuff for granted. Stopping to celebrate a meal well made, a phone call that brightened someone’s day, or a walk to someplace new seems trivial, but when you get into that habit it can really open your eyes to that fact that even when times are tough, good stuff does continue to happen. We encourage this by doing our best to regularly celebrate accomplishments, and look back on what went well whenever we can. Instead of just making a to-do list, take time to make a well done list! In our introduction to Positive Psychology group, participants practiced gratitude, and discussed their findings with the group.

The Strengths Workshop: Another concept that has particular relevance for our community is the idea of identifying and using one’s strengths and virtues. It is misleading to use accomplishments like how a person earns a living, plays sports, or performs in school to determine what their strengths are. There are so many ways that we contribute to each other’s lives. Embracing your current strengths and virtues, and finding ways to use them can be transformative. For those of us who have participated in the Positive Psychology group—whether staff members or brain injury survivors—taking the time to think about what we are good at, how it feels to help others, and which virtues we truly admire and want to live by can bring about some positive changes.
The strength workshop begins with an overview of information about positive psychology and completing the Brief Strengths Questionnaire (Paterson, 2004) as presented on the Authentic Happiness website. After identifying our signature strengths, the group works together over a 12-week period to find ways to use and showcase the strengths they identified. Iraj Dastmalchi, workshop participant, offered his experience as an example and shared his thoughts on the program.

“Something has happened to us. I used to ski a lot but I don’t anymore. We cannot look back. Like I said ‘negative is only good on batteries. If you’re negative, nothing happens. When you’re positive even something small or trivial is going to help you progress. I like the mindful activities and the soothing music. I like the ‘what went well’ activity because it helps you think of positive things that happened that day or that week and it helps you remain grateful.”

Another member of the group, who wished to remain Anonymous, told us:

“I feel like positive psychology has helped me learn so much about my life and it made me happier with myself. I can use what I learned about my strengths to build on them”. “I like doing the mindfulness activities and I still do them every day because I find that it improves my mood. I also enjoyed reflecting on my values and strengths and learning how to use them in a different way.”

Learn more about it.

You can get a great introduction to Positive Psychology by Dr. Seligman himself, along with a lot of great resources including the Brief Strengths Questionnaire at the The University of Pennsylvania’s Authentic Happiness website, www.authentichappiness.sas.upenn.edu.

**References:**


Acknowledgments: We’d like to thank the people who have worked together to develop and run the Positive Psychology workshops, including Dan O’Driscoll, Roby Miller, Amanda Muise and Marisa Chaves. We’d also like to thank participants in the CHIRS Strengths workshop for shaping the group and sharing their experiences.

PERMA graphic, James Okore

Dr. Lemsky is a clinical neuropsychologist and the clinical Director of CHIRS.
OVERVIEW

Active Provincial Engagement Network of Survivors/Persons with Lived Experience, Family Members & Caregivers

GOALS

- To identify and prioritize issues important to Ontario's brain injury community from within the community
- To promote communication, involvement, and engagement

WHY A STAKEHOLDER ENGAGEMENT NETWORK?

- To create a systematic approach to inform and respond to Government
- To advocate for the needs of the brain injury community, by the brain injury community
- To mirror the successful and effective work of the Ontario Spinal Cord Injury Alliance

NETWORK MEMBERSHIP

<table>
<thead>
<tr>
<th>Total</th>
<th>Survivors</th>
<th>Family &amp; Caregivers</th>
</tr>
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<td>439</td>
<td>357</td>
<td>82</td>
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(November 2019)

JOIN THE NETWORK & HAVE YOUR VOICE BE HEARD

visit: http://obia.ca/brain-injury-speaks/

Network Organization

Coordinator (ONF/OBIA)

Provincial Advisory Team

Network

Advocacy | Community | Dialogue

We need your help to advocate for the Ontario brain injury community.

- Survivors, family & caregivers: we want you to share your experiences and stories
- Brain injury service providers: we want you to talk about Brain Injury Speaks with your clients
2013 was a life-changing year for me. I was in two motor vehicle collision (MVCs) a few months apart. I sustained mild Traumatic Brain Injuries (mTBI) in both, and a whiplash injury, too. I’d hoped for a quick recovery, yet symptoms persisted day in and day out for months. Some of them included: extreme fatigue, dizziness, visual issues, as well as light and noise sensitivity—the list goes on. Eventually I was diagnosed with Post-Concussive Syndrome (PCS). I experienced regular setbacks. Examples: three weeks of intense vertigo (feels like the room is spinning) plus debilitating headaches and exhaustion. New signs made appearances as time passed. They included TMJ pain, ringing in my ears and then, in 2019, seizures.

(2019) I was sitting in a drug store parking lot with my mother when, shockingly, I suffered what appeared to be a seizure. A few seizures later, I was in an ER waiting room, uncomfortably impatient to get triaged. Until then, my seizures had been relatively short and well contained, although I didn’t understand the strange, unsettling sensations taking over my body.

At times I’d managed to suppress them but then came the moment, only a bare few seconds, when I was totally overpowered by a strong physical rush. My body shook rapidly and aggressively. I can’t remember seeing the medical staff, but I heard them talking about me as they lugged my uncooperative body onto a gurney and into the ER. I continued to shake with no control over my body. After 24 hours, I was transferred to the epilepsy monitoring unit for another 24 hours.

I had electrodes attached to my head so the doctors could study my brain activity (electroencephalogram – EEG). I continued to seize during most of my hospital stay. After the observation time had passed, I was told that my brain was actually fine. In fact, the doctor said, my scans were normal, as was my electrical brain activity.

So what had happened to me?

There are some distinct differentiating factors in the presentation of an epileptic seizure versus a non-epileptic seizure. To the average person, it’s hard to tell the difference between one kind of seizure and the other. Many people don’t realize – I hadn’t – that there are multiple types of seizures. I was told by the doctor that I had experienced Psychogenic Non-Epileptic Seizures (PNES). Upon discharge, I was given a short list of psychotherapists and sent on my way. I left the hospital being rolled out in a wheelchair. I was in a fragile state, completely exhausted, confused, and worst of all, still having regular seizures. I was given next to no tools on how to function in my new reality.

All sorts of questions swirled through my mind. Could I continue to live alone? Would I able to go back to school and function normally? How long before I’d seize again? Would my condition improve or worsen? How will a psychotherapist rid me of this severe physical disability? And so on!

My new reality: long doctor’s visits, multiple hospitals, six months. All for nothing.

What do you do when no one pays attention to you? When you and your symptoms are pushed to the curb and you’re left for hours or days in the hospital, waiting and hoping for answers? It was incredibly frustrating to have been examined by so many neurologists and psychiatrists only to leave each time with no resources to help.
There is hope for a better tomorrow.

Thomson Rogers is dedicated to getting accident victims the compensation and support they deserve.
On my fourth or fifth emergency visit, I arrived by ambulance as usual and was rolled into the hospital. There, after only a glance from the ER doc, I heard him say the word “fake.” Tears filled my eyes as my non-verbal, deeply frustrated self waited and hoped to be taken seriously. I wasn’t “faking” any of this!

PNES used to be called pseudoseizures—pseudo literally means fake as in “fake” seizure(s). The reason for the name is that an epileptic seizure causes abnormal brain activity, whereas a non-epileptic seizure (PNES) does not. PNES can mimic the appearance of one thing while being something else. Again, that’s why the two conditions are usually indistinguishable to the average observer.

As you can imagine, being a patient labeled with pseudoseizures is invalidating and degrading. “Pseudo” and “fake” are descriptors still regularly used. Although “PNES” is certainly an improvement, it contains the word “psychogenic,” which can imply that the problem is all in one’s head, making patients feel disregarded.

PNES can stem from several different causes, some of which do not reside in the psyche. Don’t get me wrong: I’m not discounting the psychological nature of PNES or the potential impact of psychological factors in any disease. But to imply that psychological factors are the only ones to consider does patients a huge disservice. This mindset leads them down a narrow path with little or no direction for recovery, completely discounting the possibility of a physiological component. In my opinion, a holistic view and treatment approach is essential with every condition and disease because everything within us is connected. Body, mind, spirit: all in one.

The trouble with PNES—beyond the inherent stigma—is that the diagnosis exists between two disciplines of medicine: psychiatry and neurology. When I realized the lack of clear responsibility, my initial reaction was “great!” Now I’d have two specialists consulting together in attempts to tackle my case! Twice as many chances to be cured.

Nope. That hope was far from the reality I encountered. Yes, it’s true: the disciplines can overlap considerably in many conditions, including PNES. Nonetheless, I found that instead of having two experts co-consulting and collaborating, I got bounced back and forth between them. Eventually, one would take it on, ultimately discharging me with no help or guidance. Sadly, there’s ignorance—even among medical professionals—about those of us who suffer from PNES. Let me share a bit more, in hopes of spreading some enlightenment.

I once had an ER doctor approach my bedside. I was still in the midst of a seizure when I heard him sternly announce: “You have 15 seconds to come out of this, or I am leaving. And I don’t know when I’ll be back.” This came after he’d attempted to free me by pinching my upper shoulder extremely hard. His experiment didn’t work. I’d felt all the pain but got no relief at all. Countless times physicians have made me feel like an annoying inconvenience—perhaps because it’s difficult for them to acknowledge their lack of knowledge about what to do?

There’s little help or understanding, it seems. I’ve been told by some not to return to the ER. (What else is a seizure, may I ask, but an emergency?) Some doctors have insisted that I have complete control—what ignorance!—while others assure me that I have no control at all. The amount of contradictory information is overwhelming.

To convey the seriousness of these seizures, I should mention the huge safety risk that accompanies having seizures. I regularly drop to the ground, lose the ability to stand and then become non-verbal and physically paralyzed post-seizure.

In fairness, I want to acknowledge the few fantastic ER docs who genuinely seemed to care and focused on trying to help. But from a patient’s point of view, the overall system appears flawed. PNES often falls through the cracks between two different medical specialties—with neither neurology nor psychiatry assuming responsibility for treatment.

My mother—a previous case manager—and myself—a driven and resourceful individual—have joined forces to help facilitate an effective course of treatment for my seizures. I’ve personally called more than 40 psychologists, psychotherapists and social workers, finding only two who’d ever treated a few cases like my own. Because the condition is so rare, there’s scant available information and experience within the medical community.

Today the cause of my seizures remains unknown. I did have the privilege of being seen by an epileptologist (epilepsy specialist) who informed me that there’s a link between brain injury and non-epileptic seizures. Finally: a potential lead that remains to be explored. It seems that, after a brain injury, the body and brain are in a state of conflicting distress. Maybe this concept will provide an avenue for further research.

My experience motivated me to write this article. I consider it essential—not just for me but for every sufferer—to bring awareness to the stigma associated with PNES. Please know that if you are currently suffering from it, I see you and I hear you. You are 100% valid and so are your symptoms. Take some time to explore all possibilities for your condition with the goal of determining the root cause of PNES so a true solution can be found. Here’s rooting for us all!

Christine is currently a second-year student pursuing her degree in Neuroscience at Carleton University in Ottawa, Ontario. 

Christine is currently a second-year student pursuing her degree in Neuroscience at Carleton University in Ottawa, Ontario.
EPS Settlements Group of Canada has launched!

Brad Cantwell, President of EPS Settlements Group, and Bob Nigol are pleased to announce a partnership through the launch of EPS Settlements Group of Canada.

EPS Settlements Group is the flagship company of the oldest and largest structured settlements organization in North America.

Bob Nigol is a former owner and President and CEO of Henderson Structured Settlements and now the Managing Partner of EPS Settlements Group of Canada.

Together Brad and Bob wish to invite past and prospective clientele to engage in what assuredly will be the very highest standard of service achievable in the structured settlements market in Canada.
Emotional Problems After Traumatic Brain Injury

By Tessa Hart, PhD and Keith Cicerone, PhD (reprinted with permission from Brainline.org)

Brain injury and emotions

A brain injury can change the way people feel or express emotions. A person with Traumatic Brain Injury (TBI) can have several types of emotional problems.

Difficulty controlling emotions or “mood swings”

Some people may experience emotions very quickly and intensely but with very little lasting effect. For example, they may get angry easily but get over it quickly. Or they may seem to be “on an emotional roller coaster” in which they are happy one moment, sad the next and then angry. This is called emotional lability.

What causes this problem?

- Mood swings and emotional lability are often caused by damage to the part of the brain that controls emotions and behaviour.
- Often there is no specific event that triggers a sudden emotional response. This may be confusing for family members who may think they accidently did something that upset the injured person.
- In some cases the brain injury can cause sudden episodes of crying or laughing. These emotional expressions or outbursts may not have any relationship to the way the persons feels (in other words, they may cry without feeling sad or laugh without feeling happy). In some cases the emotional expression may not match the situation (such as laughing at a sad story). Usually the person cannot control these expressions of emotion.

What can be done about it?

- Fortunately, this situation often improves in the first few months after injury, and people often return to a more normal emotional balance and expression.
- If you are having problems controlling your emotions, it is important to talk to a physician or psychologist to find out the cause and get help with treatment.
- Counseling for the family can be reassuring and allow them to cope better on a daily basis.
- Several medications may help improve or stabilize mood. You should consult a physician familiar with the emotional problems caused by brain injury.
What family members and others can do:

- Remain calm if an emotional outburst occurs, and avoid reacting emotionally yourself.
- Take the person to a quiet area to help him or her calm down and regain control.
- Acknowledge feelings and give the person a chance to talk about feelings.
- Provide feedback gently and supportively after the person gains control.
- Gently redirect attention to a different topic or activity.

Anxiety

Anxiety is a feeling of fear or nervousness that is out of proportion to the situation. People with brain injury may feel anxious without exactly knowing why. Or they may worry and become anxious about making too many mistakes, or “failing” at a task, or if they feel they are being criticized. Many situations can be harder to handle after brain injury and cause anxiety, such as being in crowds, being rushed, or adjusting to sudden changes in plan.

Some people may have sudden onset of anxiety that can be overwhelming (“panic attacks”). Anxiety may be related to a very stressful situation — sometimes the situation that caused the injury — that gets “replayed” in the person’s mind over and over and interferes with sleep (“post traumatic stress disorder”). Since each form of anxiety calls for a different treatment, anxiety should always be diagnosed by a mental health professional or physician.

What causes anxiety after TBI?

- Difficulty reasoning and concentrating can make it hard for the person with TBI to solve problems. This can make the person feel overwhelmed, especially if he or she is being asked to make decisions.
- Anxiety often happens when there are too many demands on the injured person, such as returning to employment too soon after injury. Time pressure can also heighten anxiety.
- Situations that require a lot of attention and information-processing can make people with TBI anxious. Examples of such situations might be crowded environments, heavy traffic or noisy children.
- Anxiety can be helped by certain medications, by psychotherapy (counseling) from a mental health professional who is familiar with TBI, or a combination of medications and counseling.

What can be done about anxiety?

- Try to reduce the environmental demands and unnecessary stresses that may be causing anxiety.
- Provide reassurance to help calm the person and allow them to reduce their feelings of anxiety when they occur.
- Add structured activities into the daily routine, such as exercising, volunteering, church activities or self-help groups.

Depression

Feeling sad is a normal response to the losses and changes a person faces after TBI. Feelings of sadness, frustration and loss are common after brain injury. These feelings often appear during the later stages of recovery, after the individual has become more aware of the long-term situation. If these feelings become overwhelming or interfere with recovery, the person may be suffering from depression.

Symptoms of depression include feeling sad or worthless, changes in sleep or...
appetite, difficulty concentrating, withdrawing from others, loss of interest or pleasure in life, lethargy (feeling tired and sluggish), or thoughts of death or suicide.

Because signs of depression are also symptoms of a brain injury itself, having these symptoms doesn’t necessarily mean the injured person is depressed. The problems are more likely to mean depression if they show up a few months after the injury rather than soon after it.

What causes depression?

• Depression can arise as the person struggles to adjust to temporary or lasting disability and loss or to changes in one’s roles in the family and society caused by the brain injury.

• Depression may also occur if the injury has affected areas of the brain that control emotions. Both biochemical and physical changes in the brain can cause depression.

What can be done about depression?

• Anti-depressant medications, psychotherapy (counseling) from a mental health professional who is familiar with TBI, or a combination of the two, can help most people who have depression.

• Aerobic exercise and structured activities during each day can sometimes help reduce depression.

• Depression is not a sign of weakness, and it is not anyone’s fault. Depression is an illness. A person cannot get over depression by simply wishing it away, using more willpower or “toughening up.”

• It is best to get treatment early to prevent needless suffering. Don’t wait.

Temper outbursts and irritability

Family members of individuals with TBI often describe the injured person as having a “short fuse,” “flying off the handle” easily, being irritable or having a quick temper. Studies show that up to 71% of people with TBI are frequently irritable. The injured person may yell, use bad language, throw objects, slam fists into things, slam doors, or threaten or hurt family members or others.

What causes this problem?

Temper outbursts after TBI are likely caused by several factors, including:

• Injury to the parts of the brain that control emotional expression.

• Frustration and dissatisfaction with the changes in life brought on by the injury, such as loss of one’s job and independence.

• Feeling isolated, depressed or misunderstood.

• Difficulty concentrating, remembering, expressing oneself or following conversations, all of which can lead to frustration.

• Tiring easily.

• Pain.

What can be done about temper problems?

• Reducing stress and decreasing irritating situations can remove some of the triggers for temper outbursts and irritability.

• People with brain injury can learn some basic anger management skills such as self-calming strategies, relaxation and better communication methods. A psychologist or other mental health professional familiar with TBI can help.

• Certain medications can be prescribed to help control temper outbursts.

• Family members can help by changing the way they react to the temper outbursts:

  • Understand that being irritable and getting angry easily is due to the brain injury. Try not to take it personally.

  • Do not try to argue with the injured person during an outburst. Instead, let him or her cool down for a few minutes first.

  • Do not try to calm the person down by giving into his or her demands.

  • Set some rules for communication. Let the injured person know that it is not acceptable to yell at, threaten or hurt others. Refuse to talk to the injured person when he or she is yelling or throwing a temper tantrum.

  • After the outburst is over, talk about what might have led to the outburst. Encourage the injured person to discuss the problem in a calm way. Suggest other outlets, such as leaving the room and taking a walk (after letting others know when he/she will return) when the person feels anger coming on.
Questions to ask your physician or treatment provider to better understand your problem

If you or your family members are experiencing anxiety, feelings of sadness or depression, irritability or mood swings, consider asking your doctor:

- Would psychological counseling be helpful?
- Would an evaluation by a psychiatrist be helpful?
- Are there medications that can help?

More about medications

If you or your family member tries a medication for one of these problems, it is very important to work closely with the physician or other health care provider who prescribes them. Always make a follow-up appointment to let him or her know how the medication is working, and report any unusual reactions between appointments. Remember that:

- There can be a delay until the beneficial effects of medications are felt.
- Doses might need to be adjusted by your doctor for maximum benefit.
- You may need to try one or more different medications to find the one that works best for you.
- Except in an emergency, you should not stop taking a prescribed medication without consulting your doctor.

Peer and other support

Remember, too, that not all help comes from professionals! You may benefit from:

- A brain injury support group — some are specialized for the person with TBI, others are for family members, and others are open to everyone affected by brain injury.
- Peer mentoring, in which a person who has coped with brain injury for a long time gives support and suggestions to someone who is struggling with similar problems.
- Check with your local Brain Injury Association to find out more about these resources.
- Talk to a friend, family member, member of the clergy or someone else who is a good listener.

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Brain Injury and/or a Primary Mental Health Disorder? A conundrum

By Chanth Seyone, MD., FRCPC

Symptoms and signs are what we see in someone who is unwell. Each by itself does not provide a diagnosis but if enough of them are present in specific combinations, a diagnosis can be made, and appropriate treatment initiated.

However, what are the specific symptoms of a brain injury? Are they like symptoms that occur in individuals who only have mental health issues? What happens if an individual who has mental health issues has a brain injury? How do you then diagnose a brain injury and what is the treatment that can be initiated? Is the treatment for the brain injury, for mental health issues, or both?

In individuals who have a severe injury with skull fractures and intracranial brain damage, a brain injury is not in doubt. What about those individuals who have no objective evidence of having sustained a brain injury? Do we assume that these individuals do not have a brain injury or consider them as having a brain injury but without objective signs? How do we tell the difference?

I am going to attempt in this brief narrative to try and explain how one can go about trying to make this determination. It may be easier to try and explain using an actual case.

Let me introduce you to Mr. XY. He sustained an anoxic brain injury secondary to a suicide attempt in May 2012. He was 16 years of age, a Grade 10 student at the time. He was found hanging by a belt on a tree, possibly there for 15 minutes before being found. There were initially no vital signs. CPR was started, he responded, and was transferred to The Hospital for Sick Children. He initially was given a grave prognosis. If he survived, the expectation was that he would have severe deficits neurologically and cognitively. He, however, did recover and surprisingly had no neurologic deficits. A CT scan showed no abnormalities, and an EEG did not identify any seizures. An MRI indicated bilateral thalamic and anterior putamen swelling consistent with a post-anoxic encephalopathy. His past psychiatric history was positive for a previous suicide attempt in October 2011, apparently triggered by a difficult relationship with, and absence of, a father. Family history is positive for a “bipolar affective disorder.”

On assessment, he was guarded. Apparently, signs and symptoms have been present for several years, pre-dating his brain injury. He was “seeing things” since about the age of eight years. He has auditory hallucinations of a female voice telling him to kill himself and delusions of “having had children with a therapist, an education assistant was married to him, that
he can die if he ‘does something,’ has an STD…”*. He has compulsions of walking in circles, not touching doorknobs due to “germs,” and checks doors and alarms in the middle of the night. All of this started even before his brain injury. Surprisingly, he was not depressed. However, he did have panic attacks before his brain injury, not after, and generalized anxiety, mostly after his brain injury. He has cognitive deficits now. Prior to his injury, he was intellectually gifted especially in math.

Thus, his symptoms suggest severe mental health problems even before his brain injury and ongoing problems after his brain injury. Diagnostically, he has a mood disorder (including a likely Bipolar Affective Disorder (BADI) pre and possibly post brain injury; a psychotic disorder pre and post brain injury; an Obsessive Compulsive Disorder (OCD) pre and post brain injury; an anxiety disorder pre and post brain injury; and a cognitive disorder only post brain injury.

What about the brain injury? Can it lead to or exacerbate these diagnoses? Yes, for almost all.

What is possible after an ABI? Just about anything.

So, how do we separate out what is what? By a good and thorough assessment to identify timelines of symptoms, identify characteristic symptoms, identify location of Injury, and identify response to treatment. What then are the similarities and differences, if any?

1. **Mood Disorder** - can be very similar; diagnosed based on timeline; location of injury.

2. **BAD** - can be very similar; diagnosed based on timeline; location of injury

3. **OCD** - Can be very similar; diagnosed based on timeline; location of injury

4. **Anxiety Disorder** - can be very similar; diagnosed based on timeline; location of injury

5. **Cognitive Disorder** - only occurs after a brain injury

6. **Psychotic Disorder** - Some differences exist between a disorder due to a brain injury and a primary illness such as Schizophrenia. A primary psychotic disorder is characterized by delusions (unreal beliefs) that are fixed and false, hallucinations that are often auditory, disorganized thinking, grossly disorganized or abnormal motor behavior (including catatonia) and the presence of negative symptoms or diminished emotional expressions. In a psychotic disorder due to a brain injury on the other hand, the delusions are variable, often persecutory, not firm, hallucinations are uncommon, disorganized thinking is uncommon, grossly disorganized or abnormal motor behavior (including catatonia) is uncommon, and negative symptoms or diminished emotional expression is uncommon.

The location of injury can help to differentiate pre and/or post brain injury diagnosis. Depressive disorder is more prevalent in left dorso-lateral frontal and left basal ganglia damage, a bipolar affective disorder is increased in right hemisphere lesions especially affecting the baso-temporal cortex or limbic system and anxiety disorders occur more commonly after right hemisphere lesions.

So, we can make a diagnosis as to whether issues are pre and/or post brain injury, or related only to mental health issues only in psychotic disorders and a cognitive disorder. We can't easily in mood disorder (including BAD), OCD, or an anxiety disorder, especially if the location of injury cannot be visualized. In our patient, a primary mental health diagnosis such as schizophrenia needs to be seriously considered on the characteristics of his psychotic symptoms. In addition, he has a brain injury, an anxiety disorder, OCD and a cognitive disorder.

Diagnosis done; now what? Why is it important to identify the timeline of symptoms? It helps to identify complex cases, identify needs and resources, identify service streams and priorities, identify primary, secondary and tertiary service providers, identify management strategies and gives an estimate as to prognosis. Should our patient be treated in a mental health facility or a brain injury facility? Would it be ideal to have him treated primarily in a mental health facility with secondary care being provided by brain injury experts?

As such, it is important to estimate clinically the relative impact of the brain injury as well as the primary mental health issues in the presentation of each patient, as the priorities and sequence of managing these patients will be different and treatment will vary. If a symptom or disorder is present pre-injury, the likelihood is that it will be present post-injury in a modified or magnified fashion. Even in those individuals who have both a brain injury and a primary mental health issue, mismanaging them in the wrong treatment stream does them a disservice in terms of resources and expertise.

Finally, remember, getting to know and understand an individual, their family of origin and life experiences are paramount in trying to tease out these complex issues.

As Shelley aptly put it:

A man, to be greatly good, must imagine intensely and comprehensively; He must put himself in the place of another and of many others; the pains and pleasures of his species must become his own.

Percy Bysshe Shelley (1792–1822), English poet; A defense of poetry (written 1821; Published 1840) ◊◊◊
Mental Health and Wellness... Let’s do this!

By: Meg Soper, Keynote Humorist Speaker

Everywhere I turn I see advertisements that tell me to invest my hard-earned dollars and be ready for retirement. But no matter how much we sock away, and how secure our financial future is, let’s not lose sight of also investing in the most important asset we own: our self!

Without our physical and mental health, money is just that—a commodity of which no quantity can substitute for our wellbeing.

So, on the topic of investing in ourselves, here are a few of my favourite strategies to bolster our mind, body, and spiritual wellbeing.

Laughter – It’s No Joke!

I would not be where I am today were it not for my experience as a stand-up comic. There was something so exhilarating about getting people to laugh; it is difficult to explain the feeling, but I know I will never tire of watching people’s expression change when they let go with laughter.

Humour is a powerful coping mechanism. Nothing cuts stress like a good laugh, and I have seen this firsthand in the O.R. During my 25+ years as an O.R. nurse, we were confronted by some very long and difficult cases. And one thing that always helped to break the tension and bring our focus back to the present moment would be humour. Now while there is nothing funny about a patient who is fighting for their life, I vividly remember the tough cases where a member of our surgical team would do something to get us laughing and, almost magically, it helped us realize that this situation was manageable.

As I have learned, laughter does not take conscious thought—it is a reflex; and when one person smiles or laughs, it brings out the same reaction in others. Brain science tells us that laughter stimulates the left pre-frontal cortex—a part of the brain that helps us feel good and be motivated—helping alleviate anxiety and frustration. Studies show that laughter sends chemical signals that inhibit the firing of nerves in our reptilian brain, helping us manage our fears and temper negative emotions! So, when fear or anxiety start to take over, remember to look for the humour—it just might make all the difference.

The Digital Detox Challenge

For those of us who feel the grip of technology is getting a tad too tight, I offer my Digital Detox Challenge (DDC), where for one day (or even just a few hours) you say No to the Glow, turn off all your screens and take the time to catch your breath and bring things back to center. This is guaranteed to energize, improve focus and boost your resilience.

Step 1 is a piece of cake: just decide when YOU will start your DDC! So, choose a day—and commit! See if you can get significant others or the whole family to join in, as this will make the experience more powerful for everyone.
Some of my audience members start with one day on the weekend and take it from there. Others have established a screen free time of day that becomes a part of their routine in their household. The objective is to create boundaries with our time and energy and be mindful of how easily we get in the pattern of staring at a screen. So, I challenge you to say No to the Glow and take on the DDC. It might even become a habit!

Get Outside

We can boost our immune system just by being outdoors! Even better...spend time in nature. We used to call it going for a hike but now we can call it forest bathing. Studies show that phytoncides are chemicals that are produced by plants and trees to protect themselves from harmful insects. These chemicals make their way to your brain through your nose and work to stimulate or relax your brain, which may ultimately benefit your immune system by lowering your stress response. Set aside at least 20 minutes each day to get outside and see if you notice a difference in your physical and emotional health.

Fuel it up

What we put in our body and how we move our body will affect how you feel and how you think. Every day we are faced with many options in terms of nutrition and we can be mindful of how small steps lead to big change. Aiming for five different colors of vegetables a day and choosing a fruit or vegetable as a snack over processed food is one of those small steps. Pay attention to how eating certain foods makes you feel in the moment and the next day. The less processed or high sugar foods you take in the more energy you will have to get you through the day.

Resilience

“My barn having burned down; I can now see the moon.”

~ Mizuta Masahide (17th century Japanese poet and samurai)

Resilience is a topic that both fascinates and puzzles. I mean, why is it that some people come back stronger than ever after tremendous hardship while others who are blessed with love, support and promise struggle to cope? If only resilience were something you could put in a bottle and take a swig of during life’s difficult moments.

I think of resilience as the ability to ‘bounce back’ from challenge and adversity. It is what I consider to be one of life’s building blocks; the Swiss Army Knife of character traits.

I believe resilience above all determines who will succeed in life – more than education, experience or training. And while I am sure that some people are born with the resilience gene, I firmly believe that resilience is a skill that we can build up and bolster.

I believe that resilience requires three things:

- a belief that one is in control of their own destiny, no matter what happens to them.
- A sense of optimism that is grounded in reality.
- The ability to improvise and adapt in the face of life’s inevitable ups and downs.

When it comes to personal resilience, I think of Alvin Law. Alvin was born without arms as a result of his mother taking thalidomide during pregnancy. In his words...

“The best thing that ever happened to me is being born without arms. It brought me to circumstances never thought possible.”

He learned to use his feet for hands, became an award-winning musician, has worked in advertising, PR, broadcasting and helped raise millions for charity, to which I say ‘WOW!’ No wonder he also thrives as a highly successful motivational speaker.

Alvin demonstrates the incredible power that our own beliefs and attitudes hold in helping us overcome obstacles and re-write our own narrative.

We can all be grateful for the people we know who inspire us to shift our perspective, breathe deeply and bounce back when life dares us to complain.

We can all bolster our sense of resilience by making a conscious effort to create capacity in our lives. Maintaining a sense of humour, unplugging the device, getting outside in nature, reaching for the right bite, and being grateful for the people on our team in life are all steps we can take towards maintaining our mental health and wellness.

The goal in life is not to live like everyone else, but to know what brings value and joy to YOUR life so you can fill it with the hobbies, activities, and people that lift you up.

Meg Soper is a keynote humourist speaker who combines the skills of a premiere stand-up comic with hands-on experience in healthcare to motivate, inspire, and entertain her audiences.

Meg believes laughter is truly the best medicine available to deal with the day-to-day stress in our lives. Incorporating humour into her presentations helps her connect with the audience, break barriers, and deliver practical strategies for life and work. Learn more at https://megsoper.com/
By: Kim Belfry, LYB Instructor

What a wonderful, dynamic, life changing program Love Your Brain (LYB) Yoga is. Our fourth Fundamental Series is underway now in Peterborough, Ontario. Truly an inspirational experience for all participants. It has been a pleasure to see others become more comfortable in an unfamiliar setting and share their life experiences.

The LYB Foundation was founded by brothers Adam and Kevin Pearce. In 2014 Kevin sustained a Traumatic Brain Injury (TBI) during snowboard training for the 2010 Winter Olympics in Vancouver. His story was documented in the HBO Documentary “The Crash Reel”. LYB is a non-profit organization, their mission is to improve the quality of life of people effected by TBI through programs that build community and foster resilience. Presently, 3,364 people with TBI and caregivers have been served.

The LYB Yoga program currently runs in 38 US States and six Canadian Provinces. The cities in Ontario are Ottawa, Toronto, Peterborough, London and Kitchener. The program runs four, six-week sessions per year. Each 200 Hr. Yoga Teacher attends the LYB Yoga three-day training held in various cities prior to instructing. The format of each class starts with a preset theme, a quote that is repeated during the class bringing thoughts back. Slower paced gentle yoga asanas are performed with adaptations as needed. Meditation that reflects the theme follows. To foster community the class meets in a circle formation for a facilitated discussion. Community builds each week through the discussion; I feel this is the most beneficial segment of the program. A very cohesive group forms from sharing life events, emotions and strategies during discussion.

A quote from a LYB Yoga participant, The Willow Studio Nov. 2019:

“The environment and the energy at the studio was very welcoming and professional. The entire experience helped contribute to a greater sense of self and healing for me. The fact that it was with other community members with TBI made it such a supportive and understanding environment which I have craved for the past three years since my injury. I loved feeling worthwhile with this group. They helped me to be more accepting and loving of myself.”

Evidence-based practices for yoga and meditation were implemented when developing the program. Evaluation from the program at Dartmouth College found improvements in quality of life, positive mood, and resilience (Donnelly et al.2018 Donnely et al 2019, Donnely et al 2020).

Registration for the series takes place online and potential clients may first sign up to be on a waitlist. Registration opens six-weeks prior to the start date. LYB handles all the administration and notification to participants, studio, and instructors. Studio time and props are generously donated by owners who appreciate the many benefits of the program. The studio will need our instructors to take the LYB Yoga teacher training. There is a scholarship program available. Once this is in place you will need to advertise for clients.

Visit the website www.loveyourbrainyoga.com; it contains all the information you will need, the staff is very well educated about all aspects of the program and available by email.

LYB yoga can also be used in clinical settings and there is a course developed specifically for clinicians. An advanced LYB Yoga TT is coming soon as well. The LYB Foundation runs retreats for those living with TBI and Caregiver Retreats. They are committed to all those living with the effects of TBI.
Get Connected with Peer Support

"I want to give back and help others who are trying to cope with their brain injury."

"This program has made me understand I am not alone."

OBIA’s Provincial Peer Support Program connects persons with lived experience (the Mentor) with an individual who is living with the effects of acquired brain injury and who requires support (the Partner). This program is available to survivors, family members and/or unpaid caregivers.

For more information contact:

Ontario Brain Injury Association
1-800-263-5404  peersupport@obia.on.ca
Fundraising for LYB Yoga takes place during “Mindful March” and is done by studios and Yoga Teachers offering different events to promote the program in their community. There is no charge for participants of the program and they are open to those living with the effects of TBI, post-concussion syndrome, and caregivers.

I am very fortunate to now be employed by the Brain Injury Association Peterborough Region (BIAPR). My change in occupation came after bringing LYB yoga to our city. For myself, the reciprocal advantages have been tremendous. I am now able to suggest LYB yoga to BIAPR clients. As well, our clients attending LYB yoga encourage others to join BIAPR. Since the first series, we now have Neuropsychologists, OT's, PT's, and massage therapists recommending our program. The benefits of the program combined with the positive experiences of participants will keep your Fundamental Series full.

I am always available to share about this program and can be reached at: lybyogaptbo@outlook.com

Experiencing this program as an instructor has been inspirational for myself as well as participants. Last Sunday, my son attended his first LYB Yoga class—I was not the instructor. When I asked him later how he liked the program, he responded with “I loved it!” His injury was more than 20 years ago and since then, he has never responded with such enthusiasm. Living with a flat affect, this response was a true testimonial to the benefits of LYB Yoga. ☠️

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OBIA Advisory Council (OAC) Report

The last meeting of the OAC was held on Saturday, January 25, 2020 and was held online.

Melissa Vigar, Brain Injury Society of Toronto (BIST), shared a video “The Invisible Me,” which was developed collaboratively by BIST and the Toronto Police Service. This video will be used during training for all police offers. Following this presentation, Melissa also shared their project findings for the “Homelessness and Brain Injury” study, and a presentation on “Financial Abuse: How to spot and stop it”.

Following Ruth Wilcock’s OBIA report, approval was made to continue with two initiatives for Brain Injury Awareness Month: Unmasking Brain Injury and the Anyone, Anywhere, Anytime poster project.

Gazal Kukreja provided an update on the Brain Injury Speaks Stakeholder Engagement Network, and participating associations shared brief updates of their activities. The next meeting is scheduled for March 21, 2020.

Archived videos of past workshops can be found on OBIA’s Vimeo page: https://vimeo.com/obia.

The following reports are from some of the local community associations:

Headwaters Acquired Brain Injury Group (HABI)

The Headwaters Acquired Brain Injury Group (HABI) is thrilled to celebrate its 10th anniversary! HABI started in 2009 with a handful of individuals with lived experience with acquired brain injury, some local professionals, and the support of OBIA. HABI is run by and for people with acquired brain injury living in the Headwaters Region. We are a volunteer group under the umbrella of OBIA focused on achieving common goals created by our members. HABI
seeks to enhance the lives of people living with ABI and their families through education, public awareness, support, and social connection.

During the past 10 years we have:

- trained more than 80 local individuals and support personnel through the Brain Basics Workshops
- delivered HABI and OBIA brochures to every physician in our local area to promote awareness of ABI and local resources
- hosted more than 75 guest speakers to promote quality of life and education for our members
- reached out to our community holding benefit concerts and community BBQs
- celebrated our friendship with socials, dinners out, family BBQs, and special events
- learned from and become inspired by each other through our monthly “Speakers Corner” where members share their journey of recovery

Here are a few reflections from our members:

“HABI is like a sanctuary for me. It is a place to belong, a place to feel safe and to be amongst friends. While together, we heal, we learn, we share, we are a community. Thank you. Here is to 10 more years.”

BIA London and Region

The association hosted an Annual Speakeasy Dinner and Casino Night in November.

BIA Windsor-Essex

The Brain Injury Association of Windsor and Essex County is thrilled to be the recipient of a grant from the Solcz Family Foundation to fund a group of programs aimed at children. This includes the STAR program for middle and high school students about the need to tell when they’ve hit their head, the Helmets for Kids program for low income neighbourhoods, a new Paediatric Caregiver Support Group and an accompanying Children’s Social Group. BIAWE has identified a serious lack of supports for children with an acquired brain injury and their families in the community and is endeavouring to fill some of these gaps.

BIAWE has commenced the last phase of the home improvement project with funds donated by the Lowe’s Heroes Program. Persons with an ABI were provided with much needed appliances and home renovations materials. Now our volunteers are painting rooms in a residential home for those with severe brain injuries. We have been working with several community agencies, each of which has taken on one resident’s room to paint. This is truly a community effort, spearheaded by BIAWE in keeping with its mission to enhance the lives of those with an acquired brain injury.

BIA Waterloo-Wellington

Fundraising events – Thank you our sponsors, volunteers, and guests who supported our 2nd Annual Oktoberfest Warm-up event held in October. We had a great time! We’re looking forward to our “A Brighter Day!” concert with survivor Russell Scott and friends on Friday April 3, 2020. Our 3rd Annual Comedy night is on Thursday, June 4. Tickets for both events are available on our website. Contact info@biaww.com for more information and sponsorship opportunities.

Card making – Thanks to all of our elves, we made more than 6,500 greeting cards
last year! In addition to supporting our programs, some of the proceeds sent three brain injury survivors to Camp Dawn. Our cards are available for sale out at 9 generous community supporters.

**Holiday parties** – We had a great time at our various parties in December. Thanks to the volunteers who arranged all of the details!

**New Office!** We are very pleased to announce that we moved into a brand new office space this past January. You can find us at 493 Lancaster St. W, Kitchener, ON N2K 1L8, Ph: 519 576-3535.

**BIST Toronto**

The Brain Injury Society of Toronto (BIST) has had a busy and exciting past few months.

Back in fall, BIST hired a Violence Impact Coordinator who is helping members who have been affected by intimate partner violence. She provides support with applying for financial assistance, housing and medical referrals. Questions about the program? Contact Isabelle Rivaletto at: isabelle@bist.ca.

BIST has also begun some work around financial abuse and fraud. This affects everyone, but more specifically, those who are most vulnerable, including those living with ABI who are aging. We are busy creating a toolkit and running trainings and are excited to share our resources with everyone shortly!

In November, registration for our 4-week Persistent Concussion Series filled up quickly. Attendees received tips and resources for living with concussion symptoms.

In November we were also honoured to be part of two collaborative presentations at the Provincial ABI conference in Niagara. We thank our friends and partners in North Bay as well as Tanya Jewell for collaborating with us.

BIST ended off the decade with its annual Holiday Party. There was plenty of food, games and guests! Thank you to everyone who came out!

In March 2020, we are hosting our 2nd annual free 5-week ABI Info series, with speakers lined up such as Dr. Chanth Seyone and Dr. Hiten Lad. It is anticipated to be another informative event, beneficial for all who attend.

We are busy starting to plan our signature fundraising events such as the Mix and Mingle (in partnership with OBIA), Birdies for Brain Injury and our Hero 5K. We hope to see everyone out and about throughout the year!
The Relationship Between Substance Use Disorder and Traumatic Brain Injury:

The relationship between Traumatic Brain Injury (TBI) and Substance Use Disorder (SUD) is a bi-directional one in which substance misuse is associated with increased risk of sustaining a TBI, while a history of TBI is implicated in the development of SUD. For many individuals, a history of substance use precedes their traumatic brain injury. In terms of the association with actual injury, it is estimated that at least 20% of adults are intoxicated at the time of their injury. Studies have indicated; however, that a prior history of substance use is more common than intoxication at the time of injury when it comes to traumatic brain injuries.

Although many individuals have a substance use disorder prior to their injury, it is estimated that 10-20% of individuals with TBI develop a substance use disorder for the first time after their injury.

Effective rehabilitation for those who have sustained TBI is essential. There are a number of factors which may make recovery from a TBI more difficult if there is a concurrent SUD. First, a history of SUD has been thought to hasten the recovery of brain pathways involved in TBI. Second, individuals with TBI often report low mood, low concentration and poor memory following their injury and these consequences are often more frequent and severe in those with a concurrent SUD, further hastening recovery. Third, a history of SUD following a TBI leads to a greater risk for subsequent head injury. Finally, SUD is associated with increased length of hospital stay, and lower adherence and participation in rehabilitation programs, factors which impact recovery.

Treatment Strategies for Those with SUD and TBI

Although more research is needed in the development of effective treatment programs for patients living with concurrent SUD and TBI, there are several strategies that have been shown to help patients succeed in their recovery. First, it is important to determine the patient’s preferred communication and learning style and when possible, modify communication so that the person can understand and appreciate what is being asked of them. Materials and information should generally be presented in a concise manor, incorporating visual cues or examples whenever possible. Assistance should be provided...
when appropriate, keeping in mind that some patients may require more time to complete certain tasks. Family and friends should be involved in the treatment plan whenever possible. Most importantly, patients being treated for concurrent SUD and TBI require patience from their care providers, families and friends. People don’t follow through or drop out of care because the treatment plan does not meet their specific needs. Thus, regular feedback and follow-up is tremendously important for insuring that patients are not lost to follow-up and care. In many cases, several courses of treatment may be necessary.

Resources for Patients, their Families and Care Providers

For patients living with both acquired brain injury and substance use, the SUBI (Substance Use and Brain Injury) project is a great resource which acts to facilitate the interdisciplinary management that many of these patients require. This program offers access to information for patients and links to organizations that focus on consequences of brain injury, substance use and nicotine dependence. It has also developed a workbook for clients to help manage these co-occurring conditions. This group has also worked to develop specific recommendations for providers for screening, prevention, and education of concurrent SUD and TBI. More information can be found on https://www.subi.ca.

The Toronto ABI Network is another great resource, which connects patients with ABI to community resources and works to increase availability of resources for those with ABI. It also provides information for professionals, individual patients and their families, including educational material and access to resources in the community. More information can be found on http://abinetwork.ca.

Screening and Treatment of Substance Use Disorders:

Effective SUD treatment involves recognition of this potential issue in those who have sustained a TBI and effective screening or referral to appropriate services and professionals.

Therapeutic strategies for those with concurrent SUD and TBI is varied and includes; motivational interviewing, feedback and education, brief interventions, cognitive behaviour therapy and various other behavioural programs.

Pharmacological therapy is often used to address substance withdrawal, reduce substance use and maintain abstinence7. Clinicians generally consider the unique circumstances of each patient when considering medications to treat SUD to account for possible side effects and to ensure that medication with multiple benefits are selected for appropriate patients.

Alcohol Use Disorder:

Studies have found that incidents of alcohol use increases two to five years after TBI (Kreutzer et all, 1996). Protective factors which have been shown to limit use of alcohol include reduced availability of drugs and alcohol in institutional settings and living close to family members who are involved in helping reduce the individuals’ substance use.

Screening tools often employed by clinicians to screen for alcohol use disorder include the CAGE questionnaire and AUDIT survey, in addition to a thorough history. A good physical exam may often bring to light physical findings associated with intoxication, severe use or withdrawal, such as evidence of associated infections, hepatitis, oral thrush, needle marks, and change in vitals.

Clinicians should assess high risk behaviours associated with excess alcohol use, including; sexual (abuse/unwanted), financial, criminal, self-harm behaviours and impaired driving.

Signs of alcohol overuse include; decreased inhibitions (potentially leading to anger/violence), drowsiness, confusion, impaired coordination and slurred speech.

Pharmacotherapy in the acute setting to combat withdrawal include treatment with benzodiazepines in a monitored setting. This is particularly important if they have a history of seizures. Patients should also receive thiamine.

Long term pharmacotherapy for alcohol use disorder includes:

1. Disulfiram: This medication is an aversion treatment which can cause dizziness, flushing, nausea/vomiting and low blood pressure with concurrent alcohol use. It is contraindicated in liver failure, cardiac disease, psychosis and in those who are pregnant. It is started at least 48 hours following last alcohol consumption and given under direct supervision to ensure adherence. If the person is prone to impulsive drinking because of executive dysfunction, then this medication might not be a good option due to the dangerous reactions described above.

2. Naltrexone: This medication works by decreasing the reinforcing effects of alcohol. It is absolutely contraindicated in severe liver failure. It is contraindicated in those taking any opioid because of the risk of precipitated acute opioid withdrawal. It can be given even while the person continues to drink because it reduces drinking frequency and amount of alcohol consumption per sitting.

3. Acamprosate: This medication helps to reduce the withdrawal affects associated with abstinence. It is contraindicated in those with severely compromised kidney function. Patients need to be abstinent for at least 3 days to begin this medication and it can be taken concurrently with the medications discussed above. It delays and prevents a lapse to drinking. However, should
the person start drinking again, the medication doesn’t help the person achieve abstinence again and should be discontinued till the person stops drinking for 3 days again.

**Opioid Use Disorder:**

Prior to prescribing medication for opioid use disorder, it may be important for patients to have an assessment to determine their risk of addictive disorders and coping mechanisms. It is important for care providers to ensure that a discussion regarding urine drug testing is conducted. Assessment of pain and function should be conducted regularly incorporating the “five As”: Analgesia, Activity, Adverse effects, Aberrant behaviour and Accurate medical records.

Opioid intoxication may present as excess drowsiness, nausea, constipation and confusion. Opioid overdose may lead to respiratory depression (<12 breaths/min), coma or even death.

For acute intoxication, prompt administration of naloxone (Narcan) is essential. The effects of this medication last from 45 minutes to 4 hours. Long acting injectable naltrexone can be used during maintenance treatment.

Pharmacotherapy for opioids use disorder includes:

1. **Methadone**: This medication acts to prevent withdrawal and reduce cravings. It requires daily administration.

2. **Buprenorphine**: Can rapidly alleviate withdrawal. Side effects include sedation, headache, nausea, constipation and insomnia. Care should be taken to ensure this medication is not taken in combination with other substances, especially benzodiazepines and alcohol.

3. **Clonidine**: This medication is non-opioid medication used to alleviate the symptoms of acute opioid withdrawal but does not work after 7 days. Withdrawal alone is not recommended due to the high rates of relapse and risk of overdose due to loss of tolerance.

**Tobacco Use Disorder:**

When it comes to identifying tobacco use disorder and readiness to cut back, it is important that clinicians regularly document smoking status and evaluate the patient’s interest in quitting. They should also offer tools, techniques and follow-up. Nicotine withdrawal symptoms should be discussed so patients are aware of what to expect.

In general, nicotine withdrawal symptoms peak in the first three days following smoking cessation and can be expected to subside over the next three to four weeks. Withdrawal symptoms include: increased appetite, weight gain, mood changes, insomnia and anxiety. There are several pharmacological therapies that can be used to alleviate these symptoms. It is generally recommended that patients who wish to quit are given access to a combination of behavioural and pharmacologic treatments and given access to resources that offer support. In Canada, patients can be referred map.naquitrline.org, which offers a helpline, phone counselling and free access to cessation medication.

Pharmacotherapy for smoking cessation includes:

1. **Nicotine Replacement Therapy (NRT)** (long acting: once daily) - e.g. nicotine patch; short acting as needed (gum, lozenge, inhaler, mouth spray): Generally work by reducing cravings. Adverse effects include arthralgias, nausea, diarrhea, and dysmenorrhea. Although safer than smoking, caution is advised in prescribing NRT immediately post MI or in angina/CAD in uncontrolled settings.

2. **Buproprion (Zyban)**: This medication is not a good first line option due to its risk of causing seizures. It is a good option for those with concomitant depression. It may delay weight gain and cravings post smoking cessation. Buproprion is usually initiated one week before cessation of smoking. Main adverse effects include insomnia and agitation. This medication is relatively contra-indicated in those with a history of seizures, head trauma, eating disorders or in patients who were on a MAO inhibitor within 14 days of starting this medication.

3. **Varenicline (Champix)**: Side effects of this medication include nausea, insomnia, and taste disturbance. It is contra-indicated in those with end stage renal disease, diagnosis of epilepsy or those with active thoughts of suicide.

4. **Cytisine**: An herbal version of varenicline in its mechanism of action and is generally considered safe. Its use in patients with ABI has not been described.

5. **Nortriptyline**: This medication should be started 2 weeks prior to the quit date. It can be considered a good option in those with co-morbidity pain disorder, migraines, depression, neuropathy or insomnia. Side effects include; dry mouth, dizziness, drowsiness and weight gain. It is contra-indicated in those with ECG abnormalities, active thoughts of suicide or seizure risk.

In conclusion, careful evaluation and identification of substance use disorder in those with a history of TBI is essential in order to ensure that individuals receive appropriate care and follow-up. Individualized non-pharmacological and pharmacological therapy tailored to each individual’s specific needs and goals is a crucial part of a good treatment plan.
REFERENCES


Lauren Hough, Community Outreach and Assistant to the Executive Director

Lauren Hough began her position with OBIA in May 2019 as a student placement and moved into the position of Support Services in August. In December 2019, she began her new role as Community Outreach and Assistant to the Executive Director.

Prior to joining OBIA, Lauren worked for the Lions Foundation of Canada Dog Guides as a Dog Guide Instructor, where she worked with families and children with autism spectrum disorder across Canada.

Her love of learning and desire to support others drove Lauren to continue her studies at Mohawk College in the Brain Disorder Management graduate program. Throughout this program, her interest in acquired brain injury began, which prompted her desire to complete her student placement with OBIA. Following her graduation from Mohawk College in the fall of 2019, Lauren began a Master of Applied Disability Studies with Brock University.

Lauren is passionate about OBIA and its mission to educate, raise awareness, and support those living with a brain injury and their families. As the new Community Outreach Coordinator and Assistant to the Executive Director, Lauren looks forward to developing relationships within the brain injury community and raising awareness about OBIA’s programs.

When Lauren is not at work, she enjoys spending time with her family, travelling and keeping an active lifestyle.
Individuals with an acquired brain injury often demonstrate risky decision-making and reduced impulse control. This increases the risk for addiction-related disorders and may result in a poorer quality of life.

In Ontario, a history of problem gambling is reported in 1.6% of the general population. In the traumatic brain injury population, this number is much higher. A recent study suggested those with a brain injury are more likely to have a moderate to severe gambling problem.

OBIA pursued a community research grant supported by Gambling Research Exchange Ontario to explore problem gambling in the brain injury community. The goal was to raise awareness and develop suitable programming for those struggling with problem gambling.

Four populations were surveyed from across Ontario including individuals with a brain injury, family members, and service providers for both brain injury and problem gambling.

Sixty individuals with a brain injury took part in the questionnaire of which 36% reported they gamble. Among those who gamble, 46% had a change in their gambling activity since their brain injury, with more than half stating their gambling activity has increased. In addition, 60% of those who gambled had high rates of anxiety, frustration, and depression which the Centre for Addictions and Mental Health state are risk factors for problem gambling.

Craig, a brain injury survivor, said: “Gambling, I knew it was wrong but keeping track of my losses kept me in touch with reality. My self esteem had been eradicated and gambling, for a time, was my only friend”. Craig is not alone, and his experience illustrates the need for more support in the community to help those with problem gambling.

When surveying service providers for both individuals with a brain injury and those with problem gambling, it became clear education and training are greatly needed.

Among 60 brain injury services providers, 40% reported seeing individuals with problem gambling. However, 50% of providers were unaware of problem gambling supports in their region and 85% felt ill equipped to work with clients struggling with problem gambling.

OBIA had 41 problem gambling service providers participate in our questionnaire, and 60% stated they do NOT screen for a brain injury during their intake process. In addition, although most knew of brain injury supports in their area, more than 75% felt they were not well equipped to work with individuals with a brain injury.

The OBIA Problem Gambling Research initiative suggests there is a gap in current programming, and nearly all participants felt they would benefit from more information about problem gambling and acquired brain injury. This project highlights the importance of implementing the appropriate screening measures during intakes at addiction centres. As well, reducing the negative perception associated with gambling may help those with a brain injury feel comfortable disclosing a gambling problem to a loved one or health care provider and encourage them to seek help.

By Lauren Hough, OBIA Community Outreach

OBIA’s Problem Gambling Research Initiative
OBIA is grateful to all who participated in our study and hopes this research will increase awareness and help support individuals with a brain injury who struggle with problem gambling.

References:


60% of those who gambled reported experiencing anxiety, depression and frustration.

25% of those who gambled reported having an increase in their gambling activities since their brain injury.

40% of brain injury service providers saw clients struggling with problem gambling.

80% of participants believed there is stigma about problem gambling.

#IAmTheFaceOfBrainInjury

Do you have a story of survival? Do you have coping strategies to share?

Are you a caregiver to someone with ABI?

To help spread the awareness of how brain injury impacts our lives, OBIA is pleased to share stories from our readership. The goal is simple:

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I am a survivor! I am a survivor because I have been through a lot, and I still continue to fight for my independence.

On March 3, 2017, my whole life changed! That was the day the car I was in became involved in a T-bone car accident. I was severely injured with both physical injuries and a brain injury. Following the accident, I was taken to an acute care trauma hospital, then a rehab hospital for a total of seven months. While I was in the hospital it felt like my recovery was very slow and it seemed like it was taking forever. When I came home after seven months in the hospital I was in a wheelchair, and I wasn’t able to eat or take care of my hygiene needs. Once I got home it felt like my progress sped up.

Now, it is almost two years since I came home from the hospital and a lot has changed! My therapies continue to be almost every day. I am progressing in all my therapies—actually I think I am doing amazing with all my therapies. I am getting a lot stronger both physically and emotionally. Right now, I am using a walker for longer distances but I am able to use a cane for shorter distances. My swallowing has improved, so now I can eat whatever I want. As well, I can do most things on my own including brushing my teeth, brushing my hair, washing my face, getting dressed, tying my shoes, and going to the washroom on my own. Also, I have started cooking with some help and I am working to cook more challenging dishes.

This has been very good progress, but I still have my down days. These are the days when I feel like hiding under a rock because nothing is going right. Before the accident, I coped by drinking my pain away. Following the accident I came to realize that drinking wasn’t going to work anymore. So, one day I woke up and made a decision “I’m going to change myself.” I used all of my resources (family, friends, and therapists) as well as my stubbornness, to make the changes I needed to make. The biggest change I made was that I started talking about things that were bothering me so I could get them off my chest. I have also incorporated inspirational and positive messages into my morning routine. Every morning I find my quote on google, write it out and look at throughout the day to remind me to stay positive.

Also, I attend my local brain injury support group, have signed up for peer mentoring, and help support brain injury awareness when I can. My advice to you is to find something you like that will help you stay positive; to have a lot of family and friends around for support and never give up.

I have shared my story with you in the hope that my experience may help you in your recovery. I think that you have to keep yourself busy and get involved in a lot of activities. I would suggest you include a brain injury support group into your recovery plans. My plans for the future include continuing to help other brain injury survivors and giving back to the brain injury community as much as I can. My hope is that my words have shed some light on my experience of recovery to give others hope! ☂️

By Jocelyn Barrett
Dean Irvine: Art as therapy

By Lauren Hough, OBIA Community Outreach

Sergeant (retired) Richard Dean Irvine served in the Canadian Armed Forces for 22 years, and for 14 of those years, he struggled with challenging symptoms from eight concussions. Dean’s seventh known concussion was caused by a baseball hitting his head while on duty on base in Canada. In addition to the diagnosis of mild traumatic brain injury (concussion), he sustained several fractures to his face, needing surgery to repair the damage. Other concussions were from three motor vehicle collisions while on duty and different training exercises in the Forces. Throughout this time, the strict and regimented routine of the military helped Dean cope with these symptoms.

Dean was being treated and managing his symptoms during his career in the military. However, he expresses that even though he knew he was still alive because his heart was beating and he felt safe, he always felt something was missing and the loss of identity was causing him to feel lifeless, like he was on autopilot. He reacted to events and finished his missions, but often felt dissociated from himself.

Following Dean’s release from the military in 2018, he began to fall apart with the loss of the routine that he held up while in the forces. For the years after the baseball’s line drive to his head, Dean battled symptoms of depression and post-traumatic stress disorder (PTSD). He began taking medication and participated in psychotherapy to treat his symptoms. Unfortunately, these treatments were not successful, and he continued to struggle.

In the spring of 2017, Dean was diagnosed with a brain injury and this is when things began to improve for him. He was accepted as a Team Canada member for the Invictus Games in 2018, and was consumed by positivity from family, friends, coaching staff, and teammates. From this support, a spark was ignited, and Dean trained for wheelchair rugby with the Brock Niagara Penguins, and became more motivated while playing wheelchair basketball.

Dean participated in OBIA’s Level 1 and Level 2 Rehabilitation training programs, accessed support from the Clubhouse at the Brain Injury Association of Niagara (BIAN) and began to
receive appropriate treatment for his brain injury. After finding OBIA and BIAN, his life started to change again, as he learned to put his brain first and understand his injury better.

In May 2019, Dean began painting and for him, it has been a powerful therapy. While Dean is painting, he can go to his own place and separate from everything and everyone around him. He paints what he is remembering and feeling at that time and this has helped him to come to terms with many of his past traumas. It doesn’t matter to Dean if people do not like his paintings; they are a part of him, he understands them, and that is what matters to him.

To date, Dean has created more than 30 paintings, and continues to paint frequently. He gives away many of his paintings, and stores the others. Recently, some of Dean’s paintings were displayed at an art show in Barrie, and another is on the mantle in Premier Doug Ford’s office.

Prior to his release from the military, Dean began a program in his community called Our Canadian Soldier Day. Dean and his family go to schools and encourage children, youth, soldiers, veterans, and seniors to create their own soldiers out of paper. More than 2,000 paper soldiers have been crafted by children to remember friends who passed away in Afghanistan or other areas overseas. Dean says he is amazed and inspired by how different each one is and often sees community spirit within the crafts. Dean has always felt that Canadians and community has held him together through Our Canadian Soldier day—without them he does not know if he would be here today.

Dean’s story is not a story of defeat and despair—he wants it to be a story of hope and courage. His message to those with a brain injury is:

“Have the courage to try to find and put together your heart and mind; these are the important pieces of courage needed to carry on. Try to find the courage and meaning to move forward and try anything you need to succeed for you and your future.”

As a father, husband, and veteran, many can relate to Dean’s experience with brain injury. Years of trials and errors, challenging symptoms, hard work and the hope and support you can find in your family and community has brought Dean to place in his life where he does not feel that lifeless feeling he had before.

Recently, Dean began attending Brock University full time with the help of the Access Center to pursue a career as a recreation therapist. The spark that his Invictus journey ignited has taught Dean a lot about himself and his community. He wants to help others who have shared a similar experience to his own and hopes that his art will help them as well.

Dean is not the same person he was before his brain injury, but he feels this is a good thing. He knows that without having sustained his brain injuries, he never would have found art. Dean is finally feeling confident and ready for each new day in his life.
Depression is a feeling of sadness, loss, despair or hopelessness that does not get better over time and is overwhelming enough to interfere with daily life. There is cause for concern when feeling depressed or losing interest in usual activities occurs at least several days per week and lasts for more than two weeks.

Symptoms of depression include:

- Feeling down, sad, blue or hopeless.
- Loss of interest or pleasure in usual activities.
- Feeling worthless, guilty, or that you are a failure.
- Changes in sleep or appetite.
- Difficulty concentrating.
- Withdrawing from others.
- Tiredness or lack of energy.
- Moving or speaking more slowly, or feeling restless or fidgety.
- Thoughts of death or suicide.

Feeling sad is a normal response to the losses and changes a person faces after Traumatic Brain Injury (TBI). However, prolonged feelings of sadness or not enjoying the things you used to enjoy are often key signs of depression, especially if you also have some of the other symptoms listed above.

How common is depression after TBI?

Depression is a common problem after TBI. About half of all people with TBI are affected by depression within the first year after injury. Even more (nearly two-thirds) are affected within seven years after injury. In the general population, the rate of depression is much lower, affecting fewer than one person in 10 over a one-year period. More than half of the people with TBI who are depressed also have significant anxiety.

What causes depression after TBI?

Many different factors contribute to depression after TBI, and these vary a great deal from person to person.

**Physical changes in the brain due to injury.** Depression may result from injury to the areas of the brain that control emotions. Changes in the levels of certain natural chemicals in the brain, called neurotransmitters, can cause depression.

**Emotional response to injury.** Depression can also arise as a person struggles to adjust to temporary or lasting disability, losses or role changes within the family and society.

**Factors unrelated to injury.** Some people have a higher risk for depression due to inherited genes, personal or family history, and other influences that were present before the brain injury.
What can be done about depression after TBI?

If you have symptoms of depression, it is important to seek professional help as soon as possible, preferably with a healthcare provider who is familiar with TBI. Depression is not a sign of weakness, and it is not anyone’s fault. Depression can be a medical problem, just like high blood pressure or diabetes. You cannot get over depression by simply wishing it away, using more willpower or “toughening up.” It is best to get treatment early to prevent needless suffering and worsening symptoms.

If you have thoughts of suicide, get help right away. If you have strong thoughts of suicide and a suicide plan, call a local crisis line, 9-1-1, or go to an emergency room immediately.

The good news is that certain antidepressant medications and psychotherapy (counseling) treatments, or a combination of the two, can help most people who have depression.

Medications

Antidepressant medications work by helping to re-balance the natural chemicals (called neurotransmitters) in the brain. Antidepressants are not “addictive.”

It is also important to know that even if antidepressants help with depression, they usually do not have to be taken forever. Sometimes a medication can help re-balance the brain’s chemistry and can eventually be discontinued (for example, after 6-12 months). However, each person’s situation is unique, and both taking and discontinuing antidepressants should always be done under a doctor’s supervision.

In addition to helping with mood, antidepressants can also help with the other symptoms of depression, such as low energy, poor concentration, poor sleep and low appetite. Some antidepressants can also help with anxiety symptoms.

There are many different types or “classes” of antidepressant medications. Studies of depression in TBI have found that some classes may work better than others.

Selective serotonin reuptake inhibitors, commonly called SSRIs, have been found to be the most effective antidepressants for people with TBI. Specifically, sertraline (Zoloft®) and citalopram (Celexa®) may have the fewest side effects and may even improve cognition (thinking ability).

Serotonin-norepinephrine reuptake inhibitors, or SNRIs, such as venlafaxine (Effexor®) are newer drugs that also may be a good option for people with TBI.

Some types of antidepressants should be avoided in most cases because they have side effects that can cause problems in people with TBI. These include monoamine oxidase inhibitors (MAOIs). Tricyclic antidepressants (TCAs) are often used safely at low doses for sleep or pain, but may cause side effects at higher doses.

After starting antidepressants, it can take a few weeks to feel better. Sometimes your physician will need to change the dose over time or switch to a different medication if one doesn’t work well enough. In some cases, two different antidepressants can be used together if a single medication is not effective.

It is important to take antidepressant medication every day, even if you are feeling better. Do not stop it abruptly. In most cases, your physician will recommend taking the medication for at least several months.

Psychotherapeutic (counseling) approaches

There are many different kinds of psychotherapy and counseling. For people with depression, the most effective types of therapy are those that focus on day-to-day behavior and thinking.

Cognitive-Behavioral Therapy (CBT) helps people learn how to change the way they behave, think and feel about things that happen to them, and the way they see themselves. CBT has reduced depression in the general population and is currently being tested to determine the best ways to adapt it for people who have the types of thinking and memory problems that can happen with TBI.

Behavioral activation therapy helps people with depression become more active and begin to enjoy doing pleasurable activities again. This increased activity helps to improve mood. A professional counselor can help you set up a routine of pleasurable activity and evaluate the effects on your mood.

Remember, many people do best with a combination of approaches, such as antidepressant medication plus sessions with a trained counselor to work on changing behavior.

Other treatment approaches

Other approaches such as exercise, acupuncture and biofeedback have been shown to be helpful in treating depression in the general population. Some people with TBI also find them helpful. A professional specializing in TBI should be consulted about these treatments. Treating anxiety and pain can also help to reduce depression. Brain injury support groups may be a good source of additional information and support for depression and other challenges following a TBI.

How to find help

Many mental health professionals are qualified to treat depression. Psychiatrists have specialized training in medication management and counseling for depression, and psychologists are trained to provide counseling for depression. Some social workers and licensed professional counselors are also trained to provide counseling for depression.
Physicians—such as primary care physicians, neurologists and physiatrists—and nurse practitioners with experience in treating depression can often get treatment started.

When available, it is best to get treatment from a comprehensive brain injury rehabilitation program that can address all aspects of TBI recovery.

For more general information about depression, contact the Canadian Mental Health Association (CMHA) at (416) 646-5557 or visit their website at: https://cmha.ca/

References


Eligibility

- Brain injury/concussion within past 5 years
- Age 18 to 60
- Women: not currently pregnant
- Not currently taking any street drugs
- Otherwise healthy

Results and Compensation Provided

To learn more, please call (416) 535-8501 ext. 36450 or email TBI.study@camh.ca

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Call OBIA 1-855-642-8877
Toll-Free Support Line 1-800-263-5404 (HELPLINE)

Brain Injury Associations

Ontario Brain Injury Association
Phone: 905-641-8877 or 1-855-642-8877
Toll-free support line 1-800-263-5404
Email: obia@obia.on.ca Website: www.obia.ca
- www.facebook.com/OntarioBIA
- www.twitter.com/OntarioBIA
- www.instagram.com/OntarioBIA
- www.LinkedIn.com/company/Ontario_Brain_Injury_Association

Belleville
BIA of Quinte District
Phone: 613-967-2756 or Toll free: 1-866-894-8884
Email: info@biaqd.ca
Website: www.biaqd.ca

Chatham-Kent
New Beginnings ABI & Stroke Recovery Association
Phone: 519-351-0297
Fax: 519-351-7600
Email: info@newbeginnings-cksl.com
Website: www.newbeginnings-cksl.com

Dufferin County
Headwaters ABI Group (HABI)
Phone: 519-215-1519

Durham
BIA of Durham
Phone: 905-723-2732 or Toll free: 1-866-354-4464
Email: information@biad.ca
Website: www.biad.ca

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BIA of Fort Erie
Phone: 905-871-7789
Email: biafeoffice@gmail.com
Website: http://braininjuryfe.wixsite.com/biafe

Hamilton-Wentworth
Hamilton BIA
Phone: 905-538-5251
Email: info@hbia.ca
Website: www.hbia.ca

London and Region
BIA of London and Region
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Email: info@braininjurylondon.on.ca
Website: www.braininjurylondon.on.ca

Niagara Area
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Website: www.bianiagara.org

North Bay Area
BIA of North Bay and Area
Phone: 705-478-8664
Email: contact@bianba.ca
Website: www.bianba.ca

Ottawa Area
BIA of Ottawa Valley
Phone: 613-233-8303
Email: contact@biaov.org
Website: www.biaov.org

Peel-Halton
BIA of Peel & Halton
Phone: 905-823-2221 or 1-800-565-8594
Email: biaph@biaph.com
Website: www.biaph.com

Peterborough Area
Brain Injury Association Peterborough Region
Phone: 705-741-1172 or 1-800-854-9738
Email: biapr@nexicom.net
Website: www.biapr.ca
Sarnia-Lambton
BIA of Sarnia-Lambton
Phone: 519-337-5657
Email: sarnia.biasl@gmail.com
Website: www.sarniabiasl.ca

New Beginnings ABI & Stroke Recovery Association
Phone: 519-491-2668
Email: info@newbeginnings-cks1.com
Website: www.newbeginnings-cks1.com

Sault Ste. Marie
BIA of Sault Ste. Marie & District
Phone: 705-971-1050
Email: braininjuryssmd@gmail.com
Website: www.soobraininjury.com

Sudbury and District
BIA of Sudbury & District
Phone: 705-670-0200
Email: info@biasd.ca
Website: www.biasd.ca

Thunder Bay
BIA Thunder Bay & Area
Phone: 807-621-4164
Email: biatba@yahoo.ca
Website: www.bisno.org/brain-injury-association-of-thunder-bay.php

Timmins
Seizure & Brain Injury Centre
Phone: 705-264-2933
Email: sabicrl@eastlink.ca
Website: www.seizureandbraininjurycentre.com

Toronto (GTA)
Brain Injury Society of Toronto
Phone: 416-830-1485
Email: info@bist.ca
Website: www.bist.ca

Waterloo-Wellington
BIA of Waterloo-Wellington
Phone: 519-576-3535
Email: info@biaww.com
Website: www.biaww.com

Windsor-Essex
BIA of Windsor and Essex County
Phone: 519-981-1329
Email: info@biawe.com
Website: www.biawe.com

York Region
BIA of York Region
Phone: 905-780-1236
Fax: 905-780-1524
Email: n/a
Website: www.biayr.org

Provincial Associations

Brain Injury Canada/Lésion Cérébrale Canada
Phone: 613-762-1222, Toll free Line: 1-866-977-2492
Email: info@braininjurycanada.ca
Website: www.braininjurycanada.ca

British Columbia Brain Injury Association
Phone: 604-984-1212
Email: info@brainstreams.ca
Website: www.brainstreams.ca

Central Alberta Brain Injury Society (CABIS)
Phone: 403-341-3463
Email: cabis@telus.net
Website: www.cabis.info

Saskatchewan Brain Injury Association
Phone: 306-373-1555 or Toll free (in Sask) 866-373-1555
Email: info_sbia@sasktel.net
Website: www.sbia.ca

Manitoba Brain Injury Association
Phone: 204-975-3280 or Toll Free: 866-327-1998
Email: info@mbia.ca
Website: www.mbia.ca

Ontario Brain Injury Association
Phone: 905-641-8877 or 1-855-642-8877
Toll free support 1-800-263-5404
Email: obia@obia.on.ca
Website: www.obia.ca

Newfoundland and Labrador Brain Injury Association
Phone: 709-579-3070
Email: nlbia2011@gmail.com
Website: www.nlbia.ca/index.php

Regroupement des associations de personnes traumatisées cranio-cérébrales du Québec
Phone: 450-575-8227
Email: info@raptccq.com
Website: www.raptccq.com

Brain Injury Association of Nova Scotia
Phone: 902-473-7301
Email: info@braininjuryns.com
Website: http://braininjuryns.com/

Brain Injury Association of Canada (New Brunswick)
Phone: 506-721-8003
Email: biacnb@icloud.com
Website: www.biacnb.org

Brain Injury Association of P.E.I.
Phone: 902-314-4228 or 902-367-3216
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11 Armstrong St. N.
(705) 647-6330

OTTAWA
Chateau Laurier (by Appt)
(613) 234-1866
Events Calendar

Various dates to the end of March, 2020
Caregiver Education Program
Support, Hope & Resiliency: An Education and Training Program for Caregivers of Acquired Brain Injury Survivors
Location: various locations across the province
Contact: Nancy LaJoie
Phone: 905-641-8877 ext. 248
Email: nlajoie@obia.on.ca
Website: www.obia.ca/caregiver-education-program/

April 30 - May 1, 2020
Hamilton Health Sciences presents
The 27th Annual Conference: Neurobehavioural Rehabilitation
Location: Hamilton Convention Centre, Hamilton, ON
Contact: June Ciampichini, Conference Coordinator
Phone: 1-905-521-2100 ext. 40339
Email: ciampich@hhsc.ca
Website: www.hamiltonhealthsciences.ca/healthcare-providers/abi-conference/

April 30 - May 1, 2020
Brain Injury Canada presents
The 2020 Brain Injury Conference in Ottawa
Location: Ottawa, ON
Contact: BIC office
Phone: 1-866-977-2492
Email: info@braininjurycanada.ca
Website: www.braininjurycanada.ca

June 10, 2020
BIST/OBIA presents
The 17th Annual BIST/OBIA Mix and Mingle
Location: Steamwhistle Brewery, Toronto, ON
Contact: Terry Bartol
Phone: 905-641-8877 ext. 234
Email: tbartol@obia.on.ca
Website: www.obia.ca

June 11-12, 2020
OBIA presents
Mental Health, Addictions and Brain Injury (Level 2) Training Program
Location: Brock University, St. Catharines, ON
Contact: Diane Dakiv
Phone: 905-641-8877 ext. 231
Email: training@obia.on.ca
Website: www.obia.ca

June 20, 2020
OBIA presents
Annual General Meeting
Location: Miles Nadal Jewish Community Centre, Toronto, ON
Contact: Diane Dakiv
Phone: 905-641-8877 ext. 231
Email: ddakiv@obia.on.ca
Website: www.obia.ca

September 24, 2020
PIA Law and OBIA presents
Back to School Conference - SAVE THE DATE
Location: King Edward Hotel, Toronto, ON
Contact: Terry Bartol
Phone: 905-641-8877 ext. 234
Email: tbartol@obia.on.ca
Website: www.obia.ca

November 12-13, 2020
Toronto ABI Network presents
Conference 2020: Connecting, Learning, Inspiring- SAVE THE DATE
Location: Marriott Eaton Centre, Toronto, ON
Contact: Terry Bartol
Phone: 416-597-7021
Email: info@abinetwork.ca
Website: http://www.abinetwork.ca/abi-conference-2020

For more listings, check: www.obia.ca/calendar
Pathways to Independence specializes in providing services and supports to adults with an acquired brain injury (ABI). These services could be a place to call home or day services designed to support a person living with a brain injury to reintegrate into their community.

Pathways Service Plan supports a person’s rehabilitation and reintegration to the community following a brain injury. In addition to assisting with activities of daily living, Pathways employees actively work with the person to access social networks and community partners to develop and support the implementation of a person’s individualized service plan.

Pathways ABI programs and services are tailored to accommodate individual needs and provide a continuum of care.

1 in 26 Canadians are living with a brain injury

ABI is not a developmental disability or autism

There will be 18,000 new brain injuries this year

Men experience brain injuries twice as often as women

Brain injuries can be a non visible disability

ABI affects cognitive, emotional, behavioural, & physical functioning

Reach out to us to find out more about Pathways ABI Services:
289 Pinnacle St., Belleville, ON K8N 3B3  T 613.962.2341  F 613.962.6357
356 D Woodroffe Ave, Unit 202, Ottawa, ON K2A 3V6  T 613.233.3322

www.pathwaysind.com

Support Services: There is hope, there is help!

OBIA’s Support Services:
- Provides listening and emotional support to discuss the difficulties and frustrations associated with brain injuries
- Empowers the caller to cope with specific aspects of their life
- Supports families, friends, co-workers as well as professionals who may be supporting survivors and seeking information
- Is responsive to the needs of persons from diverse backgrounds and experiences
- Makes the appropriate community referrals

Call our toll free Support Line
1.800.263.5404

Email: support@obia.on.ca
FROM MEDICAL REHAB TO RECOVERY

TRAUMATIC BRAIN INJURY RECOVERY PARTNERS

MEDICAL REHAB IS JUST THE BEGINNING

Suffering from a Traumatic Brain Injury (TBI) can lead to cascading events with disastrous impacts on the patients and their families, including ongoing physical, emotional, financial, social and professional effects (during and after their rehabilitation).

THE RIGHT HELP TO BRIDGE THE MEDICAL-LEGAL GAP

HIMPRO has helped over 1150 serious injury victims get access to the best medical, financial and logistical resources available to maximize their recovery.

How do we achieve such a track record?
"HIMPRO has built an exceptional team of vetted medical and rehab professionals with a deep understanding of how to secure the best support for each individual client suffering from TBI."
David B. Himelfarb - Managing Partner

FREE INITIAL CONSULTATION

Visit
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to learn how we help brain injury victims

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BUILDING WINNING CASES THROUGHOUT ONTARIO
Featured Training Program

Mental Health, Addictions and Brain Injury (Level 2)

Prerequisite Required:
Neurorehabilitation: Assisting Recovery and Function in Everyday Life Following Brain Injury
NO EXCEPTIONS

June 11-12, 2020

This Level Two course is designed to increase your understanding of the relationship between traumatic brain injury, substance misuse and mental health challenges, and to assist you in developing a greater appreciation of the factors which make brain injury rehabilitation more challenging when a co-morbid disorder is present.

Objectives:
- To extend your knowledge of brain function with respect to addictive behaviours and the brain’s response to trauma.
- To expand your appreciation of the pre-injury and post-injury influences on addictive behaviour and mental health.
- To expand your range of knowledge on how traumatic brain injury impacts substance abuse and mental health treatment and how substance misuse impacts recovery from injury.

DETAILS

Location: Brock University
1812 Sir Isaac Brock Way,
Room: TH325
St. Catharines, ON

Date: June 11-12, 2020

Professors: Dawn Good, PhD, C.Psych
Carolyn Lemskey, PhD, C.Psych ABPP-CN

For more information about this and/or other Certificate Training Programs visit www.obia.ca
905.641.8877 1.855.642.8877
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Bayshore HealthCare has been enhancing the quality of life, dignity and independence of Canadians in their homes since 1966. Offering a wide range of personal and community health care services through more than 60 home care offices and 30 community care clinics across Canada, we strive to make a difference in our clients’ lives—every visit, every time.
We want to hear from you.

Survivors and Caregivers are invited to participate in OBIA's Annual Research Questionnaire.

Your participation will enhance our ability to provide a greater unified voice on behalf of people living with the effects of brain injury in Ontario.

In appreciation for your participation in our research study, you will receive a free one year dual membership with both OBIA and the participating local brain injury association of your choice and a Survivor Identification Card.

Contact OBIA’s support services to request a copy.

1.800.263.5404
www.obia.ca
WE’RE COMMITTED TO HELP MAKE THE FUTURE A BRIGHTER ONE FOR YOUR LOVED ONES.

Our full-circle care promise means you won’t be handling these challenges alone and he’ll have the support needed when you’re not around.
Kevin Begins with a Solid Foundation.

Whether it’s breaking ground on his new home, or building a solid case for his clients, Kevin understands that careful planning and attention to detail are vital components for success.

Although never an easy feat, Kevin believes that it is a lawyer’s job to bring a client’s story to life. And he is always up for the challenge. Reciting facts in court doesn’t make a case compelling. A client’s story has to be carefully framed and shaped with the utmost skill.

Helping clients understand the legal blueprint of their case while giving them a sense of security sets Kevin apart. Helping clients navigate difficult barriers, and open doors to new opportunities is what gives Kevin a sense of purpose.

To learn more about Kevin visit www.oatleyvigmond.com/kevin

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