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### **Brain Injury and Personnel Preparation**

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According to the Centers for Disease Control (Langlois, et.al, 2006), Traumatic Brain Injury (TBI) impacts over 1.4 million persons annually in the U.S.. The age groups most affected are 0-4, 15-19, 19-25 among military personnel in war zones, and persons over 60 (BIAA, 2010). These numbers include shaken baby and child abuse cases, automobile accidents, sports injuries and falls. We do know that seniors with vision loss are more likely to fall, and that falls among seniors are one of the major causes of traumatic brain injury in that age group. We also know that seniors often have strokes and other neurological conditions known as acquired brain injury (ABI) that impact cognition and independence in much the same way as a TBI. Unfortunately, the recent wars in the Middle East have added to the numbers of young persons with TBI and vision loss, but the related work of the Department of Veterans' Affairs has also given us more empirical information on how to work with this population. One of the roles of universities is to conduct research and integrate the results of that research into the preparation of professionals in a given program of study. As a result, I feel our vision related personnel preparation programs need to address this issue.

At Mississippi State University (MSU) we have a Vision Specialist in Vocational Rehabilitation Graduate Certificate Program that is designed for Vocational Rehabilitation Counselors with caseloads of persons who are blind and visually impaired. Usually about 80 percent of the class is comprised of

working VR counselors, some with many years of experience, and a few teachers (TVI, VRT, COMS) or graduate students. They come from all over the country. Over the last 5 years we have noticed that more and more VR counselors serving persons who are blind have persons with brain injuries on their caseloads. In our program under the general topic of special populations we have covered acquired and traumatic brain injury and HIV in a rather superficial way along with aging, diabetes and deafblindness which had more attention. But due to the increase of brain injury on caseloads, and my personal experience when my husband who has been legally blind all his life acquired a traumatic brain injury, over the last 3 years we have increased the attention we give this area of service.

The motivation for the increased attention is that specialization in the blend of brain injury and vision is not well addressed in our field, and resources vary considerably around the country. Our program consists of 4 hybrid distance education courses with 3 weeks of intensive residency. In a nutshell, our courses cover medical aspects of blindness and low vision with implications for employment, low vision, special populations, history and legislation, assistive technology, O&M, VRT, transition, various resources including organizations and professionals, special education perspectives, career development, job placement, and a field experience/practicum. The courses are packed, so the issue is always how much attention to give various topics in order to prepare people for the entry level skills, knowledge and abilities they will need.

Typically, in our program at MSU, students have a number of readings on acquired and traumatic brain injury, and a 3-4 hour lecture/discussion, and are required to do a paper on a case study. This year the class attended the International AERBVI Conference and we used the conference as the forum for the lecture and discussions on brain injury. However, we found that although all the presentations were excellent, the students missed the basics from systematic lectures and as a result, the case study was much more challenging for them to address. For me this was a confirmation that continuing education alone may leave too many gaps. Issues that make TBI unique include the lack of local resources, getting a good post-injury ophthalmological assessment of functional vision, finding and understanding treatment options, and understanding information on prognosis – especially implications for employment. In my own searching and experience, I have found literature and presentations vary considerably in their vocational prognosis and therapeutic recommendations. However, there are some basic guidelines that I think are important to cover that can assist both the consumer and the professional.

Addressing related vision impairment is basically left out of many of the current brain injury treatment options. It is important that we learn the language, the personnel and the basic strategies of treating brain injury and whenever possible integrate them into our programs. As a result, it is my opinion that in the field of blindness and low vision, our university programs need to learn how to utilize research findings and best practice guidelines to prepare professionals to become part of a treatment team that will counsel, guide and instruct persons

with vision loss and brain injury to enable them to learn strategies that will increase their independence and productivity. We are doing this at MSU even though we are having to sacrifice other topics. Still, what we are able to cover is simply the basics.

### **References**

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