This document is intended to serve as an informational guide for military members who are suffering from a traumatic brain injury. The document outlines the process that injured warriors should expect to go through from the initial injury to receiving permanent care. Individuals using this guide should recognize that it is not intended to be a final authority on the matter, but rather that it is simply meant to serve as a guide post for locating source material and professional assistance.
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A VETERAN’S GUIDE TO TRAUMATIC BRAIN INJURIES

Preface:

Traumatic Brain Injury (TBI) has become one of the signature injuries of the wars in Iraq and Afghanistan. Along with its counterpart, Post Traumatic Stress Disorder (PTSD), it has ravaged the military ranks, leaving soldiers and families to cope with complications that can last a lifetime.

TBI stems from a blunt force or concussion to the head. It often occurs despite a lack of external physical injury and can have serious consequences for the unfortunate victim. Those consequences range from behavioral disorders and emotional instability, to physical handicaps. Moreover, the impact of a TBI on a service member’s career and quality of life can be devastating.

Because TBIs often occur without any evidence of external injury, identification and treatment efforts are often hampered.1 In fact, it is not uncommon for military personnel to leave a combat zone never having known they suffered a TBI, and symptoms may not become evident for months later. Moreover, the difficulty associated with diagnosis is compounded by the fact the symptoms of TBI are very similar to those associated with Post Traumatic Stress Disorder (PTSD).2 As a result, it is often difficult to discern the presence of a TBI.

For those suffering from a TBI, the physical pain, if present at all, may easily be overshadowed by the secondary effects of the injury. Victims of such an injury are prone to a wide range of psychological and physiological problems. Often, TBIs can lead to unorthodox behavior on the part of the injured individual.3 Some soldiers simply lose the ability to control their emotions, which may result in harm to their families, their local community, or themselves. Additionally, these individuals may find themselves facing a dishonorable discharge, or worse, prison time.

With such high stakes, the DoD and the VA have implemented recent studies to evaluate the impact that TBIs have on military personnel. For example, the DoD has implemented several screening processes for returning combat veterans.4 Additionally, the DoD established the Defense and Veterans Brain Injury Center (DVBIC), “to serve active duty military, their beneficiaries, and veterans with traumatic brain injuries (TBIs) through state-of-the-art clinical care, innovative clinical research initiatives and educational programs.”5 Likewise, the VA has
recently modified its disability rating system with regard to TBIs in order to better enable raters to provide suffering veterans with compensation.6

Due to these difficulties, and the confusion within the military community over how to deal with TBIs there is a fundamental need for a comprehensive guide for veterans and active military to better navigate the topic. This guide will explore some of the major topics associated with TBI and will provide sources for assisting injured warriors in receiving aid.

Definition of Traumatic Brain Injury:

The simplest definition of a Traumatic Brain Injury (TBI) was provided by a recent DoD task force: “A blow or jolt to the head or a penetrating head injury.”7 The Department of Defense (DoD) defines TBI more thoroughly as “[a] traumatically induced structural injury and/or physiological disruption of brain function as a result of external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event: (1) Any period of loss of or a decreased level of consciousness; or (2) [a]ny loss of memory for events immediately before or after the injury; or (3) [a]ny alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.); or (4)[n]eurological deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia, etc.) that may or may not be transient; or (5) [i]ntracranial lesion.”8 The DoD goes on to outline events that constitute an external force: “the head being struck by an object, the head striking an object, the brain undergoing an acceleration/deceleration movement without direct external trauma to the head, a foreign body penetrating the brain, forces generated from events such as blast or explosion, or other force yet to be defined.”9

TBIs are categorized according to severity at the time of injury. There are three levels of severity: Mild, Moderate, and Severe. The level of severity is indicated by the injury’s immediate effects on the patient. According to the Defense and Veterans Brain Injury Center (DVBIC), 90% of TBIs are mild. However, this conclusion may be different for those who are injured by explosions. One recent study by DVBIC revealed that of the soldiers who were treated at Walter Reed Army Medical Center for injuries caused by explosions, 60% suffered from some form of TBI. Of those, 44% had suffered a mild TBI, while the remaining 56% suffered from either a moderate or severe TBI.10 In addition, a 2009 study by the VA found that nearly half of the patients at an inpatient clinic who had suffered a TBI had mental health problems, and all suffered from some form of head pain.11

Mild TBI (mTBI) is classified as a “concussion” and may involve loss of consciousness from zero to thirty minutes. Likewise, there may be a momentary alteration of consciousness that lasts for less than twenty-four hours, and/or amnesia lasting for less than one day. Mild TBI is the most difficult for health care providers to identify because it may occur without a loss of
consciousness, alteration of consciousness, or amnesia. These difficulties are complicated by the fact that many individuals fail to seek immediate treatment for mTBIs due to the fast tempo of combat operations. Accordingly, the identification methods discussed below are crucial to a rapid diagnoses and treatment, which often occurs at outpatient clients. DVBIC reports that nearly 85% of those suffering from a mTBI will recover completely within months with “minimal intervention.” However, while some patients do recover fully from mTBI, many continue to suffer from some form of head pain, and mental health issues.

Moderate TBI occurs where a patient experiences a loss of consciousness that lasts between thirty minutes, but for less than twenty-four hours. Additionally, there may be an alteration of consciousness that lasts for more than twenty-four hours, and amnesia between one and seven days. Due to the fact that moderate TBI is manifest by loss of consciousness, alteration of consciousness, or amnesia, the injury is often accompanied by a primary diagnosis of TBI during treatment of the conditions. Those suffering from a moderate TBI will likely require inpatient treatment at a VA Polytrauma Rehabilitation Center (PRC). The symptoms of moderate TBI are often longer lasting than those of mTBI, and may even occur for the remainder of the injured service member’s life.

Finally, Severe TBI is present were the patient suffers a loss of consciousness lasting more than twenty-four hours, an alteration of consciousness lasting more than twenty-four hours, and/or amnesia lasting more than seven days. Individuals with severe TBI may need treatment at a PRC, Military Treatment Facility (MTF), or a civilian rehabilitation facility. The most severely injured will likely remain in the VA healthcare system for the remainder of their lives, and may need constant treatment. Additionally, veterans suffering from very severe TBI may require demanding caregiver assistance from family and friends.

**Common Causes of Traumatic Brain Injury:**

Since 2001, of approximately 35,000 military members wounded in action, over 25,000 were injured by an Improvised Explosive Device (IED) in the wars in Iraq and Afghanistan. A recent Defense Task Force stated, “[b]last and concussive events are a leading cause of TBI for active duty military personnel involved in war zones.” Some estimates state that nearly 360,000 returning Iraq and Afghanistan veterans may suffer from a TBI. Notably, there were over 22,000 veterans being compensated by the Department of Veterans Affairs (VA) for TBIs in 2008. A quarter of these veterans suffered their TBI while serving in Iraq or Afghanistan. In addition, the majority of TBIs suffered from combat stemmed from closed head injuries (non-penetrating).

However, combat injuries are not the exclusive cause of TBIs. The same Defense Task Force goes on to state, “the injury may be caused by falls, motor vehicle accidents, assaults
and/or other incidents.”

For example, elderly veterans may suffer a TBI as a result of falling. Likewise, bumpy conditions within a tank that lead to a track member striking his/her head may cause a TBI.

In short, TBIs are caused by an impact to the head, either physical or concussive in nature. The injury frequently accompanies explosions and the majority of TBIs occur without any external wounds. However, a brain injury can occur from virtually any forceful impact or jolt to the head.

**Symptoms of Traumatic Brain Injury:**

Aside from the initial indications of TBI stemming from unconsciousness and amnesia as outlined in the section covering mild, moderate, and severe TBIs, there are other indicators. These indicators are often important in diagnosing those individuals who have suffered from a mTBI because that injury often occurs without the immediate presence of unconsciousness or amnesia which can lead to earlier diagnosis. However, these additional symptoms may be difficult to identify because TBI often occurs in conjunction with PTSD, and the symptoms are quite similar. Therefore, many individuals suffering from a TBI may not realize it as their symptoms might have been identified in the diagnosis stage as stemming from a PTSD.

The following table outlines the primary symptoms DVBIC associates with a TBI:

<table>
<thead>
<tr>
<th>Hearing Loss</th>
<th>Memory Loss</th>
<th>Sleep Disturbance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperacusis</td>
<td>Vertigo</td>
<td>Insomnia</td>
</tr>
<tr>
<td>Tinnitus</td>
<td>Psychiatric</td>
<td>Blurred Vision</td>
</tr>
<tr>
<td>Neurologic</td>
<td>Acute Stress Reaction</td>
<td>Photophobia</td>
</tr>
<tr>
<td>Dizziness, Lightheadedness</td>
<td>Anxiety/Irritability</td>
<td>Malaise and Fatigue</td>
</tr>
<tr>
<td>Headache</td>
<td>Depression</td>
<td>Nausea</td>
</tr>
</tbody>
</table>

Notably, depression is listed as being the most common symptom. However, these symptoms are not conclusive, and serve only as indicators that a TBI may be present.

**Identifying Those who Suffer:**
With the recent changes made by the DoD, identification of a TBI can occur through several different screening phases. For example, some TBIs will be identified immediately after the injury event occurs, such as moderate, severe, and mTBI that is accompanied by unconsciousness or amnesia. Many of the remaining mTBIs will be identified well after a military member returns from deployment. Finally, some TBIs will not be identified until the military member re-enters civilian life. As a result, it is important to assess how the process works at each of these stages.

First, TBIs may be identified during the initial injury treatment. For military members who are injured in combat, this often occurs in the form of a screening test that is administered by the onsite medical personnel. As of 2006, the DoD has utilized a screening test called the Military Acute Concussion Evaluation (MACE). The MACE test “measures[s] four cognitive domains: orientation, immediate memory, concentration, and memory recall” and is conducted by medical personnel in the field. Medical staff will determine whether there is evidence of a TBI, or whether the injured individual is in need of immediate removal from the field based upon an individual’s MACE score. Importantly, many individuals suffering from a TBI were injured before the MACE test was utilized. Accordingly, the DoD has provided additional opportunities for those individuals to receive a diagnosis for their injury as discussed below.

Second, some service members will sustain a head injury that they are not treated for while in theater. Often, this will occur when a military member suffers a head impact due to bumpy road conditions, accidents, explosive concussions, and various other dangerous activities which fail to result in an externally manifested injury. This situation is often present when a mTBI does not manifest itself through unconsciousness or amnesia. Accordingly, the DoD conducts a post deployment survey known as the Post-Deployment Health Assessment (PDHA). Returning military members will be evaluated based on the answers provided in the PDHA. Thus, military members returning from the field should be certain to answer the questions asked in their PDHA as accurately as possible, and should mention any physical or concussive head injuries they may have sustained.

Finally, a military member suffering from a TBI who has come through initial injury treatment (if any occurs) without a MACE score that indicates the presence of such an injury, or who begins to suffer from TBI symptoms after having completed the PDHA survey should contact their base medical personnel immediately. Veterans should contact the VA in this situation. Partially due to the difficulty that is sometimes associated with diagnosing a TBI, the DoD has created the War Related Illness and Injury Study Center (WRIISC) to provide second opinions for veterans receiving, or failing to receive, a diagnosis from the VA. In the event that you believe that you do indeed have a medical injury, such as a TBI, for which you have not received a diagnosis from the VA, you may request a review by WRIISC.

Each of the screening methods above lead to a further evaluation of the injured person by DoD medical personnel, and initiates the diagnosis process. Individuals who are identified as
having a high MACE score, PDHA score, or who later are referred or self refer for treatment are assessed further by medical personnel. Upon evaluating the individual, the medical personnel will either make an official diagnosis, or will determine that the symptoms are caused from some other injury.

It is crucial that injured personnel build a sufficient record of the injury and diagnosis while they are still in service in order to ensure continued treatment through the VA. For more information visit our section on How to File a Disability Claim.

**Receiving Treatment for a Traumatic Brain Injury:**

Identifying and diagnosing a TBI is only part of the battle. After these steps have been completed, the complicated task of treating a TBI begins. This often involves specialized treatment plans that are catered to the individual in order to achieve an optimal recovery. For a treatment plan to be successful, it requires the best efforts of medical personnel, the injured individual, and family.

The rehabilitation process may be an extremely long and grueling trial for both the injured individual and his/her family depending on the nature of the injury. The goal of rehabilitation is to allow the injured person to realize the greatest level of independence possible. This process also involves learning how to compensate for the loss of former abilities as a result of a TBI. Initial treatment may come in the form of emergency room and intensive care unit treatment in the case of individuals who have moderate or severe TBI with a prolonged level of unconsciousness.

Following treatment in the intensive care unit, if any, the individual will generally be placed in an Acute Rehabilitation Unit which consists of a variety of professionals who will help the person achieve the best results from rehabilitation. Some of the professionals that the injured person should expect to encounter during this phase of the treatment include: Physiatrist, physical therapists, occupational therapists, speech therapists, rehabilitation nurses, case managers, and neuropsychologists. The Acute Rehabilitation Unit is designed for those individuals with intensive care requirements. The VA has specialized Polytrauma System of Care which helps to streamline this process.

Some individuals may move right to a Sub-Acute Rehabilitation system. This system is designed for those who need less intensive care. Individuals who have gone through acute rehabilitation treatment may be transferred to this type of system after making satisfactory progress in the acute program. Likewise, individuals who do not require intensive treatment may begin the rehabilitation process here. Typically, a individual will work closely with a care provider who will create a plan for the injured warrior to follow.
Similarly, the injured individual may be placed in a Day Rehabilitation Program which allows the individual to return home at the end of each day’s treatment. Often this treatment occurs in a group setting. Likewise, outpatient rehabilitation may be utilized for those who require even less intensive care.

In addition, there may be home services available to some individuals. An injured individual may also require independent living treatment, and brain injury support groups can be very helpful in the path to recovery. One such program is the military [Vocational Rehabilitation and Employment Service](#) which can assist a wounded warrior with finding meaningful training and eventual employment. Notably, it has been estimated that family members will ultimately provide nearly 80 percent of all long-term services directly in the home.

Importantly, the exact type of treatment that occurs will be highly dependent on the nature of the injury, and will be determined on a case by case basis. **If you are experiencing a medical emergency, you should contact 911.** For non-medical emergencies there are several excellent resources available to service members and their families:

**Defense and Veterans Brain Injury Center**: The DVBIC is a congressionally created organization that specializes in researching and treating TBIs. The center has programs and information available for injured military members and veterans, as well as for families. Many individuals who are diagnosed with a TBI will be referred to DVIBIC. To receive treatment through DVBIC an individual must be a military member with TRICARE, or a veteran with Veteran’s benefits. To contact the DVBIC visit their online contact page, or send mail to:

DVBIC Headquarters  
Defense and Veterans Brain Injury Center  
Building 1, Room B209  
Walter Reed Army Medical Center  
6900 Georgia Avenue, NW  
Washington, DC 20307-5001

1.800.870.9244  
202.782.6345 (phone)  
202.782.4400 (fax)  
662.6345 (DSN)  

**TRICARE**: TRICARE is part of the Military Health System (MHS) and provides care for active military members, retirees, and family. Individuals who are still serving or are retired should contact TRICARE about treatment for a TBI. However, the easiest process may be to simply
visit your local base medical facility. The MHS also provides a 24/7 support line for individuals with questions about TBI. To contact the 24/7 Outreach Center call 1-866-966-1020.

**Army Wounded Warrior Program:** This program is run by the U.S. Army and is a very good resource for veterans and soldiers who have been severely injured during combat operations in Iraq or Afghanistan. The AWWP provides information about several programs available to these individuals and will help a former or current soldier receive the treatment they need. To contact the Army concerning the wounded warrior program call 1-877-393-9058.

**Air Force Wounded Warrior Program:** This program is managed by the U.S. Air Force and is designed to assist airmen who have been injured in Iraq or Afghanistan. The program will assist these individuals with the process of separation if needed, and will provide services following the members discharge. To contact the Air Force concerning this program call 1-800-581-9437.

**U.S. Marine Corps Wounded Warrior Regiment:** This program is run by the U.S. Marine Corps and provides wounded marines and sailors attached to marine units who are injured in Iraq or Afghanistan with comprehensive assistance. The program assists these individuals by helping them through the transition process to civilian life and beyond. The Marine Corps Wounded Warrior Call Center can be reached at 1-877-487-6299.

**Navy Safe Harbor Program:** This program is run by the U.S. Navy for sailors who are injured in Iraq or Afghanistan. The program is designed to provide non-medical assistance with transition to civilian life and beyond. To contact the Navy about this program call 1-877-746-8563.

**Department of Veterans Affairs:** For individuals who have separated from the military, the VA provides a broad range of services to veterans. Veterans who believe that they are suffering from a TBI should contact the VA and file a disability claim. You can contact the VA online, or by phone at 1-800-827-1000. To locate a VA facility near you visit the locations map.

**How the VA Evaluates a Traumatic Brain Injury Claim:**

The Department of Veteran Affairs (VA) will evaluate your TBI claim according to the guidelines it has set forth in the Code of Federal Regulations. The VA does not rely on the type of TBI (Mild, Moderate, Severe) because these identifications are given according to the conditions experienced at the time of the injury. Instead the VA focuses on the current effects that the injury is having on the veteran. Specifically, the VA identifies three main categories of
dysfunction that may lead to a disability rating for TBI: cognitive problems, emotional/behavioral problems, and physical problems.

Cognitive problems are defined by the VA as, “decreased memory, concentration, attention, and executive function of the brain.” The VA goes on to say that executive function of the brain includes such things as, “goal setting, speed of information processing, planning, organizing, prioritizing, self-monitoring, problem solving, judgment, decision making, spontaneity, and flexibility in changing action when they are not productive.” The regulation specifies that not all of these symptoms will necessarily be present, and the severity of each may vary from day to day. The VA will evaluate cognitive problems on a scale of “0” to “total” using the “Evaluation of Cognitive Impairment and Other Residuals of TBI Not otherwise Classified (ECI)” table.

The ECI table evaluates several categories of cognitive impairment: (1) Memory, attention, concentration, executive functions; (2) Judgment; (3) Social interaction; (4) Orientation (ie person, time, place, situation); (5) Motor activities; (6) Visual spatial orientation (ie getting lost in unfamiliar surroundings, difficulty reading maps, following directions, judging distance, utilizing GPS devices); (7) Subjective symptoms; (8) Neurobehavioral effects (ie irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, belligerence, apathy, lack of empathy, moodiness, lack of cooperation, inflexibility, and impaired awareness of disability); (9) Communication; and (10) Consciousness (ie vegetative state, minimally responsive state, coma). Each of these ten categories is rated on the scale encompassing 0, 1, 2, 3, and total. However, consciousness is rated as either 0 or total because “impaired consciousness would be totally disabling.”

Once each of the scores for these respective categories has been determined by the VA, a disability rating will be assigned. The VA will assign this disability rating, “based on the level of the highest” score. The VA will give a score of “0” a rating of “0” percent. A score of 1 will be given a rating of 10 percent. A score of 2 will be given a rating of 40 percent. A score of 3 will be given a rating of 70 percent. Finally, a score of “total” will be given a rating of 100 percent. Thus, if a veteran receives a score of 1 on all of the categories above, his rating will be 10 percent. However, if the veteran receives a score of 1 on all of the above categories, but receives a score of 3 on the social interaction category (or any other category) the overall rating will be 70 percent.

Emotional/behavioral problems are evaluated using the ECI table when the veteran has not been diagnosed with a mental disorder. However, if the veteran has been diagnosed with a mental disorder the VA uses a different table to determine the disability rating called the “Schedule of ratings – mental disorders (SR).” Determining whether or not a veteran has been diagnosed with a mental disorder is also governed by the Code of Federal Regulations which states that a diagnosis is given by a medical examiner. The VA considered a mental disorder to be: (1) Schizophrenia and other psychotic Disorders; (2) Delirium, Dementia, and Amnestic and
Other cognitive Disorders; (3) Anxiety Disorder; (4) Dissociative Disorders; (5) Somatoform Disorders; (6) Mood Disorders; (7) Chronic Adjustment Disorder; and (8) Eating Disorders.\(^{41}\)

Like the ECI table, the SR table measures the severity of the mental disorder based upon a set formula. The language of the formula provides that a disability rating of zero percent will be given for, “[a] mental condition [that] has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication.” On the opposite end of the spectrum, a “[t]otal occupational and social impairment, due to such symptoms as: gross impairment in private behavior, persistent delusions of hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names or close relatives, own occupation, or own name . . . .” will merit a disability rating of 100 percent. The SR table allows for degrees between the above extremes to be rated at increments of 10, 30, 50, and 70 percent.

Finally, a disability rating may be awarded for physical problems associated with a TBI.\(^{42}\) The VA will evaluate physical dysfunction based on “[m]otor and sensory dysfunction, including pain, or the extremities and face; visual impairment; hearing loss and tinnitus; loss of sense of smell and taste; seizures; gait; coordination, and balance problems; speech and other communication difficulties, including aphasia and related disorders, and dysarthria; neurogenic bladder; neurogenic bowel; cranial nerve dysfunctions; autonomic nerve dysfunctions; and endocrine dysfunctions.”\(^{43}\) However, this list is not exhaustive, and the VA will make case by case determinations of additional physical claims under TBI.\(^{44}\) For those physical conditions not listed, the ECI table is used to find a rating percentage. Those physical conditions that are listed are rated according to the separate tables for each of those categories. Once the rating percentages for each individual ailment are identified, the VA will then combine them to achieve a final rating percentage using the “Combined Rating Table.”\(^{45}\)

In summary, the VA will use different tables and formulas to determine a veteran’s disability rating for a claim stemming from TBI depending on the type of consequences that are being claimed. The end result of the VA’s determination is based entirely upon your previous medical records and the report that they are given by the medical examiner who evaluates you. For these reasons, veterans should be certain to keep their medical records from the service, and should be completely honest with the medical evaluators investigating their claim. In order to receive treatment from the VA for your TBI you must receive a disability rating of at least zero percent for that injury. A rating of zero percent does not mean that you do not have a disability; it simply means that you have not reached a compensable level for that injury. You will still qualify to receive medical treatment for that injury.
Living with Traumatic Brain Injury:

Despite the best efforts of medical personnel, living with TBI can remain a difficult and challenging task for both injured warriors and their families.

I. The Impact of TBI on the Injured

The physical implications of suffering from a TBI can include a vast array of problems such as head pain, headaches, migraines, loss of hearing, visual impairment, confusion, and much more. Some individuals may experience difficulty accomplishing tasks that seem quite simple. Verbal and cognitive ability may also be impaired. Thus, an injured warrior may encounter significant physical limitations many of which were discussed in previous sections.

In addition, mental health problems are quite common for those suffering from a TBI. While TBI is not a mental health problem itself, the neurological effects of the injury seem to make those suffering from it more prone to psychological harm. In a 2009 VA study, 36% of those suffering from a TBI at an inpatient clinic also suffered from depression, and an additional 35% suffered from PTSD.

With the increased propensity to suffer from psychological problems, active military members may be more prone to behavioral problems and substance abuse. These activities conflict with military standards of discipline and often result in a behavioral discharged from the armed forces. These instances of involuntary separation may come in the form of personality disorder discharges, dishonorable discharges, or other medical discharges. In particular, dishonorable discharges have a drastic impact because they result in the veteran being unable to receive VA assistance. Thus, the very injury that causes the individual to act inappropriately may go untreated in the civilian world if the member fails to seek treatment before a behavioral problem arises. This dilemma is discussed extensively in our personality disorder discharge link above.

Accordingly, it is important that those suffering from a TBI to recognize the danger of psychological damage, and attempt to seek treatment at the first sign of trouble. Veterans and service members should discuss this risk with their families in order to prepare them for the possibility of the change, and enlist their help in realizing prompt treatment.

There are several useful websites available to assist veterans and their families in learning how to live with a TBI in general:
**Traumatic Brain Injury: The Journey Home.** This site provides extensive information about TBIs that may be very informative for those suffering from a TBI, and their families. The site includes an interactive look at the brain and how TBI impacts it, as well as the stories of several individuals suffering from TBI.

**Brainline.org:** This site is funded by DVBIC and provides extensive information about preventing, treating, and living with TBI.

**Brain Injury Association of America:** The BIAA provides information, education, and support to individuals with a TBI. The BIAA can be reached by telephone at 1.800. 444.6443.

**Afterdeployment.org:** This site focuses on individuals who are returning from a combat zone. There is a sound treatment of the issues that often arise for returning veterans such as PTSD, depression, alcoholism, and more.

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### II. The Impact of TBI on Families

The role of families in the rehabilitation process is crucial and may account for nearly 80 percent of total care provided over the course of the veteran’s life. For family members, assisting an injured veteran who is coping with a TBI can be a challenging prospect. However, they should know that they are not alone, and there are resources and organizations available to help. For more information on how families can help see [A Family Guide to Traumatic Brain Injury](#).

Id. at 68-69.

*See infra* note 15.

*See infra* section Process of Identification.


Defense Health Board, at 91.


*Id.*


*Id.*


PTSD Research Quarterly, at 2.


Defense Health Board, at 91.


http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1582.

*Id.*
Defense Health Board, at 91.
Defense Health Board, at ES-1.


Defense Health Board, at 68-69.

PTSD Research Quarterly, at 2.