**TABLE 471e-2 SPECIFIC CONSIDERATIONS IN THE MEDICAL EVALUATION OF VETERANS**

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| Occupational context of health concerns | Deployment locations and dates, combat experiences or other deployment stressors, frequent moves, separations from family, impact of deployment on civilian occupation (for reservists) |
| Medical problems during deployment | History of deployment-related injuries (including concussions), environmental exposures, sleep pattern during deployment, use of caffeine/energy drinks, use of other substances |
| Current medical history | Current symptoms, level of chronic pain, sleep problems, evidence of persistent physiologic hyperarousal (hypertension, tachycardia, panic symptoms, concentration/memory problems, irritability/anger, sleep disturbance), chronic use of caffeine or energy drinks, chronic use of nonsteroidal anti-inflammatory medications, chronic use of narcotic pain medications, chronic use of nonbenzodiazepine sedative-hypnotic medications, chronic use of benzodiazepines for sleep or anxiety |
| Mental health assessment | Screen for PTSD, major depressive disorder; ask about suicidal or homicidal ideation, intent, or plans, as well as access to firearms |
| Alcohol/substance use | Screen for alcohol and substance use disorders, quantity and frequency of use, and evidence of tolerance; inquire about "self-medication" (e.g., use of alcohol to sleep, "calm down," or "forget" war-zone experiences) |
| Functional impairment | Impact of current symptoms on social and occupational functioning; high-risk behaviors (e.g., drinking and driving, reckless driving, aggression) |
| Social support, impact of military service on marriage and family | Level of social support; readjustment stress on spouse, children, or other family members |

***Abbreviation:*** PTSD, posttraumatic stress disorder.

Screening for PTSD, depression, and alcohol misuse should be performed routinely in all combat veterans. Three screening tools, which are in the public domain, have been validated for use in primary care, and have been used frequently in veterans: the four-question Primary Care PTSD Screen (PC-PTSD), the two-question Patient Health Questionnaire (PHQ-2), and the three-question Alcohol Use Disorders Identification Test-Consumption module (AUDIT-C) (Table 471e-3).

Because the clinical definition of an acute concussion/mTBI does not include symptoms, time course, or impairment, there is currently no clinically validated screening process for use months or years after injury. However, it is important to gather information about all injuries sustained during deployment, including any that resulted in loss or alteration of consciousness or loss of memory around the time of the event. If concussion injuries have occurred, the clinician should assess the number of such injuries, the duration of time unconscious, and injury mechanisms. This should be followed by an assessment of any PCS immediately following the injury event (e.g., headaches, dizziness, tinnitus, nausea, irritability, insomnia, and concentration or memory problems) and the severity and duration of such symptoms.

## TREATMENT NEUROPSYCHIATRIC ILLNESSES IN WAR VETERANS

Given the interrelationship of postwar health concerns, care needs to be carefully coordinated. Specific techniques that have been found to be helpful include scheduling regular primary care visits instead of as-needed visits, establishing care management, using good risk-communication principles, establishing a consultative step care approach that draws on the expertise of specialists in a collaborative manner (instead of immediately referring the patient to a specialist and relying on the specialist to provide care), and having behavioral health support directly within primary care clinics (both for referrals and to provide education and support to primary care professionals prescribing treatment for depression or PTSD).

It is important not to implicitly or explicitly convey the message that physical or cognitive symptoms are psychological or due to "stress." Even if depression or anxiety plays a large role in the etiology of physical health symptoms, the treatment approach should be designed within a patient-centered primary care structure, and referrals should be managed from within this framework. For example, it might help to explain that the primary goal of referral to a mental health professional is to improve sleep and reduce physiologic hyperarousal, which in turn will help with treatment of war-related chronic headaches, concentration problems, or chronic fatigue. If, however, the primary care professional conveys the message that the cause of headaches or concentration problems is anxiety or depression, and this conflicts with the patient's own viewpoint, then this could damage therapeutic rapport and in turn exacerbate the symptoms.

Specific questions related to military service (Table 471e-2) combined with screening for depression, PTSD, and alcohol use disorders (Table 471e-3) should be a routine part of care for all veterans. A positive screen for depression or PTSD should prompt follow-up questions related to these disorders (or use of a longer screening tool such as the nine-question Patient Health Questionnaire or National Center for PTSD Checklist), as well as risk assessment for suicide or homicide. It is important to assess the impact of depression or PTSD symptoms on occupational functioning and interpersonal relationships.

A positive screen for alcohol misuse should prompt a brief motivational intervention that includes bringing attention to the elevated level of drinking, informing the veteran about the effects of alcohol on health, recommending limiting use or abstaining, exploring and setting goals related to drinking behavior, and follow-up and referral to specialty care if needed. This type of brief primary care intervention has been found to be effective and should be incorporated into routine practice. One way to facilitate dialogue about this topic with veterans is to point out how hyperarousal associated with combat service can lead to increased craving for alcohol as the body searches for ways to modulate this. Veterans may consciously or unconsciously drink more to help with sleep, reduce arousal, or avoid thinking about events that happened "downrange." A key educational strategy is to help the veteran to learn that drinking to get to sleep actually damages sleep architecture and makes sleep worse (e.g., reduces rapid eye movement [REM] sleep initially followed by rebound REM activity and early morning wakening).

### SPECIFIC TREATMENT STRATEGIES FOR PTSD AND COMORBID DEPRESSION

PTSD and depression are highly comorbid in combat veterans, and the evidence-based treatments are similar, involving antidepressant medications, cognitive behavioral therapy (CBT), or both. Psychoeducation that assists veterans to understand that their symptoms of PTSD have a basis in adaptive survival mechanisms and skills they exhibited in combat can facilitate therapeutic rapport. Remaining hypervigilant to threat, being able to shut down emotions, being able to function on less sleep, and using anger to help focus and control fear are all adaptive beneficial survival skills in a combat environment. Therefore, PTSD for warriors is both a medical disorder and a set of reactions that have their roots in the physiologic adaptation and skills they successfully applied in combat.

It is important to know that combat is not the only important trauma in a war-zone environment. Rape, assault, and accidents also occur. Rape or assault by a fellow service member, which affects a greater number of women veterans, but also occurs in men, can be particularly devastating because it destroys the vital feeling of safety that individuals derive from their own unit peers in a war environment.

The treatments for PTSD considered by most consensus guideline committees to have an A level of evidence include CBTs and medications, specifically selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs), with the strongest evidence from double-blind, placebo-controlled studies