TABLE 471e-3 PRIMARY CARE MENTAL HEALTH SCREENING TOOLS

PC-PTSD Screen

1. Have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:		
Have had nightmares about it or thought about it when you did not want to?	Yes	No
Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	Yes	No
Were constantly on guard, watchful, or easily startled?	Yes	No
Felt numb or detached from others, activities, or your surroundings?	Yes	No

Note: Two or more "yes" responses (three or more a more specific cutoff) are considered a positive screen.

Source: A Prins et al: The Primary Care PTSD Screen (PC-PTSD): Development and operating characteristics. Prim Care Psychiatr 9:9, 2004.

PHQ-2 Depression Screen

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all (0)	Few or several days (1)	More than half the days (2)	Nearly every day (3)
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless.	0	1	2	3

Note: If either (or both) questions are marked 2 or 3 (more than half the days or higher), this is considered a positive screen for depression.

Source: K Kroenke et al: The Patient Health Questionnaire-2: Validity of a two-item depression screener. Med Care 41:1284, 2003.

AUDIT-C Alcohol Screen

3a. How often do you have a drink containing alcohol?				
Never (0)	Monthly or less (1)	Two or four times a month (2)	Two to three times per week (3)	Four or more times a week (4)
3b. How many drinks containing alcohol do you have on a typical day when you are drinking?				
1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7 or 9 (3)	10 or more (4)
3c. How often do you have six or more drinks on one occasion?				
Never (0)	Less than Monthly (1)	Monthly (2)	Two to three times per week (3)	Four or more times a week (4)

Note: A positive AUDIT-C screen is defined as a total score for men ≥4; for women ≥3. A report of drinking 6 or more drinks on one occasion should prompt an in-depth assessment of drinking.

Source: K Bush et al: The AUDIT Alcohol Consumption Questions (AUDIT-C): An effective brief screening test for problem drinking. Arch Intern Med 158:1789, 1998.

for sertraline, paroxetine, fluoxetine, and venlafaxine (of which paroxetine and sertraline received U.S. Food and Drug Administration approval for PTSD). **(See Table 466-3 for recommended dosages.)** Prazosin has also gained very strong evidence recently through randomized placebo-controlled studies for its effectiveness in controlling nightmares as well as global PTSD symptoms, through modulation of the physiologic processes associated with PTSD.

CBT interventions include narrative therapy (often called "imaginal exposure"), in vivo exposure focused on retraining the body not to react to stimuli related to traumatic reminders (e.g., a crowded mall), and techniques to modulate physiologic hyperarousal (e.g., diaphragmatic breathing, progressive muscle relaxation). A number of complementary alternative medicine approaches including acupuncture, mindfulness meditation, yoga, and massage are also being used in PTSD. Although not evidence-based treatments per se, if they facilitate a relaxation response and alleviation of hyperarousal or sleep symptoms, they can be considered useful adjunctive modalities.

There have been no head-to-head comparisons of medication compared with psychotherapy for treatment of PTSD. It is reasonable for primary care clinicians to consider initiating treatment for mild to moderate PTSD symptoms with an SSRI and to refer patients to a mental health professional if there are more severe symptoms, significant comorbidity, safety concerns, or limited response to initial treatment. All PTSD treatments are associated with a sizable proportion of individuals who fail to respond adequately, and it is often necessary to add modalities or switch treatment. SNRIs may be useful alternatives to SSRIs if there has been nonresponse or side effects with SSRIs or if there is comorbid pain (duloxetine, in particular, has indications for pain). Both SSRIs and SNRIs can increase anxiety initially; patients should be warned about this possibility, and treatment should be initiated with the lowest recommended dose (or even one-half of the lowest dose for a few days) and gradually increased thereafter. Antidepressants also are likely to be useful in comorbid depression, which is common in veterans with PTSD. All antidepressants have potential drug-drug interactions that must be considered.

Many other medications have been used in PTSD, including tricyclic antidepressants, benzodiazepines, atypical antipsychotics, and anticonvulsants. In general, these should be prescribed in conjunction with psychiatric consultation because of their greater side effects and risks. Benzodiazepines, in particular, should be avoided in the treatment of PTSD. Studies have shown that they do not reduce core PTSD symptoms, are likely to exacerbate substance use disorders that are common in veterans with PTSD, and may produce significant rebound anxiety and anger. Individuals with PTSD often report symptomatic relief upon initiation of a benzodiazepine, but this is generally short lived and associated with a high risk of tolerance and dependence that can worsen recovery. Atypical antipsychotics, which have gained widespread popularity as adjunctive treatment for depression, anxiety, or sleep problems, have significant long-term side effects, including metabolic effects (e.g., glucose dysregulation), weight gain, and cardiovascular risks.

Sleep disturbance should be addressed initially with sleep hygiene education, followed by consideration of an antihistamine, trazodone, low-dose mirtazapine, or nonbenzodiazepine sedative-hypnotic such as zolpidem, eszopiclone, or zaleplon. However, the nonbenzodiazepine sedative-hypnotics should be used with caution in veterans because they can lead to tolerance and rebound sleep problems similar to those seen with benzodiazepine use.

TREATMENT STRATEGIES FOR CONCUSSION/mTBI AND POSTDEPLOYMENT POSTCONCUSSIVE SYMPTOMS

Concussion/mTBI is best treated at the time of injury with education and rest to allow time for the brain to heal and protect against a second impact syndrome (a rare but life-threatening event involving