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Veterans' and Families' Mental Health

2.00 Contact Hours

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Outcomes

≥ 92% of participants will know how to care for veterans and their families.

We need awareness of the mental and emotional toll serving in the military brings to the service people and their families who serve and protect our lives and our country. As active service transforms into the status of being an honored veteran, emotional and mental trials increase rather than decrease. Returning to a life where those around you have no clue about the hardships and dangers that were once your daily fare and remain ever present, just in the background. Some visible, most hidden, memories and habits may be soul-shattering, enough to fracture and break the minds of many veterans and all too many family members to whom the strain is an unwanted new companion. From awareness can spring hope, care, and partnership with those who want help to bring back to wholeness from wounds still fresh to them.

Objectives

At the completion of this course, the participant will be able to:

1. Describe the current state of mental health in military veterans and their families.
2. Recognize adjustment disorder.
3. Summarize the diagnosis and treatment of stress disorders.
4. Outline three factors of importance in managing a client with suicide risks.
5. List three symptoms of major depression.

Introduction

As of September 2023, there are 2.86 million active service members in the United States (US) military (USAFacts Team, 2024), and 16.2 million living veterans of US military service (USAFacts Team 2023b); that is 6.2% of our adult American population. These men and women, heroes all, have placed themselves in harm's way to protect our country, keep violence from our shores, and further our way of life. As a health professional, I want to say thank you. Thank you for your service and the support of your families, who share the burden of your trials while experiencing their own joy and sorrow.

Going into harm's way is a polite way of stating that there will be frequent risk with hopes for reward, and boredom interspaced with sudden moments of sheer terror. Those experiences change each person facing the perils accompanying military service. Many changes for the better, some for the worse, and all affected gain memories and life experiences that may become intrusive or burdensome.

Table 1. Who Are Considered Veterans?

Title 38 of the United States Code defines a veteran as “a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.”
This includes reservists, members of the National Guard, cadets and midshipmen at military academies, commissioned officers outside the Armed Forces, and those in training for military service.
(USAFacts Team, 2023b)

Mental health is as important, if not more so, than physical health. Just as our minds and emotions control our bodies, injury to our minds and spirits can lead to loss of control and damage critical life functions. There is no way to emphasize enough the crucial role that mental health and mental healing play in the lives of our military, our veterans, and their families.

Together, we will examine some of the more pressing issues related to mental health for military personnel past, present, and those closest to them.

Veterans and Mental Health

59.3 million adults, or 23.1% of the US, possess a mental illness (Duszynski–Goodman, 2024); this is a quarter of our population. This compares with research indicating that as many as half of all military veterans report significant difficulties acclimating to the return to civilian life. According to Mission Roll Call, a nonprofit veteran's service organization, around 41% of veterans need mental services every year (Mission Roll Call, 2024). Be aware, quantifying and categorizing mental health issues in this client base is difficult. Denial of need is, unfortunately, a common view within this demographic. Add in the differences between war and peacetime service, assignments, level of exposure to direct danger and epidemiology in this area will have a fluidity that may offend those of a statistical nature. Please see table 2 for important statistics.

Table 2. Veterans' Mental Health by the Numbers

- 41% of all veterans would benefit from mental health services in any given year.
- Over 40% of veterans struggle with active mental illness and/or substance abuse.
- Fewer than half of veterans returning to our communities that need mental health treatment receive it.
- Over 38% of veterans have a medical code in their record indicating an active mental health disorder.
- Twenty-two veterans commit suicide every day.
- An estimated 30% of those having served in Iraq and Afghanistan have shown mental illness.
- Over 20% of veterans return home with a diagnosis of traumatic brain injury (TBI) and/or post-traumatic stress disorder (PTSD).
- 44% of veterans with significant mental illness have received no treatment for it.
- 92% of veterans with significant substance use impairment have received no treatment for it.

(Mission Roll Call, 2024; The Zebra, 2024; Vankar, 2023)

Conflict and war have always placed a heightened toll on the delicate balance we term sanity. Current conflicts particularly bring us to the brink with multiple deployments into distinctly unfamiliar cultural settings and occurrences that challenge fundamental beliefs about ourselves, our humanity, and the world in which we live.

Exposure to events such as civilians or “friendly” forces suddenly turning violent and deadly or using children as human shields and as mobile platforms for suicide bombs destroys our belief in safety and trust. Death and destruction of communities by their fellow countrymen committed from inconceivable motives shake the concepts of civilized behavior to the very core. Repeated exposures to terror and horror beyond what most civilians will ever see, except in nightmares, are life-changing. It is no wonder many veterans' return home dramatically changed.

The demands and stresses placed on the loved ones of service members are equally intense. Occurrences such as frequent relocation, the chance of sudden deployment, and continual preparation for unwelcome news concerning their loved ones going away to danger zones all take a toll on the mind and body. Add to this the fact that the person they are closest to will, in all probability, return to them differently, if they return at all.

An increase in recognition of mental issues amongst military members, present and past, demonstrates the need for preventive services and ongoing mental and emotional help for active military, our veterans, and the families of service men and women.

Veterans and Adjustment Disorder

One of the most common problems encountered by those leaving active duty is a condition known as adjustment disorder.

Adjustment disorder is an extreme response to the stress of life changes. Marriage, deployment, parenthood, divorce, school, work problems, and many more can initiate adjustment disorder. For veterans and their families, returning to civilian life after service can create stress and uncertainties that result in adjustment disorders for them or their loved ones.

Table 3. Case Study: Glenda

Glenda returned two months ago from her second combat tour. Now home, she is having a tough time adjusting to a life that is different from when she left.

Her husband takes care of their five-year-old daughter and works from home. Recent economic changes mean that he has lost much of his business and is not keeping up the way he had been with work, home, and their daughter.

Glenda struggles with anger at her husband for losing his former clients and tells him he should just find the courage and handle things directly. Their daughter cries when she reaches out to pick her up, and if she disciplines their daughter, her husband intervenes, saying she is expecting too much from the child, leading to sharp words and angry shouting between the adults.

Glenda frequently goes out to “run,” spending more and more time away from home. When

she is home, she sits for hours on end, ignoring what is happening around her. This time, coming home is harder than being away.

Adjustment disorder can happen to anyone coping with a major source of stress. Even when the individual is glad to be home, returning from a deployment is stressful.

Adjustment disorder can happen to the family members the individual is returning home to as well. A military spouse is used to acting independently, handling everything without negotiating or conversing about it and courses of action. Suddenly, having a spouse return adds a major change to what the family is doing and how they are to accomplish it.

Adjustment disorder is a stress-related, typically short-term issue with coping that may occur when a person is faced with a stressful event or situation (Khoddam, 2023). It is common for feelings of distress, discomfort, and emotional/mental turmoil to be present. Ramifications can be considerable, up to and including the potential for suicidal feelings and thinking.

Unusual feelings associated with a change may begin soon after the stress occurs or within three months of the event. These feelings typically resolve when the stressful situation goes away, or the person affected has had an opportunity to adapt to the change, usually within six months.

Symptoms associated with adjustment disorder focus on things that are unusual for that person and may include (Booth, 2024):

- Depressed mood
- Worry
- Sadness
- Anxiety
- Sleep disturbances
- Poor concentration

Many who recovered from adjustment disorder report feeling hopeless and trapped in an unwanted situation with a lack of good options, all while being cut off or isolated from others who would typically be of help.

Treatment for Adjustment Disorder

Because adjustment disorder is typically a time-limited occurrence, treatment focuses on helping to deal with the changes and stresses that are triggering the condition. Support in the form of individual, couples, and group counseling can positively impact the situation and feelings. Medications may serve as short-term help for some symptoms; however, adjustment disorder typically resolves independently with time and support. It is important to realize that a long-term course of pharmacotherapy may not be warranted. Of help in the short term are agents such as:

- Anxiety-lowering agents – benzodiazepines
- Antidepressants – particularly selective serotonin reuptake inhibitors (SSRIs) or serotonin and norepinephrine reuptake inhibitors (SNRIs)
- Plant extracts with medicinal qualities – kava kava or valerian

Traumatic Stress

Stress disorders are a major focus of attention for returning and retired service personnel. Both acute stress disorder and PTSD are real diseases. They are psychiatric conditions with changes in neural functioning that occur when a person has been exposed to overwhelming stress, trauma, or horror. Witnessing or learning of horrific events can set the stage for stress disorder just as readily as the event happening to that person.

For most survivors or witnesses of trauma, life returns to near normal, given time and support. Sometimes, stress reactions refuse to fade, and symptoms move from an acute response to the stress event into a stable and life-impairing condition.

When a sudden, horrific event occurs, it is common for our minds to reel away from the unexpected, unwanted reality. The condition referred to as acute stress disorder may occur as we struggle to make sense of a sudden traumatic event and come to terms with what has happened.

Acute stress responses are reactions that occur within us immediately after a violation of our sensibilities and our perceptions of the world (Scott, 2023). They include such feelings or alterations of perceptions as:

- Dissociation or detachment – that feeling of numbness or being distanced by space from emotions or surroundings.
- Intrusion – the feeling that something unwanted is pushing in on us.
- Negative or dark moods.
- The impulse to avoid situations or persons associated with the event.
- Heightening of our senses and automatic responses, such as startle reflexes.

We are learning that changes in the brain and neural tissues occur during strong stress responses. However, currently, there are no available blood tests or diagnostic imaging studies that can reliably diagnose stress disorders, although exciting research is being done with imaging scan technology. It is important, therefore, to be able to spot acute responses to stress and catch acute stress disorder before it turns into PTSD so that we can better prevent and ameliorate rather than wait to treat a well-established condition.

Veterans and Acute Stress Disorder Diagnosis

Most of us will experience acute stress symptoms at some point in our lives. In general, acute stress progresses through five sets, or phases, of symptoms.

1. Intrusion – re-experiencing events.
2. Avoidance – efforts to avoid thoughts, feelings, and memories of the initiating event.
3. Negative Alterations – in mood and thinking associated with the event.
4. Marked Physiological Reactivity – to people, places, or things associated with the event (e.g., increased heart rate, rapid breathing, etc.).
5. Recovery – of individual functioning over time.

Please see table 4 for more information.

Table 4. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
Diagnostic Criteria – Acute Stress Disorder

The first criterion is exposure to actual or threatened death, severe injury, or sexual violation in one (or more) of the following ways:

- Directly experiencing the traumatic event(s).
- Witnessing, in person, the event(s) happening to others.

- Learning that the event(s) occurred to a close family member or close friend (in cases of actual or threatened death of a family member or friend, the event[s] must have been violent or accidental).
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains or police officers exposed to details of child abuse).

The second criterion is the presence of at least nine of 14 symptoms from any of the five categories—intrusion, negative mood, dissociation, avoidance, and arousal—beginning or worsening after the traumatic event(s) occurred.

Intrusion symptoms include the following:

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s); children may engage in repetitive play during which themes or aspects of the traumatic event(s) are expressed
- Recurrent distressing dreams in which the content or effect of the dream is related to the event(s); children may experience frightening dreams without recognizable content
- Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring
- Intense or prolonged psychological distress or marked physiologic reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)

Negative mood consists of the following:

- Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings)

Dissociative symptoms include the following:

- Altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, or feeling that time is slowing)
- Inability to remember an important aspect of the traumatic event(s), typically resulting from dissociative amnesia and not from other factors (e.g., head injury, alcohol, or drugs)

Avoidance symptoms include the following:

- Efforts to avoid distressing memories, thoughts, or feelings about or strongly associated with the traumatic event(s)
- Efforts to avoid external reminders (e.g., people, places, conversations, activities, objects, or situations) that arouse distressing memories, thoughts, or feelings about or strongly associated with the traumatic event(s)

Arousal symptoms include the following:

- Sleep disturbance (e.g., difficulty falling or staying asleep or restlessness during sleep)
- Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects
- Hypervigilance
- Problems with concentration
- Exaggerated startle response

The third DSM-5 diagnostic criterion for acute stress disorder is that the duration of the disturbance is three days to one month after trauma exposure. Although symptoms may begin immediately after a traumatic event, they must last at least three days for a diagnosis of acute stress disorder to be made.

The fourth criterion is that the disturbance causes clinically significant distress or impairment in social, occupational, or other key areas of functioning.

The fifth and final criterion is that the disturbance cannot be attributed to the physiologic effects of a substance (e.g., a medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and cannot be better explained by a diagnosis of a brief psychotic disorder.

Acute stress disorder may progress to PTSD after one month, but it may also be a transient condition that resolves within one month of exposure to the traumatic event(s) and does not lead to PTSD.

(American Psychiatric Association [APA], 2022)

Table 5 helps to define acute stress disorder and PTSD.

Table 5. Acute Stress Disorder vs. PTSD

• Acute stress disorder occurs immediately after a traumatic event and lasts for days to a month.	• PTSD develops after one or several traumatic events and may last for months or years.
• Acute stress disorder is a short-lived response to trauma.	• PTSD has long-term mental and emotional effects and often requires treatment to resolve.
• Acute stress disorder and PTSD share many symptoms (avoidance, anxiety, flashbacks, etc.), yet acute stress disorder has a shorter duration.	

(Fanai & Khan, 2023)

Acute Stress Disorder Treatment

The focus of treatment following a stressful or violent event is the identification of those persons most seriously impacted and initiating care for emotional trauma. The reduction of continuing stresses must be emphasized; this reduction means pressures from situations or events other than the impacting event and removing ongoing dangers or risks from the event that initiated this situation. Physical safety is important. If possible, relocate the individuals exposed to the stressor. Encourage contact with persons that each victim feels are safe, such as family and loved ones, trusted colleagues, religious support, and healthcare providers. Many acutely stressed individuals feel isolated or cut off from the people around them; this feeling is a normal response, so focusing on social support and a sense of community is important.

It is pertinent to support an individual's self-concept and self-esteem. Let them know that distressing thoughts or feelings will occur and are a normal response to an abnormal event, not a sign of weakness. It is common for survivors of trauma to feel that they are in some way guilty of what happened, so assist with reframing or putting into a proper context the distressing thoughts and beliefs that may occur. Discuss coping mechanisms, or thoughts, behaviors, and habits that a person uses to combat stress, and work to promote healthy coping with the emotions now being felt.

General help measures include the following (Fanai & Khan, 2023):

- Make sure the person is safe.
- Provide emotional support.
- Provide support for practical issues of concern.
- Make sure someone is tasked with follow-up.
- Address potential suicidal ideation.

Medications are important adjuvants to emotional support; however, they will not fix stress problems alone. Use appropriate medications that help to decrease symptoms interfering with function and healing, such as the emotional arousal created by acute stress disorder.

Common pharmacological adjuvants include such items as:

- Beta-blockers.
- Alpha-antagonists.
- Benzodiazepines.
- Non-activating SSRIs (those that are not stimulating or energizing).

Diminish the stress for the individual, including pressure to talk about the trauma and the feelings held. That said, discussing feelings once the patient is ready is an important part of healing.

Therapy choices may include the following (Bryant, 2024):

- Trauma-focused cognitive behavioral therapy (Preferred Choice).
- Patient education.
- Cognitive restructuring.
- Exposure therapy.
 - Imaginal exposure.
 - In vivo exposure.

The good news is that most of those diagnosed with acute stress disorder will find it tends to resolve within the first few weeks after the stressful event. Those who do not find a resolution may be diagnosed with subsequent PTSD (BetterHelp, 2024).

Veterans and Post-Traumatic Stress Disorder Diagnosis

The military often involves extremely high exposure to stress and traumatic events. A 2020 study of the men and women who have spent time in a war zone as military, contracted civilians, reporters, or aid workers, revealed that around 83% go on to experience some degree of PTSD (Statista, 2024).

Stress disorders are complex somatic, cognitive, affective, and behavioral consequences of psychological trauma. Stress disorders are caused by experiencing, witnessing, or being confronted with an event involving significant injury, death, or threat to the physical integrity

of that person or someone close to them. These events are accompanied by a response involving helplessness, intense fear, or horror.

Intrusive thoughts and feelings characterize PTSD, and there are often nightmares and flashbacks of past traumatic events, desires to avoid reminders of the trauma, and the presence of hypervigilance and sleep disturbances. All of these can lead to considerable occupational, social, and interpersonal dysfunction.

It has been shown in assorted studies that a direct relationship can be observed between the severity of a traumatic event and the risk of developing a stress disorder. Prior exposure to repeated traumatic events and such factors as the event's duration, severity, and proximity may also contribute to the degree of stress the individual experiences.

Table 6. Events Often Associated with PTSD Onset

- | | |
|-----------------------------------|--|
| • Military combat. | • Natural Disasters. |
| • Terrorist attacks. | • Serious accidents. |
| • Violent physical assault. | • Sexual assault. |
| • Severe physical injury. | • Incest. |
| • Life-threatening illness. | • Childhood sexual abuse. |
| • Severe motor vehicle accidents. | • Observing or learning about a traumatic event. |
| • Negative media saturation. | |

The initiating events associated with PTSD are the same as in acute stress disorder. PTSD may be considered an extension of acute stress disorder and has acute, chronic, or delayed subtypes.

Acute PTSD typically lasts three months or less, while chronic PTSD symptoms last longer than three months. In delayed-onset PTSD, the symptoms that characterize the condition tend to be unnoticed for at least the first six months following the traumatic event, creating a time-lapse that may make linking the symptoms with an initiating event tricky to isolate.

Table 7. Definition Time

“Complex” PTSD or CPTSD is a newer term used interchangeably for both delayed-onset PTSD (symptoms taking longer than six months to manifest) and the all-to-common ‘hard to diagnose’ disorders that spew a spread of symptomatology across the spectrum of emotional/behavioral/cognitive functioning.

Be aware that CPTSD is not in the DSM-5 but is listed in the World Health Organization’s (WHO) International Classification of Diseases, 11th Revision (ICD-11). The term was developed in the 1990s during research for “Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV Field Trial for Post-traumatic Stress Disorder.” Whether CPTSD arrived too late to make the DSM-5 revision or failed to gain enough support during the cavalcade of expert-led committees delegated to determine version five contents is unknown. What is important is that the undefined term of CPTSD is commonly used, so be aware of it.

Disorders of Extreme Stress Not Otherwise Specified (DESNOS) is another term commonly used.

CPTSD or DESNOS can be argued as being used incorrectly, or at least unnecessarily, for both of its primary uses (delayed and complicated forms of PTSD).

- PTSD, with an onset more than six months from the trigger incident(s), is known in the DSM-5 as Delayed Onset PTSD.
- PTSD with complicating factors may be referred to as DESNOS.

One last word about DESNOS (and the term CPTSD when/if it is used for complex cases): DESNOS all too frequently is birthed from severe, protracted abuse, most notably childhood sexual abuse, victims of torture, or living in a war zone.

(Gore, 2024a; Morales-Brown, 2023)

Research into identifying and treating stress disorders has led to recent changes in diagnostic criteria. In the recently released DSM-5, greater focus is placed on the behaviors that accompany PTSD. Four distinct clusters or groupings of behaviors are proposed as significant indications for diagnosis.

Re-experiencing Behaviors

For example, spontaneously occurring memories of a past traumatic event such as nightmares or recurrent dreams related to an incident or incidents, illusions or hallucinations, flashbacks (the sudden powerful re-experiencing of past events), or other intense, prolonged forms of psychological distress.

Avoidance Behaviors

These take the form of abruptly shying away from or pre-planned evasion of situations that might bring distressing memories, thoughts/reminders of past events, feelings associated with the initiating traumatic experience, or external reminders of the event.

Negative Cognitions and Mood-related Behaviors

These include such items as persistent blame of themselves or others, distorted feelings or overpowering emotions related to events or persons associated with stressful events, estrangement from others, a marked decrease in activities that formerly interested that person, or the inability to remember aspects of what occurred.

Arousal Behaviors

This can be demonstrated by reckless, aggressive, self-destructive behaviors. Sleep disorders, hypervigilance, and the formation of protective habits such as always sitting with a back to the wall, sleeping facing a locked door, etc., are all examples of arousal. Please note that current diagnostics emphasize an element of avoidance or flight from traumatic reminders. A strong flight response or reaction is also typical of the arousal behaviors of stress disorders.

In addition to the presence of key behaviors are three conditions or criteria that aid in diagnosing PTSD. These three criteria are:

- The duration of symptoms for the person has been longer than one month.
- The disturbance causes significant distress or impairment in that individual's functioning.
- The disturbance is not attributable to the effects of a substance or other medical conditions.

While no physical diagnostic tests can readily catch a stress disorder's presence, there are physical signs to notice. The presence of poor hygiene or poor personal appearance, in general,

can be a tip-off to poorly functioning cognitive processes. The presence of unexplained bruises or injuries, such as bruised or lacerated knuckles from punching inanimate objects, and indications of fatigue from poor sleep may indicate difficulties. Heightened startled responses to sudden noises or shadows may be clues as well.

Mental status checks can also be helpful, as an orientation to person and place can be affected by stress disorders. Not knowing the current time or date may reveal where an individual's internal attention is focused. The area most affected by stress disorders such as PTSD is memory. Reports of forgetfulness, particularly in details associated with a specific traumatic event, are frequently reported. Poor concentration with pressured or abnormally slowed speech may also be an indicator. Mood changes are common with stress disorders, as are feelings of generalized nervousness, fear, anxiety, guilt, and depression.

Please be alert for suicidal thoughts or feelings when PTSD is suspected. Changes in mood and struggles with core beliefs brought about by an intense trauma can be difficult for an individual (table 8). A small percentage of stress disorder clients may also become homicidal during the difficulties of dealing with delusional feelings, new phobias, hallucinations, and reliving experiences during flashbacks.

Table 8. Core Beliefs

Core beliefs are the foundational bedrock of our minds. They are the fundamental beliefs about our world, ourselves, and everything around us by which we measure all experiences.
Core beliefs form the rules by which we perceive and interpret what is happening all around us.
Core beliefs typically bypass conscious thought and operate outside an individual's perceptions.

(Schaffner, 2024)

Post-Traumatic Stress Disorder Treatment

The goal of treatment is helping a person come to terms with how they are and who they will be after an extremely traumatizing event. It is impossible to go back in time and make the event not happen or even undo the consequences and results of the event. For this reason, those who have experienced trauma are often referred to not as victims but as survivors of trauma.

Table 9. Example Goals for PTSD Resolution

• Safety and stabilization of symptoms • Resolution of distress with traumatic memories • Reintegration of core beliefs establishing greater function and sense of identity

Coming to a resolution with the trauma often is best facilitated with a combination of medication to lower the impact of symptoms and nonpharmacologic therapies that help reconcile disrupted cognitive and emotional processes.

Pharmacotherapy in PTSD

Pharmacotherapy decreases intrusive thoughts and images, such as flashbacks and hallucinations, while diminishing arousal symptoms like hypervigilance, irritability, and anger. Helping to stabilize mood symptoms such as depression is also important, as is relieving sleep disturbances.

SSRIs are considered first-line medications for treating PTSD, although other categories of antidepressants, such as SNRIs, are occasionally used. Beta-blockers and atypical antipsychotics have been used in conjunction with SSRIs with mixed results (Stein, 2024).

Beta-blockers such as propranolol are used in some stress disorder clients to decrease hyperarousal symptoms. A decrease in exaggerated hyperarousal state and explosive bouts of anger by using beta-blockers needs more research (Stein, 2024).

Atypical antipsychotics and anticonvulsants have both shown some positive effects as monotherapy and an aid to antidepressants (Gore, 2024b). Provider judgment should always preside over individual cases.

Alpha-adrenergic receptor blockers such as prazosin have reduced nightmares and improved sleep for veterans and civilians (Stein, 2024). The use of alpha-blockers has demonstrated an increase in normal dreaming and sleep patterns. Caution should be taken to avoid hypotension or orthostatic hypotensive events when used due to their blood pressure-lowering effect.

Benzodiazepines are typically used for anxiety or hyperarousal symptoms, such as in stress disorders (Mansour et al., 2023). While useful in controlling acute anxiety, be cautious of a tendency toward substance abuse that may accompany stress symptoms.

Nonpharmacological Therapies

Nonpharmacologic therapies provide the mainstay of stress disorder treatment, typically in conjunction with medication used to diminish symptoms.

The goal of treatment is to aid the individual in resolving distressing memories and regaining function following extreme traumatic events. Friends and family are essential to this resolution, and it is also important to support the loved ones of the trauma survivor. Individual and family therapy is often essential. Psychotherapies of use include the following (Mansour et al., 2023; Stein & Norman, 2024):

- Cognitive behavior-oriented therapies
 - Cognitive therapy
 - Cognitive behavior therapy
 - Desensitization/exposure therapy
 - Eye movement desensitization and reprocessing (EMDR)
 - Couples therapy
- Support therapies
 - Mindfulness-based stress reduction
 - Recreation therapy
 - Art therapy
 - Animal therapy
 - Relaxation therapy
 - Anxiety management therapy
 - Coping skills training
- Psychotherapy
 - Psychodynamic psychotherapy
 - Eclectic psychotherapy

- Hypnosis

Cognitive behavior and support-oriented therapies are the mainstays for acute stress disorder and PTSD. Cognitive-behavioral approaches include CBT, exposure therapy, EMDR, and a handful of less commonly used approaches, all of which center on aspects of mental avoidance the survivor has developed toward the past injury or traumatic event. The general premise from which cognitive therapies operate is that the traumatic incident has established a deeply rooted fear response in the mind of the survivor, which in normal instances would, with time, become reconciled with the survivor’s worldview and core beliefs. However, due to the extent of this new conditioned fear response, the survivor of trauma actively avoids any thoughts or situations that remind them of the traumatic event, shying away from the process that would allow healing and reconciliation. This aversive pattern of avoidance occurs unconsciously, though there are also some conscious aspects. It is as though the individual is making every effort to avoid an operation that might heal serious illness, all without being aware of their avoidance and actively slamming the door on any helpful realization; this avoidance makes aiding a stress disorder survivor challenging!

Table 10. Eye Movement Desensitization and Reprocessing

EMDR is a relatively new form of cognitive therapy that uses rhythmic motions to aid in awareness of body sensations occurring during distressing thoughts or remembrances.
Several studies have shown positive results with PTSD clients, although more and better-crafted research is needed.
While thinking of troubling memories or images, the client is guided to pay attention to outside stimuli, such as following a moving light or finger tapping on alternate hands. Discussion of thoughts and somatic feelings follow each session to lower feelings of distress as the sessions progress.
(APA, 2023)

Support-oriented therapies focus on general adaptation and wellness skills, such as functioning in group settings, regaining the ability to manage daily life stresses, and so forth. Please do not dismiss the importance of supportive therapies like recreational play and art therapy. Easing into healthy activities and situations provides an incredible foundation for the mental reconciliation processes within the stress disorder sufferer behind the scenes.

Table 11. Military Sexual Trauma

Often linked with PTSD is the unacceptable phenomenon of rape and sexual abuse among our armed forces and their families. Sexual abuse is much more common than most professionals are aware of, frequently due to pressure on abuse survivors to remain silent, and there are victims of both sexes.

A 2023 annual confidential survey of sexual harassment and assault in the military shows an overall decline compared to previous years. Over 80 percent of military sexual assault victims were male, a number that might seem surprising until reminded that forced sexual behaviors, sexual assault, sexual abuse, and rape have little to do with sex and everything to do with having power and control over the victim.

(Baldor, 2024)

Major Depression in Veterans

The mood disorder known as major depression is both common and disabling. Population studies in more than a dozen countries show that major unipolar depression is active in around 3.8 percent of citizens (Gillette, 2023). The WHO ranks major depression as the eleventh cause of disability and death worldwide (Rush, 2024), and here in the US, major depression ranks second among all diseases and injuries leading to disability.

Veterans of military service and their families are at considerable risk of developing conditions such as depression. Around 11.4 percent of veterans fit the diagnostic criteria for major depressive disorder, with veterans of the Afghanistan and Iraq conflicts running at around 15 percent (Moore et al., 2023).

Depression frequently shows up among active service personnel experiencing stress disorders. Several studies among those with PTSD revealed many show symptoms of depression. The families of service members, particularly spouses, show a higher incidence of symptoms of depression than the general population.

Major depressive disorder, aka unipolar major depression, is recognized when a person suffers at least one episode of severely depressed mood lasting at least two weeks in those with no history of hypomania or mania. Five or more accompanying symptoms should be present to confirm the diagnosis. Symptoms of depression may include the following (APA, 2022):

- Irritability
- Fatigue or lack of energy
- Difficulty concentrating
- Feelings of hopelessness, helplessness, worthlessness, guilt, self-hate
- Social isolation
- Insomnia or hypersomnia (excessive sleeping)
- Loss of interest in once pleasurable activities
- Changes in appetite with weight gain or loss
- Suicidal thoughts or behaviors

Major Depressive Disorder Treatment

Major depression is extremely reoccurring, with an estimated return rate greater than 40 percent. Evidence strongly supports treatment, including medication, psychotherapy, and lasting support measures.

Pharmacotherapy

Pharmacotherapy for major depression begins with the use of antidepressants. The clinician best determines the choice of medication, considering the client's needs. Should a trial of one antidepressant prove unsatisfactory, other antidepressants are available.

Antidepressant types include the following (Rush, 2024):

- SSRIs
- SNRIs
- Atypical antidepressants
- Serotonin modulators
- Tricyclic antidepressants
- Monoamine oxidase inhibitors (MAOIs)

Psychotherapy

Psychotherapy for major depression centers around cognitive behavior therapy and interpersonal psychotherapy, though other available therapies also show efficacy. One good finding from treatment with psychotherapies is that improvement often persists after a course of treatment, leading to what is often lasting relief from serious bouts of depression.

Psychotherapies used with major depression include:

- Cognitive behavior therapy
- Interpersonal psychotherapy
- Behavioral activation
- Family and couple's therapy
- Problem-solving therapy

Supportive Care

Supportive care found useful for major depression includes such things as:

- Guided self-help
- Relaxation and positive activities
- Exercise
- Support groups

Traumatic Brain Injury and Veterans

Traumatic brain injury (TBI) might be the medical area most associated with the recent conflicts in Iraq and Afghanistan; however, it is not just our service members that TBI affects. Traumatic brain injuries are a leading cause of death in North America, accounting for 30 percent of all injury deaths in the US (USAFacts Team, 2023a).

Blows or concussive injuries to the brain occur when the head is suddenly exposed to an explosive wave of pressure or when an object forcefully impacts or penetrates the surface of the head.

Causes of TBI may include yet are not limited to the following:

- Struck in the head
- Nearby blast or explosion
- Sudden abrupt stops or changes in movement

The damage that occurs and the symptoms arising from that damage can range from mild to severe. Mild traumatic brain injury (MTBI) commonly goes by the term concussion. MTBI may lead to a brief loss of consciousness or disorientation, commonly up to 30 minutes. Damage may or may not be visible with imaging studies and can include such symptoms as:

- Headache
- Dizziness
- Blurred vision
- Tired eyes
- Ringing of the ears
- Odd or foul taste in the mouth
- Fatigue or tiredness
- Changes in sleep patterns
- Mood and behavioral changes
- Memory and attention changes

Severe TBI symptoms may include all of those found in mild injuries as well as:

- Headaches, which get worse and fail to go away
- Vomiting
- Nausea
- Convulsions
- Inability to awaken from sleep
- Dilation of one or both pupils of the eye
- Slurred speech
- Weakness
- Loss of coordination
- Confusion
- Restlessness
- Agitation

Diagnostic imaging studies are helpful for diagnosis, revealing skull fractures and evidence of swelling or bleeding into the tissue. When a head injury is associated with loss of consciousness for over 30 minutes or amnesia, health professionals should suspect severe traumatic brain injury.

TBI Treatment

Treatment of brain injury revolves around adequate oxygenation and blood flow to all areas of the brain. Depending on the situation, surgical intervention or conservative treatment can address acute oxygenation deficits and adequate circulation. Treatments can include diuretics, anti-seizure medications, coma-inducing drugs, blood clot removal, repairing damaged tissue, or opening a window into the skull.

Lingering neurological deficits resulting from acute brain injury are very individualized. Some of the more common problems include the following:

- Mental processing – cognition, memory, thinking, and reasoning
- Mood and behavior – depression, anxiety, personality changes, aggression, acting out, and social difficulties
- Communication – understanding, expression
- Sensory processing – hearing, sight, taste, and touch

Rehabilitation post-injury is an important facet of TBI treatment and may include the following:

- Physical therapy
- Occupational therapy
- Speech and language therapy
- Recreational therapy
- Psychotherapy
- Family and group therapies

Depression, PTSD, and suicidal thinking are all associated with TBI and its recovery.

Military-Related Suicide

Service men and women, along with their families, are afflicted with high rates of suicidal thinking and behaviors.

Suicidal ideation, willingly or unwillingly thinking about ending one's life, and suicidal behaviors are the most serious and common psychiatric emergencies worldwide. A recent Pentagon study revealed by USA Today journalist Tom Brook revealed that active-duty military is nine times more likely to die by suicide than by actions from the enemy (Brook, 2024).

The frequency of suicides continues after active duty in the lives of our veterans. Current information shows that the rate of veterans committing suicide runs about 1.5 percent higher than the national civilian average (Adams, 2024). On average, 22 veterans successfully commit suicide each day.

Certain positive factors have been shown to protect individuals from suicidal thoughts. Good social support and family connections are chief among these protective elements. Being a parent or currently expecting a child, possessing a religious faith, and being active in religious activities are all associated with a lower risk of suicide.

Suicide Prevention

The treatment for suicide-related issues with the greatest positive impact on active duty, veterans, and military family members is prevention. Recently, the Veterans Administration and the Department of Defense (VA/DoD) have focused on the early identification of those having difficulties and ways to promote prevention. Warning signs include the following (VADoD, 2024):

- Anxiety, agitation, sleeplessness, or mood swings
- Hopelessness, feeling like there is no way out
- Feeling like there is no reason to live
- Unusual rage, anger, frustration
- Engaging in risky activities without thinking
- Increasing alcohol or drug abuse
- Withdrawing from family and friends

Some warning signs should provoke higher levels of concern; these include the following:

- Self-destructive behavior, such as drug abuse
- Stockpiling or obtaining weapons, strong prescription medications, and items associated with self-harm
- Talking or thinking about hurting or killing oneself

- Looking for ways to kill oneself
- Talking about death, dying, or suicide

Suicide Evaluation

The long-standing advice that asking about suicide initiates suicidal thoughts or actions has been shown to have no support in any well-structured study. What has been shown repeatedly is that many clients, not all, appreciate and welcome the opportunity to discuss disturbing thoughts and suicidal feelings. It has also been found that many suffering from suicidal thoughts would not have spoken of their feelings without questioning prompts from those concerned about them. Please be aware that the best intervention may be a spouse, friend, or health professional having the courage to care enough to ask about suicidal thoughts or feelings.

Several suicide evaluation scales are used; however, none have been associated with a consistently high predictive value. Depression rating tools also show a poor predictive value for suicide. Two tools have shown reasonable success with the risk of suicide screening: the Patient Health Questionnaire-9 (PHQ-9) and the Beck Hopelessness Scale (Murphy, 2023; University of Washington Psychiatry & Behavioral Sciences, 2024).

The following questions may help elicit information concerning the presence of suicidal feelings or a suicide plan.

- “Have you made any preparations for suicide?” (e.g., gathering pills, changing wills, suicide notes) or “How close have you come to completing a suicide plan?”
- “Have you practiced the suicidal act?” or “Have you already attempted to end your life?”
- “How strong is your intent to carry out your suicidal thoughts and plans?”
- “How accessible are your support systems when you have suicidal thoughts?”
- “Do you have a specific method, place, and time to end your life?”
- “Are the means of committing suicide available or readily accessible?” “Do you know how to use these means?”

Management and Treatment of Suicide

Three factors are the focus of managing the acute risk of suicide.

- Reducing immediate risk
- Managing underlying factors
- Monitoring those at risk and follow-up

Reducing the Immediate Risk of Suicide

Reducing the immediate risk associated with strong suicidal feelings is the first step of acute management. Immediate control of stresses and the environment is essential in controlling self-harm actions. This step is accomplished with inpatient psychiatric services, such as hospitalization.

The highest priority is the safety of the client at risk, clients with a plan, and the intent to end their life. In the environment, objects that might be used to inflict harm should be cleared, and possessions should be searched for items that might also be used.

For those with an elevated risk of suicide, yet not an imminent risk, for example, with no specific plan or intent, inpatient hospitalization may not be needed.

Table 12. Suicide Prevention Hotlines

Suicide prevention and veteran support hotlines are important resources that allow 24/7 access to communicate with a nonjudgmental person who can guide those who are suicidal to help and support services.

Veterans Crisis Line

- Dial 1-800-273-8255 and Press 1 to talk to someone
- Start a confidential online chat session at www.VeteransCrisisLine.net/chat
- Send a text message to 838255 to connect to a VA responder
- Connect through chat, text, or TTY if you are deaf or hard of hearing

National Suicide Prevention Lifeline

- www.suicidepreventionlifeline.org Funded by the US Department of Health and Human Services
- 1-800-273-TALK (also chat on the website)
- Spanish language line 1-888-628-9454.

Managing Underlying Suicide Factors

Managing underlying factors takes the form of reconnecting clients with suicidal feelings with close family or friends that can remind the person that they are cared for, have others in their lives, and are not alone. The feeling of aloneness or that everyone would be better off with them dead are common intrusive thoughts. The presence of caring family and concerned friends helps to counter unwanted thinking, allowing time for the underlying cause of negative thoughts to be treated with individual and group therapies.

It is important to remove items that can facilitate suicidal actions, especially if those items or ones like them are in the person's suicide plan. Removing firearms from the access of a person with life-ending feelings is essential, as completed suicide is three or more times more likely when guns are accessible.

Monitoring Those at Risk and Follow-up

Monitoring those at risk and follow-up activities complete the acute care plan. Note the inclusion of following up on what is being done on an emergent basis, as it is not enough to stop one attempt or near-miss suicide act. Unless there is continuing care and the presence of support, suicidal feelings are likely to return.

The practice of "contracting for safety" is a valuable tool to help offset active feelings of suicide. Contracting safety or having the client agree to do themselves no harm helps the client offset the impulse to act on suicidal thoughts. Safety contracts cannot be predetermined, as they must be specific to everyone's needs; however, the idea is that the person promises their caregivers that they will not try to harm themselves when suicidal. Such contracts and an open dialog about what the person feels they should do and how they are currently thinking can aid in building therapeutic rapport and an alliance against suicidal thoughts.

Table 13. Antidepressants and Suicide

In 2003, the Food and Drug Administration (FDA) issued a Blackbox Warning that antidepressants might increase the chance of suicidal thoughts. A more current retrospective review of multiple studies revealed a lack of unambiguous evidence that treatment of depressed persons with antidepressant medications increases their risk of suicidality (e.g.,

suicidal fixation, action to prepare for a suicide attempt, attempt, non-fatal self-harm, or death). Debate on the subject continues.

What is known is that antidepressants may be of some benefit to most of those fighting suicidal ideation. We also know that some studies hint at an age-specific increase in the risk of suicide attempts (non-fatal, self-harm) when persons aged 18–24 expressing suicidal thoughts are placed on antidepressants during the first several weeks of depression treatment.

The same literature reveals no increased risk in persons 25–30 years and what seems to be a lowering of suicidality in persons 31 years of age and older in those same first weeks of treatment with antidepressants.

Remember – clinician discernment regarding each individual and their needs should be the deciding factor regarding antidepressant use for depression in the potentially suicidal.

Heightened awareness by clinicians and family should be present when beginning treatment for depression or suicidal feelings, whether antidepressants are used or not.

(Gupta, 2024)

Suicide Pharmacotherapy

Pharmacotherapy for suicide prevention focuses on treating underlying mood or anxiety conditions. Antidepressants can be helpful; however, there is an underlying concern that in select individuals, their use may increase the chance of a suicide attempt during the first few weeks of antidepressant treatment. Good clinician judgment of the individual and their risk factors is called for with the use of any antidepressant in individuals at higher risk for suicidal thoughts and feelings.

A recent meta-analysis of multiple drug trials indicates that using lithium in clients showing depression (unipolar major depression and bipolar depression) can lower the risk of suicidal actions. The action of lithium, which may create this effect, is not currently known. However, suicidal acts occurred fewer times in clients treated with lithium than in other compounds (Tondo & Baldessarini, 2024).

Following suicidal acts, family, friends, and coworkers may be at an increased risk for suicidal thoughts and feelings, PTSD, major depression, and other anxiety disorders. A need for healing and support in the grieving process is essential whenever there is a loss or perception that a loss is pending.

Grief

Grief is an ugly, gut-wrenching companion to life. Acute grief reactions are painful, mentally and physically impairing, yet very normal and valuable, helping each of us come to terms with new circumstances surrounding our lives after a loss. Bereavement, the loss felt upon the death of a loved one, is frequently the trigger for the grieving process; however, other situations, such as crippling injuries or memory/cognitive losses in a loved one, can also be a starting point for grief.

Differing cultural backgrounds and personalities play a role in how grief is expressed; however, general patterns are recognized, such as acute separation distress or what is referred to as the stress/trauma reaction to acute grief.

Indications of separation distress include:

- Intense longing for, yearning, and seeking proximity to the deceased
- Loneliness, social withdrawal, disinterest in other people
- Painful and contradicting emotions – sadness, crying, guilt, anger, anxiety
- Somatic symptoms include unusual pains, disrupted sleep, loss of appetite, nausea, etc.
- Feeling drawn to items or persons associated with the deceased
- Confusion as to one's own identity and feeling lost or uncertain without the deceased person's presence

Indications of a stress/trauma reaction to grief include:

- Intense disbelief, denial
- Shock, numbness
- Sudden impairment of attention, concentration, or memory

Thoughts and images of a person lost frequently occur in grief. These images may be detailed and vivid to the point of hallucination. The presence of auditory, visual, or tactile illusions indicates an intense longing for the presence of the deceased and can be very frightening. Please remember as caregivers to assure grieving families experiencing these unnerving sensations that missing a person to the extent of feeling their presence can be unsettling yet is not abnormal and tends to be a transient display of how much they miss their lost loved one.

Table 14. Case Study: Yolanda

Yolanda's husband, Henry, received a medical discharge after an improvised explosive device (IED) explosion took his left leg below the knee and caused intracranial bleeding due to concussion forces. Now, three years after Henry returned home, Yolanda finds herself sobbing each night silently after she helps him from his wheelchair into bed. Henry does not remember her; his memories are shattered and vastly different from those of the man she loved and married. The man who came home in many ways was just a shell.

Yolanda felt the acid come up her throat again; the reflux and muscle aches had been with her since Henry came home. She still loved him, yet this was not Henry, was it? She could feel the desire to escape all this, to end the torment in her soul. It was always there.

The loss of a loved one, death or change, is one of the hardest forms of loss we know. Grieving is not limited to the death of loved ones, as any great loss must be reconciled.

Emotional and somatic symptoms, as well as confusion and uncertainty, may all accompany grief. Support from outside, from friends, family, and support groups, are all essential during the struggle to reconcile grief.

The course of acute grief does not follow a specific fixed-order series of stages. Grief is erratic, and the process of adaption to loss is unique for everyone. The course of acute grief tends to run from six to twelve months. For some, the time spent in grief is shortened, and occasionally, the process takes longer. Not feeling grief is an abnormal occurrence of great loss, especially losing

a loved one. The adjustment process of grief promotes a progression from that person being preeminent in our thoughts to their new home of residing comfortably in our hearts.

Please be aware that while the loss of a person may become less sharp with time, feelings about them may never completely resolve. The person is not forgotten and will still be missed, particularly during special times such as holidays, anniversaries, or times of stress.

Grief coping tips:

- Take one day at a time. Long-term planning can wait for a while.
- If you need to plan a funeral, get help yet still be involved.
- If you work, do your best to return to work as soon as possible. It helps to keep busy doing familiar tasks.
- Continue current hobbies or groups and consider taking up new activities while meeting new friends.
- Speak to family and friends about your feelings and thoughts and shared remembrances.
- Find a reason to go out every day. Plan and remind yourself that you have something to do tomorrow.
- Cry. Tears have their place, grieve, and allow feelings out. Be careful not to spend too much time in self-pity; moderation is the key to every success, and you have a precious life yet to live.
- Exercise, eat well, and take care of your health.

Remember, grief is terrible and normal. Group and individual therapies can be helpful, as well as joining face-to-face and online support groups. The best therapy is finding someone else with grief whom you can help through the process.

Conclusion

Our veterans are the “greatest generation,” every generation. They have risked everything for us, and our support of them and their families should be just as giving. It is important to recognize that mental wellness is just as important as physical health. Our minds and emotions control our bodies and interpret everything happening around us. Injuries to the mind and spirit lead to losing control over our lives. Adjustment disorder, stress disorders, TBIs, suicidality, and grief are conditions that require us to raise awareness and give back to those who mean so much to us. Mental health and quality healing play crucial roles in the lives of our active military, our esteemed veterans, and we, the people who love them.

Implicit Bias Statement

CEUFast, Inc. is committed to furthering diversity, equity, and inclusion (DEI). While reflecting on this course content, CEUFast, Inc. would like you to consider your individual perspective and question your own biases. Remember, implicit bias is a form of bias that impacts our practice as healthcare professionals. Implicit bias occurs when we have automatic prejudices, judgments, and/or a general attitude towards a person or a group of people based on associated stereotypes we have formed over time. These automatic thoughts occur without our conscious knowledge and without our intentional desire to discriminate. The concern with implicit bias is that this can impact our actions and decisions with our workplace leadership, colleagues, and even our patients. While it is our universal goal to treat everyone equally, our implicit biases can influence our interactions, assessments, communication, prioritization, and decision-making concerning patients, which can ultimately adversely impact health outcomes. It is important to keep this in mind in order to intentionally work to self-identify our own risk areas where our implicit biases might influence our behaviors. Together, we can cease perpetuating stereotypes

and remind each other to remain mindful to help avoid reacting according to biases that are contrary to our conscious beliefs and values.

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