AUMUNS '26

STUDY GUIDE

UNDER SECRETARY GENERAL: BARAN İNCE & DORUK ŞENTÜRK

ACADEMIC ASSISTANT: ESMANUR ÇAPRAZ

IAAP

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1.1 Letter from the Secretary General

Letter from Secretary-General

Honourable participants,

First order of business, I would like to welcome you all with open arms and utmost gratitude for attending our conference. I truly hope you can find a little solace and comfort with your peers here, as our conference and team truly care about you and we will be trying our best to accommodate you.

I would also like to remind you that we intend to keep everyone involved in a place of safety, and comfort. As we all witnessed the last events in our country, I can promise that those who act out of order will be taken care of and thrown out of the conference immediately.

As the Secretary-General, I offer you a variety of global problems to work on and create solutions accordingly, as it is what boils down to with every Model United Nations conference around the globe. I truly hope this will be a place where you can learn and grow both intellectually and personally. You are in a place where you will be heard, valued, and supported.

What I offered is only possible with an academic team like this, so those who I have in my team should know that I offered their positions accordingly, and knowingly. I expected the best, which they gave in return. I am truly grateful for everyone in my team, and I know for a fact that also our delegates will feel the same way I do.

Those who will be attending a conference for the first time, I hope our conference will get you hooked on MUN conferences and make you expand your horizon as much as you can in order to become a better version of yourselves in every possible area that we can offer. Attending a conference where everyone is your peer might be a little overwhelming but rest assured, me and my academic team, will be here to ensure your careers as MUNers will begin smoothly, and in any occasion that might make you uncomfortable in or outside of our formal sessions, I truly have the greatest organization team that ever existed, so you can rely on them as much as you can rely on me.

I also would like to extend my special thanks to my executive team, Ekin Su Öztürk and Emir Güneş, who gave their incredible efforts to ensure our organization team is spotless, in and out of our conference. Also, Mert Sürücü, for sticking with me throughout this almost five year old journey of MUNing, with an unbelievable amount of ups and downs, and yet we are still here.

I truly can not wait to see you all in AUMUN’26.

Truly yours,
Bedirhan CURA
Secretary General

1.2 Letter from the Under-Secretaries General

Dear delegates, distinguished academic team and fellow participants;

We are honored to welcome you all to the first annual Aksu Aircraft Maintenance Technology Vocational and Technical Anatolian High School Model United Nations Conference (AUMUN'26). As Doruk ŞENTÜRK and Baran İNCE, it's a pleasure to serve you as an Under Secretaries-General of the IAAP committee with our academic assistant Esmanur Çapraz.
We are 12th students in Maya Science and Technology High School & Bahçeşehir Parkorman Campus High School.

The agenda item of the committee, Post-Traumatic Stress Disorder (PTSD), holds a major role in our society as a psychiatric and security issue, which is a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event. These symptoms have a possibility of causing huge damage to the patient and its environment. In this committee, "the impact of PTSD on societal stability and public security" will be our main discussion topic as the agenda item stated as. We highly believe that this guide, as it states, will help your committee roles and processes well-enough.

Lastly, we want to thank the executive team for giving us an opportunity to serve as under secretaries general in this delightful conference and our academic assistant, our magnificent friend, Esmanur Çapraz, for her partnership and existence. We cannot wait to meet all of you personally and we hope you can have a great time with the time you spend in the conference. You can contact us at any kind of situation or problem, do not hesitate to ask us any questions about the committee. See you soon!

Sincerely,

Doruk ŞENTÜRK & Baran İNCE
Under Secretaries-General of IAAP

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1.3 Letter from the Academic Assistant

Distinguished delegates, distinguished academic team, and fellow participants;

It is such a great honor and privilege for me to be serving you as the Academic Assistant of the IAAP Committee. My name is Esmanur Çapraz, and I am currently a student at Antalya Erünal Social Sciences High School. I strongly believe that this study guide has been carefully prepared to support you throughout the committee, and to help you better understand the agenda of the IAAP. I expect all delegates to thoroughly review this guide and come to the committee well prepared, with sufficient knowledge of the policies and perspectives of the country they will be representing. I would like to express my sincere gratitude to our Executive Team for their great efforts for this conference, as well as to our Under Secretaries-General, Doruk Şentürk and Baran İnce, for their leadership and support throughout this whole process. It has truly been a pleasure to work alongside them.

Should you have any questions, concerns, or need academic guidance at any point, please do not hesitate to reach out. I am always happy to assist you. I am very much looking forward to meeting each of you and sharing an unforgettable conference experience together.

Best regards,

Esmanur Çapraz
Academic Assistant of IAAP

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2. Introduction to the Committee

The International Association of Applied Psychology (IAAP) acts as a Non-Governmental Organization under the United Nations umbrella and an Associate Member of the International Social Science Council under UNESCO. As the oldest international association of psychologists, it maintains consultative status with the Economic and Social Council (ECOSOC), allowing it to actively contribute to global policy-making through psychological expertise. IAAP was founded in 1919 by Edouard Claparéde under the name of International Association of Psychotechnics (Association Internationale de Psychotechnique), with the secretary general Jean Maruace Lahy. The present name of the association was adopted in 1955. The current president is Lori Foster, PhD (United States).

IAAP consists of individuals with an expertise in applied psychology. There are over 2,500 members which are scholars, researchers, and professionals in 90+ countries, all aiming for better frameworks and guidelines in the matters of psychology. The diversity of its membership reflects a global commitment to addressing contemporary challenges such as mental health, work-life balance, and

community resilience through evidence-based practices. Every four years, International Congresses of Applied Psychology (ICAP) are organized under the association, with two journals sponsored, Applied Psychology: An International Review and Health and Well-being, both under Wiley publishing. An open access journal, Applied Psychology Around the World, is available on the IAAP website.

The journal is organized around 18 divisions in sub-specialties of applied psychology. These divisions, ranging from Clinical and Community Psychology to Political Psychology, ensure that the association provides a holistic understanding of how psychological principles apply to different sectors of human life. The IAAP Handbook of Applied Psychology, which is the organization's first official publication, was published in 2011 by Wiley and Blackwell, which includes 33 chapters produced by authors from different cultural, linguistic and theoretical backgrounds. By bridging the gap between theoretical research and practical application, the IAAP continues to advocate for the use of psychological science in promoting social justice, sustainable development, and global well-being.

3. Introduction to the Agenda Item

3.1. What is Post-Traumatic Stress Disorder (PTSD)?

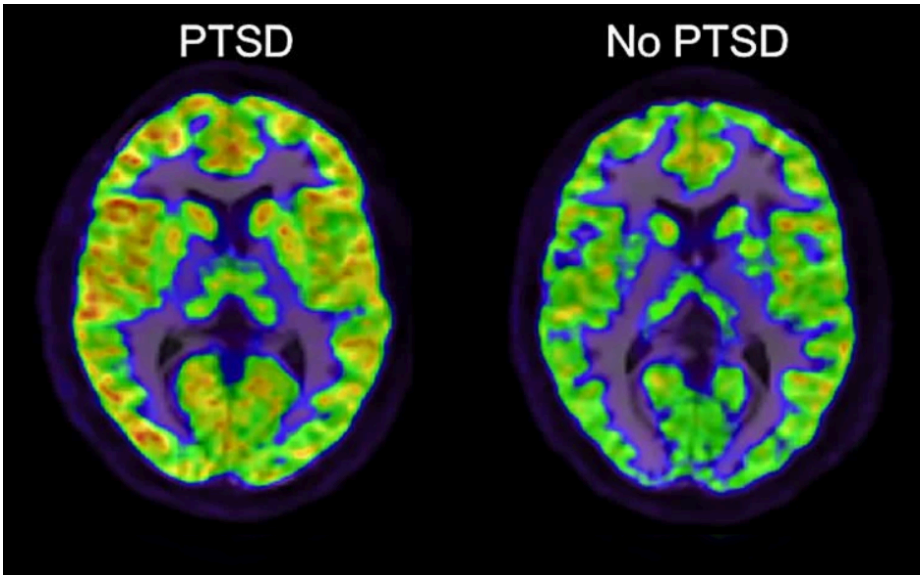
Post-traumatic stress disorder (PTSD) is a psychiatric condition that may occur in people who have experienced or witnessed a traumatic event or series of traumatic events. The individual often experiences the event or events as emotionally or physically harmful or life-threatening. Examples include, but are not limited to, abuse (physical, sexual, emotional), natural disasters, serious accidents, terrorist acts, war/combat exposure, intimate partner violence, and medical illness. However, most individuals who experience traumas do not go on to develop PTSD.

Many people who are exposed to a traumatic event experience symptoms similar to PTSD in the days following the event. However, for a person to be diagnosed with PTSD, symptoms must last for more than a month and must cause significant distress or problems in the individual's daily functioning. Many individuals develop symptoms within three months of the trauma, but symptoms may appear later and often persist for months and sometimes years. PTSD often occurs with other related conditions, such as depression, substance use, memory problems and other physical and mental health problems.

Long after threats fade, the mind stays locked in alert mode, shaped by deep shifts in how nerves and signals work. Because bodies stay tense and emotions raw, daily life twists in ways that push people away from routines or familiar places. Relationships thin out. Work grows harder. Focus slips. Seen across whole

communities, these personal struggles pile up, hospitals stretch, trust weakens, shared sense of safety erodes. When too many carry unseen wounds, quiet ripples become waves that shake foundations meant to hold society together.

PTSD brain scans show measurable structural and functional changes, notably an overactive amygdala (fear center), underactive prefrontal cortex (emotional regulation), and a smaller hippocampus (memory center). These scans reveal that PTSD is a physical change in the brain, not a personal failure, often displaying a "diamond pattern" of high activity.



3.2. Common Symptoms of PTSD

Symptoms of PTSD usually begin within 3 months of the traumatic event, but they sometimes emerge later. To meet the criteria for PTSD, a person must have symptoms for longer than 1 month, and the symptoms must be severe enough to interfere with aspects of daily life, such as relationships or work. The symptoms also must be unrelated to medication, substance use, or other illness. The course of the disorder varies. Although some people recover within 6 months, others have symptoms that last for 1 year or longer. People with PTSD often have co-occurring conditions, such as depression, substance use, or one or more anxiety disorders. After a dangerous event, it is natural to have some symptoms. For example, some people may feel detached from the experience, as though they are observing things as an outsider rather than experiencing them. A mental health professional, such as a

psychiatrist, psychologist, or clinical social worker, can determine whether symptoms meet the criteria for PTSD.

PTSD symptoms are generally clustered around four main categories that alter the individual's perception of the world and paralyze their daily life following a traumatic experience. The most common of these symptoms is the involuntary and repetitive reliving of the traumatic event; this manifests as intense scenes, nightmares, or excessive emotional and physical reactions to cues that remind the person of the trauma, known as "flashbacks," where the individual feels as if the event is happening again in the present moment. Individuals tend to avoid places, people, or even thoughts and feelings directly related to the trauma in order to protect themselves from these painful memories, which constitutes the first stage of social isolation and detachment from community life.

Another important dimension of the psychological process is the negative changes in a person's beliefs and mood regarding themselves, other people, and the world. This situation is often characterized by an inability to remember significant parts of the traumatic event, a constant feeling of guilt and shame, a complete loss of interest in activities that were once enjoyable, and emotional alienation from the environment. Individuals may begin to see the world as a completely dangerous place; this leads to a condition known as "emotional numbing," which causes the blunting of the ability to feel positive emotions such as love or happiness.

Finally, one of the most prominent physical manifestations of PTSD is the state of "hyperarousal." Individuals in this state remain constantly on alert as if an attack could happen at any moment and exhibit an exaggerated startle response to the slightest sound or unexpected movement. Insomnia, sudden outbursts of anger, difficulty concentrating, and a tendency toward risky or self-harming behaviors are direct consequences of this state of hyperarousal. The persistence of these symptoms deeply undermines not only the individual's mental health but also their family relationships, professional performance, and consequently, their capacity to maintain social order.

3.3. The Nexus Between Mental Health and Public Security

Public safety sector workers including firefighters (structural and wildland), law enforcement officers, emergency medical services (EMS) clinicians, and corrections personnel are at a high risk of occupational exposure to traumatic events and stress. As such, mental health programs are critical for addressing the unique challenges these workers face. Effective programs must be multi-faceted, address organizational factors, and focus on building resilience, stress management, post-traumatic stress disorder awareness, and coping strategies. Such programs are critical for recognizing

and addressing how the physical and psychosocial work environment and the organization of work can protect workers' health.

The National Occupational Research Agenda (NORA) Public Safety Sector Council highlighted the importance of mental health programs in its 2019 National Occupational Research Agenda for Public Safety. Objective 6 notes the importance of considering the design of work, management practices, and the work environment in which workers operate to protect and advance worker safety, health, and well-being.

Because mental health issues among public safety workers is a growing concern, the NORA Public Safety Sector Council held a meeting with experts across the public safety sector to discuss efforts to evaluate the effectiveness of existing mental health programs in February 2024. This meeting furthered the Council's conversation on mental health and prevention efforts. During the meeting, presenters described existing approaches to addressing mental health in the public safety sector. A summary of key messages from the meeting follows.

One of the primary reasons for the neglect of mental health in security discussions is the stigma associated with mental illnesses. Historically, mental health conditions have been misunderstood and even feared. This stigma has often resulted in discrimination against those suffering from mental health issues, further pushing these concerns to the peripheries of public and policy discourse. The societal view of mental health as a personal weakness rather than a medical issue has significantly hindered its recognition as a matter of public health and safety.

Society’s views on mental health are changing. More and more people recognize that mental health has a significant impact on overall health outcomes, societal stability, and economic productivity. The concept of human security is also evolving, with more of an emphasis on the protection of individual freedoms and well-being. These factors have helped elevate mental health from a purely medical concern to a broader societal issue. Advances in psychology and medicine in recent decades have illuminated the complexities of mental health disorders. The lack of scientific and medical consensus on mental health issues contributed to their exclusion from health and security policies. Without a clear understanding of the causes, impacts, and treatments of mental disorders, policymakers have been slow to recognize their significance in the context of national and global security.

Economic considerations have also played a role in the neglect of mental health as a security issue. Mental health programs often require substantial long-term investment in healthcare infrastructure, professional training, and public education. In many regions, particularly in lower-income countries, resources are scarce, and immediate physical health crises and economic development priorities take precedence. While these issues are particularly pronounced in the U.S., similar trends can be observed in many Western European nations, as well as developed Asian countries. The prevalence of dementia in Japan, for example, is estimated to be

between 8% and 10%, and has become a critical area of concern for health services and policy makers. The stigma surrounding mental health in Japan is profound, resulting in limited research and data collection that could inform better practices and policies. This stigma affects not only the general population but is particularly acute in the aging population, who may suffer silently from conditions like depression and anxiety.

The societal impact of these mental health challenges is severe, with Japan historically experiencing one of the highest suicide rates among industrialized nations. This rate is notably high among the elderly, who often face social isolation in addition to their health issues. Recent efforts to address mental health more openly are a step toward mitigating this crisis, but much work remains to be done to change public perceptions and improve mental health services. Moreover, the societal norms that pressure individuals to continue working into older age without adequate support for mental health exacerbate these challenges. Japan's approach to mental health care is evolving, with an increasing focus on integrating mental health care with primary health services and community support. However, the implementation of such integrated care models is slow and faces numerous hurdles due to the existing healthcare structure and cultural attitudes towards mental health and aging.

4. Common Medications in PTSD Management and the Possible Adverse Effects

4.1. Selective Serotonin Reuptake Inhibitors (SSRIs)

Selective serotonin reuptake inhibitors (SSRIs) are a class of medications most commonly prescribed to treat depression. They are often used as first-line pharmacotherapy for depression and numerous other psychiatric disorders due to their safety, efficacy, and tolerability. This activity will highlight the mechanism of action, adverse event profile, and other key factors (e.g., off-label uses, dosing, pharmacodynamics, pharmacokinetics, monitoring, relevant interactions) pertinent for members of the interprofessional team in the care of patients with depression and other psychiatric disorders for which SSRIs are indicated.

The therapeutic actions of SSRIs have their basis on increasing deficient serotonin that researchers postulate as the cause of depression in the monoamine hypothesis. As the name suggests, SSRIs exert action by inhibiting the reuptake of serotonin, thereby increasing serotonin activity. Unlike other classes of antidepressants, SSRIs have little effect on other neurotransmitters, such as dopamine or norepinephrine. SSRIs also have relatively fewer side effects than TCAs and MAOIs due to fewer effects on adrenergic, cholinergic, and histaminergic receptors.

SSRIs inhibit the serotonin transporter (SERT) at the presynaptic axon terminal. By inhibiting SERT, an increased amount of serotonin (5-hydroxytryptamine or 5HT) remains in the synaptic cleft and can stimulate postsynaptic receptors for a more extended period.

SSRIs are only available orally and come in multiple forms, including tablets, capsules, or liquid suspension/solution. There are currently no parenteral (IV, IM, SubQ), rectal, or other forms of SSRIs. SSRI administration is typically once-daily medication in the morning or nighttime. Except for vilazodone, SSRIs may be taken without regard to food. Vilazodone should be administered with food.

The popularity and widespread use of SSRIs is due in part to their relatively fewer side effects than prior commonly used antidepressants such as TCAs and MAOIs. SSRIs have little or no effect on dopamine, norepinephrine, histamine, or acetylcholine (except for paroxetine). This characteristic leads to fewer complaints of side effects such as xerostomia, sedation, constipation, urinary retention, and cognitive impairments. Increased tolerability compared to other classes of medications make SSRIs first-line options for their indicated uses. Although relatively safer due to their selectiveness for serotonin, SSRIs are not without risks.

In 2004, the FDA issued a black box warning for SSRIs and other antidepressant medications due to a possible increased risk of suicidality among pediatric and young adult (up to age 25) populations. The risk and benefits of initiating SSRI therapy on acutely suicidal patients must be weighed, keeping in mind that depression itself is a large risk factor for suicidality and requires treatment. Common side effects from SSRIs include sexual dysfunction, sleep disturbances, weight changes, anxiety, dizziness, xerostomia, headache, and gastrointestinal distress.

SSRIs also have the potential to prolong the QT interval, which can lead to fatal arrhythmia, torsade de pointes. Citalopram has correlations with a longer QT duration than the other medications in this class. Coagulopathy also correlates with SSRI use.Although infrequent, as with all medications that increase serotonin activity, it is important to be aware of the risk of serotonin syndrome, particularly when prescribing multiple medications that may have serotonergic effects.

SSRIs are metabolized by and have effects on the cytochrome P450 system. Fluoxetine, paroxetine, sertraline, citalopram, and escitalopram are inhibitors of CYP2D6. Fluoxetine and fluvoxamine are inhibitors of CYP2C19. Fluvoxamine is an inhibitor of CYP1A2.

The effect of SSRIs may take up to 6 weeks before the patients feel the effects of treatment. If patients tolerate the current dose well, the clinician can consider an increase in dosage after several weeks. All patients under the age of 25 should be continually assessed for suicidal ideation and other unusual behaviors, as highlighted in the FDA black box warning for all SSRI medications. For patients with cardiac risk factors, an EKG may be an option to monitor for QT prolongation and arrhythmias. Weight should be regularly measured and tracked to determine any adverse metabolic

changes, and vital signs should also be regularly measured to monitor for adverse changes. Anxiety, insomnia, and sexual dysfunction (delayed ejaculation, decreased sexual desire, and anorgasmia) require regular assessment.

SSRI overdose is relatively infrequent due to their increased safety profile and tolerability compared to other classes of antidepressants. SSRI overdoses are rarely fatal and usually do not have serious consequences. Out of all the SSRIs, citalopram and escitalopram are more likely to cause overdose due to differences in their structures. Citalopram and escitalopram have an increased risk of cardiotoxicity due to QT prolongation, which can progress to serious arrhythmias such as Torsades.

Serotonin syndrome is a life-threatening consequence of increased serotonergic activity. It can result from overdosing on SSRIs or from combining multiple medications that increase serotonin levels. Serotonin syndrome is characterized by mental status changes, autonomic dysfunction, and dystonias. Findings may include agitation, tachycardia, hypertension, hyperthermia, hyperreflexia, tremor, nausea, vomiting, and clonus. Serotonin syndrome may present similarly to neuroleptic malignant syndrome and malignant hyperthermia. This is especially important to keep in mind since commonly prescribed psychiatric medications can cause both serotonin syndrome and neuroleptic malignant syndrome. In general, serotonin syndrome is distinguishable by taking a thorough history. Serotonin syndrome also has a rapid onset and resolution. There is no definitive treatment for serotonin syndrome aside from discontinuing the offending agent, supportive measures, and benzodiazepines for agitation. Cyproheptadine has shown some success in several small studies and case reports for patients who do not respond to initial treatment.

4.2. Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

In the pharmacological treatment of Post-Traumatic Stress Disorder (PTSD), particularly in complex cases that do not respond adequately to first-line treatments such as SSRIs or exhibit more resistant symptoms, Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) stand out as a vital clinical tool. The key distinguishing feature of this drug group is that it provides dual neurotransmitter regulation by blocking not only serotonin levels but also norepinephrine reuptake in the synaptic gap. This mechanism offers a strategic advantage in balancing the amygdala hyperactivity and prefrontal cortex weakness that underlie the neurobiological basis of PTSD. Especially large-scale placebo-controlled studies on Venlafaxine (Venlafaxine ER) have proven that this agent can be as effective as SSRIs, and in some chronic cases even more effective, in treating traumatic re-experiencing (flashbacks) and avoidance behaviors. The activation of the norepinephrine system helps the individual regain their attention mechanisms and cognitive flexibility, while also contributing to the dissipation of the intense "brain fog" caused by the trauma.

The clinical success of SNRI use lies in the simultaneous management of other psychiatric conditions that accompany PTSD and are referred to as "comorbidities." Major depressive disorder, chronic pain syndromes, and generalized anxiety, which are frequently observed in individuals who have experienced trauma, can be more comprehensively managed thru norepinephrine regulation. Especially the efficacy of agents like Duloxetine on physical pain symptoms is a critical factor that enhances the success of treatment for patients with embodied trauma. These medications modulate faulty signals that keep the nervous system's "fight or flight" response constantly activated, enhancing the individual's capacity for emotional regulation. This situation not only leads to individual recovery but also directly affects the patient's ability to adapt to their social environment and fulfill their professional responsibilities. Therefore, when SNRI treatment is considered as a public health strategy, it holds high socio-economic value in terms of preventing workforce loss and preserving family dynamics.

However, the long-term success of these medications depends on the meticulous management of the complex adverse effects and clinical risks they bring. The use of SNRIs can cause common side effects such as gastrointestinal disturbances, dry mouth, and sweating, as well as dose-dependent increases in systolic and diastolic blood pressure due to the increase in norepinephrine. These physiological changes can be perceived as a recurrence of trauma by PTSD patients who already experience palpitations and panic attacks, leading to a "nocebo" effect and causing the patient to reject the treatment. Additionally, due to the generally short half-lives of these medications, missing even a single dose can lead to severe withdrawal symptoms (dizziness, "electric shock" sensations, intense irritability). These risks pose a serious public safety issue, especially in post-conflict areas where access to medication is limited or regular monitoring is not possible; as a withdrawal crisis experienced by an individual who suddenly cannot access the medication can trigger aggression or self-harm tendencies.

In conclusion, while SNRI group medications offer a multifaceted solution for managing PTSD, their application must be conducted within the framework of "trauma-informed care." It is essential that the medication is not viewed merely as a biochemical intervention, but rather positioned as part of psychosocial rehabilitation. Regular monitoring of the patient's metabolic data during the treatment process, providing detailed psychoeducation about side effects, and personalizing dosage adjustments according to the individual's genetic predisposition maximize recovery rates. The role of international organizations like IAAP at this point is to develop standard protocols that minimize the side effects of pharmacological interventions and to organize the safe distribution of these drugs, especially in low-income or war-torn countries. In this way, pharmacotherapy will not just be a method of symptom suppression, but will become a fundamental psychological defense line in the reconstruction of social peace and public safety.

The uncontrolled use or overdose of SNRI group medications can lead to a potentially life-threatening series of toxic effects on the central nervous system and cardiovascular system. The most common and dangerous clinical picture encountered in cases of overdose is "Serotonin Syndrome," which occurs due to excessive serotonin accumulation in the body; this condition is characterized by mental confusion, severe agitation, muscle rigidity, tremors, and uncontrollable high fever. With the excessive blockade of norepinephrine reuptake, the patient may experience severe tachycardia (an extreme increase in heart rate), hypertension attacks, and in rare cases, seizures. Especially the high-dose intake of agents like Venlafaxine can disrupt the heart's electrical conduction system, increasing the risk of fatal arrhythmia. Such acute medical crises not only threaten the individual's physical integrity but also create sudden pressure on emergency services and intensive care resources, straining the operational capacity of the healthcare system.

Evaluating drug overdoses from the perspective of social security and stability deepens the psychological dimension of the issue. Self-harming tendencies or impulsive behaviors observed in individuals diagnosed with PTSD, when combined with substance abuse, can trigger psychotic episodes where the individual's judgment is completely lost or severe confusion (clouding of the mind) states. In post-war regions or societies with weak social support mechanisms, such medical emergencies can turn into difficult crisis moments for law enforcement and first response teams to manage. The unpredictable and aggressive behaviors that an individual under the toxic effects of the drug may exhibit toward the environment pose a security risk that disrupts public order. Therefore, it is a vital necessity for the solutions developed within the framework of IAAP to encompass not only the supply of drugs but also the supervision of their prescription processes and the training of local intervention teams against potential overdose situations, in order to protect public safety.

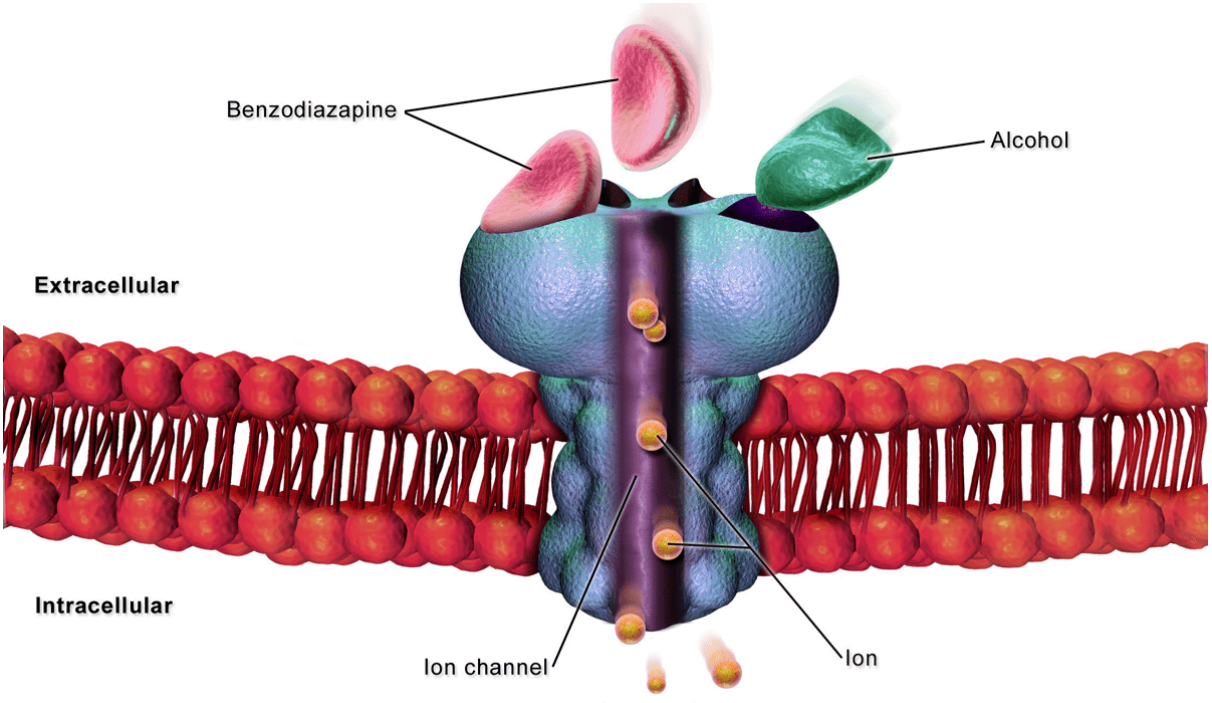
A comparison of serotonin norepinephrine reuptake inhibitors

FEATURE	VENLAFAXINE	DULOXETINE	DESVENLAFAXINE	MILNACIPRAN	LEVOMILNACIPRAN
Year of FDA Approval	1993: IR; 1997: XR	2004	2008	2009	2013
Generic	Yes	Yes	No	No	No
FDA Indications	• Major depression • Generalized anxiety disorder • Panic disorder • Social phobia	• Major depression • Generalized anxiety disorder • Diabetic peripheral neuropathy • Fibromyalgia • Musculoskeletal pain • Osteoarthritis	Major depression	Fibromyalgia	Major depression
Half-Life (Hours)	• Venlafaxine: 5 • Desvenlafaxine: 11 • Venlafaxine XR: 11 • Desvenlafaxine XR: 13-14	12	11	• D-enantiomer: 8-10 • L-enantiomer: 4-6 (overall: 8)	12
Metabolism/excretion	Mainly hepatic (P-450)	Mainly hepatic (P-450)	Partially hepatic, but not via P-450	Minimal hepatic, but not via P-450	Minimal hepatic, some P-450
Metabolites	Desvenlafaxine (o-desmethyl-venlafaxine)	Multiple, but fleeting or inactive	None	None	None
Dosing	• Venlafaxine IR: twice per day • Venlafaxine XR: once per day	Once per day	Once per day	Twice per day	Once per day
5HT:NE Effects	30:1	10:1	10:1	1:1	1:2
5HT/NE	Sequential (5HTthen NE)	Sequential (5HTthen NE)	?	Simultaneous	Simultaneous ?
DA effects	Low affinity	Low affinity	Low affinity	No affinity	No affinity

DA: dopamine; 5HT: serotonin; FDA: United States Food and Drug Administration; IR: immediate release; NE: norepinephrine; XR: extended release

4.3. Benzodiazepines

Benzodiazepines, like alprazolam (Xanax), lorazepam (Ativan), clonazepam (Klonopin) and clonazepam) act on the central nervous system (CNS) and brain. They are known pharmacologically as GABAergic agents, sedative-hypnotics, or minor tranquilizers. Benzodiazepines work by enhancing a very important neurotransmitter called GABA (gamma-aminobutyric acid) at the GABA A receptor. This results in the sedative, hypnotic (sleep-inducing), anxiolytic (anti-anxiety), anticonvulsant, and muscle relaxant properties for which the drugs are prescribed.



Simply put, GABA sends its inhibitory message by binding at special sites called GABA-A receptors on the outside of the receiving neuron. Once GABA is bound to the GABA-A receptor, the neuron opens a channel which allows chloride ions to pass inside of the neuron. These negative chloride ions make the neuron less responsive to other neurotransmitters (norepinephrine [noradrenaline], serotonin, acetylcholine and dopamine) which would normally excite it. Benzodiazepines also bind to their own receptors (benzodiazepine receptors) that are situated on the GABA-A receptor. Combination of a benzodiazepine at this site acts as a booster to the actions of GABA,

allowing more chloride ions to enter the neuron, making it even more resistant to excitation.

Long-term benzo usage can cause what is known as ‘uncoupling’ of the GABA-A receptor. Uncoupling results in a decrease in the ability of BZs to potentiate the action of GABA on GABA-A receptors and in a decrease in the ability of GABA to potentiate BZ binding. This may be due to changes in GABA-A receptor gene expression where the neurons swap out GABA-A receptors that contain subunits benzos bind to with ones that don’t, to combat the action of the drug. FDA information for Ativan states withdrawal symptoms can be experienced by some after as little as one week of use, suggesting uncoupling occurs even with shorter-term use. When the brain’s output of excitatory neurons is reduced, a consequence of the enhancement of GABA’s inhibitory activity caused by benzodiazepines, there may be impairment of certain functions, as the excitatory neurotransmitters are necessary for normal alertness, memory, muscle tone and coordination, emotional responses, endocrine gland secretions, heart rate and blood pressure control and a host of other functions. Other benzodiazepine receptors not linked to GABA are present in the kidney, colon, blood cells and adrenal cortex and these may also be affected by some benzodiazepines. These direct and indirect actions are responsible for the well-known adverse effects of dosage with benzodiazepines. There are also various subtypes of benzodiazepine receptors, all of which have slightly different actions. The alpha 1 subtype is responsible for sedative effects, the alpha 2 for anti-anxiety effects, and both alpha 1 and alpha 2 (as well as alpha 5) for anticonvulsant effects. All benzodiazepines combine, to a greater or lesser extent, with all these subtypes and all enhance GABA activity in the brain.

Benzodiazepine administration may lead to common adverse effects, including, but not limited to, respiratory depression, respiratory arrest, drowsiness, confusion, headache, syncope, nausea and vomiting, diarrhea, and tremors. In neonates, less than 1% of patients treated with benzodiazepines experience laryngospasm and bronchospasm. They may also experience ventricular arrhythmias, including ventricular bigeminy or premature ventricular contractions, vasovagal syncope, bradycardia, or tachycardia. Gastrointestinal reactions may include retching, nausea and vomiting, and excess salivation. CNS and neuromuscular adverse effects may include euphoria, hallucination, ataxia, dizziness, seizure-like activity, and paresthesia. Visual disturbances may include diplopia (“double vision”), cyclic eyelid movement, loss of balance, and difficulty focusing the eyes on objects. Long-term use of benzodiazepines can lead to cognitive impairment. Rare cases of cholestatic liver injury have been reported with benzodiazepines like alprazolam, clonazepam, diazepam, and flurazepam. Hypertension, as well as hypotension, is observed with remimazolam. Monitor the blood pressure during the procedure.

5. Post-War Trauma and Its Multi-Dimensional Consequences

5.1. Civilian Trauma and the Collapse of Social Infrastructure

The relationship between civilian trauma and the collapse of social infrastructure constitutes one of the most critical intersections of modern post-conflict reconstruction and public security studies. For civilian populations, trauma is not only an individual psychological injury but also a systematic erosion of the invisible bonds that hold society together, the "social fabric." Reports from the World Health Organization (WHO) and the United Nations (UN) emphasize that the collapse of infrastructure in conflict zones means not only the destruction of buildings but also the complete erosion of individuals' trust in state institutions and their perception of social security. From a sociological perspective, infrastructure elements such as education, health, and legal systems provide individuals with "ontological security"; when this safety net collapses, individuals enter a constant survival mode, leading to a societal paralysis referred to as "collective trauma." Research shows that the disruption of access to social services amplifies the effects of trauma with a multiplier effect and fundamentally undermines individuals' capacity for recovery (resilience).

The civic trauma that arises with the collapse of social infrastructure leads to the depletion of "social capital," which is one of the greatest threats to economic and political stability. Modern research, based on the work of theorists like Robert Putnam, indicates that in traumatized societies, "trust" is replaced by "suspicion" and "defensive isolation." Civilian populations, unable to access psychosocial support due to the collapse of the healthcare system, tend to express their trauma as social anger or radicalization because they cannot process it. Data published by the Lancet Commission on Global Mental Health reveals that in regions experiencing war and infrastructure collapse, mental health problems are not only a health crisis but also a structural security risk that reduces gross domestic product (GDP) and increases crime rates. Inadequate infrastructure pushes individuals to the margins of society, and this feeling of exclusion creates fertile ground for recruitment by terrorist organizations or marginalized groups; therefore, the absence of a hospital or school essentially means the breakdown of a society's psychological defenses.

One of the most devastating aspects of this process is the intergenerational transmission of trauma due to the lack of social infrastructure. When social infrastructure is functional, a traumatized family can be rehabilitated through state-provided support mechanisms; however, in a scenario where infrastructure collapses, trauma directly impacts parenting styles and child development. Field

studies conducted by organizations such as the Yale Child Study Center show that children growing up in societies with collapsed post-conflict infrastructure suffer from cognitive developmental disorders due to "toxic stress," and these children have a higher propensity for violence in adulthood. This situation poses a lasting threat to social stability, not only for the present but also for decades to come. When the civilian population, emerging from the protective umbrella of the welfare state, begins to establish its own security and justice mechanisms, the concept of "the rule of law" gives way to "the justice of the powerful," opening the door to chaos resulting in the complete disintegration of public security.

Furthermore, the collapse of physical infrastructure (electricity, water, transportation) deprives individuals of the ability to perceive the world as a "predictable place," which is a major factor in the chronicity of post-traumatic stress disorder (PTSD). In a civilian population living in constant uncertainty, the nervous system is under a constant state of "threat perception." This leads to a decrease in empathy within society and an increase in aggression towards groups perceived as "the other." Data from modern conflict zones such as the Balkans, Syria, and Ukraine prove that each day that social institutions (courts, municipalities, social welfare organizations) remain dysfunctional, further erodes society's ability to coexist peacefully. Consequently, the treatment of civil trauma is not merely a clinical process but a massive state and societal project requiring the reconstruction of social infrastructure, justice, and institutions through a "trauma-informed" approach. Trying to improve individual mental health without repairing the social infrastructure is no different than restoring a building without a foundation.

The most important point emphasized by IAAP and similar international organizations is that "sociopolitical rehabilitation" must be carried out simultaneously with psychological rehabilitation. If a state or international mechanism wants to rebuild a society, it must begin with the society's "trust infrastructure" before physical buildings. The most basic needs of traumatized civilians are to know that they have access to a fair legal system, accessible healthcare, and a safe educational environment for their children.

One of the most comprehensive scientific studies examining the tangible effects of civic trauma on social infrastructure is the research series conducted by Natascha Korf and deepened in the World Bank's "Social Capital and Violent Conflict" reports. These field studies, particularly conducted in post-conflict regions such as Sri Lanka and Rwanda, have revealed with concrete data the devastating impact of the collapse of social trust and institutions on social capital. The key findings of the research show that the severe trauma experienced by individuals largely destroys the "bridging social capital" that permeates the entire society. As a result, it has been found that individuals only take refuge in their own narrow family or tribal structures, meaning that "bonding social capital" has become excessively strong. In the Rwandan example, it was determined that the trust of the civilian population in state institutions and

different social groups decreased by 70%, and this loss of trust created a collective defense mechanism in society. These scientific data have demonstrated that in scenarios where civic trauma is not rehabilitated and social infrastructure is not repaired, large segments of society become disconnected from a shared ideal of the future, and this disconnection increases the likelihood of violence recurring in post-conflict areas by approximately 40%. Therefore, this study provides a scientific basis for why the construction of trauma-focused social institutions, rather than the construction of a society's physical buildings, should be a primary priority for public safety.

5.2. Displacement and the Refugee Crisis as a Traumatic Catalyst

Forced displacement and refugee crises are defined in modern psychology not merely as a displacement event, but as a multi-layered traumatic catalyst that disrupts the psychological defense mechanisms of both individuals and society. Data published by the United Nations High Commissioner for Refugees (UNHCR) shows that the number of forcibly displaced persons worldwide has reached record levels; therefore, it is necessary to address the process experienced by these groups within the framework of the "triple trauma paradigm." This paradigm argues that trauma begins with the initial event in conflict zones, deepens with the struggle for survival during the migration journey, and becomes chronic with the uncertainty, discrimination, and cultural adaptation difficulties in the countries of refuge. This situation, referred to as "acculturation stress" in academic literature, results in the loss of the individual's identity and sense of belonging, becoming one of the most fundamental factors increasing the severity of PTSD symptoms.

In the context of the refugee crisis, trauma transcends being merely an individual health problem and functions as a systemic pressure element that directly impacts social cohesion and public safety. A comprehensive meta-analysis published by the Journal of the American Medical Association (JAMA) and conducted by Steel et al. reveals that PTSD prevalence rates in populations that have experienced conflict and forced displacement may be ten times higher than in the general population. This high trauma burden places a huge cost on social services and health systems in the host countries; it also triggers the risk of "marginalization" when combined with structural barriers such as language barriers and economic exclusion. In scenarios where trauma is left untreated and refugees are not integrated into society in a healthy way, the intense feeling of isolation experienced by these groups fuels social polarization and creates a safety net where radical movements can find fertile ground.

One of the most devastating effects of the displacement process is the disintegration of social networks and family structures that provide an individual's "ontological security." Research in the field of social psychology indicates that the feeling of "loss" experienced by refugees is not only the loss of physical property, but also the loss of social status and future projections. This situation traps the individual in a cycle of constant uncertainty and helplessness, paralyzing the healing process of post-traumatic stress disorder (PTSD). Particularly in individuals living in camps for extended periods or under temporary protection status, "liminality" acts as a catalyst, keeping the effects of trauma alive. During this process, the deprivation of basic rights such as education and employment makes it difficult to process traumatic memories and leads to a chronic wave of unrest that threatens social stability.

As a concrete example of research, field studies conducted on Syrian refugees following the large wave of migration to Europe in 2015, detailed in "The Lancet," reveal the psychological cost of displacement in numbers. According to this research, only 20% of PTSD and severe depression cases among refugees were directly caused by the war, while the remaining 80% were directly linked to the migration process and subsequent poor living conditions. This data scientifically establishes that displacement itself is a source of trauma, and that public security policies should focus not only on border security but also on the psychosocial well-being of refugees. For organizations like IAAP, these findings demonstrate why a trauma-focused integration policy is not only a humanitarian duty but also a strategic necessity for maintaining global security.

6. PTSD as a Public Security Threat

6.1. Link Between Untreated Trauma and Violence/Crime Rates

Trauma and crime are intricately connected phenomena, with trauma often serving both as a precursor to criminal behavior and as a consequence of it. Within the field of forensic psychology, understanding the nuanced relationship between trauma and crime is essential for effective intervention, assessment, and rehabilitation of individuals entangled in the criminal justice system. Psychological trauma, particularly in early developmental stages, can profoundly alter the course of an individual’s life, increasing vulnerability to both victimization and perpetration of crime.

Numerous studies have established that Adverse Childhood Experiences (ACEs), including physical abuse, emotional neglect, sexual assault, and exposure to domestic violence, significantly elevate the risk of later involvement in criminal activities. These traumatic experiences disrupt the development of critical emotional regulation skills, impair attachment patterns, and can lead to maladaptive coping mechanisms such as substance abuse or aggression. As a result, individuals with a history of trauma are more likely to engage in impulsive and risk-prone behaviors, which can culminate in criminal conduct.

Furthermore, trauma impacts the neurobiological systems that govern stress response, including the Hypothalamic-Pituitary- Adrenal (HPA) axis. Dysregulation of this system can lead to heightened reactivity, hypervigilance, and difficulty distinguishing between safe and threatening situations. For some individuals, this persistent state of psychological arousal may lead to reactive violence or criminal behavior under perceived threat. In forensic evaluations, it is important to assess not just the presence of trauma but also its developmental timing, severity, and cumulative effects.

On the other side of the spectrum, criminal acts can themselves be a source of trauma. Victims of crime often suffer from Post- Traumatic Stress Disorder (PTSD), anxiety, depression, and other psychological sequelae. The experience of being a victim may not only disrupt the individual's sense of safety but can also result in long-term emotional and behavioral consequences. Additionally, perpetrators of crime may experience trauma during the act or from the repercussions that follow, such as incarceration or social isolation. In such cases, the cycle of trauma is perpetuated and passed on intergenerationally, especially when children witness or are affected by the criminal actions of caregivers. The prison environment often exacerbates pre-existing trauma or introduces new traumatic experiences, further complicating the psychological rehabilitation of inmates. High rates of untreated trauma among the incarcerated population highlight the need for *trauma-informed care* in correctional settings. Therapeutic approaches such as Cognitive- Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), and Dialectical Behavior Therapy (DBT) have demonstrated efficacy in addressing trauma-related symptoms and reducing recidivism.

Forensic psychologists play a vital role in evaluating trauma histories, assessing risk, and recommending appropriate treatment and legal outcomes. A *trauma-informed approach* in forensic assessments considers how past victimization or trauma exposure may have influenced an individual's mental state at the time of the offense, capacity for rehabilitation, or risk of reoffending. Courts are increasingly recognizing the mitigating effects of trauma, particularly in juvenile justice proceedings, where developmental factors are given greater weight. Research in forensic psychology continues to explore the mechanisms linking trauma and crime, emphasizing the importance of early intervention and prevention strategies.

Community-based programs that provide support to at-risk youth, *trauma-informed policing practices*, and rehabilitation initiatives focused on healing rather than punishment all contribute to breaking the trauma-crime cycle.

6.2. Trauma as a Recruitment Tool in Radicalization and Extremism

The challenges involved in preventing domestic radicalization and violent extremism include the fact that people who are radicalized or engage in violent extremism often have experienced trauma and have mental health conditions. Research suggests that for some individuals, these issues may contribute to their involvement in domestic radicalization or violent extremism. For example, a person's vulnerability may lead them to an ecological niche where recruiters offer a supposed better path. Fortunately, only a small minority of people with trauma exposure and mental health issues have taken such a path, and many others do so without any apparent trauma or mental health concerns. Nonetheless, attending to these issues could prove fruitful in preventing radicalization and extremist acts.

Law enforcement, governments, and communities have increasingly employed innovative approaches when responding to individuals involved in domestic radicalization and violent extremism. They have learned that they can further prevention efforts by better attending to trauma and mental health. Yet questions remain regarding the effectiveness and scalability of such approaches. Moreover, law enforcement, government, and community responses may inadvertently exacerbate trauma exposure and mental health issues for some individuals in ways that can complicate efforts to prevent radicalization.

Understanding and addressing the complexity of trauma exposure and mental health issues relative to domestic radicalization and violent extremism remains a major challenge. Multidisciplinary research can help unpack this complexity. This article discusses three studies funded by the National Institute of Justice (NIJ) that illustrate how trauma and mental health issues are neither necessary nor sufficient to explain domestic radicalization and violent extremism.However, when present, these factors can have a significant yet varied impact across the violence prevention spectrum. This knowledge, along with additional perspectives based on trauma-informed care, can help strengthen programs and policies and guide recommendations.

7. Past Actions and International Framework

7.1. UN Security Council Resolutions on Mental Health and Peacebuilding

Security on the global stage once focused only on politics and armed conflict, yet lately attention has turned to how inner emotional strength shapes lasting peace. Nowhere is this clearer than in recent official decisions embedding mental wellness support within peace efforts worldwide. In 2022, all members agreed on Resolution 2668, a turning point, marking the first time troops' psychological struggles were formally noted at such high levels. Serving amid chaos and danger leaves deep marks, the document observes, subtly weakening mission outcomes when left unaddressed. Because of this, countries and top administrators are urged to weave strong mental care systems throughout every phase: preparation, service, return. The well-being of those deployed now quietly stands linked to whether peace initiatives endure or unravel.

Mental health finds its place within peace and security largely due to the Youth, Peace, and Security framework, shaped by Resolutions 2250 (2015) and 2535 (2020). Though frequently overlooked, young individuals tend to carry lasting emotional wounds from war, yet simultaneously hold power to reshape communities. Because of this duality, Resolution 2535 directly calls for psychosocial aid where violence has occurred or just ended. When trauma goes unnoticed in younger generations, isolation grows; so does despair, opening doors to radicalization or renewed fighting. Since healing supports stability, the Council sees mental health and psychosocial services not as optional charity, rather as prevention rooted in foresight. Through such care, trust forms more easily, allowing youth to step forward in reconstructing what was broken. What emerges is less about relief, more about laying groundwork for lasting connection across fractured groups.

Starting off differently, the Women, Peace, and Security (WPS) framework has opened doors to confronting emotional harm caused by wartime sexual abuse. Though early progress came through Resolution 1325 (2000), pushing for female involvement in peacemaking, later momentum emerged under Resolution 2467 (2019), spotlighting care centered on those who survived violence. Instead of generic responses, this measure insists on fair access to full mental health aid for people harmed during war. Because shame tied to assault often deepens wounds, affected individuals may face long-term separation from home, blocked from returning. With its emphasis on counseling and emotional recovery, the Council now treats healing inner distress as key - not only for personal revival but also for rebuilding fairness after fighting ends.

In the end, the idea of "Sustaining Peace", laid out in two joint Resolutions 2282 (2016) passed by both the Security Council and the General Assembly, forms the main structure guiding current actions. Rather than seeing peace as an outcome, this document treats it as something built steadily, starting well before violence ends and continuing long afterward. Instead of isolated projects, what's needed now is a connected strategy targeting deep reasons behind recurring conflicts, such as the emotional scars and broken trust left by shared suffering. Highlighted within the text, the Peacebuilding Commission (PBC) gains renewed purpose, positioned as central to aligning diverse initiatives while pushing for mental health and psychosocial support systems (MHPSS) to be part of rebuilding plans at country level. Together, these agreements signal a shift: quiet streets do not mean safety returns when people still carry invisible wounds from past violence.

7.2. WHO Mental Health Action Plans

One hundred ninety-four countries agreed under the WHO Comprehensive Mental Health Action Plan 2013–2030 to work toward better mental health outcomes while supporting broader global goals. Because it rests on a shared hope: living in a society that respects, supports, and safeguards emotional well-being. In such settings, prevention takes root, mental conditions are addressed early, people recover, their dignity remains intact. Progress hinges on four clear aims shaping policies across borders. Stronger oversight and decision-making systems form the starting point for change within nations. This process begins with shaping national policies, strategies, and legal frameworks rooted in global human rights principles. Because effective change requires more than intent, sufficient funding must be directed toward these initiatives. Coordination across different areas, education, work conditions, legal systems, and support networks, becomes essential when tackling the broader causes of mental distress. When responsibilities extend beyond healthcare alone, outcomes often improve simply due to wider engagement. Mental well-being gains traction only if multiple societal layers take part.

A main aim of the strategy involves offering complete mental health and social support within local environments, blending services so they respond directly to community needs. Instead of relying on big psychiatric institutions, care moves closer to everyday health systems like clinics and general hospitals. Being treated near home helps lower negative perceptions tied to long-term hospital stays. Emphasis grows on recovery, not just managing illness, but helping people meet life targets, whether it is work, shelter, or joining social circles. Linking mental well-being with routine medical care seeks to reach those currently missing out, especially where help for emotional struggles remains scarce.

Working toward better mental health through preventive steps forms the third goal of the worldwide strategy. Life experiences, biology, and surroundings shape psychological well-being at every stage. Early help for young kids involves visits to

expecting mothers and offering emotional care to at-risk households. Programs in schools aim to strengthen how youth manage feelings and relationships. Suicide prevention receives special attention due to its serious impact on population health. One way to address suicide is limiting how easily someone can act on it. Media coverage that avoids sensationalism plays a role too. People at risk need support spotted early, followed by proper care. Efforts to reduce stigma matter because they shift attitudes. When discrimination drops, reaching out for help becomes less intimidating. Safety grows where acceptance exists.

Strengthening information systems, evidence, and research in mental health forms the last goal of the WHO action plan. To work well, policies need reliable data alongside findings from science. Countries are supported in building stronger skills when gathering, studying, or applying mental health statistics - helpful for tracking movement toward set aims, both within nations and worldwide. Research into why mental conditions occur, how they might be avoided, or ways to treat them gains emphasis here. Attention turns especially toward regions with fewer resources, where numbers and insights about mental health remain limited. One way to improve global responses is by gathering strong data on what actually works in practice. When people share insights across borders, lessons from one region might reshape strategies elsewhere. These four goals together point toward real shifts in how societies support mental well-being. With enough momentum, progress in mental care could finally match attention given to bodily health worldwide.

8. Case Studies

8.1. Post-Apartheid South Africa

The Apartheid regime that ruled South Africa from 1948 to 1994 is defined as a legal and systematic mechanism of oppression based on racial discrimination. During this period, the political, social, and economic rights of the non-white population were systematically restricted; the social structure was sharply divided. The first democratic elections held in 1994 and the election of Nelson Mandela as president are considered the biggest steps the country took toward the ideal of a "Rainbow Nation." However, the completion of the political transition does not mean that the deep scars left by the regime on collective and individual memory have been erased.

Established in the post-apartheid era to ensure social peace and reconciliation, the Truth and Reconciliation Commission (TRC) aimed to uncover past human rights violations and give a voice to the victims. The Commission's work has revealed that the Apartheid regime caused severe psychological damage to individuals not only thru physical violence but also thru dispossession, humiliation, and systematic exclusion. In this process, the cases of Post-Traumatic Stress Disorder (PTSD) observed in the

oppressed masses have not been limited to individual experiences but have become a "collective trauma." The systematic violence perpetrated by the regime has made PTSD symptoms such as anxiety, depression, and involuntary recollections of the past (flashbacks) chronic for a large portion of the population.

In South Africa, the healing process of trauma is quite complex due to the continuation of economic inequalities and structural issues. Although political freedoms were gained in the post-apartheid era, high unemployment rates, poverty, and incidents of social violence continue to exist as environmental factors triggering the recurrence of trauma. This situation leads individuals to remain in a constant state of "hyperarousal" not only due to past violent events but also because of current socio-economic uncertainties. Therefore, in the South African example, PTSD is not only considered a clinical condition related to the past but also a dynamic process fueled by contemporary social instability.

Psychosocial rehabilitation in post-apartheid South Africa should be seen as an integral part of political reforms. The psychological wounds inflicted by the systematic oppression the society has endured can only be healed thru the effective functioning of justice mechanisms and the implementation of trauma-focused social policies. Confronting the trauma of the past is not only a historical responsibility but also a vital step that must be taken to protect the social stability and public safety of future generations.

8.2. The Long-Term Impact of the Vietnam War on US Society

The Vietnam War (1955-1975), or simply the Vietnam War, is also known as the Vietnam War Against the United States, the Second Indochina War, and the Second Vietnam War. Vietnam was a French colony before World War II, and after the surrender of Japan, Vietnam was eventually divided into "South Vietnam" and "North Vietnam" under the influence of various forces. Since then, the two sides have experienced border incursions and armed conflicts. At first, the United States did not directly intervene in the conflict between the two countries but provided material support and military assistance to the South Vietnamese regime. However, with the destabilization of the South Vietnamese regime and the gradual disadvantage of the U.S.-backed South Vietnam in the political and armed conflicts between the two countries, the U.S. economic subsidies and military assistance to South Vietnam gradually escalated. As the war escalated, the U.S. began to directly intervene in the war, but the U.S. intervention did not have a positive impact on the war, as time went by, the battle line was gradually stretched, the U.S. invested a large amount of money in South Vietnam, the army. But in the process, the United States did not occupy any

strategic advantage and even can be said to have had no progress, and a long time of capital investment and military service policy of the wrong implementation of the United States nationals are very dissatisfied. Finally, in 1973, the United States troops withdrew from South Vietnam, North Vietnam in 1976, the complete reunification of Vietnam, the formation of the new Socialist Republic of Vietnam. The Vietnam War was declared officially over.

During the Vietnam War, there was strong discontent within the American domestic community. There were two main reasons why the U.S. domestic community was dissatisfied with the U.S. military action against Vietnam. First, the United States in military operations against Vietnam for the first time in the form of live broadcast presented to the domestic public, but due to the United States did not achieve the original expected results, the United States intended to show the military's strong, as well as the control of the war situation, but in fact, the U.S. military in the Vietnam battlefield did not make effective progress, but instead there are this huge casualties and losses, with the advancement of the war, the United States has never abandoned As the war progressed, the U.S. never gave up on Vietnam and was still paying for it in terms of military funding and troop replenishment, which led to strong protests from the American domestic public. The second reason was that many Americans believed that the U.S. intervention in the war was wrong.

Under the pressure of domestic public opinion and enormous economic pressure, the withdrawal of American troops from Vietnam in 1973 signaled the complete withdrawal of the United States from the Vietnamese civil war and its non-interference in Vietnamese politics. On July 2, 1976, North and South Vietnam were reunited, and the U.S. war deployment in Vietnam was declared a failure. As a Proceedings of the 2nd International Conference on Interdisciplinary Humanities and Communication Studies' result, the U.S. suffered a great blow both internally and externally. Within the United States, antiwar marches and waves led to a negative attitude towards the government. The Vietnam War was the longest war in American history. Over ten years of the Vietnam War cost the United States at least two hundred and fifty billion dollars. From an external point of view, it was not just a loss of the war for the United States, but also a turning point in the Cold War when the United States and the Soviet Union confronted each other. The Vietnam War changed the Cold War in some ways, as the U.S. loss in Vietnam led to the strengthening and expansion of the ideology of Soviet Communism, and to a certain extent weakened U.S. dominance over the Third World. The U.S. war also consumed many human resources according to the website National Archives, statistics show that the U.S. in Vietnam as of 2008, according to statistics, there were 58,220 deaths, while another source shows that the number of deaths from 1960 onwards has risen sharply every year, the highest figure in 1968 deaths reached 16,899. This side projection shows that the US military was relatively passive during the Vietnam War and shows the failure of the US in this military operation. Also, the negative effects were that the Vietnam War exacerbated racial and civil rights issues within the United States, the anti-war

movement made the national system fragile and led to a disconnect between the American popular level and the governmental level, as well as creating a lot of discontent amongst the American masses, which had a great negative impact on the American society.

8.3. Modern Conflicts: Syria and Ukraine

The on-going Syrian conflict began in 2011 as a civil uprising rooted in the Arab Spring and escalated to an armed conflict with targeted strikes on healthcare facilities and personnel, terrorism, and chemical attacks. During the course of the conflict, at least 400,000 Syrians have lost their lives, and 5.6 million refugees out of a pre-war population of 22 million were displaced from Syria. The United Nations initially described the Syrian conflict as the "worst man-made disaster the world has seen since World War II", but has since released a blank statement, signalling that words can no longer describe the crisis in Syria.

The Syrian conflict has widespread consequences on civilian health and well-being beyond mortality and displacement. Due to widespread destruction of health care facilities, progress in infant mortality has reversed, infectious diseases have been on the rise, and patients with chronic diseases have lost access to treatment. The damage to residential buildings and food distribution systems disrupt the basic needs for shelter and food. Exposure to war-related brutality is a salient risk factor for debilitating psychological conditions, with long-term impact that usually persists beyond the course of the war. Armed conflicts also destroy families and communities and force civilians into displacement, thus severely compromising social capital. Based on prior findings from major disasters, younger age, being female, exposure to the conflict, and lack of social support are additional risk factors for well-being decrease. However, objective assessment of population well-being is obstructed by the unprecedented "weaponisation of health care" (i.e., the denial of access to health care as a strategy of war). Therefore, Syrians' self-reported well-being could be particularly relevant to measuring an important aspect of the impact of the conflict. Based on the World Health Organization's holistic definition of health, we sought to assess the changes in self-reported physical, mental, and social well-being and to characterise well-being by sex, age, social support, and exposure to the conflict.

Although a large corpus of research has focused on individual major population events, comparison across different events is rarely conducted. Notably, in mental well-being research, studies have found little to no long-term decrease following the 2007-2008 global financial crisis, 2011 Fukushima disaster, or 2015 Paris terrorist attack. These findings give evidentiary support to an influential hypothesis in the psychology literature that life circumstances may play a limited role in changing

long-term well-being. However, these findings do not appear to be consistent with empirical research on disaster and health. To clarify such apparent divergence, researchers adopted a global perspective to evaluate the changes in well-being in Syria relative to the rest of the world, including comparisons with other countries' experiences with armed conflict, social unrest, and natural disasters.

The ongoing Russia-Ukraine War is the largest conventional armed conflict in Europe since World War II. Since Russia's full-scale invasion of Ukraine in 2022, the frontline stretches more than 3000 km, with 1000 km of active combat line. Even though the current number of active military personnel on both sides exceeds one million, Russia asymmetrically possesses a tenfold superiority in terms of weaponry and firepower. The mobilization of half a million civilians during the initial months of the full-scale invasion posed significant challenges to effective military preparation and training. The dynamics of warfare, characterized by intense combat and the introduction of novel weaponry, have given rise to new forms of mental maladjustment, stemming from insufficient military defense and a lack of relevant prior combat experience among recruits.

This war has not only reshaped the geopolitical landscape but has also illuminated the profound psychological toll that such warfare exacts on the military. Ensuring the mental fitness and overall well-being of Ukrainian military personnel is of critical importance, as sustained physiological and psychological stressors can adversely affect motivation, and might cost lives of many. Service members deployed in frontline operations frequently encounter traumatic experiences, including combat situations, alongside persistent chronic stressors such as harsh field conditions, sleep deprivation, and high workloads. The cumulative impact of these stressors can lead to a range of psychological responses that pose significant risks to the well-being of the service member, their unit, and the overall effectiveness of their combat mission.

The psychological impact of combat and operational stress on military personnel has been a subject of extensive research, particularly in the context of modern warfare. Various mental health programs and interventions have been developed and implemented by North Atlantic Treaty Organization (NATO) countries to address these mental health issues, with a specific focus on prevention frameworks aimed at mitigating the psychological sequelae of combat stress. However, operational stress control (COSC) models must be adapted to reflect the realities of modern warfare, particularly in large-scale combat operations characterized by long-range precision munitions and advanced air defense systems, since these factors hinder access to and mobility within operational areas and disrupt support capabilities. The complexities of large-scale combat operations, particularly in the context of the war in Ukraine, necessitate a better understanding of the existing interventions' adaptation and contextualization for soldiers, who are subjected to prolonged combat-related stress, and the challenges of operating in a chaotic and rapidly evolving environment.

9. Questions to be Addressed (QTBA)

1) How can member states effectively incorporate mental health support into national security frameworks to ensure long-term societal stability?

2) What regulatory protocols should be established to manage the adverse effects and risks of PTSD medications while facilitating the social reintegration of patients?

3) In post-conflict environments, how can mental health interventions contribute to the restoration of fractured social infrastructures and the rebuilding of public trust?

4) What strategic international cooperation models can be implemented to mitigate the traumatic impact of displacement and promote the successful integration of refugee populations?

5) How can international oversight be strengthened to prevent the overdose or misuse of PTSD-related controls?

6) What measures should be prioritized for civilians in conflict zones to prevent the intergenerational transmission of trauma and disrupt the cycle of systemic violence?

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