How Applying Interdisciplinary Studies Can Benefit Veterans with Non-Combat PTSD

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How can the Veterans Affairs (VA) support veterans with non-combat-related Post Traumatic Stress Disorder (PTSD)? As a veteran after 10 ½ years of military service, I struggle with non-combat-related PTSD. After multiple deployments to the Middle East and being injured, my life changed drastically. Finding the support needed was difficult. Once I started receiving care at the VA, I saw just how much support was out there. Jervy Fermin said it perfectly, "the courage it takes to leave behind what's not for you anymore, is the same courage that will help you find your way to what is" (The Minds Journal, 2022).

Method

Interdisciplinary problem-solving is the ability to integrate knowledge, methods, and perspectives from different disciplines to address complex and real-world issues. It takes many different disciplines for the VA to successfully support veterans who struggle with PTSD not related to combat. And because it is not directly related to combat, it requires a higher burden of proof to earn a service connection and VA disability benefits. Many different disciplines are needed to best treat PTSD such as psychologists, nutritionists, and sociologists. An entire team of medical professionals needs to come together to help the veteran become healthy again. A high level of problem-solving is best used in this case to better understand what these non-combat veterans need.

The integration method used is problem-centered integration. This question requires many different disciplines to come together to do something about a difficult problem. The overall goal of problem-centered integration is to help solve a problem. The VA does a great job at that, having different disciplines working to help assist veterans in any way they can.

Justification for the Interdisciplinary Method

An interdisciplinary approach is needed for this question because it requires expertise from different disciplines. This is to better understand PTSD in veterans and find support through the VA. PTSD is a very complex mental health condition. It is most often caused by exposure to death, threatened death, serious injury, or sexual violence done upon the sufferer or to someone close to them. It is characterized by recurring distressing memories, nightmares, flashbacks, avoidance of triggers related to the trauma, detachment, anger, irritability, and trouble sleeping, among other symptoms. Non-combat-related PTSD must be service-connected, meaning

it must be related to a veteran's service, and may include traffic collisions, training accidents, military sexual trauma, survivor's guilt, fear of hostile military, and ongoing exposure to death and violence, to name a few. Despite many misconceptions, veterans with non-combat PTSD typically experience the same symptoms and hardships as veterans with combat PTSD. Non-combat PTSD stressors are taken just as seriously as combat PTSD by medical professionals and the VA. (Craig, 2021).

This is an important question because non-combat veterans can experience PTSD just like combat veterans do. Non-combat veterans face many hurdles as well and the symptoms for them are often the same as those that have PTSD as a result of direct combat. This just shows that these veterans need support from the VA as well, which is important for individuals to remember (Writer, 2022). Most people have the assumption that service members only get PTSD from combat-related trauma and experiences, when in reality many service members never see combat and still develop PTSD. The disciplines of psychology, sociology, and nutrition will be justified in better understanding PTSD in non-combat veterans.

Psychology Discipline

Psychology is an important discipline in answering this question. The science of psychology benefits society, enhances our lives, and helps to understand and improve the world around us. This discipline has a wide range of benefits including; researching mental health to enhance well-being, better understanding of relationships, self-improvement, and battling addictions. The specific symptoms that manifest in the veteran may differ from person to person. Over 1.7 million veterans received mental health services at the VA last year. The services range from peer support with other veterans to counseling, therapy, medication, or a combination of these options. The goal is to help the veteran take charge of their treatment and live a full and meaningful life (Veteran Affairs, n.d.). The VA provides mental health services for PTSD. One specifically is the VA's TeleMental Health program. This program remotely connects veterans with a VA mental health provider from any location. Another option is the VA's suite of mental health apps. These apps enable veterans to be more involved with their care and symptoms. Veterans have access to these free self-guided apps and have a quick connection to the support they need. The VA apps have the best and latest research including input from subject matter experts and other veterans. Although, these apps are not designed to replace treatment with a healthcare professional. Veterans are encouraged to schedule an appointment with a provider by using their VA medical services (VA News, 2023). The provider will refer the veteran to the psychology department where they can receive more in-depth assistance. Effective treatments for PTSD are greatly needed for non-combat veterans. Clinical trials have shown that prolonged exposure (PE) therapy has been highly successful (Eftekhari, et al., 2013).

VA psychologists can help the veteran with first-line, second-line, and alternative pathways for treatment. The first-line approach is the use of psychological interventions for PTSD by a range of authoritative sources. Two of the most studied types of cognitive behavioral therapy (CBT) are cognitive processing therapy (CPT) and prolonged exposure (PE) therapy. These are recommended as first-line treatments in PTSD practice guidelines around the world, including the guidelines jointly issued by the VA and the Department of Defense (DoD). If a patient does not respond to nondrug treatment alone, then pharmacotherapy is also recommended as a first-line approach. Second-line therapies are less strongly supported by evidence, and many have more side effects. For example, Prazosin is effective in randomized clinical trials in decreasing nightmares in PTSD. Its effectiveness for PTSD symptoms other than nightmares has not been determined. Alternative pathways are other treatments rather than relying on antidepressants. Researchers are looking at the role of the inhibitory neurotransmitter gamma aminobutyric acid (GABA) and the excitatory neurotransmitter glutamate in PTSD. Both of these play a role in encoding fear memories. Clinical research also suggests that smoking cannabis (marijuana) reduces PTSD symptoms in some patients. The table below shows suggested nonpharmacological and pharmacological treatments for PTSD. The drugs listed are the only ones approved to treat PTSD by the Food and Drug Administration (Reisman, 2016).

First-Line	Second-Line	Alternative Pathways
Nonpharmacological[29,38–47]		

• Cognitive behavioral therapy
  ○ Cognitive processing therapy
  ○ Prolonged exposure therapy
• Eye-movement desensitization and reprocessing		

Pharmacological[48–60]		

• Antidepressants
  ○ Sertraline*
  ○ Paroxetine*
  ○ Fluoxetine
  ○ Venlafaxine
	• Nefazodone
	• Mirtazapine
	• Tricyclic antidepressants (e.g., imipramine)
	• Monoamine oxidase inhibitors (e.g., phenelzine)
	• Prazosin
		• Gamma-aminobutyric acid
		• Glutamate
		• Vortioxetine
		• Vilazodone
		• Anticonvulsants (e.g., topiramate)
		• Antiepileptics
		• Cannabis

Figure 1. (Image provided by the Food and Drug Administration; Reisman, 2016.)

Nick Wilson conducted a study in 2021 that compared the lifespans of World War II veterans with and without combat exposure. The combat-exposed military personnel were derived from a random (10%) sample of the military roll of the 28th (Māori) Battalion from New Zealand. One non-combat cohort was the 15th Reinforcements of this same Battalion, since the

war ended before they reached the front line. The other non-combat cohort was Māori personnel who were only involved in Jayforce, which occupied Japan at the end of WW2. Data on lifespan were mainly derived from an official repository of birth and death records, but supplemented with other sources, including military files. By 1985, more than 10,000 of these veterans were officially recognized as suffering from 'nervous system disabilities', with cases of PTSD and alcohol misuse. A more current study published in 2020 of New Zealand military personnel reported that 10% of participants had symptoms indicative of a clinical diagnosis (a diagnosis made based on medical signs and reported symptoms, rather than diagnostic tests) of PTSD. It also reported that risk factors for PTSD were trauma exposure, older age, male sex, and Māori ethnicity. It found that there was no statistically significant reduction in the average lifespan associated with combat exposure. That is, the mean lifespan of the combat-exposed veterans was 66.7 years versus two non-combat-exposed cohorts at 67.2 years and 66.9 years. There were no statistically significant reductions in lifespan between combat and non-combat-exposed veterans (Wilson et al., 2021).

Kathryn Macia conducted a study in 2020 to examine the PTSD networks of veterans with combat versus non-combat identified trauma, or index trauma. Network structure, connectivity, and centrality of PTSD symptoms were examined in veterans with combat and non-combat criterion with stressors as their perceived worst trauma. This is the first study to examine PTSD networks associated with combat versus non-combat index trauma. The study included 944 veterans who presented for psychological services to PTSD specialty clinics at two VA facilities. All veterans completed a PTSD checklist for the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) Posttraumatic Stress Disorder Checklist, (PCL-5) with Criterion A face page. This data was collected as part of routine clinical care without informed consent. Of the 944 veterans in total, 599 (63.5%) identified combat-related trauma as their index event. The remaining 345 veterans reported non-combat types of index trauma, including physical/sexual abuse in adulthood (22.8%) and childhood (2.5%), witnessing violence (6.5%), serious accidents (2.0%), and other events (2.8%). Many similarities were made between the combat and non-combat trauma networks. The network theory approach views disorders as systems of mutually interacting symptoms. Network analysis provides a better understanding of the structure and a foundation for explaining which symptoms are most central, and which ones impacted by or have the greatest spreading influence to other symptoms. There were strong positives between symptoms that were theoretically related or similar like avoidance. Negative emotion was a highly central symptom. Of course, there were some differences associated with certain symptoms. Detachment was relatively more central and the connections of negative emotion with blame and lack of positive emotion with reckless behavior were stronger for veterans with combat-related index trauma (Macia et al., 2020).

In 2001, Begić and Jokić-Begić conducted a study to analyze violent behavior in 116 combat veterans. 79 of these veterans were diagnosed with PTSD. 37 veterans had a diagnosis of other psychiatric disorders. Of 116 veterans (79 with PTSD), 86 (74.1%; 75 with PTSD) presented some kind of aggressive behavior. Aggression is a very common symptom in both combat and non-combat veterans and is usually the main reason for seeking help. In this research, it was shown that aggression appeared more often in combat veterans than the non-combat. Aggression was typically aimed at the spouse who is usually the first to insist on treatment. The number of violent acts in the past year for veterans with PTSD was 18.2, and for non-PTSD veterans, it was 2.7. Violent behavior is far more frequent among combat veterans with PTSD.

AGGRESSIVE BEHAVIOR AND ACTS OF VIOLENCE IN THE PRECEDING YEAR

	Combat Veterans with PTSD (n = 79)		Combat Veterans without PTSD (n = 37)	
Aggressive behavior	75	94.9%	11	29.7%
Acts of violence	18.7[a]		2.7	

Figure 2. (Begić & Jokić-Begić, 2001, p. 672)

There are various types of aggression. They can be combined, and with time, one type of aggression can be replaced with another. Auto-destructive behavior dominates (attempted suicide), followed by heteroaggressive behavior (physical and verbal aggression). In two-thirds of examinees, aggression appears more than one year after being exposed to traumatic experiences in war; on average, it lasts 10 months before the start of treatment.

DIRECTION OF AGGRESSION

	Combat Veterans with PTSD (n = 79)		Combat Veterans without PTSD (n = 37)	
Autoaggression	13	17.3%	2	18.2%
Heteroaggression	47	62.7%	8	72.7%
Combined aggression	15	19.9%	1	9.1%

Figure 3. (Begić & Jokić-Begić, 2001, p. 672)

It was shown that aggression can be directed toward belongings such as damaging a telephone booth, throwing a television through a

window, and demolishing furniture. Besides being cruel to people, aggressive behavior towards animals was also found. Aggression toward objects was found while a veteran was under the influence of alcohol, and they damaged the inventory of a bar. Sexual aggression, fast driving, disregarding traffic rules and signs, driving under the influence, use of weapons, and mistreatment of children are some other aggressive behaviors that were found. According to this study, 43 veterans go to a psychiatrist mainly for aggressive behavior. Most of the veterans go on their own or are persuaded by their partners. Others attend treatment with a close person. Eight veterans were brought to treatment by the police. The frequency of aggression is increased in veterans of lower socioeconomic status, less education, previous maltreatment, and earlier manifestations of aggression. Aggressiveness in veterans mainly with PTSD is a problem for the individual and also for the health service (Begić & Jokić-Begić, 2001).

Sociology Discipline

Social connectedness is an important factor related to PTSD in veterans as their behaviors and relationships are highly affected. The VA has multiple social services to help with everyday life changes. Social connections, support, and resources can provide the veteran with information or emotional support that can be used to deal with the challenges of a stressful event. Veterans with many social connections such as high social support and social capital tend to have better well-being as compared to those who are more socially isolated (Adams et al., 2017). The VA offers regular outreach events such as online support groups, seminars, networking sessions, and coffee & community to name a few. The VA also works with accredited organizations to obtain service and therapy dogs. These dogs act as a social facilitator between the veteran which reduces the risk of social isolation. Animals are largely dependent on humans for exercise, feeding, grooming, etc. This enabled the veteran to express nurturing and protective behaviors and engage with other individuals. These dogs are known to work as social facilitators via their learned behaviors and their presence as companion animals. The dogs help their handler reconnect with society, improve individual quality of life, and most importantly, help the veteran reclaim control of their life (Veteran Affairs, n.d.).

It is important to understand how transitioning military veterans to civilian life works along with the variables that affect their transition. In 2020, Gary Blau and Glen Miller conducted an online survey of 153 military veterans. This survey was broken down into combat (92) versus non-combat (61) veterans. Comparing the mean differences between continuous variables, the combat veterans reported an overall higher education level, higher perceived occupational alternatives, and higher life satisfaction versus the non-combat veterans. Both combat and non-combat veterans reported significant relationships between negative traumatic events and

positive personal accomplishments to life satisfaction. Positive relationships between the highest education level and perceived occupational alternatives to life satisfaction were only found for combat veterans. The survey results did suggest that work-related variables are important for understanding military veterans' life satisfaction. In this survey, higher meaningfulness of volunteer work was stronger for smaller subsets of the non-combat versus combat samples. There are a few different factors that mitigate PTSD. First, volunteering was positively related to posttraumatic growth in a survey of 3,157 US veterans. Volunteering can be even stronger when employees perceive less meaning in their jobs. These combined results suggest that finding meaningful work, either paid or volunteer, may be important to both combat and non-combat veterans as they transition back to civilian life. Second, higher education can be one way to help military veterans find rewarding, meaningful work to help increase their life satisfaction. This can also help to reintegrate veterans into their communities. A qualitative study found the university-related educational experiences of 11 student veterans helpful as they transitioned from military to civilian life. In this study, veterans going back to school to further their education perceived higher occupational alternatives than those not going back to school. Veterans who had a more recent powerful traumatic event were more likely to be going back to school than veterans whose traumatic event was longer ago. The results between combat and non-combat veteran samples support personal accomplishment as a positive correlation for life satisfaction. Third, veterans find it very important to have meaningful work, either through perceived occupational alternatives, or volunteering. Education can be one means to help veterans perceive greater occupational alternatives. As veterans transition back to civilian life, military out-processing should continue to counsel/prepare transitioning veterans on finding/interviewing for jobs as well as identifying realistic new careers (Blau & Miller, 2020).

Meaghan Mobbs and George Bonanno published an article in 2018 to address the expanding needs of returning veterans. While dealing with PTSD, veterans have a high-stress level during the transition to civilian life. Veteran treatments and supports need to not only consider PTSD, but also the wider range of challenges, rewards, successes, and failures that transitioning veterans might experience, as well as the factors that might moderate these experiences. In this argument, the authors start by considering what it means to become a soldier regarding transitioning into military service. Along with what kind of stressors veterans might experience when they attempt to transition out of military service. One of the primary reasons for past failures in veteran treatments is that the dominant focus on PTSD has complicated highly pressing transition issues. Research has found that many returning veterans struggle regardless of whether they have PTSD or not. PTSD develops in a small minority of both combat and non-combat veterans. Survey studies have suggested that 44% to 72% of veterans experience high levels of stress during the transition to

civilian life, including difficulties securing employment, interpersonal difficulties during employment, conflicted relations with family, friends, and broader interpersonal relations, difficulties adapting to the schedule of civilian life, and legal difficulties. The transition stress has been found to predict both treatment-seeking and the later development of mental and physical health problems, including suicidal ideation. As a result of this, there are no resources available to address the cognitive, emotional, behavioral, or psychological impacts of the soldier-to-civilian transition. The VA needs to accommodate these issues (Mobbs & Bonanno, 2018).

Transitioning out of the military back to civilian life has a major impact on prior service members. They find themselves unprepared for the instability of the initial phases of transition, and how this period may threaten their sense of self and self-worth. During this time, they may struggle with any number of interrelated concerns, including unresolved or prolonged grief and bereavement over fallen comrades, loss of their previous military identity, nostalgia for the order and purpose that characterized their service experiences, a sense of moral injury, confusion about military-civilian differences, and changing masculine roles. Bonds between service members may act as a protective factor in the development of PTSD, but the actual or perceived loss or weakening of these bonds during the transitional period and beyond may be associated with increased distress over the lifespan. Findings also suggest that veterans may experience grief-like symptoms in response to the loss of their military self and the roles, values, and sense of purpose this lifestyle may have held for them. This amounts to stable changes in the social environment for the veteran. For these reasons, trauma-focused and non-trauma-focused events might aggravate the shame and guilt in veterans. They are not typically assessed or targeted for treatment, and when they are, treatment remains largely ineffective in treating the guilt and shame associated with morally injurious events. A veteran's experience of shame and guilt-related distress may be further worsened by involvement in civilian contexts in which there is minimal shared experience and understanding. 40% of veterans report 'getting socialized to civilian culture' as a key transitional challenge. The media has tended to represent veterans as either broken warriors or unhinged and armed. Many service members with PTSD may not seek out mental health services for fear of confirming these unsavory stereotypes. Another key source of transition stress is the socialized masculinity of the military. Members of the military are molded, both explicitly and implicitly, by the cultural norm that warfare and the wagers of war are masculine by nature. This is due to the physical isolation of entry-level training, training exercises, deployments, the general community insulation by way of gated military installations, and the widespread use of behavior modification and reinforcement. Aside from the various social implications, a large body of research suggests that the more men 'do their gender' and define themselves

along traditional gender roles, the less likely they are to seek care (Mobbs & Bonanno, 2018).

It is important to understand that entry-level training is meant to strip away the remnants of the civilian identity and transform men and women into Soldiers, Sailors, Airmen, and Marines. This transition from civilian to military life requires rapid adjustment to an institutionalized lifestyle in which individuals are obligated to submit to an abundance of situations such as concentrated unremitting supervision; intense physical training in the form of more routine forms such as running but also ruck marching, obstacle course training, and teambuilding drills; group meals in which eating is constrained by time; and separation from loved ones. The peer bonding that occurs during training events is grounded in the service member's ability to trust other members of their unit and the general ability to function and work as a team. Relationships formed during a period of service are consequently described by many veterans as some of the closest they form in their lives (Mobbs & Bonanno, 2018).

Nutrition Discipline

Nutrition is a key discipline to draw from in answering this question. The VA offers Registered Dietitian Nutritionists (RDNs) as the food and nutrition experts. They have special training to offer medical nutrition therapy along with working as part of the health care team in treating the veteran. VA nutrition helps teach the veteran how to make healthy food choices and will show how to prepare foods. RDNs are assigned to the veteran through their primary care provider. The RDN will emphasize how important it is to keep self-compassion in mind when making any dietary changes. An RDN will put the veteran on a healthy diet. This includes avoiding refined/processed sugars, increasing micronutrient intake, increasing probiotic/prebiotic levels, and supplementing with omega-3s. A healthy diet can help alleviate PTSD symptoms. Eating well is a powerful act and a vital part of self-care. Nutrition plays an important role in preventing chronic diseases along with improving mental health (Military Wellness, 2022).

Shaline Escarfulleri published an article in 2021 associating PTSD, diet, and exercise. PTSD is connected with chronic health conditions with cardiovascular and cardiometabolic disease being at the top. Behavioral contributors to physical health rely on diet and exercise. The lack of exercise, consuming non-nutritious foods (high in sugar, saturated fats, sodium), and nicotine all contribute to negative physical health behaviors such as weight gain, low motivation, and not enough sleep. Research on PTSD and emotion regulation found that people experiencing worse PTSD symptoms eat poorer quality foods. They do this to reduce their emotional burden which would explain the association between cardiometabolic health along with accelerating aging (Escarfulleri, et al., 2021).

In Shaline Escarfulleri's article, it was suggested that PTSD severity has an impact on emotion regulation strategies and diet quality. Poor diet in those with PTSD has also been linked with dementia. Foods rich in vitamin E, B12, and fish have been associated with a decreased risk for dementia. Sugary drinks have been linked to an increased risk. Nutritionists need to understand how trauma-related psychiatric symptoms influence diet and food choices. The Veterans Administration has a weight loss program called "Move!". Research gathered from this program showed that veterans with PTSD lost less weight than those without PTSD. Intervening on diet quality alone may not be sufficient if eating habits are impacted by trauma exposure and PTSD, so treatment must also address the upstream components leading to the lack of a nutritious diet.

Results also suggested the importance of considering other types of therapy that could be useful in PTSD treatment. For instance, therapies that directly address emotion regulation, like mindfulness and Dialectical Behavior Therapy and Prolonged Exposure which requires engagement with trauma-focused emotions, could help enrich not only the PTSD symptoms but also problematic physical health behaviors as well. In a study of 2,832 military veterans, those with probable PTSD were two times more likely to fail to engage in exercise during a given week compared to those without probable PTSD. There were no significant indirect effects of PTSD on exercise engagement (Escarfulleri, et al., 2021).

Conclusion

In conclusion, non-combat-related PTSD veterans need support from the VA. The three disciplines, psychology, sociology, and nutrition mentioned above all share an important piece of common ground along with complementing one another. Psychology and sociology both study human interaction. These disciplines are both vital in a better understanding of PTSD in non-combat veterans as they both understand identity, violence, crime, and intimacy. They also utilize communication, interpersonal, analytical, research, listening, observational, and problem-solving skills (Simkus, 2023). Nutrition relates to psychology by developing a comprehensive understanding of dietary quality and its relation to various components of mental health. It also aims to spread awareness about the importance of quality nutrition for overall health (Wikimedia Foundation, 2023). Sociological perspectives suggest that underlying social relations can help explain collective food and eating patterns along with understanding eating patterns (Delormier et al., 2009). These disciplines come together to help veterans with their PTSD. The overall goal of the VA is to assist veterans with difficult problems, which is why problem-centered integration is used.

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