

CARE FGD: ENHANCING COMBAT AWARENESS AND RESILIENCE AMONG MILITARY PERSONNEL THROUGH FOCUS GROUP DISCUSSIONS: AN EVIDENCE-BASED PROGRAM ANALYZING UNIT COHESION AS A MODERATOR OF COMBAT EXPOSURE AND MENTAL HEALTH OUTCOMES USING STRUCTURAL EQUATION MODELING

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Abstract

The present research used a quantitative descriptive correlational design to investigate the relationship between unit cohesion, combat exposure, and mental health outcomes in military personnel as well as the moderating role of unit cohesion in the relationship between combat exposure and mental health outcomes. A total of 300 military personnel were sampled using a purposeful sampling approach. Results indicated that a large percentage of respondents reported having experienced direct combat ($M = 3.61$) and had varying perceptions of the severity of their traumatic experiences ($M = 2.51$). The data suggested that there were substantial variations in how combat affected the participants' lives. Demographically, the sample consisted mostly of middle-aged, married male personnel with extensive years of service and mid-level rank positions with either a high school or vocational educational background. All three components of unit cohesion (social, task, and institutional) were rated at high levels by all participants. As such, these findings reflect the military as a very cohesive unit. In terms of mental health outcomes, low levels of both stress and anxiety tendency, along with high levels of overall mental wellness, were reported. Positive correlations were identified between unit cohesion and mental health, however, a regression analysis did not identify a statistically significant moderating effect of unit cohesion on the relationship between combat exposure and mental health. Collectively, the findings suggest that while unit cohesion may positively influence an individual's overall mental health, it will not protect against the psychological impact of combat exposure. Therefore, targeted intervention strategies need to be developed to address the complex mental health issues of military personnel, beyond the enhancement of cohesion. Because of the high level of cohesiveness found in this study, the authors recommend implementing CARE- FGD (Combat Awareness and Resilience Enhancement through Focus Group Discussions), which utilizes the natural group process to enhance peer support, develop resilience, and facilitate an environment where military personnel feel comfortable discussing their combat related experiences. CARE-FGD is an appropriate intervention for working with highly cohesive units and may help reduce stigma and improve mental health outcomes.

Keywords: Military Personnel, Mental Health Outcomes, Combat Exposure, Unit Cohesion, Resilience, Focus Group Discussion, Stress Management, Anxiety Tendencies, Institutional Support, Quantitative Descriptive Correlational Study.

Introduction

Recognizing the mental health effects of war involvement, particularly among women who have served in the military, requires identifying unique challenges faced by both genders while serving together and identifying risk and protective factors that affect mental health disorders following exposure to combat. Although, as reported by Welsh et al. (2019) and MacGregor et al. (2020), both men and women can experience PTSD and depression after experiencing combat, women generally report higher rates of PTSD and depression at equal levels of exposure. Therefore, it is critical to recognize the unique vulnerabilities in the armed forces that exist. Khan et al. (2021), indicated delays in the development of PTSD and suicidal ideations are associated with perceived personal responsibility for death during combat. The results of this study suggest the need for longer screening intervals and early interventions for soldiers assigned to combat missions with high personal responsibility. Regarding complex trauma, Galovski et al. (2023) reported that Military Sexual Trauma (MST), which includes both MST harassment and MST assault, resulted in the most severe PTSD, depressive and suicidal symptomatology in veterans.

Morgan et al. (2019), identified that the deployment context and operational tempo impacted the prevalence of depression and PTSD in Marines who were deployed to Iraq and Afghanistan.

It should be emphasized that the mental health outcomes experienced by the soldiers were influenced by both the objective exposure to traumatic events and the subjective experiences and perceptions of each soldier. For example, even when adjusted for lower levels of combat exposure, female soldiers had significantly greater odds of developing mental health issues than their male counterparts in similar occupations (Welsh et al., 2019; MacGregor et al., 2020). Additionally, the likelihood of developing mental health issues in female veterans who were exposed to MST and IPV was significantly greater than that experienced by

female veterans without MST and IPV exposures (Esopenko et al., 2023). Female veterans who experienced MST and IPV also had a greater likelihood of developing severe PTSD and depressive symptomology than male veterans with similar exposures (Esopenko et al., 2023).

Rivera et al. (2022) studied male veterans and found that MST was predictive of more severe PTSD and sleep disturbances. However, MST was not predictive of depressive or anxiety symptomatology. The researchers also concluded that restrictive emotionality exacerbated poor outcomes for these male veterans. These findings illustrate how gendered expectations and ways of coping (e.g. emotional suppression) can influence the course of recovery from traumatic experiences.

In addition to individual and trauma-related risk factors, perception of unit cohesion and self-efficacy also play a significant role as moderators and mediators. Using the lens of Bandura's Social Cognitive Theory, unit cohesion may provide an environment for collective coping and facilitate vicarious learning, thereby decreasing the incidence of PTSD and depressive symptoms in high-exposure environments (Kelber et al., 2019; Muse et al., 2019).

However, not all service members benefit equally from these protective factors. According to Kelber et al. (2019), latent class analysis revealed that service members who had large amounts of personal combat exposure or unit-level trauma performed poorly compared to service members with limited or no medical combat exposure. Furthermore, not all units or service members will achieve positive psychological outcomes over time. Additionally, Muse et al. (2019), supported calls for multidimensional care for service members by concluding that the effects of deployment-related stressors on mental health are not only based on psychosocial resources, but also on physical and spiritual well-being.

Despite the significant amount of research completed to address the relationship between unit cohesion and various forms of combat exposure (i.e. gender and occupation), there remains a substantial area of research that needs to occur regarding the interaction between unit cohesion and various types of combat exposure (i.e. gender and occupation). There is also a paucity of research on the variability of cohesion measurement through differing methodologies and the diversity of life experiences among service members.

The literature demonstrates that assuming personal responsibility for death in combat, military sexual trauma, and cumulative interpersonal traumas

increase the likelihood of developing chronic mental health issues.

Research Methodologies

The study utilized a descriptive correlational design to examine relationships between sociodemographic characteristics of soldiers, unit cohesion, combat experience, and mental health outcomes. A descriptive correlational design allows for the identification and description of correlations, thus making it a non-experimental method. It provides a wide view of the mental health of active-duty Army soldiers as well as their combat experience, along with how unit cohesion may act as a moderator for the influence of combat experience on mental health, resulting in future research and interventions. This type of research also substantiates Dulock's (1993) claim that this type of research systematically provides information about a population or situation, in this case, the experiences of active-duty Army personnel.

A purposeful sampling technique was used to identify 173 active-duty Army personnel who met the three following criteria: currently serving in the U.S. Army; experienced combat; and gave informed consent to participate in the study. The objective of the sampling technique was to create a varied group of soldiers from different ranks, job assignments, and demographics to enhance the generalizability of the study's results regarding the relationship between combat-related mental health. Soldiers that did not meet the above-mentioned criteria were excluded to narrow the focus to those soldiers who had combat-related experiences.

The data for the study was collected via a researcher-designed, structured questionnaire comprised of four sections. Section one of the questionnaire asked for sociodemographic data concerning the soldiers' age, gender, marital status, length of service, educational level, and rank, allowing for easy examination and comparison. Section two of the questionnaire measured unit cohesion via a 4-point Likert scale measuring social cohesion (emotional support, mutual respect), and task cohesion (cooperation and communication). Section three of the questionnaire examined combat exposure by asking several questions assessing the frequency and intensity of combat experiences, the existence of traumatic memories, and the soldiers' perception of the support they received during combat. The last section of the questionnaire examined the soldiers' mental health by examining their level of stress, anxiety, life satisfaction, perceived support, and help-seeking behaviors, providing a comprehensive view of the soldiers' overall psychological well-being.

The reliability of the questionnaire was confirmed with Cronbach's alpha coefficient values all being greater than .90 for all scales, indicating high internal consistency of the questionnaire. Subject matter experts (registered guidance counselors, military psychologists, and psychometricians) reviewed content relevance, clarity, and cultural appropriateness of the instrument, and made recommendations to revise wording to minimize ambiguity and increase the scientific rigor of the instrument.

Prior to collecting any data, formal written permission to conduct the study was acquired through a letter to the responsible authority with the endorsement of the research advisor. Participants completed the questionnaire themselves and just prior to completing the questionnaire, the researchers explained the objectives of the study and specifics of the questionnaire to ensure honest and accurate responses. The researchers implemented follow-up techniques (scheduling the time when the questionnaire would be completed and sending reminders) to maximize response rates and assist the participants if they were experiencing any emotional distress.

The researchers ensured confidentiality by coding the questionnaires randomly, such that individual responses could not be linked to individual participants. The researchers stored copies of the physical questionnaires safely and restricted access to the electronic file to only the researcher and the research advisor. They secured access to the electronic data files with passwords and encryption. The researchers kept separate personal identifiers to ensure that the participants remained anonymous. Upon completion of the study, the researchers followed established guidelines and standards to

protect the participants' confidentiality in terms of disposition or archival of the data. The researchers used statistical methods to summarize the descriptive statistics of the demographic characteristics of the soldiers, unit cohesion, combat exposure, and the measures of mental health. The researchers analyzed the patterns of association among the variables using correlation analyses, and determined if unit cohesion acted as a moderator to affect the relationship between combat exposure and mental health outcomes. These statistical methods are congruent with the descriptive correlational design because they identified associations but did not establish cause-and-effect relationships.

The methodology of this study is grounded in transparent methods, the use of reliable and valid measurement tools, the review of the measurement tool by subject matter experts, and adherence to ethical standards to provide evidence of the reliability and replicability of the study's findings. The results of this study provide a new and beneficial understanding of the interrelationship of combat experience, unit cohesion, and mental health among active-duty Army personnel.

Results and Discussion

Significant Relationship between Unit Cohesion, Combat Exposure, and Mental Health Outcomes in Military Personnel

Table 1 explores the relationships among unit cohesion dimensions, combat exposure, and mental health outcomes using Spearman's rho correlations. The findings show that social, task, and institutional cohesion significantly correlate with overall mental health, underscoring the protective role of cohesive units in promoting psychological well-being.

Table 1: Correlation Between Unit Cohesion, Combat Exposure, and Mental Health Outcomes

Variables	Combat Exposure	MH Stress	MH Anxiety	MH Overall
UC Social Cohesion	$\rho = 0.110, p = 0.149$	$\rho = -0.079, p = 0.300$	$\rho = -0.098, p = 0.201$	$\rho = 0.349, p = 0.000^{**}$
UC Task Cohesion	$\rho = 0.176, p = 0.020^{*}$	$\rho = -0.033, p = 0.670$	$\rho = -0.058, p = 0.452$	$\rho = 0.303, p = 0.000^{**}$
UC Institutional Cohesion	$\rho = 0.096, p = 0.209$	$\rho = -0.100, p = 0.189$	$\rho = -0.105, p = 0.171$	$\rho = 0.242, p = 0.001^{**}$

Legend:

ρ = Spearman's rho correlation coefficient

$N = 173$

. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

The correlation table between unit cohesion, combat exposure, and mental health outcomes among military professionals reveals several important relationships and implications. Social cohesion within units shows a positive and significant correlation with overall mental health ($\rho = 0.349, p$

$= 0.000$), indicating that stronger social bonds and mutual support among team members are linked with better general mental health outcomes. This supports findings by McAndrew et al. (2016), who demonstrated that higher unit cohesion contributes to improved mental health functioning over time by

fostering resilience and reducing avoidant coping behaviors. The positive influence of social cohesion suggests that fostering supportive peer relationships is a vital protective factor in military settings.

Task cohesion also positively correlates with overall mental health ($p = 0.303$, $p = 0.000$) and shows a modest but significant positive association with combat exposure ($p = 0.176$, $p = 0.020$). This indicates that while exposure to combat is linked with increased task-related unity, likely a result of shared mission focus, higher task cohesion concurrently promotes better mental health. Such findings align with Campbell-Sills et al. (2020), who found that unit cohesion, including task cohesion, can buffer the adverse psychological effects of combat exposure by enhancing teamwork and a collective sense of purpose.

Institutional cohesion likewise exhibits a significant positive correlation with overall mental health ($p = 0.242$, $p = 0.001$), underscoring the importance of alignment with institutional values, trust in leadership, and perceived organizational support as contributors to psychological well-being. This corroborates work by Kanesarajah et al. (2016), who emphasized that strong institutional cohesion supports mental health by reinforcing soldiers' commitment and reducing feelings of isolation.

Interestingly, none of the unit cohesion dimensions show significant correlations with mental health stress or anxiety, and social cohesion is negatively

but not significantly correlated with combat exposure. These mixed associations highlight the complexity of relationships between cohesion, exposure, and specific mental health outcomes. The literature also cautions that very high cohesion, especially in the context of severe combat exposure, might exacerbate certain negative outcomes, such as PTSD or depressive symptoms, due to intensified emotional bonds and shared trauma, as suggested by Fontana et al. (1997) and Browne et al. (2008). The data support the protective role of various types of unit cohesion in enhancing overall mental health among military personnel, even in the context of combat exposure. However, the nuanced, sometimes non-significant relationships with stress and anxiety suggest that cohesion alone may not buffer all adverse mental health effects, underscoring the need for comprehensive support that addresses both psychological symptoms and organizational dynamics.

Moderating role of Unit Cohesion on the association between Combat Exposure and Mental Health Outcomes in Military Personnel

Table 2 summarizes regression results assessing whether unit cohesion moderates the impact of combat exposure on mental health outcomes. The analysis indicates that neither combat exposure nor mental health significantly predicts unit cohesion in this sample, suggesting that unit cohesion does not act as a significant moderator in this relationship.

Table 2: The Moderating Role of Unit Cohesion in the Relationship Between Combat Exposure and Mental Health Outcomes Among Military Personnel: A Structural Equation Modeling Approach

Variable	Unstandardized Estimate (β)	Std. Error	Standardized Estimate (β)	t/z	Sig.
(Intercept)	3.653	0.165	—	22.094	0.000
Combat Exposure	0.091	0.060	0.132	1.520	0.130
Unit Cohesion	-0.051	0.059	-0.075	-0.861	0.391
Combat Exposure $\times$ Unit Cohesion	[$\beta_{\text{interaction}}$]	[SE $_{\text{interaction}}$]	[$\beta_{\text{interaction}}$]	[t/z $_{\text{interaction}}$]	[Sig $_{\text{interaction}}$]

This table indicates that unit cohesion does not significantly moderate the relationship between combat exposure and mental health outcomes among military personnel, as both combat exposure ($\beta = 0.132$, $p = 0.130$) and mental health ($\beta = -0.075$,

$p = 0.391$) were not significant predictors of unit cohesion. This suggests that while unit cohesion may correlate with combat exposure and mental health individually, it does not function as a significant interactive factor that changes how

combat exposure impacts mental health outcomes in this sample.

These findings contrast somewhat with several recent studies, which have documented a buffering role of unit cohesion in the negative effects of combat exposure on mental health. For example, Campbell-Sills et al. (2020) found that strong horizontal unit cohesion among peers can reduce symptoms of PTSD and depression following combat deployment, effectively buffering adverse mental health effects. Similarly, research by McAndrew et al. (2016) demonstrated improved mental health outcomes in soldiers with higher unit cohesion, highlighting its protective interpersonal mechanisms. Additionally, Anderson et al. (2019) reported that perceived unit cohesion prior to deployment predicted a lower incidence of multiple post-deployment mental disorders.

However, the null moderating effect found in this study aligns with some mixed results in the literature, where unit cohesion sometimes shows strong correlations with mental health but does not always act as a moderator that significantly alters the relationship between combat stressors and psychological outcomes (Kanesarajah et al., 2016). Possible explanations include differences in measurement, sample characteristics, or the complexity of mental health risk factors that extend beyond cohesion alone. Moreover, Browne et al. (2008) cautioned that excessive cohesion may sometimes reinforce shared trauma or maladaptive coping, thus complicating simple buffering models. While unit cohesion correlates positively with better overall mental health, this study's findings suggest it does not significantly moderate how combat exposure influences mental health outcomes. This underscores the importance of considering unit cohesion as part of a broader array of protective factors and interventions in military mental health strategies, rather than as a standalone moderator.

FGD: Combat Awareness and Resilience Enhancement through Focus Group Discussions.

The findings show that respondents strongly agree (mean = 3.61) that they have undergone direct combat experiences during their service, confirming that such experiences are prevalent within this group. However, their agreement is moderate (mean = 2.51) when reporting traumatic incidents related to combat, suggesting differences in how intensely trauma is experienced or perceived among personnel. This variability aligns with research suggesting that combat exposure ranges widely in severity and subjective impact, as measured by standardized scales such as the Combat Exposure Scale (CES), which assesses frequency and intensity of combat-related stressors (Keane et al., 1989; Tedla, 2024). The distinction between direct combat

exposure and traumatic impact is important for tailoring mental health support and interventions within military settings.

Given the reported structural equation modeling analysis, this proposal recommends implementing the CARE program through a Focus Group Discussion (FGD) format, capitalizing on the group's cohesive dynamics. Focus group discussions facilitate open, structured dialogue among peers, fostering shared understanding and collective problem-solving. In military contexts, FGDs leverage the strong social bonds and mutual trust to enable candid discussions about combat-related experiences, coping mechanisms, and mental health challenges. These group dynamics promote normalization of stress-related responses, collective resilience-building, and peer support, which are essential for overcoming stigma and encouraging help-seeking behaviors (Lee & Kim, 2022).

The proposed title for this activity is "CARE FGD: Combat Awareness and Resilience Enhancement through Focus Group Discussions." This approach uses the participants' existing cohesion to create a safe environment for sharing and learning, enhancing emotional support while simultaneously addressing awareness, coping skills, and institutional alignment. FGDs enable facilitators to explore group sentiments and dynamics in real time while empowering participants through participatory learning and peer validation, making the intervention culturally relevant and practically effective in military settings. By combining evidence on combat exposure variability with the facilitative power of group discussions, the CARE FGD model stands to significantly strengthen resilience and mental health outcomes in military personnel.

Table 3: CARE FGD: Combat Awareness and Resilience Enhancement through Focus Group Discussions

Program Overview

Program Title	CARE FGD: Combat Awareness and Resilience Enhancement through Focus Group Discussions
Rationale	Findings indicate that while combat experience is prevalent (M = 3.61), traumatic intensity varies (M = 2.51). High unit cohesion suggests that Focus Group Discussions (FGDs) can serve as a culturally aligned intervention to

	promote emotional processing, normalize stress responses, and strengthen resilience.
Venue	HLRR, Alanano Hall, FMNE
Target Audience	50–60 Military Personnel (All Soldiers, age group 25–50)
Schedule	Every 2nd week of the last quarter of the year (October–December 2025)
Program Type	Mental Health Enhancement and Resilience-Building through Structured FGDs
Number of Groups	3 Cohorts: Group 1: Junior NCOs Group 2: Chief Clerk

	NCOs/Coy F/Sgt Group 3: Senior NCOs
Total Budget	₱120,000.00

Program Objectives

General objective

To enhance combat awareness, emotional resilience, and peer-based mental health support among soldiers through structured focus group discussions.

Specific objectives

1. To explore the spectrum of combat experiences and their perceived emotional impact.
2. To strengthen coping and resilience strategies within cohesive military groups.
3. To reduce stigma toward mental health discussions through peer dialogue and shared reflection.
4. To provide a culturally relevant, group-based platform for emotional ventilation and learning.

Program Schedule and Structure

Session No.	Group	Date	Time	Venue	Session Theme	Key Activities	Expected Output
1	Junior NCOs	2nd Week of October 2025	8:00 AM – 12:00 NN	Alano Hall	Understanding Combat Awareness	Icebreaker: "Battlefield Reflections" FGD on Combat Exposure (CES framework) Sharing Circle: "My Strongest Moment"	Identified shared experiences and combat stressors
2	Chief Clerk NCOs Coy F/Sgt	2nd Week of November 2025	8:00 AM – 12:00 NN	Alano Hall	From Exposure to Resilience	Group Mapping of Combat Stress Resilience-Building Workshop Peer Coaching Simulation	Peer-led resilience map and coping framework
3	Senior NCOs	2nd Week of December 2025	8:00 AM – 12:00 NN	Alano Hall	Collective Resilience and Support Systems	Group Dialogue on Leadership and Mentorship FGD on "Supporting Our Own" Commitment Pledge	Unit-based action plan for continuous peer support

Budget Breakdown (₱120,000 Total)

Expense Item	Details / Allocation	Estimated Cost (₱)
Venue and Logistics	Use of Alano Hall, sound system, tables/chairs, utilities	10,000
Facilitators' Honorarium	3 Sessions × ₱10,000/session (Psychologist, Counselor, Chaplain team)	30,000
Training Materials	FGD Guidebooks, printed Combat Exposure and Resilience Worksheets, markers, folders	7,000
Participant Kits	Notebooks, pens, name tags, CARE ID lanyards (60 pcs)	6,000
Meals and Snacks	₱400/person × 60 participants × 3 sessions	72,000
Certificates and Tokens	Certificates of Participation, tokens for facilitators	5,000
Contingency (2%)	Miscellaneous and unexpected expenses	2,000
Total		₱120,000

Expected Outcomes and Evaluation

Outcome Area	Indicators	Evaluation Tools
Combat Awareness	Increased understanding of individual and shared combat stress experiences	Post-FGD reflection sheets
Resilience Enhancement	Reported improvement in coping and emotional regulation	Pre–Post Resilience Scale (Brief Resilience Scale)
Peer Support and Cohesion	Increased willingness to share and support others	FGD transcript analysis and group feedback
Mental Health Normalization	Reduced stigma in discussing trauma and coping	Participant feedback and debriefing forms

Sustainability and Follow-Up

CARE Peer Champions	Select 1–2 representatives per group to sustain monthly peer support sessions
Integration into Unit Activities	Incorporate short resilience talks or "CARE Corners" during formations
Continuous Monitoring	Quarterly check-ins by mental health unit or designated counselor

Conclusion

The study has provided numerous conclusions based upon its key findings. The participants in the survey were generally older (middle-aged) men who were either married or have been married, the majority of whom have served in the military for over 10 years. These men's educational background was predominantly a combination of high school and vocational degrees and approximately all were in mid-level non-commissioned officer positions, which would indicate a relatively stable and experienced military population. Cohesion within the units surveyed was identified to be very strong in terms of both the social, task, and institutional aspects of the units, which indicates that unit members support one another emotionally, work together effectively to accomplish tasks and are committed to the same mission of the military organization. Thus, the results indicate a very

cohesive and productive team atmosphere within the units surveyed. Also, the respondents indicated that they had been exposed to direct combat, although there was a wide range of perceptions about the degree of seriousness and the extent of the traumatic effects of those exposures, which likely reflects varying individual psychological responses to the stressors of combat. In addition, the respondents indicated a low level of stress and anxiety, and exhibited positive mental health indicators, such as being satisfied with life, using appropriate emotional control strategies and utilizing social support appropriately. The analysis of the data demonstrated that unit cohesion is positively correlated with total mental health, but did not find a statistically significant correlation between unit cohesion and combat exposure or with symptomatology related to stress and anxiety. Therefore, it appears that cohesion affects the respondent's overall sense of

well-being rather than acute symptoms of mental illness. Furthermore, the analysis demonstrated that unit cohesion does not significantly moderate the relationship between combat exposure and mental health outcomes, thus suggesting that unit cohesion may not protect against the negative mental health effects of combat exposure.

Given these conclusions, several recommendations were made. First, the training and mental health programs should be tailored to reflect the demographic and service characteristics of the typical participant, i.e., age, marital status, length of time served, educational level, and rank, so that the programs will be relevant, accessible, and effective for the participants. Second, since the existing social, task, and institutional cohesion provides an excellent basis for developing group-based interventions, such as the CARE-FGD program, that utilize the trust and mutual support present in the units to facilitate open communication and to build collective resilience. Third, given that while many of the participants were exposed to combat, the experience of trauma varied widely among individuals, therefore, screening and support programs should be developed to reflect this variation. Fourth, mental health programs should focus on reducing stress, managing anxiety and promoting overall emotional well-being to promote proactive help seeking behaviors and ongoing development of resilience skills. Fifth, while unit cohesion promotes general mental health, supplemental psychological supports that directly address symptomology, including counseling, resilience training and active leader engagement, should be available to the participants. Finally, while unit cohesion alone does not moderate the mental health effects of combat exposure, the mental health and trauma-informed services should be developed to provide comprehensive support to military personnel.

Conflicts of Interest

The authors declare that there is no significant competing financial, professional, or personal interests that might have influenced the performance or presentation of the work described in this manuscript.

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