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Combat Exposure and Mental Health in the Military: the Role of Collective Identity

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Combat Exposure and Mental Health in the Military: The Role of Collective Identity

By

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An undergraduate honors thesis submitted in partial fulfillment of the requirements for a

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in

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and

Psychology

Thesis Advisor

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Dedication

I dedicate this to my brother in law, SSG Ian A. Carroll, United States Army Special Forces and his wife Amy Carroll. Your sacrifices mean everything. Thank you.

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Abstract

Significant evidence links combat exposure to psychiatric disorders and poor mental health outcomes in service members, creating the need to elucidate the factors associated with promoting psychological health and resilience in the military. Social identity theory postulates that an individual's identification with a group, such as the military, can be instrumental in the provision of a sense of belongingness that is crucial for social integration, meaning and support during times of difficulty. This study examined how collective military identification interacted with the effects of combat exposure on mental health outcomes, in light of the protective capacity of social belongingness to support psychological health and resilience. I conducted a secondary analysis on a sample of 430 veterans and active duty reservists representing all branches of the military, who had deployed at least once. I hypothesized that collective military identity would provide a buffer against the deleterious effect of combat exposure on mental health, such that those with stronger levels of collective military identification would show a weaker relationship between combat exposure and poor mental health outcomes – assessed in terms of PTSD, psychological distress and perceived stress. My results indicated that collective military identity and combat exposure were both significantly and positively associated with PTSD symptoms; however, collective military identity did not buffer the effect. The findings present an unexpected, positive relationship between collective military identity and PTSD symptoms in veterans and reservists with the need for future research to further clarify this relationship.

Keywords: military, veterans, social identity theory, collective identity, combat exposure, PTSD

Combat Exposure and Mental Health Outcomes in the Military: The Role of Collective Identity

Through a long history of wars in the 20th century, much research has been done to understand the health effects that accompany combat-related traumatic experiences in military personnel. The sheer psychological, social, and physical toll that war takes on those who bravely serve is incontrovertible. Posttraumatic stress disorder (PTSD) is a psychiatric disorder that is commonly associated with the military (Hoge et al., 2004; Xue et al., 2015), in which the exposure to trauma on deployment can lead to chronic behavioral and psychological difficulties that are characterized by flashbacks, hypervigilance, loss of pleasure, and emotional detachment (APA, 2013). A large study examining the trajectories of PTSD symptoms in 8,178 military service members over a 10-year period found those who were combat-deployed had higher PTSD symptoms than those who were non-combat deployed (Donoho et al., 2017). Likewise, veterans returning from war tend to experience problems transitioning back into civilian living, as demonstrated by higher rates of job burnout, job strain, and work-family conflict (Vinokur et al., 2011). Other problematic health outcomes include increased rates of depression, anxiety, risk-taking, and heavier alcohol consumption (Killgore et al., 2008). Since combat exposure is associated with higher risk of poor mental health outcomes in veterans, there has been a growing demand to elucidate how resilience and psychological health can be targeted and maximized as a means of attenuating the impact of exposure to intense stress (Meredith et al., 2011; Solomon & Mikulincer, 2006).

Social Belongingness and Resilience

Psychological resilience has not received a consensus definition in the literature, yet one prominent definition suggests that it is the process of coping with the experience

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of something adverse or stressful (Meredith et al., 2011). Researchers have further emphasized that resilience is best conceptualized as a multi-dimensional interaction between the individual, their experiences and context. This can be categorized in terms of individual-level factors (e.g., positive coping, physical fitness), family-level factors (e.g., emotional ties, closeness), unit-level factors (e.g., positive command climate, teamwork), and community-level factors (e.g., belongingness, collective efficacy) (Meredith et al., 2011). While resilience is made up of a constellation of factors, evidence suggests that experiencing a strong sense of belongingness or social integration within one's community is at least one of the many evidence-informed factors that contributes to psychological resilience (Meredith et al., 2011). In recognizing the multi-dimensional evidence-based factors that contribute to resilience, there is a rising need for further clarifying these factors, the strength of their utility for maximizing resilience, and how to best implement them for purposes of training, treatment and prevention. Additionally, more investigation is needed on how identifying with the military as a group may affect resilience in deployed active duty samples as well as veterans returning to the civilian world.

Group Identification and Psychological Benefits

Social identity theory postulates that an individual's identification with a group, such as the military, can be instrumental in the provision of a sense of belongingness that is crucial for social integration and support during times of difficulty (Tajfel & Turner, 1986; Jetten et al., 2017). One aspect of the social identity approach emphasizes that individuals derive their sense of meaning and value directly through a desired group that represents some feature of their social affiliation (Hogg, 2016; Tajfel & Turner, 1986).

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The military happens to be a highly identified group in which individuals adopt a unique culture and value system, emphasizing collectivism over individualism, submission to authority within a strict hierarchy, and unwavering dedication to one's duty and mission (Coll et al., 2011). This environment can provide the opportunities and resources for bolstering social connections within a purpose-filled organization, which could be beneficial for health and well-being. For example, one study found evidence that social support is associated with lower risk of PTSD in military populations (Brewin et al., 2000). Another study conducted on a sample of military cadets found that public and private collective self-esteem (cadets' internal and external evaluations of the military's value as a group) were negatively related to depression (Rohall et al., 2014). The study further suggested that while promising results are anticipated on the role of collective identity in the military, there remains a huge gap in knowledge due to the lack of rigorous research on the topic in military populations. Since there is some evidence that suggests that collective self-esteem (i.e. collective military identity) is associated with lower levels of depression and that social support is associated with lower risk of PTSD in military populations, it is plausible that higher levels of belongingness to a group such as the military, may diminish poor mental health outcomes for service members who are exposed to combat.

Outside of research conducted on military populations, there is a growing body of work indicating that group memberships can be beneficial for psychological health (Haslam et al., 2018). For example, one study investigating the role of group memberships in participants with orthopaedic injuries and brain injuries found that forming new group memberships was associated with lower levels of PTSD symptoms

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(Jones et al., 2012). Why exactly group memberships are beneficial to psychological health is not clear yet, but there are indicators that it could be due to the social support, efficacy and belongingness it affords (Brown, 2020; Greenaway et al., 2015; Kyprianides et al., 2019). Furthermore, in alignment with the integrated social identity model of stress which states that group membership structures the way stress is experienced and appraised by individuals, there is evidence that suggests group membership plays an important role in how traumatic events are interpreted in the individual's life (Haslam et al., 2005; Muldoon et al., 2016). For example, a study conducted in Turkey compared political and non-political prisoners who had experienced torture and violence with the aim of assessing their psychological preparedness (Başoğlu et al., 1997). They found that while the political prisoners had experienced more violence over a longer period of time, they scored lower on Post-Traumatic Stress (PTS) than the non-political prisoners likely due to the preparedness afforded by an identity associated with a meaningful political cause (Başoğlu et al., 1997). This example suggests that the nature or severity of the trauma are not the only important factors that determine how trauma is experienced, but rather the identity available may help supply meaning that better prepares individuals to encounter and overcome great levels of suffering (Muldoon et al., 2016). Theoretically, in the same way that a political prisoner who strongly identifies with their political group has a cause that makes enduring suffering worthwhile, service members who highly identify with the military may be more psychologically prepared for the trauma that accompanies combat exposure due to the meaning associated with fighting alongside one's unit and for one's country.

Present Study

My research aimed to explore how the link between combat exposure and poor mental health outcomes – assessed in terms of perceived stress, PTSD, and psychological distress, may differ based on one’s level of collective military identification. I proposed a moderation model, where collective military identity buffers the relationship between combat exposure and PTSD, perceived stress, and psychological distress. More specifically, combat exposure would increase the risk of incurring symptoms of PTSD, psychological distress, and perceived stress – however collective military identification would provide a buffer against that deleterious effect, such that those with stronger levels of collective military identity would show a weaker relationship between combat exposure and PTSD, psychological distress, and perceived stress. The following hypotheses were tested:

H1: Collective military identity will buffer the relationship between combat exposure and PTSD symptoms.

H2: Collective military identity will buffer the relationship between combat exposure and perceived stress.

H3: Collective military identity will buffer the relationship between combat exposure and psychological distress.

Method

Overview

A secondary analysis was conducted on data collected through the Study for Employment Retention of Veterans (SERVe; Hammer et al., 2017). Previous SERVe studies investigated the work and health-related components involved in the lives of

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service members and military couples who are reintegrating back into civilian life, and provided workplace interventions for supporting the employment retention of veterans (Arpin et al., 2018; Hammer et al., 2017, 2019; McCabe et al., 2019; Mohr et al., 2018). Service members were recruited through a combination of emails, oral presentations, flyers and newsletters and consented through a brief online screener survey. The inclusion criteria consisted of working a minimum of 20 hours per week at an organization participating in the SERVe intervention study and having served in the military in post-9/11 conflicts including the National Guard and Reserves. All participants contributed to the study via online surveys and were compensated with a \$25 gift card for each survey completed (Hammer et al., 2019).

Participants

The SERVe sample consists of 497 veterans and reservists representing all branches of the military, the majority of which were separated from the military for an average of 6 years. However, for the sake of this study, 67 service members were excluded because they had never deployed (and thus had no opportunity for combat exposure; i.e., 10%) or failed to provide information about combat exposure, which is a central focus of the present study. This resulted in a total sample of 430 veterans and reservists. The average age is 40 years old, 84% male and 86.0% White. Of the overall SERVe sample, 75% of those who deployed with an average of three deployments since 9/11 reported at least one combat exposure. For more demographic information on this sample, see (Hammer et al., 2017).

Procedure and Measures

Participants completed a baseline assessment (e.g., Internet-based) prior to the intervention study, which included a variety of comprehensive measures related to work, family and health characteristics (Hammer et al., 2017; Mohr et al., 2018).

Collective Military Identity

Participants' levels of collective military identity or belongingness were measured using the 'Importance to Identity' subscale of the Collective Self Esteem Scale, a validated scale designed to measure collective identity in individuals as distinguished from personal identity (CSES; Luhtanen & Crocker, 1992). This 4-item scale is predicated on social identity theory and two of its distinguished aspects of the individual's self-concept, namely, personal and collective identity (Tajfel & Turner, 1986). The creators of this scale made a note of the similarity between their use of collective identity or collective self-esteem and Tajfel and Turner's use of social identity, in that both point to the multiple potentials of an individual's self-concept to derive value through affiliation with ascribed groups (e.g., race, ethnicity, religion) (Luhtanen & Crocker, 1992). In this study, the subscale measured the degree to which service members endorsed the military as an important part of their collective identity on a Likert-type scale of 1 (Strongly agree) to 5 (Strongly disagree). Participants were asked to rate the extent of agreement or disagreement with each subscale while reflecting on their most recent unit, on statements such as 'Belonging to the military is an important reflection of who I am'. The responses to the four items were averaged such that the higher total scores indicated stronger levels of military identification. The scale reported a Cronbach's $\alpha = .79$ and reported a mean total score value of 3.78 (SD = .84).

Combat Exposure

Service members' frequency of exposure to wartime-related stressful events was assessed through the Combat Exposure Scale, a validated measure developed specifically for military populations (CES; Keane et al., 1989). The CES is a subjective and retrospective measure made up of 27-items that takes into account different kinds of wartime experiences and the frequency of their occurrence. Participants were asked to rate statements such as 'Feeling directly responsible for the death of a combatant' on a Likert-type scale of 1 (Never) to 4 (5 or more times). For purposes of the present study, the CES responses were recoded into a categorical variable (0=no, 1=yes) indicating whether a particular kind of combat exposure was experienced. The responses to the dichotomous 27-items were summed where higher total scores indicated a higher number of wartime-related stressful events experienced. The scale reported a Cronbach's $\alpha = .95$ and reported a mean total score value of 6.44 ($SD = 6.92$).

Posttraumatic Stress

Participants' levels of posttraumatic stress were measured using a modified version of the Posttraumatic Stress Disorder Checklist, a 4-item validated screening tool developed for combat deployed active duty soldiers (PCL-M; Bliese et al., 2008). Participants were asked to rate the extent they experienced 4 kinds of diagnostic symptoms for PTSD, with statements such as 'Repeated disturbing memories, thoughts, or images of the stressful experience' on a Likert-type scale of 1 (Not at all) to 5 (Extremely). The responses to the 4-items were summed where higher total scores indicated higher levels of posttraumatic stress. The scale reported a Cronbach's $\alpha = .92$ and reported a mean total score value of 7.72 ($SD = 4.15$).

Perceived Stress

Participants' levels of appraising situations in life as stressful was measured using the Perceived Stress Scale, a validated scale that emphasizes experienced levels of stress as distinguished from measures that capture depressive symptomology (PSS; Cohen, Kamarck, & Mermelstein, 1983). The PSS can be utilized in identifying whether the levels of stress perceived are a risk factor for poor mental health outcomes. The PSS measured the subjective appraisal of stressful events in service members' lives in the last month through 4-items rated on a scale of 1 (Never) to 5 (Very often), with questions such as 'In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?'. The responses to the 4-items were averaged where higher total scores indicated higher perceptions of stress in relation to events in the last month. The scale reported a Cronbach's $\alpha = .76$ and reported a mean total score value of 2.37 ($SD = .83$).

Psychological Distress

Participants' severity levels of non-specific psychological distress were measured using the Psychological Distress scale, a validated short-form scale typically used for screening general mental health symptoms (i.e. anxiety, depression) in primary care contexts (K6; Kessler et al., 2002). Participants were asked to rate 6-items on a Likert-type scale of 1 (None of the time) to 4 (Most of the time), with statements such as 'Feel so depressed that nothing could cheer you up'. The responses to the 6-items were averaged where higher total scores indicated greater severity of non-specific psychological distress. The scale reported a Cronbach's $\alpha = .90$ and reported a mean total score value of 1.84 ($SD = .74$).

Data Analysis

Moderated one-way independent samples ANOVAs were conducted to investigate the hypotheses. Separate models were run for each outcome of interest including PTSD, psychological distress, and perceived stress. Models included grand-mean centered combat exposure and collective self-esteem as predictors, as well as the interaction effect between the two predictors, which allows for the testing of moderation. Analyses controlled for military rank, educational level, length of deployment, and gender. Potential covariates were determined based on previous research conducted using the SERVe sample (Mohr et al., 2018); covariates retained were those that revealed significant associations with mental health outcomes (see Table 1).

Results

Descriptive Statistics

All correlations among the predictors and outcomes were significant and positive (see Table 1). All mental health outcome variables, including post-traumatic stress, psychological distress, and perceived stress were significantly and positively associated with each other. Combat exposure was significantly and positively associated with all three mental health outcome variables, with the largest correlation with posttraumatic stress relative to perceived stress and psychological distress. However, the more unexpected significant and positive correlations were between military collective identity and all three mental health outcome variables. Further, a significant and positive correlation was found between collective military identification and combat exposure.

Hypothesis Testing

Hypothesis 1 stated that military collective identity would buffer the relationship between combat exposure and PTSD. ANOVA analysis revealed that combat exposure was significantly related to PTSD symptoms ($B=.213$; 95% CI=.159, .267) at $F(1, 409)=61.09$, $p < .001$. In addition, collective military identity was significantly and positively associated with PTSD symptoms ($B=.825$, 95% CI=.382, 1.268) at $F(1, 409) = 13.42$, $p < .001$. However, the hypothesized interaction effect between collective military identity and combat exposure was not significant ($B=.019$, 95% CI=-.045, 1.268) at $F(1, 409) = .34$, $p = .561$. Thus, hypothesis 1 was not supported (see Table 2).

Hypothesis 2 stated that collective military identity would buffer the relationship between combat exposure and perceived stress. ANOVA analysis revealed that combat exposure was significantly and positively related to perceived stress ($B=.018$; 95% CI=.007, .030) at $F(1, 424)=9.68$, $p < .01$. However, collective military identity was not significantly related to perceived stress ($B=.082$, 95% CI=-.013, .177) at $F(1, 424) = 2.86$, $p = .092$. The hypothesized interaction effect between collective military identity and combat exposure was not significant ($B=.012$, 95% CI=-.003, .026) at $F(1, 424) = 2.60$, $p = .107$; thus, hypothesis 2 was not supported (see Table 2).

Hypothesis 3 stated that collective identity would buffer the relationship between combat exposure and psychological distress. ANOVA analysis revealed that combat exposure was significantly and positively related to psychological distress ($B=.019$; 95% CI=.009, .029) at $F(1, 410)=12.89$, $p < .001$. However, collective military identity was not significantly related to psychological distress ($B=.074$, 95% CI=-.011, .159) at $F(1, 410) = 2.95$, $p = .086$. The hypothesized interaction effect between collective military

identity and combat exposure was not significant ($B=.019$, 95% CI=-.045, 1.268) at $F(1, 409) = 2.88$, $p = .090$. Thus, hypothesis 3 was not supported (see Table 2).

Discussion

The purpose of this study was to investigate whether collective military identity moderated the relationship between combat exposure and PTSD, psychological distress, and perceived stress in a sample of U.S. Military veterans and current reservists.

Although higher levels of combat exposure were significantly associated with higher levels of PTSD, psychological distress and perceived stress – contrary to my hypotheses, collective military identity did not significantly buffer the relationship for any of the mental health outcomes, as evidenced by the lack of significant interaction effects.

Furthermore, collective military identity was significantly and positively associated with PTSD symptoms and combat exposure but was not significantly related to psychological distress or perceived stress. The details of these findings are discussed below.

Having predicted that collective military identity would serve a beneficial role in buffering the impact of combat exposure on mental health, the most unexpected finding was for a significant and positive association between collective military identity and PTSD symptoms. However, it is slightly more telling when taking into consideration that collective military identity was uniquely related to PTSD symptoms, but not more generalized psychological distress (i.e., anxiety, depression) or subjective appraisals of stress in the last month. This indicates a tighter knit relationship between stronger levels of collective military identification and a very particular kind of mental health status that is encompassed by PTSD symptomology rather than more generalized psychological distress or perceived stress. It is important to note that the majority of the sample of

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service members were separated from the military for on average, 6 years. Therefore, it makes sense that veterans parted from the military for that long who continue to retain lingering military-related PTSD symptoms are more likely to be strongly reminded of the salience of their military identity, since that represents the context of their trauma. One can imagine a multiplicity of ways for consistent cues of military service to arise in the civilian context, either through commercials, films, and holidays – all serving as reminders of the connection between being a soldier and experiencing trauma in combat. In that sense, the simplest explanation would be that service members who have PTSD symptoms will also be more strongly reminded of the impact the military has had on their life and the irrevocable role it continues to play in their self-concept. This suggests an important need for identifying lingering PTSD symptoms in veterans even years after service and providing the necessary interventions to alleviate those symptoms. Further, it calls for a deeper investigation of the valence of collective military identity in veterans who continue to suffer from lingering PTSD symptoms.

A potentially novel, positive and significant association was found between collective military identity and combat exposure. It is not clear why this is the case; being a cross-sectional analysis, it is unclear whether strong levels of collective military identification preceded combat exposure or followed from it. It is very well possible that combat exposure could promote collective military identification due to the psychological, social, and physical costs that accompany the trauma of combat (Aronson & Mills, 1959). It would be very difficult to elude war-related experiences without leaving with an important impression of the meaning of such a difficult and potentially life-threatening experience to one's life and sense of self (Park et al., 2006). Even though

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war-related experiences bring about a myriad of dangers to psychological and physical health, these dangers are faced directly by a unified group of service members who fight not only for a greater cause, but for one another. Thus, the experience of enduring adversity and suffering together could further strengthen group bonds or unit cohesion and thereby reinforce the importance of the military to the collective identity of the service member. While there is some evidence indicating that unit cohesion and social support are associated with lower levels of depression and suicide ideation (Rugo et al., 2020) – conversely in this sample, there was no indication of trauma reduction or post-traumatic growth due to the meaning making capabilities of stronger levels of collective military identity, as evidenced by the lingering presence of PTSD symptoms. While there is little to no research on the role of combat exposure in collective military identification, one study investigating the impact of military trauma exposure on the valence of identity change in a sample of UK military veterans found that trauma alone was not related to measures of identity change but rather PTSD was associated with a negative change in worldview (Brewin et al., 2011). In other words, war-zone stress did not necessarily impact view of self in any significant way, instead PTSD in service members played a more salient role in negatively shaping their view of the world. It is important to note that they were not assessing social identity such as collective military identity, but rather more personal domains of identity. The qualitative analyses provided in their study was particularly telling, with service members seeing the world in a profoundly new way after their military experience, as marked by brutality, distrust, and estrangement (Brewin et al., 2011). The emphasis on estrangement was portrayed by a theme of alienation from civilian life, with mentions of importantly belonging to the military while finding

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isolation in the civilian world. Consistent with Brewin et al.'s results, our sample of veterans endorsed strong levels of collective military identity, even after having 6 years of separation from the military and undergoing the adjustments of transitioning to civilian life. It is unfortunate that our study did not include any personal measures of identity, through which the implications of personal and collective domains of identity for psychological health could be explored in greater distinction.

To my knowledge, the present study is the first to investigate the moderating role of collective military identity on the link between combat exposure and poor mental health outcomes in a sample of veterans and reservists. One previous study investigated the role of both private and public collective self-esteem in a sample of military cadets and found that both forms of collective self-esteem were positively related to higher levels of personal self-esteem and lower reported levels of depression (Rohall et al., 2014). My results were not consistent with Rohall et al.'s findings, with no significant relationship found between collective military identity and psychological distress, a potential proxy for depression. This could be due to differences in the nature of the two study populations, being that Rohall et al. looked at cadets and the present study at veterans and reservists. Cadets are still in an earlier stage of their development and participation in the military, lacking the potentially traumatizing experiences of deployment and direct exposure to combat that veterans and reservists would have more likely encountered. Therefore, the military could likely play a more symbolically idealistic role in the self-concept of a cadet than a veteran who has experienced the realities of war. A second reason could be due to the use of different subscales of the CSES between studies, wherein Rohall et al. measured 'private and public collective self-

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esteem' but I measured 'importance to identity'. For instance, their subscales emphasize how service members personally evaluated the military as well as outside perceptions of the military, whereas mine measured the importance of being a member of the military to the service member's self-concept. A third factor to take into account is while the psychological distress scale used in this study (K-6; Kessler et al., 2002) does not measure specific disorders like depression, it is utilized as a measure of non-specific yet heterogenous symptoms that tend to be prevalent across a wide scope of mental disorders. Consequently, individuals who are struggling with depression are more likely to score higher on the psychological distress scale. Thus, it is worth noting the discrepancies between their measures and ours as well as differences in population and the influence those factors may have had on the contradicting results. Additional research is needed help disentangle the mixed results.

Consistent with previous studies, combat exposure was significantly and positively associated with poor mental health outcomes in service members as shown by higher rates of PTSD symptoms, psychological distress, and perceived stress (Donoho et al., 2017; Schnittker, 2018; Xue et al., 2015). There continues to be an ongoing emphasis in the literature on both the short-term and long-term detrimental health implications of traumatic exposures to combat on the lives of service members (Donoho et al., 2017; Killgore et al., 2008); nevertheless, it is important not to overstate the role of PTSD in US veterans as recent evidence has indicated the majority (85%) of the returning service members from Iraq and Afghanistan did not develop PTSD (Bonanno et al., 2012). One study advocated for the inclusion of daily stressors as mediators of the influence of war exposure on mental health to gain perspective on the stressful contributions of the

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immediate social and material conditions in the lives of service members in relation to distal war experiences (Miller et al., 2010). Nevertheless, the present study upholds the finding that combat exposed veterans and reservists tend to have higher rates of psychiatric relevant symptoms as well as more general stress likely generated out of daily living circumstances.

Limitations

One important limitation of the present study is due to the nature of the sample being majority veterans and reservists, but not actively deployed service members. The levels of collective military identity may vary across deployment status and recent activity with the military. The veterans who represented most of the SERVe sample were approximately 6 years removed from their service; therefore, the data reported for levels of collective military identity and combat exposure are retrospective for the majority of the sample. Further, this sample may not be generalizable to active duty samples. It could be that active duty service members who are exposed to combat may leave with a more drastic impact of the military on their sense of identity due to the extreme nature of wartime experiences, and endorse much stronger levels of collective military identification than prior to deployment. Since actively deploying troops would have a much more immediate rather than retrospective access to their most recent combat experiences, they could in turn provide unique reports that may help disentangle the temporal relationships between these variables. Lastly, it may be the case that these results were affected by selection bias as certain types of veterans (e.g., highly military self-identified veterans) may have been most motivated to sign up for this study.

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There are a variety of issues that have been recently proposed on the limitations of social identity theory for making scientific predictions, as well as strengths for its use as more of a general framework for understanding intergroup behavior and collective identity (Brown, 2020). One issue relevant to this study arises from the possibility for an individual to be associated with a multitude of groups at any given time, which rightfully complicates group membership and how it can be isolated and studied in any meaningful way. A highly identified group, such as the military, is uniquely distinguished from other groups in its culture, customs, traditions, behavior and worldview; however the problem of isolating one group membership in the individual arises when identities become increasingly multi-faceted across a multiplication of intersectional categories as captured by religion, ethnicity, gender and so forth (Brown, 2020). For example, a service member could be an artist, Catholic, and Middle Eastern, rendering the traceability of each one's function in the individual very difficult in the midst of a complex mixture of group affiliations. Further, attempting to isolate and draw connections between an amalgamation of collective identities and their influence on mental health outcomes seems even more difficult. Social identity theory assumes the salience of one predominant group identity, which may be especially problematic when considering all the other unaccounted for group influences in each service member (Tajfel & Turner, 1979; Brown, 2020). Further, this sample is predominantly composed of veterans and reservists who have had the chance to incorporate a multitude of groups into their lives since the line between civilian and military living was gradually blurred over a 6-year period. While the case for studying the role of collective military identity is worthwhile when taking into account the distinctiveness of military group culture and dynamics,

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future studies may benefit from gaining a larger picture of the salience of other group identities and/or involvements operating in service members in comparison to collective military identity. This could provide insight into the degree to which veterans are beginning to socially integrate in civilian society upon returning from war.

The collective-self-esteem scale is designed to capture the degree to which an individual feels that a particular group is an important part of their self-concept (CSES; Luhtanen & Crocker, 1992), but it does not capture positive or negative evaluations of the contributing role of a given collective identity. Collective self-esteem is a construct that is predicated on social identity theory, operating on the assumption that individuals who endorse a strong sense of belonging to a group would do so with positive attribution (Luhtanen & Crocker, 1992; Tajfel, 1974). However, an individual could very well feel that they strongly belong to a group and that it plays a central role in their self-concept, but simultaneously feel that it is playing a negative rather than positive role. In other words, while the ingroup could be a source of positive distinctiveness for the individual, I don't see why it could not also be a source of negative distinctiveness especially when considering the complexity of a group's associations. For example, there is evidence that suggests that psychological problems are often stigmatized in military populations, creating a barrier for pursuing help (Greene-Shorridge et al., 2007); therefore negative aspects of a group's culture may factor into those who strongly identify with the military. In this study and due to the limitations of the collective-self-esteem scale, I did not capture whether service members would evaluate their varying levels of collective military identification as positive and beneficial, or negative and detrimental. While one could argue that according to the CSES, service members who endorsed high levels of

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collective self-esteem did so because the military plays both an important and positive role in their self-concept, I find the CSES lacking the necessary valence for differentiating between positive or negative evaluations of one's collective military identity. Having access to the evaluations service members have of the role of their collective military identity in their life would provide a greater understanding of whether it is functioning positively or negatively in the individual. Further, gathering qualitative data from combat exposed veterans may prove useful for gaining the necessary insight on the stories they tell about their military experiences and identity.

Another limitation in this study is due to a limited analyses of combat exposure, where I only considered the presence of combat exposure and not associations with different kinds of combat exposure. One researcher claimed that combat exposure alone is a rudimentary indicator, while more attention should be paid to broader kinds of trauma such as the exposure to the dead and wounded outside of direct combat (Schnittker, 2018). The importance of this arises from the multiplicity of roles assigned to service members (medical personnel) who may not experience direct exposure to combat, but still experience the equally traumatizing after-effects of those who are dead or wounded. In this study, I did not explore different kinds of war-related experiences and their relationships with different mental health outcomes. Future studies would benefit greatly from investigating more specific links between types of trauma experienced, with and without combat, in relation to mental health outcomes.

Lastly, this study is cross-sectional in nature, and thereby limiting all causal interpretations of the relationships between the variables. It is not clear whether service members had strong levels of collective military identification prior to being exposed to

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combat or after being exposed to combat, or before or after the emergence of PTSD symptoms. The moderation hypotheses in this study may lead to more interesting results in active duty samples and with longitudinal designs, by gaining a more precise picture of pre-deployment levels of collective military identity and then examining those levels of collective military identity in relation to buffering effects on psychological health both during deployment and after. Future studies should employ longitudinal designs to clarify the causal relationships between these variables.

Implications

Further research is needed on the role of collective military identity in relation to PTSD symptomology, both in active duty samples and separated service members who are transitioning back into civilian living. It is not yet clear why collective military identity is positively and significantly associated with PTSD symptoms, and whether it is sample-dependent (active duty vs. veterans). It is also not clear how levels of collective military identity will vary both before and after exposure to combat. If we gain a greater understanding of the complexity of these relationships, we may discover the conditions under which collective military identity may be beneficial, detrimental or even indirectly related to psychological health and resilience. For example, strong levels of collective military identity may not be advantageous for separated service members attempting to start new lives as civilians, especially if it is a pressing reminder of trauma or alienation in the civilian world – but may be suitable during deployment for maximizing social support. It could also be the case that stronger levels of collective military identification may indicate the presence of stronger social bonds within one's unit, which creates the capacity for greater trauma via experiencing the injury or loss of a close friend in war.

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Additionally, the role of collective military identity should be investigated in active duty military populations by virtue of its potential influence on unit cohesion. Do varying levels of collective military identity impact the performance levels of active duty service members within their units? Could there be any potential negative effects of group identification across differing military samples? With further knowledge of this topic, we can gauge where and when collective military identity is salient in its influence on psychological health and resilience, whether prior to deployment in active duty samples, or after separation from the military in veterans and for better or worse. If varying levels of collective military identity prove important, such findings can inform resilience training programs, and interventions for strengthening group cohesion and identification in active duty military personnel. Research on this topic can also contribute to a growing need in assisting the transition of service members back to civilian living, especially if pursuing social integration with new groups (e.g., faith-based communities, sports teams) rooted in the civilian context may be of aid (Angel et al., 2018; Meredith et al., 2011; Mobbs & Bonanno, 2018).

Conclusion

In summary, the results of this study suggest that US veterans and reservists who report that the military plays an important role in their sense of identity also counter-intuitively show higher rates of PTSD symptoms and exposure to combat. This study is among the first to explore psychological health associations with the importance of the role of the military to the identity of service members. The implications suggest that there is an ongoing need to investigate and provide for the social and psychological needs of veterans and reservists adjusting to civilian living, as well as to examine the potential role

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of collective military identity in relation to resilience and psychological health in active duty samples. Future studies should investigate these questions using a more rigorous methodology.

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Table 1
Means and Standard Deviations for and Correlations among Combat Exposure, Collective Self-Esteem, Posttraumatic Stress, Psychological Distress, Perceived Stress and Covariates

	M	SD	Correlations										
			1.	2.	3.	4.	5.	6.	7.	8.	9.		
1. Combat Exposure	6.44	6.92	1.00										
2. Collective Self-Esteem	3.78	.84	.21**	1.00									
3. Perceived Stress	2.37	.83	.19**	.11*	1.00								
4. PTSD symptoms	7.72	4.15	.40**	.24**	.48**	1.00							
5. Psychological Distress	1.84	.745	.21**	.12*	.69**	.68**	1.00						
6. Gender	.16	.37	-.14**	-.07	.05	-.01	.03	1.00					
7. Military Rank	2.36	1.22	-.08	-.01	-.22**	-.19**	-.24**	.01	1.00				
8. Educational Level	3.79	.79	-.13**	-.11*	-.15**	-.14**	-.14**	.09*	.39**	1.00			
9. Length of Deployment	7.91	4.29	-.07	.04	.04	-.13**	.03	.04	-.07	0	1.00		

Notes. $N = 430$. * $p < .05$, ** $p < .01$.

Table 2

One-way ANOVA predicting Mental Health Outcomes

	<i>PTSD Symptoms</i>	<i>Perceived Stress</i>	<i>Psych. Distress</i>
	<i>B</i>	<i>B</i>	<i>B</i>
Combat Exposure	.21***	.02**	.02***
Collective Military Identity	.83***	.07	.08
Combat Exposure * Collective Military Identity	.02	.01	.01
Educational Level	-.33	-.06	-.06
Military Rank	-.52**	-.13***	-.13***
Length of Deployment	-.12**	.01	.01
Gender	-1.17*	-.26*	-.25*
Adjusted R ²	0.23	.09	.11

Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. *B* represents unstandardized regression coefficients.

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