Examining if religion, spirituality, and religious attendance buffers the impact combat exposure has on mental health symptoms

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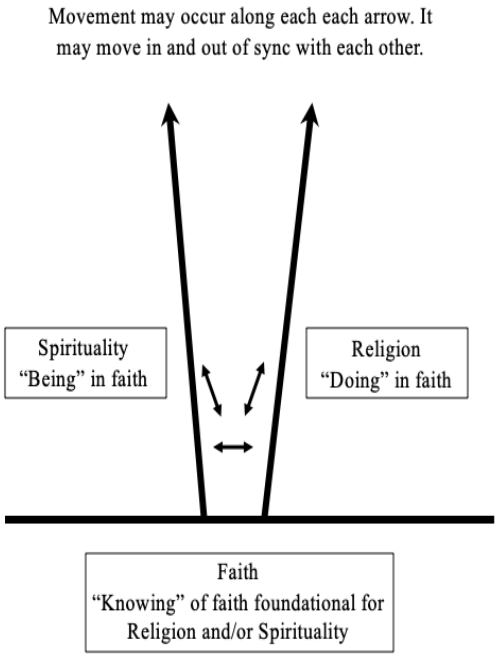
Context

- Recent estimates found that more than 193,000 Service members experienced a deployment in a single year (Bialik, 2017)
- The relationship between combat exposure and mental health symptoms
- Important buffers or moderators
  - Currently:
    - Unit cohesion (Kanesarajah et al., 2016; Reed-Fitzke & Lucier-Greer, 2019; Williams et al., 2016), Unit morale (Dyches et al., 2017), Social support (Muse et al., 2019), Marital status (Watkins et al., 2017), and Interpersonal relationships (Reed-Fitzke & Lucier-Greer, 2019)
  - Possible moderators:
    - Religion/Spirituality
- With such a large percentage of Service members identifying as religious/spiritual (over 76%), next steps in the literature are to determine how religion/spirituality impacts the mental health of Service members

Theoretical Orientation

- Religious Coping Theory (Pargament, 2001)
- Newman's (2004) framework of understanding the interrelationship between religion and spirituality
- Pearlin's (1990) Stress Process Model



Current Study

- **Hypothesis 1 (H1):** Higher levels of Soldiers' combat exposure will be associated with higher levels of adverse mental health (i.e., anxiety, depression) symptoms.

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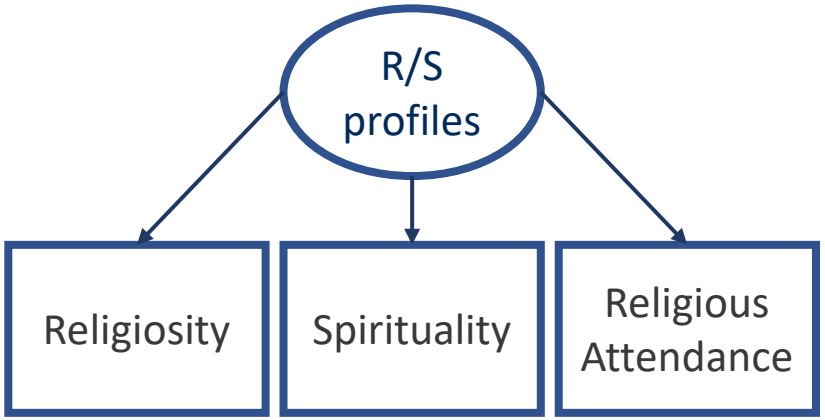

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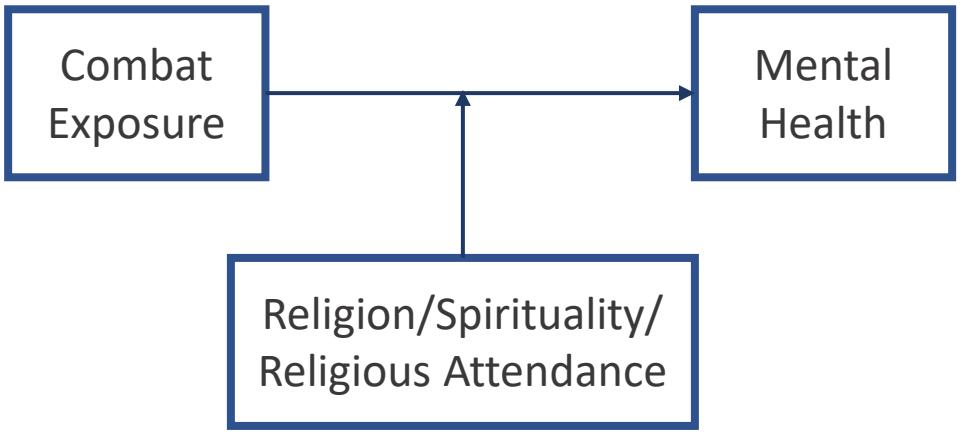

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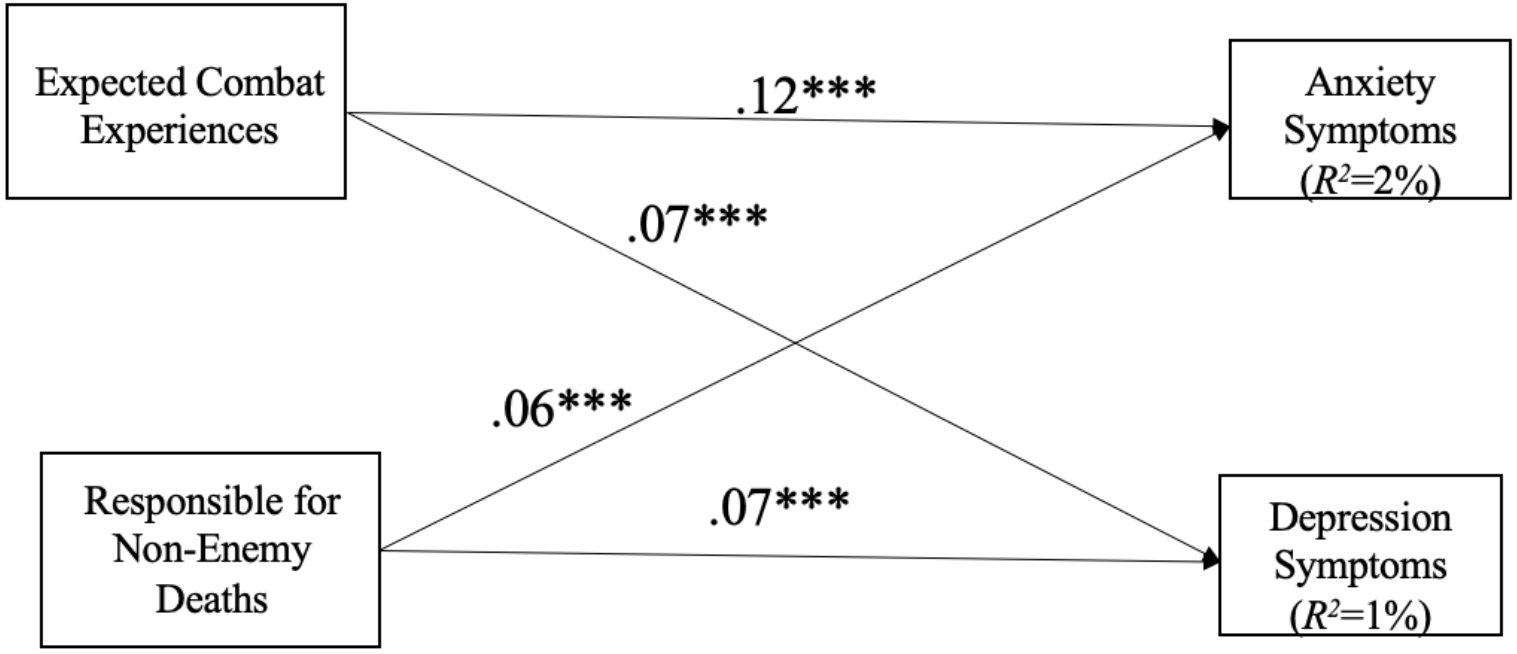
- **Research Question 1 (RQ1):** Do different groups of Soldiers emerge from the measures of religion, spirituality, and religious attendance?
- **Research Question 2 (RQ2):** Does religion/spirituality moderate the relationship between combat exposure and mental health?

Methods: Data

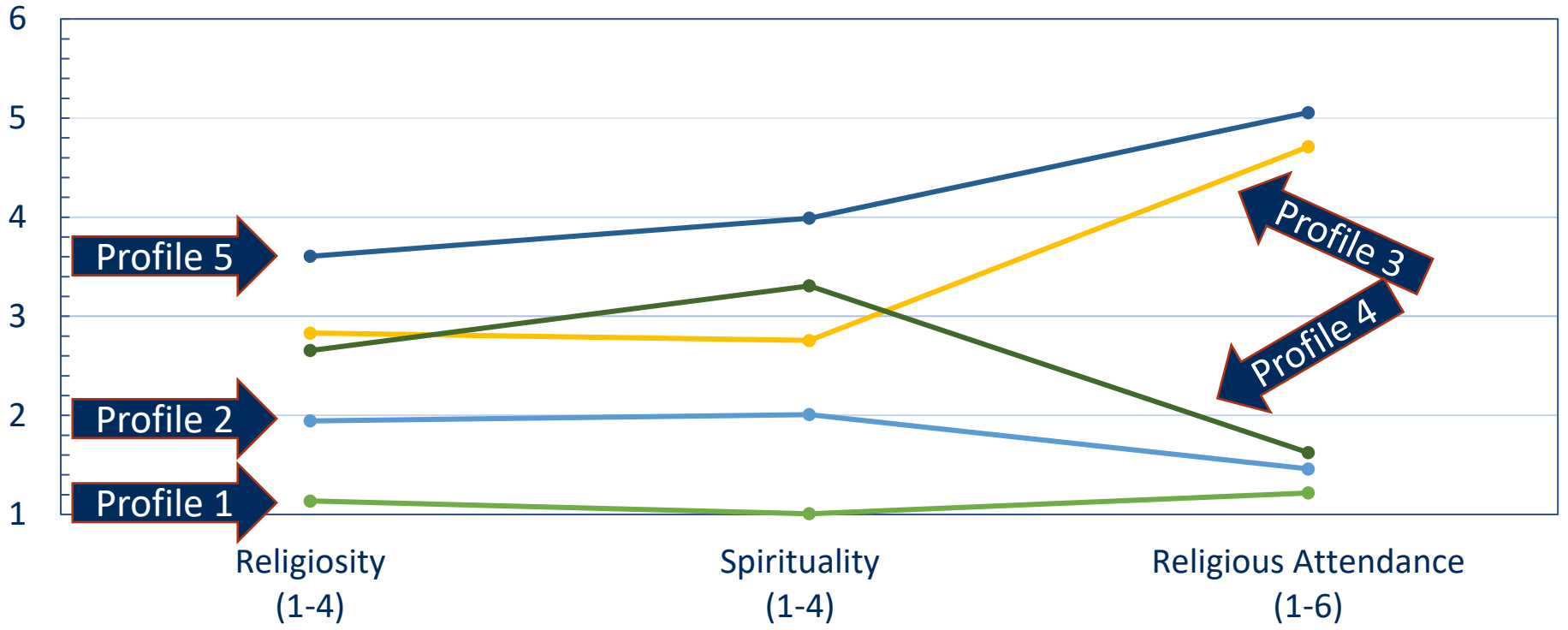
- Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS; Ursano et al., 2015)
  - All Army Study (AAS; 2011-2012) component
- The analytic sample consisted of 13,155 Soldiers
- Measures included:
  - Predictor:
    - Combat Exposure (Sherman et al., 2021)
      - Expected combat experiences
      - Responsible for non-enemy death
  - LPA indicators:
    - Religiosity (single item; how religious are you?)
    - Spirituality (single item; how spiritual are you?)
    - Religious attendance (single item; frequency of attendance?)
  - Distal outcomes:
    - Anxiety symptoms (Generalized Anxiety Disorder Scale)
    - Depressive symptoms (CIDI-SC Major Depressive Episode Scale)
  - Control Variables:
    - Gender, Age, Education, Marital Status, Race

H1: Associations between Combat Exposure and Mental Health Symptoms



Note. Path analysis where symptoms of anxiety and depression were regressed onto the two components that emerged from the DRRI combat exposure scale. Gender, age, education, marital status, and race are accounted for in the model. Standardized coefficients are presented. CFI = 1.00; TLI = .996; RMSEA[90% CI] = 0.01[.00, .03] p<.001***

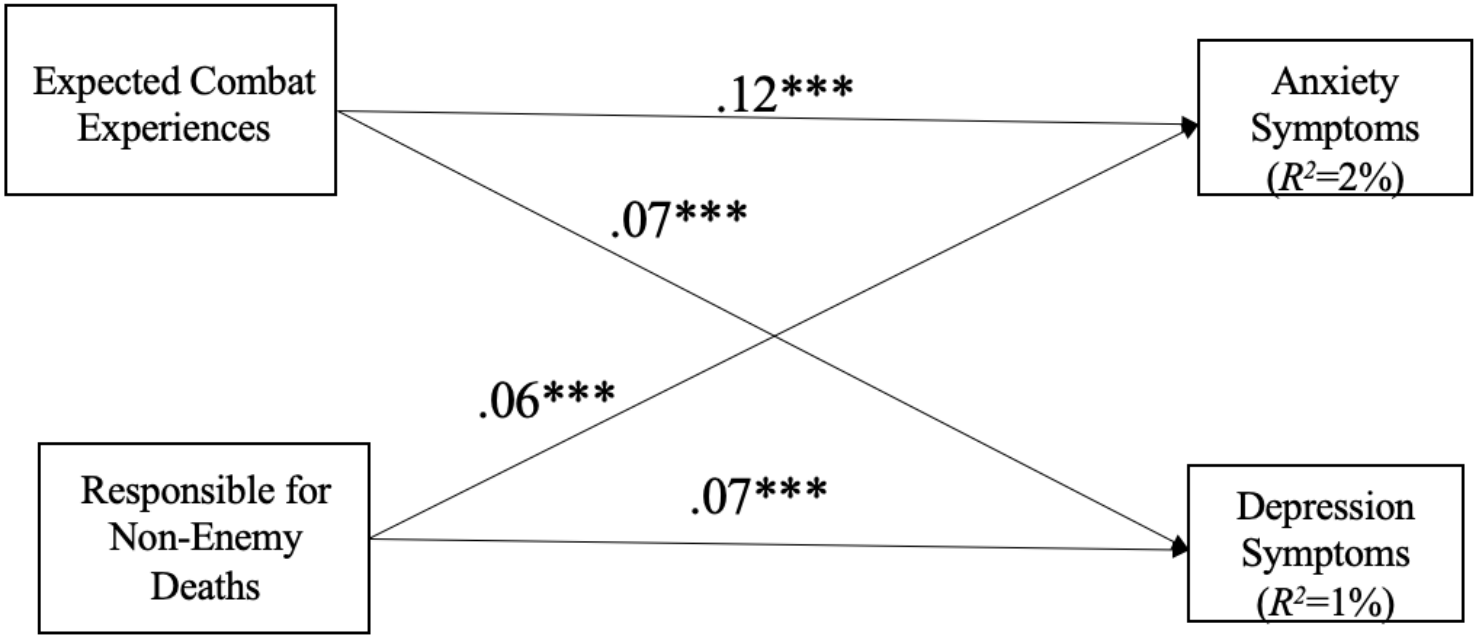
RQ1: *Latent Profile Analysis (LPA) with five profiles*



- Profile 1: Non-religious/spiritual & Non-attenders (n=2,601; 20%)
- Profile 2: Slightly religious/spiritual & Non-attenders (n=3,328; 26%)
- Profile 3: Moderately religious/spiritual & Frequent attenders (n=1,775; 14%)
- Profile 4: Moderately religious/spiritual & Infrequent attenders (n=4,183; 30%)
- Profile 5: Very religious/spiritual & Frequent attenders (n=1,268; 10%)

RQ2: Moderation

- No significant path differences for the four paths were found across the five groups



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Implications

- Researchers:
  - Continue examining what moderators may help buffer the negative impacts of combat exposure on mental health symptoms
- Practitioners:
  - Consider that religion and spirituality may be used to cope but that it can take positive and negative forms
- Policy makers and military leadership:
  - Consider implementing more training and preparation for Service members before they deploy to combat zones
  - Debrief after combat exposure, especially intense combat exposure, within Units may benefit the mental health of Service members

Thank you!

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