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Emotional Intelligence's Impact on the Relationship Between Trait Anxiety and Veteran Reintegration to Civilian Life

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Walden University

College of Psychology and Community Services

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Felicia H. Rapozo

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Walden University
2022

Abstract

Emotional Intelligence's Impact on the Relationship Between Trait Anxiety and Veteran Reintegration to Civilian Life

by

Felicia H. Rapozo

MPhil, Walden University, 2020

MA, Fayetteville State University, 2014

BA, University of North Carolina at Greensboro, 2009

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

May 2022

Abstract

Every year in the United States, over 200,000 individuals leave the military and begin their transition to civilian life, a period known as veteran community reintegration (VCR). A significant number of these individuals have reported VCR challenges, with a substantial number reporting mental health concerns. Recent studies have found that a number of individual differences (e.g., social support) can influence VCR challenges; however, no known studies have examined the influence of trait anxiety and emotional intelligence (EI) on VCR. Therefore, the purpose of this quantitative study was to address this gap by determining whether the relationship between trait anxiety and perceived VCR challenges was moderated by EI. The military transition theory and the EI theory were used as the theoretical foundations for this study. Online surveys were administered to 182 post-9/11 veterans who had recently separated from the military. Participants were recruited from SurveyMonkey's audience panel. With a standard multiple regression analysis, the present study found three significant results: (a) trait anxiety predicted perceived VCR challenges, (b) EI predicted perceived VCR challenges, and (c) EI moderated the relationship between trait anxiety and perceived VCR challenges. The results revealed that high levels of EI had the strongest buffering effect on the relationship between trait anxiety and VCR challenges, while low levels of EI had the weakest buffering effect on the relationship between trait anxiety and VCR challenges. Results may inform a positive social change by aiding in the development of transition programs and services, including EI training, to ease the stress veterans experience during VCR.

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Dedication

This dissertation is firstly dedicated to my husband, Amaurys Rapozo. Thank you for always pushing me, supporting me, and buying me ice cream when the stress was just too much. You were there for all the tears and rants. I am grateful for everything you have done to support me through this process. You believed in me when I did not believe in myself. Thank you for everything. I never would have gotten this far without all your support.

Secondly, I want to dedicate this dissertation to my three children: Bryson, Liliana, and Gabriela. Everything I do is for you. Many times, you have asked me why I wanted to get a PhD. I hope that one day you will look back on this and understand that I did it for myself, but also to show you that you are far more capable than you know and that anything is possible.

Finally, I want to dedicate this dissertation to my grandmother, Geraldine Hall. You always believed in me. You always bragged about how smart I was and even when I did not feel it, you reminded me. Every time you looked at me, I could see the pride you had for me. I am the woman, wife, and mother I am today because of you. I would have loved to have you here so that you could finally see me become a “doctor.” I know that in your eyes, I was always a “doctor” and I know you are in heaven watching over with such pride. I love you and miss you every day.

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I also want to think my friend and fellow Walden student, Devon Scherer. You were always there to listen to me complain or rant. We have never met in person, but I am so grateful we have traveled on this journey together.

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Chapter 1: Introduction to the Study

Discharge from the military (i.e., separation) is an important part of every military service member's career when they begin the transition from service member to civilian. But for some individuals, this transition period is fraught with challenges that make adjusting to civilian life difficult. Community reintegration challenges faced during this period can manifest in all aspects of an individual's life, including psychological, social, and physical health, employment, housing, financial, legal, or spiritual (Elnitsky, Fisher, et al., 2017). One of the main concerns is mental health, with veterans having high rates of mental illness and suicide compared to their civilian counterparts (Derefinko et al., 2018; Disner et al., 2017; Haller et al., 2016; Hourani et al., 2012).

Studies have found that individual differences in self-efficacy and levels of social support can mitigate challenges veterans face when reintegrating to community life. But research is needed to determine whether individual differences in trait anxiety and emotional intelligence (EI) are related to veteran community reintegration (VCR; Castillo et al., 2019). By identifying factors that may exacerbate the challenges faced by veterans reintegrating into community life (i.e., trait anxiety) or that may mitigate those challenges (i.e., emotional intelligence), findings from this study can effect positive social change. These results may aid in developing transition programs and services, including EI training, to ease the stress veterans experience when transitioning from military service to civilian life.

Chapter 1 will present a short discussion of the study's topic, research problem, purpose, and research questions and hypotheses. Following this, the theoretical

foundation will be presented as will the nature of the study, variable definitions, assumptions, the scope, and delimitations. The chapter will end with a brief discussion of the study limitations and significance.

Background

Every year, thousands leave the military to begin the process of reintegrating into civilian life. Leaving the military means a loss of identity, homes, employment, finances, and even friends (Binks & Cambridge, 2018; Pease et al., 2016). In addition to these losses, a number of veterans begin the community reintegration process with mental and/or physical health issues. For others, these issues do not appear until after reintegration has started, and a significant number of veterans have shown a decline in mental health after separating from the military (Schultz et al., 2014). The stress of leaving the military, combined with multiple personal losses and other aspects of the reintegration process, may help to explain the high rates of mental illness rates among veterans. With as many as 17 veterans dying from suicide every day (U.S. Department of Veteran Affairs [VA], 2019), there is an obligation to understand the challenges they face, especially the challenges related to mental health.

Anxiety disorders are among the most common mental health concerns for veterans often accompanied by major mental health disorders prevalent in the veteran population such as post-traumatic stress disorder (PTSD) and major depressive disorder (Knowles et al., 2019; Shepardson & Funderburk, 2016; Shepardson et al., 2019). Previous research suggests that the development of anxiety disorder is associated with trait anxiety, where higher levels of trait anxiety were a risk factor for the development of

an anxiety disorder (Muris et al., 2001). Trait anxiety is described as the tendency to assess situations as threatening, resulting in a heightened fear response (Cho et al., 2019; Knowles & Olatunji, 2020). It is associated with a number of problems that could make the reintegration process harder, such as depression, anger, fatigue, sleeping difficulties, and low self-esteem (Huang et al., 2012; Segalàs et al., 2021; Weeks et al., 2019). Thus, individual differences in trait anxiety may be a risk factor for some veterans' successful community reintegration.

EI is another individual difference that may influence veterans' successful community reintegration. It is described as an individual's ability to recognize and understand their own and others' emotions to guide their thinking and behavior (Oden et al., 2015). Individuals with higher levels of EI have reported lower levels of stress, PTSD symptoms, alcohol use problems, impulsivity, and trait anxiety (Andrei et al., 2018; Gaher et al., 2014; Singh & Sharma, 2012). Veterans face many of these same issues during their community reintegration period. Consequently, it is possible that high levels of EI may be a protective factor for veterans negotiating community reintegration. But to date, research on trait anxiety and EI has used civilian rather than veteran populations. Furthermore, there was no known literature that addresses how individual differences in trait anxiety and EI influence VCR challenges. This study addressed this gap in the literature, focusing on whether the relationship between trait anxiety and perceived VCR challenges was moderated by EI.

Problem Statement

Of the number of veterans reintegrating every year, as many as 75% have reported having difficulties with VCR challenges (Whitworth et al., 2020). These challenges are interrelated and multidimensional, suggesting that issues in one area of VCR may influence issues in another area (MacLean et al., 2014; Oster et al., 2017). For example, a veteran with mental health problems may have difficulty gaining/maintaining employment, finding/keeping housing, and maintaining family cohesion, which may exacerbate the mental health problems. Further, prevalence rates for anxiety disorders in veterans ranged from 3.6% to 13% (Hourani et al., 2012; Knowles et al., 2019; Nason et al., 2019), with over 50% reporting impairment in their lives (Mather et al., 2010). Compared to Vietnam-era veterans, Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) veterans have had significantly higher prevalence rates of anxiety disorders (Knowles et al., 2019).

Although there is great deal of research on VCR challenges, trait anxiety, and EI, there is still a lot that is not known. Many of the studies on anxiety and EI used civilian rather than veteran samples (e.g., Coccaro et al., 2016; Malinauskas & Malinauskiene, 2020; Segalàs et al., 2021; Wang et al., 2019). Additionally, much of the literature has focused on the reintegration of soldiers/veterans following a deployment rather than separation from the military (Brenner et al., 2015; Cederbaum et al., 2017). Reintegrating following a deployment has its challenges, but reintegration following separation has unique challenges that those returning from deployment do not have to negotiate (e.g., finding employment, changing health providers, loss of military self). Additionally, many

of the studies using veterans who have separated from the military have used samples from VA health care system who may differ in important ways from veterans not recruited from the VA health care system (Derefinko et al., 2019). Thus, there was a need to study reintegration following separation from the military rather than following deployment, using a veteran sample from a non-VA affiliated system.

Finally, most studies that investigate mental health in veterans tend to focus on PTSD due to research funding that prioritizes PTSD (Mobbs & Bonanno, 2018; Oster et al., 2017). However, the prevalence of anxiety disorders reported among veterans separating from the military warrants examination of its influence on veterans during VCR (Castillo et al., 2019; Oster et al., 2017). Individuals diagnosed with anxiety disorders may also have higher levels of trait anxiety, leading to heightened fear responses to inherently stressful situations like the multiple changes one must negotiate during community reintegration (Muris et al., 2001). Thus, the study aimed to address examine the extent to which EI may moderate the relationship between trait anxiety and perceived VCR challenges in a non-VA sample of post 9/11 veterans.

Purpose of the Study

The purpose of this quantitative study was to examine the relationship among trait anxiety, EI, and perceived VCR challenges in a non-VA sample of post 9/11 veterans. Specifically, this study investigated if the relationship between trait anxiety and perceived VCR challenges was moderated by EI. This was done to addressed the gap in the literature and develop more understanding of the reintegration process.

Research Questions and Hypotheses

Research Question 1: To what extent does trait anxiety, as measured by the State-Trait Inventory for Cognitive and Somatic Anxiety-Trait version (STICSA-T), relate to perceived community reintegration challenges, as measured by the Military to Civilian Questionnaire (M2CQ), among military veterans?

$H_0$1: Trait anxiety is not a significant predictor of perceived community reintegration challenges.

$H_1$1: Trait anxiety is a significant predictor of perceived community reintegration challenges.

Research Question 2*:* To what extent does emotional intelligence, as measured by the Emotional Intelligence Scale (EIS), relate to perceived community reintegration challenges, as measured by the M2CQ, among military veterans?

$H_0$2: Emotional intelligence is not a significant predictor of perceived community reintegration challenges.

$H_1$2: Emotional intelligence is a significant predictor of perceived community reintegration challenges.

Research Question 3: To what extent does emotional intelligence, as measured by the EIS, moderate the relationship between trait anxiety, as measured by STICSA-T, and perceived community reintegration challenges, as measured by the M2CQ, among military veterans?

$H_0$3: Emotional intelligence does not moderate the relationship between trait anxiety and perceived community reintegration challenges.

$H_1$3: Emotional intelligence does moderate the relationship between trait anxiety and perceived community reintegration challenges.

Theoretical Foundation

Two theories provided the foundation for this study. The military transition theory (MTT; Castro & Dursun, 2019; Castro & Kintzle, 2017) explained how multiple factors influenced veterans' transition from military to civilian life. The theory involves three interrelated phases that describe how various factors can impact the transition process: (a) approaching the military transition (i.e., the personal, cultural, and transitional factors that create the foundation of the transition trajectory), (b) managing the transition (i.e., the factors that impact an individual's progression from the military to civilian life, e.g., social support), and (c) assessing the transition (i.e., the outcomes that are associated with the transition, such as work, family, physical and psychological health, general well-being, and community). MTT explained that certain factors create the foundation on which a veteran approaches the transition, including trait anxiety that would likely lead to greater difficulty experienced by veterans dealing with community reintegration challenges and EI may mitigate these challenges.

Goldman's (1995) emotional intelligence theory was also used. It is comprised of four domains: self-awareness, self-management, social awareness, and relationship management (Cherniss & Goleman, 2001). EI theory explained the potential for veterans high in EI to deal with the challenges of reintegration to civilian life more successfully than their low-EI veteran counterparts. A detailed explanation of both theories is presented in Chapter 2.

Nature of the Study

For this study, I used a cross-sectional, quantitative survey design to examine the extent to which EI moderated the relationship between trait anxiety and perceived VCR challenges. Using online surveys, data were collected at one time point to determine relationships among variables (Creswell & Creswell, 2018). The online survey design also allowed for a diverse veteran population to participate in this study.

The population of the study was veterans who served on active-duty status in the U.S. military after 9/11, had separated from the military within the past 2 years, were at least 18 years old, currently living in the United States. Participants who had retired from the military or were currently in the Reserves or National guard were excluded from study's sample. Participants were recruited through Survey Monkey's participant pool after a lack of response from veteran-affiliated Facebook groups. A direct message was sent to Facebook group administrators requesting permission to post study information and a survey link to the veteran group page. However, after weeks of continuous recruiting among Facebook veteran groups, there were no participants volunteering for the study. Therefore, upon institutional review board (IRB) re-approval, participants were recruited using Survey Monkey's audience panel. Additionally, the 33-item EIS (Schutte et al., 1998) was replaced with the 10-item Brief EIS (BEIS-10; Davies et al., 2010) to reduce the total number of survey questions allowed by Survey Monkey. A convenience sampling strategy was used due to time and funding constraints.

Data were analyzed using the Statistical Package for Social Sciences (SPSS) version 27.0. Descriptive statistics and a standard multiple regression analysis were

completed to determine the extent to which EI moderated the relationship between trait anxiety and perceived VCR challenges. A standard multiple regression analysis was an effective method for examining relationships among multiple variables and also for examining moderation (Warner, 2013).

Definitions

Emotional intelligence (EI): The ability to recognize and understand an individual's own and others' emotions and use this information to guide thinking and actions (Oden et al., 2015).

Military to civilian transition: There is no consensus in the literature on the definition; however, it can be defined as the time during which an individual moves from a military to a civilian lifestyle (Blackburn, 2017; Castro & Dursun, 2019; Elnitsky, Fisher, et al., 2017).

Post 9/11 veteran: Veteran who has served after September 2001 (National Center for Veterans Analysis and Statistics, 2018).

Trait anxiety: The tendency to assess situations as threatening, resulting in a magnified fear response (Cho et al., 2019; Knowles & Olatunji, 2020).

Veteran community reintegration: A general, holistic term used to describe the overall psychosocial functioning of a veteran during separation from the military; can refer to a number of functioning issues, such as psychological health, social, physical health, employment, housing, financial, legal, or spiritual (Elnitsky, Fisher, et al., 2017).

Veteran: An individual who has served active-duty in the U.S. military and who has been discharged or released from the military (Parker et al., 2019).

Assumptions

There were a number of assumptions in this study. First, it was assumed that participants would follow the instructions for completing the surveys accurately. Second, it was assumed that participants would be truthful and accurate with their answers. Due to the mental health stigma and fear of appearing weak, veterans may have been disinclined to disclose their anxiety symptoms and VCR challenges. However, participants were given the requirements of the study that detailed the need for only veterans. Furthermore, participants were reminded that the online survey was anonymous and there was no identifying information requested, with the hopes that this would ensure participants feel comfortable answering the anxiety and VCR challenge questions honestly.

Scope and Delimitations

The goal of the study was to determine whether EI had the potential to moderate the relationship between trait anxiety and perceived VCR challenges in a non-VA sample of post-9/11 veterans. Much of the literature used samples recruited from the VA health care system (Disner et al. 2017; Sayer et al., 2015), which was the reason a non-VA sample was warranted. The sample was limited to veterans who were at least 18 years old, previously served in the U.S. military on active-duty status post- 9/11, currently lived in the United States, and discharged from the military within the past 2 years (honorable, medical, dishonorable, etc.).

Although there could be cross-cultural similarities among military personnel transitioning from military to civilian life, the examination of cultural differences among military members was beyond the scope of this study. Post 9/11 veterans were chosen

because of differences in military service before and after 9/11 (e.g., military drafts vs. voluntary commitments, advancements in medical care, mental health increases; Castro & Kintzle, 2014). Though some individuals have reported persistent VCR challenges many years after separation from the military, research suggested significant decreases in VCR challenges after 2 years (Castillo et al., 2019). Persistent VCR challenges were outside the scope of this study; therefore, the study only sampled from veterans who had separated from the military within the past 2 years. Finally, individuals who live outside the United States may experience differences in access to resources that veterans living in the United States may not experience; excluding these veterans limited both the representativeness of the sample and the generalizability of its findings.

Limitations

The choice of convenience sampling limited both the representativeness of the sample and the generalizability of the study's findings. Individuals who chose to participate in the study may be different from those who chose not to participate in the study. There is no way of knowing the differences between veterans who participated in SurveyMonkey's audience panel and those that did not. However, SurveyMonkey's audience panel included participants from all regions of the United States, across all ages, and genders, providing a more diverse sample. Finally, when using a self-report survey, such as the one utilized for this study, there was the potential for social desirability bias. Social desirability bias occurs when participants feel a need to report the socially preferred answers even if those are not honest answers about themselves (Larson, 2019). These veterans may not want to honestly report issues related to anxiety or reintegration

challenges, leading to a social desirability bias. This limitation was addressed in two ways: by informing and reminding participants that the survey was anonymous and by using a passive deception strategy. These strategies allowed the collection of data related to these sensitive topics (i.e., anxiety, reintegration challenges), while reducing the effects of the stigma related to these topics.

Significance

Given the incidence of veterans reporting significant challenges during reintegration, findings from the study provide insights into the specific issues they face (see Sayer et al., 2010). The study was significant in that it extends the current literature by revealing how individual differences in trait anxiety and EI exacerbate or mitigate, respectively, the challenges faced by veterans transitioning from military to civilian life. By advancing understanding of the challenges veterans face, these findings may aid in developing transition programs and services, including EI training, to ease the stress veterans experienced when transitioning from military service to civilian life, leading to positive social change.

Summary

Increases in mental health issues have become a major problem for veterans leaving the military. The literature suggested that reintegration is a critical period that should be studied to understand these mental health crises (Derefinko et al., 2018; Disner et al., 2017; Schultz et al., 2014). Although veteran reintegration has generated increased research interest, there were still gaps due to the singular attention to deployment-focused reintegration (Brenner et al., 2015; Cederbaum et al., 2017), PTSD (Mobbs & Bonanno,

2018), and VA-affiliated samples (Derefinko et al., 2019). To address these gaps, the study aimed to examine the relationships among trait anxiety, EI, and perceived VCR challenges in a non-VA sample of post 9/11 veterans. Both MTT and EI theory informed the study. A cross-sectional quantitative survey design was used to collect data from Survey Monkey's audience panel. The findings of the study may aid in developing transition programs and services that ease the stress veterans experienced when transitioning from military service to civilian life.

Chapter 2 will present the literature search strategy and an analysis of both theoretical frameworks, followed by an exhaustive review of the literature related to key variables (e.g., military culture, challenges faced during reintegration). The chapter will end with a summary conclusion.

Chapter 2: Literature Review

Every year in the United States, more than 200,000 individuals leave the military and begin the reintegration into the civilian world (Ainspan et al., 2018; Zogas, 2017). Among those reintegrating into civilian life, between 40% and 75% of these veterans reported having reintegration challenges with community involvement, productivity, employment issues, sleep disturbances, suicide risks, substance abuse, and mental disorders (Haller et al., 2016; Sayer et al., 2010, 2015; Short et al., 2016; Whitworth et al., 2020; Zogas, 2017). Many researchers have examined this reintegration period, also known as VCR, to understand the causes of these challenges and their negative impacts on veterans (Ainspan et al., 2018; Binks & Cambridge, 2018; Romaniuk & Kidd, 2018). These studies suggest that many of the challenges experienced by veterans may be related to the stress from these VCR challenges, also known as reintegration stress. Reintegration stress is related to social support, family and spousal relationships, mental and physical issues, finances, employment, and educational issues (Elnitsky, Blevins et al., 2017; Mobbs & Bonanno, 2018; Pease et al., 2016). Additionally, this type of stress has been found to be related to loss of self-identity, disconnection from both military and civilian societies, low levels of treatment seeking, and both mental and physical health problems (Binks & Cambridge, 2018; Interian et al., 2014; Kline et al., 2010; Pease et al., 2016).

During the VCR period, mental health issues, specifically anxiety, can add more stress and reintegration challenges for veterans (Haller et al., 2016; Hourani et al., 2012). Veterans' prevalence rates for anxiety disorders ranged from 3.6% to 13% (Hourani et al., 2012; Knowles et al., 2019; Nason et al., 2019), with as much as 53% to 88%

reporting some impairment caused by an anxiety disorder (Mather et al., 2010). OEF/OIF veterans have had significantly higher prevalence rates of obsessive-compulsive disorder, social anxiety disorder, generalized anxiety disorder, and panic disorder than Vietnam-era veterans (Knowles et al., 2019). Anxiety disorders are extremely common, under-treated, and co-morbid with other mental health issues prevalent in the veteran population such as PTSD and suicidal behaviors (Knowles et al., 2019; Shepardson & Funderburk, 2016; Shepardson et al., 2019). These findings suggest a need to further examine anxiety during VCR into civilian life, especially in more recent veterans such as OEF, OIF, Operation New Dawn (OND), and Operation Inherent Resolve (OIR) veterans.

Additionally, when studying the VCR challenges unique to each veteran, it is important to look at individual differences such as EI (Castillo et al., 2019). Research has shown a positive relationship between high EI and a person's ability to cope with stress (Cejudo et al., 2018; Singh & Sharma, 2012). High EI was found to be associated with lower rates of suicidal ideation, lower levels of social anxiety, fewer PTSD symptoms, and even less alcohol use (Abdollahi et al., 2016; Cejudo et al., 2018; Gaher et al., 2014). Given the impact EI may have on a person's ability cope with stress, it is important to look at how EI may influence veterans during their reintegration to civilian life. Additionally, given the associations found between trait anxiety, the development and/or exacerbation of anxiety disorders, and a number of issues prevalent in the veteran population (e.g., sleep and health issues), it is essential to examine the relationship between trait anxiety and VCR challenges. However, there is a lack of literature on EI during the reintegration to civilian life for veterans.

Despite what is known about VCR challenges and anxiety in veterans, most studies fail to report on additional mental health problems other than PTSD, even though veterans experience many different mental health issues (Oster et al., 2017). As for the literature on anxiety, there are no known studies that look at anxiety and EI during VCR. A large majority of the studies examining anxiety in veterans are concerned with comparing these disorders in veterans who have PTSD and those that do not have PTSD. Additionally, much of the VCR research focuses on reintegration following deployment, and not following discharge (Brenner et al., 2015; Cederbaum et al., 2017). In studies that focus on veterans following a deployment only, the sample usually includes active-duty soldiers, which excludes individuals reintegrating into civilian life following separation from the military. These individuals do not have to cope with VCR challenges in the same way that veterans leaving the service do (e.g., finding employment, changing health providers, loss of military self).

Furthermore, much of the research, that does study veterans who have left the service, use VA populations (i.e., individuals seeking treatment from VA services; Disner et al. 2017; Sayer et al., 2015). However, not all veterans are using the VA health care system. In fact, only 61% of veterans who have separated from the military since 2002 have used the VA health care system and only about 40% of those screening positive for mental health issues are seeking help (DeFraia et al., 2014; Derefinko et al., 2019; Haller et al., 2016). These findings suggest there are major gaps in the literature that do not examine other sources of mental health problems, specifically anxiety, the reintegration period following discharge, and samples that do not use the VA health care system;

therefore, there is a need to examine these variables with samples from outside of the VA system. Thus, the purpose of this quantitative study was to address a gap in the literature by examining the relationship between trait anxiety and perceived VCR challenges in a non-VA sample of veterans and if that relationship was moderated by EI.

Chapter 2 will continue with a literature search strategy, followed by a detailed description of military transition and EI theories, including reviews of studies that have applied each in ways similar to the study I completed. This will be followed by an exhaustive review of the literature related to key variables (e.g., military culture, challenges experienced by veterans during reintegration, trait anxiety, EI). The chapter ends with a summary and conclusion.

Literature Search Strategy

The peer-reviewed literature examined for this study was mainly accessed through the Walden University Library. A large majority of the searches were completed through EBSCOhost. There were a number of databases searched, specifically: Thoreau PsycINFO, PsycARTICLES, and Military and Government Collection. In addition, Google Scholar was used periodically to search for further literature pertaining to the topic. The key terms used in the study's literature search included: *military to civilian transition, transition stress, military transition, transition, reintegration, readjustment, veteran community reintegration, veterans, military, social anxiety, social anxiety disorder, social phobia, trait anxiety, anxiety, emotional intelligence,* and *trait emotional intelligence.* Finally, most of the literature found for the study was from 2010 to 2020. There was older literature used for the discussion of the theory on which military

transition and EI theories was based. However, since the sample were those that served after 9/11, most of the studies used were conducted after 2001.

Theoretical Foundation

The study was informed by two theories. First, the MTT was used to explain stresses experienced by military veterans as they transition from military to civilian life. Second, the theory of emotional intelligence explained the potential for EI to moderate the stress experienced by military veterans during the transition to community life. These theories will be discussed in the following sections.

Military Transition Theory

The MTT explains the process by which veterans transition from military to civilian life (Castro & Kintzle, 2014). Transitioning from the military to the civilian world can create opportunities for both growth and vulnerabilities to negative outcomes (Castro & Dursun, 2019). Veterans transitioning out of the military must make a number of adjustments such as geographic location, family roles, social identity, social support, career, their community, and even their culture may change (Castro & Kintzle, 2014; 2017). The MTT is comprised of three interacting and intersecting components: approaching the military transition, managing the transition, and assessing the transition.

Approaching the Military Transition

The first component, approaching the military transition, includes personal, cultural, and transitional factors that can influence the veteran's ability to manage or deal with the transition (Castro & Kintzle, 2014). Personal factors include health, preparedness, expectations, including a dispositional tendency toward anxiety; trait

anxiety is defined as the tendency to "appraise situations as threatening, avoid anxiety-provoking situations, and demonstrate high baseline physiological arousal" (Knowles & Olatunji, 2020, p. 1). Individual differences in trait anxiety may be considered a personal factor as it can influence the veteran's ability to manage their transition. For example, for those veterans high in trait anxiety, the transition from military to civilian life may exacerbate what for most is, by nature, a stressful time.

Military cultural factors (e.g., type of military discharge and combat history) may complicate the approach to military transition. Veterans with a combat history are at a higher risk of reintegration difficulties due to mental health issues associated with combat (Castro & Kintzle, 2014; Castro & McGurk, 2007). For those leaving the military with a medical discharge, persistent physical and/or health problems will complicate their transition; they will have to change medical providers and find employment with possible disabilities (Castro & Dursun, 2019; DeFraia et al., 2014). Similarly, those leaving the military with a dishonorable discharge lose their VA benefits and will have to begin their transition without the benefits that accompany an honorable discharge (Department of VA, 2020b). The medical issues associated with medical discharge and the loss of benefits associated with dishonorable discharge may affect these veterans' transition.

Transition factors include the nature of the transition (e.g., predictable vs. unpredictable; Castro & Kintzle, 2017). Individuals who are expecting to leave the military (e.g., those voluntarily ending their contract after time served) can prepare for their transition by seeking employment and making plans for education and/or housing. However, there are individuals who are unexpectedly forced to leave the military. For

instance, with the intent to downsize the military, the U.S. Army's Qualitative Management Program forces enlisted soldiers to leave involuntarily if they have any negative evaluations on their record (U.S. Army Human Resources Command, 2020). There are also programs forcing soldiers to leave the military if they are not promoted within the time allowed (Schirmer et al., 2005; Tice, 2016). Similarly, soldiers expecting to get promoted but unexpectedly are not will be forced to leave the military; denied the time needed to prepare, these soldiers will likely find the transition to civilian life difficult. These factors will influence the veteran's community reintegration process and, ultimately, their transition outcomes.

Managing the Transition

The second component of the MTT, managing the transition, refers to a number of factors that impact the veteran's progression from military member to civilian, including individual adjustment, community, organizational, and transition factors (Castro & Kintzle, 2014). Individual adjustment factors include attitudes, beliefs, and coping styles (Castro & Kintzle, 2017). A veteran's attitudes and beliefs during the transition can create problems that affect the veteran's ability to transition. For example, when a veteran with "counterproductive beliefs" about mental health treatment, experiences stress related to their transition, they will be less motivated to seek out or participate in treatment (DeFraia et al., 2014, p. 526). The veteran's reduced motivation to participate in treatment will only make the transition period harder and the mental health issues worse (DeFraia et al., 2014). Additionally, EI may play a role in individual adjustment given its association with emotion regulation and stress management (Moradi

et al., 2011). EI's ability to facilitate an individual's self-regulation as a means to their desired goals makes it a coping mechanism (Riley & Schutte, 2003).

Community factors include elements such as social support from family, spouses, friends, community, and even society (Castro & Kintzle, 2017). Previous research has shown the importance of social support for dealing with life's stresses. For example, previous research has shown that greater social support was associated with a decreased risk of suicidal ideation in a veteran sample (Pietrzak et al., 2017) and greater social support from significant others, family, and military peers was associated with fewer symptoms of PTSD (Wilcox, 2010). Thus, community factors may influence the veteran's transition to civilian life.

Organizational factors (i.e., military transition management) include several benefits provided by the military (e.g., VA benefits, education benefits, and career planning). VA benefits can influence a veteran's transition. For instance, if a veteran is struggling with their transition and needs counseling or healthcare, having access to VA hospitals will be beneficial. If the veteran decides to pursue education, they may take advantage of the VA's GI Bill, which helps veterans pay for tuition and fees, provides a monthly housing allowance, and pays book and supply fees (Department of VA, 2020a). For veterans pursuing an education, these benefits will allow them to focus on their studies.

Transition factors (i.e., civilian transition support) include resources utilized by civilians to support transitioning veterans such as student veteran services or employer programs aimed at hiring veterans (Castro & Kintzle, 2017). For example, employment

for transition veterans is a major challenge (Pease et al., 2016). When companies or businesses create initiatives to hire veterans, they are supporting veterans during their progression from military to civilian life.

Assessing the Transition

The final component of the MTT, assessing the transition, refers to transition outcomes related to work, health, family, community, and general wellbeing (Castro & Kintzle, 2017). By assessing these outcomes, it is possible to determine if a veteran has successfully transitioned from a military to civilian role. For example, work outcomes may be measured by determining if the veteran obtained employment while family outcomes may be measured by how well the veteran has re-acclimated to their new family role (Castro & Kintzle, 2017). These outcomes are also interconnected and can influence one another. For example, if a veteran is having trouble finding employment, yet their spouse is employed, then the veteran may be forced to revise their family role (e.g., become a stay-at-home parent). However, according to the MTT, a success or failure in one outcome does not mean the veteran has succeeded or failed in the overall transition. Overall, the MTT described the factors that influence the individual before, during, and after the military to civilian transition process and informed the study by explaining how pre-transition factors influence factors during and ultimately the outcomes of the transition from military to civilian life.

Previous Utilization of the MTT

The MTT is a newer theory in the literature. However, the MTT has been used to explain the influence of several factors on VCR outcomes, such as traditional masculinity

ideology, employment experiences, multiple psychosocial factors, military sexual assault (MSA), and suicide risks. For example, O'Loughlin et al. (2020) used the theory to examine the relationship among five features of traditional masculinity ideology (i.e., restrictive emotionality, avoidance of femininity, toughness, dominance, and self-reliance) and factors associated with difficult VCR (i.e., PTSD, depression, perceived social support, and alcohol-related problems). O'Loughlin et al. found that restrictive emotionality was the most significant contributor to PTSD, depression, and perceived social support, whereas avoidance of femininity was the most significant contributor to alcohol-related problems.

Similarly, Keeling et al. (2018) explored the experiences veterans had with employment barriers, which provided support for the MTT. Through thematic analysis, two employment barriers were found: personal barriers and organizational and societal barriers (Keeling et al., 2018). The personal barriers included unpreparedness for the transition (i.e., approaching the military transition), which influenced veterans' ability to manage the transition and led to problems gaining employment. In addition, there were military and civilian cultural clashes (i.e., managing the transition) between veterans and their employers/coworkers (e.g., differences in work ethic and camaraderie), leading to workplace problems such as frustrations, termination, or voluntary exit from employment (Castro & Kintzle, 2017; Keeling et al., 2018). Additionally, Keeling et al. found organizational and societal barriers, including military discharge status, lack of transition support, starting over, negative experiences with organizational support services, and perceived employer stigma and discrimination. For instance, military discharge status

(i.e., approaching the military transition) has the potential to influence access to VA benefits, increasing the likelihood of negative VCR outcomes. Moreover, lack of transition support, starting over, negative experiences with organizational support services, and perceived employer stigma and discrimination would impede veterans' ability to manage the transition. The more support and access to military and civilian resources veterans have the better they are at managing their transition and succeeding in the transition process (e.g., gaining employment).

Bowes et al. (2018) used the MTT to explore the relationship between psychosocial factors (i.e., mental health, experiential avoidance, stigma, self-stigma, attitudes toward and likelihood of seeking treatment, and reappraisal and suppression of emotions) and VCR outcomes (e.g., quality of life). The veterans (N = 154) completed questionnaires related to demographic information, the use of mental health services, attitudes toward seeking treatment, emotion regulation, quality of life, and VCR difficulties (Bowes et al., 2018). Bowes et al. found that mental health, cognitive reappraisal, and experiential avoidance were predictors of VCR challenges. Cognitive reappraisal is related to emotional regulation; it is the ability to produce non-threatening or positive evaluations of a stressful situation in order to change the emotional response and lessen the distress involved. Experiential avoidance is an attempt to avoid or alter undesirable thoughts, emotions, urges, memories, and/or physical sensations. Bowes et al. found that both cognitive reappraisal and experiential avoidance partially mediated the relationship between mental health and VCR outcomes. Specifically, as the number of mental health problems and level of experiential avoidance increased, VCR difficulties

increased, while increases in the level of cognitive reappraisal led to fewer VCR difficulties. These findings suggest that in a given situation, the use of cognitive reappraisal (positive coping) or experiential avoidance (negative coping) are coping strategies that influence the relationship between mental health and VCR outcomes. Bowes et al. argued that these findings support the MTT such that personal characteristics (i.e., the veteran's mental health before the transition and individual adjustment factors (i.e., coping mechanism) are related to VCR outcomes.

The MTT has also been used to explain the relationship between MSA (i.e., sexual assault that occurred during military service) and a number of VCR health and behavioral outcomes (physical health symptoms, PTSD, depression, alcohol use, and also risk-taking behaviors) in veterans. The participants, male (n = 2,208) and female (n = 327) veterans, completed an MSA survey instrument, the Patient Health Questionnaire-15 to assess physical health symptoms, PTSD Checklist, the Patient Health Questionnaire-9 to assess depressive symptoms, the Alcohol Use Disorders Identification Test, questions related to risk-taking behaviors, and questions related to demographic and military service (Schuyler et al., 2017). Schuyler et al. (2017) found that males who reported sexual assault were four times more likely to report physical health symptoms, PTSD, and depression, and were also the most likely to engage in risk-taking behavior than males who did not report sexual assault. In addition, Schuyler et al. found that female veterans who experienced MSA were twice as likely to report physical health symptoms, three times more likely to report depressive symptoms, and almost seven times more likely to report PTSD compared to female veterans who did not report MSA; female

veterans who experienced MSA were significantly more likely to report risk-taking behaviors compared to female veterans who did not experience MSA. Schuyler et al. argued that MTT can explain these findings.

For example, the sexual assault occurred before the transition (i.e., approaching the military transition), which may have influenced the development of physical and behavioral health symptoms. This pre-transition period is important, because a majority of female assault victims experience some type of social or professional retaliation after reporting sexual assault while still in the military (Morral et al., 2015); assault victims may be forced to separate from the military earlier than anticipated as punishment for reporting the assault, possibly leading to changes in their military discharge status. Females forced to leave the military with a dishonorable discharge may not have access to the resources typically available to veterans, such as VA health care (i.e., managing the transition).

Finally, the MTT has been used to explain suicide risks in veterans. Barr et al. (2019) examined the relationship between discharge status and suicide risks in veterans. A number of suicide predictors were examined to determine if dishonorable discharge predicted suicidal behaviors. Male and female veterans (N = 722) completed demographic and military-related questions, PTSD Checklist, Patient Health Questionnaire-9 (for depression), Alcohol Use Disorders Identification Test, Patient Health Questionnaire-15 (for physical health), Disability Assessment Schedule 2.0 (for physical disability), and the Suicide Behaviors Questionnaire-Revised. Barr et al. found that those veterans who were dishonorably discharged were more likely to experience

depression, alcohol use, physical disability, physical health, PTSD, and suicidal behaviors. Barr et al. argued that the MTT can explain why discharge status may be a risk factor for suicide. Because service members who leave the military with a dishonorable discharge are often forced to leave, typically without warning or preparation, factors such as discharge status (i.e., dishonorable) and nature of the transition (i.e., unexpected), bode poorly for their transition to civilian life; without time to prepare (i.e., approaching the transition) and denied access to benefits typically offered to veterans (i.e., managing the transition), the transition process and its outcomes may be fraught (i.e., assessing the transition).

How the MTT Relates to the Study

The MTT explains VCR challenges that service members/veterans' encounter before, during, and after their transition to civilian life and how these challenges are related to multiple VCR outcomes (Castro & Kintzle, 2014; Schuyler et al., 2017). When a service member is approaching the transition, there are multiple factors that influence their ability to manage the transition, e.g., if the service member has mental health issues like anxiety; anxious tendencies will likely exacerbate an already challenging transition process. The veteran's coping abilities (e.g., EI) while managing mental health challenges will determine the success—or not—of their community reintegration.

The goal of the study was to determine if individual differences in trait anxiety and EI are related to perceived VCR challenges, such that EI moderated the relationship between trait anxiety and perceived VCR challenges among veterans. MTT explained how individual differences in trait anxiety and EI influenced the veterans' ability to

negotiate the *approach, management, and assessment* of their transition from military to civilian life.

Emotional Intelligence Theory

Goleman's (1995) EI theory is based on a performance model and was used as the secondary framework for the study (Cherniss & Goleman, 2001). Specifically, Goleman's EI theory defines four domains: self-awareness, self-management, social awareness, and relationship management (Cherniss & Goleman, 2001). Performance in these four EI domains can be used to assess an individual's level of EI. Self-awareness is defined as one's ability to have an accurate awareness of their own emotions, such as a veteran feeling sad, and is able to distinguish between feeling sad and angry. Self-awareness makes a person better able to deal with their own emotional reactions, learn from their mistakes, and make improvements (Cherniss & Goleman, 2001). These skills can be useful as they make it easier for veterans to deal with their own emotions and reactions, which can sometimes be an issue for reintegrating to community life. Self-management is defined as one's ability to regulate or control their own emotions, such as a soldier afraid in a combat situation who is able to control their fear and remain calm; the ability to manage one's emotions increases adaptability, achievement motivation, initiative taking, and stress handling (Cherniss & Goleman, 2001). Social awareness is the ability to recognize and empathize with others' emotions (e.g., a veteran recognizes that their spouse is overwhelmed with work and empathize with them by expressing their understanding). The ability to read emotional cues (e.g., nonverbal facial or tone of voice cues) enables the empathic person to help meet others' unspoken needs and concerns

(Cherniss & Goleman, 2001). Finally, relationship management is the ability to influence others' emotions, such as a deployed solider who knows their fellow soldiers are afraid and is able to help their peers remain calm by their own actions and demeanor. According to Goleman's EI theory, relationship management makes a person better able to develop others' abilities by sensing others' reactions and then responding in a way that positively influences another person's emotions (Cherniss & Goleman, 2001).

EI may play a role during VCR. When in the military, controlling and suppressing emotions (i.e., self-awareness and self-management) are necessary methods for emotion regulation in risky and potentially deadly situations such as when deployed to a combat situation (Bowes et al., 2018). However, these emotion-regulation behaviors may not be appropriate in the civilian world and continuing to use them may make reintegration more challenging (Adler et al., 2011). For instance, during VCR, a majority of veterans reported having difficulty relating or feeling connected with civilians and with spousal/romantic relationship issues (Sayer et al., 2010; Sherman et al., 2015). If a veteran is expressing happiness or joking around when having a serious or upsetting conversation, it could make developing relationships harder because the emotions expressed may be interpreted as inappropriate and insincere. Additionally, without adequate EI skills, veterans may have trouble with social awareness and relationship management. For example, when an individual is interacting with another person and especially when trying to create relationships, it is essential to read others' emotional cues, show the appropriate emotional responses, and influence others' emotions. However, when a veteran lacks these EI skills, they may have a hard time feeling

connected, which is necessary for building and managing new relationships.

Another challenge faced by veterans during VCR is the tendency toward aggression and outbursts (Sherman et al., 2015). When in intense situations, such as a combat deployment, soldiers may be able to control their emotions very well; keeping calm when in danger is necessary for survival. However, in normal situations, veterans may have trouble knowing and understanding how they should be feeling and expressing their emotions (i.e., having self-awareness and self-management). In fact, Sayer et al. (2010) found that veterans, both with and without PTSD, reported controlling anger as the most common issue for them. These findings suggest that veterans do struggle with self-management skills thereby limiting their EI skills. In sum, the theory of EI explains how individuals can regulate their own and others' emotions to guide thinking and behavior with the potential to mitigate the many challenges veterans face as they transition from the military to civilian life.

Previous Utilization of EI Theory

While EI has seldom been applied to military and veteran populations, it has been used with civilian populations to explain the relationship between EI skills and success in a number of areas. Costa and Faria (2020) examined the relationship between ability and trait EI and students' academic achievement. Tenth grade students (N = 523) completed the Emotional Skills and Competence Questionnaire and the Vocabulary of Emotions Test (Costa & Faria, 2020). The questionnaire assesses three dimensions of trait EI (i.e., perceiving and understanding emotions, expressing and labeling emotions, and managing and regulating emotions (Costa & Faria, 2020), whereas the Vocabulary of Emotions Test

assesses ability EI (i.e., cognitive abilities needed to use and process emotional information) (Costa & Faria, 2020; Pierkarska, 2020). Students' GPA was the measure of academic achievement. Findings showed a significant positive correlation between ability EI and students' GPA and a significant positive correlation between the manage and regulate emotions dimension of trait EI and GPA. These findings suggest that higher levels of EI (both ability EI and trait EI) are related to higher levels of academic achievement, providing support for the relationship between EI (e.g., emotion regulation) and successful outcomes (e.g., academic achievement).

Previous studies have examined the relationship between EI and conflict management styles. For example, Chan et al. (2014) had 568 undergraduate nursing students complete the Schutte EIS, the Rahim Organizational Conflict Inventory-II (ROCI-II), and demographic information. The ROCI-II measures five types of conflict management: integrating, dominating, obliging, compromising, and avoiding. Findings indicated that level of EI was a significant predictor of all five types of conflict management such that students with higher levels of EI used the integrating, obliging, comprising, and dominating types of conflict management, while students with lower levels of EI used avoiding types. These findings suggest that those with lower levels of EI chose to avoid rather than deal with conflict in some manner. In other words, individuals with higher levels of EI are better able to deal with and manage conflict than individuals with lower levels of EI.

Finally, Fteiha and Awwad (2020) used Goleman's EI theory to examine the relationship between EI and stress-coping styles. The participants were undergraduate

students (N = 265) who completed the EIS and the Stress Coping Style Inventory (Fteiha & Awwad, 2020). The Stress Coping Style Inventory assesses four types of coping styles: active problem coping (i.e., actively focusing on solving the problem), active emotional coping (i.e., actively focusing on positive emotions), passive problem coping (i.e., coping by avoiding the problem), and passive emotional coping (i.e., coping by self-blaming, blaming others, acting out). Findings indicated a strong positive correlation between level of EI and active emotional and active problem coping styles such that individuals with higher levels of EI are better able to cope with stress. Fteiha and Awwad's findings are relevant to the study in that veterans who have higher levels of EI skills may be better able to cope with the stress of VCR better than veterans who have lower levels of EI skills. This possible relationship helps make the case that EI has the potential to moderate the relationship between trait anxiety and perceived VCR outcomes.

How EI Theory Relates to the Study and Research Questions

Research has provided evidence that higher levels of EI lead to better outcomes in various aspects of life (Cherniss & Goleman, 2001), providing support for EI's potential to mitigate challenges and improve outcomes for VCR. If the results bear this out, findings from the study have implications for positive social change. EI training could be added to military protocols not just for reintegration preparedness, but for combat deployment as well. When used in tandem, MTT and EI theories provide a foundation both for explaining and mitigating the difficulties veterans encounter when transitioning from the military to civilian life.

Literature Review Related to Key Variables

Military Culture

Military culture comprises a set of values, standards, perceptions, and traditions that guide not only how military members think and communicate, but also how they interact with each other and civilians (Coll et al., 2011). The military culture emphasizes hierarchical organization, camaraderie, and conformity (Romaniuk & Kidd, 2018). As part of their initial training (e.g., boot camp, basic training), individuals are trained to embrace and embody a warrior mindset (Bryan et al., 2012). The warrior culture leads to military members valuing strength, resilience, collectivism, self-reliance, personal sacrifice, mission-focused, and fearlessness of death (Bryan et al., 2012; Bryan & Morrow, 2011; Redmond et al., 2015). Violation of these principles can lead to being shamed by peers and even disciplinary actions from leaders (Bryan et al., 2012).

The warrior culture is useful to ensure combat readiness, but also sets these military members, and ultimately veterans, apart from civilians. With less than 7% of the U.S. population having served in the military, military members and veterans are in the minority and, therefore, may find that others in their community or employment do not relate to military culture and mindset (Manning, 2019). For instance, Matthews et al. (2006) compared two military samples (one American and one Norwegian) and one civilian (American) sample on a number of character strengths (e.g., honesty, hope, bravery, industry, teamwork). Matthews et al. found that the American military and Norwegian military samples were significantly more related on a number of character strengths compared to the American military and American civilian samples. These

findings suggest that military members, even if they are from different countries, are more similar in character and culture than civilians and military members from the same country. In fact, almost half of veterans reported having difficulty with feeling as though they belong in civilian society or feeling that they do not fit in with civilian culture and communities (Castro & Kintzle, 2014; Sayer et al., 2010; Sherman et al., 2015). Thus, military culture may play a major role in how military members and veterans interpret and experience their world.

Furthermore, the reintegration period from military to civilian life was described as reverse culture shock, with the initial culture shock occurring when the individual first joined the military (Bergman et al., 2014; Castro & Dursun, 2019). While in the military, service members are assigned a job, given the education and training needed to complete their job, and managed by experienced and trained professionals (Castro & Dursun, 2019). Additionally, military pay and benefits are standardized, meaning the performance of the service member will not affect their pay and benefits (Castro & Dursun, 2019). For example, an enlisted soldier with an E-7 rank and an excellent performance, will have the exact same base pay as an enlisted soldier with an E-7 rank and a terrible performance. The culture within a military workforce is also more focused on working as a team, putting the wellbeing of the group first, compared to the civilian workforce where individual skills and successes are prioritized (Castro & Dursun, 2019; Redmond et al., 2015). Furthermore, the military provides service members with housing and food allowances, health care, access to military shopping centers, schools, and heavily subsidized daycares (Castro & Dursun, 2019). Given these entitlements, service members

are oblivious to the true cost of these services in the civilian world (Castro & Dursun, 2019).

Major changes between the military and civilian culture can lead to significant culture shock for veterans. Indeed, a number of researchers have argued that the reverse culture shock experienced by reintegrating veterans is similar to the experiences and culture shock experienced by immigrants coming to the United States (Castro & Dursun, 2019; Coll et al., 2011). For example, immigrants coming to the United States will have to sort out cultural differences, such as employment, housing, new friends, and new communities. In addition, there may be a change in status (e.g., lower class compared to upper class), language, and even changes in their identities or roles (e.g., being a lawyer in a home country but now working at a grocery store) (Coll et al., 2011). These are similar to the changes veterans experience when transitioning to the civilian world.

With very few studies on the topic, Demers (2011) investigated the lived experiences of both current soldiers and veterans after returning home and transitioning into civilian life. Participants (N = 48; male = 45) were assigned to six focus groups and a semi-structured interview guide was used to ask participants questions about how their deployments impacted their lives, interactions with family and friends, and support they sought out and/or received (Demers, 2011). Using thematic analysis, Demers found two themes: “deploying to war” and “coming home.” The “deploying to war” theme included three subthemes (i.e., “we were warriors,” “no fear,” and “feeling high”) that, according to Demers, were influenced by the military warrior culture that forces service members to remain strong and fearless when facing death (Bryan et al., 2012). The “coming home”

theme also included three subthemes: “time travelers,” “no one understands us,” and “crisis of identity” (Demers, 2011). The “time travelers” sub theme captures individuals’ sense of disconnection (i.e., caught between the military and civilian cultures) when they returned to the US. Similarly, “no one understands us” and “crisis of identity” suggest similar issues with being caught between two cultures. For example, identity is tied to community, but veterans unable to connect with their new community cannot create a community identity and may, therefore, experience a “crisis of identity” during their reintegration period (Demers, 2011).

Attempting to further examine the influence military culture can have on VCR challenges, McCormick et al. (2019) conducted a phenomenological study to explore how veterans define military culture and how military culture may affect veterans over time. Participants (N = 44; 81.4% male) were veterans recruited from veteran organizations and were assigned to seven focus groups and questioned using a semi-structured interview guide (McCormick et al., 2019). The authors found that veterans defined military culture in much the same way as civilians would, including patriotism, discipline, courage, mission first, structure, and camaraderie (McCormick et al., 2019). Furthermore, when describing the changes that occurred during their transition to civilian life, many participants reported having personal struggles such as disparate from civilian culture, interpersonal difficulties, divorce, and mental health issues (McCormick et al., 2019). These findings suggest that military culture plays a role in the struggles individuals have when reintegrating into civilian culture. While qualitative studies offer insights into veterans lived experience, quantitative research is needed to examine

relationships among the issues raised in the qualitative exploration.

In a quantitative investigation of difficulties experienced during VCR related to male MSA, O'Brien et al. (2015) examined the relationship among military cultural male rape myths and beliefs, male MSA, and treatment seeking and recovery after leaving the military. Rape myths, including "a man can't be raped by a woman," "men/real men/strong men don't get raped," "male-on-male rape is about homosexuality," and "male rape is not serious" are widely endorsed within military culture (O'Brien et al., 2015) and explain why male MSA survivors delayed or refused treatment. A sample of male (n = 172) and female (n = 158) veterans and survivors of MSA seeking treatment for PTSD completed Minnesota Multiphasic Personality Inventory-2 personality inventory, demographic, treatment, military and legal history, and other symptom-measure questionnaires (O'Brien et al., 2015). Results indicated that the belief that men do not get raped was related to treatment seeking, such that male MSA survivors tend to treatment five years later than female MSA survivors (O'Brien et al., 2015). Believing that real/strong men don't get raped, male MSA survivors reported less pride in their veteran status compared to female MSA survivors (O'Brien et al., 2015). Results showed, further, that believing male-on-male rape is about homosexuality, veterans felt compelled to prove their manliness by displaying hypermasculine behaviors and physical aggression, which led to some reporting criminal history. In fact, 40% of male MSA survivors reported a history of arrest for a violent crime and 21.4% reported serving time in prison for a violent crime, compared to females (18.5%, 13%, respectively). These findings suggest that beliefs and myths about male rape, amplified by military culture,

cause male MSA survivors to struggle seeking treatment and recovering from MSA. The authors argue that there is a need for future research to study military culture and its impacts on individuals' ability to cope.

Paskell et al. (2019) examined a number of military cultural factors and individuals' abilities to rehabilitate following a musculoskeletal injury, where military culture was defined as: higher adherence to masculine norms, higher levels of perceived personal control and autonomous motivation, lower levels of emotion-focused coping strategies, and greater use of problem-focused coping strategies. In a between-groups design, male military personnel (n = 16) and male athletes (n = 22), completed questionnaires regarding demographics and musculoskeletal injuries, the Brief Illness Perception Questionnaire, Conformity to Masculine Norms Inventory, Treatment Self-Regulation Questionnaire, and the Brief COPE. Results indicated that athletes had a higher adherence to masculine norms, higher level of both emotion-focused and problem-focused coping strategies than the military sample; however, there were no significant differences found on perceived personal control or autonomous motivation. These findings were not expected as they challenged the hyper masculine view of military culture. These results may be due to small sample sizes and the use of the Conformity to Masculine Norms Inventory, which may measure outdated military norms for masculine behavior (Paskell et al., 2019).

The Conformity to Masculine Norms Inventory assesses levels of violence, risk taking, winning, emotional control, power over women, dominance, playboy, disdain for homosexuality, pursuit of status, self-reliance, and primacy of work, which may not be

consistent with masculine norms expressed in today's military (Paskell et al., 2019). Furthermore, masculinity has previously been found to be positively related to injury-related behaviors (i.e., higher level of masculinity is associated with higher levels of injury-related behaviors) and masculine viewpoints often encourage a man "to sacrifice his body for the team" (Reidy et al., 2016; Young et al., 1994, p. 177). The military culture promotes certain health-related practices for men as a way to demonstrate their masculinity, including refusing to admit pain, denying weakness and vulnerability, not needing or seeking help, not complaining, and maintaining a physically robust appearance (Abraham et al., 2017). Therefore, since these injury-related behaviors (e.g., refusing to admit pain, denying weakness) are more acceptable in the military culture, it may be useful to also examine less acceptable behaviors, such as emotional coping, to determine their relationship to with military culture.

In an effort to evaluate unrelated physical health variables and military culture, Ramon et al. (2020) asked if adherence to masculine norms, mindfulness, and self-compassion predict coping and quality of life. Participants (N = 164) were male and female military veterans who completed demographic information, Five Facet Mindfulness Questionnaire, Self-Compassion Scale-Short Form, Masculine Behavior Scale, Brief COPE, and The Veterans Research and Development (RAND) 12-Item Health Survey. Ramon et al. found that adherence to masculine norms was related to lower wellbeing, lower self-compassion, lower mindfulness, lower use of active coping skills, greater use of avoidant coping skills, and lower levels of mental health-related quality of life. These findings suggest that the masculinity norms related to military

culture can influence life for veterans reintegrating into the community. The authors did note that future research with a larger, ethnically and educationally diverse veteran sample was needed.

Overall, studies suggest that military culture may create a mindset that makes reintegration to community life difficult for veterans. Taught to be strong, resilient warriors, veterans may find that these qualities may not have the same value in civilian life and may at the extreme manifest as criminal behavior. The military cultural indoctrination may lead to veterans having trouble feeling connected to family and friends, seeking treatment for traumatic events (e.g., MSA), coping with daily stresses, and overall quality of life.

Challenges Experienced by Veterans During Reintegration

During reintegration, veterans can experience a number of challenges. These challenges involve individual (e.g., psychological health), interpersonal (e.g., relationship issues), community (e.g., work or school), and societal (e.g., VA health care system) domains of daily community life (Aronson et al., 2020; Binks & Cambridge, 2018; Elnitsky, Blevins et al., 2017; Elnitsky, Fisher et al., 2017). A number of researchers have argued that the reintegration period is critical, because veterans' ability to cope with the stress of reintegrating can influence its outcome (Castillo et al., 2019; Derefinko et al., 2018; Elnitsky, Fisher et al., 2017; Pease et al., 2016). When military members leave the service, some start the VCR process with physical and/or health issues, and for others these issues increase or do not appear until after leaving the service (Derefinko et al., 2018).

Moreover, veterans from current war campaigns, such as OEF, OIF, OND, or OIR may have a harder time feeling connected to civilian life because there is such a divide between the military and civilian cultures. For instance, current civilians do not have much experience with the military compared to civilians from past wars; therefore, it may be harder for civilians to grasp the difficulties veterans face during reintegration. After World War II, around 50% of the U.S. male population and 15% of the U.S. female population under the age of 35 were World War II veterans (Castro & Kintzle, 2014). Today, only 12% of the U.S. male population and 3% of the U.S. female population under the age of 35 are Iraq/Afghanistan veterans (Castro & Kintzle, 2014). These differences between veteran and civilian military experience may make it difficult for civilians to relate to veterans attempting to reintegrate. The myriad challenges faced by reintegrating veterans are multidimensional and interrelated (MacLean et al., 2014; Oster et al., 2017). From the literature, a number of these challenges stand out as major difficulties for veterans, including fear of disclosure, suicide, PTSD, additional psychosocial challenges (e.g., social support, life satisfaction), physical health challenges, and anxiety.

Fear of Disclosure

From the beginning of a military career, service members learn that appearing weak, whether mentally or physically, is viewed negatively by peers and those in the chain of command. These attitudes may be related to the military's requirements for deployment readiness. In order to qualify for deployment, military service members must have medical readiness, both physical and mental (Curley et al., 2020). Injuries and/or

mental health issues are documented in profiles maintained by health care providers, alerting the member's chain of command that the individual has physical or mental restrictions (e.g., no physical exercise, no access to weapons) (Curley et al., 2020). Curley et al. sampled soldiers from two active-duty U.S. Army brigades (N = 1,043) to examine attitudes toward mental health profiles. Soldiers were questioned about their attitudes toward mental health profiles, anxiety, depression, alcohol misuse, PTSD, and their utilization of mental health care. The authors found that attitudes were more negative toward mental health profiles than for physical profiles. Furthermore, more than 95% of the soldiers would prefer their chain of command not learn about their mental health condition during their pre-deployment screening (Curley et al., 2020). These fears relate to the negative impact these profiles and mental health issues can have on their military career and perpetuate the warrior culture and hypermasculinity associated with military culture (Williamson et al., 2019).

Military attitudes toward masculinity can carry over during reintegration, making veterans reluctant to disclose both mental and physical health issues for fear they will appear weak. For example, a veteran may refuse to disclose a mental and/or physical health issue when seeking employment, knowing that any workplace accommodation would be perceived as weakness (Baldridge & Swift, 2013). Gonzalez et al. (2020) aimed to understand why veterans with disabilities chose to not disclose a request for a workplace accommodation. Veterans with disabilities (N = 231) were sampled. The independent variables included psychological safety (i.e., a mental/emotional comfort level that allows for taking interpersonal risks in the work environment such as self-

disclosure), veteran identity strain (i.e., feelings of disconnect between the responsibilities and values that are associated with military experience vs. civilian work), disability invisibility (i.e., the degree to which a disability is visible to others such as use of a wheelchair), the workplace climate for inclusion (i.e., how inclusive the workplace is for employees), and the dependent variable was likelihood of withholding an accommodation request.

It was hypothesized that the relationship between veteran identity strain and withholding an accommodation request would be mediated by psychological safety and that the negative relationship between veteran identity strain and psychological safety would decrease when an employee perceives their organization as highly inclusive, especially for employees with higher degrees of disability invisibility (Gonzalez et al., 2020). The authors found that the relationship between veteran identity strain and withholding an accommodation request was mediated by psychological safety, suggesting that veterans with more military to civilian identity conflicts, were more likely to withhold an accommodation request due to a decrease in psychological safety (Gonzalez et al., 2020). Additionally, the authors found that when an organization was rated as a highly inclusive work climate, the negative relationship between veteran identity strain and psychological safety was weaker, particularly for veterans with higher degrees of disability invisibility (Gonzalez et al., 2020). This finding suggests that highly inclusive work climates may buffer the impact that military to civilian identity conflicts can have on psychological safety when veterans need or want to make an accommodation request, especially for veterans with fewer visible disabilities (Gonzalez et al., 2020). Therefore,

fear of disclosure and/or weakness associated with military culture, may cause veterans to withhold a necessary accommodation request at their employment. These fears can be deterred by a work climate that is veteran inclusive, possibly helping to ease the military to civilian identity conflicts.

Additionally, the fear of appearing weak, associated with mental health-related stigma, is a major barrier for veterans, preventing them from accessing the help they need (Williamson et al., 2019). In fact, Defraia et al. (2014) argued that veterans who hold negative attitudes toward treatment while dealing with the challenges associated with reintegration to civilian life, will be even less motivated to seek treatment. Currier et al. (2017) examined the role mental health treatment-related stigma had on student veterans' intentions to seek treatment. Undergraduate student veterans (n = 251) were gender-matched with a control comparison group of nonveteran students (n = 251). Students completed five questionnaires, including the PTSD-Checklist-Civilian, Patient Health Questionnaire-8 for depression, Self-Stigma for Seeking Help, General Help-Seeking Questionnaire, and the Endorsed and Anticipated Stigma Inventory (Currier et al., 2017).

Currier et al. (2017) found that almost two-thirds of student veterans would likely not seek treatment if they had a psychological crisis occur. Additionally, when compared to the civilian student group, student veterans expressed less self-stigma about treatment seeking but greater negative beliefs about mental health treatment, suggesting that veterans had better viewpoints of themselves for seeking treatment than civilian students, but student veterans did not believe that mental health treatment was an effective method of dealing with mental illness. The authors argued that this finding suggests that some

campaigns initiated by the VA or Department of Defense may have helped decrease self-stigma associated with treatment-seeking, but because of the negative views of treatment, veterans may not choose the most effective forms of treatment (e.g., therapy) instead choosing other less effective forms of mental health treatment (e.g., wellness coach). Furthermore, of those student veterans that were in need of mental health treatment (due to clinical threshold levels of PTSD and/or depression), almost 25% had more negative beliefs about mental health treatment and more negative self-stigma about seeking treatment compared to the nonclinical student veterans (Currier et al., 2017). Civilian students who met the clinical threshold levels for PTSD and/or depression did not have more negative stigma compared to those civilian students with nonclinical thresholds. Currier et al. (2017) concluded that mental health-related sigma is still a significant problem for student veterans and may actually lead to greater chronicity and/or severity of mental health problems. As for limitations, the authors stated that there was on average a nine-year age difference between the student veterans and the civilian students and that maturity levels may have influenced the results.

The fear of disclosure and stigma only increase issues for veterans during reintegration. While disclosing a mental health issue allows individuals to receive support, not disclosing a mental health problem can lead to vigilance, suspiciousness, depression, anxiety, guilt, social avoidance, decreased self-esteem, and identity ambivalence (Grice et al., 2018; Pachankis, 2007). Many of these same issues are prevalent during VCR (Hourani et al., 2012; Mobbs & Bonanno, 2018). Examining veterans six months after separation, Hourani et al. (2012) found that 38% of veterans

reported a mental health issue with some functional impairment in their lives. Of that 38%, 25% were chronic and 13% had a newly developed mental health issue (Hourani et al., 2012). A number of researchers have argued that the maintenance and/or development of mental health issues after separation from the military may be due to delayed onset of symptoms or after leaving the military, they may finally overcome the stigma and fear of negative consequences whereby their symptoms may manifest (Copeland et al., 2011; Mansfield et al., 2011). Some may finally report the symptoms they have been ignoring (Copeland et al., 2011; Mansfield et al., 2011).

Overall, the literature suggests that because of the military (warrior) culture and hypermasculine values, veterans have a fear of appearing weak and, thus, a fear of disclosing their mental health and/or physical issues. The fear of disclosure may lead to numerous problems that may exacerbate mental health issues for veterans and create more VCR challenges. It is also possible that some veterans have a delayed onset of mental health issues because they are finally outside the military environment and feel less stigma and fear of disclosure. These findings begin to explain the innumerable challenges veterans report during their VCR.

Suicide

For veterans who cannot abandon these masculine values, mental health problems may persist and/or a new one may develop, increasing the risk of suicide. Suicide is a major mental health problem for veterans with a 21% greater risk than for civilians (Derefinko et al., 2019). Additionally, even though veterans represent only 8.5% of the U.S. adult population, 18% of all suicides were committed by veterans with about 17

veterans dying from suicide every day (Braden et al., 2017; U.S. Department of VA, 2019).

Reger et al. (2015) aimed to examine suicides in U.S. military personnel, including suicides occurring after separation from the military. Participants (*N* = 3,945,099) were all uniformed service members that served in the military sometime between October 7, 2001 and December 31, 2007. Participants completed demographic and military information, suicide mortality from the Department of Defense Medical Mortality Registry, and the National Death Index. The authors found that separation from the military significantly increased the suicide rate. This finding was significant for both service members who had deployed and those who did not. Furthermore, suicide rates were also high for military members who separated with a non-honorable discharge and for those with less than four years of military service (Reger et al., 2015). Reger et al. argued that the transition from military to civilian life may increase suicide risk but that they had not collected mental health data, which has been associated with increased risk of suicide. Thus, future research should look at the relationship between the transition from military to civilian life, mental health, and suicide risk.

To determine if the transition from military to civilian life increases suicide risk, Haller et al. (2016) examined the relationship between reintegration difficulties and suicidal ideation in OEF/OIF/OND veterans and if reintegration difficulties contributed to suicidal ideation more than PTSD, depression, and substance abuse. The participants (*N* = 232) were given the M2CQ, Patient Health Questionnaire-9 (for depression levels), PTSD Checklist-Specific, and the Alcohol Use Disorders Identification Test. The authors

found that reintegration had a unique effect on suicidal ideation that was over and above the effect of PTSD and depression in these veterans and that the relationship between reintegration difficulties and suicidal ideation was stronger for those with substance abuse (Haller et al., 2016). The authors stated that a limitation of their study was the fact that the sample was veterans seeking treatment for PTSD, which may have influenced the results. Therefore, it may be useful to look at the influence of mental illnesses on suicide other than PTSD.

Jahn et al. (2018) examined differences in suicidal ideation (e.g., wanting to kill oneself) and death ideation (e.g., wanting to die but without specific thoughts of killing oneself) in individuals with serious mental illness, such as bipolar disorder, schizophrenia, schizoaffective disorder, major depression disorder (with and without psychotic features), and other psychotic disorders. Participants included veterans (n = 261) and civilians (n = 255) who were receiving treatment for a serious mental illness. Participants were given the Brief Symptom Inventory, General Self-Efficacy Scale, Self-Esteem Rating Scale-Short Form, Sense of Belonging Instrument, and demographic and clinical questionnaires. Jahn et al. found that compared to civilians with serious mental illness, veterans with serious mental illness reported death ideation and suicidal ideation more than twice as often. Furthermore, significant predictors of death ideation were depression and psychotic symptoms, while significant predictors of suicidal ideation were depression and hostility (Jahn et al., 2018). The authors argued that more research is needed to understand why differences in suicidal ideation occurred between civilians and veterans, nothing that veterans had significantly higher levels of hostility than civilians

and higher levels of reported death and suicide ideation (Jahn et al., 2018). The finding that hostility was found to be a significant predictor of suicidal ideation is consistent with previous results using adolescent populations.

Wilks et al. (2019) examined the relationship between anger and suicidal ideation, while controlling for risk (e.g., PTSD, traumatic brain injury [TBI]) and protective factors (i.e., social support) in Iraq/Afghanistan era veterans. Participants (N = 2467) completed the Traumatic Life Events Questionnaire, the Combat Exposure Scale, Alcohol Use Disorders Identification Test, Drug Abuse Screening Test, Symptom Checklist-90-Revised Hostility Index, Medical Outcomes Study, Beck Scale for Suicide Ideations, demographic questionnaires, parent history of suicide, and self-reported TBI. After controlling for PTSD and TBI, which have been shown to be significant risk factors for suicidal ideation, anger was significantly related to suicidal ideation such that veterans with greater anger reported greater suicidal ideation (Wilks et al., 2019). Results also indicated that veterans with PTSD reported higher levels of suicidal ideation than those without PTSD and social support was found to be a protective factor against suicidal ideation for both high and low levels of anger. These findings provide support for increased risk of suicidal ideation experienced by veterans during reintegration; indeed, anger control is the most common VCR issue reported by Iraq and Afghanistan era veterans (Sayer et al., 2010), potentially contributing to the relationship between PTSD and suicidal ideation (Wilks et al., 2019).

Posttraumatic Stress Disorder

One of the most common mental health problems experienced by

OIF/OEF/OND/OIR veterans is PTSD, which is distinguished by a range of symptoms including re-experiencing trauma, avoiding reminders of the trauma, emotional numbing, and hyperarousal (American Psychiatric Association, 2013). In the United States., the prevalence PTSD is significantly higher in veterans (10-25%) than in civilian populations (3-12%; Brancu et al., 2014). Previous research has documented the negative consequences of PTSD on veterans, including psychological distress, comorbidity with other mental disorders, suicidal risks, and even impaired social functioning (Brancu et al., 2014; Wingo et al., 2017).

Larson and Norman (2014) investigated risk of and protective factors against functional impairment during the initial transition from military to civilian life. Participants were Marines who had recently separated from the military. Participants (N = 2,116) completed the Deployment Risk and Resilience Inventory, Unit Support Scale, Connor-Davidson Resilience Scale, Posttraumatic Growth Inventory, Post-deployment Social Support Scale, Center for Epidemiologic Studies Depression Scale, and a number of questions regarding demographics, unlawful behavior, financial problems, work-related problems, limitations because of mental health, readjustment to civilian life, combat-related events, spiritual beliefs, and alcohol and drug use (Larson & Norman, 2014). Data were collected before and after military separation. The authors found that PTSD was a significant predictor of functional difficulties during reintegration for all factors assessed (i.e., alcohol use, financial problems, work-related problems, reintegration difficulties, and limitations because of mental health) except for unlawful behavior; veterans who reported alcohol use were at increased risk of engaging in

unlawful behavior. These findings suggest that PTSD is a risk factor that may lead to increases in the number of reintegration challenges during the VCR. Larson and Norman stated that although they examined numerous predictor variables, other risk factors of PTSD should be examined as should a sample of veterans that includes other military branches.

Smith et al. (2014) examined the prevalence and relationships between compulsive sexual behavior and stress-related conditions (i.e., PTSD) in OIF/OEF/OND male veterans. Compulsive sexual behavior is described as a series of usual, recurrent paraphilic (e.g., fetishism, sadism) or normophiliac (e.g., sexual fantasies or urges, intercourse) thoughts and/or actions that cause significant distress or life problems (Smith et al., 2014). Participants (N = 258) completed the Minnesota Impulsive Disorder Inventory, Primary Care Evaluation of Mental Disorders, Alcohol Use Disorder and Associated Disabilities Interview Schedule-IV, PTSD Symptom Checklist, Deployment Risk and Resilience Inventory and a number of questions related to demographic information, childhood trauma (physical and sexual), and television and internet usage. The authors found that only the association between compulsive sexual behavior and PTSD was significant such that compulsive sexual behavior increases as the severity of PTSD increases; only the PTSD symptom of re-experiencing trauma was significantly related to compulsive sexual behavior. The authors argued that veterans may participate in compulsive sexual behavior as a way to cope with the distress of re-experiencing their traumas. These findings provide further evidence of the difficulties created by symptoms of PTSD. Owing to sensitive nature of the study variables (e.g., compulsive sexual

behavior), participants may have underestimated their behaviors, potentially affecting the results.

In a further examination of the impact that PTSD symptoms can have on veterans, Barr et al. (2016) explored the relationship among suicide plan, suicidal ideation, non-suicidal risk to life behavior, and three different PTSD symptoms (i.e., avoidance, re-experiencing, and hyperarousal) in veterans. Participants (N = 1,356) completed questionnaires related to alcohol use, pain medication use, suicide plan, suicidal ideation, non-suicidal risk to life behavior, military and demographic information, and the PTSD Checklist (Barr et al., 2016). The authors found that among the PTSD symptoms, re-experiencing was associated with suicidal ideation, avoidance was associated with a suicide plan, and hyperarousal was associated with non-suicidal risk to life behavior. Experiencing these symptoms may cause the individual to distance themselves from others and social activities, leading to a decrease in social ties, increased loneliness (Solomon et al., 2015), and eventually suicidal behaviors (Teo et al., 2018). For veterans, something as innocuous as walking or driving down the street may cause PTSD symptoms; for example, to a civilian, a bag of trash or cardboard box in the street is just trash, but to a veteran, those pieces of trash signify a possible improvised explosive device. According to Barr et al., these findings are consistent with previous work in which avoidance symptoms and loneliness can lead to suicide risks. However, since Barr et al. did not examine the influence of loneliness on PTSD, it may be useful to examine its role on PTSD in veterans.

To determine the influence of loneliness on PTSD in veterans, Solomon et al.

(2015) examined the longitudinal relationship between loneliness, social support, and PTSD symptoms. Solomon et al. collected data from two groups of veterans, one group with and one without a diagnosed combat stress reaction at three time points over a 20-year period. A combat stress reaction is a psychological breakdown on the battlefield (e.g., overwhelming anxiety or total psychological withdrawal), leading to soldiers failing to function in their military role (Solomon et al., 2015). Participants (N = 346) completed the Impacts of Event Scale, UCLA Loneliness Scale, and the Perceived Social Support Scale. Results indicated that for both groups of veterans, with and without a combat stress reaction diagnosis, there was a positive association between PTSD symptoms and levels of loneliness at each time point (cross-sectionally). However, baseline levels of PTSD did not predict future loneliness. Consistent with previous longitudinal findings, Solomon et al. argued that this may have been due to the unstable nature of PTSD where there may be periods of "waxing and waning" in symptoms (p.15). Furthermore, the higher levels of PTSD and lower levels of perceived social support were associated with higher levels of loneliness (Solomon et al., 2015). Interestingly, social support was the only variable that predicted loneliness both cross-sectionally and longitudinally, suggesting that social support is an important factor to consider when studying PTSD and the VCR process. Overall, this finding points to the importance of social support on the VCR process.

Additional Psychosocial Challenges

Aside from suicide and PTSD, there are additional challenges that veterans can experience during their VCR. For example, it was reported that between 29-56% of veterans have at least some difficulties with social relations such as getting along with

relatives, spouse, or children (Sayer et al., 2010). These social challenges decrease the chances of having a successful VCR; given that social support is a major protective factor against VCR challenges, the decline in social support among personnel separating from the military reported by Drebing et al. (2018), is noteworthy. Previous research has shown the importance of social support on mental health symptom severity and distress, academic adjustment, relationship quality in romantic partners, and participation in community, family, and social activities (Campbell & Riggs, 2015; Cederbaum et al., 2017; Eakman et al., 2019; Ketcheson et al., 2018).

Social support has also been shown to be a protective factor against developing mental illness. For example, Sripada et al. (2015) examined the relationship between two types of social support (general and military) and mental health conditions (suicide risk, depression, anxiety, PTSD) in a National Guard sample. Participants (N = 1,448) completed the Interpersonal Support Evaluation List-12, PTSD Checklist-Specific Version, General Anxiety Disorder-7, Suicide Behaviors Questionnaire-Revised, and the Patient Health Questionnaire-9 for depression (Sripada et al., 2015). The authors found that both high levels of general social support and high levels of military social support were associated with a lower likelihood of having a mental illness, suggesting the importance of social support in safeguarding against mental illness in veterans. This finding is consistent with previous work that found a relationship between mental illness and lower levels of social support (Tsai et al., 2012). Therefore, social support may be beneficial in helping veterans with their mental health issues during their VCR.

Social support has been found to be related to other factors that influence the

VCR process, such as life satisfaction. Life satisfaction is an aspect of wellbeing that involves an individual's ongoing appraisal of their quality of life (Evans et al., 2018). Recent findings have shown an association between social support and life satisfaction in veterans with reintegration difficulties such that higher levels of social support were related to higher levels of life satisfaction (Mitchell et al., 2020). In an investigation of the impact of low life satisfaction on veterans, Krigbaum et al. (2020) assessed the relationship between life satisfaction and employment in a veteran sample. Participants (N = 146) completed questionnaires regarding employment and life satisfaction such as the Satisfaction with Life Scale (Krigbaum et al., 2020). Results found that life satisfaction was a significant predictor for securing employment, indicating that life satisfaction increases the chances of making a successful transition to civilian employment. However, veterans with lower life satisfaction experienced more difficulty finding and gaining employment, putting them at higher risk of experiencing financial problems.

Indeed, 27% of veterans reported having issues with food insecurity, while 30% reported money mismanagement issues such as forging or bouncing a check (Elbogen et al., 2013; Widome et al., 2015). To determine the impact of financial problems on reintegration in veterans, Elbogen et al. (2012) investigated the relationship between VCR and financial wellbeing. Participants (*N* = 1,388) completed the Quality of Life Index, Quality of Life Interview, Financial Capacity Instrument, Drug Misuse Screening Test, Alcohol Use Disorder Identification Test, Conflict Tactics Scale, MacArthur Community Violence Scale, Davidson Trauma Scale, and the Patient Health

Questionnaire (Elbogen et al., 2012). The authors found that veterans who had enough money to cover the cost of their basic needs had lower levels of reintegration difficulties, including criminal arrest, substance abuse, suicidal behavior, homelessness, and aggression; financial strain can increase stress and make reintegration more challenging and may worsen certain symptoms, such as physical aggression. Because finances and money problems may not be a topic many veterans wish to discuss, the reliability of self-report data may be limited.

Studies show that aggression is a major social problem for veterans during their VCR. In fact, 60% of veterans reported some family violence and 28% reported that their partner feared them (Sherman et al., 2015). Van Voorhees et al. (2018) examined risk and protective factors (e.g., PTSD, social support) and violence at two time points. Participants (N = 1,090) were a sample of Iraq and Afghanistan veterans and completed the Conflict Tactics Scale, MacArthur Community Violence Scale, and the Quality of Life Index. Results showed that the level of violence at baseline predicted increases in PTSD symptoms. Violence was negatively associated with social support such that the risk of violence increased as social support decreased (Van Voorhees et al., 2018). These findings help to provide support for the idea that social support can be a major protective factor for a number of challenges faced by veterans during their VCR.

Physical Health Challenges

Physical health challenges pose another reintegration difficulty for many veterans. Compared to previous conflicts, Post-9/11 veterans have suffered more injuries (Ainspan et al., 2018). Largely due to the advances in medical care, many of the service members

who would have died in combat are now surviving their injuries; however, many of these veterans return home with disabilities (Ainspan et al., 2018). Some of the physical health challenges faced by veterans included musculoskeletal pain, fatigue, back pain, post-concussional disorder, and chronic, widespread pain (Phillips et al., 2016; Sherman et al., 2015). In addition, among veterans who had deployed at least once since 9/11, more than 90% were at a higher risk of scoring below the norm for physical functioning compared to the general population (Kline et al., 2010). These physical health challenges may impact a veteran's ability to reintegrate successfully. For example, in a study examining the impact physical injuries can have on VCR, those injured veterans who had less community reintegration also had lower levels of general self-efficacy, more difficulty with environmental barriers (e.g., transportation, help at home), and reported that their injuries as more disabling (Hawkins et al., 2015). Furthermore, physical health challenges have been associated with more impaired social functioning, which may decrease a veteran's ability to remain resilient and be successful in their VCR (Wingo et al., 2017).

For Post 9/11 veterans, one of the most common physical injuries is a combat-related TBI (Aase et al., 2018). In fact, prevalence rates for a mild TBI range from 12-23% (Aase et al., 2018). Symptoms of a mild TBI may include multiple neurocognitive and physical symptoms such as, depression, headaches, irritability, poor sleep, and cognitive difficulties (Gfeller & Roskos, 2013; Lange et al., 2019). These symptoms can be temporary, prolonged, or permanent, depending on the severity of the TBI (Lange et al., 2019). To examine TBI's influence on neuropsychological functioning, Gfeller and Roskos (2013) compared three different populations on a number of neuropsychological

and neuropsychiatric symptoms. (Gfeller & Roskos, 2013). Participants included military veterans with a history of TBI (n = 74), civilians with a history of TBI (n = 67), and a healthy civilian control (n = 66). Participants completed a semi-structured interview to gather demographic information, health and psychiatric history, history of TBI injury, social history, Disability Rating Scale, Test of Memory Malingering, Work Memory Test, and a number of neuropsychological, psychological, and neurobehavioral test batteries. Gfeller and Roskos found that compared to both the civilian control and civilian TBI groups, the veteran TBI group displayed significantly higher rate of failure on effort tests associated with diminished neuropsychological test performance and increases in symptom reporting on both neurobehavioral and psychological batteries. Military veterans also displayed significant neuropsychiatric symptoms compared to the civilian control and civilian TBI groups (Gfeller & Roskos, 2013). These findings indicate that even when compared to civilians with TBIs, veterans with TBIs have more neuropsychological and neuropsychiatric impairment.

Stein et al. (2015) examined the relationship between a deployment-acquired TBI and mental health. Participants (N = 4,645) were U.S. Army Soldiers returning from, on average, a 10-month deployment; data were collected at immediate return to the United States, 3 months after returning, and 9 months after returning to the United States. Participants completed the Composite International Diagnostic Interview screening scales, Columbia-Suicide Severity Rating Scale, and a number of questions related to deployment stress, TBI status, and demographic information (Stein et al., 2015). The authors found that 18% of soldiers reported exposure to a mild TBI, while 1.2% reported

exposure to a more-than-mild TBI. Additionally, the authors found that a deployment-acquired TBI significantly increased risks of PTSD, major depression, and generalized anxiety disorder, even after controlling for pre-deployment mental health, deployment stress, and prior history of TBI. These findings suggest that a TBI can increase the risk of developing a mental illness after a deployment, which can make VCR more difficult. Failure to obtain information about other physical injuries sustained made it impossible to determine how they may have influence VCR.

Lange et al. (2019) examined the long-term neurobehavioral symptoms of TBIs at various levels of severity in military members and veterans. Participants were assigned to four groups: uncomplicated mild TBI (n = 158), complicated mild TBI, moderate, severe, or penetrating TBI's (n = 105), injured controls, such as an orthopedic or soft-tissue injury (n = 101), and non-injured controls (n = 81). Participants completed the TBI-Quality of Life, Neurobehavioral Symptom Inventory, and PTSD Checklist at 5 years after injury and 10 years after injury (Lange et al., 2019). The authors found that the non-injured controls had better scores on all measures than the other groups at the 5- and 10-year time point. Furthermore, many veterans reported poor long-term neurobehavioral symptoms following a TBI or an injury without TBI, suggesting that, regardless of injury type, physical health issues may have long-term effects on mental health and quality of life (Lange et al., 2019). One limitation may be the cross-sectional design of the study in that the 5- and 10-year post-injury groups were measured independently at a single point in time; longitudinal measurement may result in different findings.

Georgantas et al. (2020) provided additional support for the relationship between

physical health and mental health problems by examining the relationship among demographic variables and mental health (e.g., anxiety) in veterans. Participants (N = 231) provided demographic information and completed the Spielberg's State-Trait Anxiety Inventory (STAI). The authors found that the presence of a serious health problem was an independent predictor of anxiety, suggesting physical health problems related to anxiety may present challenges for veterans during reintegration. A limitation of this study is that instead of asking about particular physical health issues or symptoms, the authors chose to ask the participants to report if they had a serious health problem. Therefore, it may have been more useful to look at particular physical health issues or symptoms when studying this relationship between mental health and physical health problems. However, the authors asked only if participants had a serious health problem rather than asking about the specific health problem and/or symptoms, making it difficult to determine which problems/symptoms predicted anxiety.

Anxiety

Anxiety disorders are also a common mental health problem for military members and veterans, with prevalence rates ranging from 15-20% (Shepardson & Funderburk, 2016). Previous research has shown that individuals with anxiety symptoms and behaviors have increased risk of suicidal behaviors, PTSD, lack of social support, physical health issues, social isolation, loneliness, and even disruptions in positive experiences or events (Georgantas et al., 2020; Kashdan, Frueh et al., 2006; Kashdan, Julian, et al., 2006; Meltzer et al., 2013; Pfeiffer et al., 2009; Romero et al., 2015; Teo et al., 2013). Anxiety can increase the number of VCR challenges that veterans experience,

making the transition to civilian life more difficult.

The limited research on anxiety disorder in veteran populations suggests that anxiety negatively impacts the VCR process. For example, Pfeiffer et al. (2009) examined the relationship between anxiety disorder and suicide in depressed veterans. Participants (N = 887,859) were part of a national database of veterans in depression treatment; therefore, demographic, PTSD, suicide, and anxiety disorder data were collected from treatment and administration records (Pfeiffer et al., 2009). The authors found that for veterans with panic disorder, generalized anxiety disorder, and anxiety disorders not otherwise specified, there were significant increases in the risks of a completed suicide. These findings suggest that veterans with a comorbid anxiety disorder are at a higher risk of dying by suicide. However, the findings are limited to a sample of depressed veterans, which makes generalization to non-depressed veterans impossible. Therefore, future research is needed to look at anxiety in veterans without a comorbid depressive disorder.

In addition to increasing suicide risks, anxiety disorders can also increase functional impairment. One study found that 53-88% of military personnel with an anxiety disorder reported role impairment in all domains of life (Mather et al., 2010). To explore the relationship between anxiety disorders and impaired functioning, Disner et al. (2017) examined the impact of a number of factors, such as internalizing disorders (e.g., anxiety), and TBI symptoms on functional impairment in a sample of reintegrating veterans. Participants (N = 295) completed the Social Adjustment Scale–Self-Report: Short, Clinician Administered PTSD Scale for DSM-IV, Structured Clinical Interview for

DSM-IV-TR, Multidimensional Personality Questionnaire–Brief Form, Minnesota Blast Exposure Screening Tool (Disner et al., 2017). The results demonstrated that increases in internalizing symptoms were the strongest predictor of increases in functional impairment (specifically social and occupational impairment), even surpassing the effects of TBI symptoms (Disner et al., 2017). These findings provide support for the argument that anxiety disorders may impact a number of social and occupational areas during reintegration to civilian life.

Himle et al. (2014) examined social anxiety and employment barriers in unemployed individuals. The authors examined the relationships between a number of employment-related factors (e.g., perceived barriers, skills, and job aspirations) and social anxiety. Participants (N = 265) completed the Mini-Social Phobia Inventory and questions regarding employment barriers, employment skills, job aspirations, and demographics (Himle et al., 2014). The authors found that 35% of participants screened positive for social anxiety disorder. Furthermore, participants with social anxiety reported perceiving more employment barriers related to experience and skills, fewer skills needed for socially skilled occupations, and less education than participants who did not have social anxiety (Himle et al., 2014). These findings suggest that individuals with an anxiety disorder, e.g., social anxiety, may experience more employment barriers than individuals without an anxiety disorder. Considering that many veterans already have a number of employment barriers (e.g., physical and mental health issues), these additional barriers can make VCR even more difficult. The major limitation of this study is the population that was sampled from was civilians and not veterans. Therefore, these

findings may not generalize to reintegrating veterans. However, a previous study found that veterans with an anxiety disorder had greater percentage of unemployment compared to veterans without an anxiety disorder (84.6%, 61.5%, respectively; Kashdan, Frueh et al., 2006). Therefore, it is plausible that veterans with anxiety disorders may experience similar barriers to employment.

Campbell and Riggs (2015) examined academic adjustment/functioning, psychological functioning, and social support in veterans. Participants (N = 117) were military veterans attending a university who completed the Generalized Anxiety Disorder 7-item, Impact of Event Scale–Revised, Patient Health Questionnaire-9, Multidimensional Scale of Perceived Social Support, Student Adaptation to College Questionnaire, Unit Support Scale from the Deployment Risk and Resilience Inventory, and the Background Information Questionnaire–Student Veteran Version (Campbell & Riggs, 2015). The authors found that social support and anxiety, but not depression, were associated with academic adjustment such that higher levels of anxiety were associated with lower levels of academic adjustment (Campbell & Riggs, 2015). These results suggest that anxiety disorders can impact a veteran's ability to achieve their academic goals.

In addition, some studies have focused on the relationship between anxiety disorders and comorbid mental disorders, e.g., the relationship between PTSD and social anxiety. Similar to the avoidance and hyperarousal symptoms reported from patients with PTSD, patients with social anxiety reported avoidance and hyperarousal symptoms in response to socially stressful events (Erwin et al., 2006). This finding indicates a possible

relationship between anxiety disorders and PTSD. For example, Knowles et al. (2019) examined comorbidity of multiple disorders and PTSD symptoms in veterans. Participants (N = 2,460) completed the Mini International Neuropsychiatric Interview and the PTSD Checklist-Civilian Version (Knowles et al., 2019). The authors found a significant relationship between PTSD and social anxiety disorder. Compared to veterans without PTSD, veterans with PTSD had a higher risk of also having social anxiety and obsessive-compulsive disorder. Also, veterans with PTSD and more than one comorbid anxiety disorder reported higher levels of PTSD symptom severity, suggesting that anxiety disorders may increase the severity of PTSD symptoms in veterans (Knowles et al., 2019). Additionally, compared to Vietnam veterans, OIF/OEF veterans had significantly higher rates of social anxiety disorder, panic disorder, generalized anxiety disorder, and obsessive-compulsive disorder (Knowles et al., 2019). These findings provide support for the argument that anxiety disorders increase the risk of a comorbid mental disorder and symptom severity. However, the authors argued that their results found high rates of comorbidity in veterans both with and without PTSD. Therefore, future research should examine anxiety disorder comorbidity with other disorders, while controlling for PTSD.

Kashdan, Frueh et al. (2006) explored anxiety disorders in veterans. Participants (N = 733) were recruited from VA primary care clinics and completed the PTSD Checklist Military Version, Short-Form Health Survey, Trauma Assessment for Adults-Interview Version, Clinician-Administered PTSD Scale, Mini International Neuropsychiatric Interview, telephone interviews, and a retrospective review of primary

care charts (12-months preceding). The authors found that 3.6% of veterans met the criteria for social anxiety. Furthermore, 73.1% and 26.9% of veterans with, and without, social anxiety also had PTSD, respectively (Kashdan, Frueh et al. 2006). Veterans with social anxiety were at higher risk of also having another anxiety disorder such as panic disorder, agoraphobia, generalized anxiety disorder, and obsessive-compulsive disorder compared to veterans without social anxiety (Kashdan, Frueh et al., 2006). There was also significantly higher risk of suicide in veterans with social anxiety (53.8%) compared to veterans without social anxiety (8.1%; Kashdan, Frueh et al. 2006). After controlling for the severity of PTSD and major depression, veterans with social anxiety were still at a higher risk of suicide and comorbidity with other anxiety disorders compared to veterans without social anxiety (Kashdan, Frueh et al. 2006). These findings provide support for the fact that anxiety disorders are related and may increase the risk of developing other anxiety disorders. Having used the VA health care system for recruitment, the authors acknowledge the potential for different results for veterans who do not use VA healthcare.

Overall, veterans experience a number of challenges as they leave the service and move into the civilian world. These challenges generally are interrelated; a challenge in one aspect of a veteran's life can lead to challenges in other aspects. For example, a veteran who is experiencing dissatisfaction with life may exhibit increased aggression. These challenges can make the overall VCR process more difficult and may preclude its success.

Trait Anxiety

Trait anxiety is defined as the tendency to assess situations as threatening, resulting in a magnified fear response (Cho et al., 2019; Knowles & Olatunji, 2020). Individuals with high trait anxiety are more vulnerable to stress and mental health issues (Huang et al., 2012; Wang et al., 2019). Furthermore, trait anxiety may impact an individual's life in a number of ways from procrastination to the development of mental health disorders. Procrastination is not a major problem for most, but around 15-20% of adults reported problematic procrastination (Zhang et al., 2020). Procrastination can negatively influence academic performance, job satisfaction, and even physical and mental health (Zhang et al., 2020).

In an examination of the relationship between trait anxiety and procrastination, Van Eerde (2003) conducted a meta-analysis that examined relationships among procrastination and a number of personality, self-image, motive, affect, and performance variables. The goal of the study was to systematically evaluate and consolidate the literature on procrastination. There was a total of 88 articles used, with effect sizes of 121 independent samples used for data analysis (Van Eerde, 2003). The average sample size was 172, but ranged from 32 to 618 (Van Eerde, 2003). Participants' ages ranged from 16 to 43 the majority of which were college students (Van Eerde, 2003). Van Eerde found a moderate effect size for the positive correlation between trait anxiety and procrastination. These findings suggest that as symptoms of trait anxiety increases, procrastination also increases (Van Eerde, 2003). Therefore, those individuals with higher levels of trait anxiety may have more problems with procrastination, leading to problems in other areas

of a person's life such as employment or mental health. Van Eerde argued that procrastination may be a way for the individual to have temporary relief from the pressures related to completing a task by deadline; however, procrastination has short term benefits (relief from pressure) and long-term costs (not meeting the deadline). The author suggested that future research should focus on the emotions associated with procrastination.

In addition to procrastination, trait anxiety is related to substance abuse. Teichman and Cohen (2012) examined the relationship among several mental health disorders (e.g., trait anxiety) and substance abuse in a sample of Israeli veterans diagnosed with PTSD. The authors hypothesized that use of psychoactive substances would be positively related with levels of trait anxiety. Participants (N = 201) completed the Israeli National Household Survey of Drinking and Drug Use, the Posttraumatic Diagnostic Scale, the STAI, Beck Depression Inventory, and demographic questionnaires (Teichman & Cohen, 2012). The authors found that level of trait anxiety was positively associated with the use of a psychoactive substance, suggesting that as trait anxiety increased, the use of a psychoactive substance also increased. Furthermore, after controlling for a number of variables (e.g., depression, resilience, previous drug use), trait anxiety explained 6.7% of the variance in psychoactive substance use (Teichman & Cohen, 2012). These findings suggest that individuals with higher levels of trait anxiety are at higher risks of substance use. The authors argue that the use of substances may be a way in which veterans self-medicate to cope with their anxiety symptoms. A limitation of this study is that the sample was Israeli veterans, therefore the results could be different

for veterans from other countries, such as the United States. Thus, future research should sample from other countries to see if these results generalize across different veteran nationalities.

Huang et al. (2012) examined the relationship between trait anxiety and a number of mood variables (i.e., tension, anger, fatigue, depression, confusion, vigor, and self-esteem), hypothesizing that an increase in trait anxiety would be associated with an increase in negative mood (Huang et al., 2012). Participants (N = 148) were college students who completed the Profile of Mood States–Short form. The participants were also screened with the State–Trait Anxiety Inventory to assess their level of trait anxiety and eligibility for the study. Eligible participants with were then placed into two groups based on trait anxiety levels, high trait anxiety (n = 21) and low trait anxiety (n = 20) and given the Implicit Association Test–Anxiety. The authors found that participants with high trait anxiety had significantly more negative moods, specifically higher levels of tension, anger, fatigue, depression, and confusion, and lower levels of vigor and self-esteem; participants in the low trait anxiety group were more likely to consider themselves calmer and not anxious (Huang et al., 2012). These findings suggest that those individuals with higher levels of trait anxiety had more negative mood, including depressive symptoms. The authors argued that more research is needed to confirm these findings due to the small sample size.

In an attempt to provide more support for the relationship between trait anxiety and depressive symptoms, Wang et al. (2019) examined the relationship between trait anxiety and depression in Chinese urban adults. The authors hypothesized that trait

anxiety would be significantly correlated with depression. Participants (N = 1,619) completed questionnaires, including the STAI and the Beck Depression Inventory (Wang et al., 2019). The authors found that trait anxiety was positively correlated with depression, indicating that as the level of trait anxiety increased, the level of depression also increased. The authors argued that because the study used non-clinical adults, these findings could be different for participants with clinical levels of depression and anxiety; therefore, future research should utilize other populations.

Additionally, trait anxiety was found to be associated with sleeping difficulties. One study found that when compared to healthy controls, the severity of trait anxiety was independently associated with sleeping difficulties (i.e., poor sleep quality) in patients with obsessive-compulsive disorder (Segalàs et al., 2021). However, a previous study found more support for this relationship by examining the relationship between trait anxiety and sleeping difficulties, while controlling for depression. Weeks et al. (2019) examined the influence of both state and trait anxiety on sleeping difficulties while controlling for depression. The authors hypothesized that both state and trait anxiety would be associated with and predict different types of sleep difficulties (i.e., difficulty getting to sleep, problems with quality of sleep, difficulty awakening from sleep, and difficulty with behavior following waking). Participants (N = 292) were older adults who completed the STAI, the Leeds Sleep Evaluation Questionnaire, the Beck Depression Inventory-II, and demographic information (Weeks et al., 2019). The results suggested that higher levels of trait anxiety were associated with more sleep difficulties, specifically difficulty getting to sleep, problems with quality of sleep, difficulty awakening from

sleep, and difficulty with behavior following waking, even after controlling for age, gender, and depression scores. Moreover, trait anxiety was found to be a stronger predictor than state anxiety for sleeping difficulties (Weeks et al., 2019). Thus, trait anxiety could influence an individual's sleep quality independent of depression levels. However, these studies utilized clinical and/or civilian populations (persons with obsessive-compulsive disorder/older adults) and may not generalize to a military population.

To examine the influence of trait anxiety on sleeping difficulties in a military sample, Larsson et al. (2008) examined the impact of baseline trait anxiety and exposure to a traumatic event on post-trauma anxiety and insomnia in Swedish soldiers. It was hypothesized that for those with higher levels of baseline (pre-trauma) trait anxiety, exposure to a traumatic event would predict higher levels of post-trauma anxiety and insomnia (Larsson et al., 2008). Participants (N = 44) completed the State Trait Anxiety Inventory, General Health Questionnaire (to assess general anxiety and insomnia), and a traumatic situation questionnaire. The authors found that baseline trait anxiety positively interacted with traumatic event exposure to predict higher levels of post-trauma anxiety and insomnia. These findings indicate that those individuals with higher levels of trait anxiety who experience more frequent traumatic events, are at a higher risk of increased general anxiety and insomnia following the traumatic event compared to soldiers with lower levels of baseline trait anxiety who experience fewer traumatic events (Larsson et al., 2008). Major limitations of this study were the small sample size and the type of exposure questionnaire, which only asked if the soldiers had been exposed to six different

types of traumatic situations. Thus, future studies should use a more comprehensive type of trauma exposure questionnaire with a larger sample. Overall, these findings suggest that trait anxiety may be a risk factor for future issues such as anxiety, sleeping difficulties, and/or post-trauma distress.

Since active-duty soldiers and veterans are at higher risk of PTSD, the findings that trait anxiety may increase the risk of distress following a traumatic event suggests a potential relationship between trait anxiety and PTSD. Kok et al. (2016) explored both the mediating and moderating influence of trait anxiety on the relationship between trauma/stressful life events and the development of PTSD and depression in a sample of cardiac surgery patients. The participants (N = 2458) completed the Self-Report Inventory for PTSD, the Beck Depression Inventory-Revised, the Childhood Trauma Questionnaire, the Life Stressor Checklist Revised, and the STAI-Trait scale (STAI-T). The authors found that trait anxiety positively mediated the relationship between stress exposure and depression for the female and male groups and for the whole cohort, which suggests that increases in trait anxiety can increase the positive strength of the relationship between stress exposure and depression. For example, individuals with higher levels of trait anxiety and more frequent stress exposure were at greater risk of developing depression. The authors also found that trait anxiety mediated the relationship between stress exposure and PTSD for female patients while trait anxiety partially mediated the relationship for the male group and the whole cohort such that individuals with higher levels of trait anxiety and more frequent stress exposure are at greater risk of developing PTSD. There was no significant moderation effect of trait anxiety on the

relationship between stress exposure and depression, but there was a moderation effect of trait anxiety on the relationship between stress exposure and PTSD. Therefore, trait anxiety had no effect on the strength of the positive relationship between stress exposure and depression, but trait anxiety did have an effect on the strength of the positive relationship between stress exposure and PTSD. These findings suggest that trait anxiety is a risk factor and may help to explain the development of both depression and PTSD after experiencing a stressful event.

The relationship between trait anxiety and the development of PTSD is also supported by research linking trait anxiety to an increase in physiological reactions (e.g., heart rate and breathing) similar to the physical (hypervigilance) PTSD symptoms (American Psychiatric Association, 2013; Efinger et al., 2019). Efinger et al. determined how different types of emotional reactivity (e.g., emotional experience, emotion-expressive behavior, and physiological responses) were related to trait anxiety. Emotional experience refers to emotions experienced by participants during the presentation of stimuli while emotion-expressive behavior refers to conscious/unconscious facial expressions that reflect emotional experience (e.g., frowning; Efinger et al., 2019). Physiological responses were heart rate changes, skin conductance, and respiratory rate. The authors hypothesized that trait anxiety would positively correlate with emotional experience (i.e., higher trait anxiety, more negative experience) and physiological responses (i.e., higher trait anxiety, more physiological responses), but there would be no relationship between trait anxiety and emotion-expressive behavior. Participants (N = 77) completed the STAI and viewed 72 negative images from the Geneva Affective Picture

Database, rating their emotional experience while viewing the images (i.e., very positive to very negative; Efinger et al., 2019). Additionally, sensors were used to measure negative emotion-expressive behavior, changes in heart rate, level of skin conductance, and respiratory activity (Efinger et al., 2019).

As hypothesized, the authors found that trait anxiety was positively correlated with physiological responses (e.g., as level of trait anxiety increased, physiological response also increased) but was not related to emotion-expressive behavior. However, contrary to the authors' hypothesis, trait anxiety was not significantly correlated with emotional experience (Efinger et al., 2019). Therefore, only physiological responses (e.g., heart rate changes, skin conductance, and respiratory rate) were correlated with trait anxiety, indicating that individuals with high trait anxiety had more heart rate changes, higher skin conductance, and higher respiratory rate compared to those with low trait anxiety. Because this was an all-female student sample, the generalizability of the results to a mostly male military population may be limited.

An increase in physiological symptoms may be related to the tendency among individuals with trait anxiety to overestimate the level of situational threat. Sep et al. (2019) conducted a meta-analysis to determine if there was a relationship between anxious personality (e.g., level of trait anxiety) and generalizing fear to safe/novel situations in healthy subjects (i.e., no reported anxiety disorders). The authors hypothesized that healthy individuals with higher levels of trait anxiety would show more fear generalization than individuals with lower levels of trait anxiety. Sep et al. also argued that if a positive relationship between trait anxiety fear generalization increased

the risk of developing an anxiety disorder due, then the relationship between trait anxiety and fear generalization should be present before individuals develop an anxiety disorder. There were 4,892 studies screened but only 19 were used for the analyses (Sep et al., 2019). The participants (N = 1,348) from these screened studies were healthy participants. The authors found a significant positive correlation between trait anxiety and fear generalization such that for healthy individuals or individuals who had not yet developed an anxiety disorder, higher levels of anxious personality were related to higher levels of fear generalized to safe and novel situations (Sep et al., 2019). The authors argued that these findings suggest an increased risk of developing anxiety because of the increases in fear generalization.

Cobb et al. (2017) examined the relationship among trait anxiety, anxiety disorders, and deployment stressors in a sample of soldiers before and during a deployment. It was hypothesized that trait anxiety would moderate the relationship between deployment stressors and general anxiety symptoms. Participants (N = 223) completed the trait scale from the STAI, Deployment Risk and Resilience Inventory, and the Combat Experience Log Anxiety Subscale. The authors found that higher levels of pre-deployment trait anxiety predicted increased risk for general anxiety symptoms during the deployment (Cobb et al., 2017). Furthermore, for soldiers with high levels of pre-deployment trait anxiety, increases in deployment stressors were related to increases in general anxiety symptoms during the deployment (Cobb et al., 2017). These findings provide strong support for the relationship between trait anxiety and the development of anxiety disorders in a military sample. However, the study's sample was active-duty

soldiers, necessitating further studies to examine trait anxiety in transitioning veterans.

Overall, trait anxiety has been found to be associated with several issues, such as procrastination, sleeping difficulties, depression, PTSD, and other anxiety disorders, especially problematic for a veteran during their reintegration. However, much of the previous research within this area uses civilian rather than veteran samples, pointing to a need for research to study the influence of trait anxiety on reintegration in a U.S. veteran population.

Emotional Intelligence

EI is defined as the ability to recognize and understand an individual's own and others' emotions and use this information to guide thinking and actions (Oden et al., 2015). The four main domains of EI are self-awareness (i.e., able to recognize one's own emotions), self-management (i.e., able to control and regulate one's emotions), social awareness (i.e., ability to recognize and empathize with others' emotions), and relationship management (i.e., ability to influence others' emotions; Cherniss & Goleman, 2001). Individuals with higher levels of EI skills have been found to be better leaders, perform better academically, less likely to use drugs, alcohol, and/or cigarettes, and more effective at encouraging children's social-emotional development (Daffey-Moore, 2015; Oden et al., 2015; Walton & Hibbard, 2019; Williston & Roemer, 2017). In addition, previous research has also found that as EI increases, levels of binge eating, state anxiety, and trait anxiety decrease (Andrei et al., 2018). However, a large majority of EI research is focused on civilian populations. Thus, there is a need to study EI and its influence on veterans while they are reintegrating into civilian life.

A major finding within the EI literature is the relationship between EI and stress. Singh and Sharma (2012) examined the relationships among general intelligence, EI, and stress. Participants (N = 34) were male university students who completed the Wechsler Adult Performance Intelligence Scale, EIS, Perceived Stress Scale, an acute stress questionnaire, and a salivary sample was taken to assess baseline cortisol level. While participants played a stressful computer game, heart rate and sweat gland activity were recorded to assess the level of stress, followed by another salivary cortisol sample after completion of the computer game. Singh and Sharma found that EI scores were negatively correlated to both acute stress levels and perceived stress levels, while general intelligence scores were not significantly related to stress levels. These findings suggest that individuals with higher levels of EI are better able to handle stress than individuals with lower levels of EI or individuals with high general intelligence, concluding that level of general intelligence does not influence stress management.

Gaher et al. (2014) investigated the relationship among PTSD symptoms, negative urgency (i.e., impulsivity), alcohol use issues, and EI in a sample of post 9/11 veterans. The authors hypothesized that low EI would predict higher levels of negative urgency and would be negatively associated with symptoms of PTSD and alcohol problems. Participants (N = 90) completed the National Center for PTSD Checklist of the Department of Veterans Affairs, Modified Daily Drinking Questionnaire, UPPS Impulsive Behavior Scale, EIS, and questions related to alcohol consumption and alcohol-related problems (e.g., have you gotten into an argument/fight, taken foolish risks, drink more than intended, blacked out). The authors found that EI was negatively

associated with negative urgency, PTSD symptoms, alcohol use, and alcohol-related problems, indicating that veterans with higher levels of EI had lower negative urgency/impulsivity, fewer symptoms of PTSD, less alcohol consumption, and fewer alcohol-related problems. Furthermore, EI was found to be a predictor of negative urgency, suggesting that as levels of EI increases, decreases in negative urgency or impulsivity would occur. However, the authors recruited a veteran sample with moderate to heavy alcohol consumption, limiting the generalizability of the findings. Findings from a veteran sample with a normal range of alcohol usage may be different.

A commonly reported issue among veterans is impulsivity and aggression (Sherman et al., 2015). Coccaro et al. (2016) investigated the relationship among perceived EI, aggression, and impulsivity in an adult sample. Participants (N = 1,544) completed the Trait Meta-Mood Scale, Life History of Aggression, Buss-Perry Aggression questionnaire, Life History of Impulsive Behavior, Barratt Impulsiveness Scale, and demographic information. The Trait Meta-Mood Scale measures three domains of EI: attention (i.e., the extent in which a person can "attend" to or be aware of their emotions), clarity (i.e., how well a person can understand their emotions), and repair (i.e., a person's effort involved in regulating their emotions; Coccaro et al., 2016). The authors hypothesized that EI would be associated with both aggression and impulsivity, but that each EI domain (i.e., attention, clarity, and repair) would be related to aggression and impulsivity differently; however, the authors did not specify in which way they expected these to be related. Coccaro et al. found that attention was positively associated with both aggression and impulsivity such that increases in emotional awareness led to

increases in both aggression and impulsivity. On the other hand, clarity and repair were both negatively associated with aggression and impulsivity, indicating that increases in emotional regulation and clarity reduced aggression and impulsivity. Furthermore, clarity was the strongest predictor of impulsivity while repair was the strongest predictor of aggression, suggesting that understanding emotions (i.e., clarity) and using this information to regulate emotions (i.e., *repair*) are the EI components with the greatest impact on aggressive and impulsive behaviors. However, the sample was majority white participants from higher-than-average household incomes, limiting the generalizability of the findings. Since some post-9/11 veterans have financial issues (Sherman et al., 2015), future research should use a typical veteran sample or at least an average household income sample.

In addition to the relationship between EI and aggression, Perera and DiGiacomo (2015) examined the relationship between EI and perceived social support among university freshmen as they transitioned into college life. The authors hypothesized that EI would be associated with perceived social support but did not specify the hypothesized direction of this relationship. Participants (N = 470) completed the Trait Emotional Intelligence Questionnaire-Short-Form, Social Provisions Scale (to assess perceived social support), and demographic survey. Perera and DiGiacomo found that EI was a positive predictor of perceived social support, indicating that as levels of EI increased, perceived social support also increased. As for limitations, the authors did not measure stress, which has been shown to be independently related to both EI and social support (e.g., Cohen & Wills, 1985; Singh & Sharma, 2012). The population in this study was

university students who were transitioning into college life, and with any transition there will be some stress. Therefore, it may be useful for future studies to examine the relationship between EI, perceived social support, and stress.

In a longitudinal study, Malinauskas and Malinauskiene (2020) examined the relationship among EI, perceived social support, stress, and wellbeing in a male university student sample. Participants (N = 604) completed the Schutte EIS, Multidimensional Scale of Perceived Social Support, Perceived Stress Scale-10, and the Ryff Psychological Wellbeing Scale at two time-points three months apart. The authors hypothesized that (1) perceived stress would mediate the relationship between EI and wellbeing and (2) perceived social support would mediate the relationship between EI and wellbeing. Malinauskas and Malinauskiene found that EI was negatively associated with perceived stress and positively associated with social support, such that high levels of EI decreased perceived stress and increased perceived social support, respectively. The authors also found that perceived stress did not mediate the association between EI and wellbeing but that perceived social support did positively mediate the relationship between EI and wellbeing, implying that increases in perceived social support help to strengthen the positive relationship between EI and wellbeing over time.

With a sample of active-duty military members, Krishnakumar et al. (2019) examined the relationship among work-related EI and task performance, discipline, organizational citizenship, and performance commendations. The authors hypothesized that EI would be positively related to job performance and organizational citizenship behavior. Participants (N =152) completed the North Dakota Emotional Abilities Test and

a number of questions related to job satisfaction and job performance (e.g., task performance, discipline, organizational citizenship behavior, performance commendations). The authors found that EI was positively related to task performance, discipline, organizational citizenship such that individuals with higher levels of EI reported receiving more performance commendations. These findings suggest that individuals with higher levels of EI have higher overall job performance and more performance commendations than individuals with lower levels of EI. Krishnakumar et al. also questioned if individuals with higher levels of EI may have better job performance because they are more satisfied with their jobs. However, the authors found no significant relationship between EI and job satisfaction. Because participants were active-duty military members, it was not possible to obtain actual job performance records; data collection relied instead on self-report instruments vulnerable, in this case, to over- or underreporting job performance and/or commendations. Future research should use multiple types of data, such as organizational records, to analyze the relationship between EI and job performance.

Veterans who have issues with job performance, may have trouble obtaining or maintaining employment, leading to financial problems, even homelessness (Elbogen et al., 2012). For military veterans, previous research has shown a negative relationship between job performance and depression (Zivin et al., 2016). To address this problem, Moore and Skinner (2017) explored the relationship between emotional regulation (i.e., a component of EI) and depressive symptoms in a 6-month rehabilitation and addiction treatment program for homeless veterans. Specifically, the authors examined six different

types of emotion regulation: problem solving, positive reappraisal, impulse control, acceptance, clarity, emotional awareness, tolerance of distress while involved in goal-oriented behavior, and the perceived ability to use an appropriate strategy to cope. The authors hypothesized that changes in emotion regulation during early treatment would predict changes in depressive symptoms later in the treatment program. Participants (N =186) completed the Beck Depression Inventory-II, Coping Response Inventory, and Difficulties in Emotion Regulation Scale. Moore and Skinner found that early treatment changes in only one type of emotion regulation (i.e., tolerance of distress while involved in goal-oriented behavior) was related to changes in depressive symptoms later in the treatment program. However, depression was measured at only three time-points over a 6-month period, and changes in depression could have been influenced by other variables that may have occurred at the start of or during the treatment program.

Several studies have found a significant relationship between mental health and EI (Antoñanzas, 2017; Martínez-Monteagudo et al., 2019; Moeller et al., 2020). Adding to that research, Obeid et al. (2021) explored the relationship between EI and a number of mental health issues: alcohol use disorder, alexithymia, anxiety, depression, perceived stress, social anxiety, burnout, and suicidal ideation in an adult sample. Participants (N = 789) completed the Quick Emotional Intelligence Self-Assessment, Alcohol Use Disorders Identification Test, Toronto Alexithymia Scale, Rosenberg Self-Esteem Scale, the Hamilton Depression Rating Scale, Hamilton Anxiety Scale, Evaluation of the Three-Dimensional Work Fatigue Inventory, Columbia–Suicide Severity Rating Scale, Perceived Stress Scale, and the Liebowitz Social Anxiety Scale. Separating participants

into low, moderate, and high EI groups (using a cluster analysis), Obeid et al. found that individuals with both low and moderate EI were significantly more likely to have problems with alcohol use disorder, alexithymia, anxiety, depression, perceived stress, social anxiety, burnout, and suicidal ideation compared to individuals with high EI.

Throughout the literature, higher EI skills have been found to improve individuals' abilities to handle stress, increase job performance, and even decrease psychopathology. Many researchers argue that EI training can improve quality of life. However, there is a dearth of literature studying EI in veteran populations. Therefore, future research should explore EI in a veteran population, which was a goal of the study.

Summary

The goal of the study was to examine the relationship between trait anxiety and perceived VCR challenges in a non-VA sample of OIF/OEF/OND/OIR veterans and if EI moderated that relationship. Military transition theory provided a foundation for explaining veterans' ability to negotiate the *approach, management, and assessment* of their transition from military to civilian life. Additionally, EI theory explained EI's potential to mitigate challenges and improve outcomes for VCR. Research, to date, has not examined the potential for trait anxiety to increase perceived VCR challenges or for EI to mitigate them. The research suggest that these individual differences can influence veterans' ability to transition from military to civilian life successfully. Results may persuade military administrators to incorporate EI training into transition-based training for reintegrating personnel. Chapter 3 will provide details of the planned research design, instruments, sampling procedures, and statistical methods employed.

Chapter 3: Research Design and Methodology

The purpose of the study was to determine whether EI moderated the relationship between trait anxiety and perceived VCR challenges in a sample of a non-VA, post-9/11 veterans. Chapter 3 will include a detailed discussion of the sample, sampling methods, recruitment procedures, inclusion and exclusion participant criteria, and data collection procedures. Each of the study's instruments will be discussed, including the validity, reliability, and justification for use. Finally, the descriptive and inferential analyses will be discussed, ending with a discussion of the threats to validity and ethical concerns.

Research Design and Rationale

The study followed a cross-sectional quantitative survey design to examine the extent to which EI moderated the relationship between trait anxiety, and perceived VCR challenges. Data were collected at one time-point, justifying the use of a cross-sectional design (Creswell & Creswell, 2018). A quantitative survey design was the most appropriate for examining relationships among variables (Creswell & Creswell, 2018). Surveys were administered to participants online, which was the most time- and cost-effective data collection method (Groves et al., 2009; Rice et al., 2017). This type of survey distribution allowed a diverse veteran sample to participate, adding to previous research that mainly samples from VA health care systems.

Methodology

Population

The target population for this study was veterans who served on active-duty status in the U.S. military after 9/11, such as those who have served in the OEF/OIF/OND/OIR

campaigns, and recently separated from the military (i.e., within the past 2 years). For this study, a veteran was defined as an individual who has served active-duty in the U.S. military and who was discharged or released from the military (e.g., honorable, medical, dishonorable). There are approximately 4.2 million post-9/11 veterans, with 2.8 million of those veterans having only served post-9/11 (National Center for Veterans Analysis and Statistics, 2018).

Sampling and Sampling Procedures

A convenience sampling strategy was used for this study. The initial plan was to recruit participants from Facebook groups with veteran-affiliation (e.g., veteran groups, veteran support groups, women veteran groups, etc.). I contacted the Facebook group administrators and requested permission to post a description of the study and a SurveyMonkey link. With a lack of responses, recruitment was later changed to Survey Monkey's participant pool. To be included in the study, participants had to (a) be at least 18 years old, (b) have served in the U.S. military on active-duty (officer or enlisted) following 9/11, (c) be currently living in the United States, and (d) be discharged from the military within the past 2 years (honorable, medical, dishonorable, etc.). To control for differences in military culture across countries, the study only included individuals who had served in the U.S. military and who currently live in the United States.

Excluded from the study were individuals who were (a) retired from the U.S. military, (b) currently in the Reserves or National Guard, (c) separated from the military for more than 2 years, and (d) currently living outside of the United States. Research suggested that retired veterans tend to do better during reintegration possibly because

they are older and usually receive additional retirement benefits that can help during the reintegration process (MacLean et al., 2014; Reger et al., 2015). Additionally, veterans in the Reserves or National Guard were not included in the sample as they continue having a connection to the military, even when not on active-duty status, and unlike individuals who have completely separated from the military, will not have to deal with the loss of their military identity, lifestyle, friends, and peers. In addition, much of the research involving reintegrating veterans does not report time since separation from the military and those that do report have ranged from three months to over 6 years (e.g., Aronson et al., 2020; Sayer et al., 2015). But on average, 2 years since discharge is sufficient time for veterans to have reintegrated successfully as evidenced by the significant decrease in reintegration challenges veterans experience after a 2-year period (Castillo et al., 2019).

To determine the minimum sample size for the study, a power analysis using G*Power 3.1 was completed (Faul et al., 2009). The minimum recommended sample size was calculated using the following parameters for linear multiple regression (fixed model, R^2 increase): an alpha level of .05, power of .80, an estimated effect size of .04 for the moderator, one tested predictor (interaction variable), and three total predictor variables (i.e., trait anxiety, EI, interaction variable). The recommended sample size using these parameters was 199. The estimated effect size for the moderation was chosen because the effect sizes of relationships among trait anxiety and a number of individual reintegration challenges (i.e., PTSD, depression, sleeping difficulties, stressors, negative drug-use consequences) ranged from small to medium (Pearson's *r*s = .25 to .46; Clayson et al., 2019; Larsson et al., 2008; Piacentine, 2013; Weeks et al., 2019). Similarly, the

effect sizes of EI and a number of individual reintegration challenges (i.e., alcohol consumption, alcohol problems, negative urgency/impulsivity, symptoms of PTSD) were also within the small to medium range (Pearson's *r*s = -.25 to -.41; Gaher et al., 2014). However, moderations tend to have small effect sizes (Aguinis et al., 2005); therefore, an estimated effect size of .04 for the moderation relationship appeared to be an estimated effect size consistent with the literature.

Procedures for Recruitment, Participation, and Data Collection

Initial recruitment was through Facebook veteran groups. Facebook groups associated with military veterans were identified and a direct message was sent to group administrators asking permission to post a flyer with a description of my study and the SurveyMonkey link. The flyer that described the study included a brief overview and purpose of the study, eligibility information, and survey link. The survey included the informed consent form, eligibility screening questions, demographic information, followed by the self-report questionnaires. However, over a course of 6 weeks, there were no participants volunteering for the study. Therefore, changes were requested and approved by IRB for a change in recruitment and a change to the EI survey used. Recruitment went from using Facebook veteran groups to using Survey Monkey's audience panel for volunteers.

Other changes to data collection included replacing the 33-item EIS (Schutte et al., 1998) with the 10-item BEIS (Davies et al., 2010) to reduce the total number of survey questions allowed by Survey Monkey. The BEIS was created using the same questions as the EIS, but a simplified, shorter version. The BEIS was found to be reliable

and valid (Davies et al., 2010). The BEIS had high internal consistency with a Cronbach's alpha of .91 in university students (Balakrishnan & Saklofske, 2015). There were no reverse scored items and the survey took approximately two minutes to complete (Davies et al., 2010).

As mentioned, I used the SurveyMonkey survey platform to administer the online survey. To participate, individuals indicated their agreement on the consent form. By allowing participants to "agree" or "disagree" instead of signing with their name, the study was able to maintain participant anonymity. Furthermore, because the study dealt with challenges faced by veterans transitioning from military to civilian life and the stigma associated potentially with transition difficulties, a passive deception strategy was used. The consent form described the study as an examination of how mood, attitudes, and behaviors influence the military to civilian transition. In addition, the consent form described instructions on how to participate, privacy-related concerns, the voluntary nature of the study, the risks and benefits of participating in the study, and contact information for a crisis phone number/website. My contact information and Walden University's participant advocate was also provided. Individuals who declined participation and/or those who do not meet the inclusion criteria were directed to a "Thank you" page, which thanked the participants for their interest in the study.

Eligible participants continued onto the demographic questionnaire. The questionnaire recorded information such as age, gender, race, military branch, length of time since separation, and military grade. Following the demographic questionnaire, participants completed the survey instruments for trait anxiety, EI, and perceived VCR

challenges. The estimated time needed to complete the questionnaires was around 25 minutes. Once participants either completed or decided to withdraw from the study before completing the survey, they were directed to a debriefing page that provided more in-depth study details, reasoning behind the need for the deception, and crisis phone number/website in the event that participants experienced psychological stress or other issues (e.g., symptoms of PTSD, anxiety, or depression) related to the study. Following this page, participants were sent to a "thank you" page that thank them for their participation; my contact information was available for those who may have had questions, comments, or if they wished to receive a summary of the results after the study was completed.

Instrumentation and Operationalization of Constructs

Demographic Questionnaire

A demographic questionnaire was used to gather basic information and verification of participant eligibility, including age, race, gender, education level, employment/student status, and state of residence. In addition to the basic demographic information, there was number of questions related to the military demographics, including military branch, rank/grade, officer or enlisted, number of years in the service, and type of discharge. The demographic questionnaire took about 5 minutes to complete.

State–Trait Inventory for Cognitive and Somatic Anxiety

The STICSA is a 21-item inventory that measured the cognitive and somatic facets of anxiety at both the state and trait levels (Ree et al., 2008). The 21 items are the same for both the state and trait measurements, but the instructions alternate between how

the participants feel right at this moment (state) and how a participant feels in general (trait). For the study, only the trait version of the STICSA was used to assess the level of trait anxiety. Furthermore, there were two subscales in the STICSA: cognitive (e.g., "I can't get some thought out of my mind") and somatic (e.g., "My heart beats fast"). STICSA may be scored using the total sum across both subscales or by each subscale independently (Carlucci et al., 2018). Total scores of the STICSA-T were used to assess the overall level of trait anxiety, where higher scores indicate higher levels of trait anxiety. The STICSA-T asked participants to indicate "how you generally feel," using a 4-point scale ranging from 1 (*almost never*) to 4 (*almost always*). There were no reverse-scored items. The STICSA-T took approximately 6 minutes to complete. The STICSA-T was in the public domain and was allowed to be used for research purposes without author permission.

Reliability and Validity. Across a number of studies, the STICSA-T showed high internal consistency, specifically among both young and old adults, students, and clinical groups, with Cronbach's alpha ranging from .75 to .95 (Grös et al., 2007; Ree et al., 2008; Roberts et al., 2016; Van Dam et al., 2013). Additionally, test–retest reliability was assessed over a 2-month period with a student sample ($N = 129$) and Pearson's r ranged from .60 to .66 (Ree et al., 2008).

In addition to good reliability, the STICSA-T also showed strong validity. As for convergent validity, the STICSA-T was compared to numerous anxiety measures in at least four different studies with sample sizes ranging from 129 to 722 (Carlucci et al., 2018; Grös et al., 2007; Ree et al., 2008; Roberts et al., 2016). In an examination of the

convergent validity of STICSA-T, correlations were computed with the STICSA-T and the STAI-T, the Cognitive Somatic Anxiety Questionnaire, the Trimodal Anxiety Questionnaire, the Mood and Anxiety Symptom Questionnaire Anxiety subscale, and the Depression Anxiety Stress Scales Anxiety subscale. Correlations between these tools ranged from *r*s = .57-.74; Carlucci et al., 2018; Grös et al., 2007; Roberts et al., 2016). These findings provided evidence of strong convergent validity for the STICSA-T with other trait anxiety measures.

Previous research showed a significant overlap between anxiety and mood disorders symptoms/behaviors, therefore higher correlations between anxiety measurements and mood disorder measurements were expected (Brown et al., 2001). The STICSA-T was found to have even stronger discriminant validity than the most commonly used trait anxiety measurement in the literature (i.e., STAI). Studies examining the discriminant validity of the STICSA-T and correlations among a number of depression questionnaires had sample sizes ranging from 225 to 567 (Carlucci et al., 2018; Grös et al., 2007; Ree et al., 2008; Roberts et al., 2016). Comparing STICSA-T with Mood and Anxiety Symptom Questionnaire-Depression, Depression Anxiety Stress Scales-Depression, Teate Depression Inventory, Beck Depression Inventory-II, and the Center for Epidemiologic Studies Depression Scale, Pearson's correlations ranged from .35 to .64 (Carlucci et al., 2018; Grös et al., 2007; Roberts et al., 2016). Compared to these same depression scales, the correlations were lower for the STICSA-T than correlations between the depression scales and STAI-T. Compared to the STICSA-T (*r*s = .35-.64), the STAI-T was more strongly correlated to numerous depression scales (*r*s =

.66-.71; Carlucci et al., 2018; Grös et al., 2007; Roberts et al., 2016). Because of the higher correlations with depression scales, recent research showed that the STAI may be a better measure of negative affect and not state/trait anxiety (Carlucci et al., 2018; Hill et al., 2013). Many researchers are now arguing that the STICSA-T was a better measurement of state/trait anxiety (Carlucci et al., 2018; Grös et al., 2007; Van Dam et al., 2013). Overall, these findings provided strong evidence of discriminant validity, as well as strong evidence for the use of the STICSA-T rather than the STAI-T for trait anxiety.

Ree et al. (2008) examined the construct validity of the both the state and trait subscales of the STICSA in a sample of 129 college students. Participants were sampled at two time points: baseline and a stressful condition (e.g., exam time). The state anxiety scores were expected to increase while trait anxiety was expected to stay the same. The authors found that state anxiety scores did increase from baseline to exam time, suggesting that the state version of the STICSA did measure state anxiety at a stressful time (i.e., construct state anxiety). The authors also found no significant differences in trait scores between baseline and exam time, suggesting the trait subscale did assess anxiety in general (i.e., construct trait anxiety). Additionally, Grös et al. (2007) compared four different participant groups with anxiety disorders (i.e., panic disorder, obsessive-compulsive disorder, social phobia, other anxiety disorders) to a control (no anxiety disorder) group (N = 567) to determine if those who have an anxiety disorder had higher levels of anxiety than the control group. The authors found that the four anxiety groups scored significantly higher than the control group on the trait and state scales of STICSA.

Grös et al. argued that in conjunction with their own findings and the findings of other studies, STICSA was a better measurement of pure state and trait anxiety constructs.

Emotional Intelligence Scale

The EIS is a 33-item scale that measures the self-reported level of EI (Schutte et al., 1998). Participants were asked to report how much they agree or disagree with each statement (e.g., “I know why my emotions change,” “I use good moods to help myself keep trying in the face of obstacles,” "I can tell how people are feeling by listening to the tone of their voice”) on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Responses were summed to get a total score, where higher scores indicate higher levels of EI. There are three reverse-scored items. The scale takes approximately seven minutes to complete. The EIS was in the public domain and was allowed to be used for research purposes without author permission.

Reliability and Validity. The EIS had high internal consistency with a Cronbach’s alpha of .90 in university students, community members, and clergy men and women (Francis et al., 2019; Schutte et al., 1998). Test-retest reliability was assessed over a 2-week period and a correlation of r = .78 was found (Schutte et al., 1998). Additionally, the authors assessed the reading level of the test to ensure that the scale could be used in the general public. The EIS was analyzed using Flesch-Kincaid reading grade-level formula and found to have a 5th grade reading level (Schutte et al., 1998).

To determine the convergent validity of the EIS, Schutte et al. (1998) assessed the correlations between the EIS and the Trait Meta Mood Scale (i.e., another EI scale) and the Toronto Alexithymia Scale. Alexithymia is a personality trait where a person has

difficulties recognizing emotions, either their own emotions or the emotions of others (Caffrey, 2019). There were significant correlations (N = 49) between the EIS and the three subscales (i.e., clarity, attention, and mood repair) of the Trait Meta Mood Scale with Pearson's rs of .52, .63, and .68, respectively (Schutte et al., 1998). There were also significant correlations (N = 25) between the EIS and the Toronto Alexithymia Scale with r = -.65, suggesting that higher scores on the EIS are related to lower levels of alexithymia. These results provided evidence of convergent validity for the EIS.

When tested for discriminant validity, correlations between EIS and SAT scores (i.e., cognitive ability as it relates to college aptitude) researchers found no significant relationship between EIS and SAT scores (r = -.06, p > .05), suggesting that the EIS scale and SAT measure different constructs (Schutte et al., 1998; Singh & Sharma, 2012). Schutte et al. also examined the relationships between EIS and the big five personality dimensions (i.e., neuroticism, extraversion, agreeableness, conscientiousness, and openness) in a sample of 23 college students. The authors found a significant relationship between EIS and openness (r = .54, p < .009) but no significant correlations between EIS and the four other personality dimensions (ps > .05; neuroticism: r = -0.28; extraversion: r = 0.28; agreeableness: r = 0.26 and conscientiousness: r = 0.21). Schutte et al. argued these findings were evidence of discriminant validity for the EIS. Singh and Sharma (2012) examined the relationship between EIS and a measurement of general intelligence (i.e., the Wechsler Adult Performance Intelligence Scale) in a male sample (N = 34). The authors found no significant correlation between the EIS and the general intelligence measurement (r = -.26, p > .05), suggesting that the two measures were different and

therefore additional evidence of discriminant validity.

Military to Civilian Questionnaire

The M2CQ is a 16-item instrument that measures difficulties in a number of reintegration domains such as social relations, productivity, community or civic engagement, perceived meaning in life, and self-care and leisure (Sayer et al., 2011, 2015). Participants reported how much difficulty they had with each of the items on a 5-point scale ranging from 0 (*no difficulty*) to 4 (*extreme difficulty*) in the past 30 days (Sayer et al., 2011; Sayer et al., 2015). Examples of items on the M2CQ include: "making new friends," "getting along with your spouse or partner," "finding or keeping a job," "feeling like you belong in civilian society," and "finding meaning or purpose in life" (Sayer et al., 2011, p. 6). There were four items that allow participants to choose a "not applicable" response on items that may not apply to them, such as difficulties related to spouses/partners, children, work, and school. For example, a participant who does not have any children may choose the "not applicable" response for the "getting along with your child or children" item. Scoring on the M2CQ involved summing all completed items and dividing by the number of items completed (Sayer et al., 2015) where higher scores suggest greater difficulty with reintegration. The M2CQ took approximately five minutes to complete (Sayer et al., 2011). The M2CQ was in the public domain and was allowed to be used for research purposes without author permission.

Reliability and Validity. The M2CQ is the most commonly used veteran reintegration measurement in the current literature. Internal consistency was calculated using Cronbach's alpha and found to be .95 in military and veteran samples (Sayer et al.,

2011). Although the M2CQ was initially developed to assess reintegration difficulties following deployments, other researchers have used it to measure community reintegration following discharge from the military with high levels of internal consistencies as well (Cronbach's alphas = .87 - .93; Castillo et al., 2019; Sayer et al., 2015).

To determine construct validity, Sayer et al. (2011) compared the M2CQ scores to a separate single-item measure (N = 731) that assessed the overall difficulty of reintegrating to civilian life. The authors found that the total scores were significantly related to the overall reintegration difficulty single-item ($p < .001$), providing evidence that the M2CQ measures the community reintegration construct. Sayer et al. also examined theoretically related constructs of overall mental health, probable PTSD, and problem alcohol or drug use with the M2CQ, comparing the M2CQ to the Mental Component Summary of the Short Form-12, version 2 (a mental health assessment), the Primary Care PTSD Screen, and the 2-Item Conjoint Screen (an alcohol and drug problem measurement) using sample sizes ranging from 285 to 454. There were significant correlations between the M2CQ and all three measurements (ps < .001), suggesting all instruments were measuring similar constructs as evidence of construct validity.

Finally, convergent validity was examined by comparing the M2CQ with another veteran reintegration measurement, the Enriched Life Scale, in a sample ($N = 529$) of U.S. military veterans (Angel et al., 2019). The Enriched Life Scale measures enrichment of the veteran's life as they are transitioning to the civilian world; higher scores on the

Enriched Life Scale suggest more enrichment while low scores indicate more reintegration difficulties. Comparing the correlations of the M2CQ and the Enriched Life Scale, Angel et al. (2019) found a significant negative correlation between the two measures (ps < .05), indicating that inverse scores of Enriched Life Scale were measuring a similar construct (veteran reintegration) as the M2CQ, providing evidence of convergent validity.

Data Analysis Plan

All data were downloaded from the SurveyMonkey survey platform to the Statistical Package for Social Sciences (SPSS) version 27.0. Standard multiple regression analysis was completed to determine the extent to which trait anxiety was related to perceived VCR challenges and if EI moderated that relationship. An interaction variable was created by multiplying the two mean-centered independent variables (i.e., trait anxiety x EI) to test the moderation relationship. The dependent variable (i.e., perceived VCR challenges) was regressed on the two independent variables and the interaction variable (i.e., trait anxiety, EI, and trait anxiety x EI, respectively). All multiple regression assumptions were checked in SPSS (e.g., normality, homoscedasticity, independence of residuals, linearity, and multicollinearity). Normality and linearity were checked by examining histograms, the Shapiro-Wilk's test, and scatterplots. Additionally, homoscedasticity and independence of residuals were checked by examining a scatterplot of the residuals followed by examining variance inflation factor (VIF) values for multicollinearity. Multicollinearity VIF concerns were a risk when using an interaction variable, but previous research suggests that these concerns may be ignored (Friedrich,

1982).

Research Questions

Research Question 1: To what extent does trait anxiety, as measured by the STICSA-T, relate to perceived reintegration challenges, as measured by the M2CQ, among military veterans?

$H_0$1: Trait anxiety is not a significant predictor of perceived reintegration challenges.

$H_1$1: Trait anxiety is a significant predictor of perceived reintegration challenges.

Research Question 2: To what extent does emotional intelligence, as measured by the EIS, relate to perceived reintegration challenges, as measured by the M2CQ, among military veterans?

$H_0$2: Emotional intelligence is not a significant predictor of perceived reintegration challenges.

$H_1$2: Emotional intelligence is a significant predictor of perceived reintegration challenges.

Research Question 3: To what extent does emotional intelligence, as measured by the EIS, moderate the relationship between trait anxiety, as measured by STICSA-T, and perceived reintegration challenges, as measured by the M2CQ, among military veterans?

$H_0$3: Emotional intelligence does not moderate the relationship between trait anxiety and perceived reintegration challenges.

$H_1$3: Emotional intelligence does moderate the relationship between trait anxiety and perceived reintegration challenges.

Threats to Validity

First, there were threats to validity related to the sampling method chosen. With convenience sampling, there was a risk of selection or volunteer bias that can influence the generalizability of the results. In order to decrease these biases, multiple Facebook veteran groups from multiple geographic locations in the United States were chosen and groups with a diverse membership from across the United States, including diverse age ranges, races, genders, and geographic locations were also chosen. Furthermore, the use of an online survey risks the threat of nonresponse bias; eligible participants may not complete the full questionnaire leaving missing data. Nonresponse bias was concerning because it may suggest differences in characteristics or circumstances which led some veterans to participate and others to decline. For example, requests for information about reintegration challenges may have made some uncomfortable; they may have declined to participate or may have withdrawn from the study before completing the survey. To minimize these threats, the participants were informed and reminded that the information collected was confidential and anonymous, and that no identifying information would be requested or included. Furthermore, the survey was set up so that participants could not leave any items unanswered. They could choose to answer or withdraw from the survey. Using this method also helped to address participants unintentionally leaving questions unanswered. Additionally, participants may have fallen prey to social desirability bias given the desire to present themselves in the most socially favorable light. To mitigate this threat to validity, participants were again reminded that no identifying information would be requested or included in the study. Knowing that their responses would be

documented anonymously, participants may be more likely to respond honestly.

Ethical Procedures

Before any data were collected, I received approval from Walden University's IRB (approval number: 11-23-21-0997914). The informed consent provided participants with a brief description of the study, risks and benefits of their participation, and their privacy rights. The survey was completed anonymously with no identifying information at any time, eliminating risks to participant privacy. Providing information about challenges faced during the transition from military to civilian life may have caused some stress or anxiety. On both the consent form and the debriefing page, participants were given a website link and phone number for the Veterans Crisis Line(https://www.veteranscrisisline.net; 1-800-273-8255, Press 1), which is a free confidential support website and phone line where veterans can reach out to chat, text, or call during a crisis. Additionally, participants were reminded that they may stop at any time without penalty of any kind. Moreover, the SurveyMonkey data platform used encrypted software to protect data. Once data were transferred from the SurveyMonkey data platform to SPSS for data analysis, it was stored on a password/fingerprint-protected computer that is accessible only by me. The dataset will be stored safely and deleted after five years in accordance with the data retention period.

Summary

The purpose of this study was to address a gap in the literature by determining the extent to which EI moderated the relationship between trait anxiety and perceived VCR challenges in a non-VA sample of veterans. The study used a cross-sectional, quantitative

survey design. The sample included individuals who served on active-duty in the U.S. military after 9/11, were at least 18 years old, currently lived in the United States., and discharged from the military within the past two years. Veterans who were retired from the military and/or were currently in the Reserves or National Guard were not included in the sample. The survey was administered through the SurveyMonkey survey platform with participants initially recruited through social media (i.e., Facebook), followed by Survey Monkey's audience panel. Data were analyzed using standard multiple regression and moderation analysis. All concerns regarding threats to validity and ethical considerations were discussed as well as plans to address them. Chapter 4 will present the results of the study.

Chapter 4: Results

The purpose of this quantitative study was to address a gap in the literature by examining the impact of individual differences in trait anxiety and EI among veterans on VCR and its associated challenges. Addressing this gap was accomplished by examining the extent to which EI moderated the relationship between trait anxiety (TA) and perceived VCR challenges in a non-VA sample of post 9/11 veterans. The research questions were designed to determine these relationships, with EI being measured by the EIS, reintegration challenges being measured by M2CQ, and trait anxiety being measured by the STICSA-T. In this chapter, the details describing data collection, screening procedures, and recruitment, including changes in recruitment methods, will be discussed. There will also be a discussion of the sample demographics. Following this, the results of the descriptive statistics, statistical assumptions met, and the standard multiple regression analysis will be reviewed. The chapter will end with a summary.

Data Collection

Initial recruitment began in December 2021 using Facebook veteran groups. Admins from 32 Facebook veteran groups were contacted for permission to enter the group to post my informational flyer and study link or if they (the group admin) would post the flyer and link for me. Twelve group admins responded, with 10 group admins agreeing to post for me or allowing me to post within the groups. Across the 10 groups, there were approximately 76,518 members; however, after continuous recruitment for 6 weeks, no participants volunteered to participate in the study.

Because recruitment from Facebook veteran groups was unsuccessful, recruitment

was accomplished through Survey Monkey's audience panel. After submitting and getting approval to make changes from the IRB, the 33-item EIS (Schutte et al., 1998) was replaced with the 10-item BEIS (Davies et al., 2010) to reduce the total number of survey questions allowed by Survey Monkey. Data collection using Survey Monkey's audience panel occurred over a 3-day period in January 2022.

The anonymous online survey began with the informed consent form, including a description of the purpose of the study, requirements to participate, instructions on how to participate, privacy-related concerns, the voluntary nature of the study, the risks and benefits of participating, and contact information for me, Walden University's participant advocate, and a crisis phone number/website. To participate, individuals had to be at least 18 years old, currently living the in United States, served on active-duty in the U.S. military at any time since September 11, 2001, separated from the military within the past 2 years, discharged but not retired from the military (e.g., honorable, medical, dishonorable), and currently not serving in the Reserves or National Guard.

Individuals who declined participation were directed to close their window/tab, and those who met the inclusion criteria and chose to participate were told to click the "Next" tab at the bottom on the screen to indicate their consent. Following this, participants were directed to the demographic questions related to their military background, such as the military branch they had served, number of years the individual served, their pay grade at the time of discharge, and how long they had been discharged from the military. After the demographic questions, the participants completed the survey instruments for trait anxiety (STICSA), EI (BEIS-10), and perceived VCR challenges

(M2CQ).

SurveyMonkey sent the survey to 2,000 prospective participants. Among those, 700 chose to participate in the study and of those, 30.43% (N=213) met the study inclusion requirements and completed the rest of the questionnaires. At the end of the study, after debriefing, 19 participants chose to withdraw from the study. Thus, the final sample size was 183 participants. The sample included slightly more male (51.1%) participants, with most in the 30 to 44 (29.7%) and the 45 to 60 years old range (39.0%). Additionally, 23.1% reported a household income of $25,000 to $49,000, and 33.7% of participants reported living in the southern United States. Detailed demographics are displayed in Table 1. As for the participants' military backgrounds, a large majority did not report this information. However, among those who did, most reported having served in the Army (28.0%) or in the Navy (11.5%), been enlisted personnel (80.7%), served an average of 6.53 years, and almost 60% reported 18 months or less since discharge from the military. Detailed demographics about the participants military information are displayed in Table 2.

Table 1

General Demographics of Veteran Sample

Variable	*n*	%
Gender (*N* = 182)		
Male	93	51.1
Female	89	48.9
Age (*N* = 182)		
18 – 29 years old	38	20.9
30 – 44 years old	54	29.7
45 – 60 years old	71	39.0
61+ years old	19	10.4
Household Income (*N* = 182)		
$0 - $9,999	17	9.3
$10,000 - $24,999	16	8.3
$25,000 - $49,999	42	23.1
$50,000 - $74,999	37	20.3
$75,000 - $99,999	25	13.7
$100,000 - $124,999	15	8.2
$125,000 - $149,999	6	3.3
$150,000 - $174,999	8	4.4
$175,000 - $199,999	1	0.5
$200,000 +	9	4.9
Prefer not to answer	6	3.3
Region of the United States (*N* = 181)		
Northeast	45	24.9
South	61	33.7
Midwest	44	24.3
West	31	17.1

Table 2

Military Demographics of the Veteran Sample

Variable	*n*	%
Military Branch (*N* = 105)		
Army	51	28.0
Air Force	18	9.9
Navy	21	11.5
Marines	12	6.6
Coast Guard	2	1.1
Space Force	1	0.5
Pay Grade (*N* = 57)		
E1 – E4	28	49.1
E5 – E9	18	31.6
O1 – O9	8	14.0
W1 – W9	3	5.3
Months since Discharge (*N* = 67)		
0 – 6 months	17	25.4
7 – 12 months	14	20.9
13 – 18 months	9	13.4
19 – 24 months	11	16.4
24+ months	16	23.9

Because I used a convenience rather than a random sampling strategy, the sample characteristics may not be fully representative of the veteran population in the United States. For example, unlike the majority male veteran samples represented in the literature, my sample was almost half female veterans. Therefore, the results can be generalized only to military veterans who participate in SurveyMonkey audience panels and not generalized to all U.S. military veterans.

Results

Descriptive Statistics

Means, standard deviations, and correlation coefficients for all variables are shown in Table 3. Bivariate correlations show that the variables of trait anxiety and perceived VCR challenges were significant and positively associated ($r(182) = .582$, $p < .001$), suggesting that as levels of trait anxiety increased, so did the number of perceived VCR challenges. Additionally, the relationship between EI and VCR challenges was also significant and positive ($r(182) = .213$, $p = .002$). On the EI measurement (BEIS-10), higher scores indicate lower levels of EI; therefore, the positive relationship between EI and VCR challenges suggests that decreases in EI levels are associated with increased perceived VCR challenges. No significant relationship between trait anxiety and EI ($p = .233$) was found.

Table 3

Mean, Standard Deviation, and Correlations for Study Variables

				Correlation Coefficients	
	M	5% Trimmed Mean	*SD*	EI	VCRC
Trait Anxiety	50.10	49.80	15.01	-.054	.582***
Emotional Intelligence	24.98	24.96	6.86		.213**
VCR Challenges	1.62	1.59	0.93		

** $p < .01$, ***$p < .001$

Exploratory Data Analysis

Normality

Univariate outliers were investigated by *z*-scores (Warner, 2013). No univariate outliers were found for the trait anxiety and VCR challenges variables. One univariate outlier was found within the EI variable. This case was identified and removed from the sample, leaving the new sample of 182.

Tests of normality, skewness values, and kurtosis values are shown in Table 4. All variables were found to be normally skewed and kurtotic. For the Komogorov-Smirnov test of normality, trait anxiety and VCR challenges were found to be normally distributed ($p = .200$; $p = .097$, respectively). EI was found to be significant ($p = .006$), suggesting a non-normal distribution. Williams et al. (2013) argued that a multiple regression analysis is permitted when some variables are not normally distributed as long as there are normally distributed errors. Therefore, the data were considered to have met the requirement of normally distributed data required to complete a parametric analysis. An examination of the histograms and normal Q-Q plots suggested data were acceptable and

are provided in Appendix F. Examination of the boxplots noted two outliers on the VCR challenges variable. However, examination of the 5% trimmed mean (shown in Table 3) suggested that these cases did not influence the data and could be retained in the dataset (Pallant, 2016). Therefore, these cases were left in the sample.

Table 4

Normality Testing for Study Variables

Variable	Statistic[a]	*df*	*p*	Skewness (*SE* = .180)	Kurtosis (*SE* = .358)
Trait Anxiety	.048	182	.200	.202	-.398
Emotional Intelligence	.081	182	.006	.017	-.446
VCR Challenges	.061	182	.097	.199	-.218

[a.] Kolmogorov-Smirnov test of normality

Assumption Testing for Multiple Regression

In order to determine if the data met the assumptions for a multiple regression analysis, linearity, multicollinearity, homoscedasticity, and independence of residuals were assessed. Linearity was determined by the examination of the normal P-P plots and scatterplots (see Figures 1 and 2). As previously mentioned, examination of correlations found a significant positive relationship between each predictor variable (trait anxiety and EI) and the VCR challenges variable. There was no significant relationship found between the two predictor variables, trait anxiety and EI, suggesting that these predictor variables were not multicollinear. Furthermore, the VCR challenges was regressed onto the trait anxiety and EI variables to examine the tolerance and VIF statistics. For both the trait anxiety and EI variables, tolerance (.997) and VIF (1.003) statistics were within acceptable ranges. Therefore, the assumption of multicollinearity was met.

Figure 1

P-P Plot for Dependent Variable

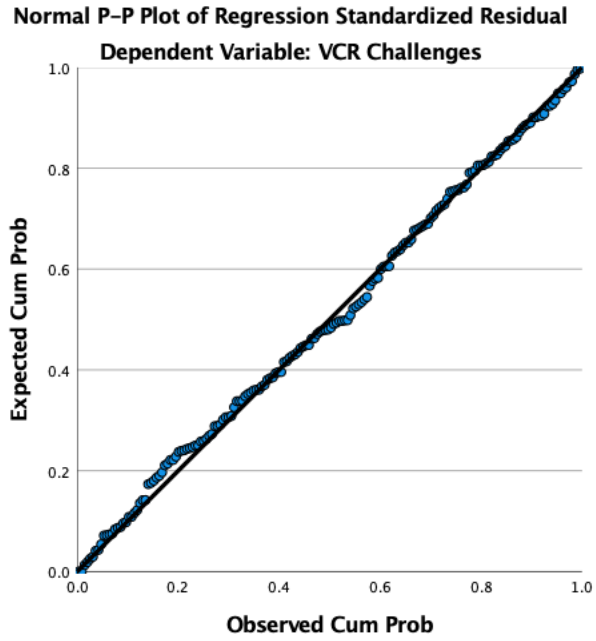
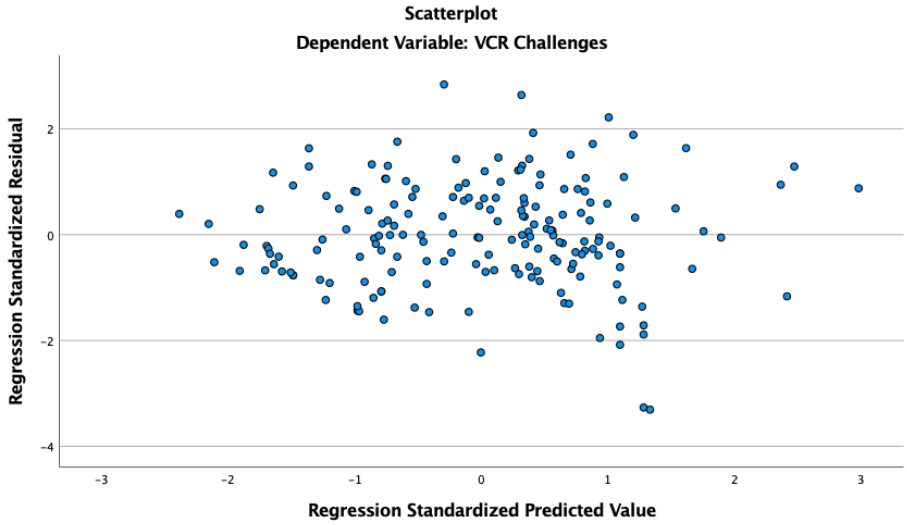


Figure 2

Scatterplot for Dependent Variable



Examination of the residuals scatterplot suggests there were no violations and thus the assumption for homoscedasticity was met. In order to assess the independence of residuals, a Durbin-Watson test was completed. The Durbin-Watson statistic was 2.02, meeting the assumption that the residuals were independent. Multivariate outliers were examined using Mahalanobis distance. There were no significant multivariate outliers found. Overall, the data met all assumptions for multiple regression analysis.

Reliability of Measurements

Reliability analyses were completed to determine the Cronbach's alpha of the study's measurements. Cronbach alphas were high for measurements: STICSA-Trait (α = .949), BEIS-10 (α = .846), and M2CQ (α = .915). These results suggest high internal consistency within the study's measurements.

Multiple Regression Analysis

In order to answer the research questions, the two predictor variables (TA and EI) were first mean centered, then the mean centered predictor variables were multiplied by each other to create the interaction variable (TAxEI). Following this, the VCR challenges variable was regressed onto the two predictor variables (TA and EI) and the interaction variable (TAxEI) in a standard multiple regression analysis.

The overall regression model was significant and explained a substantial proportion of the variability (43.5%) in perceived VCR challenges (R^2 = .435, $F(3, 178) = 45.75$, $p < .001$; see Table 5 for multiple regression results). The main effect of trait anxiety on perceived VCR challenges was significant and positive, uniquely explaining about 39% of the variability in VCR challenges (b = .040, $p < .001$, sr^2 = .390). This

finding indicated that an increase in trait anxiety was associated with increases in the number of perceived VCR challenges. Thus, the result provides support to reject the first null hypothesis and accept the first alternative hypothesis (TA was a significant predictor of perceived VCR challenges). The main effect of EI on perceived VCR challenges was also significant and positive, uniquely explaining about 3.3% of the variability in VCR challenges (b = .026, p = .002, sr^2 = .033), such that lower levels of EI were related to increases in the number of perceived VCR challenges. This finding provides support to reject the second null hypothesis and accept the second alternative hypothesis (EI was a significant predictor of perceived VCR challenges). The interaction variable (TA x EI) was also statistically significant (b = .001, p = .001, sr^2 = .037); therefore, the alternative hypothesis was accepted (EI moderated the relationship between trait anxiety and perceived VCR challenges).

Table 5

Multiple Regression Model Results

					95% *CI* for *b*		
	b	*SE*	*t*	*p*	Lower	Upper	sr^2
Intercept	-1.023						
Trait Anxiety	.040	.004	11.075	<.001	.033	.047	.390
Emotional Intelligence	.026	.008	3.218	.002	.010	.041	.033
Interaction (TAxEI)	.001	.000	3.410	.001	.001	.002	.037

Examination of the Interaction

In order to investigate the extent of the interaction, the moderator variable (EI) was trichotomized into three nearly equal groups. Scores in the lowest third of the

distribution were put into the high EI group (n = 61), those in the middle third of the distribution were put into the moderate EI group (n = 60), and those with the highest scores were put into the low EI group (n = 61). Using the split file function in SPSS, a regression analysis was completed for each of the three EI groups. These results are shown in Table 6 and Figure 3.

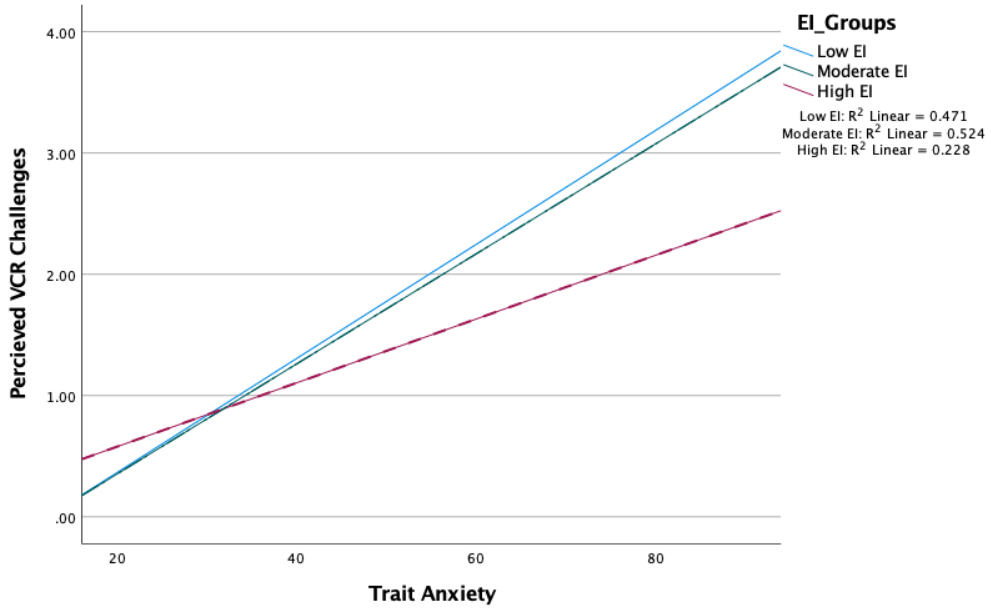
Table 6

Regression Model Results for Trait Anxiety and VCR Challenges Based on Level of Emotional Intelligence

Level of EI	*b*	*SE*	*t*	*p*	95% *CI* for *b*		sr^2
Low EI	.047	.007	7.242	<.001	.034	.060	.471
Moderate EI	.045	.006	7.992	<.001	.034	.057	.524
High EI	.026	.006	4.180	<.001	.014	.039	.228

Figure 3

Relationship Between Trait Anxiety and Perceived VCR Challenges Based on Emotional Intelligence (EI) Level



The analysis indicated that the influence of high EI on the relationship between trait anxiety and perceived VCR challenges was statistically significant and positive, with a large effect size *(b* = .026, *p* < .001, sr^2 = .228), explaining approximately 23% of the variability in perceived VCR challenges. This finding suggested that at high levels of EI, the relationship between trait anxiety and perceived VCR challenges got weaker. The impact of moderate EI on the relationship between trait anxiety and perceived VCR challenges was also statistically significant and positive with a large effect size *(b* = .045, *p* < .001, sr^2 = .524), revealing that at moderate levels of EI, the relationship between trait anxiety and perceived VCR challenges got even weaker. Moderate EI accounted for approximately 52% of the variability in perceived VCR challenges. Finally, the effect of

low EI on the relationship between trait anxiety and perceived VCR challenges was statistically significant and positive with a large effect size *(b* = .047, $p < .001$, sr^2 = .471), accounting for approximately 47% of the variability in perceived VCR challenges. Thus, at low levels of EI, the relationship between trait anxiety and perceived VCR challenges became weaker. However, comparing the three levels of EI, the results revealed that high levels of EI had the strongest buffering effect on the relationship between trait anxiety and VCR challenges, while low levels of EI had the weakest buffering effect on the relationship between trait anxiety and VCR challenges. Overall, these results suggested that as the level of EI increased, the relationship between trait anxiety and perceived VCR challenges became weaker. These findings provided support for the moderating effects of EI on the relationship between trait anxiety and perceived VCR challenges. In other words, higher levels of EI can weaken the impact of trait anxiety on perceived VCR challenges and therefore buffer against the effects of trait anxiety on perceived VCR challenges.

Post Hoc G*Power Analysis

Because this study did not meet the minimum sample size of 199, a post hoc G*Power analysis was conducted to determine the achieved power of the study. Cohen's f^2 was calculated from the R^2 of the multiple regression model containing the interaction variable and was found to be .770. The achieved power analysis was calculated using the following parameters for linear multiple regression (fixed model, R^2 increase): the calculated effect size of .770, an alpha level of .05, total sample size was 182, one tested predictor (interaction variable), and three total predictor variables (i.e., trait anxiety, EI,

interaction variable). The achieved power of this study was >.999, providing confidence in the results of this study even though the initial minimum sample size was not met.

Summary

A standard multiple regression was performed to determine the extent of the relationship among trait anxiety, EI, and perceived VCR challenges in a sample of 182 military veterans. In addition, the extent of the impact of EI on the relationship between trait anxiety and perceived VCR challenges was also examined. The results indicated that trait anxiety and EI were both significant predictors of perceived VCR challenges. Furthermore, EI was found to moderate the relationship between trait anxiety and perceived VCR challenges, in that as level of EI increased, the relationship between trait anxiety and perceived VCR challenges would get weaker. These results provide evidence of EI buffering the effects of trait anxiety on perceived VCR challenges. Chapter 5 will discuss the interpretation of the findings, limitations of the study, recommendations for future research, and the implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of the study was to examine the extent to which EI moderated the relationship between trait anxiety and perceived VCR challenges in a sample of post 9/11 veterans. The process of transitioning from the military to civilian life is an important and challenging time for each veteran. There are many challenges unique to each individual that are faced during the reintegration period, including psychological, social, physical health, employment, housing, financial, legal, or spiritual (Elnitsky, Fisher, et al., 2017). Although many veterans are able to transition successfully to civilian life, there a number of issues that may significantly increase during reintegration to civilian life, such as mental illness and substance abuse (Derefinko et al., 2018; Disner et al., 2017). There are as many as 17 veterans dying by suicide every day in the United States (U.S. Department of VA, 2019), and many more individuals who suffer from other mental health concerns that can lead to suicide, such as anxiety, depression, and PTSD (Knowles et al., 2019; Shepardson & Funderburk, 2016; Shepardson et al., 2019; Schultz et al., 2014).

The goal of the current study was to address the gap in the literature related to the potential for trait anxiety to increase perceived VCR challenges or for EI to mitigate these challenges. To achieve this, I used a cross-sectional, quantitative survey design and recruited participants using SurveyMonkey's audience panel. A standard multiple regression analysis was completed to determine the extent to which EI moderated the relationship between trait anxiety and perceived VCR challenges. The present study had three major findings: (a) trait anxiety independently predicted perceived VCR challenges, (b) EI independently predicted perceived VCR challenges, and (c) EI moderated the

relationship between trait anxiety and perceived VCR challenges.

Interpretation of the Findings

Trait Anxiety

Answering the first research question, which examined the extent of the relationship between trait anxiety and perceived VCR challenges, the results showed that trait anxiety was a significant positive predictor of perceived VCR challenges. In other words, veterans who tended to score higher in trait anxiety also tended to experience more VCR challenges as they reintegrated into civilian life. This finding was consistent with previous research that showed relationships among trait anxiety and a number of individual challenges that can be present during reintegration. As an individual difference variable, trait anxiety has been shown to predict a number of issues that can make transition more difficult, such as lower self-esteem, more sleeping difficulties, and more substance use (Huang et al., 2012; Teichman & Cohen, 2012; Weeks et al., 2019). In everyday situations, anxiety responses tend to be exaggerated for individuals with higher levels of trait anxiety (Cho et al., 2019; Raymond et al., 2017). In fact, individuals who have higher levels of trait anxiety tend to experience generalized fear responses to situations that would be experienced as safe and/or novel for individuals with lower levels of trait anxiety (Sep et al., 2019). For veterans, these increases in fear inducing experiences could lead to increases in internalizing symptoms, possibly developing into mental disorders, such as anxiety, PTSD, or depression (Cobb et al., 2017; Efinger et al., 2019; Huang et al., 2012; Kok et al., 2016). Therefore, higher levels of trait anxiety may lead to an increase in mental health issues.

The significant positive relationship between trait anxiety and VCR challenges indicated by my results was consistent with the MTT in that it explains how events before and during the transition can influence VCR outcomes, including the tendency for individuals high in trait anxiety to experience exaggerated fear/anxiety responses as they approach and move through the reintegration process (Castro & Kintzle, 2014). Assessing trait anxiety in veterans starting the transition process may better prepare those whose trait anxiety is high to deal with the challenges that arise inevitably during reintegration into civilian life (Castro & Kintzle, 2014).

Emotional Intelligence

Answering the second research question, which examined the extent of the relationship between EI and perceived VCR challenges, the results indicated that EI was a significant positive predictor of perceived VCR challenges, suggesting that as scores of EI increased (i.e., higher scores meant lower levels of EI), perceived VCR challenges also increased such that veterans with lower levels of EI perceived more VCR challenges. This finding was consistent with previous research showing relationships between EI and number of individual VCR challenges (Gaher et al., 2014). Emotion expression is an important part of life, influencing social skills, emotional adaptation, emotional sensitivity, empathy, and practical intelligence (Drigas & Papoutsi, 2018). A veteran with lower levels of EI may not understand their emotions and may overreact with emotional outbursts or act inappropriately, potentially with negative consequences. On the other hand, a high level of EI enables the veteran to identify the emotion and use that knowledge to appropriately manage their anxiety, communicate, empathize, problem

solve, and manage conflicts (Drigas & Papoutsi, 2018). Therefore, unlike the high EI veteran, a veteran low in EI may not be able to cope well with the stressors of reintegration and would be less inclined to deal successfully with the inevitable challenges that arise during reintegration.

These findings also provided theoretical support for Goleman's (1995) theory of EI defined as self-awareness, self-management, social awareness, and relationship management (Cherniss & Goleman, 2001). These skills have been shown to increase individuals' ability to cope with stress such that veterans attempting to reintegrate into civilian life are better able to cope with the challenges likely encountered during VCR (Fteiha & Awwad, 2020).

Emotional Intelligence as a Moderator

Support for the MTT was further demonstrated by results indicating that EI moderated the strength of the relationship between trait anxiety and perceived VCR challenges. For example, a veteran with a high level of trait anxiety would be at risk of increased perceived VCR challenges; however, for the veteran high in EI, high levels of trait anxiety would have less impact on perceived VCR challenges compared to a veteran with low EI levels whose high trait anxiety would exacerbate perceived VCR challenges. Consistent with previous research that has shown that EI can buffer the negative effects of stress, alcohol use disorder, alexithymia, anxiety, depression, social anxiety, burnout, and suicidal ideation, results of the present study likewise indicated that EI diminishes the negative influence of trait anxiety on perceived VCR challenges (Obeid et al., 2021; Singh & Sharma, 2012).

Much of the current EI literature argues for EI's buffering effect on stress through stress reactivity and recovery (Lea et al., 2019). When an individual is threatened by some type of stressor, their "flight or fight" response will activate until the stressor is removed. Stress recovery is how quickly an individual returns from an elevated to a normal state. Because an individual with higher levels of EI understands and can control their emotions, they will react less and recover faster when faced with a stressor (Lea et al., 2019). Consistent with managing the transition component of the MTT, a veteran with high levels of trait anxiety about to start their reintegration, will be introduced to a number of new and novel situations, likely to activate frequent fight or flight responses. Conversely, veterans with higher levels of EI will be able to react less and recover faster from stressors associated with novel situations, decreasing the perceived number of VCR challenges experienced during the transition from military to civilian life. Currently, there is not an established or widely accepted theory to explain the reintegration process. Results from the present study provided significant support for the MTT as a satisfactory explanatory device.

Limitations of the Study

First, the changes made to the sampling technique influenced the generalizability of this study. In general, the study was limited to U.S. veterans who were at least 18 years of age, currently living in the United States, served on active-duty at some point after 9/11, and had been discharged from the military with the past two years. However, after recruiting through Facebook veteran groups for six weeks, there were still no volunteers, forcing me to recruit using different methods (i.e., SurveyMonkey's audience panel).

Because the veteran sample was recruited using SurveyMonkey's audience panel, the findings are only generalizable to this population of veterans, findings that may be different for veteran populations not included in the SurveyMonkey audience panel.

Additionally, use of a convenience sample may be limited by response bias, defined as the tendency to favor one response option over another response option (Bowen et al., 2020). Individuals who comprise the audience panel may differ from those not included in this panel. However, due to possible response bias, it was impossible to know if and how these differences exist. For example, only 40% of participants answered the optional military demographic questions, making it impossible to know to what extent this bias influenced the results and interpretation of findings. Although honest reporting of participant eligibility was assumed, participant anonymity precluded the ability to verify eligibility, posing a threat to internal validity; screening questions were asked to minimize this threat.

In addition, there was a limitation related to social desirability bias (i.e., the tendency to present oneself in the best possible light (Grimm, 2010). There were a number of sensitive questions related to symptoms of anxiety and VCR challenges that may disincline participants to be entirely truthful about emotional and/or psychological problems experienced during reintegration. To mitigate this type of bias, participants were reminded that all responses were anonymous.

Time and resources were limitations that compelled the use of a cross-sectional design; however, this design was a good choice to provide a snapshot of this process and its associated challenges. As a correlational study, causation cannot be inferred. For

instance, even though trait anxiety was found to predict perceived VCR challenges, it cannot be argued that an individual's level of trait anxiety caused their perceived VCR challenges. Additionally, reintegration is a process that can occur over a period of years, and although a cross-sectional design was adequate, a longitudinal study would have been better able to assess this process and its associated challenges and outcomes over a period of years (e.g., before/during/after transition).

Recommendations

Although the topic of VCR is beginning to gain interest among researchers, there are still major gaps to address. Not studied previously, the present study examined the relationships among TA, EI, and perceived VCR challenges and found that EI moderated the relationship between trait anxiety and perceived VCR challenges. Although these findings offer insights into how individual differences can impact the reintegration process and its outcomes, there is still much that needs to be examined in order to understand this process more fully.

To confirm these findings and to increase their generalizability, future research should replicate this study with different veteran populations. Furthermore, Mobbs and Bonanno (2018) argued that a longitudinal study would provide a fuller understanding of the VCR process from its natural start as the veteran begins, and throughout, their transition to civilian life. Future research should aim to recruit samples from multiple veteran outlets rather than VA-recruited as most research has done or Survey Monkey-recruited as the present study did.

Future research should continue to investigate the benefits of EI to mitigate the negative impact of VCR that many veterans experience. Studies have shown that higher levels of EI can increase an individual's ability to cope with stress, with some researchers even arguing that EI could be considered a coping mechanism (Riley & Schutte, 2003; Singh & Sharma, 2012).

Implications

This study's results can impact positive social change in a number of ways, especially by increasing veterans' EI skills. Mattingly and Kraiger (2019) found significant positive effects of EI training on EI scores, suggesting that EI trainings can increase EI levels, potentially beneficial for military veterans transitioning from military to civilian life. Awareness of these benefits could prompt veterans to seek out EI training either during their military service or soon before starting the transition to civilian life. Not only would EI training reduce the challenges veterans experience during the transition process, but its benefits would also extend to the veteran's family and professional life; a less stressful VCR may return the veteran more easily to family and professional relationships.

Findings from this study have implications for positive social change at the organizational level, including civilian health systems (including mental health providers), companies hiring veterans, or school veteran organizations by offering or suggesting EI trainings to help veterans during transition by helping to blunt the influence of anxiety on transition challenges or even reduce the number of challenges encountered. Finally, positive social change at the societal/policy level may include changes to the

current transition assistance program offered by the Department of Defense. The Department of Defense requires all military personnel to participate in the transition assistance program trainings as part of their military exit process. These results may lead to the Department of Defense adding EI training to the current transition assistance program curriculum. By increasing veterans' EI skills prior to leaving the military, veterans would have these skills available to help them cope with and, therefore, lead to a more successful transition to civilian life.

Conclusion

With over 200,000 veterans leaving the military every year, there is a significant number of individuals transitioning from military to civilian life (Ainspan et al., 2018; Zogas, 2017). A large majority of those reintegrating have reported challenges during their transition. Many veterans experience a decrease in mental health and general wellbeing following separation from the military (Pease et al., 2016; Sherman et al., 2015). With more than a dozen veterans dying everyday by suicide (U.S. Department of VA, 2019), it is essential that researchers understand the reintegration period so that programs and resources can be developed to ease the transition to civilian life. Veterans who transition successfully face less risk of mental health concerns, divorce, homelessness, physical health issues, and even suicide (Elbogen et al., 2012; Haller et al., 2016; Hawkins et al., 2015; McCormick et al., 2019). The goal of this study was to determine the extent to which EI moderated the relationship between trait anxiety and perceived VCR challenges in sample of post 9/11 military veterans. The results indicated that the level of EI changed the relationship between trait anxiety on perceived VCR

challenges, confirming the moderation hypothesis. Implications for positive social change include the benefits of added EI training to the current Department of Defense's transition program. Finally, findings from this study may prompt future research with the potential to improve current transition resources and programs, leading, ultimately, to more successful transitions to civilian life for veterans.

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Appendix A: Eligibility and Demographic Questionnaire

Eligibility: (6 questions)

E1. Have you served on active-duty in the U.S. military at any time since September 11, 2001?

Responses:

Yes (continue)
No (End study)

E2. Have you separated from the military within the past 2 years?

Responses:

Yes (continue)
No (End study)

E3. How did you separate from the military?

Responses:

Discharged (e.g., honorable, medical, dishonorable) (continue)
Retirement (End study)

E4. Are you currently serving in the Reserves or National Guard?

Responses:

Yes (End study)
No (continue)

E5. Are you currently living in the United States?

Responses:

Yes (continue)
No (End study)

E6. What is your current age?

Responses:

Numeric response (any response under 18 - End Study)

Demographics: (12 questions)

D1. What is your gender?

Responses:

Male
Female
Other:_____
Prefer not to answer

D2. What is your race/ethnicity?

Responses:

White/Caucasian
Black/African American
Asian/Asian American
American Indian or Alaska Native
Native Hawaiian or other Pacific Islander
Hispanic/Latino
Other or Multi-racial
Prefer not to answer

D3. What is your highest level of completed education?

Responses:

High school degree or equivalent
Associate's degree
Bachelor's degree
Master's degree
Doctoral or professional degree (e.g., Ph.D., M.D., Ed.D)
Prefer not to answer

D4. What is your marital status?

Responses:

Single
Living with partner
Married
Separated
Divorced
Widowed
Prefer not to answer

D5. How would you describe your current employment status?

Responses:

Employed, full time
Employed, part time
Not employed, but looking for work
Not employed, and not looking for work
Student
Homemaker/Stay at home parent
Prefer not to answer

D6. What state do you currently reside in?

Responses:

_____(List of U.S. States)

D7. What military branch did you serve in?

Responses:

Army
Air Force
Navy
Marines
Coast Guard
Prefer not to answer

D8. How many years did you serve in the military?

Response:

_____(Open-ended answer)

D9. What was your pay grade at the time of separation from the military?

Responses:

E-1	E-7	W-4	O-5
E-2	E-8	W-5	O-6
E-3	E-9	O-1	O-7
E-4	W-1	O-2	O-8
E-5	W-2	O-3	O-9
E-6	W-3	O-4	O-10

D10. How long (in months) have you been discharged from the military?

Responses:

_____ months

D11. What type of discharge did you received at separation?

Responses:

Honorable discharge
General discharge
Other than Honorable discharge
Bad conduct discharge
Dishonorable discharge
Other: _____

D12. Which conflict/campaign did you serve? (Choose all that apply)

Responses:

Operation Enduring Freedom (OEF)
Operation Iraqi Freedom (OIF)
Operation New Dawn (OND)
Operation Inherent Resolve (OIR)
Other: _____
None

Appendix B: State–Trait Inventory for Cognitive and Somatic Anxiety

Below is a list of statements which can be used to describe how people feel. Beside each statement are four numbers which indicate how often each statement is true of you (e.g., 1 = *not at all*, 4 = *very much so*). Please read each statement carefully and choose the number which best indicates how often, in general, the statement is true of you.

	Not at all	A little	Moderately	Very much so
1. My heart beats fast.	1	2	3	4
2. My muscles are tense.	1	2	3	4
3. I feel agonized over my problems.	1	2	3	4
4. I think that others won't approve of me.	1	2	3	4
5. I feel like I'm missing out on things because I can't make up my mind soon.	1	2	3	4
6. I feel dizzy.	1	2	3	4
7. My muscles feel weak.	1	2	3	4
8. I feel trembly and shaky.	1	2	3	4
9. I picture some future misfortune.	1	2	3	4
10. I can't get some thought out of my mind.	1	2	3	4
11. I have trouble remembering things.	1	2	3	4
12. My face feels hot.	1	2	3	4
13. I think that the worst will happen.	1	2	3	4
14. My arms and legs feel stiff.	1	2	3	4
15. My throat feels dry.	1	2	3	4
16. I keep busy to avoid uncomfortable thoughts.	1	2	3	4
17. I cannot concentrate without irrelevant thoughts intruding.	1	2	3	4
18. My breathing is fast and shallow.	1	2	3	4
19. I worry that I cannot control my thoughts as well as I would like to.	1	2	3	4
20. I have butterflies in my stomach.	1	2	3	4
21. My palms feel clammy.	1	2	3	4

Appendix C: Emotional Intelligence Scale

Instructions: Indicate the extent to which each item applies to you using the following scale:
1 = strongly disagree
2 = disagree
3 = neither disagree nor agree
4 = agree
5 = strongly agree

Items
1. I know when to speak about my personal problems to others
2. When I am faced with obstacles, I remember times I faced similar obstacles and overcame them
3. I expect that I will do well on most things I try
4. Other people find it easy to confide in me
5. I find it hard to understand the non-verbal messages of other people*
6. Some of the major events of my life have led me to re-evaluate what is important and not important
7. When my mood changes, I see new possibilities
8. Emotions are one of the things that make my life worth living
9. I am aware of my emotions as I experience them
10. I expect good things to happen
11. I like to share my emotions with others
12. When I experience a positive emotion, I know how to make it last
13. I arrange events others enjoy
14. I seek out activities that make me happy
15. I am aware of the non-verbal messages I send to others
16. I present myself in a way that makes a good impression on others
17. When I am in a positive mood, solving problems is easy for me
18. By looking at their facial expressions, I recognize the emotions people are experiencing
19. I know why my emotions change
20. When I am in a positive mood, I am able to come up with new ideas
21. I have control over my emotions
22. I easily recognize my emotions as I experience them
23. I motivate myself by imagining a good outcome to tasks I take on
24. I compliment others when they have done something well
25. I am aware of the non-verbal messages other people send
26. When another person tells me about an important event in his or her life, I almost feel as though I have experienced this event myself
27. When I feel a change in emotions, I tend to come up with new ideas
28. When I am faced with a challenge, I give up because I believe I will fail*
29. I know what other people are feeling just by looking at them
30. I help other people feel better when they are down
31. I use good moods to help myself keep trying in the face of obstacles
32. I can tell how people are feeling by listening to the tone of their voice
33. It is difficult for me to understand why people feel the way they do*

• These items are reverse scored.

Appendix D: Brief Emotional Intelligence Scale

Instructions: Indicate the extent to which each item applies to you using the following scale:

1 = strongly agree
2 = agree
3 = neither disagree nor agree
4 = disagree
5 = strongly disagree

Items

---

1. I know why my emotions change
2. I easily recognize my emotions as I experience them
3. I can tell how people are feeling by listening to the tone of their voice
4. By looking at their facial expressions, I recognize the emotions people are experiencing
5. I seek out activities that make me happy
6. I have control over my emotions
7. I arrange events others enjoy
8. I help other people feel better when they are down
9. When I am in a positive mood, I am able to come up with new ideas
10. I use good moods to help myself keep trying in the face of obstacles

Appendix E: Military to Civilian Questionnaire

Over the past 30 days, have you had difficulty with…

	No difficulty	A little difficulty	Some difficulty	A lot of difficulty	Extreme difficulty
1. Dealing with people you do not know well (such as acquaintances or strangers)?	0	1	2	3	4
2. Making new friends?	0	1	2	3	4
3. Keeping up friendships with people who have no military experience?	0	1	2	3	4
4. Keeping up friendships with people who have military experiences (including friends who are active-dutyor veterans)?	0	1	2	3	4
5. Getting along with relatives (such as siblings, parents, grandparents, in-laws and children not living at home)?	0	1	2	3	4
6. Getting along with your spouse or partner (such as communicating, doing things together, enjoying his or her company)? *	0	1	2	3	4
7. Getting along with your child or children (such as communicating, doing things together, enjoying his or her company)? *	0	1	2	3	4
8. Finding or keeping a job (paid or nonpaid or self-employment)? *	0	1	2	3	4
9. Doing what you need to do for work or school? *	0	1	2	3	4
10. Taking care of your chores at home (such as housework, yard work, cooking, cleaning, shopping, errands)?	0	1	2	3	4
11. Taking care of your health (such as exercising, sleeping, bathing, eating well, taking medications as needed)?	0	1	2	3	4
12. Enjoying or making good use of free time?	0	1	2	3	4
13. Taking part in community events or celebrations (for example, festivals, PTA meetings, religious or other activities)?	0	1	2	3	4
14. Feeling like you belong in “civilian” society?	0	1	2	3	4
15. Confiding or sharing personal thoughts and feelings?	0	1	2	3	4
16. Finding meaning or purpose in life?	0	1	2	3	4

* Respondents are also given a “Does not apply” response option.

Appendix F: Histograms and Q-Q Plots

Figure F1

Histogram for Trait Anxiety

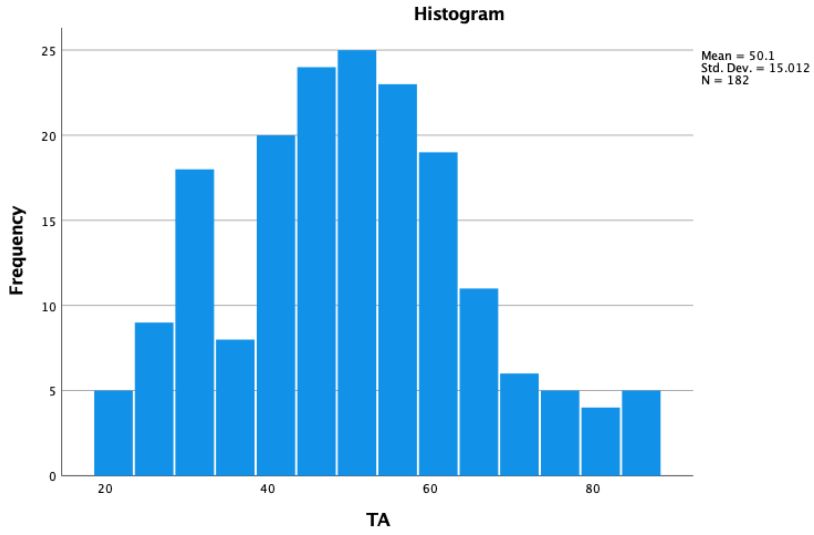

Figure F2

Normal Q-Q Plot of Trait Anxiety

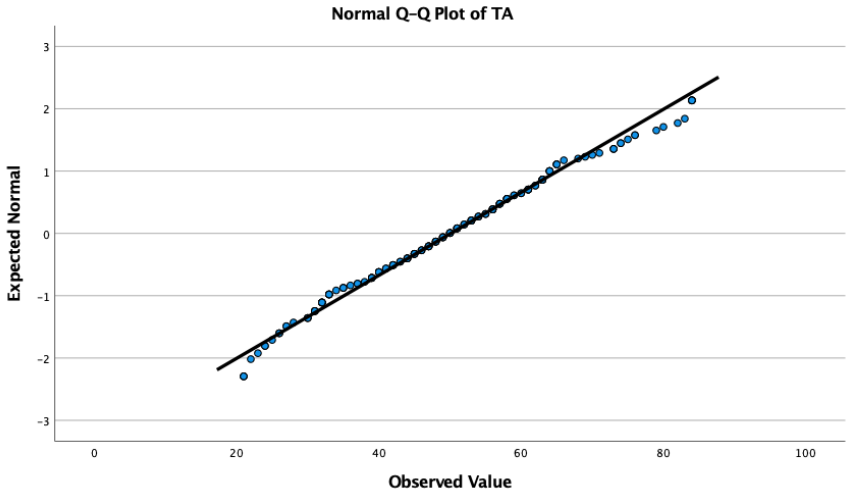

Figure F1

Histogram for Emotional Intelligence

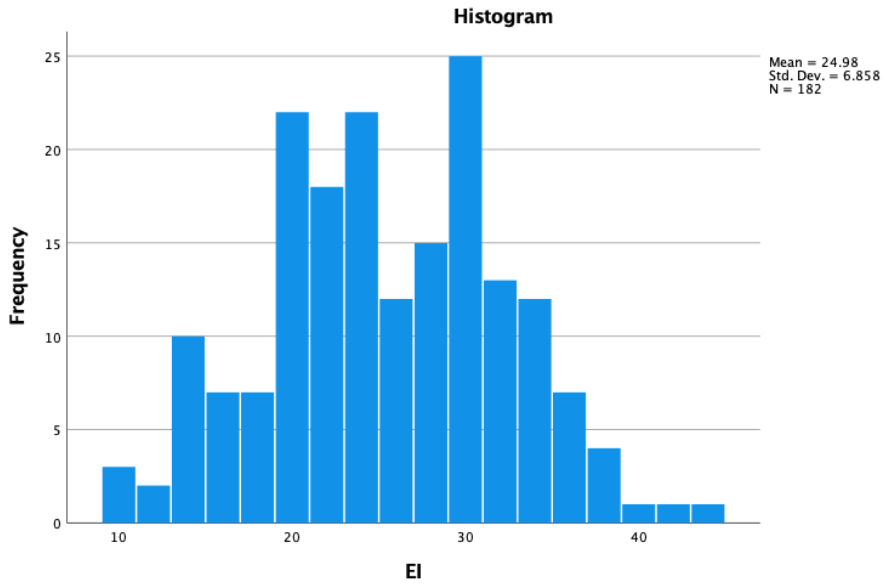

Figure F2

Normal Q-Q Plot for Emotional Intelligence

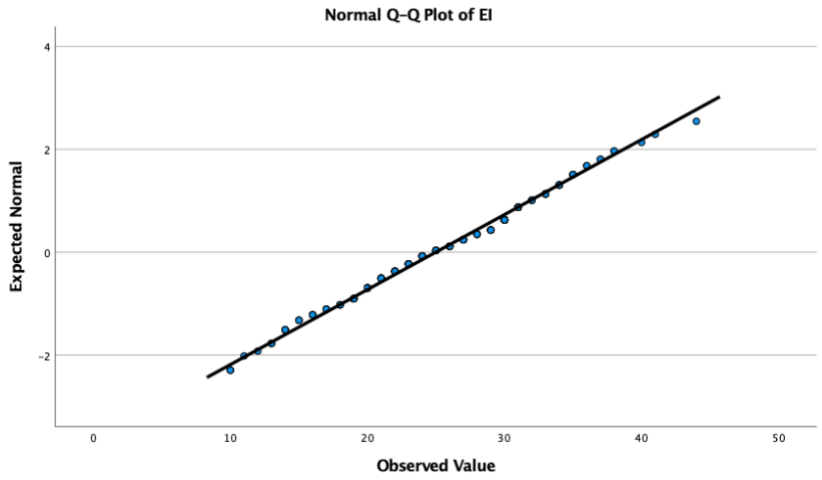

Figure F3

Histogram for Veteran Community Reintegration Challenges

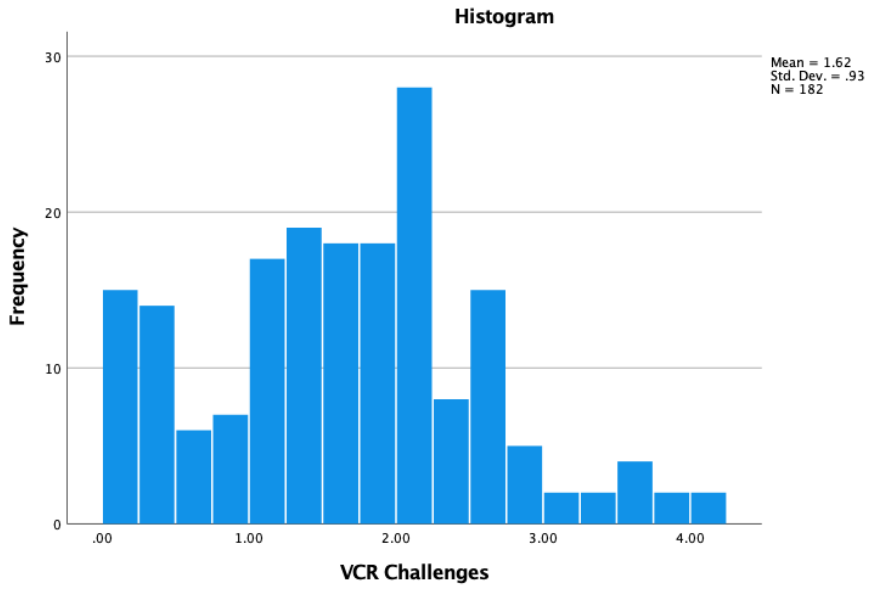

Figure F4

Normal Q-Q Plot for Veteran Community Reintegration Challenges