

The Relationship Between Combat Exposure and Social Wellness Among the Kenyan Defense Forces in Lang'ata Barracks

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Abstract

This study examined the effect of combat exposure on the social wellness of Kenya Defence Forces (KDF) personnel stationed at Lang'ata Barracks who had been deployed to Somalia. The aim was to generate context-specific evidence to inform post-deployment reintegration strategies. A cross-sectional analytical design was employed, targeting 86 KDF personnel who had experience of being deployed to Somalia. Data were collected using structured questionnaires incorporating the combat exposure scale and a validated social wellness scale. Correlation and linear regression analyses were conducted using SPSS version 28, with statistical significance set at $p < .05$. The results of correlations has established that the strongest relationship was found between combat exposure and social wellness ($r = 0.861$). Other significant predictors include education (negative correlation), age (positive), and gender (positive). On other hand, number of deployments and marital status are not significant in relation to social wellness. The regression analysis further report a significant relationship between combat exposure and social wellness ($B = 0.890$, $p < .001$). It is therefore recommended that post-deployment interventions should leverage combat-related camaraderie to sustain social connectedness, while providing targeted support to subgroups such as highly educated personnel. Longitudinal research is recommended to assess the durability of these positive effects over time.

Keywords: Social wellness, combat exposure, military deployment, unit cohesion, PTSD, Somalia

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I. Background of the Study

Combat exposure is an occupational reality for deployed military personnel and includes direct participation in firefights, exposure to improvised explosive devices (IEDs), witnessing death or severe injury, and other life-threatening experiences that meet trauma-exposure criteria. (American Psychiatric Association, 2013; World Health Organization, 2024). "Social wellness" (also described in the literature as social well-being or social functioning) refers to an individual's ability to form and maintain satisfying interpersonal relationships, participate in community life, and access social supports and resources that promote coping and life-satisfaction a multidimensional domain of overall well-being that interacts with emotional and occupational domains. (Bautista et al., 2023).

A growing body of recent research shows that combat exposure is strongly associated not only with psychiatric outcomes (posttraumatic stress disorder [PTSD], depression, substance use) but also with impairments in social functioning for example, relationship strain, loneliness, reduced perceived social support, and difficulties

with community reintegration. (Tedla et al., 2024; Beech et al., 2024; Grover et al., 2024). Perceived social support is both a buffer and a recovery factor after combat trauma: higher perceived support is linked to lower odds of PTSD, depression and suicidal ideation, whereas poor or eroded social support predicts worse mental-health trajectories and functional outcomes among combat-exposed service members and veterans. (Na et al., 2022; Grover et al., 2024).

In a large U.S. veteran cohort (N = 1,495), moral injury scores were inversely associated with quality of life. This negative relationship was stronger among older veterans, suggesting that moral injury may progressively erode social and psychological well-being over time (Renshaw et al., 2023). Further, longitudinal modeling of functioning among post-9/11 veterans demonstrated that moral injury particularly stemming from perpetration or betrayal predicted worse trajectories of intimate relationship, health, and occupational functioning, even after accounting for PTSD and depression (Maguen et al., 2020).

Longitudinal data from 238 U.S. veterans deployed to Afghanistan or Iraq revealed that higher PTSD symptom severity was linked to lower perceived social support, especially in tangible and belonging dimensions. Over time, belonging support predicted reductions in PTSD symptom severity, indicating the importance of social connection for psychological adjustment (Miller et al., 2023). A systematic review and meta-analysis of military personnel exposed to combat showed that perceived social support (PSS) is a critical factor in recovery from deployment-related trauma. The level and source of support whether from peers or family significantly influence outcomes, with variability based on deployment context and individual needs (Santa et al., 2024).

A survey study of 1,004 U.S. veterans identified distinct patterns of potentially morally injurious events (PMIEs) such as witnessing, failing to act, or experiencing betrayal and found that those in the highest-exposure groups ("high all" or "moderate all") exhibited significantly poorer behavioral health outcomes including elevated PTSD, depression, anxiety, and anger (Currier et al., 2022). PTSD and Social Support Higher PTSD linked to lower social support; belonging support weakens PTSD over time (Miller et al., 2023) Perceived Social Support (PSS) is a robust recovery factor, with effects varying by source and combat context (Santa et al., 2024) Moral injury correlates with lower quality of life and worsened functional trajectories beyond PTSD/depression (Renshaw et al., 2023; Maguen et al., 2020) PMIEs & Behavioral Health Patterns High levels of varied PMIE exposure associate with multiple negative psychological outcomes (Currier et al., 2022)

Mechanisms that link combat exposure to poorer social wellness include trauma-related symptoms (e.g., avoidance, emotional numbing), moral injury (guilt, shame, loss of trust), repeated separations from family and community, stigma around help-seeking, and the breakdown of "fictive kin" (the close bonds with comrades that can be hard to translate into civilian/family contexts). These processes can lead to withdrawal, conflict in intimate relationships, and diminished community participation. (Beech et al., 2024; Gettings et al., 2022; Grover et al., 2024). Intervention studies and systematic reviews from the last five years emphasize that interventions directly targeting social connection (peer support, group programs, community reintegration activities) and programs that integrate family/relationship work into clinical care show promise for improving social outcomes and reducing loneliness among veterans with PTSD. In other words, social-targeted strategies are important complements to individual trauma therapies. (Gettings et al., 2022; Eliacin et al., 2023).

In the Kenyan context, the Kenya Defence Forces (KDF) have been a major troop contributor to the African Union's missions in Somalia (AMISOM/ATMIS/AUSSOM), with contingents deployed for extended rotations; units deploy from and rotate back to garrisons such as Lang'ata Barracks in Nairobi where reintegration, family reunification, and post-deployment routines occur. (Ministry of Defence – Kenya, n.d.; Africanews, 2023; ATMIS/KDF public updates 2023–2024). The KDF has recently increased awareness and programming around mental-health and psychosocial support (e.g., mental-health forums, post-deployment counselling and wellness centre activities hosted at Lang'ata and other garrisons), but peer-reviewed research explicitly assessing social wellness outcomes among KDF personnel returning from Somalia remains sparse in the international literature. This leaves an evidence gap about the prevalence, determinants, and lived social-consequences of combat exposure in Kenyan military populations. (Ministry of Defence – Kenya, 2024 – 2025; Grover et al., 2024).

Problem of the Statement

Military personnel deployed to combat zones face a range of stressors, from direct enemy engagement and improvised explosive device (IED) exposure to witnessing injury and death. These experiences have been consistently linked to adverse psychosocial outcomes, including reduced social wellness (Beech et al., 2024; Grover et al., 2024). Social wellness encompassing relationship satisfaction, community participation, and perceived social support is a critical determinant of holistic health, influencing resilience, operational readiness, and post-deployment reintegration (Bautista et al., 2023). Global studies have indicated that combat exposure can lead to relationship strain, emotional withdrawal, community disengagement, and loss of trust in others, often mediated by posttraumatic stress disorder (PTSD) symptoms, depression, and moral injury (Gettings et al., 2022; Na et al., 2022). While protective social networks can buffer against these effects, combat trauma often erodes these very networks, creating a cycle of isolation and impaired recovery (Eliacin et al., 2023).

In Kenya, the Kenya Defence Forces (KDF) have been heavily involved in the African Union Transition Mission in Somalia (ATMIS), with soldiers stationed in high-intensity combat environments for extended rotations (Ministry of Defence – Kenya, 2024). Units such as those from Lang’ata Barracks return to a domestic context where family, peer, and community reintegration are crucial, yet little is known about the extent to which combat exposure affects their social wellness. Existing KDF mental-health initiatives emphasize psychological recovery, but empirical data specifically linking combat exposure to social-domain outcomes among KDF personnel is scarce. This gap in knowledge hampers the development of targeted interventions for post-deployment social reintegration. Without context-specific evidence, program planners and military leadership risk underestimating the scope of social wellness challenges, potentially undermining both the well-being of personnel and long-term mission effectiveness (Grover et al., 2024; World Health Organization, 2024).

Purpose of the Study

The purpose of this study is to examine the relationship between combat exposure on the social wellness of Kenya Defence Forces personnel stationed at Lang’ata Barracks who have been deployed to Somalia.

Theoretical Review

The study was informed by two major theories related to the topical issues in the present study. They included Social Ecological Model (SEM) and Stress Process Model (SPM) as stated hereunder.

Social Ecological Model

The Social Ecological Model, as applied in public health and behavioral sciences, posits that individual behavior and wellness are shaped by multiple levels of influence individual, interpersonal, community, and societal (Bronfenbrenner, adapted in current military mental health frameworks) (Centers for Disease Control and Prevention [CDC], 2022). At the individual level, combat exposure can produce PTSD symptoms, emotional numbing, and moral injury, all of which may impair social engagement (Gettings et al., 2022). At the interpersonal level, deployment-related absences and trauma can disrupt family roles, strain marriages, and diminish peer relationships (Grover et al., 2024). At the community level, stigmatization of mental health issues in military culture and lack of reintegration programs may reduce opportunities for social connection. At the societal level, broader institutional and policy environments, such as military deployment cycles and resource allocation, shape post-deployment adjustment (Ministry of Defence – Kenya, 2024).

The SEM is useful for this study because it provides a multidimensional lens, allowing researchers to assess how combat exposure interacts with personal resilience, family dynamics, community reintegration opportunities, and institutional policies to influence social wellness. This aligns with evidence that effective reintegration strategies must target multiple levels of influence rather than focusing solely on individual-level interventions (Eliacin et al., 2023).

Stress Process Model

The Stress Process Model, originally developed by Pearlin et al. and refined in subsequent decades, provides a useful framework for understanding how combat exposure impacts social wellness. The model posits that stressors both primary (direct exposure to traumatic events) and secondary (role strain, stigma, or relationship conflict) influence health outcomes through mediating factors such as coping resources and social support (Thoits, 2019). In the context of deployed military personnel, primary stressors include direct combat experiences such as firefights, IED attacks, and witnessing injury or death, while secondary stressors may involve marital strain, prolonged separation from family, or difficulties in community reintegration post-deployment (Na et al., 2022).

The model suggests that individuals with robust social support networks and adaptive coping mechanisms are more resilient to the negative effects of combat exposure, whereas those with weak or eroded support systems are more vulnerable to social withdrawal, isolation, and relationship breakdown (Beech et al., 2024). The SPM is particularly relevant to this study because it recognizes social wellness not only as an outcome but also as a protective resource that can buffer against psychological harm. In military populations, this means that interventions to strengthen social networks can mitigate the long-term effects of combat trauma on well-being (Eliacin et al., 2023).

II. Methodology

This study adopt a cross-sectional analytical design, which is appropriate for assessing the relationship between combat exposure and social wellness at a single point in time. Cross-sectional approaches are cost-effective, allow for the collection of multiple variables simultaneously, and have been used extensively in military health research examining psychosocial outcomes of deployment (Na et al., 2022; Santa et al., 2024). The research was conducted at Lang’ata Barracks, located in Nairobi County, Kenya. Lang’ata Barracks houses several units of the Kenya Defence Forces (KDF) and serves as a major base for troops deployed to and returning from Somalia

under the African Union Transition Mission in Somalia (ATMIS). Post-deployment personnel often undergo debriefing and reintegration programs here, making it a suitable setting for studying the social wellness impacts of combat exposure (Ministry of Defence - Kenya, 2024). The target population comprised all KDF personnel stationed at Lang'ata Barracks who have previously been deployed to Somalia out of whom 100 were identified to fill research questionnaire.

Personnel currently undergoing treatment for acute psychiatric conditions or those unavailable due to field assignments during the data collection period were excluded. While the study included KDF personnel who have served at least one combat deployment in Somalia and have returned within the past 36 months. Data was analyzed using SPSS version 28 and it focused on Pearson's correlation to examine associations between combat exposure and social wellness and multiple linear regression to assess the effect of combat exposure on social wellness while controlling for age, rank, marital status, and deployment duration. Statistical significance was set at $p < .05$.

Ethical Considerations

The study obtained ethical approval from an accredited Institutional Review Board (IRB) and research authorization from the Ministry of Defence. Written informed consent was also secured from each participant, emphasizing voluntary participation, confidentiality, and the right to withdraw without penalty. Psychological support services available at Lang'ata Barracks were highlighted for participants who experience distress during the study.

Findings

The results were presented in terms of correlation and regression statistics. The correlation part measured how variables associated to each other while regression model was used to determine the effect between variables.

Correlation Results

From the results given in Table 1, it is established that combat exposure was positively associated to social wellness ($r = 0.861$, $p < 0.01$). This was a clear indication that there is a very strong statistical significance in the association between combat exposure and social wellness. Therefore suggesting that in the study's sample, higher levels of combat exposure are associated with higher measured social wellness scores. This may seem counterintuitive, as many studies link combat exposure to reduced social functioning (e.g., Brewin et al., 2024; Grover et al., 2024). In the current case, it could reflect strong camaraderie, mutual support among deployed personnel, or resilience-building programs in KDF-factors that might boost perceived social wellness despite high combat stress.

Number of deployments and social wellness had non-significant positive correlation ($r = 0.109$, $p = 0.317$). Meaning that the frequency of deployments does not meaningfully relate to perceived social wellness in this sample. It may be that other factors (e.g., nature of assignments, individual coping skills, support networks) are more influential than deployment count. The association between education and social wellness provided an r value of -0.313 , ($p = 0.003$). An indication of a moderate negative and statistically significant relationship exists. Higher education levels are linked to lower reported social wellness scores. This could suggest that those with higher education may have higher expectations for social connection or be more aware of social deficits post-deployment, leading to lower satisfaction scores.

Moreover, age had a significant association towards social wellness ($r = 0.215$, $p = 0.046$). Tjis could be interpreted to mean that older personnel report slightly higher social wellness. This could be due to greater life experience, emotional maturity, or stronger established social networks among older personnel. Marital status and social wellness had Weak positive, not statistically significant relationship ($r = 0.104$, $p = 0.339$). An implication that beeing married or single does not significantly predict social wellness in this group, possibly due to the unique demands of military life where peer bonds can substitute for family support during deployment.

The linkage between gender and social wellness was positive, and statistically significant ($r = 0.432$, $p < 0.01$). Gender differences exist in reported social wellness, with one gender (likely male or female, depending on coding) reporting higher scores. This might reflect gendered experiences of deployment, support systems, or social reintegration.

Table 1: Correlation

		Social Wellness	Combat Exposure	Number of deployments into a war zone	Education	Age	Marital status	Gender
Social Wellness	Pearson Correlation	1	.861**	.109	-.313**	.215*	.104	.432**
	Sig. (2-tailed)		.000	.317	.003	.046	.339	.000
	N	86	86	86	86	86	86	86

Combat Exposure	Pearson Correlation	.861**	1	.178	-.302**	.310**	-.003	.445**
	Sig. (2-tailed)	.000		.101	.005	.004	.976	.000
	N	86	86	86	86	86	86	86
Number of deployments into a war zone	Pearson Correlation	.109	.178	1	-.145	.500**	-.340**	.016
	Sig. (2-tailed)	.317	.101		.183	.000	.001	.882
	N	86	86	86	86	86	86	86
Education	Pearson Correlation	-.313**	-.302**	-.145	1	-.202	-.121	-.424**
	Sig. (2-tailed)	.003	.005	.183		.062	.266	.000
	N	86	86	86	86	86	86	86
Age	Pearson Correlation	.215*	.310**	.500**	-.202	1	-.388**	.422**
	Sig. (2-tailed)	.046	.004	.000	.062		.000	.000
	N	86	86	86	86	86	86	86
Marital status	Pearson Correlation	.104	-.003	-.340**	-.121	-.388**	1	.127
	Sig. (2-tailed)	.339	.976	.001	.266	.000		.244
	N	86	86	86	86	86	86	86
Gender	Pearson Correlation	.432**	.445**	.016	-.424**	.422**	.127	1
	Sig. (2-tailed)	.000	.000	.882	.000	.000	.244	
	N	86	86	86	86	86	86	86

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

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

Regression Results

The regression output given in Table 2 indicate that the model gave summary results of $R = .861$ This is the correlation coefficient between combat exposure (independent variable) and social wellness (dependent variable). It indicates a very strong positive relationship between the two variables. With an $R^2 = .741$ is an indication that 74.1% of the variation in social wellness among the deployed KDF personnel can be explained by combat exposure alone. The remaining 25.9% is due to other factors not included in this model for instance, mental health status, family support, personality traits. An adjusted R^2 of .738 accounts for sample size and confirms the model's high explanatory power with minimal overfitting. Thus the high R^2 suggests that combat exposure is a major determinant of social wellness in this sample, which is unusually strong compared to most military psychology studies where social wellness is often influenced by multiple interacting factors (Brewin et al., 2024; Johnson & Williams, 2022).

Still on the same model, the ANOVA results gave an $F(1, 84) = 240.570$, $p < .001$. Meaning that the model is statistically significant, whereby combat exposure is significantly predicting social wellness. The probability that these results occurred by random chance is less than 0.1%. The high F-value indicates that the regression model provides a much better fit to the data than a model with no predictors. In practical terms, combat exposure is not just associated with social wellness it is a statistically reliable predictor of it in this military context.

The results of coefficients provided a constant ($B = -0.127$, $p = .345$). The constant represents the predicted value of social wellness when combat exposure is zero. Since it is not statistically significant ($p > .05$), it doesn't provide meaningful interpretation in this model. But on the other hand, combat exposure ($B = 0.890$, $\beta = 0.861$, $p < .001$). Could be an indication that for every 1-unit increase in combat exposure, social wellness increases by 0.89 units, holding other factors constant. β (Beta) = 0.861 is the standardized coefficient, showing that combat exposure has a very large effect size relative to other possible predictors. This finding is unusual because in much of the literature, greater combat exposure is linked to lower social wellness due to trauma effects (Gettings et al., 2022; Weiss-Dagan et al., 2024). However, in your KDF sample, higher combat exposure is linked to better social wellness scores.

Table 2: Combat Exposure and Social Wellness

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Model Summary ^b						
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate		
1	.861 ^a	.741	.738	.480428		
a. Predictors: (Constant), Combat Exposure						
b. Dependent Variable: Social Wellness						
ANOVA ^a						
	Model	Sum of Squares	df	Mean Square	F	Sig.
1	Regression	55.526	1	55.526	240.570	.000 ^b
	Residual	19.388	84	.231		
	Total	74.914	85			
a. Dependent Variable: Social Wellness						

b. Predictors: (Constant), Combat Exposure								
		Coefficients ^a						
Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.	95.0% Confidence Interval for B	
		B	Std. Error	Beta			Lower Bound	Upper Bound
1	(Constant)	-.127	.134		-.949	.345	-.394	.139
	Combat Exposure	.890	.057	.861	15.510	.000	.776	1.004
a. Dependent Variable: Social Wellness								

III. Discussion of the Findings

The correlation results reveal a very strong, positive, and statistically significant association between combat exposure and social wellness ($r = .861$, $p < .01$). This finding contrasts with much of the global literature, where combat exposure is typically associated with diminished social functioning due to PTSD symptoms, emotional withdrawal, and moral injury (Brewin et al., 2024; Gettings et al., 2022). However, in the Kenyan context, this positive relationship may be explained by unique protective factors within the Kenya Defence Forces (KDF). Deployment to Somalia often involves high-risk operations that foster unit cohesion, shared purpose, and mutual reliance, which are known to enhance camaraderie and perceived social support (Smith et al., 2023). These bonds may elevate social wellness scores despite the psychological strain of combat. Additionally, wellness and reintegration programs at Lang'ata Barracks may play a role in sustaining social connectedness post-deployment (Ministry of Defence, 2022).

The weak and statistically non-significant correlation between the number of deployments into a war zone and social wellness ($r = .109$, $p = .317$) indicates that deployment frequency alone is not a decisive factor in shaping social wellness outcomes. This aligns with findings from Vest et al. (2021), who observed that the quality and intensity of combat experiences, as well as available post-deployment support, mattered more than deployment count in predicting social outcomes. A moderate, negative, and statistically significant relationship was found between education level and social wellness ($r = -.313$, $p = .003$). This suggests that personnel with higher education levels reported lower social wellness scores. One possible explanation is that higher-educated service members may have greater awareness of social and institutional gaps in reintegration support, leading to more critical self-assessments (Weiss-Dagan et al., 2024). Alternatively, higher education may correspond to career expectations or social roles outside the military that are disrupted by deployment, affecting perceived social well-being.

Marital status showed a weak, non-significant association with social wellness ($r = .104$, $p = .339$), indicating that being married or single did not meaningfully influence perceived social wellness. This is somewhat unexpected, as marriage is often linked to greater emotional support post-deployment (Adebayo & Olagunju, 2023). However, it is possible that in this sample, peer and unit relationships during deployment compensate for family-based support, reducing the effect of marital status. The weak, positive, and statistically significant correlation between age and social wellness ($r = .215$, $p = .046$) implies that older personnel tend to report slightly better social wellness. This aligns with the suggestion by Johnson and Williams (2022) that life experience, emotional maturity, and established social networks among older veterans may help mitigate the social impacts of deployment. Gender exhibited a moderate, positive, and statistically significant correlation with social wellness ($r = .432$, $p < .01$). Gendered experiences of deployment and reintegration could account for this difference. For instance, some studies have found that female service members report stronger utilization of social support networks post-deployment, enhancing their perceived social wellness (Brewin et al., 2024). Conversely, if men scored higher in this context, it could be due to cultural or institutional norms that provide more robust peer networks for male soldiers.

The regression analysis revealed that combat exposure is a strong and statistically significant predictor of social wellness among deployed KDF personnel stationed at Lang'ata Barracks. The model explained 74.1% of the variance in social wellness ($R^2 = .741$), indicating that the extent of combat exposure accounted for most of the differences in social wellness scores within the sample. This is a remarkably high explanatory power compared to similar studies in Western contexts, where social wellness is usually shaped by multiple interacting psychosocial and demographic factors (Brewin et al., 2024; Weiss-Dagan et al., 2024). The positive regression coefficient ($B = 0.890$, $p < .001$) suggests that as combat exposure increases, social wellness scores also increase. This finding diverges from the dominant narrative in military mental health research, where intense combat experiences are often linked to social isolation, relationship strain, and reduced community participation due to PTSD symptoms, moral injury, or emotional withdrawal (Gettings et al., 2022; Renshaw et al., 2023). In this study, however, greater combat exposure appears to enhance perceived social wellness.

Recent evidence suggests that structured pre-deployment training and post-deployment reintegration programs can transform combat experiences into opportunities for resilience-building (Weiss-Dagan et al., 2024). The Ministry of Defence (2022) has implemented wellness programs, peer-support networks, and debriefing sessions for returning troops. These initiatives may help personnel reinterpret combat exposure in a positive light, reinforcing social ties. High-stakes combat environments often necessitate mutual reliance, fostering deep

interpersonal bonds between service members. Smith et al. (2023) found that such cohesion acts as a protective factor, promoting social connectedness and trust among soldiers even after deployment. In the KDF context, soldiers deployed to Somalia may perceive their combat experiences as shared milestones that strengthen peer relationships, contributing to higher social wellness scores.

In collectivist cultural settings, shared adversity can enhance group identity and social belonging (Adebayo & Olagunju, 2023). In the Kenyan military, returning from a high-risk mission may confer social prestige and recognition from peers, family, and the broader community, further enhancing social wellness perceptions. While the results are encouraging, it is important to consider potential time-lag effects. Some research warns that positive social impacts immediately after deployment may diminish over time, with delayed-onset mental health conditions later eroding social functioning (Vest et al., 2021). Therefore, longitudinal follow-up is crucial to determine whether the observed positive relationship is sustained in the years following return from deployment.

IV. Implications for Practice

Although combat exposure correlated positively with social wellness overall, subgroups (e.g., those with high education levels or limited family support) may still require targeted interventions. Post-deployment programs should deliberately build on the camaraderie and trust developed in combat, channeling these bonds into sustained social wellness and community reintegration activities. Continued assessment beyond the immediate post-deployment period is essential to detect any decline in social wellness as operational bonds weaken or other stressors emerge.

In summary, the regression findings suggest that, in this KDF sample, combat exposure is not inherently detrimental to social wellness and may, under certain conditions, promote stronger social ties and perceived connectedness. This highlights the importance of context-specific interpretations in military health research and cautions against assuming that findings from Western forces will directly apply to African military populations.

V. Conclusion

This study set out to examine the effect of combat exposure on the social wellness of Kenya Defence Forces personnel stationed at Lang'ata Barracks who had been deployed to Somalia. Guided by the purpose of generating context-specific evidence to inform post-deployment reintegration strategies, the analysis produced findings that are both statistically robust and contextually distinctive. In contrast to much of the international literature, the results indicate that in this KDF cohort, greater combat exposure is associated with higher social wellness, possibly due to unit cohesion, resilience-building, and cultural valorization of shared service. These findings highlight the importance of contextualized interpretations in military psychology. The correlation analysis revealed a very strong positive relationship between combat exposure and social wellness, suggesting that in this cohort, greater combat exposure is associated with higher perceived social well-being. While global literature often reports a negative association due to trauma-related impairments, these results point to the possibility that the KDF's operational environment, unit cohesion, and post-deployment support mechanisms foster resilience and mutual reliance, translating into improved social connectedness.

Regression results further reinforced this relationship, with combat exposure explaining 74.1% of the variance in social wellness scores. This high explanatory power underscores combat exposure as a major predictor of social wellness in the Kenyan military context. The positive regression coefficient indicates that each incremental increase in combat exposure corresponds to an increase in perceived social wellness, a finding that diverges from many Western studies but aligns with theories of shared adversity as a social bonding mechanism.

The results also highlighted the significant role of demographic factors. Education was negatively associated with social wellness, while age and gender showed positive associations, and marital status and number of deployments had no significant effect. These nuances suggest that while combat exposure has a dominant influence, personal characteristics and social positioning within the military also shape social well-being outcomes.

From a practical perspective, the findings have significant implications for military leadership and mental health practitioners. Post-deployment programs can leverage the social capital formed in combat to sustain and enhance social wellness, while also monitoring for delayed-onset difficulties that could emerge after the initial reintegration phase. Tailored support for subgroups such as those with higher education or less access to family networks can ensure that the benefits of combat-related social cohesion are maximized and equitably distributed.

It is recommended that post-deployment interventions should leverage combat-related camaraderie to sustain social connectedness, while providing targeted support to subgroups such as highly educated personnel. Longitudinal research is recommended to assess the durability of these positive effects over time. This study has contributed to filling the empirical gap in African military psychology by providing evidence that, in the Kenyan context, combat exposure can have positive social wellness outcomes when supported by strong unit cohesion, structured reintegration programs, and cultural norms that valorise shared service. While the findings challenge

prevailing assumptions from Western-based research, they also underscore the importance of contextualized interpretation and the need for longitudinal follow-up studies to assess the durability of these positive effects over time.

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