THE EFFECTS OF PTSD COUNSELING ON MILITARY CHAPLAINS

by

Bruce S. Kumor

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

Liberty University

2021

THE EFFECTS OF PTSD COUNSELING ON MILITARY CHAPLAINS

by Bruce S. Kumor

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

Liberty University, Lynchburg, VA

2021

APPROVED BY:

Mark Holland, PhD, Committee Chair

Robyn Trippany Simmons, Ed.D.,
Committee Member

Abstract

The United States military has been involved in some level of active combat since 2001. The wars in Iraq and Afghanistan are no longer as active as they were in previous years, yet the hidden wounds of war are still carried by those that have gone forward. The psychological wounds of war, particularly post-traumatic stress disorder, have been highlighted by increased direct combat experiences of service members. To alleviate these symptoms, the military has a mental health provider network to assist those in need. Within this network, military chaplains are often called to provide immediate emotional and psychological support for those experiencing post-traumatic stress symptomology. Research has shown a correlation between trauma counseling and secondary traumatic stress. This study focused on military chaplains, their wartime experiences, and how their psychological fitness has been impacted by trauma counseling. A majority of the chaplains who participated in this research indicated that they had performed many PTSD counseling sessions. Their experiences have resulted in some level of adverse effects on their psyches. Most chaplains had little to no combat experience, yet the chaplains that performed PTSD counseling demonstrated some disruption in their feelings and thought processes.

Keywords: military chaplain, secondary traumatic stress, vicarious trauma

Dedication

I dedicate this manuscript to my wife and four boys. To Amber, Oliver, August, Hudson, and Hollis—thank you for the encouragement and allowing me to dedicate a portion of our family time to pursue my higher education goals. I pray that the hard work and dedication you observed will motivate you to reach for the stars.

Acknowledgments

I want to thank my dissertation committee for their assistance in completing this dissertation. I want to thank Dr. Holland for serving as Chair of my dissertation committee. Dr. Holland provided the motivation, encouragement, and propulsion needed for this study's development and writing process. I also want to thank Dr. Robyn Simmons for serving on my committee and providing perceptive feedback in the writing process. Dr. Barker, my deepest thanks to you for taking the time to show me I was ready for a doctoral program.

I am sincerely thankful to my family for their support over the years. I have a deep appreciation for my wife, Amber. Amber was instrumental in her wisdom and guidance in honing in on a topic that is uniquely me and speaks to my heart. My wife believes in me, supported me through this entire process, and without her inspiration, this project would have never come to fruition. I want to thank our children - Oliver, August, Hudson, and Hollis - for their willingness to abstain throughout this academic effort.

I want to express my appreciation for those that made this dissertation possible. My deepest thanks to Dr. Stephen Keith and Dr. Travis Keith at Liberty Baptist Fellowship. I also send my gratitude to Vikki Teel for her support.

Table of Contents

List of Tables

List of Abbreviations

Combat Exposure Scale (CES)

Compassionate Fatigue (CF)

Impact of Event-Revised (IES-R)

Post-Traumatic Stress Disorder (PTSD)

Secondary Traumatic Stress (STS)

Trauma Attachment Brief Scale (TABS)

Vicarious Trauma (VT)

World Assumption Scale (WAS)

CHAPTER 1: INTRODUCTION

Overview

Since 2011, the United States of America has consistently been involved in some type of military conflict. In December of 2007, the United States military began withdrawing from combat operations in Afghanistan and Iraq (Burns & Miller, 2020). However, the physiological wounds of war remain within the military. Military chaplains stand on the front lines assisting military members in distress. Background information is vital to understand the plight of this issue and informs a problem and purpose statement. Out of the purpose statement evolves the study's significance, proposing a set of research questions to be answered. Finally, key definitions will be explored. This chapter will develop a foundation for this study's necessity on the effects of post-traumatic stress disorder counseling on military chaplains.

Background

The United States has been through a lengthy period of conflict with the wars in the Middle East. The wars in Afghanistan and Iraq have recently been through a significant troop withdrawal where there was a peak of 165,607 U.S. armed forces present in Iraq in the fiscal year 2007 and a low of 5,262 in the fiscal year 2017 (Peters & Plagakis, 2019). As a result of enduring military action in the Middle East, physiological war wounds are pervasive in America's military. Military chaplains stand on the front lines assisting military members in distress. Benimoff, an Army chaplain, recounted a personal war experience and said, "I have never been in a vehicle that was blown up, never been hit by a bullet—why was I dreaming about those things" (Benimoff, 2009, p. 139). Benimoff (2009), who had been to war but had not been exposed to as much danger as others, recounted praying over bodies and many stories of bloodshed. Benimoff experienced a mental crisis and, through self-reflection, was able to assess

mental stability. In a memoir, Benimoff wrote that since nightmares are a symptom of post-traumatic stress disorder [PTSD], Benimoff consulted a mentor to assist this interpersonal crisis. As a result, Benimoff discovered there had been limited attention paid to military chaplains' mental health needs. This personal testimony of Chaplain Benimoff is the foundation of this research and the need to investigate if the military has improved its care for military chaplains. This personal testimony from an active duty chaplain, along with the noted lack of care for chaplains, requires an overview of how a military chaplain serves in the role of a mental health counselor.

Military chaplains manage a wide range of pastoral care duties. Chaplains handle the formal responsibilities in worship services, funerals, honors to the dead, spiritual renewal activities, humanitarian projects, and accompanying the military into battle (Otis, 2009). Further, military chaplains provide pastoral counseling, facilitate PTSD counseling sessions, visit service members in combat, prison, and hospitals, serve in hospitals tending to the wounded, and act as ethics experts. Chaplains are viewed as advocates of spiritual, moral, and ethical maturity. Chaplains are woven into the fabric of military society and serve an essential role within the military. A chaplain’s importance is evidenced by the chaplain's relationship with the troops and the impacts on the emotional health of the troops that have access to a chaplain (Jolly, 2011). In a British hospital where some battle-wounded military landed, a chaplain served the personnel. The chaplain was one of the team, and everyone spoke to him (Jolly, 2011). A military chaplain understands the military systems and mental health issues resulting from military personnel work (Jolly, 2011). This is a crucial aspect of the military chaplain's work: One must be a frontline mental health counselor.

Society tends to consult clergy for mental health needs. In the forty years from 1950-1990, there was a decline in the population that sought mental health care from clergy, but what remained constant was that people still relied on clergy to meet their mental health needs (Wang et al., 2003). A quarter of people from 1950-1990 sought clergy's counsel for mental disorders over physicians or mental health professionals (Wang et al., 2003). Moving from the general population to the military population, the clergy was exclusively consulted for mental health issues. When a mental health issue arises in a military member, 24% of military members turn to the clergy (Nieuwsma et al., 2014). Chaplains spend an estimated 40% of their time counseling (Budd, 1999). Reflecting on Benimoff's memoir and conflict, Benimoff suffered the secondary effects of assuming the role of a mental health counselor.

A caregiver may begin to question themselves regarding why they are developing similar symptoms to a counselee's. In Benimoff's memoir, Benimoff kept dreaming about being blown up and being hit by a bullet when this was not Benimoff's personal experience (Benimoff, 2009). Benimoff was experiencing the harmful effects of secondary traumatic stress. Secondary traumatic stress is the adverse side effects of secondary exposure to traumatic events that are the same as the primary exposure (Bride & Figley, 2009). Symptoms include imagery, avoidance, hyperarousal, distressing emotions, and functional impairment (Bride & Figley, 2009). Benimoff expressed that a visit to a megachurch seemed threatening due to a more massive crowd and resulted in unexplained anger and feelings of lack of safety (Benimoff, 2009). Benimoff's experiences as a caregiver of persons who directly experienced psychological trauma made Benimoff an indirect trauma victim (Bride & Figley, 2009). While there is a vast amount of research on secondary traumatic stress and its effect on caregivers, Chaplain Bixler's statement to

Chaplain Benimoff regarding the lack of care for chaplains is the central focus of this research due to the chaplain's role as a mental health worker.

Problem Statement

Studies have shown that secondary traumatic stress can occur in a mental health worker who has been exposed to trauma through a patient's experience (Cieslak et al., 2014). Clergy are not often thought of as mental health workers; however, research has shown this to be a false perception (Nieuwsma et al., 2013). Regarding distilling clergy to a more specific role, there is limited research to distinguish the military chaplain's role in mental health counseling. Research performed in the clergy and mental health counseling is often focused on the help-seeker rather than the helper (Payne & Hays, 2016). Several factors drive a person to the clergy: ease of access, cultural normativity, and trusted relationships (Payne & Hayes, 2016). An aspect of military chaplaincy is the ministry of presence, where relationships matter (Otis, 2009). A successful chaplain will establish and maintain cordial relationships that are helpful to all ranks within the chaplain's military unit (Otis, 2009). The ministry of presence (i.e., building relationships by being with the troops) leads to the main reasons a military member would seek out the clergy.

Stateside and deployed, the military chaplain is a care provider for service members dealing with a range of mental health issues, including PTSD, reintegration, and suicidality (Bester-Dahan et al., 2016). America also served in two active combat zones for almost two decades, which took a toll on military chaplains (Bester-Dahan et al., 2016). Upon return from deployments, chaplains experienced combat-related stress, such as Compassionate Fatigue (CF) (Bester-Dahan et al., 2016). Chaplains also reported a loss in motivation, energy, and mental and spiritual well-being due to deployment and combat (Bester-Dahan et al., 2016). These concerns

are emerging issues in chaplains' mental and physical health who address traumatized service members' mental health (Bester-Dahan et al., 2016). The problem is that clergy, more specifically military chaplains, are understudied in the effects of mental health counseling.

Purpose Statement

The purpose of this study is to focus on the caregiver rather than the care-seeker in the area of mental health counseling. Military chaplains have great responsibility within their pastoral duties. One of these is performing mental health counseling. With almost two decades of active combat in Iraq and Afghanistan, military chaplains were present with their service members. Now that combat operations have slowed, this study seeks to investigate the amount of mental health counseling chaplains engage in and the history of combat or personal trauma that presents PTSD symptomology in chaplains, as well as collect data on those that have never been in combat but have PTSD symptomology due to mental health counseling and seek to understand if there is a correlation between secondary traumatic stress when the chaplain never experienced any psychological trauma. The population that will be studied are military chaplains self-identified through an online survey to develop any correlations between mental health counseling and psychological well-being.

Significance of the Study

Chaplains can be found in many different areas, including hospitals, prisons, corporations, home health, and the military. Chaplains, similar to clergy, help family members deal with the emotional distress of bereavement and the emotional reactions associated with these moments on a more frequent basis (Galek et al., 2011). Working in this environment, a chaplain has a greater chance of developing burnout and secondary traumatic stress (Galek et al., 2011). Another aspect of Galek et al.’s (2011) study was that secondary traumatic stress

manifests quickly. The number of years working as a trauma therapist contributes to symptoms of secondary traumatic stress. There were high emotional exhaustion levels and disengagement in studies related to military behavioral health professionals (Stearns et al., 2018). A correlation exists between secondary traumatic stress and burnout and chaplains and behavioral health workers. A correlation exists between secondary traumatic stress and burnout and chaplains and behavioral health workers. (Bledsoe et al., 2013). There is a lack of research on the correlation between burnout, secondary traumatic stress, and emotional exhaustion in military chaplains.

Chaplain Benimoff's memoir proposed that the idea of self-care is egocentric (Benimoff, 2009). Chaplain Benimoff felt angry and weak-minded regarding this need for self-care (Benimoff, 2009). The memoir also discussed feelings associated with being disappointed in oneself (Benimoff, 2009) and addressed the stigma associated with what one would consider a more fragile or sensitive mental state. Stigmas are dangerous because they may make a person believe that they are incompetent or carry a generalized sentiment of badness (Kim et al., 2011). The significance of this study is to research the impacts of mental health counseling on a military chaplain. Some military chaplains do not like other people helping them, as this can be viewed as a sign of weakness and a potential career-ender (Bester-Dahan et al., 2016). There may be a significant population of military chaplains experiencing the effects of mental health counseling. In that case, stigmas may have to be confronted so the caregiver can become a care-seeker to increase mental well-being.

Research Questions

RQ1: How frequently do chaplains counsel military members with post-traumatic stress disorder?

RQ2: Is there a majority or minority of chaplains suffering from PTSD symptomology due to wartime experiences?

RQ3: How has a military chaplain who has never deployed to a combat environment been affected by providing PTSD counseling to military members?

RQ4: Is there a correlation between providing PTSD counseling and secondary traumatic stress in military chaplains that have never experienced psychological trauma?

Definitions

Burnout - Prolonged three-dimensional response to job stressors, encompassing exhaustion, cynicism, and inefficacy (Cieslak et al., 2014).

Compassion Fatigue (CF) - A reduced empathic capacity or client interest manifested through behavioral and emotional reactions from exposure to others' traumatizing experiences (Cieslak et al., 2014).

Countertransference - An emotional reaction that stems from the therapist's unresolved and unconscious conflicts that arise in response to the client (Gibbons, Murphy, & Joseph, 2011).

Moral Injury - The existential wound of lament where one's morality is dissected by the destructive impact of war or other traumatic events to such an extent that a person's integrity, morality, and spiritual well-being may no longer be what they once were (Hodgson & Carey, 2017).

Post-Traumatic Stress Disorder [PTSD] – There are three main clusters of symptoms: re-experiencing, avoidance, and hyperarousal symptoms. Re-experiencing symptoms are

characterized by intrusive memories, nightmares, flashbacks, and psychological and physiological reactivity when encountering trauma cues (Dekel & Monson, 2010).

Secondary Traumatic Stress (STS) - Reactions resemble PTSD, including symptoms parallel to those observed in people directly exposed to trauma (Cieslak et al., 2014).

Stigma - An overarching term that includes problems of knowledge (ignorance), attitudes (prejudice), and behaviors (discrimination), which work synergistically to fuel social exclusion (Besterman-Dahan et al., 2013).

Vicarious Trauma (VT) - Describes the undesirable outcomes of working directly with traumatized populations and presents as negative transformation processes experienced by health professionals when exposed to traumatized patients (Nimmo & Huggard, 2013).

Summary

Chaplain Benimoff returned from the war, having felt the sting of treating service members who had experienced trauma. Benimoff was a professional in the field and believed feelings were not reality. Chaplain Benimoff had a mentor, Chaplain Bixler, who affirmed that the Army did not do a good enough job helping the caregiver. The focus was always on the care-seeker. The vast amount of research on the adverse effects on mental health workers' psyches has shown that vicarious trauma is a real threat (Wang et al., 2014). The wars in Afghanistan and Iraq have settled, and troops return home, but the war wounds can still linger. There are also personal moral injuries that troops suffer daily, ranging from relationship issues, substance abuse, and financial hardships. On the frontline stands the military chaplain, who is known to the unit, has relationships with them, is easily accessible, and welcomes the mentally-wounded service member. The purpose of this study is to understand if there are any adverse effects of mental health counseling on military chaplains. Chaplains can carry the stigma that providing

mental health counseling to military members should not affect them, but vicarious trauma and secondary traumatic stress are real threats (Benimoff, 2009). The research will better assess how prevalent vicarious trauma and secondary traumatic stress are in today's military. In the case of substantial evidence in support of this finding, a renewed effort can be presented to alleviate stigmas that inhibit caregivers from receiving the necessary help to remain effective in providing care to the wounded.

CHAPTER TWO: LITERATURE REVIEW

Overview

The United States fought in active combat on two fronts in recent years: Iraq and Afghanistan from 2001-2014. These wars have taken their toll on the physical and mental health of those deployed. War inflicts physical and mental wounds on those involved. Over 12 years (from 2002-2014), the United States military suffered 6,824 military deaths, 52,281 wounded, and 128,496 men and women reported post-traumatic stress disorder (Stearns et al., 2018). Veterans who have served since 9/11 have faced wartime challenges that are distinct from yesteryear (Nieuwsma et al., 2014). The distinction results from more extended deployments, enemies that are not distinguishable from their civilian counterparts, and higher survivability (Nieuwsma et al., 2014). Research has consistently shown that exposure to combat is associated with an increased risk of PTSD (Sundin et al., 2010).

A result of such findings is PTSD moving into the spotlight due to heightened military combat operations. The United States military has a cadre of mental health professionals that are prepared to combat PTSD. Military chaplains may or may not come to mind as an integral part of the mental health team. Military chaplains are often at the forefront of this epidemic, serving as both the single source of relief from PTSD and the bridge to mental health professionals. Research has shown that providing trauma counseling can negatively impact the caregiver (Elwood et al., 2011). The caregiver can experience a range of adverse mental health issues, including compassion fatigue, burnout, and secondary traumatic stress (Elwood et al., 2011). However, most research points towards mental health professionals and excludes the clergy's work to treat mental health issues.

The literature review will serve as a testament to the current research that has been conducted on the topic of the effects of trauma counseling on the counselor. The recent research also uncovers the need to assess military chaplains' current status and how PTSD counseling has impacted their mental fitness. This research aims to evaluate military chaplains who have been deployed and those who have not been deployed to gauge the depths of the impact of providing PTSD counseling to military members. This study aims to understand the negative impact that providing post-traumatic stress counseling has on military chaplains who have been deployed to a war zone and the military chaplains who have not been deployed to a war zone.

Conceptual Framework

Military chaplains' primary job is to ensure that religion's free exercise is supported in the military setting (Otis, 2009). Military chaplaincy dates back to July 1775, when the Army Chaplaincy program was established by the Continental Congress (Otis, 2009). The Navy followed suit in November of 1775 and established its Chaplain Corps that eventually supplied chaplains for the Navy, Marine Corps, and Coast Guard (Otis, 2009). Otis (2009) stated that approximately 3,000 chaplains are dispersed through the different military branches, providing ministry for over three million service members. Chaplains serve worldwide and can be found on military bases, ships, and deployed with their units, including combat tours (Seddon et al., 2011). What is unique to a military chaplain is that providing for the free exercise of religion is just one of the many duties the chaplain may perform. Otis (2009) stated, “[P]roviding leadership in religious services and pastoral care is the main job of the chaplains, yet military chaplains are not directly analogous to civilian clergy” (p. 7). There are distinct roles that military chaplains perform that civilian clergy may never experience, such as deploying with their military unit and experiencing direct combat action.

Civilian clergy and military chaplains perform crisis counseling, marital counseling, and bereavement counseling (Otis, 2009). A specific duty of military chaplains is to provide pastoral counseling and facilitate post-traumatic counseling (Otis, 2009). Yan and Beder (2013) stated that chaplains provide counseling for severe conditions such as PTSD, addictions, and traumatic brain injuries. It is evident that chaplains offer far more than just the free exercise of religion; they also provide valuable counseling services to military members in their time of need. The military chaplain's counseling duties are not limited to the routine task of providing marital and grief counseling. Still, they include some severe conditions that can potentially affect a chaplain's mental well-being. There are aspects of chaplain ministry that may draw a service member to a chaplain instead of military mental health providers.

Chaplains have a crucial advantage over other military mental health professionals in the way of complete confidentiality (Seddon et al., 2011). Seeking out a mental health provider in the military has stigmas attached, and they can be seen as corporate spies (Seddon et al., 2011). Military mental health providers also have to report specific subjects to higher authorities such as spousal abuse, child abuse, alcohol misuse, and the intention to inflict harm on self or others, where chaplains are not required to report these subjects due to complete confidence (Seddon et al., 2011). Collaboration is possible between chaplains and military mental health professionals. The chaplain works alongside mental health care providers providing a range of support services that include support counseling in a more confidential manner (Seddon et al., 2011).

Chaplains have an integral role in providing for spiritual fitness in the military. Among their many duties, they also provide mental health services to military members that have PTSD. Yan and Beder (2013) suggested a future study that examines the relationship between a chaplain's professional quality of life and the health outcomes of those the chaplain serves. To

further refine this suggested study would be the impact that PTSD counseling has on military chaplains based on the military's current rates of PTSD.

Terminology Associated with the Research

In everyday life, trauma abounds (Corrado, 2020). It can appear on the news, or a person can be impacted directly by a traumatic experience. America has been at war on two fronts for decades. There is also a heightened awareness concerning sexual assault and the debilitating aftereffects on a person's mental well-being. In all of these cases, trained mental health providers are ready to assist an individual working through the event's traumatic repercussions. Mental health providers may never have been victims of these incidents, but research has indicated that they are susceptible to developing similar symptomology through exposure (Cieslak et al., 2014). Lesser-known mental health providers, military chaplains, may also be vulnerable to trauma counseling's adverse effects. Three key terms that form the foundation of this literature review are PTSD, secondary traumatic stress (STS), and vicarious trauma (VT).

Post-traumatic Stress Disorder

The wars in Iraq and Afghanistan have placed PTSD in the national spotlight. PTSD is not unique to the military but can follow a wide range of trauma that a person has experienced in war or civilian life (Hapke et al., 2006). PTSD was first recognized and diagnosed among Vietnam veterans (Hapke et al., 2006). Eventually, PTSD was applied to a wide range of trauma experienced by a person (Hapke et al., 2006). Hapke et al. (2006) stated a conditional risk of PTSD after exposure to trauma that ranges between 7.8% and 23.6%. Lifetime prevalence rates for PTSD are estimated between 1.7% to 9.2% depending on age (Hapke et al., 2006). This number is not specific to the military. Still, the military does not operate in a vacuum, and a person's military experiences may result in trauma exposure and a diagnosis of PTSD.

Richardson et al. (2010) stated that U.S. combat veterans have a two to four-fold increase in PTSD prevalence than their civilian counterparts. There is an estimated prevalence rate of 4% to 17.1% (Richardson et al., 2010). Research has revealed a slightly higher rate of PTSD unique to the military (Richardson et al., 2010). Chaplains may have the opportunity to impact the lives of those who have PTSD, but the counselees' symptomology can be transferred to their counselor.

PTSD is characterized by three clusters of symptoms: re-experiencing, avoidance, and hyperarousal (Dekel & Monson, 2010). Avoidance is described by emotional detachment and a diminished interest (Dekel & Monson, 2010). Hyperarousal is characterized by sleep disturbances, irritability, and difficulty concentrating (Dekel & Monson, 2010). Re-experiencing symptomology includes intrusive memories and nightmares (Dekel & Monson, 2010). The characterizations of PTSD symptomology are an essential assessment tool when determining if any correlation exists between a military chaplain's duties as a trauma counselor and the impact on the chaplain's mental well-being. Another critical area for assessment is the health of the military members' current intimate relationships. Research has indicated a correlation between relationship and intimate partner aggression for those diagnosed with PTSD (Monson et al., 2009).

PTSD is prevalent in the military and can result from fighting a war on two fronts, the duration of deployments, and repeated exposure due to war (Richardson et al., 2010). Service members are at a greater risk for developing PTSD than their civilian counterparts (Richardson et al., 2010). Military chaplains stand at the ready to deliver PTSD counseling services. Some chaplains may have been in the rotation for deployments and experienced the traumatizing events of the war. There may also be a cadre of chaplains that have never experienced active combat. The symptomology of PTSD has some evident markers. Research may indicate whether

chaplains can have PTSD without stepping foot into a war zone based solely on the trauma counseling they have performed. The research may also suggest that secondary traumatic stress is an area that chaplains need to address when counseling clients with PTSD (Besterman-Dahan et al., 2013).

Secondary Traumatic Stress

Secondary traumatic stress (STS) is a condition that occurs in professionals who are working with clients that have suffered some form of trauma. Bride et al. (2007) defined STS as a reaction to secondary or indirect exposure to another's traumatic events. Figley (1995) described secondary trauma as “the natural consequent behavior and emotions resulting from knowing about a traumatizing event experienced by a significant other or the stress resulting from helping or wanting to help a traumatized or suffering person” (p. 7). In these two definitions of STS, two words stand out: “reaction” and “natural.” The two definitions show that STS is a natural phenomenon.

Hensel et al. (2015) stated that professionals who therapeutically worked with trauma victims presented higher STS levels or PTSD related to indirect trauma exposure only. Hensel et al. (2015) reported that 34% of child protective service workers and 15.2% of social workers had been diagnosed with STS. Following the events of September 11, 2001, where America was attacked, indirect exposure to the events had a PTSD rate of 4.6% compared to direct exposure rates of 6.4% (Hensel et al., 2015).

Military chaplains take on many different roles, and one of these roles is the desire to help people suffering from traumatic experiences. Chaplains may also be exposed to secondary or indirect exposure to a traumatic event. There is no way to insulate the mind from hearing and responding to a traumatic event's debilitating effects. Criteria A number 5 of the Diagnostic and

Statistical Manuel of Mental Disorders (DSM-5) indicates that experiencing repeated trauma exposure to the adverse details of traumatic events without physically being harmed or threatened is a criterion for the diagnosis of PTSD (American Psychological Association [APA], 2013). Crisis workers can be traumatized upon learning about the counselee's traumatic incident. These incidents can result from their role as first responders to a crisis or performing duties in a military hospital. Knowing STS characteristics allows for a deeper understanding of how STS exposure can affect the mental health provider.

STS can have debilitating effects on the trauma counselor. Ortlepp and Friedman (2002) stated that STS affects cognition and how trauma counselors view the world, themselves, and others. The cognitive schemata about the world and self are disrupted within the context of trauma counseling (Ortlepp & Friedman, 2002). Just as the mind is altered in the one who suffered the traumatic event, the one exposed to the story in trauma counseling is affected in the same way (Ortlepp & Friedman, 2002). Ortlepp and Friedman (2002) revealed that 43% of counselors who perform trauma counseling had been sensitized to others' suffering. Another 20% reported that they have become more aware of their family's vulnerability to traumatic events. Ortlepp's and Friedman's research also revealed that 20% of participants acknowledged a newfound awareness of life's transitory nature. But the most significant finding of this research is that trauma counseling made a permanent change in the counselors view in regards to the kindness of the world, self-worth, and how they felt towards others afterward (Ortlepp & Friedman, 2002). The permanent change in cognitive schemata can harm trauma counselors. Another interrelated type of trauma in this area, known as vicarious trauma (VT), can also impact the trauma counselor.

Vicarious Trauma

Vicarious trauma (VT) is the cognitive schemata changes of the trauma counselors' views of themselves, the world, and others (Baird & Kracen, 2006). STS refers to a set of psychological symptoms that mimic PTSD and are a result of direct exposure to hearing a trauma survivor's story (Baird & Kracen, 2006). As the counselor listens to the traumatic event's development that has affected the person, the counselor's mind can potentially be altered, resulting in VT. As the mind continues in the trajectory of repeated exposure to traumatic events stated by the patient, the counselor can diagnose PTSD.

VT can also be seen as a natural consequence that may be unavoidable by the trauma counselor due to the empathic engagement with the client material that makes a mental health professional susceptible to VT. This is another area that needs self-assessment. Baird and Kracen (2006) stated that VT is a "normal response to ongoing challenges to a helper's beliefs and values but can result in a decreased motivation, efficacy, and empathy" (p. 182). VT can have adverse effects in the counseling environment as the counselor's mind becomes changed by the exposure. VT disrupts five cognitive schemas: safety, trust, esteem, intimacy, and control, all of which represent a psychological need (Baird & Kracen, 2006). The mind can be permanently altered by exposure to traumatic events through counseling.

Research on VT's experience has shown that there is some evidence that the amount of exposure to clients' traumatic stories increases VT's likelihood (Baird & Kracen, 2006). Research has also suggested that there is persuasive evidence that the development of VT and personal traumatic experiences are related (Baird & Kracen, 2006). Clinicians face OEF (Operation Enduring Freedom) and OIF (Operation Iraqi Freedom) veterans that present acute onset of PTSD that presents itself in a very raw or aggressive presentation that poses significant

stress in clinicians (Voss Horrel et al., 2011). There are immediate and long-term emotional and cognitive impacts of vicarious trauma exposure in four separate but interrelated terms (Cohen & Collens, 2013). The four impacts include the emotional and somatic reactions, coping with the emotional effects of trauma counseling, the changes in schemas and behaviors, and the process of schematic change concerning the experience and time performing trauma counseling (Cohen & Collens, 2013). The emotional responses that a trauma counselor experiences occur while and after the client's traumatic story is told (Cohen & Collens, 2013). Counselors should guard themselves against trauma counseling's side effects, and self-help must be a part of the process.

Because counselor impairment can have a negative impact on the outcome of therapy, seeking help at the first sign of danger can alter the cognitive path of destruction resulting from unchecked VT and STS. It is also equally important to recognize that VT and STS are natural phenomena. Ensuring an accountability system is in place can alter the course of the adverse side effects of trauma counseling. Because of VT and STS's organic nature, there is a need to continue to research the impacts for mental health professionals and clergy, more specifically military chaplains, to increase the awareness of the dangerous side effects of trauma counseling.

Related Literature

The terms “clergy” and “mental health professionals” may not seem synonymous. In the military world, the chaplain is often the first defense line when a person has experienced trauma. When a military unit undergoes some traumatic event, military chaplains are often called upon to facilitate group therapy to help the military members work through the incident. Chaplains may also be called upon to work with an individual experiencing some type of trauma, whether from war or adverse life experiences. The chaplain is a vital link to mental health professionals who stand ready to help the mentally unwell (Nieuwsma et al., 2013).

The introduction discussed the chaplain's role and the various roles a chaplain may fill. One of those roles was counseling members of the military that have been diagnosed with PTSD. Nieuwsma et al. (2014) stated that veterans are more likely to turn to clergy due to their military experiences and had unique motivations for doing so. A military member's personal reasons to seek out a chaplain for counseling include a chaplain's commitment to confidentiality and involvement in military members' daily lives, which provides a safe and accessible point of contact for an emotional problem (Nieuwsma et al., 2014). Wang, Berglund, and Kessler (2003) stated that clergy were significantly sought out by people suffering from mental disorders at a rate of 24%. Psychiatrists were sought out by 17% of the population seeking help for mental health, and another 17% sought out a medical doctor (Wang et al., 2003). These statistics can be a manifestation of expectations.

These statistics can also be a representation of the military member's expectations of the outcome of counseling. Symptom severity for a person with PTSD may not be the primary motivation for seeking counseling (Nieuwsma et al., 2014). The person living with PTSD might seek a new meaning to life based on the concept that wartime experiences can cause moral injury (Nieuwsma et al., 2014). Often, chaplains can be seen as the moral authority of the military unit. A moral injury is a construct used to describe a disruption in an individual's sense of personal morality and capacity to behave in a just manner (Drescher et al., 2011). Moral injury received in war can be alleviated by a chaplain's initiative to show counselee's a different perspective in life. Nieuwsma et al. (2014) stated that the spiritual and religious struggles that ensue from combat experiences could result in service members seeking out a chaplain for mental health services.

A military unit will often have a chaplain attached to it. Seeking out a chaplain for mental health services allows the service member to see someone they are familiar with in a convenient

setting (Nieuwsma et al., 2013). Nieuwsma et al. (2013) stated that stigmas could prevent service members from seeking treatment for mental health issues because they are afraid they may seem weak or that receiving treatment may harm their career. A military member concerned about the stigmas attached to receiving mental health care may seek a chaplain's counsel because of his or her unique position on confidentiality.

Commanding officers of military units have a deep-seated interest in what is going on within their command. These concerns include the mission and the people entrusted to the commanding officer to make the mission happen. Round table meetings occur between the commanding officer, senior enlisted advisor, unit medical doctor, division leaders, and the chaplain. They give the commanding officer a pulse on the commanding officer's physical and mental well-being (Otis, 2009). Although advising the commanding officer is another role of chaplains, chaplains ensure any identifying information is withheld. This confidentiality is attractive to service members who need to confide in someone (Nieuwsma et al., 2014). This confidentiality is considered the main advantage of seeking out a chaplain for mental help (Nieuwsma et al., 2013). A mental health provider may pass along the current mental health of a service member to the commanding officer, which may negatively mark the service member's career (Nieuwsma et al., 2013).

One of the chaplain's many roles in the military is to serve as a crisis counselor (Nieuwsma et al., 2014). The chaplain is a source of comfort and familiarity within the unit and may also be a convenient resource, but chaplains' counseling abilities are often limited. Chaplains can be a possible bridge that allows the service member to begin in a comfortable spot and eventually transition into seeing a mental health professional. Nieuwsma et al. (2014) stated that there is a possibility that veterans with a mental health disorder would prefer to visit with a

chaplain to receive mental health services. Mental health providers may have their apprehensions about chaplains serving in a mental health capacity. Still, their services place hesitant military members in a better position to receive the help they need (Nieuwsma et al., 2014). The service members may also seek out two avenues of care based on the concept that mental health providers tend to the mind and chaplains heal the soul (Nieuwsma et al., 2014). This relates to the idea that PTSD is a psychological disorder that has adverse effects on the individual's moral code. This is an essential aspect of the current literature review in that the chaplain may be tending to the spiritual wounds that wartime experiences have inflicted. However, they are still being exposed to the stories of how the service members' experiences have impacted them both spiritually and psychologically. This aspect can place the chaplain at risk for developing VT and STS.

A chaplain has many different roles within the military. Chaplains are a beacon to those who have suffered mental wounds. They provide a source of relief through a holistic counseling framework. They tend to the mind and the soul. They provide the service member solace based on their requirement to maintain strict confidentiality. They may have to advise the commander on religious matters, but they do not have to brief the commander on who they are counseling and why. However, mental health providers have limitations of confidentiality, and therefore the service member may be inclined to avoid seeking care through them. Military chaplains are active in their duties to care for the mental and spiritual wounds of war. As providers of mental health services, it is essential to understand the effects PTSD counseling has within this profession.

Trauma Counseling Effects on Mental Health Professionals

Military chaplains and mental health professionals may not seem synonymous. However, the reality is that in a military setting, the military chaplain may have a better chance of reaching a military member that has suffered a mental wound. But there are associated job hazards. Research has shown that mental health providers that offer trauma counseling are more likely to develop STS (Bride & Figley, 2009). Mental health providers offer services that encompass mental health, child welfare, healthcare, and social work (Bride & Figley, 2009). If the military mental health provider is listed as having this occupational hazard, military chaplains are also at risk. Research on this topic has been thorough, and prevalence rates are evident for this occupational hazard (Cieslak et al., 2013).

Prevalence rates indicated that 70.2% of social workers had experienced at least one symptom of STS (Bride & Figley, 2009). Another 55% met the criteria for at least one core PTSD symptom cluster (Bride & Figley, 2009). Finally, 15.2% of the study's social workers met the criteria for PTSD (Bride & Figley, 2009). Understanding these prevalence rates and how they relate to a military chaplain being viewed as a social worker is essential. Military chaplains stand at the ready to help the community that they have been assigned to serve. The willingness to serve those affected by the mental wounds of war can also be a variable that leads to a chaplain's STS development.

Several variables can contribute to a chaplain's development of STS. Typically, STS comes on fast and can occur from consecutive interactions with traumatized clients (Galek et al., 2011). STS can also stem from a specific event, and there is a correlation between the number of hours spent counseling trauma clients and non-trauma clients and the development of STS (Galek et al., 2011). Another variable that can lead to STS is the years spent working with traumatized clients (Galek et al., 2011). America has been at war for well over a decade, and

there are still troops being deployed to various locations that may be in a combat role. Chaplains that have been with units since the inception of the Iraq and Afghanistan wars and remain today can have a long history of serving clients with PTSD. This work can put them at risk for STS and handicap the therapeutic environment based on STS's effects. However, trauma counseling is not always debilitating for the caregiver.

A person who is suffering from a mental health issue and is on the right track toward positive change in their mental well-being can create exhilaration, heightened levels of motivation, high energy, and mental alertness in the mental health professional (Craig & Sprang, 2009). This is called optimal stress and is healthy for a mental health professional to maintain (Craig & Sprang, 2009). However, the norm is that stress levels become excessive, and then the high level of stress threatens to overwhelm the mental health provider's self-efficacy (Craig & Sprang, 2009). This is a catalyst that can create a downward spiral into burnout, compassion fatigue, and STS, as mental health providers are susceptible to trauma counseling's adverse effects (Craig & Sprang, 2009).

Combat Experiences

America has been at war for over 15 years on two fronts (Burns & Miller, 2020). Over the last few years, deployments have decreased, but American troops are still a small presence overseas (Burns & Miller, 2020). Since 2001, there has been an increase in military operations and traumatic events for service members that have had a reciprocal effect on the caretakers (Owen & Wanzer, 2014). Owen and Wanzer (2014) stated that 20-30% of military personnel deployed to a combat zone experienced some psychological disturbance within the military health care team, including compassion fatigue, which resulted in decreased job performance or leaving the profession. Military health teams are comprised of medical doctors, nurses, combat

medics, and chaplains (Owen & Wanzer, 2014). Deployments and combat experiences can harm the mental health care team, and chaplains are especially susceptible to trauma counseling's side effects.

STS is a personal response to traumatic stress, and chaplains who deal with persons exposed to traumatic events are susceptible to traumatic reactions (Hotchkiss & Lesher, 2018). Chaplains benefit from the emotional rewards for caring for service members, a term known as compassion satisfaction (Hotchkiss & Lesher, 2018). There is a desire to reap the internal emotional rewards of helping a service member work through combat experiences' psychological wounds. However, with this also comes the occupational hazard of developing STS. Compassion satisfaction is how a chaplain can mitigate the damaging effects of trauma counseling through self-care practices. Hotchkiss and Lesher (2018) stated that STS and self-care practices mediated the relationship between compassion satisfaction and burnout risk.

It is essential to consider STS and self-care when determining the impacts of providing PTSD counseling to military members on military chaplains. Wartime experiences can alter the mind, especially when dealing with a heavy caseload of psychological wounds. Intrinsic emotional rewards for the chaplain can result from a positive counseling session. Self-care methodologies are important to consider regarding whether wartime experiences have created a negative or positive perception of the world and the duties chaplains have been called to perform. One of those duties is caring for deployed members.

Combat Deployments and the Chaplain's Role

According to the Geneva Convention, military chaplains are considered non-combatants (Otis, 2009). They do not go into war with a weapon or the mindset to close in on the enemy and destroy them by any means. In a deployed setting, chaplains are called to be team members of the mobile Combat Operational Stress Control teams that provide care for combat stress (Besterman-Dahan et al., 2012). They are a conduit between mental health care providers and service members to provide mental health care services when there is no immediate access to mental health care providers (Besterman-Dahan et al., 2012). The deployed chaplain has first-hand knowledge of life in a combat zone and can relate to service members' psychological distress (Besterman-Dahan et al., 2012). The chaplain in a combat zone can be seen as the psychologic medic that provides first aid after a traumatic event (Besterman-Dahan et al., 2012). Deployments for chaplains do not exempt them from caregiver strains or wartime stressors.

Levy et al. (2011) found that operational stress exposure was predictive of PTSD symptoms in chaplains. Levy et al. also uncovered that counseling stressors were not predictive for developing PTSD despite exposure to high-level counseling sessions. A key takeaway from this research is that not all chaplains were immune to wartime stressors and caregiver strains (Levy et al., 2011). Chaplains that experience wartime stress and caregiver strains and develop PTSD due to trauma counseling or wartime experiences may be a minority but are still important.

Summary

Since 2001, America has been involved in some form of combat overseas (Peters & Plagakis, 2019). The surge of military deployments has waned over the last few years, but the psychological impacts still affect service members and their mental health care providers.

Chaplains are an integral part of the mental health care team. They may also be the only source a military member seeks for mental health counseling. This is just one of the various roles that a chaplain performs. STS and VT affect military chaplains, just like any other mental health care provider; these are natural responses to hearing traumatic experiences. The military is also fluid; Chaplains come and go just like any service member. There is an old guard of chaplains and a new guard of chaplains. Just like any occupational field, there is an ebb and flow of personnel. The old guard of chaplains is those that have been involved in direct combat. The new guard of chaplains has no direct combat experience yet is exposed to combat veterans' traumatic experiences. The veterans of the wars remain in the service and may still be carrying their psychological wounds from the wars. With the wars in Iraq and Afghanistan winding down, how will the chaplains be psychologically impacted by tending to warfare's mental wounds? Based on the literature associated with counseling victims of a traumatic experience, military chaplains will suffer some adverse effects.

CHAPTER THREE: METHODS

Overview

The impact of post-traumatic stress disorder (PTSD) counseling on military chaplains will be assessed through a quantitative research design. The methodology is the cornerstone to determine any correlation between PTSD counseling and STS symptomology due to vicarious traumatization within the military chaplain community. This chapter will explain the methods of evaluating the impact of PTSD counseling on military chaplains scientifically. The design, research questions, participants, measures, variables, statistical procedures, and threats to the data will be evaluated.

Design

This research project elicited a person-centered research design that employed a quantitative framework. Heppner et al. (2016) stated that a person-centered research design is useful when analyzing individuals' heterogeneous groups. In this study, the investigator sought to determine PTSD counseling's impact on military chaplains' mental well-being. Many different layers can affect a military chaplain that is performing PTSD counseling. There is a difference between a chaplain with combat experience that performs PTSD counseling and a chaplain that has never deployed or performed PTSD counseling. The study utilized analysis of variance (ANOVA) one way between subjects as the preliminary design. Cluster analyses were used to categorize different groups as they relate to the research questions. The research design evaluated the research questions associated with this research project.

Research Questions

There are four research questions associated with the current research design. The research questions allowed for evaluating a possible correlation between personal trauma

experiences, if any, in the military chaplain's survey results and assessed how PTSD counseling impacted the chaplain professionally and personally. The four research questions are as follows:

RQ1: How frequently do chaplains counsel military members with PTSD?

RQ2: Is there a majority or minority of chaplains suffering from PTSD symptomology due to wartime experiences?

RQ3: How has a military chaplain that has never deployed to a combat environment been affected by PTSD counseling?

RQ4: Is there a correlation between PTSD counseling and STS in military chaplains that have never experienced psychological trauma?

Hypothesis

This research study evaluated the negative impacts of PTSD counseling on military chaplains. The dependent variable for this study was STS symptomology. There are several independent variables associated with the study. The first of these variables is the chaplain's combat experience (to what degree has their combat experiences changed them). Another independent variable is PTSD counseling. This allowed for examining the amount of counseling performed over their tenure to establish a baseline of whether this is commonplace in the Chaplain Corps. How has trauma counseling impacted the chaplain, and is the development of STS viable? Cognitive schemas are an important area to assess regarding the impact on the chaplain and their frame of mind. This can also lead to a covariate from the effects of trauma counseling, PTSD counseling, and changing cognitive schemas. The final independent variable was PTSD counseling and how the chaplain has been impacted by the counseling work they perform.

The alternate hypotheses for this study are:

Ha1: There will be a statistically significant difference in STS symptomology between military chaplains that have never deployed or counseled military members with PTSD and chaplains that have deployed or counseled military members with PTSD.

Ha2: War and its indirect effects change the psyche of a chaplain operating in war and performing counseling for those who have direct combat experiences as measured by the Combat Exposure Scale (CES), Secondary Traumatic Stress Scale (STSS), Impact of Events Scale-Revised (IES-R), and Post-traumatic Checklist for DSM-5-Military (PCL-M).

Participants and Setting

The research design was geared explicitly towards military chaplains. The investigator's endorsing agent granted access to their military chaplains' network through an emailed survey link. The ecclesiastical endorser allowed for disseminating the survey across the military's three branches that chaplains serve, including the United States Army, the United States Navy, and the United States Air Force.

The participants for the study would include male and female participants. Based on the biblical requirements for serving in a pastoral role, most participants would be male. A requirement for military chaplaincy is that the individual has achieved a master's level of theological training in their denomination. The military also requires a master's level of experience to serve as a chaplain. The participant pool was male-dominated, with participants having a minimum of a masters-level education.

Instruments

Several different measures were utilized for the development of the survey. Basic demographics will identify the chaplain's branch of service, gender, number of times they have engaged in counseling with a service member with PTSD, and years served. The measures used

for the research include the Combat Exposure Scale (CES), Secondary Trauma Stress Scale (STSS), Impact of Event Scale-Revised (IES-R), Trauma and Attachment Belief Scale (TABS), World Assumptions Scale (WAS), and the Post-traumatic Checklist-Military Version (PCL-M). Permission was sought to use the scales to meet the study's objective. Each scale was utilized in its entirety to understand how the combined level of combat exposure and post-traumatic counseling has impacted a chaplain's psyche and worldview. Chaplains are non-combatants, do not bear arms, and, therefore, may not be directly involved in firefights, though some chaplains have been exposed to near-death experiences in combat. The variable of "combat near-death experiences" with military chaplains was requested in the survey's CES. Due to the uncertainty of this variable, the investigator will control this measure. If more than 10% of the participants report this variable, the researcher will perform a covariate analysis. If fewer than 10% of the participants indicate this variable, these participants' responses will be eliminated. This may reduce the number of questions required on the CES. Performing post-traumatic counseling can alter the cognitive schema in a chaplain. Therefore, the other scales are vital in determining any correlation between trauma counseling experiences and the development of a belief that they [the chaplain] were on the battlefield and no longer view the world as safe.

Combat Exposure Scale

The Combat Exposure Scale (CES) is a seven item self-assessment tool that measures the level of combat exposure a service member has experienced. It was developed out of a need to measure combat exposure in a way that was easily administered, easily scored, and possessed good psychometric properties and a certain degree of external validity (Keane et al., 1989). CES utilizes a set of Likert-type questions that evaluate combat exposure levels based on a scale of one through five. A rating of one would indicate no exposure; a rating of five would indicate

exposure to certain combat experience elements that occurred fifty-one or more times. Keane et al. (1989) stated that CES merits consideration for clinicians' and researchers' further use. Guyker et al. (2013) indicated that CES's validity and reliability had strong internal consistency. The research also verified that CES has strong internal and external validity (Guyker et al., 2013). Regarding internal validity, Guyker et al. (2013) estimated that this sample's internal consistency was adequate; the Cronbach Coefficient, *a*, for the exposure to the combat environment, close physical engagement, and nearness to serious injury or death scales were .94, .81, and .82, respectively. External validity for the aspects of combat experience where a veteran felt at serious risk had a value of $r= 0.76, 0.58$, and $0.52, p< 0.0001$ for exposure to a combat environment, direct physical engagement, and nearness to serious injury or death of others (Guyker et al., 2013).

Secondary Trauma Stress Scale

The Secondary Trauma Stress Scale (STSS) is a 17-item instrument that utilizes a Likert-type scale to assess the frequency of secondary traumatic stress symptoms experienced by counselors (Bride et al., 2004). The STSS assesses the frequency of intrusion, avoidance, and arousal symptoms associated with PTSD (Bride et al., 2004). Five questions assess intrusion frequency and have a reliability score of .80 (Bride et al., 2007). Avoidance has seven items with a reliability score of .87 (Bride et al., 2007). Arousal contains five questions and has a reliability score of .83 (Bride et al., 2007). Overall, the STSS has a reliability score of .93 (Bride et al., 2007). Bride et al. (2004) stated that the STSS fills the need for a reliable and valid instrument specifically designed to measure the adverse effects of trauma counseling on the counselor. The STSS is also easily administered, scored, and interpreted (Bride et al., 2004).

Trauma and Attachment Belief Scale

The Trauma and Attachment Belief Scale (TABS) assesses disruptions in cognitive schemas in five areas of psychological need: control, esteem, intimacy, safety, and trust (Bride et al., 2007). TABS is a measure based on the constructivist self-development theory that contains 84 items (Bride et al., 2007). The scale utilizes a Likert-scale with scores ranging from 1=strongly disagree to 6= strongly agree in 10 subscales that measure each of the psychological need areas concerning self and other (Bride et al., 2007). The ten subscales are listed as 1) self-safety, 2) other-safety, 3) self-trust, 4) other-trust, 5) self-esteem, 6) other-esteem, 7) self-intimacy, 8) other-intimacy, 9) self-control, and 10) other-control (Bride et al., 2007). TABS reliability has a range of .77-.91 for the 10 subscales and carries an overall reliability score of .98 (Bride et al., 2007).

Impact of Event Scale-Revised

The Impact of Event Scale-Revised (IES-R) was developed to measure the distress related to a singular traumatic experience based on two measures of intrusion, avoidance, and hyperarousal (Bride et al., 2007). The intrusion scale comprises seven items that assess unwanted thoughts about the stressor (Bride et al., 2007). The avoidance scale encompasses eight items that measure blunted sensation, behavioral inhibition, and awareness of emotional numbness (Bride et al., 2007). Hyperarousal contains seven items (Bride et al., 2007). IES-R uses a Likert Scale on a four-point range, where 0= not at all, 1= rarely, 3= sometimes, and 5= often, indicating how often symptoms have been experienced in the past week (Bride et al., 2007). Bride et al. (2007) stated that IES-R had shown adequate evidence of convergent and discriminant validity. The full scale has alphas of .93, intrusion .80, avoidance .87, and arousal .83 (Bride et al., 2007).

World Assumptions Scale

Bride et al. (2007) stated that the World Assumptions Scale (WAS) measures the cognitive schemas changes associated with trauma. This scale contains 32 items and has three subscales that include benevolence of the world, the world's meaningfulness, and self as worthy (Bride et al., 2007). The instrument utilizes a six-point Likert scale that ranges from 1= strongly disagree to 6= strongly agree (Bride et al., 2007). Bride et al. stated that each instrument has a level of evidence regarding its validity and usefulness for specific purposes. Bride et al. confirmed that the WAS demonstrated adequate internal consistency with alphas of .82 for the benevolence of the world, .74 for the meaningfulness of the world, and .77 for self as worthy.

Post-traumatic Checklist-Military Version

The final measure for the research will be the Post-traumatic Checklist-Military Version (PCL-M). Weathers et al. (1993) stated that the PCL contains 17 items that correspond to the symptoms of PTSD. The questions correspond to the DSM symptomology of PTSD. The scale utilizes a Likert scale that indicates how much the examinee has been bothered by each symptom in the last month using a five-point scale from not at all to extremely often (Weathers et al., 1993). The difference between the PCL and the PCL-M is that the PCL-M is explicitly written for military experiences and includes re-experiencing symptoms.

In contrast, the PCL-C is generally written for a traumatic experience (Weathers et al., 1993). Weathers et al. stated that the PCL is useful in various research contexts and is easily disseminated through email when interviews are not feasible (Weathers et al., 1993). Weathers et al. reported that the PCL has excellent test-retest reliability and has very high internal consistency. The alpha coefficient was .90 for B symptoms, .89 for C symptoms, .91 for D symptoms, and .96 for all 17 symptoms (Weathers et al., 1993).

Procedures for the Study

The research utilized a quantitative research design that relied on survey research. The survey was administered through PsychData.com. It was disseminated through email to the ecclesiastical endorsing agent. Confidentiality for the survey was achieved through a disclosure at the beginning of the survey. The disclosure ensured the research participant understood that the researcher also had confidentiality in mind, which reduced personally identifiable information in the survey. To ensure this standard was met, the researcher asked general questions of the branch of service, gender, and faith background. Informed consent stated that the research collected would not be used outside of this project's scope for other endeavors. The confidentiality statement requested research participants to complete the survey in one sitting, never leave their computers unattended during the survey, and completely close their browsers after completing the survey. Finally, the confidentiality page allowed the participant to understand the data collected and its use for research purposes.

The online survey included demographic items such as general faith group (Protestant or Catholic), age, history of deployments, and the number of years participants have served in the military. Participants were asked for their level of involvement in mental health counseling for military members with PTSD. The procedures established a baseline for developing the different groups of chaplains to be evaluated in the study. The groups that emerged from the demographic information were males who have deployed or never deployed and have not performed PTSD counseling. The purpose of the study was to examine the effects of PTSD counseling on military chaplains. Those that had never offered PTSD counseling or had not been exposed to service members exhibiting the symptoms of PTSD were asked to submit the survey without answering the questions that pertain to the impact of PTSD counseling on the caregiver.

The participants who stated they had performed PTSD counseling were placed into two groups—those deployed and those not deployed. This part of the research utilized a simple mediation method of statistical analyses. The next section of the survey assessed the level of impact that PTSD counseling had on the individual chaplain. This took the causal agent of PTSD counseling and measured for the effects on Y, a military chaplain. Various measures that assess vicarious trauma, combat exposure, and PTSD determined how chaplains are affected by PTSD counseling.

Time in completion of the research survey is also a critical element. Various measures were utilized in the research. To limit the survey completion time to 30 minutes, a unique survey was developed that used multiple measures to ensure enough information was obtained to capture the essence of the research. Research participants had two weeks to complete the survey once the study was live.

Data Analysis

The statistical procedure for this study was an independent sample t-test. This enabled the researcher to evaluate groups and determine how chaplains are affected by PTSD counseling. One group of chaplains consisted of the chaplains who had never been deployed or performed PTSD counseling. The other group was the chaplains that had deployed and offered PTSD counseling. Another statistical approach that can effectively determine the correlation between variables is Pearson's *r*. This statistical procedure allowed the researcher to examine each category, i.e., chaplains that had not deployed and those who had deployed, and the correlation between the different independent variables. This procedure shows the strength of the linear relationship between two variables (Warner, 2012).

Issues in Research

There are numerous threats to research that can affect the causal relationships between variables. A thorough review of the literature revealed a causal relationship between trauma counseling and STS (Elwood et al., 2011). The research project had an end goal to determine if this relationship also exists within the Chaplain Corps and possibly highlight a need that might be unseen or hidden.

The cornerstone of the research is the survey that was disseminated to chaplains. Internal validity of the survey results may show a causal relationship between variables, but surveys can be passive. There is no control over the survey participants regarding how they answer the questions and their attitudes towards another survey. Passively answering the questions can show a causal relationship when it may not exist. Passivity can also be the cause of a Type II error, where the responses to the survey questions reveal a relationship when no relationship exists.

External validity can be threatened due to the research that has been conducted in other professional counseling fields. The research is exhaustive on how mental health providers are susceptible to STS. If chaplains are included in this professional area, they must also be in the category of individuals that are susceptible to developing STS and PTSD. Type I errors can occur in this area because mental health professionals are susceptible to STS and chaplains who are also engaged in counseling trauma survivors would also be susceptible to STS. Careful attention was placed on sampling errors and ensuring that the data received was truthfully presented to identify if there is any relationship between the variables. A truthful representation of the data utilized the confidence interval to understand the magnitude of sampling errors. This objective was achieved by first explaining that this research is specific to military chaplaincy to identify if there is a need for heightened awareness in secondary traumatic stress. The research does validate that STS exists in chaplaincy due to providing counseling to victims of traumatic

events, but what is not known is the rate at which this occurs; consequently, accuracy in reporting is essential to validate a need for greater care in this area.

Some other threats to the research are low statistical power and extraneous variance in the setting. Low statistical power is a genuine threat to the research project since the military utilizes surveys for training and healthcare purposes. Sampling size can also be reduced if the chaplain is at a high operational tempo and does not have the time to complete a lengthy survey. The survey was designed to succinctly capture the variables' full effects and highlight why this research is vital to the profession. Extraneous variance in setting can also affect the study. Not all chaplains remain stateside, and some of the chaplains that received the survey may be deployed. Their stressors may have been different than the stressors of those that were not deployed. The answers to the survey could vary depending on whether chaplains were deployed or not.

Summary

The research is focused on the impacts of trauma counseling within the military chaplaincy community. The study sought to understand the level of counseling chaplains perform and how their schemas were impacted when performing trauma counseling. Several scales were utilized to empirically assess the impacts of trauma counseling supported for validity. These scales were administered through an online survey that included demographic information and confidentiality assurance for the survey. The research methods had an end goal of assessing trauma counseling impacts for military chaplains deployed to combat zones and chaplains that had not been deployed to combat but who were still performing PTSD counseling.

CHAPTER FOUR: FINDINGS

Introduction

The data used in the current study were collected from a sample of 21 respondents who were randomly selected to avoid bias and reduce type I error. The data was collected through PsychData online using a questionnaire. The questionnaire was divided into five sections: the consent section (Consent Form), demographics, the Combat Exposure Scale, PTSD Checklist, The Impact of Event Scale, World Assumptions, Trauma and Attachment Belief, and The Secondary Traumatic Stress Scale. The data collected was numeric. The research design employed in the current study was an exploratory one as the researcher was seeking to uncover the effects of PTSD counseling on military chaplains. The data were first analyzed using descriptive statistics, central tendency, dispersion, and frequency, after which an Anova test was used to analyze the research hypotheses in SPSS.

Descriptive Statistics

Several measures were used in the research. Each measure, including the demographics, was analyzed for frequencies. The measures were used to develop a greater understanding of the frequency of PTSD counseling, combat experiences, and how the chaplain's experiences impacted their psyche.

Respondents' Demographics

All 21 respondents were male (100%), indicating gender inequality in the sample. Four (19%) of the respondents served in the United States Navy, five (23.8%) in the United States Air Force, and 12 (57.1%) in the United States Army. The majority of the respondents, 14 (66.7%), were active in terms of duty status at the time of the study, while seven (33.3%) were on reserve. Two (9.5%) of the respondents served in the military for zero to three years, seven (33.3%)

served for four to 10 years, three (14.3%) served for 11 to 15 years, seven (33.3%) served for 16 to 20 years, and two (9.5%) served for 21 years or more. The majority of the respondents, 10 (47.6%), engaged in counseling a service member with PTSD 16 or more times. Two (9.5%) of the respondents were not involved in PTSD counseling, one (4.8%) of the respondents engaged in PTSD counseling one to two times, two (9.5%) counseled three to four times, two (9.5%) counseled five to six times, two (9.5%) counseled seven to 11 times, and two (9.5%) counseled 12 to 15 times. The demographic results in Table 1 show that most of the respondents, 20 (95.2%) were Protestants, while one (4.8%) was a non-denominational Christian.

Table 1

Summary of Respondent's Demographic Profile

Gender			
	Frequency	Percent	Cumulative Percent
Male	21	100	100
Branch of Service			
United States Navy	4	19	19
United States Air Force	5	23.8	42.9
United States Army	12	57.1	100
Duty Status			
Active	14	66.7	66.7
Reserve	7	33.3	100
Years of Military Service			
0-3	2	9.5	9.5
4-10	7	33.3	42.9
11-15	3	14.3	57.1
16-20	7	33.3	90.5
21+	2	9.5	100
Number Of Times That You Have Engaged In Counseling A Service Member With PTSD Counseling			
0	2	9.5	9.5
1-2	1	4.8	14.3
3-4	2	9.5	23.8
5-6	2	9.5	33.3
7-11	2	9.5	42.9
12-15	2	9.5	52.4

16+	10	47.6	100
Religious Affiliation			
Protestant	20	95.2	95.2
Christian (Non-Denominational)	1	4.8	100

Respondents' Combat Exposure

Respondents' combat experience was measured using the Combat Exposure Scale (CES), which has seven items. The respondents' CES score was computed as the total of the seven items.

Combat Patrols/Dangerous Duties

Most of the respondents, 11 (52.4%), have not gone on combat patrols, nor do they have dangerous duties. Three (14.3%) of the respondents went on combat patrols one to three times, while four (19%) went on combat patrols four to 12 times. Two (4.8%) of the respondents went on combat patrols either 13 to 50 times or 51 times or more. There was one missing case; hence the data was analyzed based on 20 respondents, as observed in Table 2 below.

Table 2

Summary of Frequency of Going on Combat Controls

	Frequency	Percent
0	11	52.4
1-3 times	3	14.3
4-12 times	4	19
13-50 times	1	4.8
51+ times	1	4.8
Missing	1	4.8
Total	21	100

Under Enemy Fire

Respondents were asked to respond to the question, "Were you ever under enemy fire?" The frequency results are as shown below. Fourteen (66.7%) of the respondents reported never

being under enemy fire. Two (9.5%) were under enemy fire for less than one month, one (4.8%) was under enemy fire for one to three months, two (9.5%) were under enemy fire for four to six months, and one (4.8%) was under enemy fire for more than seven months. There was one missing case in this variable (see Table 3 below).

Table 3

Summary of Response to Being Under Enemy Fire

	Frequency	Percent
Never	14	66.7
<1 month	2	9.5
1-3 months	1	4.8
4-6 months	2	9.5
7+ months	1	4.8
Missing	1	4.8

Surrounded by the Enemy

As shown in Table 4 below, most of the respondents, 19 (90.5%), were never surrounded by the enemy, while one (4.8%) of the respondents was surrounded by the enemy more than 26 times. Only 20 cases were considered valid for this item as one of the cases was missing.

Table 4

Summary of Respondent's Being Surrounded by the Enemy

	Frequency	Percent
0	19	90.5
26+ times	1	4.8
Total	20	95.2
Missing	1	4.8
Total	21	100

Percentage of Wounded, Killed, or Missing Soldiers in Respondents' Units

As shown in Table 5 below, 15 (71.4%) of the respondents indicated no one in their unit was killed, wounded, or went missing in action. Five (23.8%) of the respondents reported up to

25% of the soldiers in their unit were either killed, wounded, or went missing in action. This analysis is based on 20 participants, as one of the cases was missing.

Table 5

Summary of Soldiers Wounded/Killed/Gone Missing in Respondent's Unit

	Frequency	Percent
None	15	71.4
1-25%	5	23.8
Missing	1	4.8
Total	21	100

Respondents' Firing Rounds, Being Hit by Incoming/Outgoing Rounds, and Being in Danger

As illustrated in Table 6, most respondents, 20 (95.20%), have never fired rounds at the enemy. Further, 17 (81%) of the respondents never saw someone hit by incoming or outgoing rounds, two (9.5%) saw someone hit by incoming or outgoing rounds one to two times, and one (4.8%) saw someone hit by incoming or outgoing rounds three to 12 times. The majority of respondents, 13 (61.9%), were never in danger of being injured or killed. Five (23.8%) of the respondents have been in danger of being injured or killed one to two times, one (4.8%) respondent was in danger of being injured or killed three to 12 times, and one (4.8%) respondent was in danger of being injured or killed more than 51 times.

Table 6

Frequency of Respondent's Firing Rounds, Observing Someone Hit by Incoming/Outgoing Rounds, and Being in Danger

	Never	1-2 times	3-12 times	13-50 times	51+ times
How often did you fire rounds at the enemy?	95.20%				
How often did you see someone hit by incoming or outgoing rounds?	81%	9.50%	4.80%		

How often were you in danger of being injured or killed (i.e., being pinned down, overrun, ambushed, near miss, etc.)?	61.90%	23.80%	4.80%	4.80%

Combat Exposure Scale Scores

Respondents' CES (Combat Exposure Scale) score was measured by summing up the seven CES item responses. The total CES is usually categorized into five categories: 1 (light) = 0-8, 2 (light to moderate) = 9-16, 3 (moderate) = 17-24, 4 (moderate to heavy) = 25-32, and 5 (heavy) = 33-41. Based on this criteria, 16 of the respondents have a light CES score, three have a light to moderate CES score, and one has a moderate to heavy CES score. Further, results in Table 7 indicate that on average, the respondents' CES score is seven (9.85 ± 0.963(*SD* = 4.308). The highest CES score was 24, while the lowest was seven.

Posttraumatic Checklist Scores

The respondent's post-traumatic stress and disorder (PTSD) was measured utilizing the PTSD Checklist for DSM-5 (PCL-5), which includes 20 items measured on a five-point Likert Scale: 1 = not at all, 2 = a little bit, 3 = moderately, 4 = quite a bit, and 5 = extremely. The respondents' PTSD scores were obtained by adding up the responses of the 20 items. The PTSD for DSM-5 symptom cluster severity scores were obtained by summing the scores for the items within a given cluster; i.e., cluster B (items 1-5), cluster C (items 6-7), cluster D (items 8-14), and cluster E (items 15-20). A provisional PTSD diagnosis can be made by treating each item rated as 2 = "Moderately" or higher as a symptom endorsed. It is important to note that four cases were missing from the responses of the PTSD for DSM-5 (PCL-5). Based on the above criteria, all the remaining 17 respondents met this criterion. Further, research has suggested that a PCL-5 cutoff score between 31-33 indicates probable PTSD across samples (PTSD: National Center for PTSD, n.d.). According to the data collected, only three respondents met the 31-33

cut-off. Additionally, the mean PTSD score for the respondents was 20.62 ± 2.742(*SD* = 12.564), with the lowest PTSD score being zero and the highest being 50. Respondents' PTSD (-0.063) scores were negatively skewed (see Table 7).

Impact of Event Scale-Revised Scores

The Impact of Event Scale-Revised (IES-R) of the respondents was measured using 22 items whose sum provides the IES-R score for each respondent. The score is usually between 0 and 88. The cut-off point is usually 24. In the study data, seven of the respondents have an IES-R score of 24 or more, three have an IES-R score of between 24 and 32, one has an IES-R score of between 33 and 36, and three have an IES-R score of 37 or more. The mean respondents' IES-R score is (27.19 ± 188(*SD* = 7.521), with a minimum score of 19 and a maximum score of 144, observed in Table 7 below.

Trauma and Attachment and Belief Scale Scores

The Trauma and Attachment Belief Scale (TABS) was used to measure the respondents' trauma due to stressful events using 84 items measured on a six-point Likert scale, such that 1 = strongly disagree, 2 = disagree, 3 = somewhat disagree, 4 = somewhat agree, 5 = agree, and 6 = strongly agree. The score of the items was calculated using the total of the 84 items. Although there are no cut-off points for TABS, a score greater than 60 indicates relative disruption. Twelve respondents had a TABS score of greater than 60; all the other cases were missing. On average, the TABS score for the respondents was (244.36 ± 9.822(*SD* = 32.577), with the highest score being 306 and the lowest being 204 (see Table 7).

Table 7

Summary Statistics of Respondent's CES, PTSD, TABS, WAS, and STSS

	N	Minimum	Maximum	Mean	Std. Error	Std. Deviation	Skewness	Kurtosis

CES	20	7	24	9.85	0.963	4.308	2.19	5.424
PTSD	21	0	50	20.62	2.742	12.564	-0.063	0.753
IES_R	16	19	44	27.19	1.88	7.521	1.259	0.315
WAS	14	37	133	98.86	6.269	23.455	-1.405	2.895
TABS	11	204	306	244.36	9.822	32.577	0.861	-0.029
STSS	11	17	54	30.09	3.808	12.629	0.96	-0.115

World Assumptions Scale Scores

The World Assumptions Scale (WAS) has 32 items, and the respondents' scores were computed by adding up the 32 items. These items were measured on a six-point Likert scale, such that 1 = strongly disagree, 2 = moderately disagree, 3 = slightly disagree, 4 = slightly agree, 5 = moderately agree, and 6 = strongly agree. Respondents' WAS scores were sub-divided into three groups: Benevolence of the World (added items: 2, 4, 5, 9, 12, 25, 26, and 30), Meaningfulness of the World (added items: 1, 3, 6, 7, 11, 14, 15, 19, 20, 22, 24, and 29), and Self-Worth (added items: 8, 10, 13, 16, 17, 18, 21, 23, 27, 28, 31, and 32). Respondents' Benevolence of the World score was 368, Meaningfulness of the World score was 593, and Self-Worth score was 655. These scores show that the respondents' Self-Worth scores were the highest, while their Benevolence of the World scores were the lowest. On average, respondents' WAS scores was 98.86 ± 6.269(*SD* = 23.455), with the highest WAS score being 133 and the lowest being 37. WAS scores were skewed to the left (-1.405) and had a positive kurtosis of 2.895.

Secondary Traumatic Stress Scale Scores

Lastly, the Secondary Traumatic Stress Scale (STSS) has 17 items measured on a five-point Likert scale, such that 1 = never, 2 = rarely, 3 = occasionally, 4 = often, and 5 = very often. The respondents' STSS scores were obtained by summing the 17 items. Importantly, the scoring of the STSS had three subscales, each obtained by summing items in the STSS score. These

subscales were: Intrusion (added items: 2, 3, 6, 10, and 13), Avoidance (added items: 1, 5, 7, 9, 12, 14, and 17), and Arousal (added items: 4, 8, 11, 15, and 16). The respondents' Intrusion score was 87, their Avoidance score was 140, and their Arousal score was 104. These scores indicate that the respondents are more avoidant than they are aroused and intrusive. Further, the mean STSS score was 30.09 ± 3.808(*SD* = 12.629). STSS was skewed to the right (0.96) and platykurtic (-0.115).

Findings Related to the Hypotheses

Two statistical tests were used to analyze the hypotheses. A one-way Anova test was conducted for the first hypothesis. A correlation analysis was used for hypothesis two with the variables CES, STSS, and PCL-M. Each hypothesis was rejected based on the statistical test.

Findings Related to Research Hypothesis # 1a

Hypothesis 1a*: There will be a statistically significant difference in Secondary Traumatic Stress symptomology between military chaplains that have never deployed or counseled members with PTSD and chaplains that have deployed or counseled military members with PTSD.*

A one–way Anova test was conducted to address research hypothesis 1 above. The Anova test was considered appropriate since the dependent variable (STSS) was ordinal while the independent variable (number of times of counseling) was categorical (Warner, 2012). The primary assumption of the Anova test is that the dependent variable must be normally distributed, and there must be a homogeneity of variances (Warner, 2012). Normality was tested with the Shapiro-Wilk Test, as shown in Table 8 below. As observed, the Shapiro Wilk Test statistic is 0.885 with a P-value of 0.122, which is greater than 0.05; hence the null hypothesis that STSS is normally distributed failed to be rejected. The Levene's Test was used to test the

homogeneity of variances, as shown in Table 8. Levene's Test statistic is 2.251 with a P-value greater than 0.05 ($p = 0.184$), indicating that variances are homogeneous.

Further, the Anova results in Table 9 indicate that the Anova F test statistic is 0.811 with a P-value of 0.561. Since the P-value is more significant than 0.05, the null hypothesis, that there will not be a statistically significant difference in STS symptomology between military chaplains that have never deployed or counseled members with PTSD and chaplains that have deployed or counseled military members with PTSD, failed to be rejected (Hypothesis 1a was not assumed).

Table 8

Test for Normality and Homogeneity for the STSS Dependent Variable

	Kolmogorov-Smirnov			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
STSS	0.171	11	.200*	0.885	11	0.122
Test of Homogeneity of Variances						
Levene Statistic	df1	df2	Sig.			
2.251	1	6	0.184			

Table 9

One-way ANOVA Results in Addressing Hypothesis 1a

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	559.576	4	139.894	.811	.561
Within Groups	1035.333	6	172.556		
Total	1594.909	10			

Findings Related to Research Hypothesis # 2a

Hypothesis 2a: *War and its indirect effects change the psyche of a chaplain operating and performing counseling for those who have direct experiences as measured by the Combat Exposure Scale (CES), Secondary Traumatic Stress Scale (STSS), and Posttraumatic Checklist for DSM-5-Military (PCL-M).*

Correlation analysis was conducted to address research hypothesis 2 above with the variables CES, STSS, and PCL-M; the results are shown below. However, before performing the correlation analysis, the normality assumption was tested for the variables involved using the Shapiro-Wilk test since the study sample size was small ($n < 50$). As shown in Table 10 below, the P values of Shapiro-Wilk test statistics for all the variables except STSS are less than 0.05; hence, the null hypothesis that the variables are normally distributed is rejected. Following this, Spearman's correlation analysis was preferred to address the above research hypothesis. In Table 11 below, the Combat Exposure Scale (CES) correlates positively, weakly, and insignificantly with PCL-M (0.327, p = 0.16); and negatively, very weakly, and insignificantly with STSS (-0.036, p = 0.916). Lastly, the PCL-M correlates positively, moderately weakly, and insignificantly with STSS (0.56, p = 0.073). Following these results, research hypothesis 2a is rejected.

Table 10

Testing for Normality for Correlation Analysis

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
STSS	.171	11	.200*	.885	11	.122
CES	.232	11	.101	.770	11	.004
PCL-M	.307	11	.005	.687	11	.000
IES_R	.340	11	.001	.696	11	.000

Table 11

Spearman's Correlation Analysis Addressing Research Hypothesis 2

			CES	PTSD	IES_R	STSS
Spearman's *rho*	CES	Correlation Coefficient	1.000	.327	-.271	-.036
		Sig. (2-tailed)	.	.160	.310	.916
		N	20	20	16	11

	PCL-M	Correlation Coefficient	.327	1.000	.435	.560
		Sig. (2-tailed)	.160	.	.092	.073
		N	20	21	16	11
	IES_R	Correlation Coefficient	-.271	.435	1.000	.547
		Sig. (2-tailed)	.310	.092	.	.082
		N	16	16	16	11
	STSS	Correlation Coefficient	-.036	.560	.547	1.000
		Sig. (2-tailed)	.916	.073	.082	.
		N	11	11	11	11

Summary of Research Findings

The current study was conducted to establish the effects of PTSD counseling on military chaplains using primary data. As aforementioned, the data was analyzed through descriptive statistics, correlation analysis, and regression analysis in SPSS. In summary, chaplains counseled military members with post-traumatic stress disorder more than 16 times. Further, the average chaplain's STSS score was 30, with four chaplains having an STSS score of less than the average and seven having an STSS score above the average. These results indicate that there is a minority of chaplains suffering from PTSD symptomology due to wartime experiences. A one-way ANOVA suggests that there is no sufficient evidence to support research hypothesis 1 (1a).

In contrast, Spearman's correlation analysis indicates no adequate evidence to support research hypothesis 2 (2a). These results suggest that a military chaplain who has never deployed to a combat environment is not affected by providing PTSD counseling to military members. Hence, there is no statistically significant correlation between providing PTSD counseling and secondary traumatic stress in military chaplains.

CHAPTER FIVE: CONCLUSIONS

The research indicates some secondary traumatic stress levels evident in chaplains that have conducted PTSD counseling, been deployed to combat zones, or have never been to combat but have performed PTSD counseling. A discussion of the evidence from the research will highlight the parallels between this research and prior research. A discussion of the study's implications will highlight how this research adds to the existing research body. An examination of the study's limitations in light of the research performed will outline the recommendations for further research in this field of study.

Discussion

The purpose of this study was to research the impacts of PTSD counseling on military chaplains as it relates to combat experience, lack of combat experience, amount of PTSD counseling, and the development of STSS symptomology. The CES, PTSD Checklist, WAS, IES-R, and STSS were used to quantitatively measure these events and their impact. The CES was used to evaluate the combat experience of respondents. The demographic portion of the survey identified the frequency with which each chaplain performed PTSD counseling. The PTSD Checklist measured PTSD symptomology. The WAS, IES-R, TABS, and STSS were used to measure the effects of PTSD counseling and the impact it had on the respondents' psyches. The sample size includes 21 chaplains, 14 of whom are active duty, and seven reserves. Several conclusions and suggestions for future research have been derived from this study.

Conclusions Related to the Hypotheses

Several conclusions can be made based on the statistical analysis of the data. Based on the breakdown of each test measure, there is evidence combat experiences and PTSD counseling have an impact on a chaplain's psyche.

Conclusions Related to Hypothesis 1

The first hypothesis predicts a statistically significant difference in secondary traumatic stress symptoms between military chaplains that have never deployed or counseled members with PTSD and chaplains that have deployed or counseled military members with PTSD. The research indicates no statistically significant difference between chaplains that have never deployed and those who have deployed to a combat zone.

One conclusion from the first hypothesis is that the considerable withdrawal of troops has resulted in that current military chaplains no longer have as great an opportunity to counsel members who have engaged in active combat or experience deployment to combat areas themselves with as great a frequency as those serving at the height of the wartime conflicts. The wars in Iraq and Afghanistan were at their peak from 2001 through 2011; the withdrawal of troops that began in 2011 continues to this day (Burns & Miller, 2020). Seven participants in this study had 10 or fewer years of military experience. Military chaplains with 10 or fewer years in the service would not have served through the most significant frequency of combat tours to the Middle East. Nine participants in this study had over 16 years of military service, which indicates they did serve during the pinnacle of combat tours to the Middle East. The CES scores indicate that the respondents were not heavily involved in combat, with only one respondent meeting the threshold for moderate to heavy combat experiences. Eleven (52.4%) military chaplains never went on combat patrols or had dangerous duties. This lack of experiencing combat patrols and serving in a hazardous duty potentially impacts the psychological effects of PTSD counseling that is evident in the IES-R scale scores. Seven of the chaplains met the threshold for IES-R of 24. This data begins to address the question of whether or not PTSD counseling has a psychological effect on military chaplains that have not been in combat or

served in other dangerous duties. However, the findings of this study indicated that military chaplains do perform a significant amount of PTSD counseling.

The study's first research question uncovered that out of a sample size of 21 chaplains, 10 (47.6%) had performed 16 or more PTSD counseling sessions. This finding echoes existing research indicating a military member will seek counsel from a chaplain before a psychologist to avoid the stigma attached to seeking psychological help (Kim, 2011). Based on the STSS instrument thresholds, a majority of this study's participants have few if any symptoms of STSS. The sample size for the STSS measure was 11 out of 21. Six participants' total STSS scores were below 28, indicating they do not have statistically significant symptoms of STSS. Two participants met the threshold for mild STSS, one for moderate, and two for severe. The finding of so few signs of STSS coincides with existing literature assertions that chaplains are less likely to experience distress with indirect exposure to traumatic events because their belief systems provide a connection to a higher authority (Sprang et al., 2010). Examination of the Trauma Attachment Belief Scale showed 11 participants received a score of 60, which indicates a relative disruption of the psyche, increasing the likelihood that trauma has affected their minds. Existing research suggests religious belief and spirituality serve a role in acting as a buffer against STSS (Sprang et al., 2010). This study's STSS scores indicate that the respondents are more avoidant than aroused based on the three scales of avoidance, intrusion, and arousal. The arousal score was 104, intrusion was 87, and avoidance was 140. While the research obtained in this study indicates a correlation between PTSD counseling and the effects of STSS based on the STSS scale scores, it also suggests a likelihood that the respondents' religious belief systems buffered them from developing some of the negative impacts of STSS while performing PTSD counseling.

Conclusions Related to Hypothesis 2

The second hypothesis sought to examine the changing of a chaplain's psyche through the indirect effects of operating during wartime and performing counseling for those who were active in combat, as measured by the Combat Exposure Scale (CES), the Secondary Traumatic Stress Scale (STSS), and the Posttraumatic Checklist for DSM-5-Military (PCL-M). Spearman's correlation analysis was applied to the CES, PCL-M, and STSS. The IES-R (impact of war) correlated negatively, weak, insignificantly related to CES, and positively, moderately weak, and insignificantly with PCL-M. IES-R showed a positive correlation, relatively weak, and insignificant with STSS. Individual examination of each measure indicates that there has been a certain level of disruption in the respondents' psychological states.

The PTSD checklist, based on thresholds, identified that 17 of the participants have some level of PTSD symptomology. Only one participant met a PCL-5 cut-off score of 31-33. Existing research has indicated that U.S. veterans returning from Iraq have a prevalence rate of PTSD that exceeds 12%, and those returning from Afghanistan, 14% (Vanderling et al., 2010). The research conducted in this study indicates that 16 respondents had mild exposure to combat based on the CES scores. It has previously been proven that exposure to war, whether slight or substantial, can harm a chaplain's psyche (Besterman-Dahan et al., 2012). The data obtained here still provides a correlation between providing counseling to service members in combat and a change in the chaplain's psyche when providing these services because three of the respondents met the threshold for the cutoff score (31-33) for PTSD. The result of the respondents being without combat exposure can be attributed to the low number of participants. The majority of those who participated in this study have little to no combat exposure.

All participants who responded to the scale showed some adverse impact on their psyches based on the IES-R results. A majority of the participants obtained the lower level cut-off threshold score of 24; three had over 37. Military chaplains may find themselves in different climates and locations, but the impacts on the mind in correlation to PTSD are the same; there is some change due to either combat experiences, PTSD counseling, or a combination of the two.

The TABS instrument had 12 respondents over the threshold score of 60, which indicates relative disruption. The average score for TABS was 244, the highest recorded score was 307, and the lowest score was 204. These scores suggest some level of disruption occurring in a military chaplain's mind upon performing PTSD counseling.

The STSS instrument revealed that most of the respondents were below the threshold of 28, indicating the respondents display little to no symptoms of STSS. Two research participants did score above 49, which means severe STSS. These results provide evidence that their work in PTSD counseling alters a military chaplain's mind.

One conclusion derived from this analysis is that the military chaplain's work in counseling others with PTSD is a job hazard that can alter one’s mind in a very negative way. The measures indicate some level of disruption in the schema of how the chaplains view their world and people in the world. This research suggests that spirituality can help buffer the effects of PTSD counseling but cautions that it is not an iron shield.

Implications

Several implications are inferred from the research. Implications for practice are the recognition that chaplains are performing the work of a mental health worker. The implications for research are the continued study of PTSD counseling and the adverse effects on the chaplain's psyche. Each one of these implications is important to recognize to keep the chaplain's mental fitness sharp.

Implications for Practice

The research obtained from this study indicates that regardless of the years of service, wartime experiences, or the frequency of PTSD counseling, produces a secondary effect on chaplains' minds because of the nature of their work. In the field of mental health, a chaplain may not seem to fit the mold of a behavioral health professional. The findings in this small sample of 21 military chaplains highlight the frequency of PTSD counseling performed. They also highlight the need for military chaplains to perform frequent self-check-ups of their mental fitness. While the military may be scaling back on active combat deployments, war wounds remain in perpetuity. When a military member experiences a personal trauma, there is an excellent likelihood that they will first seek out guidance from their military chaplain. The military relies on a battle buddy system that recognizes service members as best protected when they never go out alone, whether in war or in their free time.

In the New Testament book of Galatians, Paul commands believers to carry one another's burdens. Therefore, it would be prudent and well within the existing military framework for a chaplain to have a battle buddy, one that they can trust in sharing their most profound burdens (New American Standard Version Bible, 1971/1995, Galatians 6:2). Chaplains should never feel alone in their struggle with the heavy burdens they carry.

As the active warfighting military component of the Middle East's issues declines, it would be natural to expect getting assistance to those with PTSD to decrease also. Still, the U.S. Military should be cautioned to keep this issue at the forefront of their education. Based on this study's research findings, developing a program where chaplains can sit in a group setting and share the impact of their counseling sessions on their thoughts and allow their feelings to be normalized by other chaplains. The group would serve to assist chaplains in managing the effects of providing PTSD counseling in a psychologically healthy manner. This type of programming would help normalize the occurrence of symptoms of STSS that chaplains experience and underscore the fact that they are not alone. Once again, the concept of shouldering one another's burdens by creating a battle buddy system within the Chaplain Corps creates a stigma-free therapeutic environment, allowing for space and opportunity for chaplains to receive support and benefits desperately needed.

Implications for Research

The research for this current study shows that even in a relatively small sample size, most participant chaplains have provided PTSD counseling 16 or more times. These outcomes indicate that military chaplains offer an essential resource to military members that would ordinarily fall under the services provided by a behavioral health professional. It is established that service members seek behavioral health care from chaplains at a similar rate to those reported by behavioral health providers (Besterman-Dahan et al., 2012). The results of this study signify that war experiences impact only a small number of chaplains. Still, it also reveals that most chaplains sampled have experienced some impact on their psychological functioning due to their jobs. The respondents reported that they have better self-worth, based on their World Assumptions Scale score of 655, than the benevolence of the world, with a scale score of 368.

Trauma and Attachment Belief scores indicated that all 12 participants were over the threshold of 60, which indicates some disruption. The research implications suggest that military chaplains are doing more than providing for the religious and spiritual support of the troops they serve. They are also performing the work of behavioral health professionals. Placing military chaplains in this perspective should open the doors for military chaplains to receive training on the negative impacts of PTSD counseling and provide an avenue to turn to for help. There should be a type of military/officer assistance program to allow chaplains to receive anonymous counseling sessions when performing PTSD counseling.

Limitations

Not all of the research participants answered each section of the survey. The incomplete responses could be due to time constraints or simply not selecting answers in subject matters perceived as irrelevant or redundant. It is evident from this research that, just as other behavioral health professionals perform PTSD counseling, chaplains are also susceptible to the adverse effects of PTSD counseling. There is a genuine threat to the mind for those who undertake to provide counseling to those who experience PTSD. The literature has indicated that STSS is evident in mental health care workers and clergy (Nieuwsma et al., 2014). The research performed as part of this study served to narrow the field with a complete examination of military chaplains.

A pool of U.S. Military chaplains from an endorsing agency was utilized for this research. In 2012, 2,900 military chaplains in the United States military represented 130 religious organizations (Besterman-Dahan et al., 2012). This number includes the United States Military Chaplain Corps as a whole. This research sample contains only 21 of the 2,900 military chaplains serving in the military and only one of the 130 religious organizations. This study's

religious organization comprises a majority of protestant chaplains; there are an estimated 200 active, reserve, and national guard chaplains under this endorsing agency. A larger sample size would allow for examining the behavioral health work that a chaplain performs on a larger scale. A larger sample size would eliminate generalizability based on utilizing one military endorser. The larger sample size will also allow for greater diversity among the military's Chaplain Corps. Another limitation in this research was that this study focused on male protestant chaplains.

Recommendations for Future Research

Future research is recommended to expand the study's hypotheses across the Department of Defense (DOD) Chaplain Corps. This study included only a small percentage of the chaplains in the military. The study utilized an endorsing agent for the military that yielded a sample size of 21. The research indicated some psychological disturbances resulting from counseling work attended to in the chaplains' duties.

Expanding this study across the DOD would allow for a more significant analysis of chaplains with a broader variety of experience and faith backgrounds. This research was exclusive to protestant chaplains and an all-male population. Expanding the research across the DOD would also allow for an opportunity to examine how different faith backgrounds and gender is affected by PTSD counseling.

Now that the military conflicts in the Middle East are scaling back, the focus of future research should eliminate combat experiences and focus on counseling in general, researching the effects of counseling on military chaplains concerning STSS. The study could also incorporate measures that examine self-care and how well chaplains attend to their mental fitness.

Recommendations Based on the Research

A chaplain's primary duty is to provide for the spiritual and religious needs of the troops they serve. This task includes performing the behavioral health professional's work, most explicitly providing PTSD counseling. This occurrence may be rooted in the stigmas tied to individuals seeking help for their behavioral health needs. Based on this study's results, it is recommended that military chaplains be given the training similar to what behavioral healthcare workers receive in PTSD. It would also be beneficial for chaplains to work synonymously with behavioral health specialists. This training would begin the path to a future where seeking psychological help is stigma-free and simply another way to stay healthy. One way to accomplish this is establishing a system within which a chaplain can reach out to a behavioral health specialist when the burden of counseling becomes too great, or a chaplain needs personal assistance to help bear their burdens.

Summary

Chaplains are not infallible humans. Simply thinking that God will take care of them is not a good enough response to a potentially harmful side effect of their regularly performed counseling sessions. The research in this study shows that regardless of the number of years of military service, the combat experiences, or the number of counseling sessions, the occurrence of STSS is low but present in military chaplains. The effects of STSS can be detrimental to a chaplain's effectiveness in performing counseling or duties required by their faith tradition. As evidenced by the research, most chaplains surveyed have experienced an alteration of their psyche on some level due to the work they perform. The results obtained through this study show that chaplains provide military members with PTSD counseling. Attention should be given to military chaplains, just as any mental health worker, to ensure they seek and are provided with the help they need. Support may come in the form of seeking a trusted confidant that is a

behavioral health specialist or a group setting to normalize their feelings to achieve a greater level of psychological function. This change will contribute to their overall mental fitness and the mental fitness of military members who have PTSD without experiencing the adverse side effects bred by the stigmas associated with seeking such aid.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly, 19*(2), 181-8. https://doi.org/10.1080/09515070600811899

Benimoff, R., & Conant, E. (2009). Faith Under Fire: An Army Chaplain's Memoir. Crown.

Besterman-Dahan, K., Gibbons, S. W., Barnett, S. D., & Hickling, E. J. (2012). The role of military chaplains in mental health care of the deployed service member. *Military Medicine, 177*(9), 1028-33. http://dx.doi.org/10.7205/MILMED-D-12-00071

Besterman-Dahan, K., Lind, J. D., & Crocker, T. (2013). "You never heard Jesus say to make sure you take time out for yourself": Military chaplains and the stigma of mental illness. *Annals of Anthropological Practice, 37*(2), 108-129. http://dx.doi.org/10.1111/napa.12032

Bledsoe, T. S., Setterlund, K., Adams, C. J., Fok-Trela, A., & Connolly, M. (2013). Addressing pastoral knowledge and attitudes about clergy/mental health practitioner collaboration. *Social Work and Christianity, 40*(1), 23. Retrieved September 13, 2020, from https://publication.babcock.edu.ng/asset/docs/publications/PUHE/9349/2715.pdf#page=25

Bride, B. E., & Figley, C. R. (2009). Secondary trauma and military veteran caregivers. *Smith College Studies in Social Work, 79*(3), 314-29, 233. http://dx.doi.org/10.1080/00377310903130357

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social*

Work Journal, 35(3), 155-63. http://dx.doi.org/10.1007/s10615-007-0091-7

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice, 14*(1), 27-35. http://dx.doi.org/10.1177/1049731503254106

Burns, R. T., & Miller, Z. T. (2020, September 09). *US withdrawing thousands of troops from Iraq and Afghanistan*. Site Name. https://www.militarytimes.com/news/your-military/2020/09/09/centcom-boss-says-us-cutting-troops-in-iraq-to-3000-this-month/

Cieslak, R., Shoji, K., Douglas, A., Melville, E., Luszczynska, A., & Benight, C. C. (2014). A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychological Services, 11*(1), 75. http://dx.doi.org/10.1037/a0033798

Cohen, K., & Collens, P. (2013). The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious post-traumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(6), 570. http://dx.doi.org/10.1037/a0030388

Corrado, M. (2020, March 24). *Stress, crisis, and trauma: Supporting individuals in distress*. Site Name. http://www.ctipp.org/2020/03/stress-crisis-and-trauma-supporting-individuals-in-distress/

Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping, 23*(3), 319-39. http://dx.doi.org/10.1080/10615800903085818

Dekel, R., & Monson, C. M. (2010). Military-related post-traumatic stress disorder and family relations: Current knowledge and future directions. *Aggression and Violent Behavior,*

15(4), 303-09. http://dx.doi.org/10.1016/j.avb.2010.03.001

Drescher, K. D., Foy, D. W., Kelly, C., Leshner, A., Schutz, K., & Litz, B. (2011). An exploration of the viability and usefulness of the construct of moral injury in war veterans. *Traumatology, 17*(1), 8-13. http://dx.doi.org/10.1177/1534765610395615

Elwood, L. S., Mott, J., Lohr, J. M., & Galovski, T. E. (2011). Secondary trauma symptoms in clinicians: A critical review of the construct, specificity, and implications for trauma-focused treatment. *Clinical Psychology Review, 31*(1), 25-36. http://dx.doi.org/10.1016/j.cpr.2010.09.004

Figley, C. (1995). *Compassion fatigue*. Brunner/Mazel.

Galek, K., Flannelly, K. J., Greene, P. B., & Kudler, T. (2011). Burnout, secondary traumatic stress, and social support. *Pastoral Psychology, 60*(5), 633-49. http://dx.doi.org/10.1007/s11089-011-0346-7

Guyker, W. M., Donnelly, K., Donnelly, J. P., Dunnam, M., Warner, G. C., Kittleson, J., Bradshaw, C.B., Alt, M., & Meier, S. T. (2013). Dimensionality, reliability, and validity of the combat experiences scale. *Military Medicine, 178*(4), 377-384. http://dx.doi.org/10.7205/MILMED-D-12-00223

Owen, R. P., & Wanzer, L. (2014). Compassion fatigue in military healthcare teams. *Archives of Psychiatric Nursing, 28*(1), 2-9. http://dx.doi.org/10.1016/j.apnu.2013.09.007

Hapke, U., Schumann, A., Rumpf, H., Ulrich, J., & Meyer, C. (2006). Post-traumatic stress disorder. *European Archives of Psychiatry and Clinical Neuroscience, 256*(5), 299-306. http://dx.doi.org/10.1007/s00406-006-0654-6

Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of*

Traumatic Stress, 28(2), 83-91. http://dx.doi.org/10.1002/jts.21998

Hotchkiss, J. T., & Lesher, R. (2018). Factors predicting burnout among chaplains: Compassion satisfaction, organizational factors, and the mediators of mindful self-care and secondary traumatic stress. *Journal of Pastoral Care & Counseling, 72*(2), 86-98. http://dx.doi.org/10.1177/1542305018780655

Levy, H. C., Conoscenti, L. M., Tillery, J. F., Dickstein, B. D., & Litz, B. T. (2011). Deployment stressors and outcomes among Air Force chaplains. *Journal of Traumatic Stress, 24*(3), 342-6. http://dx.doi.org/10.1002/jts.20646

Monson, C. M., Taft, C. T., & Fredman, S. J. (2009). Military-related PTSD and intimate relationships: From description to theory-driven research and intervention development. *Clinical Psychology Review, 29*(8), 707-14. http://dx.doi.org/10.1016/j.cpr.2009.09.002

New American Standard Version Bible. (1995). Thomas Nelson. (Original work published 1971).

Nieuwsma, J. A., Fortune-Greeley, A. K., Jackson, G. L., Meador, K. G., Beckham, J. C., & Elbogen, E. B. (2014). Pastoral care use among post-9/11 veterans who screen positive for mental health problems. *Psychological Services, 11*(3), 300. http://dx.doi.org/10.1037/a0037065

Nieuwsma, J. A., Rhodes, J. E., Jackson, G. L., Cantrell, W. C., Lane, M. E., Bates, M. J., Dekraai, M. B., Bulling, D. J., Ethridge, K., Fitchett, G., Tenhula, W. N., Milstein, G., Bray, R. M., & Meador, K. G. (2013). Chaplaincy and mental health in the Department of Veterans Affairs and Department of Defense. *Journal of Health Care Chaplaincy, 19*, 3–21. http://dx.doi.org/10.1080/08854726.2013.775820

Ortlepp, K., & Friedman, M. (2002). Prevalence and correlates of secondary traumatic stress in

workplace lay trauma counselors. *Journal of Traumatic Stress, 15*(3), 213. http://dx.doi.org/10.1023/A:1015203327767

Otis, P. (2009). An overview of the U.S. military chaplaincy: A ministry of presence and practice. *Review of Faith & International Affairs, 7*(4), 3-15. http://dx.doi.org/10.1080/15570274.2009.9523410

Peters, H. M. & Plagakis, S. (2019, May 10). *Department of Defense contractor and troop levels in Afghanistan and Iraq: 2008.* Site Name. https://fas.org/sgp/crs/natsec/R44116.pdf

PTSD: National Center for PTSD (n.d.). *PTSD Checklist for DSM-5 (PCL-5).* Site Name. https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp#obtain

Richardson, L. K., Frueh, B. C., & Acierno, R. (2010). Prevalence estimates of combat-related post-traumatic stress disorder: Critical review. *Australian & New Zealand Journal of Psychiatry*, *44*(1), 4-19. http://dx.doi.org/10.3109/00048670903393597

Seddon, R. L., Jones, E., & Greenberg, N. (2011). The role of chaplains in maintaining the psychological health of military personnel: An historical and contemporary perspective. *Military Medicine, 176*(12), 1357-61. http://dx.doi.org/10.7205/MILMED-D-10-00124

Stearns, S., Shoji, K., & Benight, C. C. (2018). Burnout among US military behavioral health providers. *The Journal of Nervous and Mental Disease, 206*(6), 398-409. http://dx.doi.org/10.1097/NMD.0000000000000823

Sundin, J., Fear, N. T., Iversen, A., Rona, R. J., & Wessely, S. (2010). PTSD after deployment to Iraq: Conflicting rates, conflicting claims. *Psychological Medicine, 40*(3), 367-82. http://dx.doi.org/10.1017/S0033291709990791

Voss Horrell, S. C., Holohan, D. R., Didion, L. M., & Vance, G. T. (2011). Treating traumatized

OEF/OIF veterans: How does trauma treatment affect the clinician? *Professional Psychology: Research and Practice, 42*(1), 79. http://dx.doi.org/10.1037/a0022297

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research, 38*(2), 647-73. http://dx.doi.org/10.1111/1475-6773.00138

Wang, D. C., Strosky, D., & Fletes, A. (2014). Secondary and vicarious trauma: Implications for faith and clinical practice. *Journal of Psychology and Christianity*, *33*(3), 281. Retrieved September 13, 2020, from https://web-a-ebscohost-com.ezproxy.liberty.edu/ehost/pdfviewer/pdfviewer?vid=1&sid=e8d0b1df-daa3-4db8-8bf8-d9f8962317fe%40sessionmgr4008

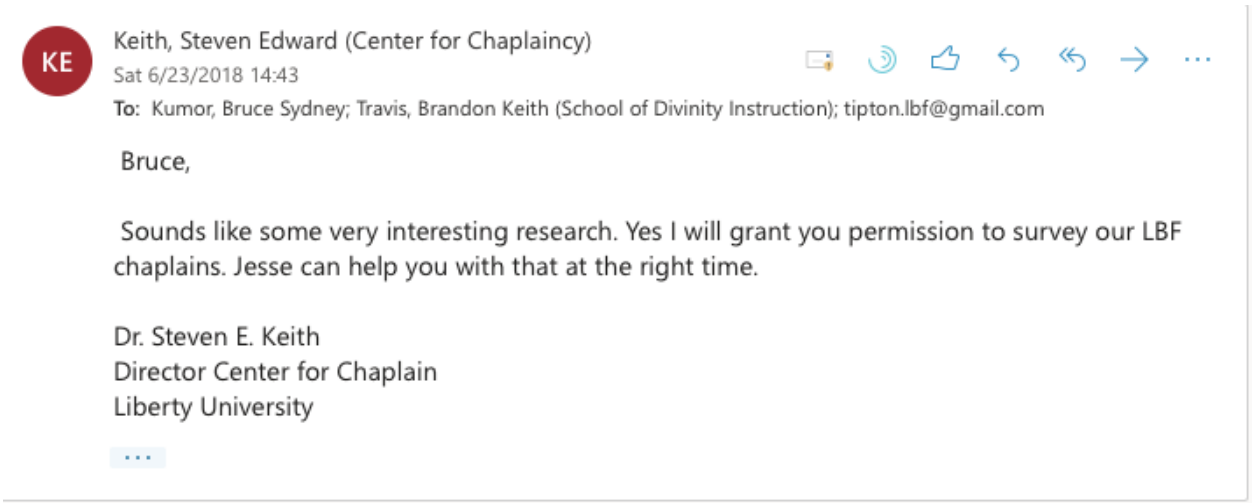
Warner, R. M. (2012). *Applied statistics: From bivariate through multivariate techniques*. Sage Publications.

Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993). The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. In the *Annual convention of the international society for traumatic stress studies, San Antonio, TX* (Vol. 462).

Yan, G. W., & Beder, J. (2013). Professional quality of life and associated factors among VHA chaplains. *Military Medicine, 178*(6), 638-45. http://dx.doi.org/10.7205/MILMED-D-13-00021

Appendix A

Institutional Permission Letter



KE

Keith, Steven Edward (Center for Chaplaincy)
Sat 6/23/2018 14:43

To: Kumor, Bruce Sydney; Travis, Brandon Keith (School of Divinity Instruction); tipton.lbf@gmail.com

Bruce,

Sounds like some very interesting research. Yes I will grant you permission to survey our LBF chaplains. Jesse can help you with that at the right time.

Dr. Steven E. Keith
Director Center for Chaplain
Liberty University

Appendix B

Informed Consent Form

Consent

Title of the Project: The Effects of PTSD Counseling on Military Chaplains
Principal Investigator: Bruce Kumor, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be a military chaplain. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?

The purpose of the study is to explore the effects of trauma counseling on the caregiver. A military chaplain is often the first person that a military member turns to in a time of distress. I would like to explore whether there is any correlation between post-traumatic stress disorder, vicarious trauma, and how the chaplain's worldview was or was not affected.

What will happen if you take part in this study?

If you agree to be in this study, I would ask you to do the following things:

1. In one sitting, complete an anonymous, online survey encompassing 179 questions that will take an estimated thirty minutes to complete.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from participating in this study.

Benefits to society include reducing stigmas associated with a chaplain's need to seek counseling when delivering PTSD counseling.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be anonymous.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted
- Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please exit the survey and close your internet browser.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Bruce Kumor. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at 703-944-7067 and/or bkumor@liberty.edu. You may also contact the researcher's faculty sponsor, Dr. Holland, at wmholland@liberty.edu.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. You can print a copy of the document for your records. If you have any questions about the study later, you can contact the researcher using the information provided above.

Liberty University
IRB-FY20-21-354
Approved on 1-15-2021

APPENDIX C

Demographic Questionnaire

Demographic Questionnaire

1. Gender
   a. Male
   b. Female
2. Branch of Service:
   a. United States Navy
   b. United States Air Force
   c. United States Army
3. Duty Status
   a. Active
   b. Reserve
4. Years of Military Service
   a. 0-3
   b. 3-10
   c. 10-15
   d. 15-20
   e. 20+
5. Number of times that you have engaged in counseling a service member with PTSD counseling
   a. 0
   b. 1-2
   c. 2-3
   d. 3-4
   e. 5-10
   f. 10-15
   g. 15+
6. Religious affiliation

a. Protestant (Methodist, Baptist, Presbyterian, or some other	b. Catholic	c. Christian (Non-Denominational)	d. Buddhist	e. Hindu

non-Catholic denomination)				
f. Mormon	g. Muslim	h. New Age/Wiccan	i. Other	

APPENDIX D

Trauma Attachment Brief Scale

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*(3), 155-63. http://dx.doi.org/10.1007/s10615-007-0091-7

Removed to comply with copyright.

APPENDIX E

World Assumption Scale

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*(3), 155-63. http://dx.doi.org/10.1007/s10615-007-0091-7

Removed to comply with copyright.

APPENDIX F

Combat Exposure Scale

Combat Exposure Scale

Please circle the number above the answer that best describes your experience.

1) Did you ever go on combat patrols or have other dangerous duty?

1	2	3	4	5
No	1-3 times	4-12 times	13-50 times	51+ times

2) Were you ever under enemy fire?

1	2	3	4	5
Never	<1 month	1-3 months	4-6 months	7+ months

3) Were you ever surrounded by the enemy?

1	2	3	4	5
No	1-2 times	3-12 times	13-25 times	26+ times

4) What percentage of the soldiers in your unit were killed (KIA), wounded or missing in action (MIA)?

1	2	3	4	5
None	1-25%	26-50%	51-75%	76% or more

5) How often did you fire rounds at the enemy?

1	2	3	4	5
Never	1-2 times	3-12 times	13-50 times	51+ times

6) How often did you see someone hit by incoming or outgoing rounds?

1	2	3	4	5
Never	1-2 times	3-12 times	13-50 times	51+ times

7) How often were you in danger of being injured or killed (i.e., being pinned down, overrun, ambushed, near miss, etc.)?

1	2	3	4	5
Never	1-2 times	3-12 times	13-50 times	51+ times

APPENDIX G

PTSD Checklist for DSM-5 (PCL-5)

PTSD Checklist – Military Version (PCL-M)

Name: _____ Unit: _____
Best contact number and/or email: _____
Deployed location: _____

Instructions: Below is a list of problems and complaints that veterans sometimes have in response to a stressful military experience. Please read each one carefully, put an "X" in the box.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful military experience?					
2.	Repeated, disturbing *dreams* of a stressful military experience?					
3.	Suddenly *acting* or *feeling* as if a stressful military experience *were happening again* (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful military experience?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful military experience?					
6.	Avoid *thinking about* or *talking about* a stressful military experience or avoid *having feelings* related to it?					
7.	Avoid *activities* or *talking about* a stressful military experience or avoid *having feelings* related to it?					
8.	Trouble *remembering important parts* of a stressful military experience?					
9.	Loss of *interest* in things that you used to enjoy?					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short?*					
13.	Trouble *falling* or *staying* asleep?					
14.	Feeling *irritable* or having *angry outbursts?*					
15.	Having *difficulty* concentrating?					
16.	Being "*super alert*" or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

Has anyone indicated that you've changed since the stressful military experience? Yes __ No__

APPENDIX H

Secondary Traumatic Stress Scale

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*(3), 155-63. http://dx.doi.org/10.1007/s10615-007-0091-7

Removed to comply with copyright.

APPENDIX I

Impact of Event Scale-Revised

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*(3), 155-63. http://dx.doi.org/10.1007/s10615-007-0091-7

Removed to comply with copyright.