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A STUDY OF THE EFFECTIVENESS OF THE CRISIS CARE & COUNSELING COURSE WITHIN THE SPECIAL OPERATIONS FORCES AT THE JOINT SPECIAL OPERATIONS UNIVERSITY

Mary Ann Quartetti
Southeastern University - Lakeland

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by

MARY ANN QUARTETTI

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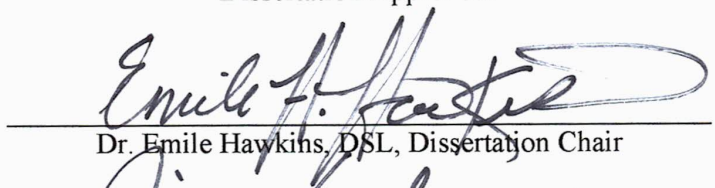

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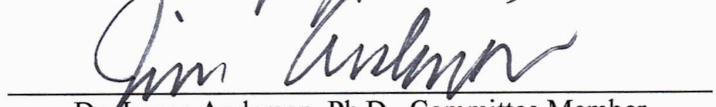
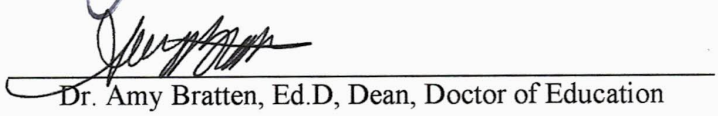


Dr. James Anderson, Ph.D., Committee Member

Dr. J.E. Caterson, D.Div, Committee Member



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DEDICATION

I would like to thank my mother for instilling the value of education. From a young age she has always made me believe that anything is possible. I would like to thank Paula Orcutt, Kelly Oglialoro, and Candi Ring. We started our first day together of this adventure, your friendship and inspiration have made this endeavor a blessing. I would like to thank my children Talia, Galina, and Joseph for their continuous support in all of my pursuits. I hope that I have shown all of you that it is ok to change directions in life; the best life is one that follows a winding road driven by passion.

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ABSTRACT

The Special Operations Forces have experienced a surge in PTSD and suicides in the past several years, now surpassing conventional military branches. Due to the attached stigma for seeking help from mental health professions and potential negative career effects, military personnel are more likely to seek counseling from their unit chaplain. The U.S. military does not require chaplains to have a counseling degree or certification in counseling as a prerequisite to performing duties as a chaplain, although most Masters of Divinity programs do include some counseling courses. The military does provide limited training to its chaplains in counseling. Special Operations Forces provide a unique military service and function. Prior to the Chaplain Certificate Program at Joint Special Operations University, SOF Chaplain specific training was not offered to SOF Chaplains. This study examined the institutional effectiveness of the Crisis Care and Counseling Course within the program. An anonymous electronic survey was distributed to participating chaplains, 100% of the program chaplains participated. The results were analyzed using Chi Square Goodness for Fit. The results indicate chaplains have been able to increase their skills and implement the skills in their units six months after program completion, particularly in the areas of suicide prevention and suicide postvention.

Key Words: Special Operations Forces, military, chaplains, PTSD, suicide prevention, suicide postvention

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I. INTRODUCTION

A Study of the Effectiveness of the Crisis Care & Counseling Course within the Special Operations Forces at the Joint Special Operations University

A pilot program was implemented at Joint Special Operation University at MacDill Air Force Base, Tampa, FL, January 2016, concluding July 2016. The program is scheduled to continue in the summer 2017. The chaplaincy program contained three graduate-level courses aimed at providing a rigorous academic foundation for Special Operation Forces (SOF) Chaplains in support of the spiritual domain. The program goal was to support SOF Chaplains as they examine in depth how their faith speaks to others in a diverse environment and what their faith brought towards providing a ready and resilient force within the SOF community.

The program involved graduate equivalency work providing the specialized training to expand the skills of the SOF Chaplain. Subject matter experts provided instruction regarding new developments in crisis care and augmented their professional skills in PTSD, suicide prevention, and suicide postvention as it relates to members of the special operations community. The program consisted of three blended modules each consisting of approximately 60 hours of classroom instruction along with approximately 120 distance learning hours. The three modules focused on the Chaplain's Scope of Practice (as it relates to the SOF community), Spiritual Resiliency, and Crisis Care & Counseling.

This chaplaincy certificate program is the first program specifically targeted to SOF Chaplains. To date, research has not been conducted on the resiliency of the SOF Chaplain. The researcher will study the institutional effectiveness and relevancy of the program as perceived by the participants and their chaplain assistants with issues directly related to PTSD, suicide prevention, and suicide postvention.

Purpose Statement

The purpose of this quantitative study was to examine the institutional effectiveness of the Crisis Care & Counseling Course within the Special Operations Forces at Joint Special Operations University with issues particularly related to PTSD, suicide prevention and suicide postvention. Data was collected through surveys given to SOF Chaplains, Chaplain Assistant(s), and members of the chaplain's Religious Support Team for the chaplains who completed the pilot program July 2016.

Research Question(s):

In order to address the stated research problem, the following research questions were posed:

Question #1

Do the Chaplains perceive the Crisis Care & Counseling course as a benefit in enhancing their ministry and ability to perform their duties within their unit in the areas of PTSD related issues, suicide prevention, and suicide postvention?

Question #2

Do the Chaplains perceive the Crisis Care & Counseling course as a benefit in enabling their skills to better advise their command in implementing religious support operations and programs within their unit in areas related to PTSD and suicidality?

Question #3

Have the Chaplains been able to implement their skills in counseling within their unit since completing the program?

Question #4

Have the Chaplains been able to use the skills from the course in other areas, such as family support groups, suicide prevention awareness groups, PTSD awareness groups, and grief support groups?

Methods

The subjects of the survey were the Chaplains who participated in the pilot program, their Chaplain Assistant(s), and members of the Chaplain's Religious Support Team. It is important to understand that some Chaplains may have more than one Chaplain Assistant or Religious Support Team Member and some may not have an assigned Chaplain Assistant or Religious Support Team Member, as this may mean that some Chaplains may be assigned with multiple job assignments outside of the traditional Chaplain duties. In addition to the survey questions regarding the effectiveness of the program, the survey included questions to identify demographics. The survey also asked the Chaplains for their age within a range, branch of service, years of military service, time as a SOF Chaplain, and number of Chaplain Assistants and Religious Support Team members under their supervision. The Chaplain Assistants and Religious Support Team members will be asked their age within a range, amount of time served under the supervision of the Chaplain, years of military service, and time serving as a SOF Chaplain Assistant or support team member. The Chaplain Assistants and support team members were surveyed as a measure of effectiveness with the Chaplain's unit.

The surveys were emailed to all participants and were accompanied with the information regarding voluntary participation and anonymity. The surveys were delivered to the participant's military email.

The researcher designed the instrument being implemented with input from the course director for the Chaplain Certificate Program. The researcher attempted to establish the validity of measurement by expert consensus. The researcher discussed the survey questions with the research and measurement expert (PhD) at JSOU, a subject matter expert (Doctorate of Ministry), and a representative from Protection of The Force and Family (POTFF). The funding for the pilot program was provided by POTFF, and, therefore the researcher sought input from their representative.

Analysis

The researcher used features of IBM SPSS Version 23 (IBM, 2015) to assess statistical significance. Chi Square Analysis was run on all data to determine whether there were significant differences in the (1) Chaplains perception of increased abilities to perform their duties within their unit in the areas of PTSD related issues, suicide prevention, and suicide postvention, (2) Chaplains perception of the Crisis Care & Counseling course as a benefit in enabling their skills to better advise their command in implementing religious support operations and programs within their unit in areas related to PTSD and suicidality, and (3) the Chaplains ability to use the skills from the course in other areas, such as family support groups, suicide prevention awareness groups, PTSD awareness groups, and grief support groups.

II. REVIEW OF LITERATURE

Suicide in the Military Population

Suicide is a subject which society prefers not to discuss. Media outlets, including social media, will create a temporary concern if the suicide victim is a public celebrity or an adolescent who suffered from bullying. The headlines scream for understanding and awareness for people afflicted with depression, but too quickly the headlines will fade. Suicide does not discriminate by race, sex, nationality, lifestyle choices, or careers. One of the fastest growing suicide populations is the United States military.

The World Health Organization (WHO) reporting data from 2012 indicated over 800,000 people worldwide commit suicide annually. Young adults aged 15 – 29 represent 8.9% of global suicides, second to traffic accidents. WHO reports the global mortality rate dropped between the years 2000 – 2012 while the worldwide population increased. The United States is reporting 12.1 suicides per 100,000 people ("World Health Statistics," 2016, p. 62). The Center for Disease Control (CDC) reports a slightly higher rate for the United States of 12.6 per 100,000 people, equating to 113 suicides per day or one every 13 minutes. The CDC also predicts for every completed suicide there are 25 attempted suicides ("Suicide," 2015). These numbers represent a 30-year high in this rate.

Suicide Awareness Voices of Education (Save, 2016) compiled the following list to identify gender, age, race and ethnic disparities:

Gender Disparities

- Suicide among males is 4 times higher than among females. Male deaths represent 79% of all US suicides. (CDC)
- Firearms are the most commonly used method of suicide among males (51%). (CDC)
- Access to firearms is associated with a significantly increased risk of suicide. (NAMI)
- Females are more likely than males to have had suicidal thoughts. (CDC)
- Females experience depression at roughly 2 times the rate of men. (SMH)
- Females attempt suicide 3x as often as males. (CDC)
- Poisoning is the most common method of suicide for females. (CDC)

Age Disparities

- 1 in 100,000 children ages 10 to 14 die by suicide each year. (NIMH)
- 7 in 100,000 youth ages 15 to 19 die by suicide each year. (NIMH)
- 12.7 in 100,000 young adults age 20 – 24 die by suicide each year. (NIMH)
- The prevalence of suicidal thoughts, suicidal planning and suicide attempts are significantly higher among adults aged 18 – 29 than among adults aged 30+. (CDC)
- Suicide is the 2nd leading cause of death for 15 to 24 year old Americans. (CDC)
- Suicide is the 4th leading cause of death for adults ages 18 – 65. (CDC)

- The highest increase in suicide is in males 50+ (30 per 100,000). (CDC)
- Suicide rates for females are highest among those aged 45 – 54 (9 per 100,000). (CDC)
- Suicide rates for males are highest among those aged 75+ (36 per 100,000). (CDC)
- Suicide rates among the elderly are highest for those who are divorced or widowed. (CDC)

Racial and Ethnic Disparities

- The highest suicide rates in the US are among Whites, American Indians, and Alaskan natives.

("Suicide Facts," 2016)

Operation Iraqi Freedom began in 2003, and by 2005 an increase in suicide with military soldiers was evident (Hill, Johnson & Barton 2006; Nelson, 2004) and has continued to increase. 2008 brought about the first time in military history in which U.S. Army soldiers committing suicide surpassed the figures being reported by the World Health Organization (Levin, 2009). In 2002, the U.S. Army partnered with National Institute of Mental Health (NIMH) to scientifically study the causes for the unprecedented rise in suicides. The NIMH awarded a grant to a research team of investigators from the Uniformed Services University of the Health Sciences, Harvard Medical School, the University of Michigan, and the University of California, San Diego to design and conduct Army Study to Assess Risk & Resilience in Servicemembers (STARRS). The research scientists were able to collect data from over 100,000 voluntary active duty soldiers. Active data gathering was completed in 2014 and the analysis phase began in 2015.

The Department of Defense contracted NIMH to continue their study from 2015 – 2020; the study is now called Study to Assess Risk & Resilience in Servicemembers Longitudinal Study (STARRS-LS) (https://www.nimh.nih.gov). See Appendix A for a comparison graph of active duty and demographically matched civilians.

As military suicide awareness grew during the STARRS study, others conducted several studies in the field. The Nock Report (Nock et al. 2013) is one of the most comprehensive reports released prior to the Army STARRS report. The report addressed specific factors important to understanding suicide among soldiers. The researchers used the vulnerability-stress model of suicide behavior to drive their study. Protective factors include family support/children, social support/networks, religious affiliation/participation, psychological factors, and mental health treatment. Vulnerability factors include family history, psychiatric factors, psychological factors, and suicidal behavior. Stressful life events include early stressors and negative life events. Nock et al. suggest an optimism regarding this topic due to ongoing studies by many researchers across the country and the commitment from the Department of Defense to continue STARRS.

Hyman, J., Ireland, R., Frost, L., & Cottrell, L. (2012) conducted a study on military personnel for the years 2005 and 2007. The study used a cross-sectional design and included the entire active duty military population. The sample size for 2005 was 2,064,183 participants and 1,981,310 for 2007. The researchers were able to identify suicide indicators related to personnel inside the U.S and deployed. The most common triggers for suicide were mental health diagnoses, deployment (especially in 2007 – Operation Iraqi Freedom), mental health visits, SSRIs and sleep prescriptions, reduction in rank, enlisted rank, and separation or divorce were

found to be consistently associated with suicide. Their recommendations included the need for more research and careful evaluation of suicide prevention programs.

Bryan et al. (2013) conducted a study, which examines combat exposure significance in suicide risk with the objective to identify any direct or indirect effects relating to depression symptom severity, posttraumatic stress disorder symptom severity, lack of belongingness, perceived burdensomeness, and fearlessness about death. The researchers implemented a structural equation model with two separate samples of deployed military personnel – clinical and non-clinical. The results showed personnel with greater combat exposure correlated directly with fearlessness about death and the severity of PTSD symptoms. The results did not show either a direct or indirect correlation on suicide risk.

Warner et al. (2011) implemented the Unit Behavioral Health Needs Assessment with a division of the U.S. Army deployed to Iraq for 15 months. This study was specific to deployed units only. The methods used were education, identification, and intervention programs implemented at each phase of the deployment cycle. The researchers were able to identify months two, six, and twelve as time periods where suicides peaked. These findings indicate a high need for military personnel to have access to mental health professionals and programs made easily available to support the soldiers.

Arvantis (2013) addressed issues related to the stigma attached to seeking mental health counseling by military personnel and issues related to the community after a suicide. Prior to the Army Study to Assess Risk and Resilience in Servicemembers (STARRS) study military personnel feared repercussions of seeking mental health counseling, such as loss of promotions, assignments, etc. The stigma indicated the person was weak and no longer as capable as those not seeking professional treatment. The Department of Defense now encourages the top ranking

officials to be alert for suicidal indicators and encourage seeking treatment. Service members still fear the stigma attached to needing help. Avantis also addressed that little is being done to help the surviving community of suicide victim including spouses, children, and other personnel assigned to the unit.

Jobes (2013) is a career suicidologist and clinician researcher focused on military and veteran suicide prevention. He concludes that the magnitude of the rising suicide rate with military personnel and veterans requires both innovative approaches and a sound scientific foundation to meaningfully impact and reduce the unprecedented high rates of suicides. Jobes explains three points from his own observations. First, soldiers do benefit from suicide-specific treatments. Second, when a suicidal soldier is able to identify the how, when, where, and why of becoming suicidal, they are often agreeable and capable of using alternative ways of coping and seeking professional help. Third, the effective clinical treatments instill hope, hope being the most important aspect for coping and finding alternatives to suicide.

Kochanski-Ruscio et al. (2014) used a retrospective chart review from 423 randomly selected inpatient medical records in a psychiatric setting in a military hospital from 2001-2006. The purpose was to identify demographic, diagnostic, and psychosocial differences based on suicide attempt status for military inpatients that had attempted suicide multiple times versus a single time. Their findings were that a number of factors emerged which were predictive for those with multiple attempts except for those with anxiety disorder. Individuals with long-term documented diagnosis of a mood disorder, substance abuse disorder, personality disorder traits, or a personality disorder were significantly more likely to attempt suicide multiple times.

Alexander et al. (2014) designed their study to analyze a prospective case-control to compare variables collected in the Department of Defense Suicide Event Report (DoDSER).

The study compared data recorded by DoDSER of individuals who committed suicide to those who attempted suicide during the same time period. The study was limited to Army personnel. The researchers intended to implement a 4:1 ratio of completed suicides. This ratio would require 444 participants for the study. The researchers report the difficulties encountered trying to achieve this number. The study was only able to interview 27 actual participants. The researchers' results mirrored previous studies completed by Laerd, Mann et al and Bachynski et al. (2009). The results confirmed recent failed intimate relationships, inpatient or outpatient mental health history, mood disorder diagnosis, substance abuse history, and history of prior self-injury were reported more frequently for suicide cases than for control cases. The Alexander et al. study highlights the difficulty non-military personnel encounter conducting military personnel studies.

Chu et al. (2015) examined the significance of major depressive episodes relevant to suicide ideation within the context of acquired capability. Three areas were considered major depressive episodes (MJD), acquired capability (AC), and suicidal history in the 3,377-sample group of military personnel. The data was analyzed using hierarchical multiple regression. The researchers found that MJD is not a sole indicator for severe suicide risk, while increased AC is necessary for increased suicide risk. The authors provide evidence MDEs are associated with high levels of suicide ideation, high levels of AC may distinguish military personnel with a history of MDEs who exhibit suicidal ideation from those who engage in suicidal behaviors.

Maguen et al. (2015) conducted a population-based, retrospective cohort study of all Iraq and Afghanistan war veterans who screened positive for posttraumatic stress disorder and/or depression, received a suicide risk-assessment, endorsed hopelessness about the present and future after their deployments. Factors being considered were alcohol use disorder and distance

from the nearest VA facility. They used bivariate and multivariate logistic regression analysis to examine variables associated with veterans admitting to having suicidal thoughts and a possible plan for suicide. The study had 45,741 participants. Their findings conclude most veterans delayed seeking professional health for the above-mentioned reasons, thus causing symptoms to worsen.

Martin et al. (2015) conducted a study using a self-reporting questionnaire. Their findings indicate for members of the National Guard an increased level in suicide ideation occurs after the members return from deployment to civilian life. The study found that the members felt isolated from their unit and this led to isolation and hopelessness. The study encouraged more support to be in place for soldiers returning from deployment.

Post Traumatic Syndrome in the Military

The American Psychiatric Association added Post Traumatic Syndrome Disorder (PTSD) to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980. The definition was refined in 2013 as:

> Post-Traumatic Stress Disorder consists of intrusive thoughts of trauma, avoidance of reminders related to the trauma, negative cognitions and moods, arousal of the nervous system when subjected to reminders of the traumatic event, and overall irritability and anxiety with distorted perceptions.

PTSD came into the spotlight in 2005 with soldiers returning from Iraq when 14 soldiers committed or attempted homicide PSTD is not limited to the military population. PTSD statistics for the general U.S. population are:

- 7.8% of Americans will experience PTSD during their lifetime
- Women are twice as likely as men to develop PTSD

- 3.6% of U.S. adults (aged 18-54) experience PTSD annually
- The most common events associated with PTSD for men are rape, combat exposure, childhood neglect, and childhood physical abuse.
- The most traumatic events associated with PTSD for women are rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse. (Spellman and Drash 2009).

PTSD statistics for military population are:

- 30% of military personnel deployed to war zones experience PTSD
- An additional 20-25% experience partial PTSD
- More than half of all male Vietnam veterans and almost half of all female Vietnam veterans experienced PTSD
- 10% of Gulf War veterans have experienced PTSD
- 6-11% of Afghanistan veterans have experienced PTSD
- 12-20% of Iraq veterans have experienced PTSD (http://www.ptsd.ne.gov/what-is-ptsd.html)

The U.S. military is invested in PTSD treatment for personnel as it impacts military readiness and the accomplishment of military goals. Military leaders and policy makers are committed to providing psychological support to individuals, units, and family members (Zang, 2017). Unfortunately, military personnel avoid professional interventions, as they fear the stigma attached with those who seek mental health treatment, which will negatively affect their careers. The Department of Defense and military leaders are working to change the attitudes and perceptions of those receiving treatment (Dingfelder, 2009).

All branches of the military provide ample physical and tactical training, however, little training is provided to prepare personnel involved in combat as to the potential internal conflicts they will encounter leading to self-judgment and shame (Blum, 2008). Shame is one component leading to PTSD; soldiers will punish themselves for actions taken during combat situations (Gaudet, et al., 2016). Bryan et al. (2014) conducted a survey of 151 active duty military personnel in the Air Force and Army. The participants were already seeking professional mental health counseling and agreed to complete the anonymous survey using a self-report methodology. The researchers examined the relation of moral injury contributing to self-injurious thoughts and PTSD. Moral injury includes events in which an individual perpetuates, fails to prevent, witnesses, or learns of acts which conflict with their own moral/ethical beliefs. Their findings concluded the military personnel and veterans who have moral conflicts with their actions might be at a higher risk for PTSD. The researchers found limitations based on their cross-sectional small and homogenous group. Even with these limitations the researchers were able to provide a new perspective for understanding PTSD. In a second study, Bryan et al. (2014) conducted an empirical study; quantitative study using an electronic survey completed by 474 military personnel and veterans representing all branches of the military who were enrolled in college courses across the Unites States to assess self-forgiveness as a protective factor for posttraumatic stress symptoms and suicide attempts. This study was conducted to evaluate three areas: if self-forgiveness will be associated with less severe posttraumatic stress symptom severity; if military personnel and veterans with a history of suicide ideation and suicide attempts will report lower levels of self-forgiveness; and if self-forgiveness will moderate the effects on risk for suicide ideation and suicide attempt. Focus areas for the survey included: suicide

ideation and suicide attempts, depression, posttraumatic stress, self-forgiveness, and trauma exposure.

The Role of the Chaplain

Military personnel hesitant to seek professional mental health services in fear of career repercussions often seek guidance from their chaplain. Chaplains are bound by confidentiality and are not required to report PTSD or suicide ideation to commanding officers unless the individual has indicated the intent to harm self or others. Chaplains offer comfort and counsel through spirituality and religiosity.

Bryan, Graham, and Roberge (2015) delve into the need for more research in the role spirituality and religiosity factors in suicide and suicide ideation. Research suggests that individuals who believe in a higher deity search for meaning in life and have the ability to forgive themselves may have a reduced risk for suicide ideation. The authors address that little research has been conducted questioning why some military personnel do not die by suicide facing the same adverse and stressful situations as their unit members. Most research focuses on the risk factors rather than protective factors. Through the fluid vulnerability theory the authors explain spirituality provides optimism, hope, and meaning in life, which then play a key role in decreasing suicide ideation. While these attributes are not exclusive to spiritual people, the authors promote further research to examine the significance of spirituality to prevent suicide ideation.

Bryan (2015) mentions several studies completed by others in which spiritual aspects relating to posttraumatic stress disorder and self-forgiveness are examined. Bryan introduces the idea of spirituality being a significant factor in how military personnel and veterans deal with

stressors leading to suicide ideation. He then explains the new addition to DSM-5, is a diagnostic criterion for PTSD focusing on "negative alternations in cognitions and moods." This addition incudes cognitive-affective state often associated with spirituality.

Currier, et al. (2015) concluded sociological data supports endorsing a religious affiliation and attending religious services are associated with lower probabilities of suicidal ideation, attempts, and deaths (AOR-1=0.64, 95% CI: 0.53–0.77). They suggest primary prevention programs be implemented to bolster resilience in the spirituality domain to service members allowing individuals to develop increased resources for dealing with potential traumas and/or high stressors which is prevalent with military personnel. Providing a cultural of spirituality may also help to alleviate the stigma attached to seeking mental health counseling. They recommended including spiritual advisors, such as chaplains, to work alongside professional mental health providers. The authors go as far as suggesting that some stressful circumstances may be best approached spiritually before a clinical approach.

The requirements to become a military chaplain are the same for all branches:

- Obtain an ecclesiastical endorsement from applicants faith group certifying the applicant is a clergy person in a denomination or faith group, qualified spiritually, morally, intellectually and emotionally to serve as a Chaplain, and be sensitive to religious pluralism and be able to provide for the free exercise of religion by all military personnel, their family members and civilians who work for the military.
- Educationally the applicant must possess a baccalaureate degree of not less than 120 semester hours, possess a graduate degree in theological or religious studies, plus have earned at least a total of 72 semester hours in graduate work in these

fields of study, or a Masters degree in Counseling with an equivalent amount of Chaplain experience. (Compilation from military chaplain websites)

Understanding the requirements to become a military chaplain it is important to note here, as there is not a requirement for any college coursework in the field of counseling. Yet, chaplains are now finding themselves providing counseling services. In response to this need, the individual military colleges offer training programs or courses for the chaplains to work within in their units with suicide and PTSD.

Special Operations Forces Chaplains

Special Operations Forces (SOF) is comprised of elite members from all military branches. SOF provides joint force commanders and chiefs of mission with discrete, precise, and scalable options, which can be synchronized, with activities of other interagency partners to achieve United States Government objectives. Special operations require unique modes of employment, tactics, techniques, procedures, and equipment. SOF missions are often conducted in hostile, denied, or politically and/or diplomatically sensitive environments. The individuals selected to serve SOF are the top 1% of all military personnel. SOF units are mission specific, often comprised of members from different branches within the unit (Special Operations. (2014). *Joint Publication 3-05*).

Admiral William McRaven announced in April, 2014 (Chumley, 2014) the suicide rate for SOF military members was at a record high, surpassing the traditional military forces. Admiral McRaven stated "My soldiers have been fighting now for 12, 13 years in hard combat – hard combat – and anybody that has spent time in this war has been changed. It's that simple." The SOF soldiers have been continuously operating combat missions longer than any other

military group in U.S. history, often several missions a year. With proper training, SOF Chaplains will be instrumental in helping SOF units.

SOF members were considered to be resistant to the psychological warfare of combat zones. As military requirements do not require a specific degree in counseling, SOF Chaplains found themselves in situations that were different from their non-SOF units requiring definitive counseling skills to meet the needs of their members. SOF Chaplains may be assigned to units comprised of several military branches, they may be assigned to multiple mission units, and they may be deployed on several missions a year. As Admiral McRaven acknowledged these conditions lead to an increase in PTSD and suicide. SOF Chaplains must have the ability to counsel with unit members they have not had the chance to build a relationship with before the mission, thus creating a need for increasing counseling skills.

III. METHODOLOGY

Participants

Seventeen Chaplains from the Chaplain Certificate Program voluntarily completed the survey, representing 100% participation. The Chaplains were emailed the survey through a secured military server (See Appendix C). The Chaplains were made aware the survey was anonymous and were not offered a monetary or credit reward. The participating Chaplains were comprised of 16 males (93.75%) and 1 female (6.25%), the majority of the Chaplains were Caucasian (64.71%), Hispanic/Latino, Black or Native American, and Asian or Pacific Islander representation were all 5.88 % respectfully, 17.65% preferred not to respond to ethnicity identification (See Appendix B).

Five of the potential 17 Chaplain Assistants and/or Religious Support Team members voluntarily completed the survey (See Appendix D). The Chaplain Assistants and Religious Support Team members were emailed the survey through a secured military server. The Chaplain Assistants and Religious Support Team members were made aware the survey was anonymous and were not offered a monetary or credit reward. The respondents were all male (100.0%), 80% identified as Caucasian, while 20% reported as Black or African American (See Appendix B). The low ratio of responses from the Chaplain Assistants and Religious Support Team Members may be attributed to deployments at the time of the survey release. Due to the low response rate (29%) the researcher did not perform inferential statistical analyses.

Measures

The researcher created the survey instrument utilized for the specific purpose of ascertaining data relevant to the research questions. The creation of the survey instrument was necessary as the university where the course was implemented did not ask these specific

questions in their end of course survey, as it would not have been appropriate at the time because the Chaplains had not yet returned to their units. The researcher formulated the survey questions after consultation with course and research experts. The purpose of the study was to determine the institutional effectiveness of the Crisis Care & Counseling course.

Four questions were provided in the survey relating to PTSD, suicide prevention, and suicide postvention (See Appendix C). The anchors used for measurement were Strongly Agree (2), Agree (1), Disagree (-1), and Strongly Disagree (-2).

Procedures

The researcher received IRB approval from Southeastern University. Upon approval an email was sent to all Chaplains who completed the Crisis Care & Counseling course notifying of the study intent and requesting the names and email addresses of their Chaplain Assistants and Religious Support Team members. One week after the initial email a letter with guarantee of voluntary participation and anonymity and a survey link was emailed through a U.S. military secured server to participating Chaplains and their Chaplain Assistants and Religious Support Team members. The researcher used a survey tool with a secured private password. The survey was open for participation for eight days. The researcher used features of IBM SPSS Version 23 to analyze the survey responses using Chi Square Goodness of Fit Formula. The survey was implemented through an online survey tool.

IV. RESULTS

The results from the survey of the participating Chaplains were analyzed with SPSS Version 23. In order to test the hypotheses, Chi Square analyses were conducted to determine whether observed sample frequencies differed significantly from the expected frequencies. Descriptive analyses revealed that some of the data were slightly platykurtic and negatively skewed and some were slightly leptokurtic and positively skewed, but none were statistically significant. Descriptive analyses revealed that all data were fairly normally distributed. Originally the items were anchored on a four-point scale ranging from 2 to -2. Chaplain responses for questions #1 and #2 were positive, therefore, the analyses reflect a two-point scale: Strongly Agree versus Agree. Confidence intervals and affect sizes were only calculated for the Strongly Agree, as this was the program's main interest.

Research Question #1 addressed the Chaplains perception of an increase or broadening of professional skills for Chaplains working within their unit on PTSD related issues, suicide prevention issues, and suicide postvention issues.

PTSD Skills

In order to assess Chaplain responses on PTSD related issues, a Chi Square analyses was conducted. Chaplain responses regarding an increase in knowledge relating to PTSD skills did not show a significant difference between Strongly Agree and Agree, ($\chi^2(1) = 1.47, p = .23$). All responses were positive with 64.71% responding they highly agreed and 35.29% agreeing

there was an increase in knowledge relating to PTSD. The confidence interval for the percentage of Strongly Agree was 42.33% to 87.63%.

Suicide Prevention Skills

In order to assess Chaplain responses regarding an increase in suicide prevention related issues a Chi Square analyses was conducted. Chaplain responses regarding an increase in knowledge relating to suicide prevention skills did show a significant difference between Strongly Agree and Agree, (χ^2 (1) = 9.94, p = .002). All responses were positive with 88.24% strongly agreeing and 11.76% agreeing that their suicide prevention skills increased. The confidence interval for the percentage of Strongly Agree was 27.44% to 72.56%.

Suicide Postvention Skills

In order to assess Chaplain responses regarding suicide postvention related issues a Chi Square analyses was conducted. Chaplain responses regarding suicide postvention skills duplicated suicide prevention results and showed a significant difference between Strongly Agree and Agree, (χ^2 (1) = 9.94, p = .002). All responses were positive with 88.24% strongly agreeing and 11.76% agreeing that their suicide postvention skills increased. The confidence interval for the percentage of Strongly Agree was 27.44% to 72.56%.

Research question #2 addressed the Chaplains perception of being able to better advise his or her command in implementing religious support operations and programs within the unit of issues related to PTSD and suicidality.

PTSD

Once again, Chi-square analyses were conducted to assess the perception of the impact of training on Chaplains' ability to inform their command on PTSD related issues. While all Chaplains did report a perceived increase, results indicated there was not a significant difference in the number of Chaplains who responded Strongly Agree and the number who responded Agree, (χ^2 (1) = 1.47, p = .23). All Chaplains responded positively with 64.71% strongly agreeing and 35.29% agreeing they were better able to advise their command on PTSD related issues. The confidence interval for the percentage of Strongly Agree was 42.33% to 87.63%.

Suicidality

The impact of training on Chaplains' ability to inform command of issues related to suicidality, results showed a significantly higher number of Strongly Agree responses than Agree responses, (χ^2 (1) = 7.19, p = .008). All Chaplains responded positively with 82.35% strongly agreeing and 17.65% agreeing they were better able to advise their command on Suicidality issues. The confidence interval for the percentage of Strongly Agree was 36.24% to 63.76%.

Research question #3 asked if the Chaplains were able to implement counseling skills after course completion within their units. All Chaplains reported they were able to implement new skills.

Research question #4 addressed the Chaplains ability to apply course skills within their units in other areas, such as: family support groups, suicide prevention groups, PTSD awareness groups, and grief support groups.

Family Support Group Implementation

Results for family support group implementation revealed four cells had expected frequencies less than five. Survey results showed three Chaplains had a negative response. However, the numbers were so low that it did not allow for a valid Chi Square analyses across the four groups. Therefore, in order to capture negative results and to contrast them to positive results, a dichotomous variable was created to divide the responses into "agrees" and "disagrees." The results for the dichotomous variable revealed a significantly higher number of "Agree" responses than "Disagree" responses, (χ^2 (1) = 7.19, p = .008). The Chaplain results varied from "strongly agree" to "strongly disagree": 41.18% strongly agreed, 41.18% agreed, 5.88% disagreed, and 11.76% strongly disagreed. The confidence interval for the percentage of Agree was 17.27% to 82.73%.

Suicide Prevention Awareness Group Implementation

As with the previous analysis, results for suicide prevention awareness group implementation revealed four cells had frequencies less than five. Survey results show two Chaplains had a negative response, again not allowing for a Chi Square Analyses across all four groups. A dichotomous variable was created to divide the responses into "Agrees" and "Disagrees." The results for this dichotomous variable revealed a significantly higher number of "Agree" responses than "Disagree" responses, (χ^2 (1) = 9.94, p = .002). The Chaplain results

varied from strongly agree to strongly disagree: 35.29% strongly agree, 53.94% agree, 5.88% disagree, and 5.88% strongly disagree. The confidence interval for the percentage of "Agree" was 15.34% to 84.66%.

PTSD Awareness Group Implementation

Results indicated a significantly higher number of Chaplains than expected agreed with their ability to implement PTSD awareness groups had increased, (χ^2 (1) = 11.20, p = .004). Chaplain results varied from strongly agree to strongly disagree: 17.65% strongly agree, 70.59% agree, and 11.76% strongly disagree. The confidence interval for the percentage Agree was 42.33% to 87.63%.

Grief Support Groups

Results for implementation of grief support groups did not show a significant difference (χ^2 (1) = 5.20, p = .07). Chaplains results varied from "strongly agree" to "strongly disagree": 35.29% strongly agree, 53.94% agree, and 11.76% strongly disagree. The confidence interval for the percentage of Strongly Agree was 49.44% to 50.56%.

As mentioned previously, only five of the potential 17 Chaplain Assistants (CA) and Religious Support Team Members (RST) responded to the survey, therefore, the only analysis conducted were descriptive statistics. Following are the findings of the survey.

Survey question #1 determined if the Chaplain trained the CA and RST on skills learned upon completion of the Chaplain Certificate Program in the areas of PTSD, suicide prevention, and suicide postvention. All CA and RST responded positively to the topic of PTSD, 40% strongly agreed and 60% agreed. All CA and RST responded positively to the topic of suicide

prevention: 80% strongly agreed and 20% agreed. All CA and RST responded positively to the topic of suicide postvention: 40% strongly agree and 60% agree.

Survey question #2 determined if the CA and RST observed a positive change with increased confidence of the chaplain within the unit in dealing with PTSD, suicide prevention, and suicide postvention related issues. All CA and RST responded positively to PTSD related issues, 80% strongly agree and 20% agree. All CA and RST responded positively to suicide prevention related issues, 100% strongly agreed. All CA and RST responded positively to suicide postvention related issues, 100% strongly agreed.

Survey question #3 determined if the CA and RST observed an increase in skill of the chaplain within the unit in dealing with PTSD, suicide prevention, and suicide postvention related issues. All CA and RST responded positively in the chaplain's increase in skills in PTSD related issues: 60% strongly agree and 40% agree. All CA and RST responded positively in the chaplain's increase in skills in suicide prevention related issues: 80% strongly agree and 20% agree. All CA and RST responded positively in the chaplain's increase in skills in suicide postvention related issues: 80% strongly agree and 20% agree.

V. DISCUSSION

Special Operations Forces Chaplains participated in an institutional effectiveness study through a quantitative survey distributed electronically. The purpose of this survey was to provide feedback regarding institutional effectiveness of a course the Chaplains completed intended to increase their crisis care and counseling skills within their units. A discussion of the findings of the survey data will be presented in this chapter.

Overview

The basis of this study was to analyze the institutional effectiveness of the Crisis Care and Counseling course offered to Special Operations Forces Chaplains to better prepare the Chaplains to deal with PTSD and Suicidality. Military personnel are hesitant to seek counseling from mental health professionals as it may affect their careers, as stated in Chapter 2. Military personnel are more prone to seek counsel from their unit Chaplain(s). Special Operations Forces are considered to be the top 1% of all military personnel, and have traditionally been considered to be impervious to PTSD or suicidal thoughts. The military provides little training to the Chaplains to deal with such issues. Prior to the Chaplain Certificate Course provided by Joint Special Operations University, no training was provided to the SOF Chaplains to deal with PTSD or suicidology. The certificate program gained significance as SOF PTSD and suicide rates surpassed the regular military rates.

This quantitative study surveyed all participating Chaplains from the certificate program. The researcher created the survey instrument. The instrument, which was comprised of three

Likert scale questions with emphasis on three domains: PTSD, suicide prevention, and suicide postvention. Likert-scale responses ranged from Strongly Agree, Agree, Disagree, and Strongly Disagree.

Research question #1 (RQ1): Research question #1 addressed the Chaplains perception as to the Crisis Care and Counseling Course increasing or broadening their professional skill sets in working within their unit in the areas of PTSD, suicide prevention, and suicide postvention.

Implications: The Chaplains did not report a significant change in their skills in dealing with PTSD. One possible reason for the lack of reported change could be due to the fact that the material was not novel. For instance, in the After Action Review (AAR) comments, Chaplains noted that they had previously received non-SOF specific training in the area of PTSD and the information provided during the course was not new to them, particularly the Applied Suicide Intervention Skills Training model. Several Chaplains suggested implementing new course material on the topic.

SOF Chaplains requesting more course material on PTSD is important. SOF units deploy on more missions than non-SOF units under extremely stressful conditions. The amount of actual time spent with unit members can be sporadic, as well as being temporarily placed with another unit due to geographical needs. Chaplains need skills to quickly identify PTSD indicators under less than optimal circumstances. One of the Chaplain participants stated, " I recommend more spiritual integration on the issue. How can we as Chaplains bring our unique spiritual giftings to the Soldier who is also spiritual so that a uniquely spiritual solution is offered not just

a model with a veneer of religion? What have other religious leaders done to confront this issue?" In the AAR, one Chaplain commented,

> "The content of this lesson was perhaps one of the best. I learned quite a deal about a subject in which I am quite familiar. From the Crisis Care Continuum to the symptoms, to the FAQs and the concept of healing/recovery/ growth. All in which a CH can insert themselves as a trusted agent leveraging a relationship that has already been created to walk alongside the operator, family member or sustainer to achieve a goal of support. I'm truly grateful for the review on the DSM-5, the points about the memory, and the principles of treatment were truly helpful."

Another AAR comment,

> "The IMI (interactive media instruction) and the reading were helpful because they clearly explained what PTSD is and how to treat it. I have read about PTSD, of course, and had some lectures on it and even counseled Soldiers who had it, but the IMI and reading gave me a deeper understanding of it and the healing process."

Another comment, "Though this information was not new for me; it was very practical and laid out in a way that supported what I have doing and saying as a Chaplain."

The Chaplains who participated in the certificate program will not be enrolled in the class again. One of the great things discovered in this study was the information made available to the participants is only available through this course, as it is SOF specific. Although there was not

significant difference in the survey results, it is recommended to continue the PTSD training as several Chaplains did find the training beneficial. Future course iterations should include more counseling skills outside of the traditional military approaches to treatment, also to include more spiritual approaches to PTSD treatment.

In contrast to the PTSD training, the Chaplains did report a significant benefit to the suicide prevention and postvention materials. Several Chaplains commented in the AAR the concept of suicide postvention is a new area of counseling they had not been previously exposed. It is noteworthy that the Chaplains reported suicide postvention as a new knowledge area and they have been able to implement the skills since returning to their units. This completely supports the goal of the course, to better prepare Chaplains in Crisis Care and Counseling. It can only be beneficial to provide the opportunity for other SOF Chaplains. Chaplain comments from the AAR: "The content was extremely useful. I believe it to be the best and most relevant/useful information yet."

> "The content was useful. There were many different learning points in which I gained resources for my counseling to those in crisis. The Spiritually-Oriented Counseling Processing Therapy was perhaps the highlight of all. Having an understanding that others in the counseling field can use spiritually focused counseling to assist counselees was encouraging."

"I think this is another useful tool that we can refer to if we find ourselves in a place of working with a SM or family member in this situation. It will be very helpful in my postvention care plan."

This study supports the continuing the suicide prevention and postvention materials as they were presented in the course, as all participants deemed the information valuable. As several Chaplains found the suicide postvention skills training a new concept, it is worth consideration to offer this specific suicide prevention and postvention education immediately to all SOF Chaplains, perhaps without having to enroll in the entire certificate program.

Research question #2 (RQ2): Research question #2 focused on the Chaplains ability to better advise their command in implementing religious support operations and programs in their units related to PTSD and suicidality.

Implications: Chaplains did not report a significant difference in briefing their command in PTSD issues, in contrast the Chaplains did report a significant difference in briefing their command on suicidality issues. The difference may be that the concept of suicide postvention is a new concept to most Chaplains and the Chaplains were able to immediately brief their command on the relevance of postvention implementation upon return to their units. In the AAR, several Chaplains mentioned they appreciated the role-playing scenarios in preparing and presenting briefings to their commanding officer and recommended more opportunity for this activity. As the SOF community copes with increasing suicides, the Chaplain's responsibilities have grown. While the needs of the unit grow, the Chaplain must advocate more for additional

support and programs. Increasing the advising and briefing skills and confidence levels of the Chaplain is paramount.

As the Chaplains expressed the desire for more opportunities for role-playing, it is recommended to make additional time in the course schedule for this activity. An additional exercise to consider adding would be how to effectively write briefs to commanders when advising for the implementation of religious support operations and programs in their units related to PTSD and suicidality.

Research question #3 (RQ3): Research question #3 prompted the Chaplains to determine if they had been able to use the skills from the Crisis Care and Counseling Course in their unit since completing the course six months prior to the survey.

Implications: 100% of Chaplains reported they were able to implement skills from their course during the time frame. Two Chaplains were present at the university three months after course completion to be presenters for a Religious Support Team training course. They reported to the researcher that two Chaplains from their cohort had experienced suicides in their units while deployed. They reported the skills from the course better enabled them to help their unit members deal with grief.

Research question #4 (RQ4): Research question #4 prompted the Chaplains to determine if they had been able to use the skills from the Crisis Care and Counseling Course in other areas, such as: family support groups, suicide prevention awareness groups, PTSD awareness groups, and grief support groups.

Implications: The Chaplains indicated their skills from the Crisis Care and Counseling Course enabled them to implement skills with a significant difference in the areas of family support groups, suicide prevention awareness groups, and PTSD awareness groups. There was not a significant difference in grief support group. During the AAR, most Chaplains mentioned that they had not previously sought to increase the availability of these programs within their unit, as these types of services were available on all military bases, although they were not SOF unit specific. The Chaplains made several positive comments in providing SOF unit specific groups to their units after the course completed.

Several Chaplains expressed interest in learning more about what the Protection of Force and Family (POTFF) can specifically do to help them within their unit. The comments in the AAR reflected that POTFF did not have ample time to explain their services to them. It is recommended the POTFF presentation time be increased during the resident phase to provide an opportunity for the Chaplains to learn about the abundant resources available to their units. Also worthy of consideration would be for Chaplains to create a plan, while in the resident phase of the course, for collaborating with the behavior health professionals to jointly offer support groups to unit/family members. This would allow for other Chaplains to share what has, and has not, worked within their units in this type of collaboration.

Limitations

The program was the initial pilot. It would have been beneficial to be able to compare the pilot program cohort to another cohort. This data collected will provide a baseline for further research with additional cohorts.

A second cohort has not been scheduled at this time for comparison purposes. The university is in process of scheduling the second cohort to begin in the summer or early fall of 2017.

An additional limitation with the pilot program group was the majority of participants were male, 16 of 17.

The Chaplain Assistants and Religious Support Team Members survey did not receive enough responses to use inferential statistics to analyze. A possible reason for the limited responses may be that several SOF units deployed prior to, and during, the survey period.

Recommendations and Future Research

The data collected indicates the Crisis Care and Counseling Course is adding value to the SOF Chaplains abilities to work with PTSD and suicidality. Further development of the curriculum and instruction for PTSD would be recommended, particularly implementing new strategies for Chaplains to use in identifying and counseling personnel as preventative care. The curriculum and instruction for suicide prevention and suicide postvention was well received by the Chaplains. Prior to the next cohort starting the program, it would be recommended to review the AAR responses for areas, which may need additional or supplemental opportunities.

In order to improve future evaluations of the course, it would be advisable to select a more diverse cohort. The cohort should be more representative of the SOF community in make-up of gender and military branch.

After the next cohort completes the program another survey addressing the institutional effectiveness would be advised to compare the results from the initial cohort. The researcher also recommends additional training for SOF Chaplains, which would be in conjunction with SOF mental health counselors. The SOF Chaplains report having limited contact with these professionals and would appreciate an opportunity to collaborate on programs which would benefit their communities. The researcher recommends longitudinal studies on future cohorts, to include an effectiveness survey to the Chaplain's command officer.

Conclusion

The data collected from this survey supports the need to employ the suicide prevention and postvention training to all Chaplains in all branches of military, not just SOF. All branches of the military are facing a crisis with suicides and suicide attempts. The Crisis Care and Counseling Course has made an immediate impact on the Chaplain's units, it is in the best interest of all to expand the program.

The unfortunate reality is that the need for counseling for PTSD, suicide prevention, and suicide postvention is not likely to decline in the near future in the SOF community. While the Chaplains excel within their units in meeting the spiritual and religious needs of their members, the stigma associated with seeing Behavioral Health professionals has forced them to venture

into areas in which they have limited training. The Crisis Care and Counseling Course has provided the SOF Chaplain an opportunity to build skills vital to deal with these issues. 100% of the participating Chaplains supported continuing the Crisis Care and Counseling Course. The evidence provided here supports their conclusion.

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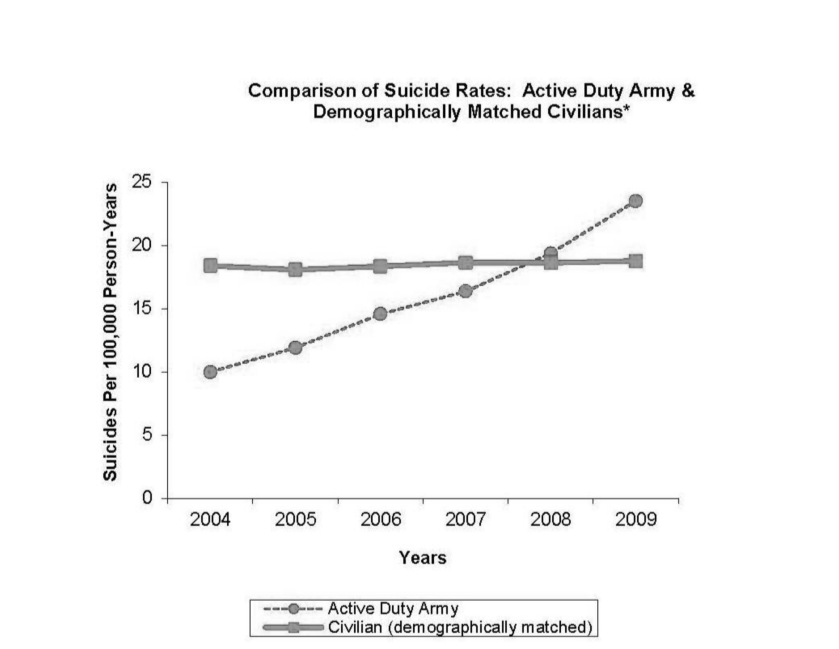
APPENDICES

Appendix A



Comparison of Suicide Rates: Active Duty Army and Demographically Matched Civilians. Army rates calculated by Army STARRS based on data provided by the Defense Manpower Data Center (https://www. dmdc.osd.mil/appj/dwp/index.jsp). Civilian rates calculated by Army STARRS based on data from the Centers for Disease Control and Prevention's WISQARS data system (http://www.cdc.gov/injury/wisqars/index.html), adjusted to reflect the age, sex and race composition of the Army.

Appendix B

Demographics for participating Chaplains and Chaplain Assistants/Religious Support Team Members (CA/RST)

	Chaplain	CA/RST
Gender		
Male	93.75	100.00
Female	6.25	0.00
Military Branch		
Air Force	23.35	0.00
Army	64.71	80.00
Marines	0.00	0.00
Navy	11.76	20.00
Years of Military Service		
0 – 5	6.25	20.00
6 – 10	12.50	20.00
11 – 15	50.00	60.00
16 – 20	31.25	0.00
Years in Special Operations Forces		
0 – 5	70.59	100.00
6 – 10	29.41	0.00
Age		
18 – 25	0.00	20.00
26 – 30	0.00	40.00

31 – 35	29.41	40.00
36 – 40	23.53	0.00
Ethnicity		
Hispanic or Latino	5.88	0.00
Black or African American	5.88	20.00
Native American or American Indian	0.00	0.00
Asian or Pacific Islander	5.88	0.00
Caucasian	64.71	80.00
Prefer not to respond	17.65	0.00

Appendix C

The Chaplain survey:

1. The Crisis Care & Counseling course has increased or broadened my professional skill sets in working with my unit on:
    - PTSD related issues
    - Suicide prevention
    - Suicide postvention

A response scale was available using the categories and scores of Strongly Agree (2), Agree (1), Disagree (-1), and Strongly Disagree (-2).

2. The Crisis Care & Counseling course has enabled my skills to better advise my command in implementing religious support operations and programs in my unit related to:

    - PTSD
    - Suicidality

A response scale was available using the categories and scores of Strongly Agree (2), Agree (1), Disagree (-1), and Strongly Disagree (-2).

3. I have been able to use these skills in counseling within my unit since completing the program.

Responses provided were: Yes or I have not had an opportunity to use these skills yet.

4. I have been able to use these skills in other areas, such as:
    - Family Support Groups

- Suicide prevention awareness groups
- PTSD awareness groups
- Grief support groups

A response scale was available using the categories and scores of Strongly Agree (2), Agree (1), Disagree (-1), and Strongly Disagree (-2).

5. I have provided my chaplain assistants, or religious support team, training on these skills.

Responses provided were: Yes or I have not had an opportunity to use these skills yet.

6. Based on my experience this program should be sustained.

Responses provided were: Yes or No

Appendix D

The Chaplain Assistant and Religious Support Team survey:

1. My chaplain has trained me on the skills learned upon completing the Chaplain Certificate Program course Crisis Care & Counseling on the following topics:
    - PTSD
    - Suicide Prevention
    - Suicide Postvention
    - Have not had the opportunity

A response scale was available using the categories and scores of Strongly Agree (2), Agree (1), Disagree (-1), and Strongly Disagree (-2).

2. I have observed a positive change with increased confidence in my chaplain within our unit in dealing with:
    - PTSD related issues
    - Suicide prevention related issues
    - Suicide postvention related issues

A response scale was available using the categories and scores of Strongly Agree (2), Agree (1), Disagree (-1), and Strongly Disagree (-2).

3. I have observed increased skills in my chaplain within our unit in dealing with:
    - PTSD related issues
    - Suicide prevention related issues
    - Suicide postvention related issues

A response scale was available using the scores of 2, 1, -1, and -2.