A COMPREHENSIVE PLAN FOR PROVIDING CHAPLAINCY SUPPORT TO WOUNDED FEMALE SOLDIERS: A DELPHI STUDY

by

Daniel Roberts

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ABSTRACT

The purpose of this qualitative Delphi study was to build consensus on a comprehensive plan and model for creating a system by which male chaplains could provide effective support to wounded female soldiers. The study was conducted in three phases, with two rounds in the first and second phase. The final product of Phase 3 was a comprehensive plan and model that answered the research questions: (a) What could be a comprehensive plan and model that male chaplains could use to provide effective support to wounded female soldiers? (b) What role might chaplains play in a comprehensive plan and model that could provide effective support to wounded female soldiers? The theoretical framework for this study was feminist systems theory (FST). This study was developed for women by listening to the voices of women. It used a methodology that gave voice to those women who experienced the traumas and stressors of deployment, and it recorded the expert opinions of female care providers, namely chaplains. Women are a minority group in the military, but in this study, they became the center of attention. It is believed that the results of this study could engender positive change for the chaplaincy and improved care for female soldiers.

DEDICATION

I dedicate this dissertation to my loving and loyal family. Without their constant support, patience, and personal sacrifice, I could never have completed this journey.

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My personal gratitude goes to my committee members, Dr. Joann Kovacich, Dr. R. J. Gore, and Dr. Melvin J. Rivers. Dr. Kovacich mentored me, encouraged me, and pushed me beyond my self-imposed limitations. By holding me to an exacting set of standards, Dr. Kovacich not only prepared me for dissertation approval but made me a better researcher. Dr. Gore, my friend of many years, honored me by joining me on this journey and helping me by providing timely information, useful criticism, and encouragement. Dr. Rivers offered a great deal of technical advice, assistance, and support. I am very proud of my committee. I could not have asked for a more competent and caring group of individuals.

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Chapter 1

Introduction

Female soldiers in the military face many stressors. Similar to male soldiers, female soldiers deploy overseas and experience the traumas of combat (Maguen, Luxton, Skopp, & Madden, 2012). By 2009, over 600 women had been wounded and over 100 killed in overseas deployments (Cater & Koch, 2010).

Female soldiers confront sexual harassment and assault in far greater numbers than men (Mattocks et al., 2012), and are more prone to mental disorders and depression than men (Cater & Koch, 2010; Goldzweig, Balekian, Rolon, Yano, & Shekelle, 2006; Kuehn, 2008; Maguen et al., 2012). One out of six female veterans of Operation Enduring Freedom (OEF, Afghanistan)/Operation Iraqi Freedom (OIF, Iraq) reported experiencing sexual harassment or assault as opposed to seven out of 1,000 men (Mattocks et al., 2012). The relationships between injury experiences and PTSD were more strongly associated with women than men (Maguen et al., 2012).

Part of the role of military chaplains is to provide support to soldiers in crisis (Besterman-Dahan, Gibbons, Barnett, and Hickling, 2012). Women prefer female crisis workers and counselors (Chowdhury-Hawkins, McLean, Winterholler, & Welch, 2008; Furnham & Swami, 2008). Ninety-five percent of U.S. Army chaplains are male (The United States Army, 2014), which means that many military women do not have ready access to a female chaplain. The goal of this Delphi study was to build consensus on a plan and model for creating a system by which male chaplains could provide effective support to wounded female soldiers. Chapter 1 includes the background of the problem, the problem statement, the purpose of the study, its significance to the chaplaincy and

leadership, the research method, and the theoretical framework upon which the study was built.

Background of the Problem

Over 200,000 women, representing just over 14% of the total force, serve in the U.S. armed forces (2011 Demographics profile of the military community, 2012). Legislators have created policy changes integrating women into a wider variety of military roles, but women still feel the pressure to fit into organizations that are predominantly male (Carreiras, 2006; Tarrasch, Lurie, Yanovich, & Moran, 2011). As a result, women "often confront rejection, alienation, prejudice, and discrimination within their units" (Tarrasch et al., 2011, p. 306). According to Demers (2013), over 100,000 military women experience gender harassment (discriminatory or sexist remarks) on a yearly basis. Gender harassment is a severe stressor that increases the total stress felt in a combat zone (Demers, 2013).

According to Maguen et al. (2012), the U.S. Department of Defense, in 2008, reported that women accounted for approximately 12% of the force serving in Afghanistan and Iraq. Over 40% of those female soldiers experienced combat exposure (Maguen et al., 2012). In Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) deployments, over 600 female soldiers have been wounded (Cater & Koch, 2010). Besides combat trauma, female soldiers endured military sexual trauma (MST). MST is defined as "sexual assault or repeated, threatening sexual harassment that occurred while the veteran was in the military" (Mattocks et al., 2012, p. 538). Approximately one in six women experienced MST during OEF/OIF (Mattocks et al., 2012).

Given these stressors, women veterans showed "elevated rates of mental health disorders" (Maguen et al., 2012, p. 311), including PTSD and depression. MST takes a more insidious toll. According to Maguen et al. (2012), female veterans "with a history of MST were five to eight times more likely to have current PTSD, three times more likely to be diagnosed with depressive disorders, and two times more likely to be diagnosed with alcohol use disorders" (p. 312) than females without a history of MST. Williams and Bernstein (2011) found that MST is four times more likely to lead to PTSD than distress related to military duty.

Taylor (2010) found that women who work in organizations in which women are the minority feel less supported than men. Taylor (2010) defined support as getting help from coworkers, being listened to by coworkers, getting needed information from supervisors, and being listened to by supervisors. Women who are underrepresented in organizations perceive a lower level of workplace support than men (Taylor, 2010).

Chaplains perform a number of services related to the emotional and spiritual well-being of service members (Howard & Cox, 2008). These include performing religious services, providing counseling, and acting "as a conduit between mental health care providers and service members who may be hesitant to seek clinical treatment" (Besterman-Dahan et al., 2012b, p. 1028). Combat may lead to inner moral conflicts and chaplains may help soldiers work through these issues (Besterman-Dahan et al., 2012b).

Problem Statement

Female soldiers account for approximately 13% of the U.S. Army (United States Census Bureau, 2011), but only 5% of the main crisis workers for female soldiers (Army chaplains) are female (The United States Army, 2014). Most women prefer female

doctors, crisis workers, and psychological counselors (Chowdhury-Hawkins et al., 2008; Furnham & Swami, 2008). Besterman-Dahan et al. (2012b) found that more than half of soldiers who sought professional help for mental health went to a chaplain. The general problem is that approximately 95% of chaplains in the U.S. Army are male, and research shows that females prefer to receive support from other women (Chowdhury-Hawkins et al., 2008; Furnham and Swami, 2008). For example, in sexual assault cases where no female crisis workers or doctors were available, four out of 10 women would not see a male doctor and three out of 10 women would not see a male crisis worker (Chowdhury-Hawkins et al., 2008). The effect of this problem is that female soldiers may be less likely to seek needed help, leading to prolonged stress and dysfunction for the soldier (Goldzweig, Balekian, Rolon, Yano, & Shekelle, 2006).

The specific problem is that male chaplains in the U.S. Army do not have a comprehensive system by which to provide emotional and spiritual support to female soldiers. Failure to provide answers to the problem could result in prolonged PTSD, depression, sexual dysfunction, relational stress, and substance abuse for traumatized female soldiers (Cameron et al., 2011; Mattocks et al., 2012). This study contributed to the body of knowledge by developing consensus on a comprehensive plan for providing emotional and spiritual support to wounded female soldiers.

The population group of this Delphi study was U.S. Army women who had been wounded or injured since 2003 during an overseas deployment, and U.S. Army female chaplains who had been deployed at least once between 2005 and 2015. Wounded females provided experiential knowledge on the unique needs of traumatized women while the female chaplains provided ministry expertise and gender-specific experience.

The group composed a panel of experts tasked with developing a comprehensive plan for chaplains in providing emotional and spiritual support.

Purpose Statement

The purpose of this modified qualitative Delphi study was to build consensus on a comprehensive plan and model for creating a system by which male chaplains could provide effective support to wounded female soldiers. This study design aligns with Passalacqua and Cervantes' (2008) call for "a model that incorporates dimensions of gender, culture, and spirituality and invites a more sophisticated inquiry about the client's life experience and perspective from these three areas" (p. 234). Opinions were gathered from two groups of experts. Following recommendations by Okoli and Pawlowski (2004), the first group, Group 1, consisted of 10 U.S. Army women who were wounded or injured since 2003 during an overseas deployment. This group included women who were injured as a result of combat, accidents, and sexual assault. Group 1 did not include female soldiers who were injured or assaulted while serving in a position in the continental United States. The second group, Group 2, consisted of 11 women currently serving as U.S. Army chaplains.

This study took place at Fort Bragg, North Carolina and consisted of a series phases and rounds. Phase 1 involved two rounds. The first round entailed semi-structured interviews of Group 1 participants. In the second round, participants validated data generated from the first round. Phase 2 also included two rounds. Group 2 participants contributed through semi-structured interviews in the first round. In the second round, participants provided consensus on the data. Phase 3 produced a comprehensive model for providing emotional and spiritual support to wounded female

soldiers. The results of this study provided information that the U.S. Army Chief of Chaplains and senior chaplain leaders could use to create training and establish female chaplain recruiting initiatives to meet the needs of women soldiers who have suffered through a traumatic event. Chaplains in the field might be able to use the information to understand the needs of female soldiers and support those needs through counseling and spiritual support activities.

Significance of This Study

More research is needed on women veterans and the gender differences associated with reactions to combat, MST, and other military-related stressors (Maguen et al., 2012; Mattocks et al., 2012). There is a greater need for research on spiritually-based intervention strategies for veterans (Bormann, Thorp, Wetherell, & Golshon, 2008). Finally, there is a need for more research that examines how gender and religious/spiritual counseling may interact (Passalacqua & Cervantes, 2008).

Chaplaincy-based research is lacking (Harding, Flannelly, Galek, & Tannenbaum, 2008). Between 1980 and 2006, chaplaincy research accounted for only 0.011% of published articles related to health care (Harding et al., 2008). Less than 20% of all articles published in the *Journal of Pastoral* Care, the main journal for chaplaincy articles, between 1990 and 1999, were scientific (Weaver, Flannelly, & Liu, 2008). Weaver et al. (2008) stated that more chaplaincy-based research should be conducted on the spiritual care chaplains provide, standards of care, the relationship between spirituality and health, theological perspectives, and chaplaincy effectiveness.

There is a general lack of research related to women in the military (Carreiras, 2006). This lack of research is significant because female soldiers have suffered more

than male soldiers in some ways (Cater & Koch, 2010; Mattocks et al., 2012). The divorce rate among enlisted women is three times higher than it is for men and "30,000 single mothers have served in Iraq and Afghanistan" (Cater & Koch, 2010, p. 11). According to Cater and Koch (2010), approximately one-third of women veterans were diagnosed with mental disorders between 2006 and 2008. The results of this research added to the body of knowledge in the areas of military-related stressors, chaplain services, and care for women veterans.

Significance of the Study to Leadership

According to Howard and Cox (2008), in a survey of over 3,000 Marines, which took place three to four months after the Marines returned from deployment, PTSD rates were 7% higher and alcohol abuse was 6% to 17% higher than before the deployment. Even if a veteran had not been diagnosed with a mental disorder, the person might experience other problems that leaders should be concerned about. These include thoughts of suicide, loss of job performance, and relational problems with spouse and loved ones (Howard & Cox, 2008). The results of this study added to the body of knowledge related to how leaders can use chaplain services to care for soldiers who are suffering from the traumas of combat and other stressors.

Nature of the Study

According to Chamberlain (2009), qualitative research methods were developed to study the "parts of the human system that are not amenable to quantitative measurement" (p. 52). This study used a qualitative Delphi technique. Researchers use the Delphi process to build consensus based on the opinions of a panel of experts (Jones & Hunter, 1995).

Research Method

According to Stephens et al. (2010), interpretivism is an appropriate approach to research in feminist system theory (FST). Interpretivists do not believe in universal standards of research (Willis, Jost, & Nilakanta, 2007), and do not embrace the expectations of objectivity employed by positivists (Stephens et al., 2010; Willis et al., 2007). Instead, all research methods, including quantitative methods are open to subjective interpretation (Willis et al., 2007). Rigorous interpretivist research "reflects qualities of responsibility, accountability, partiality and subjectivity" (Stephens et al., 2010, p. 561). This study used a qualitative methodology. Qualitative research is exploratory, subjective, and describes specific groups in a particular context (Christensen, Johnson, & Turner, 2011). Qualitative methods are accepted by interpretivists and FST practitioners (Stephens et al., 2010; Willis et al., 2007).

Research Design

The Delphi process consists of a series of rounds in which a panel of experts, through an anonymous forum, provide opinions on the matter at hand (Charlton, 2004). In the first round, the panel of experts provide opinions based on practical knowledge. The researcher then analyzes the information and feeds it back to the panel in the form of summaries "under a limited number of headings" (Charlton, 2004, p. 246). In round two, participants score their level of agreement and certainty with each statement in the questionnaire (Jones & Hunter, 1995). From the results obtained in round two, the researcher synthesizes and analyzes the data and returns the results to the panel members. This process continues until a consensus is obtained. According to Charlton (2004), three rounds will usually produce an adequate agreement.

Study Population

The study population consisted of two groups. The study population of the first group, Group 1, was U.S. Army women who were wounded in an overseas deployment. Group 1 participants did not include male soldiers or female soldiers who were injured or assaulted while serving in a position in the continental United States. Group 1 participants provided expertise on the needs of wounded military women and recommendations for the support systems that may help provide for those needs.

The second group, Group 2, consisted of female chaplains who were currently serving as chaplains, had been deployed at least once between 2005 and 2015, were in the grade of captain or above, and served in the Army for at least four years. These delineations were designed to ensure that only those chaplains with enough experience and knowledge of the stressors of deployment, the U.S. Army, the chaplain corps, and the unique challenges facing military women were included in the study. Female chaplains provided expertise on processes for providing or performing emotional and spiritual support, and ways to integrate ministry with other supporting agencies.

Research Questions

Research questions help qualitative investigators establish the boundaries of their studies (Koro-Ljungberg & Hayes, 2010). Koro-Ljungberg and Hayes (2010) described three types of boundaries that research questions create: instrumentalization, study context and setting, and epistemology. Instrumentalization referred to the selection of tools and techniques for a study based on the research questions (Koro-Ljungberg & Hayes, 2010). Situating research questions within a specific context helps set the scope of the study (Koro-Ljungberg & Hayes, 2010). Finally, research questions provide clues

about the researcher's epistemological stance (Koro-Ljungberg & Hayes, 2010). This study was based on two research questions.

Research Question 1: What could be a comprehensive plan and model that male chaplains could use to provide effective support to wounded female soldiers?

Research Question 2: What role might chaplains play in a comprehensive plan and model that could provide effective support to wounded female soldiers? The comprehensive plan and model developed in this study included support workers besides chaplains. The answer to this research question elaborated the specific role of chaplains in the comprehensive model.

Theoretical Framework

This study drew from four principles of feminine systems theory (FST): using a gender sensitive approach, listening to minority voices, using appropriate methodologies, and promoting desirable and sustainable social change (Stephens, Jacobson, & King, 2010). Gender sensitivity refers to examining in research what is distinct about the experiences of women (Stephens et al., 2010). The studies referenced in this section are gender sensitive and support the theoretical framework of this study.

According to Chowdhury-Hawkins et al. (2008), in a quantitative study in which 168 women who experienced sexual assault participated, approximately three out of four females preferred female physicians and female crisis workers. In addition, over 40% of female victims would refuse to be examined by a male doctor if given a choice (Chowdhury-Hawkins et al., 2008). Using scenario-based questionnaires, Furnham and Swami (2008) surveyed 257 participants (134 women and 123 men) and found that women prefer female psychological counselors. No studies were found that addressed

whether women prefer male or female chaplains or pastors if they were given a choice. Most female soldiers do not have a choice in chaplain gender since 95% of chaplains are male (The United States Army, 2014).

Studies provide evidence for the positive effects of the chaplain and religious services. According to Besterman-Dahan et al. (2012b), of those deployed soldiers who sought counseling, 56% sought help from a chaplain, 32% of which were female soldiers. Female soldiers sought help from both a mental health provider and a chaplain by 12% more than male soldiers (Besterman-Dahan et al., 2012b). Jarvis, Kirmayer, Weinfeld, and Lasry (2005) conducted a quantitative study in which 2,246 participants between the age of 18 and 75 were surveyed to investigate "the relationship between religious practice and psychological distress" (p. 657). Of the 2,246 participants, 1,485 were included in the analysis and 63% percent of participants were female (Jarvis et al., 2005). Only 11% of all participants had ever approached a religious leader for help with a personal problem, but the study did not provide a gender analysis of this statistic (Jarvis et al., 2005). Females attended church services more regularly than males and practiced religious rites at home more frequently than males (Jarvis et al., 2005). In addition, studies have shown that people who attend church more often are less likely to experience psychological distress (Calder, Badcoe, & Harms, 2011; Jarvis et al., 2005).

The remaining principles of FST, listening to minority voices, using appropriate methodologies, and promoting desirable and sustainable change, are captured in the methodology of this study. Listening to minority voices is the idea that the best recommendations for change do not always come from the top, and that people in the margins need to be heard (Stephens et al., 2010). The Delphi process in this study

gathered data from wounded women and female chaplains, both of whom are minorities in the military. "Once women are allowed to speak about their own space, rather than have male religious professionals speak for them from the male-dominated space, an entirely other world of experience may be identified" (Franzmann, 2000, p. 3). Interpretivism is an appropriate methodology for FST because it situates conclusions within the social context of the participants (Stephens et al., 2010). The Delphi design is appropriate because it meets the FST criteria of "tailored and responsive methods to address multifarious problems" (Stephens et al., 2010, p. 557). Finally, the study promoted desirable and sustainable social change by building consensus on a comprehensive plan and model for creating a system by which male chaplains could provide effective support to wounded female soldiers.

Definitions

The section provides the operational definitions of key terms in the study.

Wounded female soldiers. Wounded female soldiers are those who received a physical wound or injury while deployed overseas between 2003 and 2013.

Female chaplain. All chaplains in this study were commissioned officers who met all of the requirements for Army chaplaincy. U.S. Army chaplains are clergy persons endorsed by a specific denomination or faith group, possess a ministerial graduate degree with at least 72 hours of coursework, and possess a secret clearance (Army Chaplain Corps, n.d.).

Assumptions

The assumption that most women prefer to receive emotional support from other women formed the basis of this study. Chowdhury-Hawkins et al. (2008) found that 75%

of female sexual assault victims preferred female crisis workers and physicians. Furnham and Swami (2008) found that women prefer female psychological counselors.

The second assumption for this study was that chaplains are the main crisis workers for soldiers at the unit level. Chaplains provide emotional and spiritual support from a religious perspective and are embedded in the soldier's unit (Howard & Cox, 2008). To see a mental health care provider, soldiers must be referred to an agency outside the unit itself (Howard & Cox, 2008). Since approximately 95% of chaplains are male (The United States Army, 2014), most soldiers who want to see a female chaplain must be referred to one outside of the soldier's unit. This may not always be possible, especially in a deployment situation.

This study made three assumptions in regards to the safety and privacy of participants. First, it was assumed that female participants understood that a participant may end an interview at any time and stop participating in the study. A second assumption was that all participants understood that participation in the study was voluntary and that the participants' identities were kept strictly confidential. Third, it was assumed that interviews were conducted in a safe and comfortable environment for participants.

Scope

The scope of this study was limited to 10 female soldiers and 11 currently serving female chaplains. The female soldiers were wounded or injured while stationed overseas in the U.S. Army between 2003 and 2013 and were over 30 years old. Wounded female soldiers provided ideas for a comprehensive plan for a system that male chaplains can use to provide emotional and spiritual support to wounded female soldiers.

In this study, the female chaplains used for the Delphi panel were in the rank of captain or above with at least four years of military service, deployed overseas at least once between 2005 and 2015, and were serving as chaplains during the time of this study. Female chaplains offered ideas from their unique perspective as chaplains.

Limitations

The scope of this study was limited to U.S. Army female soldiers who were physically wounded or injured during an overseas deployment. The subject matter experts were those wounded women and female chaplains who have been deployed. In keeping with feminist system theory (Stephens et al., 2010), this study assumed that women are best suited to provide solutions for women and the Delphi process did not include male chaplains. As such, the results of the study are generalizable to military women of all services who have been injured, but might not be generalizable to military women who need emotional and spiritual support for other things. The comprehensive plan and model developed through this study might not be suitable for military men who need emotional and spiritual support.

There are inherent limitations to qualitative and Delphi studies. First, the Delphi technique relies on the expert opinion of others and everyone, expert or not, carries some biases (Linstone & Turoff, 2002). Second, qualitative studies, in general, carry certain limitations, including that they rely on researcher skill, are more difficult to establish rigor, use data that is more difficult to analyze, and are prone to the influence of bias (Anderson, 2010).

Delimitations

Group 1 participants were limited to those female soldiers who had been wounded or injured in an overseas deployment while serving in the U.S. Army. Male wounded soldiers were not included. Group 1 participants were recruited primarily from soldiers assigned to one of the 25 U.S. Army Warrior Transition Units.

Group 2 participants were limited to those female chaplains who were serving as chaplains during the time of this study, had been deployed at least once between 2005 and 2015, were in the grade of captain or above, and had been serving in the Army for at least four years. Chaplains from other branches, such as the Air Force or Navy, were not included. Male chaplains were not included in the study, and female chaplains who met the time in service requirement, but had not been deployed were not included. Group 2 participants were recruited from Army posts located throughout the United States.

Summary of Chapter 1

Like male soldiers, female soldiers experience the traumas of combat (Maguen, Luxton, Skopp, & Madden, 2012) and over 600 women have been wounded in overseas deployments (Cater & Koch, 2010). Female soldiers also experience sexual harassment and assault in far greater numbers than men (Mattocks et al., 2012). Unfortunately, women are also more prone to mental disorders and depression than men (Goldzweig et al., 2006; Kuehn, 2008; Maguen et al., 2012).

Military chaplains provide emotional and spiritual support to soldiers from a religious perspective (Besterman-Dahan et al., 2012b; Howard & Cox, 2008). Women prefer to get emotional support from other women (Chowdhury-Hawkins et al., 2008; Furnham and Swami, 2008) and 95% of chaplains are male (The United States Army,

2014). The purpose of this qualitative Delphi study was to build consensus on a comprehensive plan and model for creating a system which male chaplains might use to provide effective support to wounded female soldiers. Chapter 2 is a review of current research related to this study.

Chapter 2

Review of the Literature

This chapter provides a literature review of various subjects related to the current study. The review covers a brief history of the U.S. Army, history of women in the military, injuries suffered by female soldiers, the variety of methods military women have used to cope with deployment experiences, and issues that women typically face in a male dominated industry, such as the military. Other issues covered in this literature review include how spirituality and religion have helped people in coping with stress and illness, the history of the military chaplaincy, the role of chaplains in the U.S. Army, various methods that may help wounded female veterans cope with stress, and the Delphi research method.

Documentation

Literature reviewed in this study came primarily from peer-reviewed articles. Some information came from official government Web sites. The following key words were used in online library searches through the University of Phoenix: *military history, chaplain, history of women in the military, military women, military chaplain, injured soldier, female soldier, mental health disorders and women, mental health disorders and veterans, women veterans, gender and help-seeking behavior, gender inequality, women in law enforcement, workplace support, gender bias, gender inequality and religion, gender inequality and psychological health, spirituality and mental health, religion and mental health, role of chaplains, emotional support, spiritual support, social networking and emotional support, women support groups, internet support groups, Delphi method,*

feminist view on PTSD, and *online counseling.* Table 1 lists the number of articles used for each section in the literature review.

Table 1
Number of Articles Per Section

Section	Articles
Women in the U.S. Military	10
Women and Health Issues	26
Gender Inequality	17
The Role of Spirituality and Religion	24
Emotional and Spiritual Support Approaches	25
The Delphi Method	5
Total Articles Used	107

Women in the U.S. Military

History of Women in the U.S. Military

Early history of the American military woman.

Since America's first wars, women have been serving in the military (Carreiras, 2006). Women served as regular fighting troops in the militia, and as support personnel (cooking, doing laundry, tending wounds, etc.), as spies, and on warships (Devilbiss, 1990; Monahan & Neidel-Greenlee, 2010; Sherrow, 1996). Some women disguised themselves as men to serve in combat roles (Monahan & Neidel-Greenlee, 2010;

Sherrow, 1996). During this early period, women held no rank or official positions but did receive pay (Devilbiss, 1990).

Women cared for the dying and wounded (Devilbiss, 1990). Approximately 6,000 women served as nurses in the Union Army in the Civil War, and Clara Barton and Dorothea Dix won acclaim for medical work (Devilbiss, 1990). Dr. Mary Walker was the first female doctor in the U.S. Army and was the first, and only, woman ever to receive the Medal of Honor (Devilbiss, 1990; Sherrow, 1996). Ella F. Hobert served as the "only official woman chaplain in the Civil War" (Sherrow, 1996, p. 61). Congress officially established the Army Nurse Corps and the Navy Nurse Corps shortly after the turn of the 20th century (Devilbiss, 1990).

Women in the military in the 20th century.

Women were first accorded military rank in World War I (Devilbiss, 1990). As in previous wars, women were recruited to fill personnel shortages (Devilbiss, 1990). The Navy allowed women to enlist as yeomen so that the men would be free to fight (Monahan & Neidel-Greenlee, 2010). The Navy and Marine Corps employed nearly 13,000 women, and afforded women actual military rank, but did not allow women to advance beyond the rank of sergeant (Devilbiss, 1990). Except for the nursing corps, the U.S. Army refused to use women in any capacity other than civilians (Devilbiss, 1990; Monahan & Neidel-Greenlee, 2010).

The nursing corps, for both the Army and Navy, employed thousands of women during World War I (Devilbiss, 1990; Monahan & Neidel-Greenlee, 2010). Over 21,000 nurses served in the Army alone (Devilbiss, 1990; Monahan & Neidel-Greenlee, 2010). Despite dangerous and difficult work, female nurses could not become commissioned

officers (Devilbiss, 1990). Leaders in the War Department and the Surgeon General's Office did not believe that women should be able to attain any rank that would place women in a superior position over men (Devilbiss, 1990).

In addition to nurses, over 1,000 women were hired as civilian contractors to serve in the American Expeditionary Forces (AEF) stationed in Europe during World War I (Sherrow, 1996). These women served as telephone operators and translators (Monahan & Neidel-Greenlee, 2010; Sherrow, 1996). No medical benefits were afforded to the dependents and the women received no veterans' benefits after the war (Monahan & Neidel-Greenlee, 2010; Sherrow, 1996).

After World War I, the status of military women regressed. Women were expected to leave the service and return to their traditional roles as housekeepers and homemakers (Carreiras, 2006; Monahan & Neidel-Greenlee, 2010). Women who stayed in the service were granted the ability to achieve commissioned officer rank but could not go above the grade of major (Devilbiss, 1990). Rank gave women no actual authority and came with less pay than that received by male service members of the same rank (Devilbiss, 1990). Further, the law that allowed women to enlist in the Navy and Marine Corps as something other than nurses was changed so that once again women were excluded from any other job (Devilbiss, 1990).

When World War II started, the U.S. military was once again faced with a shortage of personnel, and women were allowed to enter the service in positions outside of the medical field (Carreira, 2006; Devilbiss, 1990). In 1942, the Army established the Women's Army Auxiliary Corps (WAAC), an official group of women attached to, but not in the Army (Devilbiss, 1990; Monahan & Neidel-Greenlee, 2010). In the same year,

the Navy established the Navy Women's Reserve, or Women Accepted for Volunteer Service (WAVES), and the Marine Corps established the Marine Corps Women's Reserve, or Women Marines (Devilbiss, 1990; Monahan & Neidel-Greenlee, 2010). A year later, Congress changed the WAAC to the Women's Army Corps (WAC) and gave its members full military status (Devilbiss, 1990).

During World War II, over 300,000 women served in the U.S. armed forces as pilots, medical personnel, support personnel, clerks, and mechanics (Carreira, 2006; Devilbiss, 1990). Jacqueline Cochran founded the Women's Airforce Service Pilots (WASP), a civilian flying group that ferried planes across the continental U.S. (Carreira, 2006; Sherrow, 1996). This freed male pilots to serve overseas (Sherrow, 1996). The U.S. military did not allow women to serve in roles deemed as combat roles (Carreira, 2006; Devilbiss, 1990). Meanwhile, the Soviet Union and Great Britain drafted men and women into service and both genders served in combat roles (Devilbiss, 1990).

In the United States, women have never been drafted (Devilbiss, 1990; Sherrow, 1996). During World War II, three out of four Americans believed that single women should be drafted before men with children (Devilbiss, 1990; Sherrow, 1996). Single women, at virtually the same percentage rate as Americans overall, believed that single women should be drafted before fathers (Devilbiss, 1990; Sherrow, 1996).

After World War II, the number of women serving on active duty in the military shrank from over 250,000 to just over 14,000 (Devilbiss, 1990). Throughout the U.S. military's history to this point, senior military leaders, with few exceptions, viewed women as useful for shoring up personnel shortages in a time of war, but saw no need to include women as permanent members (Devilbiss, 1990). The Women's Armed

Services' Integration Act of 1948 changed this, giving women permanent status in the military (Devilbiss, 1990). The Act came with limitations. Women could comprise no more than two percent of active duty personnel and women could not serve as generals or admirals (Devilbiss, 1990). In fact, each service could have only one female colonel, or Navy captain (Devilbiss, 1990). The Act also limited the kind of jobs women could do and "set differing enlistment standards and dependency entitlements for men and women" (Devilbiss, 1990, p. 7). Further legislation limited the number of women who could be in the service to two percent of the number of males (Monahan & Neidel-Greenlee, 2010).

In 1967, due to the manpower pressure the Vietnam War put on the services, Congress enacted Public Law 90-130, which gave the service secretaries the option to remove the two percent ceiling (Devilbiss, 1990). Women who served in the Armed Forces could no longer be discharged due to marriage (Monahan & Neidel-Greenlee, 2010). By 1967, over 600 Army nurses were serving in combat zones in Vietnam (Monahan & Neidel-Greenlee, 2010). Public Law 90-130 also allowed women to be promoted to the rank of general or admiral (Devilbiss, 1990). The first woman was promoted to the rank of brigadier general in 1970, but by 1988, there were only nine female generals (Devilbiss, 1990).

In 1988, approximately five out of every 10,000 active duty personnel were general officers (Defense Manpower Data Center, 1988). As a point of comparison, four out of every 100,000 women were general officers (Defense Manpower Data Center, 1988, Devilbiss, 1990). While a handful of women were promoted to the general ranks,

women were greatly underrepresented in the senior rank structure (Defense Manpower Data Center, 1988).

Devilbiss (1990) stated that evolutionary change happened for military women in the 1970s. The termination of the draft and the advent of the all-volunteer force in 1973 necessitated change (Carreiras, 2006; Devilbiss, 1990). According to Devilbiss (1990), the seminal developments for military women in the 1970s could be put into five categories: committees, policy, numbers, training, and roles.

Seminal developments for military women.

Committees advising policy makers.

Devilbiss (1990) identified four major committees established between 1977 and 1984 to advise policy makers and Department of Defense leaders. The Defense Advisory Committee on Women in the Services (DACOWITS) was a civilian advisory group consisting of 50 female leaders from the business and professional world (Devilbiss, 1990; Sherrow, 1996). Female recruiting was one of the issues that DACOWITS tackled in the 1950s (Sherrow, 1996). At that time, barriers to recruitment included prejudicial attitudes against women in uniform, the lack of a national crisis prompting women to join, and extraordinarily high medical and physical requirements for female recruits (Sherrow, 1996). At this time, the medical and physical standards that women had to meet to join the military were higher than the standards for men (Sherrow, 1996).

The second committee, the Committee on Women in the NATO Forces, consisted of delegates from Belgium, Canada, Denmark, France, Germany, the Netherlands, Norway, Portugal, Turkey, the United Kingdom, and the United States (Devilbiss, 1990). The third group was the Veterans Administration Advisory Committee on Women

Veterans, and the fourth was the Task Force on Equity for Women (Devilbiss, 1990). All of these groups served the military and Veterans Administration (VA) as advisory committees on military women's issues (Devilbiss, 1990).

Policies affecting military women.

After World War II, women who got married could be released from the military or be barred from reenlistment (Devilbiss, 1990). The concern was that married female soldiers would become pregnant and not be able to perform military duties (Devilbiss, 1990). This created personnel shortages that led to changes in policy (Devilbiss, 1990). New policies that allowed married women to remain in the service helped the services maintain personnel numbers, but created other problems (Devilbiss, 1990). Many of the women's spouses were also soldiers, and women requested to be stationed at the same location as their husbands (Devilbiss, 1990).

Marriage and dependency entitlements was a source of inequality. The children and civilian spouses of military women were not considered dependents unless it could be proven that adequate support came from the women, but the civilian spouses and children of military men were automatically considered dependents (Devilbiss, 1990). Dependency status entitled the family to certain benefits not available to single service members. In 1973, the Supreme Court ruled that the military must provide equal benefits and use the same rules for determining dependency for men and women (Devilbiss, 1990).

In 1951, President Harry S. Truman gave the services permission to discharge a woman "if she became pregnant, gave birth to a child, or became a parent by adoption or a stepparent" (Devilbiss, 1990, p. 11). The services established policies that allowed

women who fell into one of the categories to stay in the military only by exception (Devilbiss, 1990). In the 1970s the services rescinded these policies (Devilbiss, 1990). In 1985, a federal court judge ruled that the Air Force and the Army could ban single parents from joining (Devilbiss, 1990).

As a result of the various issues surrounding women in the military, pregnancy, mobilization of women (especially related to pregnant women), and other health issues, the military began a series of scientific studies (Devilbiss, 1990). The Army Medical Department began the U.S. Army Health Care Studies and Clinical Investigation Activity in 1985 (Devilbiss, 1990). "The study focused on pregnancy and other female-specific health issues and examined the utilization and perceptions of the Army health care system by both male and female soldiers." (Devilbiss, 1990, p. 12). Other studies that focused on the health care of military women were undertaken by the Defense Department's Health Affairs Office, the Pentagon's Health Program Review and Evaluation Office, and the Office of the Assistant Secretary of Defense for Health Affairs (Devilbiss, 1990). The results of the studies are not available, but these research efforts were part of the Department of Defense's approach to base family policies on scientific data (Devilbiss, 1990).

Personnel statistics over time.

In 1965, women accounted for approximately one percent of the active duty force (Devilbiss, 1990). Ten years later, that percentage had multiplied five times, and in another decade, the percentage doubled again, so that by 1985, 10% of the active duty military were women (Devilbiss, 1990). The elimination of the draft and the enactment

of laws meant to guarantee equal benefits for women were major contributors to the growth of the numbers (Devilbiss, 1990).

Throughout the 1970s and 80s, the military struggled with the question of how many women could or should be in the military (Devilbiss, 1990). Military planners believed that too many women in the military could adversely affect unit performance (Devilbiss, 1990). The Army conducted two studies that tested the relationship between unit effectiveness and the number of women in a unit (Devilbiss, 1990). No adverse effects were found when the composition of a unit was between zero and 35% female (Devilbiss, 1990).

In the 1980s, service secretaries were encouraged by the secretary of defense to review recruiting and career opportunities for women since women were a vital part of maintaining the end strength numbers needed to ensure readiness (Devilbiss, 1990). The Defense Authorization Act of 1985 placed new requirements on the Air Force in regards to women recruits (H.R. 5167, 1984). Following the guidelines of the law, the Air Force increased the number of women recruits from 14% in 1985 to 22% in 1988 (Devilbiss, 1990).

Training for women.

In 1948, women were first integrated into the Air Force Officer Candidate School (OCS) (Sherrow, 1996). Almost twenty women graduated from the inaugural co-ed version of the program (Sherrow, 1996). The Army integrated its OCS in 1967 (Sherrow, 1996). The Navy followed suit in 1973, and the Marines integrated its OCS in 1977 (Sherrow, 1996).

In the 1970s, the Reserve Officer Training Corps (ROTC) of all services, noncommissioned officer (NCO) academies, and other professional development schools were opened for women (Carreiras, 2006; Devilbiss, 1990). By 1981, 40,000 women had joined ROTC (Sherrow, 1996). The military service academies — West Point (Army), Annapolis (Navy), and Colorado Springs (Air Force) remained closed for women (Devilbiss, 1990). The services argued that academies existed to train officers for combat and since women were excluded from combat roles, women should not be allowed to attend (Devilbiss, 1990). The Government Accounting Office (GAO) conducted a study that revealed that many service academy graduates never received combat role assignments (Devilbiss, 1990). Public Law 94-106, requiring the service academies to admit women, went into effect in 1976 (Devilbiss, 1990).

Roles that military women have filled.

During World War II, women performed a variety of jobs that might be considered non-traditional, such as mechanical, maintenance, and other skilled fields (Devilbiss, 1990). After World War II, military women were only allowed to fill medical and administrative roles, until the 1970s (Devilbiss, 1990). During the 1970s, after service policies allowed women to enlist in many skill categories previously open only to men, women began to move away from medical and administration fields (Carreiras, 2006; Devilbiss, 1990). In approximately 10 years, the number of women serving in medical and administrative fields fell by more than 35% (Devilbiss, 1990).

In the 1970s, opportunities for women as officers greatly increased (Devilbiss, 1990). Previously, women could not supervise men and there were two different promotion lists for officers — one for women and one for men (Devilbiss, 1990). This

changed in the 70s. New policies eliminated separate promotion lists and gave women the opportunity to command men (Devilbiss, 1990).

Women joined the ranks of aviation fields in the early 1970s (Devilbiss, 1990). The first female naval aviator received her wings in 1973 (Devilbiss, 1990). In the next year, the first Army pilot began flying helicopters, and the Air Force commissioned its first female pilot in 1977 (Devilbiss, 1990). At first, women could only fly "weather, reconnaissance, tanker, personnel and cargo transport, and flying hospitals" (Devilbiss, 1990, p. 18) in the Air Force. In 1991, Congress stepped in and eliminated the rule that prevented women from operating as combat pilots (Bergquist, 2007).

In 1972, the Navy began running gender-integrated seagoing crews (Devilbiss, 1990). Six years later, the restrictions against women serving on combatant ships were partially eliminated, meaning that women could serve on such vessels for no longer than six months (Devilbiss, 1990). In the same year, The U.S. Coast Guard "removed all assignment restrictions based on gender" (Devilbiss, 1990, p. 20). In 1989, the Navy got its first female ship commander (Devilbiss, 1990).

Social factors affecting the roles of women in the military.

Gender ideologies are not only determined by internal military policies but are the product of social factors (Stachowtisch, 2012). In the nineteenth century, warfare moved away from a communal affair to an event involving centralized governments and masses of conscripted men (Stachowtisch, 2012). This served to masculinize the military institution and exclude women (Carreiras, 2006; Stachowitsch, 2012). Military jobs became more specialized and hierarchal structures became more solidified (Carreiras, 2006; Sasson-Levy, 2011; Stachowitsch, 2012).

Images of masculine heroes fighting to save the nation were promulgated to encourage the enlistment of men into the armed forces (Stachowitsch, 2011). These images of male warriorhood were portrayed as the masculine ideal for military and civilian personnel (Carreiras, 2006; Stachowitsch, 2011). At the same time, social content idealized femininity as being caring, compassionate, and passive (Carreiras, 2006; Stachowitsch, 2011). In times of national emergencies and warfare, stories of historical women of valor were promulgated to boost female recruitment, but after the conflict ended, these stories were left dormant and replaced by masculine imagery (Carreiras, 2006). Since the beginning of the War on Terror, women have played a significant role, and social discourse on military women now feature images of patriotic female warriors who also care for their young (Stachowitsch, 2011).

Media debates played a significant role in the formation of gender ideologies. Carreiras, 2006) conducted a quantitative and qualitative analysis of 97 articles (40 reports, 23 features, and 33 editorials) from the *New York Times* and *The Washington Post*, from the period of 1990 to 2005. The number of articles peaked in 1991, 1997, and 2005. Desert Shield and Desert Storm, a massively large-scale buildup and deployment of troops, occurred in 1990/1991. In 1997, a number of publicized military sex scandals captured media attention, and the invasion of Iraq in the War on Terror was in full swing in 2005 (Carreiras, 2006).

Content analysis revealed that media discourses centered around two main themes: the attributes and abilities of military women, and the gender integration process in the military (Carreiras, 2006). Some articles were descriptive while others were argumentative (Carreiras, 2006). Pundits from both sides of the issue debated about

whether there should be more or less integration, and how well or not integration was progressing (Carreiras, 2006). These media debates contributed to the ongoing change of the roles of women in the military (Carreiras, 2006).

Carrieras (2006) defined a typology of women's military integration that functioned along two dimensions: women's perception of gender differences or equality and the organization's dominant attitude towards integration. If the dominant attitude is one of loyalty and the gender difference is perceived to be high, then the result is an integration strategy of preserving traditional gender roles (Carreiras, 2006). If the dominant attitude is one of loyalty and the perception of gender difference is low (i.e., equality), then the result is an integration strategy of women adapting to the current culture of the military and eliminating all femininity (Carreiras, 2006). In other words, women act like the men. An attitude of dissent with a perception of high gender difference results in a strategy of women asserting their place while remaining fully women; and an attitude of dissent with the perception of equality results in a conformists strategy — women minimize, but not eliminate femininity, and they quietly fit into the current military culture (Carreiras, 2006).

Alternate views of women in the military.

Van Creveld (2000) agreed with what has been stated so far, that women were called upon to reduce personnel shortages and that the number of women allowed to serve in the military increased significantly during and after World War II. This happened not only in the U.S. military but in many other militaries around the world (van Creveld, 2000). As has been demonstrated in previous sections, the rights and benefits of

women increased through legislation and the judicial system (Devilbiss, 1990; van Creveld, 2000).

Despite changes in legislation and policy, there are relatively very few women in combat roles (Carreiras, 2006; Devilbiss, 1990; Sherrow, 1996; van Creveld, 2000). This is true in the military, law enforcement agencies, and the private security industry (van Creveld, 2000). Van Creveld (2000) asserted that this is because women are basically incapable of performing the types of high-stress, high-strength duties required by combat units. However, on January 24, 2013, the Secretary of Defense and Joint Chiefs of Staff signed a memo that rescinded the rule that excluded women from combat roles (The United States Army, 2013). The memo did not specify which jobs would be opened to women, but the U.S. Army began a study to determine what mental and physical requirements each job should have, and how to judge both male and female soldiers against the developed standards (The United States Army, 2013).

The purpose of the military has changed somewhat, and it is no longer a force maintained solely for the purpose of engaging in armed conflict (Elshtain, 2000; van Creveld, 2000). Van Creveld (2000) saw this change as a decline in military power. According to van Creveld (2000), "whether the influx of women into the military was cause or symptom of their decline is not at issue here; the evidence is compatible with both interpretations" (p. 438). Van Creveld (2000), in reference to women in modern conflicts, went on to state that:

> young or old, in or out of uniform, women's involvement in these conflicts is overwhelmingly as eggers-on, camp followers, and victims. Partly this is because the organizations which wage these wars take them far too

> seriously to bow to the kind of political and juridical constraints that have compelled the armed forces of [*sic*] developed world to take in women, treat them as if they were as fit for war as men, and pamper them in every imaginable way (p. 441).

According to van Creveld (2000), the more women there are in a military, the less capable that military is of performing its primary function of executing warfare. Elshtain (2000) agreed with van Creveld (2000) that the presence of masses of women in the military is not a win for feminism but disagreed that women have led to the decline of the military or are symptomatic of its decline. According to Elshtain (2000), changes in the composition of the military and its purpose represent change, but do not necessarily represent a decline.

In the 1970s, the National Organization for Women (NOW) and others saw equality in the military as an extremely important prize in the cause of women's rights (Elshtain, 2000). The protests against the Vietnam War were still fresh in the minds of political leaders, the draft became politically untenable (Elshtain, 2000; Titunik, 2008), and the military turned into an all-volunteer force (Devilbiss, 1990; Elshtain, 2000; Sherrow, 1996;). Not everyone was pleased with increasing opportunities for women in the military, and both male and female veterans argued against the integration of women into the services. In a lawsuit filed on behalf of women who wanted to enter the U.S. Air Force Academy in 1976, Lieutenant General A.P. Clark testified that integrating women would lead to increased marriages, pregnancies, and abortions (Gawlinski, 2007). Lt. Gen. Clark further stated that integration would lower morale and discipline (Gawlinski, 2007). Jacqueline Cochran, a prominent figure in the WASP organization, stated that

women were not as well suited for military service as men, and are biologically moved to be wives and mothers (Gawlinski, 2007). This biological urge caused many women to seek a discharge in the middle of their career (Gawlinski, 2007).

Summary and Analysis of Women in the U.S. Military

Since the beginning of America's history, women helped America fight and win its wars (Devilbiss, 1990; Monahan & Neidel-Greenlee, 2010; Sherrow, 1996). Most women served in support roles, but some disguised themselves to fight alongside the men ((Devilbiss, 1990; Monahan & Neidel-Greenlee, 2010; Sherrow, 1996). Thousands of women worked as nurses in the Civil War (Devilbiss, 1990), and Ella F. Hobert served as the first female chaplain (Sherrow, 1996). Female soldiers were afforded some pay but were not given rank until World War I (Devilbiss, 1990).

During World War I and World War II, women were recruited to fill personnel shortages and worked in support roles to free men to fight on the front lines (Devilbiss, 1990; Monahan & Neidel-Greenlee, 2010). Over 30,000 women served in World War I, and 10 times that many served in World War II (Devilbiss, 1990; Monahan & Neidel-Greenlee, 2010). It was not until World War II that women in significant numbers were allowed to serve in any field other than the medical field (Devilbiss, 1990). After World War II, legislation limited the number of women in the military to 2% of the force (Monahan & Neidel-Greenlee, 2010).

The 1960s and 1970s brought major changes to the plight of military women. In 1967, Public Law 90-130 allowed for the promotion of women to general or admiral (Devilbiss, 1990). The elimination of the draft in 1973 caused service secretaries to rethink women-oriented policies since they could not rely on the draft to fill personnel

shortages (Carreiras, 2006; Devilbiss, 1990). The policies that allowed the armed services to discharge women who became pregnant were rescinded and in 1973, the Supreme Court ruled that the military must provide equal benefits and use the same rules for determining dependency for men and women (Devilbiss, 1990).

Besides internal military policies and external legal action, the role of women in the military has also been influenced by social factors. Throughout history, various images and stories of heroic women have been used to boost female recruitment, especially during times of national emergencies (Carreiras, 2006). At other times, when the military resorted to exclusionary policies, public discourse about the so-called ideal woman centered on her compassionate, caring, and passive traits (Carreiras, 2006; Stachowitsch, 2011). Debates in the media about the role of military women continue to shape the integration issue (Carreiras, 2006).

Not everyone saw the permanent integration of women into the services as a good thing. Despite the fact that women had proven their value to the military, van Creveld (2000) stated that the inclusion of women in the military is either causal or symptomatic of its decline. According to van Creveld (2000), women are incapable of performing any but the most mundane and physically unchallenging duties. In response to van Creveld's assertions, Elshtain (2000) stated that van Creveld mislabeled change as decline, failed to consider the political context in which the changes he alluded to took place, and failed to make the case that either militaries are in decline or that women represent some symptom or cause of said decline. Jacqueline Cochran (as cited in Gawlinski, 2007) stated that women are not well suited for military service due to the female biological drive toward motherhood, but over 20,000 women are currently serving in senior ranking military

positions on active duty, and over 25,000 women are filling senior ranking military positions in the reserve components (2011 Demographics profile of the military community, 2012).

Women and Health Issues

Injuries Suffered by Female Soldiers

Historical wars.

The number of women who were killed or injured during the Revolutionary War, Civil War, and other battles during the early period of American history is unknown, as women had to be in disguise in order to fight alongside the men (Sherrow, 1996). During World War I, over 200 female nurses died of various diseases (Sherrow, 1996). In World War II, just over 200 Army nurses died; eight percent of which were from enemy action (Sherrow, 1996). During the Persian Gulf War, 13 women died, almost half of which were due to enemy action (Sherrow, 1996).

Modern wars.

In Afghanistan and Iraq, female soldiers perform many duties that were traditionally performed by men. Female soldiers now drive trucks, fly aircraft, operate heavy weapons on convoys, assist the wounded, and are exposed to improvised explosive devices (IEDs) and missile attacks (Cater & Koch, 2010). By 2009, over 600 female soldiers had been wounded and over 60 had been killed in combat in Afghanistan and Iraq (Cater & Koch, 2010).

More than three out of four injuries sustained during OEF/OIF deployments were from explosive blasts and approximately one out of five veterans experienced some type of traumatic brain injury (Cater & Koch, 2010). Traumatic brain injury (TBI) can “cause

chronic somatic, cognitive, and emotional/behavioral symptoms" (Cater & Koch, 2010, p. 10) and women are more susceptible to mental disorders and depression than men (Cater & Koch, 2010; Goldzweig et al., 2006; Kuehn, 2008; Maguen et al., 2012). The research does not make a connection between van Creveld's (2000) assertion that women are unsuitable to combat roles and women's susceptibility to PTSD and depression (Cater & Koch, 2010; Goldzweig et al., 2006; Kuehn, 2008; Maguen et al., 2012). Rather, there is a lack of understanding of why women are more prone to mental disorders (Women and depression, 2011).

Female soldiers in today's military face sexual harassment and assault in greater numbers than men. Approximately one in six women veterans reported experiencing sexual assault or rape as compared to seven in 1,000 men (Katz, Bloor, Cojucar, & Draper, 2007; Mattocks et al., 2012). Over half of the female veterans who sought Veterans Affairs (VA) services reported having been sexually harassed during an overseas deployment (Katz et al., 2007). Goldzweig et al. (2006), in a literature review, found that the percentage of women veterans reporting sexual harassment was as high as 79%. In the fiscal year 2013, over 2,000 sexual assaults were reported in the U.S. Army, and over 1,800 of those reports involved female victims (Department of Defense, 2014).

Related mental health disorders.

Soldiers who suffered a combat-related injury during an overseas deployment are three times more likely to suffer from PTSD than those who were not injured (Baker et al., 2009). Female soldiers who have suffered physical injuries may also suffer from emotional problems related to body image. Society continues to display a bias for beauty and attractiveness (Cater & Koch, 2010; Thombs et al., 2008). Women veterans who

have been disfigured may experience reduced self-esteem, increased anxiety, and lowered social standing (Cater & Koch, 2010). Gender is an important factor in determining the degree of body image dissatisfaction following injury. For instance, female victims of severe burns, on average, experienced a continued increase in body image dissatisfaction from the time of initial hospitalization to one year after release; while men's body image dissatisfaction decreased during the same time period (Thombs et al., 2008).

In general, one in six veterans of OEF/OIF returned from deployment with PTSD and one in five suffered a traumatic brain injury (Cameron et al., 2011). Twice as many military women are diagnosed with PTSD than military men (Feczer & Bjorklund, 2009). The rate of PTSD for female veterans who experienced MST is higher than other female soldiers (Maguen et al., 2012, p. 312). There is verifiable symptomatic overlap between traumatic brain injury (TBI) and PTSD (Cameron et al., 2011). These injuries bring a host of problems, including poor physical health, interpersonal relationship difficulties, parenting problems, partner abuse, violence, and sexual dysfunction (Cameron et al., 2011; Goldzweig et al., 2006).

While women are more likely to develop depression than men, the reasons are a mystery (Women and depression, 2011). Some theories posit that men and women get depression in basically equal numbers, but that women are more likely to talk about it than men, and thus the reported numbers for women are higher (Wilhelm, Parker, Geerligs, & Wedgwood, 2008; Women and depression, 2011). Gender differences in depression may also be explained by hormonal differences (Wilhelm et al., 2008; Women and depression, 2011); abusive experiences early in life, which happens to females to a much greater degree (Women and depression, 2011); bias in research (Wilhelm et al.,

2011); bias in diagnosis (Schwartz, Lent, & Geihsler, 2011); differences in work stressors and emotive styles (Wilhelm et al., 2008); gender and cultural biases (Schwartz et al., 2012); and the stress of caregiving - a job that falls more to women than men (Women and depression, 2011).

Gender Differences in Recovery and Help-Seeking Behavior

Female veterans expressed different recovery needs from traumatic experiences than men. In a qualitative study by Mattocks et al. (2012), the researchers identified three major coping strategies for female veterans: "behavioral avoidance, cognitive avoidance and behavioral approach" (p. 541). Behavioral coping strategies included "binging and purging, compulsive spending, over-exercising, and prescription drug abuse" (Mattocks et al., 2012, p. 542). Binging referred to overeating while purging referred to forced vomiting. Many female veterans used *retail therapy* and over-exercising as a method to avoid post-deployment feelings. Unlike male veterans, who tend to abuse alcohol or illegal drugs, women were more likely to abuse prescription drugs (Mattocks et al., 2012).

Cognitive avoidance strategies included isolation. Rather than use family members or friends as part of a social support network, some women avoided family members (Mattocks et al., 2012). A common theme among respondents was that the respondents no longer cared about things family members and friends talked about and wanted to be left alone (Mattocks et al., 2012). Many respondents felt alienated and misunderstood (Katz et al., 2007).

Not all women veterans cope in unhealthy ways. Respondents in the study by Mattocks et al. (2012) used a healthy level of exercise to cope. Some women veterans

expressed an interest in meeting with other women veterans to discuss deployment experiences (Katz et al., 2007; Mattocks et al., 2012). Women veterans found that there was a lack of support groups for women (Mattocks et al., 2012) and did not want to meet in mixed-gender groups (Katz et al., 2007).

In studies of combat veterans, both men and women reported being bothered by stigmas and barriers to mental care (Elnitsky et al., 2013; Held & Owens, 2013). Respondents worried that supervisors would treat respondents differently and fellow soldiers would see respondents as being weak for seeking mental health care (Elnitsky et al., 2013; Held & Owens, 2013). Women reported having greater difficulties getting time off than men (Elnitsky et al., 2013).

Gibbons, Barnett, Hickling, Herbig-Wall, and Watts (2012) conducted a help-seeking behavior study of military health care providers. The top two choices of support for enlisted female health care providers was military mental health and civilian mental health professionals while male enlisted health care providers used military mental health professionals and military chaplains (Gibbons et al., 2012). Female officer health care providers used military mental health professionals almost exclusively and at a much higher rate than male officers (Gibbons et al., 2012). While nearly 20% of female officers sought mental help, male officers sought help only about 8% of the time.

For women, gender plays a role in the preference of support providers. In a study by Chowdhury-Hawkins et al. (2008), female sexual assault victims overwhelmingly preferred female crisis workers and forensic examiners. Most male victims preferred female crisis workers but were less partial to the gender of the forensic examiner (Chowdhury-Hawkins et al., 2008). In a scenario in which there was no choice about the

gender of the crisis worker and forensic examiner, almost all men and women would see a female, but four out of 10 women would not see a male doctor (Chowdhury-Hawkins et al., 2008). Three out of 10 women would not see a male crisis worker (Chowdhury-Hawkins et al., 2008). Along similar lines, in a study of patient preferences for psychological counselors, both male and female patients preferred to see counselors of the same gender (Furnham & Swami, 2008).

Along related lines, there is evidence that a counselor's understanding of gender roles can affect his or her counseling competence in a multicultural setting. A counselor brings certain beliefs about gender with him or her into a counseling session and these beliefs can affect his or her counseling approach (Chao & Nath, 2011; Passalacqua & Cervantes, 2008). Chao and Nath (2011) found a positive relationship between gender roles and multicultural counseling competence. The greater the egalitarian view of the counselor, as it pertained to gender roles, the greater the counselor's multicultural counseling competence (Chao & Nath, 2011).

Summary and Analysis of Women and Health Issues

In war, women have been injured through disease, enemy action, explosions, and sexual assault. Over 200 female soldiers died in World War I and World War II each (Sherrow, 1996). As of 2009, over 600 female soldiers have been wounded in Iraq and Afghanistan, and 60 have been killed in enemy action (Cater & Koch, 2010). Sixteen percent of female veterans reported being sexually assaulted (Katz et al., 2007; Mattocks et al., 2012). In a study by Alempijevic, Savic, Pavlekic, and Jecmenica (2007), 63% of sexual assault victims suffered extra-genital injuries, including damage to arms and legs, the face, and upper body.

Sixteen percent of OEF/OIF veterans were diagnosed with PTSD (Cameron et al., 2011) and twice as many military women are diagnosed with PTSD than military men (Feczer & Bjorklund, 2009). Women are more likely to develop depression than men, but the reasons are unknown (Women and depression, 2011). It may be that women are more likely to talk about depression than men (Wilhelm, Parker, Geerligs, & Wedgwood, 2008; Women and depression, 2011). Wilhelm et al. (2008) posited that gender differences in depression may be explained by hormonal differences, bias in research, differences in work stressors, and differences in emotive styles. From a liberal feminist viewpoint, previous approaches to women and trauma-centered on personality disorders and created the impression that there was some inherent defect in women (Berg, 2002). Liberal feminism compresses multiple diagnoses into one – PTSD – which is less stigmatizing and shifts the focus to helping women cope (Berg, 2002). The change to a more liberal approach to diagnosis might contribute to the high rate of PTSD diagnosis for women.

The pressure to fit into what has traditionally been a male-dominated industry, the military, may also be a contributing factor to the higher rate of PTSD for women. Tarrasch, Lurie, Yanovich, and Moran (2011) stated that women "often confront rejection, alienation, prejudice, and discrimination within their units" (p. 306). Chronic stress degrades the mental and physical health of a person (Tarrasch et al., 2011).

In terms of care providers, women prefer to be seen by female crisis workers, forensic examiners, and psychological counselors (Chowdhury-Hawkins et al., 2008; Furnham & Swami, 2008). Whether this holds true for religious counselors cannot be determined. No research was found that confirmed or denied the preference of females for spiritual advisors or pastors. However, Rudolfson, Tidefors, and Strömwall (2012)

conducted a study investigating the role of gender in pastoral care for sexual abuse victims. Participants were 421 religious professionals, 33% of which were female. Female clerics were more likely than male clerics to believe that the sexual assaults described in the vignettes were more likely to occur (Rudolfson et al., 2012). Female clerics also perceived sexual abuse as being more pervasive than male clerics (Rudolfson et al., 2012). There was no significant difference in how male and female pastors viewed the seriousness of the situation described in the vignettes (Rudolfson et al., 2012). The study by Rudolfson et al. (2012) showed that pastoral care does have a significant gender component. For female soldiers who have been injured or traumatized due to sexual assault or other reasons, a female chaplain might provide more relatability and empathy to the soldier.

Gender Inequality

Women in the Military and Law Enforcement

Female soldiers work in a male-dominated industry (Sasson-Levy, 2011). Women represent approximately 13% of the total U.S. Army (The United States Census Bureau, 2011). Legislators have created policy changes integrating women into a wider variety of military roles, but women still feel the pressure to fit into organizations that are predominantly male (Sasson-Levy, 2011; Tarrasch, Lurie, Yanovich, & Moran, 2011). As a result, women "often confront rejection, alienation, prejudice, and discrimination within their units" (Tarrasch et al., 2011, p. 306).

According to constructionist gender theory, gender has much more to do with socially constructed differences than actual biological differences (Martin, 2011). The level of gendering refers to how much an organization recognizes and fosters gender-

based differences (Sasson-Levy, 2011). According to Sasson-Levy (2011), the military is an extremely gendered organization. Sasson-Levy (2011) based this conclusion on three assessments: gaps between males and females in the military, the difference between formal policies and actual policy implementation, and the social status of female soldiers. First, the gaps between men and women in the military exist in several areas. The female representation in the military is approximately 15% (Carreiras, 2006; Sasson-Levy, 2011; 2011 Demographics profile of the military community, 2012). Women represent a small percentage of senior leader positions (Carreiras, 2006; Sasson-Levy, 2011; 2011 Demographics profile of the military community, 2012). Less than 8% of general officers are women (2011 Demographics profile of the military community, 2012).

Second, many policies have been created to formally eliminate barriers for women in the military, but informal policies and actions serve to effectively exclude women (Sasson-Levy, 2011). Women are still informally excluded from premier command and combat-related positions (Carreiras, 2006; Sasson-Levy, 2011). Policies formally establish a gender-neutral posture, but the military is still very much a masculine-oriented culture, promoted by masculine war-like images, and evaluated against masculine physical standards (Carreiras, 2006; Sasson-Levy, 2011; Stachowitsch, 2012).

Third, the social status of women in the military remains lower than that of men in the military (Carreiras, 2006; Sasson-Levy, 2011; Stachowitsch, 2012; Tarrasch et al., 2011). Women are considered by many leaders to be too emotionally and physically weak (Sasson-Levy, 2011; Tarrasch et al., 2011; van Creveld, 2000). In Sasson-Levy's (2011) research on integrated officer training in the Israeli military, three gender

dialogues were found. The first was the official message — "everybody wins" (Sasson-Levy, 2011, p. 401). The second two messages were informal and exclusionary (Sasson-Levy, 2011). One message was that male cadets lose, meaning male cadets were disadvantaged by integration policies (Sasson-Levy, 2011). The other message was that women cadets lose, meaning the physical demands of the course were too high and inappropriate, given that the physical requirements were designed for male combat soldiers and the female cadets were not in those type of roles (Sasson-Levy, 2011).

This phenomenon is not unique to the military. In the year 2000, women represented approximately 13% of law enforcement officers (Harrison & Kanoff, 2010). As in the military, the law enforcement culture is considered to be aggressive and oriented toward males (Harrison & Kanoff, 2010). According to Harrison and Kanoff (2010), women in law enforcement and other male-dominated industries, such as the military and construction, are viewed by many men as lacking the necessary traits for success in these industries. These traits include reasoning ability, courage, strength, and aggression (Harrison & Kanoff, 2010). Instead, women are seen as being too compassionate, caring, emotional, and physically weak for tough professions (Harrison & Kanoff, 2010).

Titunik (2008) disputed that the military is an overly masculine environment that minimizes the roles and contributions of women. While some military policies are discriminatory, Titunik (2008) contended that the military environment is one that requires "teamwork, submission, obedience, and self-sacrifice" (p. 147), qualities that are often assigned to women, not hyper-masculine males. The military also rewards achievements in many ways, which is good for the advancement of women (Titunik,

2008). Citing previous studies and personal accounts of women in the field, Titunik (2008) argued that women and men experience cohesion, loyalty, and esprit de corps with each other in mixed gender units as much as men do in male-only units.

Workplace Support

Taylor (2010) found that women who work in organizations in which women are the minority feel less supported than men. Taylor (2010) defined support as getting help from coworkers, being listened to by coworkers, getting needed information from supervisors, and being listened to by supervisors. Women who are underrepresented in organizations perceive a lower level of workplace support than men (Taylor, 2010).

Peterson (2004) conducted a quantitative study to determine what adults valued at work. Over 1,100 adults who worked in organizations of at least 1,000 employees completed surveys. Approximately 45% of participants were women (Peterson, 2004). Women valued relationships, recognition, respect, communication, equality, teamwork, and family more than men (Peterson, 2004). In terms of healthy workplace expectations, women placed a significantly higher value on the understanding/caring/supportive cluster than men (Peterson, 2004).

Yragui, Mankowski, Perrin, and Glass (2012) examined workplace support from the perspective of women who were victims of intimate partner violence (IPV). IPV includes physical and sexual violence, threats of violence, and emotional abuse (Yragui et al., 2012). Yragui et al. (2012) administered quantitative surveys to 163 women who experienced IPV in the last year. Eighty-one of the women were Latino and the rest were classified as non-Latino (Yragui et al., 2012). The participants in the study identified 20 support items they most desired from their supervisors (Yragui et al., 2012). Although

the questions were related to supervisor support, 12 of the identified items could be provided by a coworker or other supporter, such as a chaplain. Of these 12 items, seven were desired by 60% or more of participants (Yragui et al., 2012). The seven items were "approached me and asked if I was okay," "listened to my problems in a private place," "gave me information on domestic violence services," "informed me about company policy on domestic violence," "kept my problems confidential," "asked me what kind of help I wanted," and "showed concern for me" (Yragui et al., 2012, p. 36).

Gender Bias

Gender differences in pay, leadership opportunities, and competency perceptions continue to persist in the market (Nadler & Stockdale, 2012). Women are still viewed as being less capable of exercising authority and are generally given lower ratings in evaluations than men (Nadler & Stockdale, 2012). Though many researchers have used gender bias to explain these phenomena, other studies have disputed these claims, showing that training and familiarity can negate gender bias (Nadler & Stockdale, 2012).

The Effects of Gender Inequality on Psychological Health

Elw'er, Harryson, Bolin, and Hammarström (2013) examined the effects of workplace gender segregation and its effects on psychological health. In this study, women were more psychologically effected by gender inequality in the workplace than men (Elw'er et al., 2013). Three possible explanations for this phenomenon were provided. One explanation was that men have more advantages, in terms of pay and opportunities, than women, even in sectors where women represent the majority (Elw'er et al., 2013). In the analysis by Elw'er et al. (2013), women did not receive higher pay, even when having more education (Elw'er et al., 2013). The second explanation for

gender inequality having a greater effect on women is that women have greater family responsibilities than men (Elw'er et al., 2013). Finally, the greater psychological effect on women may be because women with greater psychological distress early in life more often select careers in predominantly male industries (Elw'er et al., 2013).

Gender Inequality in Religious Circles

The concept of gender roles and inequality is a major one within religious circles since until the twenty-first century most religious denominations in America refused to ordain women (Gasquet, 2010; Ruether, 2011). Even among denominations who ordain women, there are continuous struggles with the role women should be allowed to play in religious leadership (Roebuck, 2012; Ruether, 2011). Religion may help shape one's view of gender roles (Carreiras, 2006; Passalacqua & Cervantes, 2008). Gender-based stereotyping by spiritual counselors may be detrimental to the client (Passalacqua & Cervantes, 2008).

Summary and Analysis of Gender Inequality

Women are underrepresented in the military, and according to Tarrasch et al. (2011), often confront rejection in what is a male-dominated industry. Titunik (2008) disputed the claim that the military culture is hyper-masculine and treats women poorly. The qualities that military training instills, discipline and self-sacrifice, "foster military effectiveness and counterbalance sexist tendencies producing a complex institutional culture congenial to women in significant respects" (Titunik, 2008, p. 137).

The difference between views expressed by Tarrasch et al. (2011) and Titunik (2008) could be explained by Kiriakidou and Millward's (2000) treatment of corporate identity. External corporate identity represents what an organization markets itself to be

and it may be different from its internal reality (Kiriakidou & Millward, 2000). The military prides itself as being an organization that instills discipline and cohesion, and provides an equal opportunity environment for all people. Military policies have changed over the years to be more inclusive, and many women have had positive experiences (Titunik, 2008), but other military women have experienced discrimination, prejudice, and harassment (Tarrasch et al., 2011). Gender inequality and discrimination are factors in the psychological health of workers (Elw'er et al., 2013). The higher psychological distress rate and PTSD rate for military women (Feczer & Bjorklund, 2009; Women and depression, 2011) may in part be explained by gender discrimination.

The concepts of workplace support, gender inequality, and psychological distress connected to gender inequality are related to this study. The U.S. Army is predominantly male (The United States Census Bureau, 2011) and female soldiers are more prone to psychological distress than male soldiers (Cater & Koch, 2010; Goldzweig et al., 2006; Kuehn, 2008; Maguen et al., 2012). Based on research by Taylor (2010) and Elw'er et al. (2013), it is reasonable to think that gender inequality partially accounts for the increased psychological distress among female soldiers.

The Role of Spirituality and Religion

In general, people with strong religious convictions and spiritual experiences tend to be healthier mentally and physically (Wachholtz & Pargament, 2008). Studies have shown that spirituality and religion can play a mediating role in helping people recover from various illnesses (Calder et al., 2011; Wachholtz & Pargament, 2008). Repetitive use of spiritual phrases can increase spiritual well-being and decrease PTSD symptoms (Bormann, Liu, Thorp, & Lang, 2012; Bormann et al., 2008). Wachholtz and Pargament

(2008) showed that spiritual meditation reduced the number of migraine headaches study participants received per month, reduced trait anxiety, and increased pain tolerance. Spiritual meditation produced greater results than secular meditation or a relaxation regimen (Wachholtz & Pargament, 2008).

Harris et al. (2008) conducted research to determine how religious factors relate to PTSD and post-traumatic growth. Feeling disconnected from God or one's faith group, religious fear and guilt, being unhappy with one's relationship with God, and praying for God to intervene without action from the praying person were positively related to PTSD symptoms (Harris et al., 2008). Seeking or providing spiritual support, praying for peace and God's will in the midst of stress, praying for God's assistance or strength to take action, meditation, and praying for God's independent intervention were shown to be positively correlated with post-traumatic growth (Harris et al., 2008).

Despite previous research and the popular belief that spirituality and health are positively related, Finfgeld (2002) questioned the benefits of traditional religious/spiritual approaches for women. "Within conventional religious traditions, women have been relegated to positions of diminished status and power and may be subject to expectations of self-abnegation. For these reasons, asserting powerlessness and abdicating control to a male-defined deity may be nontherapeutic" (Finfgeld, 2002, p. 113). In other words, from a feminist perspective, traditional views of women, as espoused by mainstream religious traditions may not be cathartic for women.

The traumas of war and personal injury can challenge one's religious beliefs (Bormann et al., 2012; Calder et al., 2011; Harris et al., 2008; Worthington & Langberg, 2012). Veterans may experience a debilitating sense of guilt for things that happened

during an overseas deployment, such as killing another person or failing to save one's comrades (Worthington & Langberg, 2012). Soldiers may also experience moral conflicts as a result of witnessing atrocities that soldiers can do nothing about (Worthington & Langberg, 2012).

These experiences may lead some veterans to heap upon themselves self-condemnation. Self-condemnation can lead to reduced mental health, reduced job performance, and relational difficulties (Worthington & Langberg, 2012). Religious activities can help reduce feelings of condemnation and guilt in veterans (Worthington & Langberg, 2012). According to Worthington and Langberg (2012), these religious activities include asking for God's forgiveness, assessing whether the standard one failed to live up to was a sacred standard or a cultural standard, making amends for sins, forgiving one's self, accepting one's self, and resolving to live righteously while affording grace and mercy to one's self.

However, one cannot assume that a strong sense of religious obligation equates to a low sense of guilt. On the contrary, Hale and Clark (2013) showed that people who consider religion to be very important or extremely important, were significantly more likely than people who consider religion to be unimportant to experience generalized guilt, situational guilt, intrusive guilt, sad negative thoughts, and guilty negative thoughts. The highly religious people were also significantly more likely to experience fear of sin and fear of God (Hale & Clark, 2013).

History of the Military Chaplaincy

Chaplains have been part of the U.S. military since its earliest days. In 1775, Congress first authorized chaplains to officially serve in the Army (Johnston, 2009). The

duties of early chaplains were to conduct religious services, perform funerals, teach the troops basic skills, such as reading and writing, and act as disciplinarians to the weak (Johnston, 2009). After the War of 1812, chaplains virtually disappeared from the military until the Civil War (Johnston, 2009).

Thousands of chaplains joined the Union Army during the Civil War (Johnston, 2009). The role of these chaplains was not well-defined (Johnston, 2009). According to Johnston (2009), chaplains were not well-respected by soldiers, and Americans in general held clergy in contempt. "This served to diminish the chaplain's traditional disciplinarian role and to produce a new arrangement in which chaplains became more personally involved in the soldier's spiritual and psychological well-being" (Johnston, 2009, p. 27).

The Confederate Army relied on visiting clergy and missionaries to provide for the spiritual needs of its soldiers (Johnston, 2009). There were few paid army chaplains (Johnston, 2009). The Confederate leadership never formalized the regulations, training, roles, or qualifications of its chaplains (Johnston, 2009).

After the Civil War, the chaplaincy faded from prominence until the 20th century (Johnston, 2009). During World War I, chaplains in general were not highly regarded by soldiers, but some of them distinguished themselves in acts of service (Seddon, Jones, & Greenberg, 2011). Chaplains were under general orders to stay away from the front lines and this was a major point of contention among the fighting men (Seddon et al., 2011). The chaplains who distinguished themselves did so by ignoring orders and putting themselves in harm's way to assist the wounded (Seddon et al., 2011).

In 1920, the military formally recognized the chaplaincy as a military branch (Johnston, 2009). From that point to the end of World War II, chaplains' main concern

was the spiritual well-being of soldiers (Johnston, 2009). As in World War I, many soldiers in World War II viewed chaplains with contempt (Seddon et al., 2011). Soldiers did not see chaplains as making valuable contributions to the war effort, but some chaplains did distinguish themselves (Seddon et al., 2011).

After World War II, chaplains became more involved in humanitarian assistance missions and civic action (Johnston, 2009). The Vietnam War saw chaplains acting as morale builders and spiritual advisors (Johnston, 2009). Around this time, chaplains added religious liaison to external religious leaders (those outside the military) as a role (Johnston, 2009).

The Role of Chaplains in Helping Soldiers

Emotional support providers.

Chaplains as emotional support providers was a common theme in literature. According to Mayer, Buchanan, and Brunko (2009), flight chaplains offer emotional support by helping first responders express their feelings, cope with pain, and find greater joy in their work. Parameshwaran (2015) emphasized the importance of using mindfulness techniques to emotionally connect with patients and offer empathetic support. According to Russell (2014), a professional chaplain can offer empathetic listening, a calming presence, and hope to patients and family members.

Piderman, Marek, Jenkins, Johnson, and Buryska (2008) analyzed quantitative surveys from over 500 patients who had been hospitalized in 2006. Seven out of 10 respondents were over the age of 55 (Piderman et al., 2008). Approximately one third of participants wanted a chaplain to visit them without having to request the chaplain (Piderman et al., 2008). Patients over the age of 35 were significantly more likely than

younger patients to want a chaplain to visit them even if they had not requested the chaplain (Piderman et al., 2008). Over 75% of participants felt that speaking to a chaplain during times of anxiety was important, and 65% of respondents wanted chaplains to listen to them (Piderman et al., 2008). By gender, 73% of women and 58% of men wanted a chaplain to listen to them (Piderman et al., 2008). Eighty-three percent of women and 70% of men wanted a chaplain to be with them during times of anxiety (Piderman et al., 2008).

In a similar study, Winter-Pfändler and Flannelly (2013) surveyed over 600 patients in Germany and Switzerland about their expectation for chaplaincy care. Just over half of the participants were female, and the average age was 62 (Winter-Pfändler & Flannelly, 2013). Using a one to four scale, one being "strongly disagree" and four being "completely agree," the average score for emotional support expectations was 3.65 (Winter-Pfändler & Flannelly, 2013). By contrast, participants scored expectations related to religion at 2.36 (Winter-Pfändler & Flannelly, 2013). In other words, patients had significantly higher expectations for chaplains to provide emotional support than religious support. Women rated emotional support higher than men did (Winter-Pfändler & Flannelly, 2013).

Religious and spiritual leaders.

Religion and spirituality can contribute to the emotional and physical well-being of soldiers (Bormann et al., 2012; Bormann et al., 2008; Harris et al., 2008; Wachholtz & Pargament, 2008; Worthington & Langberg, 2012). Chaplains serve as religious and spiritual leaders and can help soldiers connect to the divine through rites, religious services, and counseling from a religious perspective (Besterman-Dahan et al., 2012b;

Howard & Cox, 2008; Rosman-Stollman, 2008). Chaplains are embedded in every battalion and larger unit in the U.S. Army (Howard & Cox, 2008).

Looking back at Piderman et al.'s (2008) study, over 80% of participants wanted hospital chaplains to remind them of "God's care and presence" (p. 62). Seventy-six percent of women and 62% of men wanted chaplains to pray or read scripture with them (Piderman et al., 2008). Fifty-five percent of women and 45% percent of men wanted chaplains to give them religious rites, while 50% of women and 42% of men wanted chaplains to counsel them regarding moral or ethical issues (Piderman et al., 2008).

Winter-Pfändler and Flannelly (2013) asked 612 patients to rate their religious and spirituality expectations on a scale of one to four, with one being "strongly disagree" and four being "completely agree." The mean score for all participants was 2.36, with a standard deviation of 1.01 (Winter-Pfändler & Flannelly, 2013). Participants ranked religious expectations below emotional support expectations ($M = 3.65$, $SD = 0.50$) and below coping with illness or disease expectations ($M = 2.73$, $SD = 0.77$; Winter-Pfändler & Flannelly, 2013).

It should be noted that in the studies by Winter-Pfändler and Flannelly (2013) and Piderman et al. (2008), over 93% of participants affiliated themselves with a specific religious denomination. As might be expected, participants in the Piderman et al. (2008) study with no religious affiliation were much less likely to expect chaplains to provide religiously-oriented services, such as giving religious sacraments or reading scripture. In the Winter-Pfändler and Flannelly (2013) study, religiosity was positively related to expecting religious services from chaplains. Catholics expressed a greater level of religious needs than Protestants (Winter-Pfändler & Flannelly, 2013).

Links to mental health.

Chaplains can serve as a connection point to mental health providers (Besterman-Dahan et al., 2012b; Howard & Cox, 2008). In a 2005 Department of Defense quantitative survey, the sampling frame was 40,000 service members from the Army, Navy, and Air Force (Besterman-Dahan et al., 2012b). From the original 40,000, Besterman-Dahan et al. (2012b) selected those who had deployed to Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) and had received counseling in the last 12 months for mental health or substance abuse. This group included 323 males and 154 females (Besterman-Dahan, 2012).

Respondents who had sought mental health or substance abuse counseling were categorized into three groups — those who used mental health counselors only, those who used a chaplain only, and those who used both (Besterman-Dahan et al., 2012b). Forty-two percent of respondents sought help only from a mental health provider, while 31% sought help only from a chaplain, and 25% sought help from both a chaplain and a mental health provider (Besterman-Dahan et al., 2012b). The second and third category accounted for approximately 56% of the respondents, suggesting that most respondents viewed chaplains as useful in supporting mental health (Besterman-Dahan et al., 2012b). According to Besterman-Dahan et al. (2012b), of those who sought help from a chaplain (category two and three), approximately 29% (n=71) stated, "religion/spiritual beliefs are an important part of my life" (p. 1031) and approximately 20% (n=54) said, "religion/spiritual beliefs influence decisions in my life" (p. 1031). Over 50% of service members who sought help from a chaplain had attended religious services less than six times in the previous year (Besterman-Dahan et al., 2012b). A limitation of the study was

that respondents were not asked why they sought the services of a chaplain for mental health or substance abuse.

Critical incident debriefing facilitators.

Critical incident debriefings (CIDs) are group traumatic event management tools (Maloney, 2012; Seddon et al., 2011). CIDs are designed to assist first responders, military personnel, and other support providers cope with a traumatic event (such as combat) and continue to perform their duties (Maloney, 2012; Seddon et al., 2011). These debriefings are group discussions conducted by "nonmedical personnel who have been trained to provide psychological first aid" (Seddon et al., 2011, p. 1360). Chaplains have been used to conduct CIDs or be present during the debriefings (Seddon et al., 2011).

Maloney (2012) defined seven phases of a CID. The first phase is the *introduction phase* in which the facilitators introduce themselves and explain the purpose of the CID (Maloney, 2012). The second phase is the *fact phase* (Maloney, 2012). In the fact phase, group members (those who experienced the traumatic event [TE]) tell what they experienced and what they saw in the event (Maloney, 2012). The third phase is the *thought phase*, and in this phase, each member describes his or her first thoughts after his or her initial reaction to the TE (Maloney, 2012). In the fourth phase, the *reaction phase*, members describe their most powerful emotional reactions during the event (Maloney, 2012). Next is the *symptom phase* (Maloney, 2012). During this phase, members describe the physiological and psychological symptoms they experienced (Maloney, 2012). In the sixth phase, the *teaching phase*, facilitators help normalize the members' experiences and provide stress management techniques (Maloney, 2012). The final

phase, *re-entry*, is designed to assist members gain clarity and be prepared to return to their duties (Maloney, 2012).

Summary and Analysis of the Role of Spirituality and Religion

In general, there is a positive correlation between religious conviction and health (Wachholtz & Pargament, 2008). Spirituality and religion can help people recover from various illnesses, reduce PTSD symptoms, and increase one's sense of well-being (Bormann et al., 2008; Bormann et al., 2012; Calder et al., 2011; Wachholtz & Pargament, 2008). However, Hale and Clark (2013) showed that highly religious people may also be prone to more guilt, negative thoughts, and obsessive-compulsiveness.

One cannot assume that every version of religion or spirituality is helpful for treating mental, emotional, or physical illness. Religions that cause people to have guilty negative thoughts, intrusive guilt, or obsessive-compulsiveness, as defined by (Hale & Clark, 2013), may cause more harm than good. Secondly, how one goes about doing religion can make a difference. Religious fear and guilt, and praying for God's intervention without taking personal action is not helpful for an ill person, while praying for God's help in taking personal action, meditation, and praying for peace are helpful (Harris et al., 2008). Finally, Finfgeld (2002) proposed that religious denominations that take a traditional, patriarchal view of the role of women as being subservient to men, are not good for the health and well-being of women.

While chaplains can serve as connectors to mental health providers and most deployed service members saw chaplains as supportive of their mental health needs (Besterman-Dahan et al., 2012b; Howard & Cox, 2012), Finfgeld (2002) wrote that men

and women have different needs when it comes to the role of God in their lives. Finfgeld (2002) asserted:

> Whereas it might be therapeutic for men to defer to a higher power, similar gestures may be self-defeating for women who have not traditionally held positions of authority within religious institutions or society in general. Conversely, women may need to cultivate their personal strengths by recognizing the divine within versus outside of themselves. (p. 115).

Men also tend to see themselves as autonomous, while women tend to define themselves in familial terms (Finfgeld, 2002).

Emotional and Spiritual Support Approaches

This section reviews literature related to emotional and spiritual support approaches. A variety of support components are considered. Support components reviewed include support groups, exercise, counseling, information technology, and interdisciplinary teams.

Support Components

Support groups.

In a qualitative study of 19 female veterans of OEF/OIF deployments, age 23 to 55, women expressed an interest in participating in support groups that help veterans adjust to post-deployment life (Mattocks et al., 2012). Peer support groups can help people find "shared and individual pathways through illness" (Montgomery, Mossey, Adams, & Bailey, 2012, p. 529). Such groups may help attendees develop focus to manage life, prevent group members from falling into depression, assist people in

developing coping strategies, help members see other perspectives, and provide comfort to the group (McBride & Fuller, 2013; Montgomery et al., 2012).

Exercise.

Mattocks et al. (2012) conducted a qualitative study with 19 women who served in OEF or OIF. The average age of participants was 37, and 79% of the women were white (Mattocks et al., 2012). Forty-three percent of the participants had been diagnosed with PTSD or some form of depression, and an additional 10% of the women had been diagnosed with anxiety disorder (Mattocks et al., 2012). Researchers conducted semi-structured interviews to learn about the participants' military deployment experience (Mattocks et al., 2012). Participants reported using exercise in varying degrees as a mechanism to cope with stress (Mattocks et al., 2012).

The 2008 Physical Activity Guidelines Advisory report, published by the U.S. Department of Health and Human Services, stated that exercise can help protect against distressful feelings, anxiety, and depression, as well as protect against dementia and cognitive decline associated with aging (Dunn & Jewell, 2010). The report concluded that there is not enough evidence to support any claims about the ability of exercise to "prevent other mood disorders like bipolar disorder or postpartum depression" (Dunn & Jewell, 2010, p.203). Have, Graaf, and Monshouwer (2011) analyzed data from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). A total of 17,490 participants were surveyed between 1996 and 1999 (Have et al., 2010). Have et al. (2010) found a positive relationship between exercise and the improvement of mental health scores for people with mental disorders, and agreed with Dunn and Jewell (2010) that the evidence was sketchy and needed to be improved through randomized trials.

In a critical review of 16 qualitative and quantitative studies, Alexandratos, Barnett, & Thomas (2012) found that randomized control trials supported the hypothesis that exercise helped people to cope with severe mental illness. All of the trials were subject to limitations that somewhat diminished the ability to draw firm conclusions (Alexandratos et al., 2012). The qualitative studies also exhibited problems. Half of the studies did not adequately deal with potential bias (Alexandratos et al., 2012). Other problems included inadequate descriptions of exercise interventions and participants, and an overabundance of male participants, which made generalizing results problematic (Alexandratos et al., 2012).

Counseling.

Rehabilitation counseling.

Rehabilitation counseling is designed to help persons with disabilities to set and achieve personal and professional goals (Sporner, 2012). Rehabilitation counseling uses a holistic approach to case management and involves "psychological, vocational, social, and behavioral interventions" (Sporner, 2012, p. xiii). According to Sporner (2012), rehabilitation counseling can help veterans and current service members, who have been injured, modify nonessential job functions, find a military job the veterans are capable of performing, transition out of the military, and get mental health counseling if needed.

Pastoral counseling.

According to Calder et al. (2011), rehabilitation counseling, psychological counseling, and pastoral counseling go hand in hand. Pastoral counseling is designed to help injured people by working in the spiritual, emotional, and religious realm of injured people's lives (Calder et al., 2011). In a mixed methods study of patients in a

rehabilitation facility in Australia, Calder et al. (2011) found that 90% of participants found pastoral counseling to be valuable in recovery. Sixty-seven percent of the participants said that pastoral visits helped participants with spiritual issues (Calder et al., 2011). Pastoral counseling was helpful to both those who were actively involved in a faith community and those who were not. Nearly half of participants had no prior experience with a religious community, and less than 30% of participants were actively engaged in a religious community (Calder et al., 2011).

Information technology (IT).

Social networks.

Seven out of 10 people between the ages of 18 and 29 use social networking sites, such as Facebook (Gowen, Deschaine, Gruttadara, & Markey, 2012). In a survey of 207 young adults (ages 18 to 24) with mental illness, Gowen et al. (2012) found that participants used social networking sites for a variety of mental health related purposes. For these participants, the two most enjoyable features of social networking sites was "communicating with others" and "making new friends" (Gowen et al., 2012, p. 247). When asked what features participants would like to see in a social networking site for people with mental illness, respondents listed, among other things:

- the ability to connect and socialize,
- resources and materials on transition,
- the opportunity to help others,
- the ability to post blogs and links,
- chats with experts,
- discussion groups,

- and the capacity to plan local activities and meet others in person (Gowen et al., 2012).

For subject matter on social networking sites, respondents would like to see information on:

- independent living skills,
- strategies to overcome social isolation,
- relationships,
- peer support services,
- how to support a friend or family member,
- diagnosing and treating mental illness,
- and connecting to community activities (Gowen et al., 2012).

While the participants in the study by Gowen et al. (2012) wanted to use social networking sites to help deal with mental health challenges, Househ (2011) showed that privacy issues can arise from the use of such sites. In a review of Facebook groups related to anxiety, HIV, and Sickle Cell, Househ (2011) found that some users posted public comments that were demeaning, highly personal in nature, or provided a risky amount of identifying information. Women veterans expressed an interest in participating in peer support groups (Katz et al., 2007; Mattocks et al., 2012) and the participants in the study by Gowen et al. (2012) used social networking sites as peer support mechanisms.

Internet-based support groups.

Internet-based support groups have been used for various health-related issues. In this study, web-based support groups differ from social networking sites in that web-

based groups restrict access to those users who are in the group, and the forums are professionally moderated. Wiljer et al. (2011) conducted a qualitative study of a web-based support group for women who were treated for gynecologic cancer. The issues group members discussed were sensitive in nature and included cancer treatments, "managing the impact on intimate relationships, self and body image, and sexual functioning" (Wiljer et al., 2011, p. 452). The intervention included discussion forums moderated by psychologists, live chat sessions, and informative articles (Wiljer et al., 2011).

Overall, the participants found that the Internet-based support group was helpful. Subjects would participate again and would recommend the support group to other people (Wiljer et al., 2011). For many of the participants, being able to connect with others who were going through a similar experience was very valuable in helping participants cope (Wiljer et al., 2011). Participants appreciated being able to share sensitive issues with others while maintaining anonymity (Wiljer et al., 2011). Finally, the women found the articles to be informative and helpful, and suggested more information be provided through this venue (Wiljer et al, 2011). The study by Wiljer et al. (2011) was included in the literature review for this study on the basis that women veterans expressed an interest in participating in support groups (Katz et al., 2007; Mattocks et al., 2012), and Internet-based support groups are one type of support group.

Counseling through the Internet.

Internet counseling refers to one-on-one counseling via the Internet using video or audio conferencing, instant messaging, or e-mail (Gupta & Agrawal, 2012). Leibert, Archer, Munson, and York (2006) conducted a study to test the merits of counseling

through the Internet. Eighty-one participants, mostly female (over 80%), took part in the survey. The two most popular reasons for choosing online counseling was convenience and privacy (Leibert et al., 2006). By far, e-mail was the most common venue (over 50%) with instant messaging coming in second at 33%.

Participants reported a total of seven advantages to online counseling (Leibert et al., 2006). Two advantages accounted for 66% of the total. The first was that the privacy and distance created by online venues reduced participants' inhibitions in sharing sensitive or shameful information (Leibert et al., 2006). The second was that online counseling provided users greater flexibility than face-to-face counseling (Leibert et al., 2006).

Four disadvantages were identified by participants, but only one disadvantage garnered more than 4 votes (Leibert et al., 2006). This was the lack of "personal contact with a therapist" (Leibert et al., 2006, p. 78). According to one participant, "It is hard to feel supported sometimes, because you cannot see the person who you are communicating with. On the other hand, I don't feel as intimidated or ashamed when doing online counseling," (Leibert et al., 2006, p. 78).

Brief, Rubin, Enggasser, Roy, and Keane (2011) conducted a literature review of over 50 articles related to PTSD, alcohol abuse, and Internet-based intervention strategies, including counseling for veterans. Brief et al. (2011) concluded that Internet-based strategies help veterans overcome stigmas, offer a way for veterans to receive counseling in a more convenient way, reduce government costs, and enable broad dissemination of helpful information. More research is needed because "little is known about the essential components of treatment or the time necessary to achieve the expected

benefits. It is also unclear what level of therapist contact is necessary to achieve positive outcomes" (Brief et al., 2011, p. 241).

Mobile apps.

Previous research suggests that mental health software for mobile devices "can be effective in treating a range of mental health disorders, such as depression, stress, anxiety, and smoking cessation" (Donker et al., 2013, para. 8). There is a lack of quantitatively-based literature reviews of research pertaining to the effectiveness of mobile apps (Donker et al., 2013). In an attempt to rectify this, Donker et al. (2013) reviewed quantitative studies that used designs with experimental and control groups.

Over 5,000 abstracts of studies conducted from 2008 to 2013 yielded a result of eight research projects that met the inclusion criteria (Donker et al., 2013). Donker et al. (2013) gave the studies an overall low rating, citing problems with "sequence generation . . . allocation . . . blinding of outcome assessors" (para. 17). That aside, analysis of the studies revealed that there is evidence that mental health mobile apps can reduce symptoms of depression and anxiety (Donker et al., 2013). The sustainability of such results needs further research as only one study conducted follow-up testing after a six week period and this was at three months (Donker et al., 2013).

In November of 2013, the United States Army Reserve Chaplain Directorate announced the release of the Battle Buddy mobile phone app ("Stay in the Army Reserve," n.d.). The app is designed to provide information, resources, and intervention strategies to help service members prevent suicide or sexual assault of fellow soldiers ("Stay in the Army Reserve," n.d.). No research was found that tested the effectiveness of the app.

Interdisciplinary treatment teams.

Physical injuries can cause other physiological, psychological, and spiritual illnesses (Cater & Koch, 2010; Patrick, Hebert, Green, & Ingram, 2011). To fully treat an injured veteran, a variety of practitioners, medication, and treatments are often needed. Common practice does not foster close enough collaboration among providers, resulting in a fragmented approach to patient care (Howard & Cox, 2008; Patrick et al., 2011). To combat this, Patrick et al. (2011) proposed an interdisciplinary collaboration model that included a "psychiatrist, psychologist . . . , pain clinic provider, substance abuse counselor, and case manager" (p. 989). Howard and Cox (2008) proposed a model that included the unit chaplain. In both models, the patient is present when diagnosis and treatment are being discussed. The hoped-for results of a collaborative model approach are more effective treatments, reduced errors, increased patient satisfaction, and reduced duplication of effort (Howard & Cox, 2008; Patrick et al., 2011).

There are limitations and potential problems that could arise in an interdisciplinary team approach. According to Howard and Cox (2008), the team approach that includes a chaplain works best when "the chaplain has a strong background in counseling, psychology, and clinical mental health issues" (p. 339). Patrick et al. (2011) identified other complications, such as identifying which provider should take the lead. Coordinating, scheduling, and setting aside time for team meetings that involve all providers and the patient is another difficulty (Patrick et al., 2011). Finally, coming to consensus on diagnosis and treatment, and leading a heterogeneous team were included in the list of interdisciplinary team complications (Patrick et al., 2011).

Summary and Analysis of Emotional and Spiritual Approaches.

This section provided a review of a variety of emotional and spiritual support components, including support groups. In a qualitative study of 19 female veterans of OEF/OIF deployments, age 23 to 55, veterans expressed an interest in participating in peer support groups (Mattocks et al., 2012). Peer support groups can help people develop coping skills, prevent regression, see other perspectives, and find comfort (McBride & Fuller, 2013; Montgomery et al., 2012).

Regular exercise can help guard against the onset of mental health problems (Dunn & Jewell, 2010; Have et al., 2010). Some studies have shown that exercise can actually help people overcome mental health problems (Alexandratos et al., 2012; Dunn & Jewell, 2010; Have et al., 2010). The evidence is weak and more research is needed (Alexandratos et al., 2012; Dunn & Jewell, 2010; Have et al., 2010).

Two forms of counseling were reviewed. Rehabilitation counseling is designed to help persons with disabilities achieve personal and professional goals, and uses a holistic approach to case management (Sporner, 2012). Rehabilitation counseling involves "psychological, vocational, social, and behavioral interventions" (Sporner, 2012, p. xiii). Pastoral counseling works in the spiritual, emotional, and religious realms of people's lives (Calder et al., 2011). Most people in a rehabilitation medical center, even those who were not actively involved in a faith community, found pastoral counseling to be a valuable part of recovery (Calder et al., 2011).

Four implementations of information technology for emotional and spiritual support were reviewed: social networks, Internet-based support groups, counseling through the Internet, and mobile apps. Approximately 90% of adults in the United States,

age 18-29, use social networking sites (Pew Research Center, 2014). In a study of people between the ages of 18 and 24 living with mental health problems, Gowen et al. (2012) analyzed participants' use of mental health-related social networking sites. The participants liked features that allowed participants to connect with others, review information related to illnesses, and chat with experts. Wiljer et al. (2011) found that Internet-based support groups provide benefits of both peer support groups and social networking sites without the safety concerns of social networking.

Online, or Internet-based counseling provides some benefits over face-to-face counseling. Privacy, emotional distancing, and flexibility were the most popular reasons for choosing online counseling (Leibert et al., 2006). Users identified lack of personal contact with the counselor as a disadvantage to this type of counseling (Leibert et al., 2006).

Software for mobile devices (mobile apps) have been developed for a variety of uses. There is evidence that mental health-based mobile apps can contribute to the treatment of mental health disorders (Donker et al., 2013). The evidence is weak and further research is needed (Donker et al., 2013).

Finally, Howard and Cox (2008) and Patrick et al. (2011) recommended an interdisciplinary approach to caring for hurting soldiers. Wounded warriors need physical care and rehabilitation, psychological, emotional, and spiritual support (Cater & Koch, 2010; Howard & Cox, 2008; Patrick et al., 2011). An interdisciplinary team may include a case manager, psychiatrist, psychologist, pain clinic practitioner, substance abuse counselor, rehabilitation counselor, and chaplain (Howard & Cox, 2008; Patrick et al., 2011; Sporner, 2012). The benefits of such a team approach are better treatments,

fewer errors, happier patients, and reduced duplication of effort (Howard & Cox, 2008; Patrick et al., 2011). Patrick et al. (2011) identified inherent challenges with interdisciplinary teams, such as identifying the best leadership approach, coordinating for team meetings that involve all providers and the patient, and the difficulties of reaching consensus.

The Delphi Method

What is now known as the Delphi method, first began as "Project Delphi" in the 1950s (Linstone & Turoff, 2002; Okoli & Pawlowski, 2004). The Rand Corporation pioneered the method as a way to gather expert opinion about defense matters (Linstone & Turoff, 2002; Okoli & Pawlowski, 2004). In the first Delphi project, experts were asked to create a list of future developments in "scientific breakthroughs; population control; automation; space progress; war prevention; weapon systems" (Linstone & Turoff, 2002, p. 10) that had at least a 50% chance of occurring. The Delphi method was developed because of the lack of empirical data and much of the forecasting would be based on subjective judgments (Linstone & Turoff, 2002).

Since the first Delphi project, the method has evolved and been used for a variety of purposes (Linstone & Turoff, 2002; Okoli & Pawlowski, 2004). Researchers have used the Delphi method for forecasting, concept development, model development (Okoli & Pawlowski, 2004), historical data gathering, budget planning, city planning, policy development, and curriculum development (Linstone & Turoff, 2002). The Delphi method has been used in information technology, healthcare, business, communications, knowledge management, and project development fields (Okoli & Pawlowski, 2004).

According to von der Gracht (2012), Delphi studies usually involve four components: "anonymity, iteration, controlled feedback, and statistical 'group response'" (p. 1526). Participants provide opinions to the group through a moderator so that their identities and expressed opinions remain anonymous (von der Gracht, 2012). Anonymity is aimed at preventing peer pressure and respondents' fearing the repercussions of expressing honest opinions while maximizing response rates (von der Gracht, 2012). Iteration means that the Delphi process is accomplished through a series of rounds in which respondents provide opinions and then form consensus or stability around submitted opinions (von der Gracht, 2012). "After each Delphi round, the survey data is statistically analyzed and re-stated in aggregated form" (von der Gracht, 2012, p. 1527). The feedback mechanism is designed and controlled by the moderator (von der Gracht, 2012). Statistical group response gives each participant a chance to reevaluate his or her opinions against the rest of the group, and change his or her answer or maintain his or her current opinion (von der Gracht, 2012).

Experts may be gathered into separate panels that provide different perspectives on the same problem (Okoli & Pawlowski, 2004). Ten to 18 is an appropriate panel size (Okoli & Pawlowski, 2004). Panel members must be "qualified experts who have deep understanding of the issues" (Okoli & Pawlowski, 2004, p. 20).

Von der Gracht (2012) outlined two types of agreement in Delphi studies. The first is consensus. Consensus may mean unanimous agreement, but not necessarily so (von der Gracht, 2012). Researchers may define consensus in Delphi studies in different ways, including majority (over 50%), or higher agreement (von der Gracht, 2012). The

higher the percentage of agreement required in the study, the more difficult it is for panels to reach that level (von der Gracht, 2012).

The second type of agreement as defined by von der Gracht (2012) is stability. While consensus reaches for assent, stability recognizes the value in disagreement (von der Gracht, 2012). When stability is the objective, researchers may gather all differing opinions, with the goal of exploring a problem to its fullest extent (von der Gracht, 2012). The rounds end when opinions between rounds do not change beyond the level of stabilization required in the study (von der Gracht, 2012).

The Delphi process consists of a series of rounds in which a panel of experts, through an anonymous forum, provide their opinions on the matter at hand (Charlton, 2004). In the first round, the panel of experts provide their opinions based on their practical knowledge (Charlton, 2004). After the initial data are analyzed, they are fed back to the panel in the form of summaries "under a limited number of headings" (Charlton, 2004, p. 246). In round two, "participants rank their agreement" (Jones & Hunter, 1995, p. 377) with each statement in the questionnaire. "In addition to scoring agreement with statements, respondents are commonly asked to rate the confidence or certainty with which they express opinions" (Jones & Hunter, 1995, p. 311). From the results obtained in round two, the data are synthesized, analyzed, and returned to the panel members for review (Charlton, 2004). This process continues until a consensus or stability is obtained. According to Charlton (2004), three rounds will usually produce adequate agreement.

Summary of Chapter 2

This chapter provided a literature review of various subjects related to the current study. The first subject of the review was injuries suffered by female soldiers. Female soldiers are exposed to the same dangers and traumas as male soldiers when deployed overseas (Cater & Koch, 2010). Hundreds of female soldiers have been wounded in Iraq and Afghanistan since the wars began (Cater & Koch, 2010), and female soldiers have been sexually harassed and assaulted in greater numbers than men (Katz et al., 2007; Mattocks et al., 2012).

Physical wounds often bring other problems. Wounded soldiers are three times more likely to suffer from PTSD (Baker, et al., 2009) and women who have been disfigured may experience lower self-esteem and social standing (Cater & Koch, 2010). In cases of disfigurement, women are more likely to be affected emotionally for a longer period of time than men (Thombs et al., 2008). Other emotional problems related to injury and PTSD include reduced overall health, difficulties in interpersonal relationship, and sexual dysfunction (Cameron et al., 2011; Goldzweig et al., 2006).

Mattocks et al. (2012) found that women veterans used a variety of methods to cope with deployment experiences. Unhealthy coping strategies included overeating, uncontrolled spending, prescription drug abuse, isolation, and over-exercising (Mattocks et al., 2012). Healthy coping strategies included moderate exercise (Mattocks et al., 2012) and the use of women's support groups (Katz et al., 2007; Mattocks et al., 2012). Women also prefer female crisis workers and female counselors (Chowdhury-Hawkins et al., 2008; Furnham & Swami, 2008). This could be an issue for women seeking help

from a chaplain since approximately 95% of chaplains are male (The United States Army, 2014).

Women working in industries where there is gender inequality cope with a variety of issues. Women often feel pressure to fit in and may face discrimination (Tarrasch et al., 2011). Many men view women in the military, law enforcement, and other male-dominated professions as lacking the strength and aptitudes necessary to be effective (Harrison & Kanoff, 2010). According to Nadler and Stockdale (2012), gender bias in pay and leadership opportunities continues to persist in many professions. Gender bias is more psychologically stressful for women than men (Elw'er et al., 2013) and female soldiers are more prone to psychological distress than male soldiers (Cater & Koch, 2010; Goldzweig et al., 2006; Kuehn, 2008; Maguen et al., 2012).

Spirituality and religion can assist people in coping with stress and illness (Bormann et al., 2008; Calder et al., 2011; Harris et al., 2008; Wachholz & Pargament, 2008). Seeking spiritual support, seeing God as a loving being, prayer, and spiritual meditation are positively related to post-traumatic growth (Harris et al., 2008). Religious convictions can help reduce guilt in veterans who have experienced the traumas of war (Worthington & Langberg, 2012).

Chaplains serve as unit religious figures and can help soldiers connect to God through services and counseling (Besterman-Dahan et al., 2012b; Howard & Cox, 2008). Chaplains can also assist soldiers in getting help from mental health providers (Besterman-Dahan et al., 2012b; Howard & Cox, 2008). In 2005, over 50% of soldiers who sought mental health care also went to a chaplain (Besterman-Dahan et al., 2012b).

A variety of methods may be useful for helping wounded female veterans cope with stress. These include peer support groups (Katz et al., 2007; Mattocks et al., 2012), exercise (Alexandratos et al., 2012; Dunn & Jewell, 2010; Have et al., 2011; Mattocks et al., 2012), rehabilitation counseling (Sporner, 2012), chaplain pastoral counseling (Calder et al., 2011), social networking web sites (Gowen et al., 2012), Internet-based support groups (Wiljer et al., 2011), counseling through the Internet (Leibert et al., 2006), and mobile phone apps (Donker et al., 2013). Howard and Cox (2008) proposed an interdisciplinary treatment team model that included psychiatric professionals, a chaplain, and other professionals.

This chapter provided a literature review of subjects related to the current study. The review covered a brief history of the U.S. Army, women in military history, women and health issues, gender inequality, the role of spirituality and religion, emotional and spiritual support approaches, and the Delphi method. Chapter 3 describes the research method that was deployed in this study.

Chapter 3

Method

The purpose of this qualitative Delphi study was to build consensus on a comprehensive plan and model for creating a system by which male chaplains might provide effective support to wounded female soldiers. Chapter 1 described the research question, problem statement, and significance of the study. Chapter 2 provided a review of the literature relevant to the current study. Chapter 3 describes the method, design, study population, and data collection process.

Research Method

According to Stephens et al. (2010), interpretivism is an appropriate approach to research in feminist system theory (FST). Interpretivists do not believe in universal standards of research (Willis, Jost, & Nilakanta, 2007), and do not embrace the expectations of objectivity employed by positivists (Stephens et al., 2010; Willis et al., 2007). Instead, all research methods, including quantitative methods are open to subjective interpretation (Willis et al., 2007). Rigorous interpretivist research "reflects qualities of responsibility, accountability, partiality and subjectivity" (Stephens et al., 2010, p. 561). This study used a qualitative methodology. Qualitative research is exploratory, subjective, and describes specific groups in a particular context (Christensen, Johnson, & Turner, 2011). Qualitative methods are accepted by interpretivists and FST practitioners (Stephens et al., 2010; Willis et al., 2007).

A key concept of interpretivism is that what is considered truth by others, is mostly a socially constructed belief (Willis et al., 2007). FST holds that positivism is a masculine-oriented concept that serves to maintain a patriarchal point of view (Jeans,

Knights, & Martin, 2011; Stephens et al., 2010). Through the lens of interpretivist research, there is no such thing as universal truth, but conclusions are drawn as local, contextualized truths (Willis et al., 2007). Research situated in context is much more valuable to the interpretivist than generalized experiments set in a lab-like environment (Willis et al., 2007). Thus, traditional quantitative methods are generally inappropriate for interpretive research (Willis et al., 2007). Finally, data for interpretivist research may include a wide variety of qualitative sources, including "diaries, journals, debriefings, interviews, case studies, textual analysis, reflections, and much more" (Willis et al., 2007).

Research Design

Researchers have used the Delphi method for forecasting, concept development, and model development (Okoli & Pawlowski, 2004). Scholars in information technology, healthcare, business, communications, knowledge management, and project development fields have also used the Delphi technique (Okoli & Pawlowski, 2004). Other uses of the Delphi method have included historical data gathering, budget planning, city planning, policy formulation, and curriculum development (Linstone & Turoff, 2002).

The Delphi process consists of a series of rounds in which a panel of experts, through an anonymous forum, provide opinions on the matter at hand (Charlton, 2004). Experts may be gathered into separate panels that provide different perspectives on the same problem (Okoli & Pawlowski, 2004). Ten to 18 is an appropriate panel size (Okoli & Pawlowski, 2004). Panel members must be "qualified experts who have deep understanding of the issues" (Okoli & Pawlowski, 2004, p. 20).

In the first round, the panel of experts provide opinions based on the experts' practical knowledge. The data are then analyzed and returned to the panel in the form of summaries "under a limited number of headings" (Charlton, 2004, p. 246). According to Jones and Hunter (1995), in round two, "participants rank their agreement" (p. 377) with each statement in the questionnaire, and "are commonly asked to rate the confidence or certainty with which they express opinions" (p. 311). The data from round two are synthesized, analyzed, and returned to the panel members for evaluation. This process continues until consensus is obtained. According to Charlton (2004), three rounds will usually produce this result. Quantitative or qualitative data and techniques may be used in a Delphi study (Davidson, 2013).

Appropriateness of Method and Design

Quantitative methods are appropriate for determining cause and effect or correlational relationships, testing theory, comparing relationships between variables or groups, or making predictions (Koro-Ljungberg & Hayes, 2010). Quantitative research does not allow for the exploration of a phenomenon (Christensen et al., 2011). The purpose of this study was not to determine causal or correlational relationships, test hypotheses, compare variables, or make any predictions. The purpose of this study was to explore the needs of wounded military women and develop a comprehensive plan for providing effective emotional and spiritual support to such women.

Mixed methods were also considered for this study. Lee and Smith (2012) gave five reasons for using a mixed method: triangulation, complementary, initiation, development, and expansion (Lee & Smith, 2012). Triangulation uses a qualitative method to validate the results of a quantitative method or vice-versa (Lee & Smith,

2012). In a complementary approach, the second method provides additional information to that obtained by the first method (Lee & Smith, 2012). For instance, qualitative questions may give participants the opportunity to provide additional information to quantitative survey answers. Initiation is a way to explore contradictions or discrepancies in complex studies (Greene, Caracelli, & Graham, 1989; Lee & Smith, 2012). Using qualitative questions to develop a quantitative survey instrument is an example of the development reason (Lee & Smith, 2012). Finally, in the expansion mixed method, quantitative and qualitative methods are used to study multiple phenomenon within a study (Lee & Smith, 2012).

Of the reasons listed above for using mixed methods, development was considered as a possibility for this study. Female soldiers could have been asked qualitative questions to develop a quantitative survey instrument, but this would not have resulted in a comprehensive model. On that basis, mixed methods was rejected as the best fit for the purpose of this study.

Feminist system theory (FST) calls on researchers to use methods that are tailored to the phenomenon being studied, address the many facets of a problem, and allow for critical reflection (Stephens et al., 2010). The qualitative Delphi approach meets these criteria in a multitude of ways. Qualitative research is interpretive, captures the individual subjective perspectives of participants, and is explorative in nature (Christensen et al., 2011). The problem addressed in this study is multifaceted and needs to be explored from more than one angle. The wounded women in this study provide one perspective, while the female chaplains provide another perspective. The wounded women personally experienced injuries and problems, while the female chaplains

experienced deployments and have been trained as professional care givers. The Delphi method enables exploration of a problem, while recommending solutions (Charlton, 2004).

To make the case for the Delphi design, this section will review four other common qualitative designs. The first is phenomenology. Phenomenology is a study that gathers descriptive, subjective data on the lived experience of participants (Chamberlain, 2009). Phenomenologists try to get inside the inner subjective and emotional world of participants, and determine what the experience means for participants (Paley, 2005). While phenomenology might be useful for understanding the experiences of wounded female soldiers, it was not best suited for meeting the objective of this study, which was to develop a model and plan for chaplain services.

Ethnography is the second qualitative design to be reviewed. Ethnography is the study of a culture, a group of people, or a cultural event (Singer, 2009). The purpose of ethnography is to enter the space of the participants and describe the cultural characteristics of the group or event (Roberts, 2009; Singer, 2009). A key component of ethnography is direct observation of participants in their natural environment (Roberts, 2009; Singer, 2009; Willis et al., 2007). Ethnography is a descriptive method useful for determining why groups act in a certain way (Roberts, 2009; Singer, 2009). Psychologists have used ethnography to better understand cultural groups and estimate how well an intervention might work within a specific group (Christensen et al., 2011). The purpose of this study was to develop a model and plan for chaplaincy support to wounded female soldiers and get feedback on the plan. Ethnography could assist in understanding the

culture of wounded female soldiers or female chaplains, but could not fulfill the objective of this study.

Case studies, the next form of qualitative research, "are exploratory and descriptive in nature" (Breslin & Buchanan, 2008, p. 38). Case study is deep research of a single person, organization, process, or event to make sense of a larger number of similar cases (Bengtsson & Hertting, 2014). "Case studies are not a perfect solution to the problem. They cannot tell what decisions should be made, but they can connect the student to social phenomena, real life experience, and existential situations in a way that helps to sharpen thinking and inform decision-making" (Breslin & Buchanan, 2008, p. 37). Case studies have limited generalizability because they involve a small number of cases and points of view (Bengtsson & Hertting, 2014; Flyvbjerg, 2006). The Delphi method was chosen over case study on the basis that the Delphi technique was utilized to gather points of view from two divergent perspectives (wounded female soldiers and female chaplains) in order to develop and evaluate a model and plan for chaplain services.

Grounded theory is a research design for developing theory from empirical data (Christensen et al., 2011). Using a combination of inductive reasoning and abduction, theory is developed from collected data (Bryant & Charmaz, 2007; Christensen et al., 2011). Grounded theory was not chosen as a design for this project because the purpose of this dissertation was not to develop theory from data, but to build consensus on a comprehensive plan and model for creating a system by which male chaplains could provide effective support to wounded female soldiers.

Research Questions

Research questions guide the choice of method and design (Koro-Ljungberg & Hayes, 2010). For qualitative research, carefully crafted research questions establish the boundaries of a study (Koro-Ljungberg & Hayes, 2010). The Delphi method provides a mechanism for model development (Okoli & Pawlowski, 2004). The research questions for this study guided the selection of the qualitative method and the Delphi design, and support the conception of a model for chaplaincy support.

Research Question 1: What could be a comprehensive plan and model which male chaplains could use to provide effective support to wounded female soldiers?

Research Question 2: What role might chaplains play in a comprehensive plan and model that could provide effective support to wounded female soldiers? The comprehensive plan and model developed in this study included support workers besides chaplains. The answer to this research question elaborated the specific role of chaplains in the comprehensive model.

Study Population

There are approximately 75,000 female soldiers in the U.S. Army (United States Census Bureau, 2011). Since the beginning of military operations in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), over 150,000 female service members have deployed overseas (Mattocks et al., 2012), and over 600 female soldiers have been wounded (Cater & Koch, 2010). Approximately one in six women veterans reported experiencing a sexual assault (Katz et al., 2007; Mattocks et al., 2012). There are 151 female chaplains in the U.S. Army (The United States Army, 2014).

Sampling Frame

The sampling frame consisted of two groups. The first group, Group 1, consisted of 10 U.S. Army women who were wounded or injured during an overseas deployment. This group included women who were injured as a result of combat, accidents, and sexual assault. Group 1 participants were not limited to those who used a chaplain for support. One of the questions posed to participants was what role might chaplains play in the care of wounded female soldiers. Some of the participants did not use a chaplain for support and it was important to understand why they did not. Group 2 participants (female chaplains) provided recommendations to solve this problem or compensate for it. For instance, some participants did not use a chaplain for support because a chaplain was not available, or the gender of the chaplain was an issue for the participant. The model proposed in the results of this study provided a possible solution for this problem. Group 1 participants did not include male soldiers or female soldiers who were injured or assaulted while serving in a position in the United States. Group 1 participants provided expertise on the needs of wounded military women and recommendations for the support systems that may help provide for those needs.

The second group, Group 2, consisted of 11 female chaplains who were serving as chaplains during the time of this study, had been deployed at least once between 2005 and 2015, were in the grade of captain or above, and had been serving in the Army for at least four years. These delineations were designed to ensure that only those chaplains with enough experience and knowledge of the stressors of deployment, the U.S. Army, the chaplain corps, and the unique challenges facing military women were included in the

study. According to Okoli and Pawlowski (2004), Delphi panel members must be "qualified experts who have deep understanding of the issues" (p. 20).

Recruitment Strategy

Okoli and Pawlowski (2004) defined a five step procedure for identifying and recruiting expert panels for Delphi studies. In this study, a modified version of the steps offered by Okoli and Pawlowski (2004) was used (see Figure 1). In addition to relevant skills and disciplines, soldiers with the appropriate experiences (e.g., those who had been wounded) were identified. Second, since this study used a feminist system theory framework, the gender of participants was a factor. Specifically, only females were considered. Third, literature sources were not used to generate names.

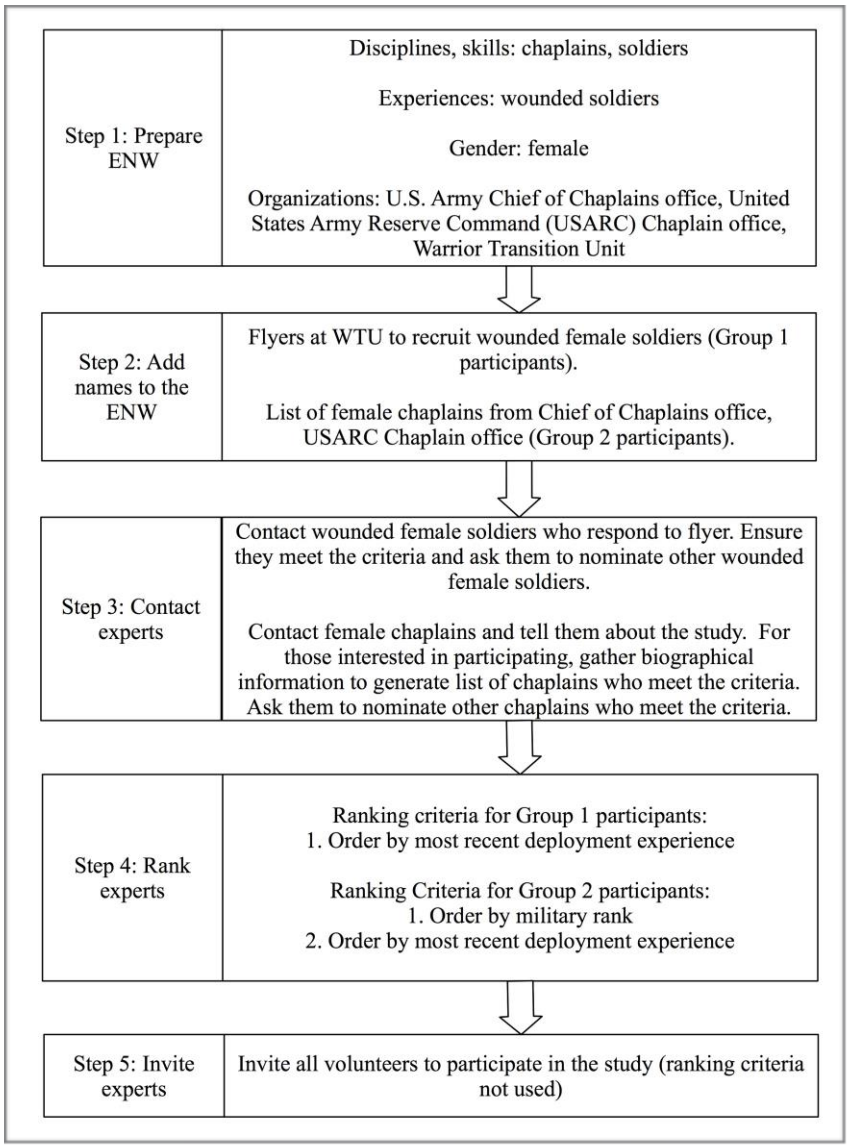

Figure 1. Participant recruitment steps. This figure illustrates the identification and recruitment process that was followed in this study.

1. Prepare an expert nomination worksheet (ENW). The preparation of the ENW involves making a list from which names of experts can be drawn. To identify name sources, Okoli and Pawlowski (2004) recommended listing disciplines and skills, relevant organizations, and relevant literature. In this

study, disciplines and skills were female chaplains and soldiers. Organizations were the U.S. Army Chief of Chaplains office, United States Army Reserve Command (USARC) Chaplain office, and a Warrior Transition Unit (WTU).

2. Add names to the ENW. The next step is to fill in the ENW with names of potential recruits from the skills, disciplines, organizations, and journals identified in step 1 (Okoli & Pawlowski, 2004). To recruit Group 1 participants, flyers were posted in the common areas of the WTU. Women who agreed to participate in the study also referred other women. For Group 2 participants, the Chief of Chaplains office sent an invitational e-mail to all active duty female chaplains, and the USARC Chaplain office provided a list of names of Army Reserve female chaplains.
3. Contact experts. In this step, the experts identified in step 2 are contacted and each expert is asked to nominate an additional expert (Okoli & Pawlowski, 2004). The experts are not recruited for the study at this point, but are told about the study and that they have been identified as an expert in a field appropriate for the study (Okoli & Pawlowski, 2004). Researchers gather biographical information from the experts and ask each one to identify other experts in the field (Okoli & Pawlowski, 2004). In this study, wounded female soldiers who responded to the flyer were contacted. Once it was determined that the interested soldiers met the criteria, the qualified soldiers were asked to nominate other wounded female soldiers. Female chaplains were contacted by e-mail. The purpose of the study was explained to

chaplains who responded. For those chaplains interested in participating, biographical information was gathered to generate a list of chaplains who met the criteria. Chaplains were asked to nominate other chaplains who also met the criteria.

4. Rank experts. From the biographical information provided in step 3, researchers rank experts from most to least qualified (Okoli & Pawlowski, 2004). For Group 1 participants, the plan was to give those with the most recent deployment experience in which they were wounded first consideration. This was because those participants would have the freshest experience. However, since only 10 soldiers volunteered, all of them were included in the study.

   For Group 2 participants, in Step 4, the research plan called for participants to first be grouped by their military rank, highest rank first. Colonels would be in the first group, lieutenant colonels in the second group, and majors in the final group. For each group, the potential participants would be ordered according to the date of their last deployment experience with the most recent experience being first. Chaplains with the highest rank were to be given higher priority on the assumption that senior chaplains would have greater experience and knowledge of the Army, ministry in general, and soldier support mechanisms. In actuality, 11 chaplains that met the inclusion criteria volunteered for the study, so all were included.

5. Invite experts. In the final step, experts are contacted by priority and invited to participate in the study (Okoli & Pawlowski, 2004). Researchers continue

to contact and invite experts until the pre-determined number of experts (typically 10-18) have agreed to participate in the study (Okoli & Pawlowski, 2004). In this step, all female soldiers and female chaplains who met the inclusion criteria were invited to participate in the study.

Informed Consent

Ethical research acknowledges that research participants are autonomous people (Christensen et al., 2011). Proper informed consent procedures ensure that pertinent information about the study is provided to participants, the participants completely understand the information provided, and those who decide to participate do so voluntarily (Christensen et al., 2011). In this study, a signed consent form represented acknowledgement from participants that the above occurred.

An informed consent form (ICF) was given to every participant. The ICF was personally handed to, or e-mailed to each potential participant. The ICF described the purpose of the study, who was conducting the study, the potential risks and benefits of the study, the location of the study, and procedures for withdrawing from the study. Each participant was required to sign the ICF. Participants, who returned the form via e-mail, were telephoned and the form was reviewed in detail to ensure that the participant completely understood the information in the consent form, including how to withdraw from the study. Participants could have withdrawn from the study at any time, even after data had been gathered. To withdraw from the study, participants could simply e-mail or call the researcher. Participants were not paid for taking part in the study. The informed consent form is provided in Appendix A.

Confidentiality

To protect the anonymity of participants, no names, ranks, or positions were revealed in any published material, and all personally identifiable information (PII) and signed consent forms were locked in a safe at the researcher's home. Randomly created three digit codes were assigned to each participant as an alias, and participants were only referred to by her alias. Research Randomizer is a free Web-based application for generating random number sets for research (Urbaniak & Plous, 2016). Each Group 1 participant was coded with a WW and a three-digit number generated from Research Randomizer (e.g., WW394). Each Group 2 participant was coded with a CH and a three-digit number generated from Research Randomizer (e.g., CH181). All randomly assigned numbers were unique. All data was recorded on paper, CDs, or DVDs, and will remain stored in a locked safe, at the researcher's home, for at least five years. After five years, all data will be destroyed using a Department of Defense authorized high security cross-cut shredder capable of destroying paper and media storage.

Face-to-face interviews with Group 1 participants took place in a confidential counseling room. Only the participant and the researcher were allowed in the room. The room had one entryway door that was closed and a sign was posted on the door to prevent interruptions.

Geographic Location

Warrior Transition Units (WTUs) are U.S. Army units established to provide administrative and medical care to injured soldiers (Wright, 2013). There are 25 WTUs (Warrior Transition Units, 2009) and over 10,000 soldiers have received treatment at WTUs (Wright, 2013). The number of female soldiers who have been treated in WTUs

is not available publicly. As of 2009, nine percent of service members in WTUs had been wounded in overseas deployments (Warrior Transition Units, 2009). Group 1 participants were recruited primarily from soldiers assigned to the WTU at Fort Bragg, North Carolina.

Study participants for Group 2 were recruited from chaplain offices throughout the U.S. Army. There are 151 female chaplains in the U.S. Army (The United States Army, 2014). Since these chaplains serve in posts scattered throughout the United States, interviews were conducted via telephone.

Data Collection

Data collection was conducted in three phases. The first phase determined the specific emotional and spiritual support needs of wounded military women. The results of this phase served as a seed for the next phase of discussions. In the second phase, participants created a list of actions chaplains can take to provide emotional and spiritual support to wounded military women. The third phase culminated in a comprehensive model and plan male chaplains can use to provide emotional and spiritual support to wounded female soldiers.

Phase 1

This phase of the study served three purposes. The first was to gather demographic data and a religious profile of participants (how participants characterize themselves religiously or spiritually and how often participants attended religious services). The second purpose was to develop a list of emotional and spiritual needs of wounded military women. The third purpose was to ask participants what support

mechanisms should be made available to assist wounded military women. Consensus on all list items was not required.

In the first round of this phase, open-ended interviews were conducted to generate demographic data, create a list of emotional and spiritual needs, and list desired support mechanisms. The list of needs and support mechanisms was fed back to each participant. Each participant reviewed the list to determine if the participant's recommendations were reflected in the list. The final list became the seed for the next phase of the study.

Phase 2

The prioritized list of emotional and spiritual needs and desired support mechanisms from Phase 1 was given to Group 2 participants (female chaplains). Open-ended interviews with Group 2 participants was conducted by telephone. After given a chance to review the list generated in Phase 1, each participant was asked two questions. The first question was what action, without regard to the gender of the chaplain, could a chaplain take to perform or provide for each need and support recommendation. The second question was what action might a male chaplain take if the wounded female preferred to receive support from a female chaplain or care provider.

From the interview answers, two lists of actions were generated. The first was a list of actions chaplains could take if the gender of the chaplain was not an issue for the female soldier. The second was a list of actions a male chaplain might take if the wounded female preferred to receive support from a female chaplain or a female care provider.

In the second round, Group 2 participants voted anonymously on the nine innovative practices (see Appendix B). The results of the second round were analyzed to

determine the percentage of chaplains who validated each item on the list. Action items validated by 50% or more by chaplains were used for the next phase. Consensus by majority agreement has been used in other Delphi studies (von der Gracht, 2012).

Phase 3

The purpose of this phase was to develop a comprehensive model based on the inputs from Phase 1 and Phase 2. The inputs from Phase 1 were the list of needs and support mechanisms generated from the female soldiers. The input from Phase 2 was the action items generated from the female chaplains. The result of this phase was a comprehensive model and plan for how chaplains might provide emotional and spiritual support for wounded military women.

Instrumentation

For the first round of Phase 1 and Phase 2, participants were asked a series of open-ended questions. The perspectives of participants can be fully explored through open-ended questions (Hesse-Biber & Leavy, 2011). The base list of questions for Phase 1 and 2 are listed in Appendix C and D, respectively. These questions served only as a base, but in keeping with the qualitative nature of the study, follow up questions were asked to "understand the data from the participants' subjective perspectives" (Christensen et al., 2011, p. 52).

In Phase 1, Group 1 participants were asked questions to determine their age, the overseas area of operations where injuries were received, and the nature of their injuries. Participants were asked to characterize themselves spiritually/religiously, and how many times in the last 12 months they attended religious services. Next, participants were asked to describe their emotional and spiritual support needs during the period of

recovery, as well as suggest what agencies or support mechanisms should be made available to wounded women. Finally, the participants were asked about the role chaplains should play in the recovery process, and if they have a preference for the gender of the chaplain or other support provider.

In Phase 2, Group 2 participants were asked two questions (see Appendix D). The first question was what action, without regard to the gender of the chaplain, could a chaplain take to perform or provide for each need and support recommendation. The second question was what action a male chaplain might take if the wounded female preferred to receive support from a female chaplain or care provider. In the second round of each phase, the data analysis procedures below were followed. Consensus on all items was not required.

Data Analysis

The first step in qualitative data analysis is coding the data. Coding is the process of breaking descriptive data into ideas and organizing them (Jacelon & O'Dell, 2005). Software exists that can greatly aid in the organizing and coding process. The software can store transcripts, search for key words and phrases, enable coding of data, and arrange coded data (Burnard et al., 2008; Jacelon & O'Dell, 2005). NVivo 10 for Mac, a software package designed to analyze unstructured data, was used to assist in the coding process (NVivo qualitative data analysis software, 2014).

Once the data was coded and organized, the data was examined for patterns within the codes (or categories) and across categories to identify themes (Jacelon & O'Dell, 2005). After the themes were developed, overlapping themes were identified, and overlapping themes were distilled into single succinct themes (Jacelon & O'Dell,

2005). These themes became inputs into the second round of each phase. In the second round of Phase 1, participants verified that the distilled themes adequately captured the information participants provided in the initial interviews.

Validity and Reliability

Research from an interpretivist's perspective does not conform to the positivist viewpoint of validity and reliability (Willis et al., 2007). Positivists believe that for a research project to be valid and reliable, it must be generalizable and replicable (Christensen et al., 2011; Willis et al., 2007). Positivist research is, in general, the search for universal truth (Christensen et al., 2011; Willis et al., 2007). Interpretivists do not believe in universal truth, but seek situated understanding (Christensen et al., 2011; Willis et al., 2007).

There are a number of accepted approaches to validity in qualitative research. Creswell (2013) offered credibility, dependability, confirmability, and transferability as sound terms for judging the validity of qualitative research. Credibility refers to authenticity and trustworthiness (Christensen et al., 2011). One of the goals of interpretivist research is to authentically depict the context and perspectives of participants (Christensen et al., 2011). Dependability and confirmability are established through a research auditing process (Creswell, 2013). In this Delphi study, auditing took place by the panel of experts in the second round of each phase. The panels audited and validated the data gathered in the first rounds.

Interpretivists do not view knowledge gained through scientific research as universal truth, or transferable outside of the context in which it was acquired (Willis et al., 2007). Findings must be situated within the social, political, historical, and

economical context of the participants (Christensen et al., 2007). From this viewpoint, transferability means that the consumer of the study must determine if the conclusions can be adapted for use in other settings (Christensen et al., 2007). In the context of this study, the U.S. Army Chief of Chaplains office, the USARC Chaplain office, Army leadership, and chaplains in the field are potential consumers of the study, and will determine if the results are useable in their particular context.

Willis et al. (2007) recommended two validation strategies for qualitative research: *member checks* and *participatory research*. In member checks, participants are given an opportunity to validate initial conclusions drawn from the data (Willis et al., 2007). Participatory research means that research subjects "actively participate in the formulation of conclusions" (Willis et al., 2007, p. 220).

Through the member checks and participatory research techniques that are part of the Delphi process, credibility, dependability, and confirmability can be accomplished. The Delphi process in this study accomplished member checks in the second round of both phases. In the second rounds, participants validated the categories and themes developed in the first rounds. Further, the Delphi process is inherently participatory. In each phase of the process, participants provided opinions and recommendations, and drew conclusions based on the opinions of other participants.

Summary of Chapter 3

The purpose of this qualitative Delphi study was to build consensus on a comprehensive plan and model for creating a system by which male chaplains could provide effective support to wounded female soldiers. Chapter 1 explained the background of the problem and significance of the study, and Chapter 2 provided a

review of pertinent literature. Chapter 3 described the problem statement, purpose statement, study population, study location, the research method, research design, the informed consent process, the rules of confidentiality, data collection methods, and data analysis processes. The following chapter describes the themes generated in Phases 1 and 2 and the development of the comprehensive female soldiers support model in Phase 3.

Chapter 4

Data Analysis and Results

The purpose of this qualitative Delphi study was to build consensus on a comprehensive plan and model for creating a system by which male chaplains could provide effective support to wounded female soldiers. Opinions were gathered from two groups of experts — 10 female soldiers and 11 female chaplains. The data was gathered in three phases. In the first phase, female soldiers were interviewed about the emotional and spiritual support needs they experienced during overseas deployment. In the second phase, female chaplains were asked to respond to the needs identified in Phase 1 with actions chaplains could take to provide emotional and spiritual support. The culmination of Phase 3 was the comprehensive model and plan. This chapter covers the data and themes generated through the qualitative Delphi process.

Phase 1

Demographics

Ten female soldiers were interviewed in Phase 1. The first three questions of the interview were designed to elicit demographic information (see Table 2). The average age of participants in this phase was 42, with an age range of 32-52. Iraq was the most common place of deployment for participants. All but two of the participants deployed to Iraq, and some of the soldiers had deployed multiple times. Four of the soldiers experienced injury due to enemy action, such as improvised explosive devices (IEDs) or mortar attacks. One soldier was sexually assaulted, and the rest of the soldiers got injured in accidents or during training overseas. Question #3 asked participants about the

date they were injured. Most participants could not remember the date, and the date had no significance to the study.

In terms of religion and spirituality, there were a variety of responses. Six out of 10 respondents characterized themselves as Christians who attended religious services or Bible studies more than 40 times a year. Two of the participants stated a belief in God and the Bible, but neither regularly attended church services. One participant specifically characterized herself as a Christian, but did not attend church; and another participant stated that she was agnostic, but believed in a higher power of some sort and did not attend church services.

Table 2

Female Soldier Demographics

Average Age	42
Age Range	32-52
Most Frequent Deployment Location	Iraq
Nature of Injury	**# of Soldiers**
Accident	5
Enemy Action	4
Sexual Assault	1
Religion and Spirituality	**# of Soldiers**
Christians, attends church 40+ times/year	6
Believes in God, does not regularly attend church	2
Christian, does not regularly attend church	1
Agnostic, believes in higher power, does not attend church	1

Data Analysis

Round one.

The objective of Phase 1 of the project was to develop a list of emotional and spiritual support needs experienced by female soldiers during overseas deployments. The first step in the data analysis process occurred during the interviews. Participants explicitly stated or implied their experienced needs. For instance, one participant stated that her injury caused her a lot of stress, so she vented her feelings to her roommate. According to this participant, her roommate listened to her and it helped her de-stress.

The second step was performed using NVivo for Mac, version 10. First, a word count query was executed (see Appendix E). These frequent words served as potential needs. Next, a series of text search queries were run using the most frequent words from the word count query as inputs into the text search queries. The text search queries returned sentence fragments as results. Each sentence fragment was reviewed for potentiality to identify an emotional and spiritual support need. Needs identified from the queries were added to the raw list of emotional and spiritual support needs.

The third step of the data analysis was to develop a consolidated list of emotional and spiritual support needs from the raw list. Each item in the raw list was reviewed. Unique items were added to the consolidated list. Items that were duplicates of items in the consolidated list, or had meanings that were very close to items that were already captured in the consolidated list, were eliminated. The final list consisted of all stated and implied emotional and spiritual support needs (see Appendix F). The next sections describe the themes that were generated from the emotional and spiritual support needs.

Theme One: Female Soldiers Needed to Talk to a Trusted Person During Deployment

Ten of 10 female soldiers said that they needed to talk to a trusted person during deployment. Participants needed help processing their emotions and unloading emotional baggage gathered from the stress and anxieties associated with their deployments. For some, telling their story was important. Others needed to talk about their mental struggles and injuries, or simply de-stress. Forty percent of participants thought that female soldiers should be able to talk to a female chaplain. For two participants, the fact that the chaplain was a neutral person (i.e., not in their chain of command) was important because the soldiers could talk to the chaplain without fear of reprisal.

Unfortunately, the need to talk to a trusted person was an unmet need for most of the participants. Eight of 10 participants expressed problems in being able to speak to someone about what was going on inside of them. Each participant had different reasons for why this was true.

Participant WW692 had several reasons for not talking to someone about the feelings she experienced during her deployments. In the first deployment, she was wounded by a mortar attack. As she moved through the medical evacuation process, from the battlefield, to the hospital, and eventually stateside, she never saw a chaplain. As far as she knows, a chaplain never visited her, though she did state that she may have been too medicated to remember. During her second deployment, she did not think the chaplain was experienced enough "in life in general" to be of much help to her. The chaplain was both very young, and freshly out of chaplain school. WW692 suffered from PTSD after her deployment and was unwilling to speak to someone in her chain of

command for fear that her career would be negatively impacted. At one point she did speak to a support provider, but the person was traumatized by her story and sat there crying while WW692 talked. This participant's self-stated criteria for a person with whom she could share her story was a neutral person (like a chaplain), who had deployment experience, knew how to ask the right questions, and was not shocked by her story. Since WW692 did not feel that there was someone she could talk to, she repressed her feelings and they came out later as anger. As of this writing, WW692 continues to suffer from PTSD.

WW681 was injured because an improvised explosive device (IED), or roadside bomb, hit her vehicle. Her injury appeared to be minor, but it caused great pain. Her supervisors did not believe that she was truly hurt, and she felt invalidated as both a soldier and an injured person. She tried to talk to a chaplain once, but according to her, he seemed to have no interest in helping her, or even listening to her. WW681 believes that not having someone to talk to greatly hindered her recovery. Because of her negative experience with a chaplain, she does not trust chaplains and has never sought the help of another one.

According to WW606, the interview for this research project was the first time anyone in the Army had ever asked her point of view. WW606 deployed overseas for the first time in 2004. There, she was wounded when an IED hit her vehicle. During the entire time she was in the corps area support hospital (CASH), no chaplain ever came to visit her. She did not see chaplains as a source of assistance, especially since even as a wounded soldier she did not receive a chaplain visitation. Fortunately, her experience

with a chaplain was much better on her second deployment, and she received tremendous support from the unit ministry team.

WW202, like other female soldiers, worked in a male-dominated environment. This participant did not feel free to unload her emotional baggage with anyone because she did not want to look weak in front of the men. She was very guarded about her emotions, and she was afraid to talk to a chaplain because she worried that the chaplain would recommend that she be sent home. So, she kept her emotions in check and inside. When she returned home, she did not discuss her experiences with friends or family. She now prefers to live in isolation, away from family and others.

WW635 kept things to herself and stayed closed off emotionally. During her deployment experience, she did talk to a couple of chaplains and they were helpful. They helped her understand the importance of not closing people off, and they helped her understand that she was forgiven by God. It took a long time for this participant to open up to counselors, but eventually she got help from behavior health counselors at the WTU.

WW195 was a victim of sexual assault. Her greatest expressed need was to have someone to which she could share her feelings. According to her, she did not need someone as close as a friend to do this with. It could be an acquaintance, but it needed to be someone who had either been through sexual assault, or someone who had helped someone else through sexual assault. She did not find anyone in her unit to talk to because she never reported the incident and did not want anyone to know about it. The chaplain she deployed with was not a resource for her. According to WW195, this male chaplain "was an idiot" who did not seem to be genuinely interested in helping anyone.

The chaplain at the WTU, a different chaplain than the one she deployed with, was supportive and tried to help, but he was a male, and after her experience, WW195 did not trust males. WW195 did receive mental health treatment at the WTU, but according to her, the behavioral health specialists used "a cookie cutter approach." They seemed to be rushing her through the process with little concern for her as an individual.

WW168 had a horrifying experience during her deployment. She tried to stop a fellow soldier from committing suicide, but did not succeed. The soldier threatened her with a weapon and when she left the room, the soldier killed himself. After the gun went off, WW168 opened the door and the body fell onto her. This was very traumatizing for her. No chaplain ever came to discuss this traumatic incident with her. She was left to cope with it on her own.

WW168 experienced physical injuries too. She fractured her hip, but was misdiagnosed with a muscle strain. She walked around for four weeks on the fractured hip before her real condition was discovered. Once the real injury was discovered, WW168 was hospitalized and evacuated to the United States. During her time in the hospital, she received a chaplain visit on the first day only. She expected to get a daily visit from someone in the chain of command or the chaplain, but no one came to visit. The interview did not determine the number of days the participant stayed in the hospital.

WW235's roommate was the person in whom she confided the most. The enlisted soldiers she deployed with also helped a great deal. They "talked about everything." When asked about chaplain support during the deployment, WW235 said that the chaplain was never around. According to her, the soldiers did not trust the chaplain because they never saw him, he did not build relationships with the soldiers, and

he never conducted any religious services. Apparently, WW235 received emotional support from her fellow soldiers. She did not receive spiritual support from anyone, but she did believe in God and prayed.

Theme Two: Female Soldiers Expected Chaplains to Possess Specific Caregiving Traits

During the course of interviews, seven participants identified caregiving traits that they expected chaplains to have. Three of 10 participants expected chaplains to be warm and caring. WW692 expected chaplains to be skilled in handling trauma, educated in how to make a soldier feel comfortable sharing difficult experiences, and proficient in asking the right questions to help a soldier tell her story. WW692 also felt that chaplains need deployment experience to be able to understand what soldiers go through. One participant stated that chaplains should be able to build relationships with all soldiers in the unit. One participant, who was sexually assaulted during her deployment, stated that chaplains should be trained and experienced in dealing with soldiers who have been sexually assaulted. Finally, one soldier expected chaplains to be willing to engage the chain of command on the behalf of soldiers when it was called for. For instance, if a soldier was not receiving the proper care, a chaplain should be willing to talk to the soldier's commander about the problem.

Theme Three: Female Soldiers had Positive and Negative Experiences with Chaplains

Positive experiences with chaplains.

Three of 10 participants said that they had good experiences with chaplains. WW635 stated that she read the Bible and occasionally listened to a couple of famous

television preachers. Otherwise, she was not very religious. During one of her three deployments, WW635 talked to a chaplain for over an hour. This chaplain helped her receive forgiveness and to understand that it takes time to get over traumatic experiences.

WW605 first deployed in 2004 to Iraq. There, she sustained wounds in an IED blast. Nine years later she deployed to Afghanistan, where she was injured during a training event. During her first deployment, she did not receive any chaplain support, but during her second deployment, the unit ministry team (chaplain and chaplain assistant) "provided tremendous support." WW605 also shared an experience that occurred during her second deployment in which she heard God's encouraging words and felt overcome by a sense of joy and peace.

For WW448, the Army and chaplains have always been there to provide the support she needed. WW448 came from a strong family support background and stated that she rarely lacks the emotional and spiritual support she needs. Her parents always provided the support she needed and the Army always gave her good mentors. WW448 was satisfied with her experience with chaplains. One chaplain in particular taught her a lot about the Bible, supported her, and had a great personal manner that she appreciated. He was warm, caring, took the time to get to know her, and made her feel safe and comfortable.

Negative experiences with chaplains.

Four of the respondents described negative experiences with chaplains. According to WW235, the soldiers in her unit did not trust the chaplain since he was never around, did not build relationships with the soldiers, and did not provide any religious services. WW168 saw a chaplain only one time, and that was after she "raised

Cain" with the hospital staff because she did not feel that the staff was properly taking care of her. The chaplain visited her for "10 minutes" to try and calm her down, but did not help her otherwise, and never visited her again during her hospital stay. WW681 was experiencing a lot of stress because her chain of command did not believe that she was really hurt. She tried to talk to a chaplain once, but he did not seem to care about her. That was in 2006, and since then, she has never talked to another person about the emotional trauma she experienced during her deployment. According to WW195, her chaplain was self-centered and had no interest in serving soldiers. She would not talk to him about anything, especially something sensitive in nature.

Theme Four: Most Female Soldiers Did Not Express a Preference for the Gender of the Chaplain

Each participant was asked if she had a preference for the gender of the chaplain. Only one participant expressed an absolute preference for the gender of the chaplain. This participant was taught to not discuss emotional issues with a man (other than her husband) for fear that an inappropriate (romantic) relationship may develop between the counselor and counselee. A second participant preferred female support providers, but would speak to a male if she trusted him.

The other nine participants stated that they would seek counseling from a male chaplain if he possessed the right traits — warm and caring, approachable, trustworthy, etc. However, four of the nine participants suggested that other female soldiers may feel more comfortable talking to a female chaplain than a male chaplain, and female soldiers should have access to a female chaplain if they so desired. Though WW606 had never

seen a female chaplain, she thought that if male soldiers saw female chaplains in unit areas, the men would have greater respect for female soldiers in general.

Other Findings

Needs specifically related to spirituality and religion.

Five female soldiers expressed needs specifically related to spirituality and religion. As religious advisers, and providers of religious activities, chaplains can help foster the fulfillment of these needs. For some participants, chaplains helped provide for these needs, but for other participants the fulfillment of these needs came from fellow soldiers. One participant stated that a chaplain helped her find forgiveness, though she did not state what she needed forgiveness for. One participant needed to know that God was in control and that God would always be there for her. WW448 stated two needs associated with spirituality and religion: a faith community to provide encouragement, support, healthy relationships, and learning opportunities; and help discovering her personal faith. One participant stated that she needed help processing her feelings about God. She was angry at God for what she was going through and the death of her fellow soldiers. Finally, one participant stated that chaplains should organize religious activities, such as chapel service, Bible studies, and prayer groups. According to this participant, such activities would not only help soldiers from a religious standpoint, but would also help soldiers build trust in each other and the chaplain.

Chaplain visitation needs.

Chaplain visitations to soldiers in the hospital or after a traumatic event were needs expressed by more than one participant. Four participants stated that they were disappointed that they received no visitation from a chaplain while hospitalized. Of the

four, one participant was directly traumatized by a fellow soldier who committed suicide, but the participant was forced to cope on her own since no chaplain visited her after the event.

Anxiety, depression, and PTSD.

The female soldiers in this study witnessed indigenous people being exposed to poverty and violence. Soldiers also personally experienced traumatic events, such as combat and injury. Participants needed help overcoming anxiety, depression, and PTSD. Two participants specifically stated that they struggled with depression. A third participant said that she was still suffering from PTSD, six years after her deployment.

The need for reassurances after being wounded.

Two identified needs fit into this category. WW692 stated that after she had been wounded from a mortar attack and was evacuated for treatment, she needed to be assured that she was going to be okay, that her family had been informed of her condition, and that her unit members were okay after the attack. Sadly, this participant could not remember seeing a chaplain after being wounded. Either no chaplain came to visit her, or, by her own admission, she may have been too incapacitated from the medication to remember. The second need this participant identified was that she needed to know that she was not alone, and that people cared for her, even though she was wounded and out of the fight.

Needs associated with the chain of command.

Two soldiers identified two needs associated with the chain of command and other leaders in the unit. WW681 was injured when her vehicle was hit by an IED. She felt that no one cared that she was hurt. She no longer felt validated as a soldier.

Therefore, she needed to know that her leaders still considered her to be a valued soldier even though she was hurt. In addition, she needed leaders and support providers to understand that there were mental injuries too, not just physical ones.

The second soldier was hospitalized after suffering a fractured hip. The soldier expected to be visited daily by her unit chaplain or someone from the chain of command. However, she was disappointed because the chaplain only visited her once and she did not recall anyone from the chain of command ever visiting her.

Unit recreational activities.

In this context, recreational events refer to sporting events and other unit activities designed to be fun. WW235 stated that "The female soldiers experienced a lot of stress." According to WW235, unit recreational activities, sponsored by the Morale, Welfare, and Recreation (MWR) department, helped soldiers reduce stress. Reducing stress through unit recreational activities could help with other expressed needs such as overcoming PTSD, needing community support, reducing anxiety and depression, and knowing that soldiers were not alone.

Warm, individualized approach to health and mental care.

WW195 identified warm, individualized approach to health and mental care as a need. She did not want to be treated like just a cog in the wheel. She wanted to be treated like an individual with unique needs. WW195 also stated that all injured soldiers should be provided a catalog of supporting agencies. This catalog should be designed so that a soldier can cross reference her injury with the appropriate supporting agencies.

Round Two

In the second round of Phase 1, all of the participants were asked to validate the final list of emotional and spiritual support needs. All 10 participants validated the list as it was presented. According to participants, the list fully captured all of their needs. Therefore, no further rounds for this phase were needed.

Phase 2

The purpose of this phase was to generate a list of actions chaplains can take to provide assistance for each support need. Group 2 reviewed the prioritized list of emotional and spiritual needs and the recommended supports from Phase 1 and generated a list of possible support actions. The result of this phase served as an input to Phase 3.

Demographics

Eleven female chaplains participated in Phase 2. A variety of ranks were represented including, one lieutenant colonel, three majors, and seven captains (see Table 3). Seven chaplains were Army Reservists, and four chaplains were on active duty. There were no chaplains from the National Guard. All chaplains were deployed between 2005 and 2015, and some served in more than one deployment.

Table 3

Female Chaplain Demographics

Rank	**# of Chaplains**
Lieutenant colonel	1
Major	3
Captain	7
Army Component	
Army Reserve	7
Active duty	4

Data Analysis

Round one.

Open-ended interviews with Group 2 participants were conducted. Each participant reviewed the list of needs and recommendations for support generated in Phase 1 and responded to two questions: 1) What action, without regard to the gender of the chaplain, could a chaplain take to provide support for the need or support mechanism; 2) What action could a male chaplain take if the wounded female preferred to receive support from a female chaplain or care provider.

After each interview, the handwritten notes were transcribed into a computer using a word processing program. The interview notes were analyzed and chaplain action items were extracted and placed into one of two lists. The first was a list of actions chaplains could take if the gender of the chaplain was not an issue for the female soldier. The second was a list of actions a male chaplain could take if the wounded female preferred to receive support from a female chaplain or a female care provider. Table 4 lists the number of themes and categories for each list. Of the 35 total categories

of actions from both lists, nine were innovative practices that were either untested or not currently in wide use. For example, two chaplains suggested reinstating the female chaplain conference. This annual conference had been cancelled in recent years due to budgetary constraints.

Table 4

Themes and Categories from Round One

Theme	Number of Categories
List 1: Actions a chaplain could take if the gender of the chaplain was not an issue for the female soldier	
Chaplain characteristics	8
External actions	9
Valuable training for chaplains	5
The chaplaincy institution	4
Subtotal	**26**
List 2: Actions a male chaplain could take if the wounded female preferred to receive support from a female chaplain or a female care provider	9
Total Categories	**35**

Round two.

In the second round, Group 2 participants were asked to anonymously vote on the nine innovative practices (see Table 5). The practices that over 50% of chaplains approved were included in the emotional and spiritual support model, along with all of the other categories of action items. This type of consensus by majority agreement has been used in other Delphi studies (von der Gracht, 2012).

Table 5

Nine Innovative Recommendations

Recommendation	Number of Votes
Chaplains should receive more training on healthy coping mechanisms.	10
Better screening of potential chaplains before accessioning.	10
Foster discussions about gender.	9
Recruit more female chaplains by sending female chaplains to their alma mater once a year to talk with seminary students about what it is like to be a female chaplain.	9
Chaplains should receive more training on healthy coping mechanisms.	8
There should be an annual chaplain conference.	8
There should be an annual female chaplain conference.	8
Be intentional about female chaplain assignments.	6
Senior chaplains should advertise and encourage the use of female chaplains for providing support to female soldiers.	6

Themes Generated from Question One: Non-Gender Chaplain Actions

Theme One: Chaplain Characteristics

This theme addresses personal characteristics that effective chaplains possess, according to female soldiers and female chaplains. The internal characteristics represent traits chaplains should think about, be aware of, or maintain. Internal characteristics prepare and sustain the chaplain to conduct effective ministry.

Self-awareness.

Chaplains need to be aware of their own emotional baggage and triggers. Chaplains should not traumatize the soldier or use the soldier to process the chaplain's

own baggage. Chaplains also need to be aware of their own strengths, weaknesses, and limitations.

Role awareness.

Chaplains must be humble and realize that they cannot do everything. Chaplains are not mental health professionals. Part of the chaplain's role is to help soldiers solve their own problems. Many of the soldiers know that their problems may not be fixable at the moment, but they just need someone to talk to. Chaplains suggested that, rather than see themselves as a counselor, chaplains saw themselves as being on the journey with the soldier.

Referral agent.

Chaplains need to know when to refer a soldier to mental health counseling. Chaplains need to know the strengths, weaknesses, and theological perspectives of other chaplains. A humble chaplain is willing to refer a soldier to another chaplain who may be better suited to take care of the soldier.

Diversity embracing.

To maintain their own religious beliefs while honoring the diversity of others, chaplains may need to create their own sacred space for prayer, meditation, and interpreting their own life experiences. One chaplain suggested that she maintains the belief that God is good, but bad things happen in this world that are not necessarily God's will. Such a belief helps this chaplain maintain a realistic viewpoint while keeping her from being disappointed in God. Other chaplains stated that chaplains can put aside their own religious beliefs to put themselves in someone else's shoes, give space for other

people to be different, suspend judgment of others, and look for God's grace in the midst of tragedy.

Internal trauma mitigating.

Chaplains who are proactive in their own healing process are more equipped to help others. Mitigating internal trauma (MIA) may mean that a chaplain allows the soldier to empty her cares onto the chaplain, but then the chaplain lets go of those cares after the counseling session. CH580 stated it this way, "After the session, I empty my rucksack at the cross and give the burden to God." According to CH483, MIA may also mean not being shocked by the soldier's story so much that all of the chaplain's personal energy goes toward himself or herself, rather than being tentative to the soldier. If a chaplain can mitigate his or her personal trauma, that chaplain can fearlessly listen to a soldier's story, even if the story is shocking.

PTSD knowledge.

Chaplains may have to provide care to soldiers with PTSD. According to one chaplain, if a chaplain cannot accurately explain PTSD to a lay person, then the chaplain does not know enough about it. Chaplains need to know the signs, symptoms, and possible consequences of PTSD.

Supporting agency knowledge.

Not all supporting agencies are effective. Chaplains need to investigate and find out which agencies are effective. Army Reserve and National Guard chaplains often have to rely on civilian supporting agencies because they do not live near an Army post.

Experience titration.

Chaplains go into counseling situations with a wide variety of experiences, but a chaplain may need to titrate his or her own experience to support the soldier's needs. For example, assume that a chaplain had witnessed so much death that he or she had become numb to it. Then assume that a soldier came to the chaplain because she was feeling traumatized over witnessing her first death. The chaplain might think about what it was like to first witness death, so that the chaplain could empathize with the soldier. On the other hand, if the chaplain has never shared in a similar experience, the chaplain could explore that experience with the soldier.

Theme Two: External Actions

This theme describes external actions chaplains can take in the conduct of their ministry to female soldiers. Female chaplains had a lot to say about how to help soldiers. There are nine categories of actions in this theme. The categories relate to a whole range of activities, such as building rapport, conducting counseling, providing spiritual guidance, assisting wounded and traumatized soldiers, and working with the chain of command. Within some categories, there are two to three sub-categories. The first category describes caring counseling techniques.

Caring counseling techniques.

Build rapport with all soldiers in the unit.

This is the cornerstone of any chaplain's ministry. Building rapport helps service members feel more comfortable in approaching the chaplain when they need help, and enables the chaplain to have the commander's ear. Chaplains suggested six ways for building rapport. The first was to take a friendship and "we're-in-this-together" approach

with soldiers. "If you come into my circle of personal care, you're on my team, you're in my group," said one chaplain. The second suggestion was to be with soldiers in as many places as possible so that soldiers are comfortable with the chaplain, and do not only see him or her in times of crisis. Effective chaplains cultivate opportunities to build rapport with soldiers. Other suggestions included being approachable, being transparent with people and not removed from the stress and pain of deployment, observing soldiers interacting with others to get clues about whether they are experiencing or have experienced some trauma, and asking God to give the chaplain a caring heart and love for His people.

Make the office space a comfortable environment for soldiers to receive counseling.

As with building rapport, making the office space a comfortable environment helps set a positive tone for counseling. Comfortable accommodations are not always available. However, even in the austerity of a deployment, a chaplain can create a sanctuary so that the person feels free and comfortable to share his or her needs. One chaplain stated that she never sets a time limit for a counseling session. She lets the soldier talk as much as the soldier needs to. Another chaplain stressed the importance of talking to the soldier face-to-face and presenting a warm, open, physical demeanor.

Ask open-ended questions in a counseling session.

Once the counseling session begins, and rapport has been built, asking open-ended questions enables the chaplain to conduct a needs assessment, clarify the problem for the soldier and the chaplain, and discover the deep-seated issues that are driving the soldier's needs. Open-ended questions help soldiers discover what they are feeling.

Open-ended questions may also help soldiers find themselves again after experiencing a crisis.

Ensure soldiers know the role of the chaplain.

Anything that a soldier shares with a chaplain is privileged communication. The chaplain cannot divulge this information to anyone without the consent of the soldier. Part of the role of the chaplain is making sure that service members understand this. The chaplain may also explain to the soldier that the chaplain has an influential role with the chain of command, but not a commanding role. The chaplain cannot order the commander to do anything.

Employ caring counseling techniques.

Employing caring counseling techniques includes talking more at the beginning of the counseling session to establish rapport, but then letting the soldier do most of the talking. The more a chaplain talks, the more the chaplain inserts his or her own narrative into the space. Being comfortable with silence in the counseling room is a crucial skill for chaplains. Silence does not mean that nothing is happening. A skilled chaplain can let the soldier talk at her own pace while the chaplain engages in empathetic listening and remains emotionally present with the soldier. Chaplains can let soldiers know that they can say anything to the chaplain. Chaplains suggested using the imagery of carrying the soldier's rucksack for her, or emptying her rucksack into the chaplain's rucksack as a way of thinking about unloading emotional baggage. Female chaplains stated that chaplains can normalize and validate soldiers' feelings, but should not say, "I know how are feeling," because no one really knows how the person is feeling. Thanking the soldier for trusting the chaplain enough to tell her story and using encouraging gestures

and body language were also techniques recommended by female chaplains. Following up with soldiers and revisiting issues previously discussed in counseling can show that the chaplain really cares about the person.

Religious activities.

Help soldiers connect to spirituality and faith.

According to one female chaplain, chaplains should not impose their own faith onto another person. There are many theological perspectives. At the same time, the chaplain can be clear with the person about his or her own theological perspective. When a soldier approaches a chaplain with spiritual questions or questions of faith, a chaplain can bring the soldier's own faith background into the conversation (if she has one) and use questions to help the person clarify her own beliefs. At times, it may be appropriate for the chaplain to share his or her own testimony.

In times of crisis, faith questions may be particularly poignant. Chaplains can help soldiers make meaning of their lives and experiences, orient to God as sovereign, and encourage soldiers to continue to seek God in the midst of their questions, doubts, anger, etc. Chaplains may talk about the hope people have in God for eternal life, use Bible stories to illustrate courses of action, help soldiers understand God's complete love and acceptance, and help soldiers build on their past successes of overcoming faith challenges.

Help soldiers find forgiveness.

Closely related to helping soldiers connect to spirituality and faith, is helping soldiers find forgiveness. According to CH206, it is very important that the chaplain offer an affirming and nonjudgmental presence. The chaplain may need to find out from

whom, or for what, the soldier needs forgiveness. CH219 stated that there are times when the chaplain may want to adopt a formal priestly role. "I teach them the difference between forgiveness and reconciliation. I teach them that forgiveness is a process, not an event," said CH219. Chaplains can also teach soldiers to be kind to themselves and that there is no act or sin that God cannot forgive. Other things that chaplains can do include using stories from the Bible to help illustrate how God forgives and helping soldiers build on past successes.

Conduct religious services.

Chaplains conduct a variety of religious services as part of their duties, including chapel services, Bible studies, devotionals, and prayer breakfasts. "Coffee house" devotionals are common practices in which chaplains pair devotionals with fun activities in a relaxing atmosphere like a coffee house. Religiously themed game nights are also common practices. Chaplains may encourage soldiers with a "word of the day" and pray with soldiers before they embark on dangerous missions. Chaplains may also sponsor spiritual fitness runs, Strong Bonds events, spiritual retreats, and similar activities.

Helping activities.

Assist wounded soldiers.

Chaplains made recommendations specifically related to helping female soldiers who were struggling with physical wounds. Not all soldiers want to see a chaplain after they have been wounded, but chaplains can place a high priority on checking in with soldiers. Chaplains are assigned to each hospital, but there may be too few of them to visit every soldier, so unit chaplains can assist by checking in on their own soldiers.

Chaplains can offer to pray with soldiers and leave get well cards. Chaplains can also ask soldiers about their experiences and what brought them to the hospital.

Often soldiers want reassurances that everything will be okay, but lying to a soldier may be harmful. In the tragedy of war, things are not always going to be okay. The chaplain may ask the soldier to clarify what okay means to her. "Sometimes things are not okay and we need to say that. I will give the soldier reassurance that everything is okay if it really is okay," stated one chaplain.

Soldiers who have been wounded, especially in an enemy attack, may worry about other members of their unit. Soldiers may feel that they let their unit down. Chaplains can help soldiers focus on their own healing process by telling them that their unit wants them to get better. Chaplains can encourage soldiers to take comfort and solace in the fact that the soldiers did everything they could to contribute to the mission. The soldiers defended their country and that they will always be part of the proud tradition of the military. For soldiers who are frustrated that they can no longer contribute to the mission as before, chaplains can help soldiers proactively find ways to continue to contribute despite their limitations.

Wounded soldiers may experience depression over injuries, scars, and physical limitations. Chaplains said that they would try to help soldiers accept this new normal. Despite her wounds, scars, and even disfigurations, a soldier is intrinsically valuable as a person, and a chaplain can help the person reframe her experience as a personal growth opportunity. Chaplains can also give a person hope by reminding them that others, through time and effort, have survived and overcome terrible injuries.

There are things that chaplains can do to make soldiers feel more comfortable as they move through the medical system. Chaplains can encourage soldiers to trust the medical professionals that are working on their case. Chaplains can also take time to help soldiers understand how the medical system is trying to help them. Building collegial relationships with hospital staff members can be invaluable for a chaplain's ministry.

Help soldiers with anxiety, depression, and PTSD.

Anxiety, depression, and post-traumatic stress disorder (PTSD) are serious conditions that may require expert care. Chaplains may need to refer soldiers to mental health professionals if symptoms are severe. A soldier with an extreme case of PTSD may need to be enrolled in a Tricare approved inpatient treatment center.

When a soldier presents with symptoms of anxiety, depression, or PTSD, a chaplain can ask open-ended questions to determine the severity of the soldier's condition. A chaplain can be a listening ear, and in the case of PTSD, a chaplain can help a soldier understand that those four letters (PTSD) do not need to define her. PTSD is part of the soldier's story, but there is hope for recovery. Chaplains can be companions to suffering soldiers and help them walk through the darkness. A chaplain may offer to incorporate meditative prayer into a counseling session to help ease a soldier's symptoms.

Chaplains can explore a number of therapeutic and stress reduction techniques with soldiers. Therapy options may include animal therapy, recreational therapy, Eye Movement Desensitization and Reprocessing (EMDR) therapy, or PTSD support groups. One chaplain stated that she encouraged soldiers to find something to hold onto, such as a talisman or mental image, that gave them strength, peace, and comfort.

When strong emotions well up or disturbing images from the past emerge in the mind of a soldier with PTSD, a chaplain can provide the soldier an opportunity to verbally process past events. No one can take away the images of the past, but verbally processing with a chaplain can help the soldier peel off the emotions associated with the event. Eventually, a soldier may be able to reach a place of recovery where she can encourage and help other soldiers who are struggling with PTSD.

Two additional recommendations were made by chaplains. First, chaplains should address the entire person — proper sleeping and dietary habits, exercise, etc., and not just the anxiety, depression, or PTSD symptoms. Second, two chaplains recommended that chaplains read the book *War and the Soul*, a book by Edward Tick that deals with healing from PTSD.

Help soldiers who have witnessed violence and/or extreme poverty in the overseas area of operation.

One of the first things a chaplain can do is help soldiers accept the poverty, violence, and injustice they experienced as part of the deployment, and at the same time make space to have conversations with soldiers about the complexities of war. Chaplains can help soldiers find language for what they witnessed. Often the violence and poverty soldiers witnessed are the results of systemic problems in the fabric of the country in which they are deployed.

Beyond helping soldiers with acceptance, chaplains can assist soldiers in taking action to ease the suffering of indigenous people. Chaplains can encourage soldiers to see God's grace in their experiences and see the positive side of the deployment. Chaplains can also help soldiers understand what the American military is trying to

accomplish overseas, and help soldiers be grateful for the blessings they have in the United States.

Help soldiers connect to a supporting community.

Chaplains should explore a soldier's relationships to see if the soldier has a support system of friends, family, faith community, etc. If the soldier does not have a support system, the chaplain can encourage the soldier to find friends and build her own supporting community. The chaplain can also offer to be a friend to the soldier. As one chaplain said, "I'm personable with soldiers at every level . . . If you come into my circle of personal care, you're on my team, you're in my group." Supporting communities may include soldiers within the unit, veterans groups, and faith communities that work with the military, such as Cru (formerly known as Campus Crusade for Christ).

Work with others.

Work with mental health professionals.

Using an interdisciplinary team approach to mental health care can be advantageous to a soldier. A chaplain should stay engaged with a soldier even after referring her to a mental health professional. One chaplain stated that she normally goes with the soldier to her first mental health appointment to help the soldier feel comfortable.

Work with the chain of command.

There are things a chaplain can do to build positive relationships with commanders and other leaders. A chaplain can be a listening ear for unit leaders, and a chaplain can ensure that leaders know how to get in touch with the chaplain if a traumatic incident occurs. Staying present and engaged in command activities helps the command

think to call the chaplain when a critical incident happens. For their part, chaplains can keep their commanders informed about what they are doing on a daily basis. In reporting to commanders, "Chaplains have to speak the commander's language and not talk about emotions too much," said CH206. Chaplain assistants can also be an invaluable resource for chaplains and commanders.

Chaplains made several recommendations for how chaplains can advocate for soldiers with the chain of command. One chaplain stated that the chaplain should get permission in writing from the soldier before the chaplain talks to the chain of command on her behalf. Whether the chaplain gets it in writing or not, the chaplain should make sure that he or she knows exactly what the soldier expects the chaplain to talk to the commander about. The chaplain does this to prevent any misunderstandings of the role of the chaplain in a particular situation. The chaplain should also double-check the facts provided by the soldier before approaching the chain of command. Soldiers do not always tell the complete story, but even if they are completely forthcoming, soldiers have one perspective and commanders have another perspective.

Chaplains stated two caveats when it comes to working with the chain of command. First, commanders need to hold all soldiers accountable for their actions. Second, in many cases it is best for the soldier to engage the chain of command herself. Chaplains can teach soldiers how to do this and empower them to work things out for themselves.

At times, the chain of command may fail to help the soldier. A chaplain may not be able to influence this. In these cases, the chaplain can talk to the soldier about maintaining her own professionalism and integrity, and focusing on the things she can

control. Chaplains can also teach soldiers what the Inspector General (IG), Equal Opportunity (EO), and other agencies are for, and how to use them.

Work with other chaplains.

CH585 stated that in a typical Army brigade there may be three to five chaplains, and these chaplains should work together to provide support to soldiers and learn from each other. Each chaplain brings his or her own unique experiences and skills to the table, and these skills and experiences can be brought to bear on complex problems when chaplains work together. Family life center chaplains, stationed at major Army installations, can be additional sources of help and support for chaplains and soldiers alike.

Play a critical role in sexual assault cases.

Two chaplains stated specifically that sexual assault victims need to be handled with "kid gloves." Others stated that a chaplain can provide a warm, safe, nonjudgmental environment for both the victim and the perpetrator to openly discuss the incident (but not together). The chaplain can help a person get past the incident by verbally processing his or her emotions and experiences. In helping victims, chaplains can avoid re-victimizing them by helping them understand that what happened to them is not their fault and that they did not ask to get assaulted. Chaplains can teach this important concept to unit leaders. Some female soldiers may only feel comfortable talking to a female chaplain, and female chaplains can make themselves available to female soldiers outside of their own unit. One chaplain stated that she handled sexual harassment cases a little differently. "In cases of sexual harassment, I talk to soldiers about modeling

professional behavior and try to help them see how they might be contributing to the problem," said CH274.

Chaplains can help victims understand their reporting rights and how to use military resources. Chaplains can assist the chain of command in reassigning the victim and protecting her. The decision to report or not report is the victim's alone and chaplains can support the victim's decision.

Facilitate groups.

Facilitate support groups.

There are a variety of support groups that chaplains can facilitate. Specifically, chaplains mentioned three types of support groups: support groups for spouses of deployed soldiers, female soldier mentoring groups, and co-ed soldier mentoring groups. Support groups offer opportunities for soldiers to tell their stories, mentor each other, and understand each other's needs.

Conduct critical incident debriefings.

Critical incident debriefings (CIDs) can help people normalize their feelings after a traumatic event. CIDs are a way for soldiers to share and process their emotions about a specific traumatic event in a supportive group setting. According to CH585, "Critical incident stress debriefings can be very helpful for processing emotions, poverty and violence."

Teach unit leaders how to provide effective support to soldiers.

Chaplains are experts in the field of emotional and spiritual support and can teach unit leaders key principles that can make them better leaders. Chaplains can teach unit leaders how to be nonjudgmental listeners and how to be empathetic to soldiers needs

while still getting the mission done. According to CH585, "Applied Suicide Intervention Skills Training (ASIST) is a good model for teaching nonjudgmental listening." Female chaplains can teach leaders that women experience the military differently than men. "It is dangerous to think of everyone as being the same. Women have different experiences," stated CH585. Chaplains can also teach leaders that there are mental and emotional injuries associated with physical injuries. Chaplains can model help-seeking behaviors, normalize discussions about emotional issues, and not tolerate attitudes that demean or dismiss emotional or mental issues.

Support unit recreational events.

In the context of this study, recreational events refer to sporting events and other unit activities designed to be fun. Recreational events are not activities with a spiritual or religious component. Chaplains can use these kinds of events to have fun and support the resiliency of themselves and soldiers.

Personal maintenance.

Since the work of a chaplain can be emotionally and spiritually draining, it is important that chaplains take steps to maintain their own spiritual and mental well-being. Chaplains can do this by engaging in recreational activities; staying connected to friends, family, and their own faith community; regularly engaging in prayer and sacred scripture study; and regularly seeing a therapist. CH860 said that being able to compartmentalize helped her and two chaplains mentioned the importance of talking things out with another trusted chaplain. Chaplain assistants can be invaluable in looking out for the chaplain and letting the chaplain know when self-care is needed. "Having an assistant that can watch out for you when you are getting burned out is critical," stated CH484.

Theme Three: Valuable Training for Chaplains

Clinical pastoral education (CPE), trauma training, and training on healthy coping mechanisms.

Chaplains identified five types of training that chaplains should receive: clinical pastoral education (CPE), training on handling trauma, training on health coping mechanisms, chaplaincy annual training, and annual female chaplain training. There are already training venues for two of the items, clinical pastoral education (CPE) and training on handling trauma. However, not every chaplain gets an opportunity to attend CPE, and many have not attended emergency medical ministry or combat medical ministry courses where training on handling trauma often takes place. While chaplains receive some training on resiliency and maintaining mental health, chaplains felt that there was a need for specific training on healthy coping mechanisms.

Annual chaplain conferences.

The U.S. Army used to hold both annual chaplain conferences and female chaplain conferences. As of the date of this research, both conferences were no longer being held due to funding issues. Chaplains suggested that these two conferences be reinstated so that chaplains could have an opportunity to train together, share their experiences, collaborate, and network with one another.

Themes Generated from Question Two: Support for Male Chaplains

Theme Four: The Chaplaincy Institution

Comprehensive chaplain directory.

Four recommendations were placed into this category. All of them were included in round two of this phase. The first recommendation was that there should be a

directory that lists all chaplains in the Army, including those on active duty, the Army Reserve, and the National Guard. The directory should list each chaplain's contact information, denomination, geographical location, gender, special qualifications, and personal skill sets. Such a directory would be especially useful for National Guard and Army Reserve chaplains who are often geographically distant from an Army post. The directory could help chaplains team up with other chaplains and match soldiers to a chaplain who could best help them.

Improved chaplain screening process.

The second recommendation was that there should be a better screening process for chaplain candidates. Currently, potential chaplains must be interviewed by a senior chaplain. One chaplain stated that when she was interviewed, she was asked about how she conducted religious services and how many funerals she had conducted. According to this chaplain, this should not be the focus of a chaplain interview, as it does not prepare a chaplain for what he or she might encounter in soldier ministry. Instead, chaplains should be screened for character traits, such as interpersonal skills, approachability, thoughtfulness, intelligence, a warm and caring personality, and the ability to process trauma in their own lives. Potential chaplains could also be presented with case studies and scenarios and asked to describe what they would do in a given scenario. Such a screening process could help determine how well the candidate might handle soldier trauma, PTSD, anxiety, depression, and other soldier trauma issues.

Gender issue discussions.

As a third step, chaplains recommended that the chaplaincy foster discussions about gender within its own ranks. Such discussions could help male chaplains

understand what it is like to be a female in the military. Open and honest discussions about gender issues and gender narratives in the military could foster better understanding, cooperation, and ministry to all soldiers.

Female chaplain assignments.

As a final chaplaincy institutional step, chaplains recommended that the chaplain corps be more intentional about female chaplain assignments to help ensure that there was a female chaplain available when one was requested. First, there could be at least one female chaplain assigned to every Army installation. Second, one female chaplain specifically trained in family life issues could also be assigned to every Army installation.

Theme Five: Gender-Specific Actions

Refer to a female chaplain.

Chaplains made nine suggestions for how male chaplains could refer a female soldier to a female chaplain. A male chaplain could contact the next higher chaplain in the chain of command, contact the garrison chaplain on the installation who should have a roster of all the chaplains on the post, and informally network with other chaplains. A male chaplain may also request the assistance of a female chaplain in other components, such as the Army Reserve, or National Guard. If a female chaplain is not available in the local area, a female chaplain could provide counseling over the phone. As a last resort, a male chaplain may be able to get a local female civilian pastor to provide counseling.

Take responsibility.

Some chaplain participants also stressed the importance of male chaplains not shirking their duties to provide support to all soldiers in their unit. One of the first things a chaplain should do is try to determine if the female soldier actually requested a female

chaplain. Some chaplains felt that it was unacceptable for a male chaplain to refer a soldier to a female chaplain just because he was uncomfortable counseling a female soldier. Chaplains stressed the importance of chaplains taking responsibility to provide ministry to all of the soldiers in their unit. As a counterpoint to the last statement, some chaplains felt that senior chaplain leaders should encourage the use of female chaplains for providing support to female soldiers.

Female chaplain recruiting.

Although most chaplain participants did not provide a recommendation for how the chaplaincy could increase the number of female chaplains in its ranks, one chaplain did. Her suggestion was that female chaplains could be sent back to their alma mater once a year to talk to female seminary students about what it is like to be a female chaplain in the Army. Presented with a positive message from actual chaplains, more students may be interested in becoming chaplains.

Summary of Findings

Four themes were generated from the data provided by 10 female soldier interviews:

1. Female soldiers needed to talk to a trusted person during deployment.
2. Female soldiers expected chaplains to possess specific caregiving traits.
3. Female soldiers had positive and negative experiences with chaplains.
4. Most female soldiers did not express a preference for the gender of the chaplain.

Five themes were generated from female chaplain interviews. Each theme contained multiple categories. Figures 2 and 3 are fishbone diagrams of the female

chaplain themes and categories.

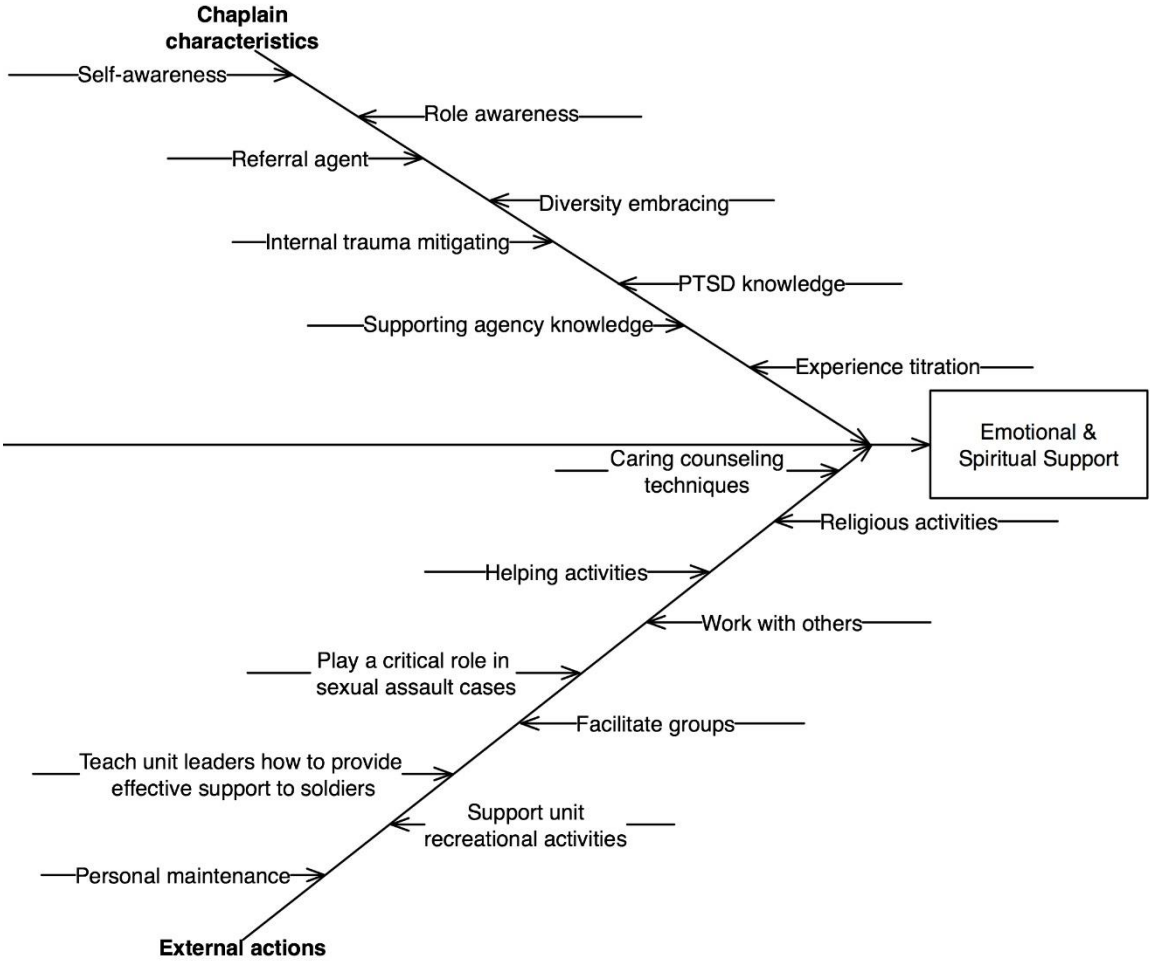

Figure 2. Fishbone Diagram of Female Chaplain Themes and Categories, Part 1

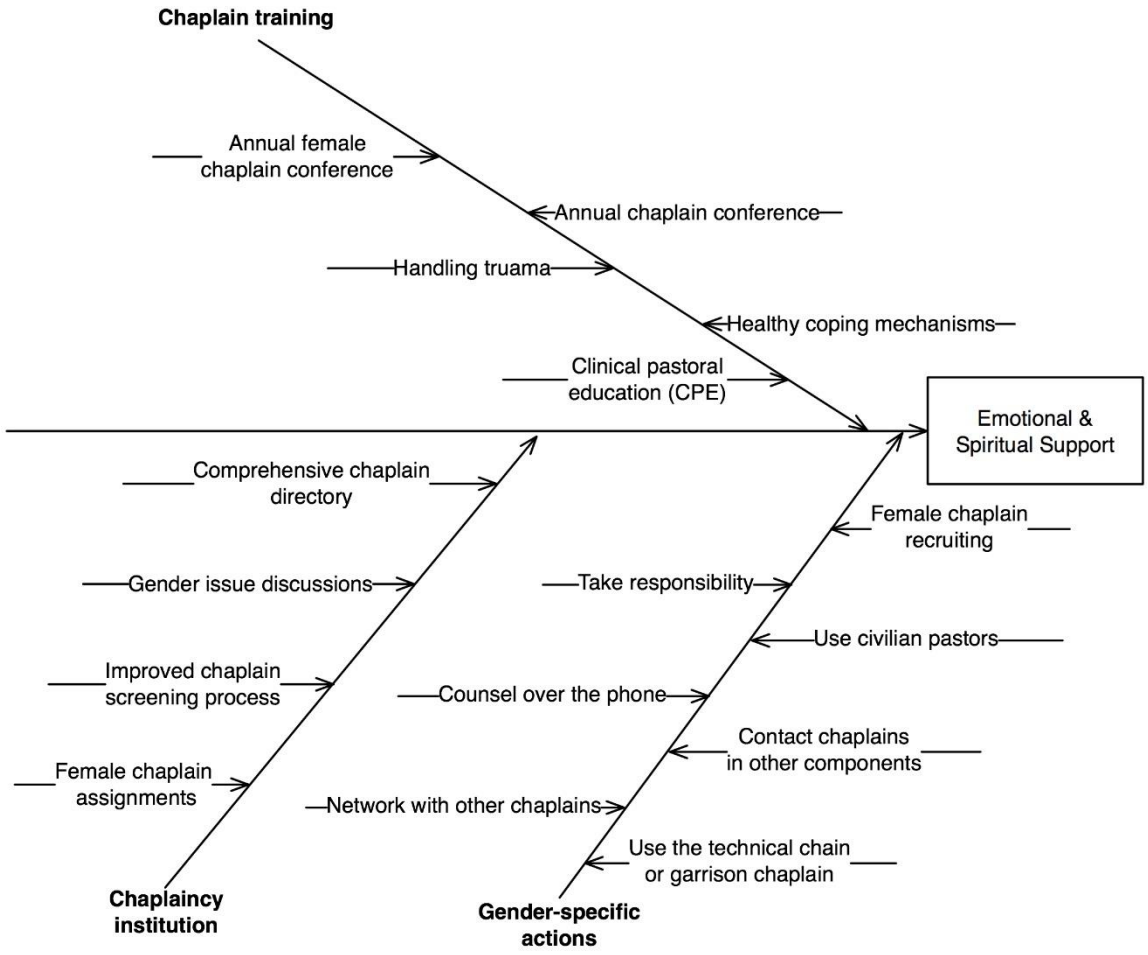

Figure 3. Fishbone Diagram of Female Chaplain Themes and Categories, Part 2

Summary of Chapter 4

This chapter described the data and themes generated in this qualitative Delphi study. The purpose of the study was to build consensus on a comprehensive plan and model for creating a system by which male chaplains could provide effective support to wounded female soldiers. Opinions were gathered from 10 female soldiers and 11 female chaplains. In Phase 1, female soldiers provided data about the emotional and spiritual support needs they experienced during overseas deployment. In the Phase 2, female chaplains identified actions chaplains could take to provide emotional and spiritual

support. The comprehensive model and plan for providing emotional and spiritual support to wounded female soldiers, the product of Phase 3, is described in Chapter 5.

Chapter 5

Conclusions and Recommendations

The purpose of this qualitative Delphi study was to build consensus on a comprehensive plan and model by which male chaplains could provide effective support to wounded female soldiers. The study was conducted in three phases. The final product of Phase 3 was a comprehensive plan and model that answered the research questions:

Research Question 1: What could be a comprehensive plan and model that male chaplains could use to provide effective support to wounded female soldiers?

Research Question 2: What role might chaplains play in a comprehensive plan and model that could provide effective support to wounded female soldiers?

This chapter compares the findings against reviewed literature, describes the comprehensive female soldier support (CFS^2) emotional and spiritual support model that was developed through the study, explains the significance of the findings, and describes the research implications of the findings. This chapter also describes the limitations and weaknesses of this study. The chapter ends with recommendations for future research.

Female Soldier Themes

Theme One: Female Soldiers Needed to Talk to a Trusted Person During Deployment

All 10 female soldier participants identified with this theme. Participants needed to unload emotional baggage, tell their story, or talk about their injuries. Four out of 10 participants felt that female soldiers should have access to female chaplains.

Theme One was not a new theme. Wadsworth and Owens (2007) identified five types of work place social support, two of which related to Theme One: “help dealing

with disappointment" and "help with personal problems" (p. 79). Taylor (2010) identified two types of work place support related to Theme One: being listened to by coworkers and being listened to by supervisors. Work place social support, both from supervisors and coworkers, was shown to be positively related to work enhancement of family life (Wadsworth & Owens, 2007).

Compassionate listening was identified in literature as a key chaplaincy role (Mayer et al., 2009; Parameshwaran, 2015; Piderman et al., 2008; Russell, 2014; Winter-Pfändler & Flannelly, 2013). Piderman et al. (2008) analyzed surveys from over 470 patients who had been hospitalized for more than 24 hours. Approximately 65% identified being listened to by a chaplain as somewhat or very important (Piderman et al., 2008).

Chan (2015) surveyed three social purpose organizations in Toronto, Canada. Social purpose organizations were defined as those groups, mostly non-profit organizations, that provide social support services to other firms (Chan, 2015). Of sixty-seven respondents, approximately 60% stated that it was very important to have a supervisor who could be approached about personal matters (Chan, 2015). Approximately 95% of respondents stated that having a supervisor who was empathetic was somewhat or very important (Chan, 2015). One respondent specifically cited willingness to listen as a very important component of trust (Chan, 2015).

Theme Two: Female Soldiers Expected Chaplains to Possess Specific Caregiving Traits

Participants identified caregiving traits that they expected chaplains to have. These traits included warm and caring personality traits, skills in handling trauma, skills

in making a soldier feel comfortable sharing difficult experiences, and knowing how to ask the right questions to help a soldier tell her story. Chaplains should also be able to build relationships with all soldiers in the unit, be trained and experienced in dealing with soldiers who have been sexually assaulted, and be willing to engage the chain of command on the behalf of soldiers when it was called for. It was also important for chaplains to have deployment experience.

Theme Two is supported by literature. Howard and Cox (2008) stated that soldiers are more apt to go to a chaplain for counseling if the chaplain interacts well and establishes a level of trust with soldiers. On the negative side, Johnston (2009) stated that some chaplains serving in Iraq and Afghanistan lacked experience and became too shocked from war experiences to be of help to soldiers. Parameshwaran (2015) described a model of chaplain spiritual care that included seven elements: active listening to a person's story, awareness of how the person's story triggers emotional responses, maintaining awareness while not personally being traumatized by the person's story, not judging the person for his or her choices, maintaining focus on the patient and not one's self, helping the person share his or her story, and not rushing the patient to a solution.

Theme Three: Female Soldiers had Positive and Negative Experiences with Chaplains

Female soldiers reported both positive and negative experiences with chaplains. Three of 10 participants said that they had good experiences with chaplains. In these positive experiences, chaplains helped soldiers receive forgiveness, overcome traumatic experiences, made soldiers feel safe and comfortable, and taught soldiers about the Bible.

Four of the 10 female soldiers described negative experiences with chaplains. Chaplains that fell into this category did not build relationships with soldiers, provide religious services, or visit soldiers in the hospital. These chaplains did not seem to care about helping soldiers.

Theme Three is not a new finding. In literature, hospital patients had positive experiences with chaplains. Patients in a private addiction treatment center described positive experiences with a chaplain (Sørenson, Lien, Landheim, & Danbolt, 2015). Patients described the chaplain as compassionate, respectful, nonjudgmental, and confident (Sørenson et al., 2015). The chaplain contributed to the patients' treatments in ways that a therapist could not, by offering forgiveness, absolution, and conversations with patients that did not get analyzed and judged (Sørenson et al., 2015).

Winter-Pfändler and Flannelly (2013) conducted a study with over 600 patients from over 30 general hospitals and psychiatric clinics. Participants were surveyed to determine their expectations for chaplain services (Winter-Pfändler & Flannelly, 2013). The finding related to Theme Three was that "the more the patients' expectations are fulfilled by the chaplain, the more patients are satisfied with the chaplain's visit; the more they evaluate the visit as important, the more they feel confident in the chaplain" (Winter-Pfändler & Flannelly, 2013, p. 166).

On the other hand, some previous studies showed that some soldiers had negative experiences with chaplains. Throughout the history of the American military, many chaplains did not earn the respect of soldiers (Johnston, 2009; Seddon et al., 2011). Soldiers felt that too many chaplains remained safely in rear areas rather than face danger near the front lines (Seddon et al., 2011).

Theme Four: Most Female Soldiers Did Not Express a Preference for the Gender of the Chaplain

Out of 10 female soldiers, only one soldier expressed an absolute preference for the gender of the chaplain. The other nine participants stated that they would seek counseling from a male chaplain if he possessed the right traits — warm and caring, approachable, trustworthy, etc. However, four of the nine participants suggested that other female soldiers may feel more comfortable talking to a female chaplain than a male chaplain, and female soldiers should have access to a female chaplain if they so desired. One participant thought that if male soldiers saw female chaplains in unit areas, the men would have greater respect for female soldiers in general.

Theme Four was a new finding not supported in the literature. In the literature, females preferred female physicians, crisis workers, and psychological counselors (Chowdhury-Hawkins et al., 2008; Furnham & Swami, 2008). No literature was found that described gender preferences as they related to chaplains and spiritual counseling.

Female Chaplain Themes

Theme One: Chaplain Characteristics

Self-awareness.

Self-awareness means understanding one's personal emotional baggage, triggers, strengths, weaknesses, and limitations. Chaplains needing to be self-aware is not a new finding. Literature sources cited similar findings. Besterman-Dahan, Lind, and Crocker (2013) found that many deployed chaplains struggled with maintaining self-awareness of their own stress. The chaplains were too busy caring for other soldiers to notice their own stress levels (Besterman-Dahan et al., 2013). More experienced chaplains

understood the need to maintain self-awareness and personal resiliency (Besterman-Dahan et al., 2013).

Parameshwaran (2015) described how chaplain self-awareness can lead to positive clinical outcomes when chaplains work with patients. In Parameshwaran's (2015) study, the chaplain's self-awareness helped him or her recognize his or her own emotional baggage and triggers, and be emotionally present with the patient he or she was working with. Self-awareness improved the chaplain's ability to listen comprehensively to the patient and help the patient articulate the patient's own story and feelings (Parameshwaran, 2015).

Jankowski, Vanderwerker, Murphy, Montonye, and Ross (2008) stated that clinical pastoral education (CPE) increased students' self-awareness. Self-awareness was positively correlated to pastoral skills after students had completed at least one unit of CPE (Jankowski et al., 2008). Emotional intelligence was positively correlated with self-awareness before and after students attended CPE training (Jankowski et al., 2008).

Role awareness.

Chaplains cannot do everything and are not mental health professionals. Chaplains can understand their role and help soldiers solve their own problems. Chaplains need to have role awareness is not a new finding. Literature suggested that chaplains are not mental health providers, but they can serve as a connection point to mental health providers (Besterman-Dahan et al., 2012b; Howard & Cox, 2012). Chaplains can contribute to the mental health of soldiers, and in a 2012 study, over 50% of soldiers viewed chaplains as useful in supporting mental health (Besterman-Dahan et al., 2012b).

Two studies investigated the role of chaplains in relation to healthcare. In a survey of 327 health care chaplains in Australia, approximately 90% of chaplains believed that consulting with doctors on a patient's care was a legitimate part of the chaplain's role (Carey & Cohen, 2008). Lewellen (2015) stated that many chaplains and doctors understand the role of the chaplain in healthcare settings to be one who helps address the patient's and family's non-medical issues that arise in a palliative care setting.

Three articles described the role of chaplains in being present with people in their pain. Seddon et al. (2011) suggested that chaplains can increase the morale of soldiers by being present with soldiers during times of crisis. Mayer et al. (2009) stated that the role of flight chaplains included listening to crew members express their feelings and concerns. In the study by Piderman et al. (2008), 219 female patients were surveyed about their reasons for wanting to see a chaplain. Over 70% of female patients stated that it was somewhat or very important that the chaplain listen to them (Piderman et al., 2008). Over 70% of female patients stated that it was somewhat or very important that chaplains be with them during times of anxiety (Piderman et al., 2008). Approximately 50% of female patients wanted chaplains to help them solve moral or ethical concerns (Piderman et al., 2008).

Referral agent.

There are times when it is best to refer a soldier to a mental health counselor. There may be times when a different chaplain could provide better support. Chaplains should be willing to make a referral.

Chaplains referring soldiers to other chaplains was not a theme found in the literature. However, chaplains making referrals to mental health professionals was

readily found in the literature. One study recently reviewed referral attitudes of U.S. Army chaplains. Ramchand, Ayer, Geyer, and Kofner (2015) surveyed over 850 U.S. Army chaplains, approximately 4% of whom were females. Eighty-five percent of surveyed chaplains stated that they knew how to refer a suicidal soldier to a mental health professional, and 87% percent of chaplains said that they would be willing to take the soldier to another helping person, such as a mental health professional (Ramchand et al., 2015).

Other studies investigated factors effecting clergy's referral patterns. Pickard and Inoue (2013) surveyed nearly 500 clergy in the St. Louis, Missouri area. Clergy who had a bachelor's degree or higher, had a good relationship with mental health professionals, and were protestant Christians, were more likely to refer older adults to mental health professionals (Pickard & Inoue, 2013). Matthews (2010) surveyed over 200 Christian clergy in Singapore and found that approximately 65% of the clergy felt that it was important to refer people to a Christian mental health professional. In a survey of 113 Southern Baptist clergy, mental health professionals who used scripture and prayer in their practice were preferred over those who used proven counseling methods (McMinn, Runner, Fairchild, Lefler, & Suntay, 2005). Based on a survey of 179 clergy in Michigan, over 80% of clergy would be willing to refer a parishioner to a mental health professional if the issue involved a nervous breakdown, domestic violence, sexual abuse, depression, or alcohol or drug addiction (VanderWaal, Hernandez, & Sandman, 2012). Of 74 clergy in the Southern California area, 51 (69%) stated that they would refer a church member to a mental health professional without reservation, and without knowing the mental health

professional's religious affiliation or professional background (Bledsoe, Setterlund, Adams, Fok-Trela, & Connolly, 2013).

Diversity embracing.

Chaplains made a variety of recommendations related to embracing diversity. Chaplains should create their own sacred space, set aside time for prayer, and suspend judgment of others. Protecting the religious freedom of others is a critical part of a chaplain's duty.

Chaplains can maintain their own religious beliefs while helping others who may be different is not a new finding. Chaplains serve to protect the religious rights of all military service members (Otis, 2009; Ramchand et al., 2015; Rosman-Stollman, 2008). While maintaining their own religious convictions, chaplains are required to respect and assist soldiers of all faith groups (Otis, 2009; Ramchand et al., 2015; Rennick, 2010; Rosman-Stollman, 2008).

Cadge and Sigalow (2013) explored two strategies that chaplains can use to respect the faith of others while maintaining their own faith convictions. The researchers gathered data for one year at one hospital with 20 staff chaplains (Cadge & Sigalow, 2013). The two strategies used by chaplains were referred to as neutralizing or code-switching (Cadge & Sigalow, 2013). Neutralizing is the process of focusing on commonalities with another person (Cadge & Sigalow, 2013). In code-switching, a chaplain uses religious language that relates to the religious background of the person the chaplain is working with or counseling, rather than using religious language that is most common to the chaplain (Cadge & Sigalow, 2013).

Chaplains as nonjudgmental listeners was a theme found in literature. Nonjudgmental listening includes respecting the religious beliefs of others and not criticizing or shaming their behaviors or feelings (Hughes & Handzo, 2009). Through nonjudgmental listening, a chaplain can help a person de-stress (Hughes & Handzo, 2009; Mayer et al., 2009), explore issues (Seddon et al., 2011), and develop solutions (Seddon et al., 2011).

Internal trauma mitigating.

Female chaplains stressed the importance of being proactive in their own healing. When counseling a soldier, chaplains must learn how to be attentive to a soldier's story, even if it is shocking. CH580 stated that giving her burdens to God helped her let go of them so that she could listen to soldiers.

The importance and process of a chaplain mitigating his or her own traumatic experience to provide help and support to another person was articulated in literature. CPE training prepares chaplains how to mitigate their own trauma, manage their emotions, and quiet their own thoughts while listening to another person's story so that chaplains can be fully attentive to the person (Jankowsi et al., 2008). Parameshwaran (2015) referred to this mitigation and management as mindfulness. Mindfulness is a constant process that a chaplain performs during an encounter with a help-seeking person (Parameshwaran, 2015). As a person shares his or her feelings, the chaplain's own thoughts and feelings bubble up, but the chaplain works to stay focused on what the person is saying (Parameshwaran, 2015). The chaplain also tries to understand deeper meanings behind the person's words (Parameshwaran, 2015). Not all chaplains manage their own internal trauma well. Johnston (2009) stated that "some chaplains [in Iraq and

Afghanistan] who had no experience suffered from war shock to the point where they were unable to adequately address the spiritual needs of the troops" (p. 30).

PTSD knowledge.

According to CH483, "Chaplains should know the signs and symptoms of PTSD. If a chaplain cannot accurately explain PTSD to a lay person, then the chaplain does not know enough about it." The view that chaplains should know the signs and symptoms of PTSD was supported in literature. PTSD rates were estimated at 5-10% for trauma victims (Sigmund, 2003) and less than 5% for United Kingdom military personnel (Seddon et al., 2011). PTSD rates among deployed Air Force chaplains was just under 8% (Levy, Conoscenti, Tillery, Dickstein, & Litz, 2011) and less than 7% for deployed Army National Guard chaplains (Besterman-Dahan et al., 2012a). Chaplains can serve as assessors and support providers of PTSD victims if they have a good working knowledge of the signs and symptoms of PTSD (Hughes & Handzo, 2009; Sigmund, 2003).

It is useful to know that feminists do not see PTSD diagnoses and symptoms in traditional ways (Berg, 2002; Tseris, 2013). Feminists criticized trauma theory for not considering the sociopolitical realities of women when diagnosing disorders (Tseris, 2013). In spite of their own criticism of psychiatry, liberal feminists maintain that PTSD as a diagnosis is useful for women because PTSD diagnosis does not assume that there is something inherently wrong with the female, but sees PTSD causality as something that occurs external to the person (Berg, 2002). An externally caused problem, like PTSD, can be diagnosed and treated without ascribing weakness or flaws in the PTSD victim (Berg, 2002). Radical feminists argue that PTSD diagnoses are not good for women because such a diagnosis still stems from a patriarchal point of view and is analyzed

using patriarchal methods (Berg, 2002). Some feminists maintain that new methods, symptom lists, and instruments should be developed to account for the sociopolitical context in which women live and the long-term abuse that many women suffer (Berg, 2002; Tseris, 2013).

Supporting agency knowledge.

According to CH483, not all supporting agencies provide quality support. A "chaplain needs to investigate to find the really good ones," stated CH483. Supporting agency knowledge was a new finding not articulated in literature.

Experience titration.

Chaplains titrating their experience to empathize with soldiers was supported in literature. Empathizing with a person means understanding the person's cognitive and emotional message — the deeper meaning behind her story (Coulehan, 2009). When empathizing, one does not take on another person's story as his or her own, but comes to understand the nuances of the other person's story (Mundle, 2012).

Titration is part of the process of empathizing with the soldier (Coulehan, 2009; Parameshwaran, 2015). Cadge and Sigalow (2013) used the term neutralizing to describe the process of finding common ground with a person to empathize with him or her. Titration occurs in an iterative loop with the counselee (Coulehan, 2009; Parameshwaran, 2015). The chaplain listens to the cognitive and emotional messages of the soldier, matches it to his or her own feelings and experiences, and then checks back with the soldier to see that the chaplain understands and that they are both on common ground (Coulehan, 2009; Parameshwaran, 2015).

Theme Two: External Actions

In this section, the external actions chaplains can take to assist soldiers are described. This theme is comprised of nine categories of actions. Some categories contain one or two sub-categories.

Caring counseling techniques.

Build rapport with all soldiers in the unit.

Building rapport helps soldiers feel more comfortable with the chaplain and enable the chaplain to have the commander's ear on important matters. Chaplains building rapport was a theme found in literature. Seddon et al. (2011) suggested that being present with soldiers can provide chaplains with opportunities to increase the morale of soldiers. Howard and Cox (2008) stated that soldiers are more apt to go to a chaplain for counseling if the chaplain interacts well and establishes a level of trust with soldiers. Being present with people helps establish trust (Howard & Cox, 2008; King, 2011; Pesut, Riemer-Kirkham, Sawatzky, Woodland, & Peverall, 2010). According to Otis (2009), effective chaplains build rapport with commanding officers, noncommissioned officers, and other unit leaders on a daily basis. The process of building rapport is often referred to as ministry of presence (Otis, 2009; Seddon et al., 2011; Swain, 2011). A chaplain who worked at ground zero after 9-11 described the ministry of presence as "being the living symbol . . . of goodness, God's grace and mercy and love" (Swain, 2011, p. 493).

Make the office space a comfortable environment for soldiers to receive counseling.

Making the office space a comfortable environment can help the soldier feel comfortable in sharing her story. CH219 stated that she never set a time limit for counseling sessions. CH408 stated the importance of presenting a warm, open, physical demeanor to the soldier. Chaplains should make the office space a comfortable environment for soldiers to receive counseling was a new finding not articulated in literature.

Ask open-ended questions in a counseling session.

Open-ended questions are a valuable tool for chaplains. According to CH483, open-ended questions help a chaplain explore a soldier's issues, build trust, and show the soldier that the chaplain cares. CH389 stated that she uses open-ended questions to conduct a needs assessment.

Chaplains asking open-ended questions and conducting needs assessments were themes covered in literature. Open-ended questions can help facilitate a person sharing his or her story and feelings with the chaplain (Cooper, 2011; Parameshwaran, 2015). Chaplains must also listen closely and interpret a person's story (Anandarajah & Hight, 2001). Through open-ended questions, the chaplain can verify that he or she understands and has properly interpreted the person's words and emotions (Cooper, 2011; Parameshwaran, 2015).

Ensure soldiers know the role of the chaplain.

Anything that a soldier shares with a chaplain is privileged communication. A soldier must provide her consent before a chaplain can divulge any information to anyone

else. Chaplains should make sure that soldiers understand the rules of privileged communication. Soldiers should also understand that the chaplain's role with commanders is an influential one and chaplains cannot order the commander to do anything.

The statement that anything that a soldier shares with a chaplain is privileged communication was confirmed in literature (Besterman-Dahan et al., 2012b; Ramchand et al., 2015; Seddon et al., 2011). The soldier must give the chaplain her consent before the chaplain can divulge any information shared in confidence (Howard & Cox, 2008; Ramchand et al., 2015; Seddon et al., 2011). According to the literature, soldiers who understand the privilege of confidentiality may feel more comfortable approaching the chaplain for help (Besterman-Dahan et al., 2012b; Howard & Cox, 2008; Ramchand et al., 2015; Seddon et al., 2011).

Employ caring counseling techniques.

Employing caring counseling techniques includes letting the soldier do most of the talking. Asking open-ended questions helps prevent the chaplain from doing too much talking. Caring counseling techniques include using empathetic listening and being emotionally present with the soldier. Chaplains should normalize and validate a soldier's feelings and use encouraging gestures and body language. CH483 stressed the importance of following up with soldiers after a counseling session.

Helping people talk through difficult issues and engaging in empathetic listening was identified as an important role for chaplains (Mayer et al., 2009; Parameshwaran, 2015; Piderman et al., 2008). Empathetic listening means being attentive to a person's cognitive messages, body language, facial expressions, emotional messages, and the

deeper meaning behind all expressions (Coulehan, 2009; Parameshwaran, 2015). In a survey of over 470 patients who were 18 years old or older, 72% of female patients and 57% of male patients stated that having a chaplain listen to them was very or somewhat important (Piderman et al., 2008). Fifty percent of female patients and 42% of male patients said that having a chaplain counsel them on moral or ethical concerns was very or somewhat important (Piderman et al., 2008).

Religious activities.

Help soldiers connect to spirituality and faith.

Chaplains can help soldiers connect to spirituality and faith in a variety of ways. Chaplains can use questions to help a soldier explore her own faith. A chaplain can share his or her own testimony, and a chaplain can help soldiers make meaning of their own experiences. Chaplains may also use stories from the Bible to illustrate faith principles.

Chaplains as a connection point to soldiers and faith is a theme documented in literature. Mayer et al. (2009) described how flight chaplains can help flight medics and crew overcome the trauma of difficult transports or dying patients. In the study by Piderman et al. (2008), 319 out of 470 hospitalized patients wanted chaplains to pray or read sacred scripture with them. Providing pastoral counseling and helping soldiers answer questions of faith are normal parts of military chaplains' duties (Bedsole, 2009; Besterman-Dahan et al., 2012b; Otis, 2009; Ramchand et al., 2015; Seddon et al., 2011).

Chaplains can help soldiers connect to spirituality and faith is a sub-category that describes ways chaplains can help soldiers use religious functioning to cope with trauma. According to Harris et al. (2008), some religious functioning was positively related to PTSD symptoms, and some religious functioning was related to post-traumatic growth.

Feeling disconnected from God or one's faith group, religious fear and guilt, being unhappy with one's relationship with God, and praying for God to intervene without action from the praying person were positively related to PTSD symptoms (Harris et al., 2008). Seeking or providing spiritual support, praying for peace and God's will in the midst of stress, praying for God's assistance or strength to take action, meditation, and praying for God's independent intervention were shown to be positively correlated with post-traumatic growth (Harris et al., 2008).

Help soldiers find forgiveness.

Chaplains can offer an affirming and nonjudgmental presence to soldiers who need forgiveness. Chaplains can teach soldiers about the process of forgiveness and the difference between murder and killing in warfare. Through the chaplain's ministry, a soldier can learn about the grace and forgiveness of God.

There is some coverage in the literature regarding chaplains helping people find forgiveness. Worthington and Langberg (2012) agreed with chaplains that self-forgiveness is a process, not an event. Worthington and Langberg (2012) identified a six-step process for self-forgiveness: receiving God's forgiveness, making amends, coming to terms with one's mistakes, attaining emotional self-forgiveness, regaining self-acceptance, and making resolutions. Attaining forgiveness is one of the primary needs of hospital patients, and chaplains can play a major role in helping patients find forgiveness for themselves (Bauman, 2008; Cooper, 2011). Chaplains can help people think through the theological and practical implications of forgiveness (Bauman, 2008; Ganzevoort, 2008; Sigmund, 2003).

Conduct religious services.

Female chaplains listed a variety of religious services that they could provide. These services included chapel services, Bible studies, devotionals, and prayer breakfasts. Chaplains sponsored spiritual fitness runs, Strong Bonds events, spiritual retreats, and other activities as part of their religious service programs.

Chaplains conduct religious services was not a new finding. Various literature sources described the chaplain's role in conducting religious services. Historically, military chaplains conducted religious services for soldiers during times of war (Besterman-Dahan et al., 2012b; Johnston, 2009; Seddon et al., 2012). In the modern era, chaplains commonly conduct religious services as part of their normal duties (Bedsole, 2009; Besterman-Dahan et al., 2012b; Earl, 2012; Otis, 2009).

Helping activities.

Assist wounded soldiers.

Chaplains made a number of recommendations related to assisting wounded soldiers. Unit chaplains should take the responsibility to visit wounded soldiers in the hospital since there may not be enough chaplains assigned to cover all of the wounded. Chaplains can help calm and reassure a wounded soldier, as long as the chaplain does not lie to do it. Soldiers may be worried about their fellow soldiers, but a chaplain can help the soldier focus on her own healing process. Chaplains can also help soldiers accept their wounds and scars while encouraging them to have hope in the future. Helping wounded soldiers trust in the care they are receiving can be an important role for chaplains.

Various articles referred to chaplains providing support for wounded soldiers. Historically some chaplains faced enemy fire to assist wounded soldiers (Seddon et al., 2011). Otis (2009) stated that visiting soldiers in the hospital and tending to the wounded is a normal responsibility of military chaplains. Researchers suggested that a collaborative model of care that included chaplains and health care personnel can be beneficial for the soldier and may result in a more comprehensive, effective plan of treatment (Besterman-Dahan et al., 2012b; Howard & Cox, 2008; Seddon et al., 2011).

Help soldiers with anxiety, depression, and PTSD.

For soldiers experiencing severe anxiety, depression, or PTSD, chaplains may need to refer soldiers to mental health professionals. Asking open-ended questions can help a chaplain determine the severity of the soldier's condition. Chaplains can help soldiers walk through the difficult days they may experience and offer hope for recovery. One female chaplain offered meditative prayer as a way to help ease a soldier's symptoms. Chaplains offered a number of therapeutic options, such as animal therapy, recreational therapy, Eye Movement Desensitization and Reprocessing (EMDR) therapy, and PTSD support groups. Other recommendations from female chaplains included helping the soldier verbally process her emotions and mental images, and helping the soldier understand the importance of maintaining proper sleeping, dietary habits, and exercise.

Principles in this finding were supported by literature sources. Using imagery for relaxation and gaining inner peace was one common strategy recommended by the female chaplains and Williams and Bernstein (2011). Feczer and Bjorklund (2009) recommended the use of EMDR therapy and Sigmund (2003) positively commented on

PTSD group therapy. Verbally processing disturbing images from the past in a safe environment, with a chaplain, can be very helpful for those suffering from PTSD (Feczer & Bjorklund, 2009; Sigmund, 2003; Williams & Bernstein, 2011). Such verbal processing can help take away the emotional power of those images (Feczer & Bjorklund, 2009; Williams & Bernstein, 2011). Feczer and Bjorklund (2009) agreed with female chaplains that Tick's book, *War and the Soul*, is a good resource for understanding PTSD. Finally, as stated by the female chaplains, once a soldier reaches an appropriate level of recovery, she may be able to help other soldiers who are struggling with PTSD (Williams & Bernstein, 2011).

Howard and Cox (2008) agreed with female chaplains that while chaplains can assist soldiers with anxiety, depression, and PTSD, chaplains may need the assistance of medical and psychological experts. Chaplains should be an integral part of the care that soldiers receive and chaplains can work in collaboration with mental health professionals (Howard & Cox, 2008). Some chaplains have more expertise than others when it comes to mental health issues, and chaplains should not hesitate to refer soldier to mental health experts for severe cases (Howard & Cox, 2008).

Help soldiers who have witnessed violence and/or extreme poverty in the overseas area of operation.

The violence and poverty soldiers witnessed in the overseas area of operations are often the result of systemic problems in the fabric of the country in which they are deployed. Chaplains can help soldiers by having conversations about the complexities of war and what they are doing to help. CH580 said, "I let the soldiers know that they are

doing what they can for now." CH860 added that "Whatever little bit of kindness you can do for someone is good, even though the problem is so huge."

The experiences of female soldiers at war were described in literature. Maguen et al. (2012) and Mattocks et al. (2012) described deployment experiences by female soldiers that were very similar to the experiences of female soldiers in this study. Traumatic experiences included extreme injustice and violence, such as death and injury to children (Maguen et al., 2012; Mattocks et al., 2012). No literature was found that specifically described chaplains' role in helping soldiers who had witnessed violence and poverty in the overseas area of operations.

Help soldiers connect to a supporting community.

Chaplains can encourage soldiers to find friends and join supporting communities, such as veterans groups, and faith communities that work with the military. Four literature sources provided information on the benefits of social support. Mattocks et al. (2012) stated that female soldiers who had frequent contact with friends, family, and other social network members may improve the soldiers' ability to cope with deployment stressors. Williams and Bernstein (2011) recommended educating veterans suffering from PTSD on developing safe social support networks. Harris et al. (2008) identified social support and spiritual support through a faith community as significant contributors to post traumatic growth. Worthington and Langberg (2012) noted that social support may increase a person's resiliency and active participation in a faith community can help restore inner peace for someone struggling with self-condemnation.

Work with others.

Work with mental health professionals to ensure female soldiers get the support they need.

Chaplains can use an interdisciplinary team approach to mental health care and stay engaged with a soldier even after referring her to a mental health professional. CH824 stated that she normally went with a soldier to her first mental health care appointment. The recommendation that chaplains work with mental health professionals was a theme found in the literature (Besterman-Dahan, 2012; Howard & Cox, 2008; Seddon et al., 2011).

Work with the chain of command to help ensure soldiers are taken care of.

Chaplain recommendations for staying engaged with the chain of command included building rapport with unit leaders, being part of unit activities, and informing the commander about issues within the unit. In advocating on the behalf of soldiers, chaplains should make sure that they know specifically what the soldier expects the chaplain to talk to the commander about. CH219 said, "If I have to engage the chain of command on behalf of the soldier, I get permission from the soldier in writing. The soldier must specify the parameters with which he or she wants me to talk to the chain of command." According to CH219, it was usually best that the soldier speak to the chain of command herself. Other chaplains echoed CH219's sentiment. If the chain of command fails to help the soldier, then the chaplain can help the soldier use other available resources, such as the equal opportunity office or the inspector general's office.

Howard and Cox (2008) made recommendations related to the finding that chaplains can work with the chain of command to help ensure soldiers are taken care of.

In the collaborative model of care endorsed by Howard and Cox (2008), a representative of the chain of command would be present in the collaborative meeting that involved the medical officer, the chaplain, and the patient (soldier). Command representation in the meeting helps build understanding, cooperation, and accountability for all parties (Howard & Cox, 2008).

In a survey of over 800 chaplains, over 50% of participants stated that they would likely notify a soldier's chain of command if the chaplain thought a person might be suicidal (Ramchand et al., 2015). When chaplains actually worked with a soldier who was suspected of being suicidal, chaplains ranked notifying the chain of command below other actions (Ramchand et al., 2015). Listening to the soldier, convincing the person to seek help, and escorting the soldier to a counselor were all ranked higher by participants (Ramchand et al., 2015). According to Earl (2012), most chaplains have a positive relationship with their chain of command.

Work with other chaplains.

Female chaplains stressed the importance of teamwork. Chaplains should be able to help each other and learn from each other. Chaplains should work with other chaplains was a new finding not supported by literature.

Play a critical role in sexual assault cases.

Chaplain participants talked about the importance of sensitivity and safety when dealing with sexual assault victims. CH274 said that she made herself available to both the victim and the perpetrator. "I make a space for both of them to seek comfort, support, and someone to talk to," said CH274. Verbally processing emotions can help take some of the sting out of the incident and help a person move on from the pain. Chaplains can

provide a listening ear. Chaplains can also help victims understand their reporting rights and make use of all of the available resources.

Previous research agreed with three data points provided by the female chaplains. First, in the DOD Sexual Assault Prevention and Response (SAPR) program, soldiers are encouraged to report rapes to chaplains (Krul, 2008; Williams & Bernstein, 2011). Second, any system of care for victims of sexual violence should avoid re-traumatizing these victims (Northcut & Kienow, 2014; Ranjbar & Speer, 2013; Williams & Bernstein, 2011). Third, victims should be provided a safe environment in which to process the trauma they experienced (Northcut & Kienow, 2014; Williams & Bernstein, 2011).

Facilitate groups.

Facilitate support groups.

Chaplains can facilitate a variety of support groups. Female chaplains specifically mentioned support groups for spouses of deployed soldiers, female soldier mentoring groups, and co-ed soldier mentoring groups. The concept of chaplains facilitating support groups was supported in the literature. Sigmund (2003) provided a case study of VA chaplains facilitating support groups for veterans suffering from PTSD. Willis and Limehouse (2011) stated that chaplains can facilitate nursing support groups because chaplains traditionally provide emotional and spiritual support to hospital staff, many chaplains are CPE trained, and chaplains are seen as neutral persons. According to Montgomery et al. (2012), peer support groups can help people find "shared and individual pathways through illness" (p. 529). Such groups may help attendees develop focus to manage life, prevent group members from falling into depression, assist people

in developing coping strategies, help members see other perspectives, and provide comfort to the group (McBride & Fuller, 2013; Montgomery et al., 2012).

Conduct critical incident debriefings.

Critical incident debriefings (CIDs) are another type of support groups that chaplains can facilitate. CIDs can also be referred to as Traumatic event management (TEM) debriefings. Chaplains may be part of CID, or TEM, teams (Besterman-Dahan et al., 2012a, 2012b; Maloney, 2012; Santiago & Abdool, 2011; Seddon et al., 2011). CIDs can provide psychological help to soldiers immediately following a traumatic event (Besterman-Dahan et al., 2012b; Maloney, 2012; Seddon et al., 2011). The TEM model "provides support, advice, and education to keep an individual functioning after a traumatic event" (Seddon et al., 2011, p. 1360).

Teach unit leaders how to provide effective support to soldiers.

Some female chaplains saw themselves in the role of teacher, too. Chaplains can teach unit leaders how to listen to soldier needs and the importance of paying attention to the emotional side of life. Chaplains can teach unit leaders to model help-seeking behaviors. Chaplains teaching unit leaders how to provide effective support to soldiers was a new finding not supported by literature.

Support unit recreational events.

Chaplains supported unit recreational events. Recreational events can support the resiliency of chaplains and soldiers. A number of studies investigated the effects of exercise on mental health. Mattocks et al. (2012) conducted a qualitative study with 19 women who served in OEF or OIF. Participants reported using exercise in varying degrees as a mechanism to cope with stress (Mattocks et al., 2012). Have et al. (2010)

analyzed data from a study involving 17,490 participants who were surveyed between 1996 and 1999, and found a positive relationship between exercise and the improvement of mental health scores for people with mental disorders. In a critical review of 16 qualitative and quantitative studies, Alexandratos et al. (2012) found that randomized control trials supported the hypothesis that exercise helped people cope with severe mental illness. All of the trials were subject to limitations that somewhat diminished the ability to draw firm conclusions (Alexandratos et al., 2012).

Personal maintenance.

Recommendations from female chaplains related to personal maintenance included taking part in recreation, maintaining connections with friends and family, being part of a faith community, and engaging in regular prayer, meditation, and Bible study. A trusted chaplain assistant can help the chaplain look out for his or her own well-being. Topics related to the spiritual and emotional well-being for chaplains were described in literature. Besterman-Dahan et al. (2013) interviewed 27 Army National Guard chaplains. Eighteen of the 27 chaplains had been deployed (Besterman-Dahan et al., 2013). A common theme among participants was that chaplains worked hard to take care of others but did not take time to care for themselves (Besterman-Dahan et al., 2013). In a study of 74 Army National Guard chaplains, 28 of whom had been deployed, Besterman-Dahan, Barnett, Hickling, Elintsky, Lind, Skvoretz, & Antinori (2012a) found a similar theme in that chaplains were likely to neglect self-care.

Positive religious coping may include reframing a problem as a spiritual growth opportunity (Besterman-Dahan et al., 2012a). Positive religious coping may help reduce worry and increase self-regulation (Besterman-Dahan et al., 2012a). The RCOPE

religious coping scale measures positive religious coping on a scale of seven to 28, with 28 being the most positive (Besterman-Dahan et al., 2012a). Chaplains who had been deployed scored an average of 23 on the RCOPE, and chaplains who had not been deployed scored an average of 24 on the RCOPE (Besterman-Dahan et al., 2012a). The *intrinsic spirituality* scale used by Besterman-Dahan et al. (2012a) was a 10-point scale and both deployed and non-deployed chaplains scored over 8 on this scale. Finally, deployed and non-deployed chaplains scored an average of 3.5 on a 5-point Likert scale for *self-compassion* (Besterman-Dahan et al., 2012a). The self-compassion score was derived from scores on *self-kindness, common humanity, judgment, isolation, mindfulness,* and *over-identification* (Besterman-Dahan et al., 2012a).

Two studies checked on the prevalence of PTSD among military chaplains. Levy et al. (2011) surveyed 183 Air Force chaplains who had been deployed and found a PTSD rate of just under 8% for these chaplains. Besterman-Dahan et al. (2012a) surveyed 74 Army National Guard chaplains and found a PTSD rate of less than 7%.

Yan and Beder (2013) conducted a study with 217 Veterans Administration (VA) chaplains. Compassion satisfaction was defined as feeling good about one's job, colleagues, and ability to make a difference (Yan & Beder, 2013). Perceived support from the Administration and integration with mental health professionals were found to be significant factors of compassion satisfaction (Yan & Beder, 2013). The same two factors — perceived support from the Administration and mental health integration — were also significantly related to lower compassion fatigue and burnout (Yan & Beder, 2013).

Theme Three: Valuable Training for Chaplains

Clinical pastoral education (CPE), trauma training, and training on healthy coping mechanisms.

Chaplains recommended that chaplains receive additional training in the form of CPE, training on handling trauma, and training on healthy coping mechanisms. Chaplains also recommended that the U.S. Army reinstate annual chaplain conferences, including an annual female chaplain conference. Various literature sources described chaplain training. Jankowski et al. (2008) compared the amount of change in pastoral skills, emotional intelligence, self-awareness, and insight for students who took at least one unit of CPE. Seventy-two male students and seventy-two female students participated in the study (Jankowski et al., 2008). CPE increased students' self-awareness (Jankowski et al., 2008). Self-awareness was positively correlated to pastoral skills after students had completed CPE training (Jankowski et al., 2008). Emotional intelligence was positively correlated with self-awareness before and after students attended CPE training (Jankowski et al., 2008).

According to Besterman-Dahan et al. (2012a), chaplains, as non-combatants, may need more "combat exposure training" (p. 162). Non-combatants, such as chaplains, may be at greater risk for PTSD and other mental health problems after combat exposure because non-combatants are not given the same level of combat training as combat troops (Besterman-Dahan et al., 2012a). In general, Army Reserve and National Guard chaplains may not be as adequately trained for deployments as active duty chaplains (Besterman-Dahan et al., 2012a).

Besterman-Dahan et al. (2013) interviewed 27 Army National Guard chaplains, 18 of whom had been deployed. Participants made two recommendations related to chaplaincy training. First, chaplaincy training should emphasize professional competence and performance (Besterman-Dahan et al., 2013). Second, chaplaincy training should include principles for maintaining mental and emotional health (Besterman-Dahan et al., 2013).

Other types of training chaplains should receive were listed in literature. Interpersonal relationships and issues associated with loss were chaplain training subjects listed by Willis and Limehouse (2011). Cross-training with mental health professionals was suggested by Sigmund (2003). Williams et al. (2004) suggested that the training needs of hospital chaplains should be assessed upon hiring and that there should be a chaplain mentorship program. Bedsole (2009) stated that chaplains who have been trained in world religions are better able to advise commanders on the religious factors in play in the overseas area of operations.

Theme Four: The Chaplaincy Institution

Comprehensive chaplain directory.

According to female chaplains, the U.S. Army chaplaincy should create a comprehensive chaplain directory. A comprehensive directory could help male chaplains make referrals to female chaplains or other chaplains who may have special skill sets. The directory could be especially useful to Army Reserve or National Guard chaplains who are not stationed near active duty installations. Creating a comprehensive chaplain directory was a new finding not articulated in the literature.

Improved chaplain screening process.

Female chaplains agreed that the chaplaincy should institute a better screening process for chaplain recruits. Rather than focusing on questions about a candidate's experience in conducting religious services, candidates should be asked questions to determine how well they may handle various kinds of trauma. According to CH585, "Most civilian pastors do not have enough experience with trauma, PTSD, etc. The interview should try to determine if the chaplain will handle such things thoughtfully, prayerfully." Chaplains also recommended that potential chaplains be screened for interpersonal skills, approachability, and compassion. Improving the chaplain screening process was a new finding not articulated in the literature.

Gender issue discussions.

Chaplains suggested that discussions among chaplains about gender issues could help the chaplain corps. Male chaplains could develop a greater understanding of what female soldiers experience. Fostering gender issue discussions within the chaplaincy was a new finding not articulated in literature.

Female chaplain assignments.

Chaplains recommended that every Army installation should have at least one female chaplain. At least one female chaplain at every installation should receive special training on family life issues. Female chaplain assignments was a new finding not articulated in literature.

Theme Five: Gender-Specific Actions

Refer to a female chaplain.

According to female chaplains, there are a number of ways to refer a female soldier to a female chaplain. Male chaplains can use the chain of command, contact the installation chaplain, or use his network of other chaplains. A male chaplain may also ask a female chaplain to provide counseling over the phone if one is not available locally, or use a local female pastor. Referring female soldiers to a female chaplain was a new finding not articulated in the literature.

Take responsibility.

Female chaplains expected male chaplains to take responsibility for all of the soldiers in their units, not just male soldiers. According to CH219, male chaplains should not refer to female chaplains just because they are uncomfortable counseling women. Male chaplains taking responsibility for female soldiers in their units was a finding not observed in literature.

Female chaplain recruiting.

One female chaplain provided a recommendation for how to increase the number of female chaplain recruits. CH389 suggested that female chaplains could be sent back to their alma mater once a year to talk to female seminary students about what it is like to be a female chaplain in the Army. Female chaplains recruiting was a new finding not articulated in the literature.

The Comprehensive Female Soldier Support (CFS^2) Model

The comprehensive female soldier support (CFS^2) model (see Figure 4) answers both research questions. CFS^2 provides a gender-specific model male chaplains can use

to provide emotional and spiritual support to female soldiers. The model includes the role of the chaplaincy institution and the role of individual male chaplains in providing support to female soldiers.

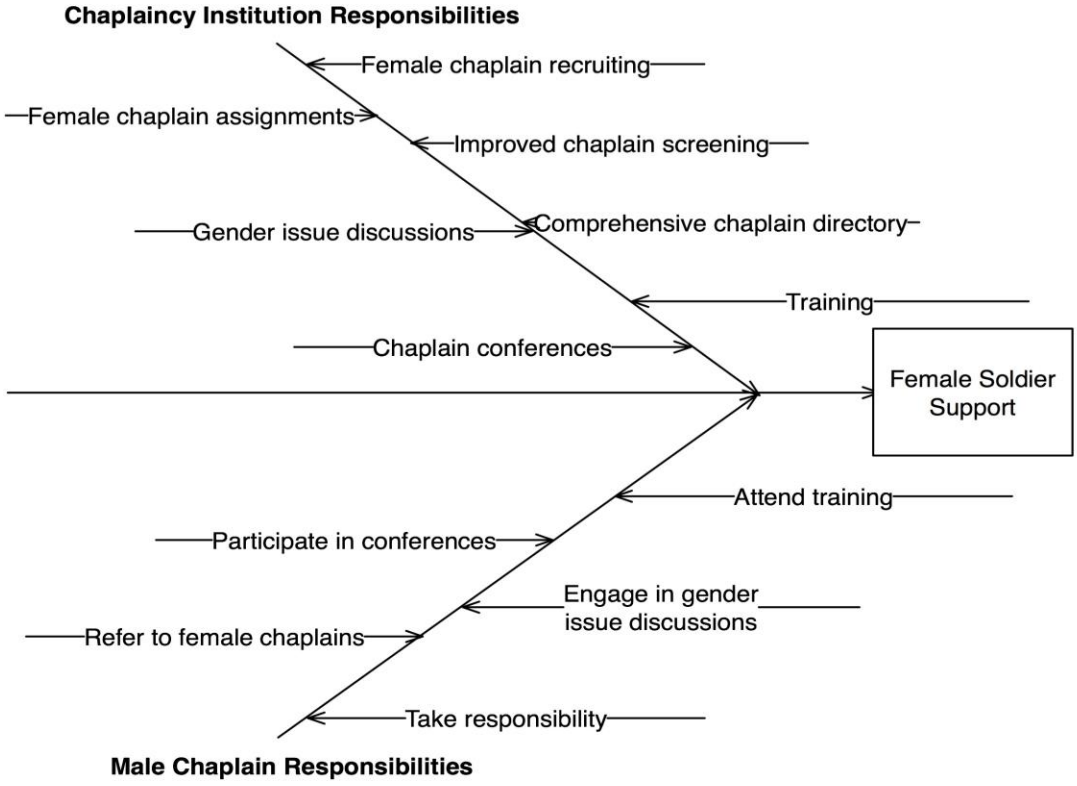

Figure 4. CFS[2] model.

Chaplaincy Institution Responsibilities

Female chaplain recruiting.

Based on the research findings, a case could be made that the military needs more female chaplains. There may be other female soldiers like WW407 who feel that it is inappropriate to discuss emotional issues with a male chaplain. Having more female chaplains may mean greater access to female chaplain care for soldiers like WW407. Increasing the number of female chaplains in the military may increase the level of

respect for female soldiers in general, as WW606 suggested. If women can be spiritual leaders (chaplains), then men may see women as worthy of other leadership positions. Finally, female chaplains can provide a positive influence to the chaplain corps by helping male chaplains understand the unique needs and experiences of military women.

Female chaplain assignments.

Intentionality in female chaplain assignments is about maximizing female chaplain availability to female soldiers. Female chaplains recommended that at least one female chaplain be assigned to every Army installation. Female chaplains also recommended that at least one female chaplain at each installation be trained in family life issues. Military women experience the following at a higher rate than military men: PTSD (Feczer & Bjorklund, 2009), MST (Mattocks et al., 2012), divorce (Cater & Koch, 2010), and homelessness (Cater & Koch, 2010). Having a female chaplain especially trained in family life issues could give female soldiers an additional point of contact for ministry.

Improved chaplain screening.

Ten of 11 female chaplains agreed that the chaplain screening process should be improved. An improved chaplain selection process could identify chaplains that possess the character traits, disposition, and interpersonal skills for providing warm and caring support to female soldiers. According to CH585, current processes screen for chaplains who have experience in conducting religious rites, but do not screen for chaplains who are prepared to minister to traumatized soldiers. CH585 recommended that potential candidates be asked scenario-based questions to see how they would respond and how prepared they may be to handle trauma, PTSD, MST, and female-specific issues.

Comprehensive chaplain directory.

A comprehensive chaplain directory could help male chaplains, especially Army Reserve or National Guard chaplains who do not live near an active duty Army post, find female chaplains. Male chaplains could use the directory to find female chaplains to which they could refer female soldiers. CH274 recommended that the directory include chaplains' personal skill sets and gender, in addition to other basic information, such as contact information, geographic location, and denomination.

Gender issue discussions.

According to CH585, women experience the military differently than men do. "The chaplaincy should talk about gender differences," stated CH585. Fostering discussions within the chaplaincy about gender issues could help male chaplains be better prepared for using resources and providing support to female soldiers. Discussing gender issues could also foster a greater spirit of cooperation between male and female chaplains.

Training.

CPE, trauma training, and training on healthy coping mechanisms were types of training recommended by female chaplains. CH483 stressed empathetic listening as a key skill for any chaplain to possess. Empathetic listening is taught in CPE, but could also be included in sustainment training events. Given that all 10 female soldier participants expressed a need to be listened to, empathetic listening could be a critical part of a male chaplain's ministry to female soldiers.

Women are more likely to experience depression than men (Women and depression, 2011). Military women are diagnosed with PTSD at a higher rate than men

(Feczer & Bjorklund, 2009) and tend to use different coping mechanisms than men (Mattocks et al., 2012). Given these factors, training on trauma and healthy coping mechanisms should include gender-specific components.

Chaplain conferences.

Eight of 11 female chaplains approved of the reinstatement of two types of annual chaplain conferences: a general chaplain conference and a female chaplain conference. Chaplain conferences would give chaplains an opportunity to network with each other, receive skills training, collaborate, and share best practices. A female chaplain conference would give female chaplains a chance to come together and discuss issues unique to them as a minority group in the Army chaplaincy.

Male Chaplain Responsibilities

Take responsibility.

Female chaplains expressed the importance of male chaplains taking responsibility for everyone in their unit, including female soldiers. According to CH408, "Male chaplains should make themselves available to their female soldiers." Taking responsibility means actively building rapport with female soldiers.

While it is acceptable to refer female soldiers to female chaplains, male chaplains should first offer caring support and assist female soldiers in every way they can. CH219 stated, "A lot of times, male chaplains just send female soldiers to me because they are uncomfortable counseling women." In CH219's experience, female soldiers rarely ask for a female chaplain. Male chaplains can use the characteristics (Theme One) and external actions (Theme Two) recommended by female chaplains as guides in providing support to female soldiers.

Refer to female chaplains.

A female soldier may request a female chaplain or a male chaplain may feel that a female soldier is best served by getting support from a female chaplain. In either case, there are several avenues to connect a female soldier to a female chaplain. If a comprehensive chaplain directory has been created, then a male chaplain may use it to locate a nearby female chaplain. A male chaplain may also contact the next higher chaplain in his chain or contact the garrison chaplain on an Army post to locate the nearest female chaplain. Networking with other chaplains can be helpful in getting female chaplain support. A female chaplain may be able to counsel a female soldier over the phone or a local civilian pastor may be available as a last resort.

Participate in chaplaincy institutional activities.

The CFS^2 model calls for the chaplaincy institution to take responsibility for providing training, conferences, and gender discussions for its members. Participating in these venues is part of the responsibility of male chaplains. Training, conferences, and gender discussions offer male chaplains the chance to increase their caregiving skills, enhance their understanding of female soldier issues, and expand their own personal chaplain network.

Significance of the Findings

This study was significant in several ways. It contributed to the body of knowledge related to spiritual intervention strategies, the intersectionality of gender and spiritual counseling, and chaplaincy-based research. The study also contributed to stressors that female veterans experience and techniques for caring for these veterans.

Significance to Leadership

Results from this study are significant to the leadership arena. The comprehensive plan and model included recommendations for how military leaders can use chaplain services to care for soldiers who are suffering from the traumas of combat and other stressors. The model also included actions that chaplains can take to teach leaders how to care for soldiers. Finally, there were recommendations for how senior leaders in the chaplaincy can improve the recruiting, selection, and training process for chaplains.

Theoretical Framework

The theoretical framework for this study was feminist systems theory (FST). This study was developed for women by listening to the voices of women. It used a methodology that gave voice to those women who experienced the traumas and stressors of deployment, and it recorded the expert opinions of female care providers, namely chaplains. Women are a minority group in the military, but in this study they became the center of attention. It is believed that the results of this study could engender positive change for the chaplaincy and improved care for female soldiers.

Unexpectedly, gender preference and gender issues did not appear in strength in this study. Both soldiers and chaplains felt that the gender of the chaplain was not important. The disposition, attitude, and skills of the chaplain were the most important criteria.

Only one soldier expressed an absolute preference for the gender of the chaplain. This soldier was taught to not discuss emotional issues with a man (other than her husband) for fear that an inappropriate (romantic) relationship may develop between the

counselor and counselee. Four soldiers suggested that other female soldiers may feel more comfortable talking to a female chaplain, but the gender of the chaplain was not a concern for these soldiers. One soldier thought that if male soldiers saw female chaplains in unit areas, the men would have greater respect for female soldiers in general.

Female chaplains recommended that the chaplain corps engage in open discussions about gender issues and narratives. Participants felt that women are often treated differently and have different expectations placed on them than men. Open and honest discussions could help male chaplains understand what it is like to be a female in the military and how to provide effective emotional and spiritual support to female soldiers.

Research Implications

The Gender of the Chaplain is not as Critical as the Skills of the Chaplain

A significant implication from this research is that the gender of the chaplain is not nearly as critical as the demeanor and skills of the chaplain. Seven out of 10 female soldiers explicitly stated that the gender of the chaplain was not as important as other things. Empathetic listening skills, relatability, and trustworthiness were all stated as being more important than chaplain gender.

A well-trained, caring, relationship-oriented male chaplain can effectively provide emotional and spiritual support to female soldiers. However, it is important that he recognize that female soldiers may have experiences and needs that are different than male soldiers. A male chaplain may need to work hard to build rapport and trust with a female soldier before she will open up to him.

The characteristics and actions in Themes One and Two from the female chaplain interviews are not generally specific to female chaplains. Neither are they overly complicated. They seem to be skills that any chaplain could learn and apply. Given that 40% of female soldier participants had decidedly negative experiences with male chaplains, more male chaplains may need to be trained on these characteristics and skills.

Limitations

This study did not ask female chaplains to identify their denomination. Different religious denominations may expect their members to take specific approaches to counseling and ministry. Knowing the denominations of participants could have allowed for supplemental analysis of data.

A second weakness of the study is that there is no way to tell if the chaplains that participated are actually good at their jobs. The inclusion and exclusion criteria were set to include chaplains with an appropriate level of experience and knowledge, but there were no criteria that evaluated actual ministry skills. However, given that all of the chaplains had deployed and had served in the Army for a number of years, it is unlikely that the information they provided was invalid. Also, the high level of agreement among chaplain participants in the second round of Phase 2 and Phase 3 speaks to the validity of the information provided by participants.

This study describes just one model. There may be other ways of providing emotional and spiritual support to wounded female soldiers. Male chaplains were not included in the study, and they may have had different perspectives about how ministry should be conducted.

Finally, the intersectionality of race and sexual orientation with gender were not discussed in this study. Female soldiers of different races or sexual orientations may have expressed different needs than White or heterosexual female soldiers. There is no way to tell based on this study.

Recommendations for Future Research

Two of the female soldiers stated that they remained in emotional and social isolation as a result of their deployments. Both participants had what they considered bad experiences with chaplains. Future research could examine the experiences of those female soldiers who are now in isolation and seek to determine what led to the isolation. An oral history project would be one way of doing this.

Another future research project could include male chaplains. Male chaplains could be presented the list of needs developed from Phase 1 and asked to provide recommendations for support actions. The recommendations from the male chaplains could be compared with the model developed from this study.

Finally, a future research project could investigate how race and sexual orientation might play a role. The project could try to determine if different racial or ethnic groups, or lesbian or bisexual women, expressed different emotional or spiritual needs. It could also investigate different approaches to ministry that non-White or non-heterosexual female chaplains might take.

Summary of Chapter 5

The purpose of this qualitative Delphi study was to build consensus on a comprehensive plan and model for creating a system by which male chaplains could provide effective support to wounded female soldiers. The study was conducted in three

phases and the final product was a comprehensive plan and model that answered the research questions. This chapter compared the findings against reviewed literature, described the CFS^2 emotional and spiritual support model, and explained the significance of the findings. The chapter also listed the research implications of the data, the limitations and weaknesses of this study, and recommendations for future research.

Conclusion

From the data provided by female soldiers, it can be concluded that the chaplaincy was not an influencing factor in the health and well-being of most of these wounded soldiers. Only three female soldiers had positive experiences with a chaplain. Four soldiers had decidedly negative experiences with a chaplain, and three others had no interaction with a chaplain during their deployment. Soldiers stated that they needed a chaplain to be warm and caring, a skilled listener, a relationship builder, and able to help soldiers work through their trauma. All 10 female soldiers listed talking to someone about their problems as an important need. Sadly, for most of the wounded soldiers in this study, no chaplain provided that need. All of the chaplains responsible for the soldiers in this study were male. From the soldiers' perspectives, only three of the chaplains provided adequate support.

The comprehensive model was designed as a solution for the problem of inadequate support by male chaplains. CFS^2 consists of two parts: chaplaincy institution responsibilities and male chaplain responsibilities. The chaplaincy institution can set up its members for success by providing a comprehensive chaplain directory and opportunities for growth. Male chaplains can take responsibility to provide the best

support they can to female soldiers, develop a network of female chaplains who can help, and continually engage in the learning process.

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Appendix A

Informed Consent

Dear _____

My name is Daniel Roberts and I am a student in the Doctorate of Management in Organizational Leadership with a Specialization in Information Systems and Technology program at the University of Phoenix. I am conducting a study called "A Comprehensive Plan for Providing Chaplaincy Support to Wounded Female Soldiers: A Delphi Study." The purpose of this study is to build a plan and model for creating a system by which chaplains might provide effective support to wounded female soldiers. The results of this study may provide information that the U.S. Army Chief of Chaplains and senior chaplain leaders can use to create training and establish female chaplain recruiting initiatives to meet the needs of female soldiers who have suffered through a traumatic event. Chaplains in the field may be able to use the information to understand the needs of female soldiers and support those needs through counseling and spiritual support activities.

Your participation in this study is completely voluntary and you may withdraw at any time, even after your participation begins. You will be asked to participate in two to three rounds of questions, in which you will provide input about the emotional and spiritual support needs of wounded military women, and make recommendations for how chaplains and other caregiving personnel can provide for that support. The results of this study may be published, but your identity will remain confidential.

Participation in this study poses no foreseeable risks to you. Your participation may provide a benefit to you, current, and future military women who get wounded or injured. If you have any questions or issues during the conduct of this study, you may contact me any time at [redacted] or [redacted]. If you have any questions about your rights as a study participant, or any other part of this study, you may also contact IRB@phoenix.edu.

You must understand that the following are applicable for this study:

1. Your participation is voluntary and you may withdraw at any time. To withdraw from the study, you need only call or e-mail me. There is no penalty for withdrawing.
2. Your identity will remain anonymous and confidential throughout the study. No one who reads the study will be able to discover that you participated.
3. All aspects of the study will be fully explained and all questions clearly answered before you participate.
4. All data will be recorded on paper, CDs, or DVDs, and remain stored in a locked safe, controlled by the researcher, for at least five years. After five years, all data will be destroyed using a Department of Defense authorized high security cross-cut shredder capable of destroying paper and media storage.
5. This study may be published.

By signing this form, you agree that you understand everything that was detailed on this form, the nature of the study, any possible risks, your rights as a participant, and that your identity will remain anonymous and confidential. By signing this form you acknowledge that you are at least 18 years old and are consenting to participate in this study.

Participant signature:_____
Date:_____

Researcher signature:_____
Date:_____

Appendix B

Innovative Ideas for the Emotional and Spiritual Support Model

Training

1. Chaplains should receive more training on healthy coping mechanisms.
2. There should be an annual chaplain conference.
3. There should be an annual female chaplain conference.

Chaplaincy Institutional Actions

4. Create a directory that lists all chaplains.
    - Such a directory could be helpful, especially for Army Reserve and National Guard chaplains, who are geographically isolated from active duty installations.
    - The directory could list each chaplain's contact information, geographical location, gender, and his or her personal skill sets so that other chaplains could make better informed referral decisions.
5. Better screening of potential chaplains before accessioning.
    - Case study/scenario-based interview questions to determine how well candidates may handle trauma and PTSD cases.
    - Screen for interpersonal skills, approachability, thoughtfulness, intelligence, warm and caring personality, and the ability to process trauma in their own lives.
6. Foster discussions about gender.
    - Help male chaplains understand what it's like to be a female in the military.

- Honest discussions about gender differences and gender narratives.

7. Be intentional about female chaplain assignments.

    - Assign at least one female chaplain to every installation.
    - Assign at least one female family life chaplain to every installation.

If the Soldier has a Preference for the Gender of the Chaplain

8. Recruit more female chaplains by sending female chaplains to their alma mater once a year to talk with seminary students about what it is like to be a female chaplain.

9. Senior chaplains should advertise and encourage the use of female chaplains for providing support to female soldiers.

Appendix C

Phase 1 Open-Ended Questions

1. In what year were you born?
2. When and where were you deployed when you received your injuries?
3. What date were you injured?
4. How were you injured?
5. How would you characterize yourself spiritually/religiously?
6. How many times over the last 12 months did you attend religious services?
7. From the time you were wounded or injured, and during the period of your recovery, what emotional and spiritual support needs did you have?
8. Do you consider yourself to be fully recovered from your wounds/injuries?
9. What ongoing emotional or spiritual support needs do you have?
10. Did you observe other women who were wounded or injured, and if so, can you comment on any emotion or spiritual support needs they may have had?
11. What agencies or support mechanisms do you recommend should be made available for wounded or injured military women?
12. Did you receive emotional or spiritual support from a chaplain?
13. Should chaplains be part of the support process?
14. Given a choice, would you have a preference for the gender of the chaplain or other support provider?

Appendix D

Phase 2 Open-Ended Questions

1. Review the list of needs and recommendations for support systems provided from wounded military women. What actions, without regard for the gender of the chaplain, might chaplains take to perform or provide for the emotional or spiritual support needs and support recommendations?

2. If a female soldier prefers to receive support from a female support provider, what actions might a male chaplain take to provide for the wounded female's support?

Appendix E

Word Frequency List

Word	Length	Count	Weighted Percentage	Similar Words
chaplain	8	84	3.05%	chaplain, chaplains
need	4	68	2.47%	need, needed, needs
soldiers	8	46	1.67%	soldier, soldiers, soldiers'
help	4	43	1.56%	help, helped, helpful, helping
female	6	39	1.42%	female, females
support	7	38	1.38%	support, supported, supporting, supportive
talk	4	34	1.24%	talk, talked, talking
deployment	10	30	1.09%	deployed, deployment
caring	6	27	0.98%	care, cared, cares, caring
emotions	8	27	0.98%	emotional, emotionally, emotions
really	6	25	0.91%	really
get	3	23	0.84%	get, gets, getting
people	6	23	0.84%	people
know	4	20	0.73%	know, knowing, knows
god	3	20	0.73%	god
feel	4	19	0.69%	feel, feelings
spiritual	9	19	0.69%	spiritual, spirituality, spiritually
want	4	18	0.65%	want, wanted, wanting
one	3	18	0.65%	one, ones
male	4	17	0.62%	male, males
person	6	17	0.62%	person, personal, personality
someone	7	17	0.62%	someone
women	5	17	0.62%	women
trust	5	15	0.55%	trust, trusted
see	3	15	0.55%	see, sees
injuries	8	15	0.55%	injuries, injury
time	4	14	0.51%	time, times
trying	6	14	0.51%	tried, try, trying

bible	5	14	0.51%	bible
family	6	14	0.51%	family
like	4	14	0.51%	like
never	5	14	0.51%	never
still	5	14	0.51%	still
wtu	3	14	0.51%	wtu
home	4	13	0.47%	home
just	4	13	0.47%	just
lot	3	13	0.47%	lot
things	6	13	0.47%	thing, things
able	4	12	0.44%	able
around	6	12	0.44%	around
got	3	12	0.44%	got
unit	4	12	0.44%	unit
provide	7	12	0.44%	provide, provided, provider, providers, provides
always	6	11	0.40%	always
back	4	11	0.40%	back
command	7	11	0.40%	command
injured	7	11	0.40%	injured
now	3	11	0.40%	now
yes	3	11	0.40%	yes
issues	6	11	0.40%	issue, issues
listen	6	11	0.40%	listen, listened, listener
assault	7	10	0.36%	assault, assaulted
think	5	10	0.36%	think, thinking
chain	5	10	0.36%	chain
relationships	13	10	0.36%	relationship, relationships
stress	6	10	0.36%	stress
first	4	10	0.36%	first
church	6	9	0.33%	church
going	5	9	0.33%	going
iraq	4	9	0.33%	iraq
sexual	6	9	0.33%	sexual

understand	10	9	0.33%	understand, understanding, understands
believe	7	9	0.33%	believe, believed, believer
experience	10	9	0.33%	experience, experiences
groups	6	9	0.33%	group, groups
take	4	8	0.29%	take, takes
deal	4	8	0.29%	deal, dealing
even	4	8	0.29%	even
faith	5	8	0.29%	faith
felt	4	8	0.29%	felt
hard	4	8	0.29%	hard
religious	9	8	0.29%	religious
comfortable	11	7	0.25%	comfort, comfortable
activities	10	7	0.25%	activities
agencies	8	7	0.25%	agencies
army	4	7	0.25%	army
available	9	7	0.25%	available
counselor	9	7	0.25%	counselor, counselors
good	4	7	0.25%	good
leaders	7	7	0.25%	leader, leaders
makes	5	7	0.25%	make, makes, making
others	6	7	0.25%	others
physical	8	7	0.25%	physical, physically
second	6	7	0.25%	second
studies	7	7	0.25%	studies, study
woman	5	7	0.25%	woman
seem	4	7	0.25%	seem, seemed, seems
alone	5	6	0.22%	alone
anyone	6	6	0.22%	anyone
came	4	6	0.22%	came
experienced	11	6	0.22%	experienced
gender	6	6	0.22%	gender
important	9	6	0.22%	important
mental	6	6	0.22%	mental, mentally
military	8	6	0.22%	military

remember	8	6	0.22%	remember
service	7	6	0.22%	service, services
speak	5	6	0.22%	speak
strong	6	6	0.22%	strong
accept	6	6	0.22%	accept, acceptable, accepted, accepts
encouraging	11	6	0.22%	encouraged, encouragement, encouraging
share	5	6	0.22%	share, shares, sharing
work	4	6	0.22%	work, worked, working, works
hurt	4	6	0.22%	hurt, hurting, hurts
keep	4	6	0.22%	keep, keeping, keeps
process	7	6	0.22%	process, processing
train	5	6	0.22%	train, trained, training
traumatic	9	6	0.22%	traumatic, traumatized
visit	5	6	0.22%	visit, visited, visits
bad	3	5	0.18%	bad
christian	9	5	0.18%	christian
combat	6	5	0.18%	combat
everyone	8	5	0.18%	everyone
hospital	8	5	0.18%	hospital
many	4	5	0.18%	many
men	3	5	0.18%	men
prayer	6	5	0.18%	prayer
received	8	5	0.18%	receive, received, receiving
religion	8	5	0.18%	religion, religions
right	5	5	0.18%	right
sense	5	5	0.18%	sense
went	4	5	0.18%	went
job	3	5	0.18%	job, jobs
learn	5	5	0.18%	learn, learned, learning
love	4	5	0.18%	love, loved
thought	7	5	0.18%	thought, thoughts
use	3	5	0.18%	use, used, uses
ask	3	4	0.15%	ask, asked

close	5	4	0.15%	close, closed
day	3	4	0.15%	day, days
hit	3	4	0.15%	hit, hits
husband	7	4	0.15%	husband, husbands
pray	4	4	0.15%	pray, prayed
read	4	4	0.15%	read, reading
resources	9	4	0.15%	resource, resources
show	4	4	0.15%	show, shows
2005	4	4	0.15%	2005
accident	8	4	0.15%	accident
angry	5	4	0.15%	angry
coming	6	4	0.15%	come, comes, coming
connect	7	4	0.15%	connect, connected
control	7	4	0.15%	control
difference	9	4	0.15%	difference, different
draining	8	4	0.15%	draining
etc	3	4	0.15%	etc
everything	10	4	0.15%	everything
fear	4	4	0.15%	fear
first	5	4	0.15%	first
great	5	4	0.15%	great, greatly
higher	6	4	0.15%	higher
hour	4	4	0.15%	hour, hours
long	4	4	0.15%	long
memories	8	4	0.15%	memories, memory
mentor	6	4	0.15%	mentor, mentored, mentoring, mentors
much	4	4	0.15%	much
new	3	4	0.15%	new
non	3	4	0.15%	non
peer	4	4	0.15%	peer
perspective	11	4	0.15%	perspective
push	4	4	0.15%	push
realize	7	4	0.15%	realize, realized, realizing
saw	3	4	0.15%	saw

stay	4	4	0.15%	stay
trauma	6	4	0.15%	trauma
without	7	4	0.15%	without
find	3	4	0.15%	find
1974	4	3	0.11%	1974
also	4	3	0.11%	also
another	7	3	0.11%	another
approach	8	3	0.11%	approach
attack	6	3	0.11%	attack
attend	6	3	0.11%	attend
became	6	3	0.11%	became
carry	5	3	0.11%	carry
catholic	8	3	0.11%	catholic
chapel	6	3	0.11%	chapel
christ	6	3	0.11%	christ
develop	7	3	0.11%	develop
dominated	9	3	0.11%	dominated
drive	5	3	0.11%	drive
else	4	3	0.11%	else
enough	6	3	0.11%	enough
ever	4	3	0.11%	ever
fellowship	10	3	0.11%	fellowship
friends	7	3	0.11%	friends
health	6	3	0.11%	health
ied	3	3	0.11%	ied
inside	6	3	0.11%	inside
instead	7	3	0.11%	instead
interested	10	3	0.11%	interested
let	3	3	0.11%	let
little	6	3	0.11%	little
made	4	3	0.11%	made
okay	4	3	0.11%	okay
organized	9	3	0.11%	organized
place	5	3	0.11%	place
power	5	3	0.11%	power

pressure	8	3	0.11%	pressure
raised	6	3	0.11%	raised
rather	6	3	0.11%	rather
real	4	3	0.11%	real
recovered	9	3	0.11%	recovered
reduce	6	3	0.11%	reduce
seen	4	3	0.11%	seen
sent	4	3	0.11%	sent
september	9	3	0.11%	september
social	6	3	0.11%	social
sometimes	9	3	0.11%	sometimes
taught	6	3	0.11%	taught
tend	4	3	0.11%	tend
tremendous	10	3	0.11%	tremendous
weapon	6	3	0.11%	weapon
willing	7	3	0.11%	willing
zone	4	3	0.11%	zone
build	5	3	0.11%	build, building, builds
changed	7	3	0.11%	change, changed
depression	10	3	0.11%	depressed, depression
express	7	3	0.11%	express, expressing
hip	3	3	0.11%	hip, hips
levels	6	3	0.11%	level, levels
line	4	3	0.11%	line, lined
look	4	3	0.11%	look, looking
medevaced	9	3	0.11%	medevac, medevaced
moved	5	3	0.11%	move, moved
open	4	3	0.11%	open, opening
preference	10	3	0.11%	prefer, preference
setting	7	3	0.11%	set, setting
suicide	7	3	0.11%	suicide, suicides
treat	5	3	0.11%	treat, treated
views	5	3	0.11%	view, views
walk	4	3	0.11%	walk, walked
weak	4	3	0.11%	weak, weakness

year	4	3	0.11%	year, years

Appendix F

List of Emotional and Spiritual Support Needs

List of Emotional and Spiritual Support Needs
help processing my emotions and unloading emotional baggage
a listening ear
to tell my story
to talk to a female chaplain
to talk about my mental struggles and injuries
to be affirmed and not judged
to destress by talking to someone I trust
help making sense of the poverty and violence I witnessed
to talk to a neutral person (like a chaplain) who was not in my chain of command
to know that I was forgiven
to know that God was in control and that He will always be there for me
help overcoming PTSD
reassurance that everything was okay -- with me, my family, and unit members
a chaplain who met some or all of the following criteria: - warm and caring - knew the right questions to ask - knew what it was like to be deployed - made me feel comfortable talking to him or her - would not be traumatized themselves - skilled in handling trauma - built relationships with all the soldiers in the unit - trained and experienced in dealing with soldiers who have been sexually assaulted - willing to engage the chain of command on behalf of soldiers
a faith community to provide encouragement, support, healthy relationships, and learning opportunities
help with anxiety and depression
leaders and support providers to understand that there were mental injuries too
to be validated by the chain of command as someone who was injured, but still valuable as a soldier and a person

to know that I was not alone, that there were people who cared about me
help discovering my personal faith
help processing my feelings about God
to attend religious activities, such as chapel service, Bible studies, and prayer groups
recreational activities to reduce stress
peer support groups for military women to share stories, experiences, and feelings; mentor each other; and provide a place of refuge
a warm, individualized approach to health care and mental care
a catalog of support agencies that shows the kind of care available to a soldier based on his or her injuries.
frequent visits from the chaplain while in the hospital
to be visited by a chaplain after experiencing a traumatic event