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Help-Seeking Behaviors Among Active-Duty Military Personnel: Utilization of Chaplains and Other Mental Health Service Providers

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Military chaplains not only conduct religious services, but also provide counseling and spiritual support to military service members, operating as liaisons between soldiers and mental health professionals. In this study, active-duty soldiers (N = 889) reported help-seeking behaviors and mental health. Using logistic regressions, we describe the issues for which soldiers reported seeking help, then outline the characteristics of those who are most likely to seek help from a chaplain. Of the soldiers who sought help from a chaplain within the previous year, 29.9% reported high levels of combat exposure, 50.8% screened positive for depression, 39.1% had probable PTSD, and 26.6% screened positive for generalized anxiety disorder. The participant's unit firing on the enemy, personally firing on the enemy, and seeing dead bodies or human remains predicted seeing a chaplain. Future research should examine ways to engage soldiers who have had more combat experiences with the chaplain community to address spiritual issues.

KEYWORDS chaplaincy, mental health, military, moral injury, stigma

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Active-duty (AD) military personnel have several options for seeking help for emotional or mental health concerns, including mental health professionals at a military facility, a general medical doctor at a military facility, a military chaplain, civilian mental health professionals, a general medical doctor at a civilian facility, a civilian pastor, rabbi, or other pastoral counselor, and self-help groups (Bray et al., 2009). Reasons for choosing which options for help-seeking behaviors are important to understand in order to develop procedures for providing the best and most relevant care to those most likely to take advantage of them. One option that has received very little research attention is the utilization of military chaplains by AD soldiers.

Military chaplains are responsible not only for conducting religious services, but also for providing counseling and spiritual support to service members of the United States military (Besterman-Dahan, Gibbons, Barnett, & Hickling, 2012). A recent nationwide representative survey of post-9/11 veterans found that roughly one-fifth had spoken to a "pastoral counselor" within the previous year (Elbogen et al., 2013; Nieuwsma, Fortune-Greeley, et al., 2014). Oftentimes, military chaplains operate as liaisons between service members and other mental health professionals (Besterman-Dahan et al., 2012) and many of those for whom they care have mental health issues (Nieuwsma et al., 2013). In fact, in the Department of Defense (DoD) Health-Related Behaviors Surveys (HRB Survey), Bray et al. (2009) showed that 21.4% of Army personnel received counseling or therapy for mental health or substance abuse in the past 12 months; 8% (more than a third of all those who sought help) received services from a military chaplain. In a study of active-duty members of the United Kingdom (UK) armed forces, non-medical sources of help, such as chaplains, were used more often than medical professional help for mental health concerns (Iversen et al., 2010). Another study of UK forces who were currently deployed in Iraq found that, for the less than half who actually received help for a problem, help was more commonly sought through informal channels (such as from a friend, chain of command, or chaplain), than from a medical professional (Mulligan et al., 2010).

Issues of stigma are a concern in the military with regard to help-seeking for both mental health and substance abuse issues, and those who screen positive for mental health issues are more likely to report concerns of stigma than those who do not (Hoge et al., 2004; Rae Olmsted et al., 2011). These concerns include endorsing reasons such as "It would be too embarrassing," "It would harm my career," "Members of my unit might have less confidence in me," "My leaders would blame me for the problem," and "I would be seen as weak" (Hoge et al., 2004; MHAT VII, 2011). Veterans who reported speaking to pastoral counselors were more likely to have indicated concerns regarding distrust of mental health care or stigma than those who had not spoken with pastoral counselors (Nieuwsma, Fortune-Greeley, et al., 2014). These concerns have led to an increased interest in understanding the roles

that chaplains play within the DoD and the Department of Veterans Affairs (VA) (Nieuwsma, Jackson, et al., 2014).

The magnitude of mental health problems among service members, especially upon return from deployment and following exposure to combat, is fairly well-documented (Hoge et al., 2004; Milliken, Auchterlonie, & Hoge, 2007). However, there is limited information on the extent to which AD soldiers seek help from chaplains, and for what conditions they tend to seek such help. There is also a dearth of information on the mental health status and combat experiences of those service members who seek care from chaplains. This is critical given that our previous work has highlighted the complex relationship between spirituality and mental health in veterans with various levels of combat exposure (Hourani et al., 2012). Interestingly, we have found that spirituality had a buffering effect against depression and PTSD, but only in those who had experienced low or moderate levels of combat (Hourani et al., 2012). In addition to PTSD, there is emerging evidence of what is referred to as *moral injury*—defined as "potentially morally injurious events, such as perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations may be deleterious in the long-term, emotionally, psychologically, behaviorally, spiritually, and socially" (Litz et al., 2009)—following combat and war, whereby veterans report challenges to their spiritual beliefs because of combat experiences (Drescher et al., 2011; Vargas, Hanson, Kraus, Drescher, & Foy, 2013). For these reasons, we will examine the relationship between combat exposures and seeking help from a chaplain, as they may be uniquely positioned to provide support for such concerns.

A better understanding of the reasons that service members and veterans choose to seek care from a chaplain is necessary to address current gaps in both help-seeking behaviors and training for mental health professionals (Chevalier et al., 2015). The present study extends previous research by describing the issues for which AD service members report seeking help and by describing the service members who are most likely to seek such help from a chaplain.

SPECIFIC AIMS

This study has five complementary aims: (1) determine the proportion of soldiers seeking any help for mental health issues in the previous year; (2) identify overall patterns in the problems for which help was sought and the types of professionals from whom the help was sought; (3) examine the mental health status of soldiers who sought help from chaplains; (4) ascertain predictors of seeking care from any mental health professional; and (5) describe key predictors of seeking care from a chaplain among those who sought help.

METHOD

Sample and Procedures

Based on the researcher's request to the installation for a sample of deployable combat platoons, fifty-two platoons of the 82nd Airborne at Ft. Bragg, NC were assigned by their command to attend a short on-site introduction to the study and its volunteer nature. A total of 891 attending soldiers agreed to participate (only two soldiers declined to participate). All participants had completed their basic and advanced military training. Data were collected on-site during two-hour sessions with platoons of up to 26 soldiers. Participants provided signed consent forms, and institutional review boards of RTI International and the US Army Medical and Material Command, Office of Research Protections, Human Research Protection Office approved the study. Soldiers filled out anonymous 30 minute self-report questionnaires that included several standardized psychological scales, and assessments of coping behaviors, combat exposure, and help-seeking behaviors (see Measures section). Additional details on procedures are available in Lewis et al. (2015).

Measures

Demographic characteristics were assessed to describe the sample and to use as control variables in all analyses. Age was coded continuously in years. Gender was coded as 0 = male and 1 = female. Additionally, we assessed level of education and used a dichotomous variable (0 = high school education or less, 1 = some college or trade school and higher) in all analyses.

Receipt of counseling was assessed by asking respondents to report on whether they had received counseling or therapy for mental health or substance abuse in the past 12 months from seven different sources of help: (1) a mental health professional at a military facility (e.g., psychologist, psychiatrist, clinical social worker, or other mental health counselor), (2) a general medical doctor at a military facility, (3) a military chaplain, (4) a civilian mental health professional (e.g., psychologist, psychiatrist, clinical social worker, or other mental health counselor), (5) a general medical doctor at a civilian facility, (6) a civilian pastor, rabbi, or other pastoral counselor, or (7) a self-help group (e.g., AA, NA). Participants were instructed to check all that apply, resulting in seven dichotomous variables (0 = no, 1 = yes).

Mental health concern was assessed using self-report and options included depression, anxiety, family problems, substance use problems, anger management, stress management, and combat/operational stress. Respondents were asked to indicate for which of these concerns they sought counseling or therapy within the past 12 months. Participants were instructed to check all that apply, resulting in 7 dichotomous variables (0 = no, 1 = yes).

Prayer as a coping behavior was measured by asking participants how often they said a prayer when they felt pressured, stressed, depressed, or anxious. Response options ranged from 1-*not at all* to 4-*a lot*.

Combat Exposure was measured using the Combat Experiences Scale, Section D of the Deployment Risk and Resilience Inventory-2 (DRRI-2; Vogt, Smith, King, & King, 2012), which assesses experiences related to combat (e.g., firing a weapon or being fired on). Respondents were asked to think about their last deployment, and to report how many times they experienced each of 17 items. Response options for each item were coded from one to five, indicating zero, 1-3, 4-12, 13-50, or 51 or more times for each experience. Totals were then used to create a dichotomized variable of combat exposure (no/low/moderate combat exposure vs. high combat exposure). High combat exposure was considered a total of 10 or greater as a combat experiences sum. In addition to using the entire scale, we also examined the following nine individual items, which we hypothesized were related to seeking help from a chaplain: (1) the participant's unit firing on the enemy, (2) the soldier personally firing his/her weapon at the enemy, (3) engaging in hand-to-hand combat, (4) witnessing members of the participant's unit or an ally unit being seriously wounded or killed, (5) the participant's unit suffering casualties, (6) seeing dead bodies or human remains, (7) handling, uncovering, or removing dead bodies or human remains, (8) someone the participant knew well being killed in combat, and (9) taking care of injured or dying people. We anticipated these items being related to seeking help from a chaplain due to the nature of these experiences and their association with death and dying.

Depression was measured using the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977), a 20-item self-report measure to assess symptoms associated with depression that have been experienced in the past week. An example item is "I felt like everything I did was an effort." Responses are on a 4-point scale where 0 = *rarely or none of the time* and 3 = *most or all of the time*. The scale provides a total score ranging from 0 to 57 ($M = 11.63$, $SD = 9.87$). CES-D scores showed excellent internal reliability in this sample (Cronbach's $\alpha = .90$). A standard cutoff score of 16 indicated probable depression (0 = no, 1 = yes).

Generalized anxiety disorder (GAD) symptoms were assessed using the seven Patient Health Questionnaire (PHQ) items to measure GAD (Spitzer, Kroenke, & Williams, 1999). An example item is "During the past month, how often have you been bothered by each of the following?: Feeling nervous, anxious, on edge, or worrying a lot about different things." Response options ranged from 0 = *not at all* to 2 = *more than half of the days*. The scale produces a total score ($M = 5.19$, $SD = 3.72$, range 0–14), with scores over 10 indicative of a probable GAD diagnosis. PHQ scores showed good internal reliability in this sample (Cronbach's $\alpha = 0.85$). Probable GAD diagnosis was coded as 1 = yes and 0 = no.

Perceived stress was measured using the Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983), a 10-item scale to assess a person's perception of stress and control. An example item is "In the last month, how often have you felt nervous and stressed?" Response options range from 0 = *never* to 4 = *very often*. The scale provides a total perceived stress score ranging from 0 to 35 (continuous), with higher scores indicating more perceived stress. The mean in this sample was 14.22 ($SD = 7.08$). Scores showed good internal consistency in this sample (Cronbach's $\alpha = 0.86$).

PTSD symptoms were measured using the PTSD Checklist-Civilian Version (PCL-C) (Weathers, Litz, Herman, Huska, & Keane, 1994), a 17-item screening instrument for PTSD. The civilian version was chosen to capture PTSD symptomatology prior to military service; it has been used frequently with military populations and has demonstrated good reliability (Wilkins, Lang, & Norman, 2011). A PCL-C cut-off score of 43 was used to indicate probable PTSD (1 = yes, 0 = no), which is a midpoint cutoff between strictest and broadest screening definitions (Bliese et al., 2008; National Center for PTSD, 2012).

Data Analysis

All analyses were run using SAS software, Version 9.4 (SAS Institute Inc., Cary, NC). Descriptive statistics were obtained to assess how frequently soldiers reported seeing various mental health professionals, as well as the most common concerns for which soldiers sought help. PROC SURVEYFREQ was used to identify significant associations between receipt of counseling or therapy for mental health or substance abuse from a variety of mental health professionals and the type of concern for which they sought help. Since receipt of counseling in each of the seven categories was coded 0 or 1 (no or yes, respectively), as were mental health concerns, we used Phi correlations in a 2×2 table to assess these associations. Additionally, for those who had seen a chaplain within the previous year, PROC SURVEYFREQ was used to determine the percentage who screened positive for mental health conditions, including depression, PTSD, and GAD, as well as those who reported high levels of combat exposure.

Lastly, logistic regressions were run using PROC SURVEYLOGISTIC to determine predictors of seeking counseling from any mental health professional within the previous year as well as specifically seeking counseling from a chaplain. In all analyses, we controlled for demographic variables including age, gender, and education. For the logistic regression model predicting whether a soldier sought counseling within the previous year, predictors included high combat exposure, GAD, depression, PTSD, and total stress scores. In the logistic regression model predicting whether a soldier reported seeing a chaplain within the previous year, predictors included the 9 items of the Combat Experiences Scale and reporting prayer as a coping behavior.

These 9 items were chosen a priori for theoretical reasons, namely their relation to death and dying, and in light of prior findings about the unique experience of killing (Maguen et al., 2010).

RESULTS

Descriptive Analyses

The sample ($N = 889$) consisted mostly of men with a mean age of 23.82 years ($SD = 4.39$, range = 18–41). Participants were mostly single or never married, followed closely by married or living as married. Most soldiers were E-4 or above in rank and slightly more than half reported having at least some college or trade school education. More than half of the sample had never been deployed, but almost a quarter of the sample reported high combat exposure. More than a quarter of the sample had CES-D scores indicative of probable depression, 14.7% were indicated for probable GAD, and 13% had PCL-C scores above 43, which indicated probable PTSD. Table 1 provides demographic, deployment, combat, and mental health descriptive results.

Of the total sample, 17.4% ($n = 155$) reported seeing any mental health professional in the past 12 months. Soldiers most often reported seeing a mental health professional at a military facility (e.g., psychologist, psychiatrist, clinical social worker, or other mental health counselor) (9.5%; $n = 85$), followed by a military chaplain (7.3%, $n = 65$), and general medical doctor at a military facility (5.2%; $n = 46$). Participants also reported seeing a civilian mental health professional (4.4%; $n = 39$), civilian pastor, rabbi, or other pastoral counselor (3.3%, $n = 29$), and attending a self-help group (e.g., AA, NA) (2.4%, $n = 21$). Respondents were least likely to report seeing a civilian general medical doctor (1.3%, $n = 12$). The most common concerns for which soldiers reported seeking mental health counseling were family problems (8.2%, $n = 73$), depression (6.3%, $n = 56$), anxiety (6.1%, $n = 54$), stress management (6.1%, $n = 54$), and anger management (4.5%, $n = 40$). Participants also reported seeking mental health treatment for combat or operational stress (2.6%, $n = 23$), substance abuse problems (1.5%, $n = 13$), and other concerns (3.6%, $n = 32$).

Bivariate Analyses

Mental Health Professionals Related to the Military

Soldiers were most likely to report seeing a *military* mental health professional for stress management, followed by depression, anxiety, combat or operational stress, anger management, family problems, and substance use problems. Results indicated that soldiers were most likely to report seeing a *chaplain* for family problems, followed by depression, anxiety, stress

TABLE 1 Descriptive Statistics of Demographic, Deployment, Combat Exposure, and Mental Health Variables

Variable	*n*	Percent
Gender		
Male	851	95.5%
Female	40	4.5%
Education		
High school or less	423	47.5%
Some college or trade school	458	51.4%
Paygrade		
E1-E3	369	41.4%
E4-E6	476	53.4%
E7-E9	23	2.6%
W1-W5	2	0.2%
O1-O3	21	2.4%
Marital Status		
Married/living as married	410	46.0%
Single, never married	437	49.0%
Separated/widowed/divorced	42	4.7%
Ever Deployed		
Yes	364	40.9%
No	508	57.0%
Combat Exposure		
No combat exposure	517	58.0%
Low/medium combat exposure	149	16.7%
High combat exposure	209	23.5%
Depression Indicated		
Yes	233	26.2%
No	653	73.3%
GAD Indicated		
Yes	131	14.7%
No	757	85.0%
PTSD Indicated		
Yes	116	13.0%
No	773	86.8%

Note. $N = 891$. Some columns do not total 100% due to missing data. GAD = generalized anxiety disorder; PTSD = posttraumatic stress disorder.

management, anger management, and combat or operational stress. Soldiers did not report seeking help from a chaplain for substance use problems. Participants who reported seeing a *general medical doctor at a military facility* most often reported depression as a mental health concern, followed by stress management, anxiety, combat or operational stress, family problems, and anger management. Soldiers did not report seeing a general medical doctor at a military facility for substance use problems (see Table 2).

Mental Health Professionals Not Related to the Military

For participants who reported seeing a *civilian mental health professional*, the most commonly reported concern was stress management, followed

TABLE 2 Phi (φ) Correlations Between Mental Health Professional Sought and Mental Health Concern

	Mental health professional at a military facility	General medical doctor at a military facility	Military chaplain	Civilian mental health professional	General medical doctor at a civilian facility	Civilian pastor, rabbi, or other pastoral counselor	Self-help group (e.g., AA, NA)
Depression	.49***	.32***	.40***	.39***	.10*	.22***	.09*
Anxiety	.46***	.27***	.39***	.33***	.14**	.25***	.06
Family problems	.34***	.21***	.53***	.35***	.12**	.35***	.04
Substance use problems	.19***	.02	−.03	.12*	−.01	−.02	.63***
Anger management	.44***	.17***	.26***	.23***	.08	.18***	.16***
Stress management	.55***	.29***	.37***	.39***	.14**	.25***	.22***
Combat/operational stress	.44***	.22***	.26***	.29***	.18**	.14**	.07

Note. ***$p < .001$. **$p < .01$. *$p < .05$.

closely by depression, family problems, anxiety, combat or operational stress, and anger management. Soldiers also reported seeing civilian mental health professionals for substance use problems. Participants who saw a *civilian pastor, rabbi, or other pastoral counselor* most often reported family problems as a concern. In addition, they cited anxiety, stress management, and depression, followed by anger management and combat or operational stress. Soldiers who reported seeing a civilian pastoral counselor did not report substance use problems as a concern. Those who reported attending a *self-help group* were also most likely to report a substance use problem as their main concern. These participants also reported stress management, anger management, and depression as mental health concerns. Lastly, the most commonly reported concerns for those who reported seeing a *general medical doctor at a civilian facility* were combat or operational stress, anxiety, stress management, family problems, and depression (see Table 2).

Overall, these results highlight which mental health professionals soldiers were most likely to seek when also reporting certain concerns. Participants who reported stress management, depression, anxiety, combat or operational stress, or anger management as a concern were most likely to report seeing a mental health professional at a military facility. Soldiers who reported family problems as a concern were most likely to report seeing a military chaplain, and those who reported substance use problems were much more likely to report attending a self-help group than seeing any other mental health professional (see Table 2).

Mental Health Status and Combat Experiences of Those Who Saw Chaplains

It is important to understand the mental health status and combat experiences of soldiers who sought help from a chaplain, regardless of whether the chaplain was sought for this specific concern. Of soldiers who sought help from a chaplain within the previous year, 29.9% reported high levels of combat exposure ($n = 19$), 50.8% screened positive for depression ($n = 33$), 39.1% reported levels of symptoms indicative of a probable PTSD diagnosis ($n = 25$), and 26.6% screened positive for GAD ($n = 17$).

Multivariate Analyses

Results of a logistic regression indicated that those who had probable PTSD and higher levels of perceived stress were more likely to report seeking counseling within the previous year, after controlling for age, education, gender, high levels of combat exposure, depression, and GAD (see Table 3). Among those who sought counseling within the previous year, four variables significantly predicted specifically seeing a chaplain. Results of the logistic regression revealed that reporting that the participant's unit fired on the enemy, the soldier personally firing on the enemy, a member of the soldier's

TABLE 3 Logistic Regression Model Parameters Predicting Receipt of Counseling in the Previous Year

Independent Variables	Receipt of Counseling in Previous Year OR (95% CI)
High Combat Exposure	1.44 (0.97–2.13)
Depression Indicated (CESD > 16)	0.91 (0.50–1.64)
Perceived Stress	1.07 (1.04–1.11)*
PTSD Indicated (PCL-C > 43)	2.23 (1.24–4.03)*
GAD Indicated (GAD > 10)	1.56 (0.96–2.54)
Gender	1.45 (0.57–3.87)
Education	0.93 (0.82–1.07)
Age	1.03 (0.98–1.07)

Note. *$p < .05$. PTSD = posttraumatic stress disorder; GAD = generalized anxiety disorder.

unit or ally unit being seriously wounded or killed, and seeing dead bodies or human remains significantly predicted seeing a chaplain (see Table 4). Engaging in hand-to-hand combat; the soldier's unit suffering casualties; handling, uncovering, or removing dead bodies or human remains; having someone the participant knew well killed in combat; taking care of injured or dying people; saying a prayer as a coping behavior; probable depression, GAD, or PTSD; and age, gender, and education were nonsignificant predictors (see Table 4).

Soldiers whose units fired on the enemy were almost four times as likely to seek help from a chaplain as those whose units did not fire on the enemy,

TABLE 4 Logistic Regression Model Parameters Predicting Seeking Help From a Chaplain

Independent Variables	Seeking Help from Chaplain in Previous Year OR (95% CI)
Unit fired on enemy	3.89 (1.06–14.23)*
Soldier fired on enemy	0.22 (0.06–0.85)*
Member of soldier's unit or ally unit seriously wounded or killed	0.23 (0.07–0.84)*
Seeing dead bodies or human remains	6.86 (2.11–22.34)*
Engaging in hand-to-hand combat	0.42 (0.02–7.95)
Unit suffered casualties	0.64 (0.19–2.15)
Handling, uncovering, or removing dead bodies or human remains	1.39 (0.38–5.05)
Someone soldier knew well was killed in combat	0.52 (0.07–3.91)
Took care of injured or dying people	1.81 (0.46–7.20)
Used prayer as a coping behavior	0.67 (0.26–1.70)
Depression Indicated (CESD > 16)	1.14 (0.18–7.24)
Perceived Stress	1.24 (0.93–1.66)
PTSD Indicated (PCL-C > 43)	0.85 (0.09–8.38)
GAD Indicated (GAD > 10)	0.15 (0.02–1.14)
Gender	0.60 (0.05–7.26)
Education	1.07 (0.50–2.31)
Age	1.04 (0.83–1.32)

Note. *$p < .05$. Analysis includes only those who received counseling in previous year.

but those who personally fired on the enemy were 78% less likely. Soldiers who reported that a member of the soldier's unit or ally unit was seriously wounded or killed were 77% less likely to see a chaplain than those who did not. The strongest predictor of seeking help from a chaplain was seeing dead bodies or human remains, with soldiers who reported seeing dead bodies or human remains being nearly seven times more likely to seek help from a chaplain than soldiers who did not. Interestingly, those who reported praying as a coping behavior were no more or less likely to seek a chaplain's help for a mental health concern.

DISCUSSION

This study sought to describe patterns of help-seeking behaviors in Active-duty soldiers, in particular the utilization of military chaplains for mental health concerns. Results revealed that slightly more than one in six soldiers reported seeking help for mental health concerns within the previous year. Chaplains were the second most reported source of help, after mental health professionals at a military facility. The most common concern for which most soldiers sought help from a chaplain was family problems, but it is important to acknowledge the mental health issues that these soldiers were also facing. Despite not reporting mental health concerns as the primary reason for seeing a chaplain, more than half screened positive for depression, more than a third reported levels of symptoms indicative of a probable PTSD diagnosis, and more than a quarter screened positive for GAD. Additionally, almost one third of soldiers who sought help from a chaplain reported high levels of combat exposure. These results highlight the need for military chaplains to be adequately trained to understand these comorbid or underlying issues and the ways in which these mental health concerns and combat experiences may interact with presenting spiritual problems.

Not surprisingly, soldiers who reported high levels of PTSD symptoms and higher levels of stress were the most likely to report seeking counseling within the previous year. Of particular note were the results of the logistic regression predicting specifically seeking help from a chaplain. It was our original belief that each of the combat exposure items that were related to death would significantly increase the likelihood of a soldier seeking out a chaplain. In addition, we hypothesized that those who reported praying as a coping behavior would be more inclined to reach out to a chaplain than to other mental health professionals. The results did not support this conclusion.

There may be several explanations for these null findings. These results would suggest that there are other reasons for the preference of talking to a chaplain, which requires an understanding of what chaplains offer that other mental health professionals do not. The first reason is absolute confidentiality. Because communication with a chaplain is a formal act of religion or as a

matter of conscience, chaplains are protected from disclosing information to third parties (see Carver, 2007). A second reason is related to the issue of stigma regarding help-seeking behaviors. It is possible that chaplains offer AD soldiers an opportunity to informally discuss mental health or emotional concerns without the perceived stigma of seeking help from a mental health or medical professional.

The second surprising finding was the differential effects of certain combat experiences to seeking help from a chaplain. Although we anticipated that all death-related combat experiences would be positively associated with the utilization of chaplains, this was not the case. Soldiers whose units fired on the enemy were more likely to see a chaplain, as were soldiers who reported seeing dead bodies or human remains. In contrast, soldiers who personally fired on the enemy, or whose unit or allied unit suffered casualties, were less likely to see a chaplain. Although these were not the expected results, one could speculate as to what makes these experiences qualitatively different from one another. One possibility is that the first two experiences (i.e., seeing dead bodies or human remains and the unit firing on the enemy) are more passive experiences, which do not preclude the soldier from seeing the chaplain as a viable option for emotional or mental health. This is juxtaposed with more engaging experiences (i.e., personally firing on the enemy or having an allied member being wounded or killed), which may result in either moral injury from personal actions taken or spiritual doubt from losing a comrade. These results are congruent with prior findings of the unique effect of indirect or direct killing on PTSD, alcohol abuse, anger/hostility, and relationship problems, even after controlling for overall combat exposure (Maguen et al., 2010). What is most concerning about this pattern of results is that, presumably, many of these experiences could benefit from the spiritual and emotional guidance of a military chaplain or pastoral counselor.

There are a few limitations to this study that should be mentioned. First, all of the data analyzed here were collected cross-sectionally, so the predictive nature of the analyses does not equate to causation. In addition, some analyses used one-item measures, which prevents the assessment of measurement error. This was done intentionally, however, with the view that there was more to be gained by looking at individual experiences and behaviors separately. Finally, the analyses discussed here utilized self-report measures, which can be vulnerable to self-report bias. It may be that soldiers under-reported their utilization of certain help-seeking behaviors or mental health symptoms.

Despite these limitations, this study provides valuable information for both chaplains and the military community as a whole. These results present data critical to understanding the patterns of help-seeking behaviors in the Active-Duty community, which can be leveraged to address gaps in training across all mental health and pastoral counselors. It is particularly crucial to understand that, although soldiers may not report seeking help for mental

health issues from military chaplains, there are possible co-occurring disorders that may affect treatment. Chaplains should be offered additional training about the ways in which common concerns, like depression, anxiety, PTSD, and combat exposure, present themselves in their military constituents. Finally, future research should examine ways to engage those soldiers who may have had more active combat experiences with the chaplain community, as this is where issues of spirituality and moral injury are best addressed.

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REFERENCES

Besterman-Dahan, K., Gibbons, S. W., Barnett, S. D., & Hickling, E. J. (2012). The role of military chaplains in mental health care of the deployed service member. *Military Medicine*, *177*(9), 1028–1033. doi:10.7205/milmed-d-12-00071

Bliese, P. D., Wright, K. M., Adler, A. B., Cabrera, O., Castro, C. A., & Hoge, C. W. (2008). Validating the primary care posttraumatic stress disorder screen and the posttraumatic stress disorder checklist with soldiers returning from combat. *Journal of Consulting and Clinical Psychology*, *76*, 272–281. doi:10.1037/0022-006x.76.2.272

Bray, R. M., Pemberton, M. R., Hourani, L. L., Witt, M., Olmsted, K. L., Brown, J. M., . . . Scheffler, S. (2009). *Department of defense survey of health related behaviors among active duty military personnel* (No. RTI/10940-FR). Research Triangle Park, NC: Research Triangle Institute (RTI).

Carver, D. L. (2007, September 25). *Policy for protection of confidential communications between unit ministry team members and military constituents [Memorandum]*. Washington, DC: Office of the Chief of Chaplains, Department of the Army.

Chevalier, L., Goldfarb, E., Miller, J., Hoeppner, B., Gorrindo, T., & Birnbaum, R. J. (2015). Gaps in preparedness of clergy and healthcare providers to address mental health needs of returning service members. *Journal of Religion and Health*, *54*(1), 327–338. doi:10.1007/s10943-014-9917-0

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, *24*(4), 385–396. doi:10.2307/2136404

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

Elbogen, E. B., Wagner, H. R., Johnson, S. C., Kinneer, P., Kang, H., Vasterling, J. J., … Beckham, J. C. (2013). Are Iraq and Afghanistan veterans using mental health services? New data from a national random-sample survey. *Psychiatric Services*, *64*(2), 134–141. doi:10.1176/appi.ps.004792011

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *The New England Journal of Medicine*, *351*(1), 13–22. doi:10.1056/NEJMoa040603

Hourani, L. L., Williams, J., Forman-Hoffman, V., Lane, M. E., Weimer, B., & Bray, R. M. (2012). Influence of spirituality on depression, posttraumatic stress disorder, and suicidality in active duty military personnel. *Depression Research and Treatment*, *2012*, 1–9. doi:10.1155/2012/425463

Iversen, A. C., van Staden, L., Hughes, J. H., Browne, T., Greenberg, N., Hotopf, M., … Fear, N. T. (2010). Help-seeking and receipt of treatment among UK service personnel. *The British Journal of Psychiatry*, *197*(2), 149–155. doi:10.1192/bjp.bp.109.075762

Lewis, G. F., Hourani, L., Tueller, S., Kizakevich, P., Bryant, S., Weimer, B., & Strange, L. (2015). Relaxation training assisted by heart rate variability biofeedback: Implication for a military pre-deployment stress inoculation protocol. *Psychophysiology*, *52*(9), 1167–1174. doi:10.1111/psyp.12455

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, *29*(8), 695–706. doi:10.1016/j.cpr.2009.07.003

Maguen, S., Lucenko, B. A., Reger, M. A., Gahm, G. A., Litz, B. T., Seal, K. H., … Marmar, C. R. (2010). The impact of reported direct and indirect killing on mental health symptoms in Iraq war veterans. *Journal of Traumatic Stress*, *23*(1), 86–90. doi:10.1002/jts.20434

MHAT VII. (2011). *Joint mental health advisory team 7 (J-MHAT 7) operation Iraqi freedom 2010*. Washington, DC: Office of the Surgeon General, United States Army Medical Command, Office of the Command Surgeon HQ, USCENTCOM, Office of the Command Surgeon, US Forces Afghanistan (USFOR-A).

Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *Journal of the American Medical Association*, *298*(18), 2141–2148. doi:10.1001/jama.298.18.2141

Mulligan, K., Jones, N., Woodhead, C., Davies, M., Wessely, S., & Greenberg, N. (2010). Mental health of UK military personnel while on deployment in Iraq. *The British Journal of Psychiatry*, *197*(5), 405–410. doi:10.1192/bjp.bp.110.077263

National Center for PTSD. (2012). *Using the PTSD checklist (PCL)*. Retrieved February 13, 2013 from http://www.ptsd.va.gov/professional/pages/assessments/assessment-pdf/pcl-handout.pdf

Nieuwsma, J. A., Fortune-Greeley, A. K., Jackson, G. L., Meador, K. G., Beckham, J. C., & Elbogen, E. B. (2014). Pastoral care use among post-9/11 veterans who screen positive for mental health problems. *Psychological Services*, *11*(3), 300–308. doi:10.1037/a0037065

Nieuwsma, J. A., Jackson, G. L., DeKraai, M. B., Bulling, D. J., Cantrell, W. C., Rhodes, J. E., . . . Meador, K. G. (2014). Collaborating across the departments of Veterans affairs and defense to integrate mental health and chaplaincy services. *Journal of General Internal Medicine*, *29*(Suppl. 4), 885–894. doi:10.1007/s11606-014-3032-5

Nieuwsma, J. A., Rhodes, J. E., Jackson, G. L., Cantrell, W. C., Lane, M. E., Bates, M. J., . . . Meador, K. G. (2013). Chaplaincy and mental health in the department of Veterans affairs and department of defense. *Journal of Health Care Chaplaincy*, *19*(1), 3–21. doi:10.1080/08854726.2013.775820

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, *1*(3), 385–401. doi:10.1177/014662167700100306

Rae Olmsted, K. L., Brown, J. M., Vandermaas-Peeler, J. R., Tueller, S. J., Johnson, R. E., & Gibbs, D. A. (2011). Mental health and substance abuse treatment stigma among soldiers. *Military Psychology*, *23*(1), 52–64. doi:10.1080/08995605.2011.534414

Spitzer, R. L., Kroenke, K., & Williams, J. B. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. *Journal of the American Medical Association*, *282*(18), 1737–1744. doi:10.1001/jama.282.18.1737

Vargas, A. F., Hanson, T., Kraus, D., Drescher, K., & Foy, D. (2013). Moral injury themes in combat Veterans' narrative responses from the national Vietnam Veterans' readjustment study. *Traumatology*, *19*(3), 243–250. doi:10.1177/1534765613476099

Vogt, D., Smith, B. N., King, D. W., & King, L. A. (2012). *Manual for the deployment risk and resilience inventory-2 (DRRI-2): A collection of measures for studying deployment-related experiences of military Veterans*. Boston, MA: National Center for PTSD.

Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (1994). *The PTSD checklist-civilian version (PCL-C)*. Boston, MA: National Center for PTSD.

Wilkins, K. C., Lang, A. J., & Norman, S. B. (2011). Synthesis of the psychometric properties of the PTSD checklist (PCL) military, civilian, and specific versions. *Depression and Anxiety*, *28*(7), 596–606. doi:10.1002/da.20837