Curr Psychiatry Rep (2016) 18:56
DOI 10.1007/s11920-016-0695-0

MILITARY MENTAL HEALTH (CH WARNER, SECTION EDITOR)

Lesbian, Gay, Bisexual, and Transgender (LGBT) Service Members: Life After Don't Ask, Don't Tell

Jeremy T. Goldbach[1] **· Carl Andrew Castro**[1]

© Springer Science+Business Media New York 2016

Abstract Lesbian, gay, and bisexual service members can serve openly in the military with the repeal of the Don't Ask, Don't Tell policy. The fate of transgender service members remains uncertain as the policy preventing them from serving in the military remains under review. The health care needs of these populations remain for the most part unknown, with total acceptance and integration in the military yet to be achieved. In this paper, we review the literature on the health care needs of lesbian, gay, bisexual, and transgender (LGBT) service members, relying heavily on what is known about LGBT civilian and veteran populations. Significant research gaps about the health care needs of LGBT service members are identified, along with recommendations for closing those gaps. In addition, recommendations for improving LGBT acceptance and integration within the military are provided.

Keywords Gay · Lesbian · Transgender · Bisexual · Military · Veteran · Mental health · Physical health · Policy · LGBT acceptance and integration

Introduction

Including both guard and reserve, nearly 71,000 (2.8%) military personnel across all the services identify as lesbian, gay, or bisexual [1••], with many others identifying as transgender [2]. Lesbian, gay, bisexual, and transgender (LGBT) individuals have always served in the military, but until 2011, homosexual behavior was ground for dismissal [3]. Although homosexual behavior has been prohibited in the military as far back as the Revolutionary War, it was not until 1942 that gay and lesbian civilians were specifically excluded from joining the military [4•]. The initial explanation for discriminating against gay and lesbian citizens ranged from homosexual behavior being morally reprehensible to gay and lesbian service members posing a national security risk [4•]. Over time, the list of objections to allowing gay and lesbian service members to join the military grew to include concerns over higher health care costs (due primarily to AIDS care), erosion of military readiness due to lower morale and unit cohesion, violation of privacy or modesty rights of non-lesbian and gay service members, and a violation of the Uniformed Code of Military Justice's prohibition against sodomy [3].

The repeal of the Don't Ask, Don't Tell, and Don't Pursue policy [subsequently shortened in the vernacular to Don't Ask, Don't Tell (DADT)] in 2011 lifted this ban, as one by one, all of these objections were shown to be without merit [5••]. Until the repeal of DADT, LGB service members could not disclose their sexual orientation ("come out"), and if they did so, then discharge from the military was common. Although intended to protect LGB service members and allow for them to serve confidentially, DADT did little to protect LGB service members from organizational discrimination, and indeed, may have actually made it easier for LGB service members to be identified and separated from military service [6].

While LGB service members can no longer be involuntarily separated from the military, for transgender service members, there is increased ambiguity about their military status. While current Department of Defense policy calls for the separation of all transgender service members, this policy is currently under review, and until this review is complete, all

This article is part of the Topical Collection on *Military Mental Health*

✉ Carl Andrew Castro
carl.castro@usc.edu

[1] University of Southern California School of Social Work, 1150 South Olive Street, Suite 1400, Los Angeles, CA 90015, USA

Published online: 16 April 2016

military discharges involving transgender service members have been put on indefinite hold. Additionally, many LGB service members have concerns over continued persecution or discrimination, lack of acceptance by unit leaders and fellow service members, and adverse impact on their military careers if the identified as LGB service members [7] should they reveal their sexual orientation.

Despite continued concerns, it has been estimated that allowing LGBT service members to openly serve in the military will result in a near doubling of enlistments [1••]. Yet, because LGBT citizens were not allowed to legally serve in the military until very recently, a paucity of research exists on the health and well-being of this military population. The lack of sufficient knowledge regarding the health care needs of LGBT service members has been acknowledged by both the Department of Defense as well as the Department of Veterans Affairs (VA), with the VA acknowledging that they must take "immediate, coordinated action to advance the health and well-being of lesbian, gay, bisexual and transgender people" [8].

In this paper, we review what is currently known about the health and well-being of LGBT service members and provide a brief framework for understanding how LGBT service members might differ from non-LGBT service members. Throughout, recommendations for meeting the health care needs of LGBT service members, including the achievement of full integration of LGBT service members into the military are provided.

Health Care Needs of LGBT Service Members

The exclusion of LGBT service members from military service meant that understanding the health care needs of LGBT service members was a low priority. Thus, the specific health care needs of LGBT service members remain largely unknown. Studies of LGBT civilians from the general population indicate that there are important health differences between LGBT civilians and non-LGBT civilians. In civilian studies, LGBT individuals consistently show increased stress and psychological vulnerability when compared to their non-LGBT peers [9••, 10]. Specifically, LGBT civilians have higher rates of depression [11], anxiety [12], posttraumatic stress disorder [13], and substance use and abuse compared to non-LGBT individuals [12, 14•, 15–18].

Similarly, LGBT civilians are at increased risk for a wide-range of physical illnesses and disease. Lesbian civilians are at increased risk for cervical and breast cancer, due to inadequate screening and increased risk of smoking, as well as sexually transmitted infections. Gay civilians are particularly at risk for increased risk of HIV transmission and anal cancer [19]. Likewise, bisexual and transgender civilians are at increased risk for a number of physical health conditions [20, 21]. Whether LGBT service members also report elevated mental and physical health concerns when compared to their heterosexual and cisgender counterparts is unknown, yet until shown otherwise, it is reasonable to suspect that similar disparities might exist within the military.

In the civilian scientific literature, these disparate health outcomes are commonly attributed to unique stressors experienced by LGBT individuals, commonly referred to as minority stress [10]. Minority stress theory states that as major life events and chronic circumstances accumulate, an individual becomes less equipped to adapt, adjust, and tolerate continued life stressors [10, 22]. The key stressors experienced by LGBT civilians that can lead to poor behavioral health outcomes include negative events (e.g., bullying, physical assault), negative attitudes about homosexuality on the part of non-LGBT civilians (e.g., homophobia, transphobia), and discomfort with homosexuality by non-LGBT civilians (e.g., internalized stigma) [23–25].

Minority stress theory also suggests that societal persecution and chronic victimization can lead to significant distress for LGBT civilians, resulting in poorer physical and mental health. Support for this contention is seen in that LGBT citizens from the general population have a greater likelihood of experiencing traumatic events such as child maltreatment, interpersonal violence, intimate partner violence, sexual assault [26, 27], child abuse or neglect [28], hate crimes [29], rejection from family, friends and religious communities [30], and unexpected death, including death by suicide [13]. Whether minority stress theory can be extended to include the military culture is unknown, yet the conceptual framework provided by minority stress theory is a reasonable start.

The concerns over health disparities between LGBT service members and non-LGBT service members do not necessarily subside after military discharge, where research has documented a higher need for mental health services for LGBT veterans compared to non-LGBT veterans. For example, Cochran et al. found that for LGB veterans accessing the Department of Veterans Affairs (VA) services, they were more likely to screen positive for posttraumatic stress disorder (PTSD), depression, and alcohol misuse than non-LGB veterans [31]. Of note, for veterans who could not or did not serve openly in the military, concealment of their sexual orientation while in the service was associated with higher rates of depression and PTSD.

Of particular interest in recent years is the prevention of suicide among both active duty and veteran personnel [32], as these make up more than 20% of suicide deaths annually in the USA [33]. Since 2001, suicide rates among active duty military members have doubled [34]. Few studies have explored suicide risk among LGBT service members [35], but general population literature consistently suggests an increased risk [36, 37•]. Blosnich, Mays, and Cochran, in a study from the California Quality of Life survey, found no differences in past 12-month suicidal ideation or attempt between LGB and heterosexual veterans [38]. However, this

same study found a three times higher odds of lifetime suicidal ideation among LGB veterans when compared to their heterosexual counterparts.

Access to Quality Health Care for LGBT Service Members and Their Families

The US military operates a universal health care system for its members and their families, with the primary mission of ensuring the medical readiness of its uniformed forces. Indeed, the military health care system is arguably the best universal health care system in the world [39]. Yet, there are reasons to believe that LGBT service members and their families are not able to rely upon the military health care system with the same confidence that heterosexual and cisgender service members and their families do, nor do they encounter health care professionals who understand the unique health care needs of LGBT service members.

Access and Use of Medical Services Within the Military

Before the repeal of DADT, if service members disclosed their sexual behavior to their military health care provider, this information could be used to discharge them from military service [40]. Understandably, this led to significant "distrust between service members and their health care providers" [41]. Despite changing policy, research finds that LGBT service members remain distrustful. Prior to the change in policy, a significant number of LGBT individuals fear they will receive poorer care, discrimination, or rejection upon disclosure to their health care provider [42]. However, even after DADT was repealed, Biddiz et al. found that despite recognizing that disclosing one's sexual orientation to a medical provider could no longer be used as a reason for military discharge or hinder career advancement, only 70% of participants stated comfort in discussing their sexual orientation with a military provider, with a smaller percent (56.7%) believing the military cares for their health and well-being regardless of sexual orientation [43]. LGBT service members have also expressed concern over confidentiality and privacy, with many LGBT service members fearing that their sexual orientation will be disclosed to others outside of the medical community. This reluctance continues to be found in studies of LGBT veterans as well, when accessing the VA for medical care [44].

Although data is lacking, based on anecdotal evidence, it is believed that this distrust of military health care providers has resulted in many LGBT service members choosing to seek health care outside of the military health care system. It is also suspected that the dependents or families of LGBT service members do not access military health care at the same rate as other dependents and families due to similar issues of trust and confidentiality. If these suspicions are true, this would be extremely unfortunate as LGBT service members would have denied themselves access to world-class health care and possibly incurring unnecessary health care costs themselves for care that otherwise would have been provided for free. This was further complicated by the fact that the military did not recognize same-sex marriages until late 2013, creating a pay and benefit disparity for this population.

Military Health Care Providers Knowledge About LGBT Health Issues

Before the repeal of DADT, medical care providers in the military were not required nor expected to be knowledgeable about LGBT health care issues. Further, the overwhelming majority of military health and mental health providers are trained within the Department system. Given that DADT was not repealed until 2011, any provider trained before this time would have been offered very limited exposure to LGBT service members and have had no opportunity to learn about special considerations for working with this population. Thus, the knowledge of military health care providers and civilian providers used by the military is questionable. Indeed, a number of studies have pointed to the need for better training of health care providers throughout the DoD and VA [42–44]. In particular, military health care providers need to understand the unique health care needs of LGBT service members and their families, know how to appropriately inquire about and be supportive of a service member's sexual orientation or gender identity to enhance trust between the LGBT service member and the providers. Care must be taken to create an open, non-hostile health care environment so LGBT service member will continue to interact with and the military health care system by returning for or remaining in care.

Another subject that must be addressed involves clinician-patient confidentiality. Many service members, including LGBT service members, wrongly believe because of military necessity that clinician-client confidentiality does not exist within the military. This may stem in part from the dual role that military providers face when working with a soldier in their unit. Many providers may report to the same commander as the soldier, thus creating an obligation both to their patient and the unit. Given that the provider is often not separate from the service member or their commanding officer, there is a general concern among service members that their disclosures will not remain confidential, particularly in times of deployment or when in austere environments.

However, while commanders are entitled to know if a service member has a medical condition that hinders their ability to perform their military job (i.e., diagnosis, limitations, and prognosis), commanders are not entitled to know other information that are not related to job performance and ability [45]. With the repeal of the DADT policy, there is no situation in which commanders are entitled to know the sexual orientation of a service member. Both health care providers and service

members would benefit greatly from training to understand the limits of military-related clinician-client confidentiality.

A final topic to confront is the issue regarding the personal views of mental health care providers and staff regarding LGBT behaviors. As noted earlier, there are still many within the military that believe that LGBT service members should not be allowed to serve or have personal (e.g., moral or religious beliefs) beliefs that being LGBT is wrong and that they should not be required as providers to support it. As an example, a recent study conducted among military personnel found that 30% of those surveyed believe that gay and lesbian relations are morally wrong [46]. While everyone, even those within the military, are entitled to hold personal views regarding LGBT behaviors, it must be appreciated that those working within the military are not entitled to act on those beliefs if those actions are in contradiction to military policy. This is of particular importance, as in 2015, the Department designated sexual orientation as a protected class under the equal opportunity policy, which offers further security to service members seeking care from a provider.

Transgender Service Members

The transgender population represents, in some ways, a minority within a minority. Research on the mental and physical health needs of active duty transgender service members remains nearly nonexistent [47]. As noted earlier, this population was not protected in the repeal of the DADT policy [2, 48, 49]. Civilians who have undergone surgery in order to change their gender, as well as individuals diagnosed with gender dysphoria (DSM-5) remain unable to serve. Yet, transgender people may be particularly drawn to military service because of its emphasis on hyper-masculine values and early attempts to repress gender dysphoria by joining a hyper-masculine culture of violence and danger [50, 51]. Some research exist to suggest there are a higher proportion of transgender individuals in the military than in the general population [52–54], with possibly more than 150,000 active duty service members, veterans, and reservists identify as transgender [55].

Military service transgender veterans encounter different challenges than non-LGBT veterans. For instance, transgender veterans disproportionately experience homelessness (21%) and report high rates of attempted suicide (40%) [56]. Additionally, upwards of 97% of transgender veterans undergo gender transition procedures after leaving the military [57]. A study by Brown and Jones found disturbing differences for transgender veterans seeking health services through the VA [58••]. In an analysis of 5135 records, transgender identified individuals reported disparities in all mental health conditions documented including depression, suicidality, serious mental illness, and PTSD. These individuals were more likely to report homelessness, military sexual trauma, and become incarcerated.

Given the additional medical requirements of transgender individuals including the possible need for surgery, hormonal therapies, and interventions taken to feminize or masculinize the body [59], special considerations for research and practice with this population are warranted. However, transgender veterans report reluctance to access health care through the VA system and report negative experiences with health care providers including discrimination and victimization [57, 60]. Thus, if the DoD begins providing medical support for gender transition procedures, including surgery, more work will be needed to ensure service members and veterans are able to receive the highest quality care.

Creating a Military Culture of Acceptance and Integration of LGBT Service Members

For over 225 years, the US military has fostered a culture in which LGBT citizens were not welcome. Indeed, with the approval of the US Congress LGBT citizens and military personnel were actively discriminated against. Displaying or stating one's sexual orientation that was other than heterosexual was ground for an immediate dishonorable discharge from the military. While the recent changes in policy have put an end to this overt, organizational discrimination, there are still many in the military who believe LGBT service members should not be allowed to serve [46]. While this group may now represent a minority view, their presence means that additional safeguards and initiatives are necessary to ensure that complete acceptance and integration of LGBT service members into the military can be achieved.

Military Culture and Leadership

Changing the culture around LGBT service members will require strong, active leadership. Leadership and cohesion within the military have been shown to influence health and performance in combat and in garrison [61–63]. For example, in a study conducted in garrison among soldiers with a high workload, soldiers in units with higher cohesion displayed fewer mental health symptoms associated with depression and anxiety than did soldiers where cohesion was lower [61]. In instances involving LGBT service members, it would be expected that similar supportive leadership and higher unit cohesion would result in fewer health concerns for LGBT service members than those who report unsupportive or negative leadership and lower unit cohesion [64]. LGBT service members may experience heightened harassment related to the "hyper-masculinity" of military service [65••]. Leadership and unit support will be extremely important when service members "come out," as this event is particularly sensitive to the presence of strong social support [10].

There are a number of factors that affect unit cohesion. One pre-DADT study [65••] found that sexual orientation disclosure was positively related with social cohesion and indirectly related with task cohesion. Harassment based on sexual

orientation, however, was negatively associated with social cohesion. Unfortunately, Stalsburg found that nearly 80% of active duty service members report hearing offensive speech, jokes, and derogatory statements made about LGBT service members within the past year [60]. More than one-third (37%) also reported witnessing harassment based on perceptions sexual orientation [60, 66]. Strong leadership at both the junior and senior levels will be necessary to stop these types of harassing behaviors and to establish a climate of acceptance and integration of LGBT service members.

Military Sexual Assault and Victimization

Victimization and harassment based on sexual orientation and gender identity is commonly reported in civilian literature and found within the US armed forces as well [65••, 67]. Burks presented a compelling conceptual framework that suggests the DADT policy may have uniquely "served to increase LGBT victimization, decrease victim reports and help seeking, and prevent sexual orientation military research" [6]. In short, the military's policy position over the past 30 years might have unintentionally amplified victimization, while minimizing important health and organizational research that informs the military on best practices to support this population.

Sexual assault in the military is of particular concern. As a previous review finds [68], much work is needed to understand and prevent sexual assault across all groups. However, the previously held DADT policy likely perpetuated rates of same-sex sexual assault, as these survivors of rape, assault, and sexual harassment are reluctant to report the violence because of fears that the experiences may be seen as "homosexual" activity [69]. Transgender service members may also be disproportionately targeted, as a recent study found 26% of transgender veterans had experienced physical assault and 16% had been raped [57]. Based on these findings, sexual orientation and gender identity-related issues should be included in the military's sexual assault prevention efforts.

Operational Considerations

The operational considerations around LGBT service members have been shown to be either without merit or have been addressed through greater general acceptance of LGBT service members by non-LGBT service members. For transgender service members, however, there may remain significant issues around the sustainment of transgender hormone treatments in prolonged austere environments where the military often operates. Approaches to overcoming these obstacles are essential for the full acceptance and integration of transgender service members. Lessons learned from other national militaries should be leveraged to avoid making unnecessary errors or assumptions around the full employment of transgender service members during military operations [5••].

Conclusion

LGBT service members have served in the US military since its inception. Despite facing major challenges including the possibility of discharge, these service members have continued to serve their nation just as much as their heterosexual and cisgender peers have. Given their commitment to service and the defense of the USA, it is essential that research, practice, and policy strategies be examined to ensure this population receives the same support and encouragement as their non-LGBT peers while they serve in the military and enjoy the same respect and high-quality health care as veterans when they leave the military. Although the repeal of DADT was an important step toward addressing the needs of the LGBT military and veteran population, far more is needed. Identifying knowledge gaps and novel ways to serve LGBT service members and veterans is imperative. Although the needs of LGBT service members may differ from their non-LGBT peers, little data exists to guide our understanding, and much of what we know is based on retrospective studies, veteran reports, and medical record reviews. More research is needed with active duty service members, relying upon novel recruitment strategies that go outside of assessing only those seeking mental and physical health care services. The needs of transgender service members, in particular, demand special attention given the unique experiences this community faces in their interactions with health care providers and the vast disparities faced in numerous mental and physical health diagnoses.

Compliance with Ethical Standards

Conflict of Interest Jeremy T. Goldbach and Carl Andrew Castro have received a grant from the Department of Defense.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

References

Papers of particular interest, published recently, have been highlighted as:
• Of importance
•• Of major importance

1.•• Gates GJ. Discharges under the Don't Ask, Don't Tell policy: women and racial/ethnic minorities. 2010. http://williamsinstitute.law.ucla.edu/category/research/military-related/#sthash.ikBT7Fr9.dpuf. Accessed 11 Sept 2013. **Provides excellent discharge statistics on the LGBT service members**.
2. Kerrigan MF. Transgender discrimination in the military: the new Don't Ask Don't Tell. Psychol Public Policy Law. 2012;18(3):500–18.

3. United States Department of Defense. Qualification standards for enlistment, appointment, and induction. Washington, D.C.: DoD Directive 1304.26″, March 4, 1994. http://biotech.law.lsu.edu/blaw/dodd/corres/pdf/d130426wch1_122193/d130426p.pdfAccessed 11 Sept 2013.
4.• Bérubé A. Coming out under fire: the history of gay men and women in World War II. Univ of North Carolina Press; 2010. **This book provides an excellent history of lesbian and gay service members in the U.S. military**.
5.•• RAND Corporation. Sexual orientation and U.S. military personnel policy: an update of RAND's 1993 study, Santa Monica, Calif.: RAND Corporation, MG-1056-OSD. 2010. http://www.rand.org/pubs/monographs/MG1056.html. Accessed 24 December 2015. **This independent report debunks many of the arguments against LGBT civilians from serving in the military**.
6. Burks DJ. Lesbian, gay, and bisexual victimization in the military: an unintended consequence of "Don't Ask, Don't Tell"? Am Psychol. 2011;66(7):604–13.
7. Biddix JM, Fogel CI, Perry Black B. Comfort levels of active duty gay/bisexual male service members in the military healthcare system. Mil Med. 2013;178(12):1335–40. doi:10.7205/MILMED-D-13-00044.
8. U.S. Department of Veterans Affairs. VA Boston Healthcare System. 2012. http://www.boston.va.gov/services/images/LGBT_VABOSTON_POLICY_LGBT_PATIENTS.pdf. Accessed 11 Sept 2013.
9.•• Thoits PA. On merging identity theory and stress research. Soc Psychol Q. 1991;54(2):101–12. **Describes minority stress theory**.
10. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull. 2003;129:674–97.
11. Williamson IR. Internalized homophobia and health issues affecting lesbians and gay men. Health Educ Res. 2000;15:97–107.
12. Cochran SD, Mays VM. Burden of psychiatric morbidity among lesbian, gay, and bisexual individuals in the California Quality of Life Survey. J Abnorm Psychol. 2009;118:647–58.
13. Roberts AL, Austin SB, Corliss HL, Vandermorris AK, Koenen KC. Pervasive trauma exposure among U.S. sexual orientation minority adults and risk of posttraumatic stress exposure. Am J Public Health. 2010;100:2433–41.
14.• Institute of Medicine. The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding. Washington: National Academies Press; 2011. **This authoritative study identifies a responsible strategy for improving the health and wellbeing of the LGBT population**.
15. Kim H-J, Fredriksen-Goldsen KI. Hispanic lesbians and bisexual women at heightened risk of health disparities. Am J Public Health. 2012;102(1):9–15.
16. Remafedi G, French S, Story M, Resnick MD, Blum R. The relationship between suicide risk and sexual orientation: results of a population-based study. Am J Public Health. 1998;88:57–60.
17. Russell ST, Joyner K. Adolescent sexual orientation and suicide risk: evidence from a national study. Am J Public Health. 2001;91(8):1276–81.
18. Tjepkema M. Health care use among gay, lesbian and bisexual Canadians. Health Rep. 2008;19:53–64.
19. Poynten IM, Grulich AE, Templeton DJ. Sexually transmitted infections in older populations. Curr Opin Infect Dis. 2013;26(1):80–5. doi:10.1097/QCO.0b013e32835c2173.
20. Abuse S, Administration MHS. Top health issues for LGBT populations information & resource kit. HHS Publication No. (SMA) 12–4684. Substance Abuse and Mental Health Services Administration: Rockville, MD; 2012. http://store.samhsa.gov/shin/content/SMA12-4684/SMA12-4684.pdf. Accessed 11 Sept 2013.
21. Brown GR, Jones KT. Mental health and medical health disparities in 5135 transgender veterans receiving healthcare in the Veterans Health Administration: a case–control study. LGBT Health; 16 Dec 2015. doi:10.1089/lgbt.2015.0058.
22. Brown GW, Harris TO, editors. Social origins of depression: a study of psychiatric disorder in women. London: Tavistock; 1978.
23. Rosario M, Schrimshaw EW, Hunter J, Gwadz M. Gay-related stress and emotional distress among gay, lesbian and bisexual youths: a longitudinal examination. J Consult Clin Psychol. 2002;70(4):967–75.
24. Goldbach JT, Tanner-Smith EE, Bagwell M, Dunlap S. Minority stress and substance use in sexual minority adolescents: a meta-analysis. Prev Sci. 2014;15(3):350–63. doi:10.1007/s11121-013-0393-7.
25. Marshal MP, Sucato G, Stepp SD, Hipwell A, Smith HA, Friedman MS, et al. Substance use and mental health disparities among sexual minority girls: results from the Pittsburgh girls study. J Pediatr Adolesc Gynecol. 2012;25:15–8.
26. Balsam KF, Rothblum ED, Beauchaine TP. Victimization over the life span: a comparison of lesbian, gay, bisexual, and heterosexual siblings. J Consult Clin Psychol. 2005;73:477–87.
27. Tjaden P, Thoennes N, Allison CJ. Comparing violence over the life span in samples of same-sex and opposite-sex cohabitants. Violence Vict. 1999;14:413–25.
28. Alvy LM, Hughes TL, Kristjanson AF, Wilsnack SC. Sexual identity group differences in child abuse and neglect. J Interpers Violence. 2013;28:2088–111.
29. Herek GM. Hate crimes and stigma-related experiences among sexual minority adults in the United States: prevalence estimates from a national probability sample. J Interpers Violence. 2009;24:54–74.
30. Gibbs J, Goldbach JT. Religious conflict, sexual identity, and suicidal behaviors among sexual minority youth. Arch Suicide Res. 2015;19(4):472–88. doi:10.1080/13811118.2015.1004476.
31. Cochran BN, Balsam K, Flentje A, Malte CA, Simpson T. Mental health characteristics of sexual minority veterans. J Homosex. 2013;60:419–35. doi:10.1080/00918369.2013.744932.
32. Kemp J, Bossarte RM. Surveillance of suicide and suicide attempts among veterans: addressing a national imperative. Am J Public Health. 2012;102 Suppl 1:e4–5.
33. Kemp J, Bossarte R. Suicide data report, 2012. Department of Veterans Affairs, Mental Health Services/Suicide Prevention Program; 2012b.
34. United States Department of Defense. The challenge and the promise strengthening the force, preventing suicide and saving lives. Final Report of the Department of Defense Task Force on the Prevention of Suicide of Suicide by Members of the Armed Forces; 2010. http://www.sprc.org/sites/sprc.org/files/library/2010-08_Prevention-of-Suicide-Armed-Forces.pdf. Accessed 10 Feb 2016.
35. Matarazzo BB, Barnes SM, Pease JL, Russell LM, Hanson JE, Soberay KA, et al. Suicide risk among lesbian, gay, bisexual, and transgender military personnel and veterans: what does the literature tell us? Suicide Life Threat Behav. 2014;44:200–17. doi:10.1111/sltb.12073.
36. Garofalo R, Wolf RC, Wissow LS, Woods ER, Goodman E. Sexual orientation and risk of suicide attempts among a representative sample of youth. Arch Pediatr Adolesc Med. 1999;153(5):487–93.
37.• King M, Semlyen J, Tai SS, Killaspy H, Osborn D, Popelyuk D, et al. A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay, and bisexual people. BMC Psychiatry. 2008;8:70. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2533652/. Accessed 10 Feb 2016. **This paper reviews the current literature on self-harm and suicide among the LGB population**.
38. Blosnich JR, Mays VM, Cochran SD. Suicidality among veterans: implications of sexual minority status. Am J Public Health. 2014;104 Suppl 4:S535–7. doi:10.2105/AJPH.2014.302100.

39. United States Department of Defense. Task force on the future of military health care: final report; 2007. http://www.naus.org/wp-content/uploads/2015/07/MilHealthCare TaskForceFINALREPORT12-07.pdf.pdf. Accessed 20 May 2008.
40. Katz KA. Health hazards of "don't ask, don't tell.". N Engl J Med. 2010;363:2380–1.
41. Smith DM. Active duty military personnel presenting for care at a gay men's health clinic. J Homosex. 2008;54(3):277–9.
42. Seaver MR, Freund KM, Wright LM, Tjia J, Frayne SM. Healthcare preferences among lesbians: a focus group analysis. J Womens Health (Larchmt). 2008;17(2):215–25. doi:10.1089/jwh.2007.0083.
43. Biddix JM, Fogel CI, Black BP. Comfort levels of active duty gay/bisexual male service members in the military healthcare system. Mil Med. 2013;178:1335–40.
44. Mattocks K. Viewpoints: Kristin M. Mattocks, Patient 'wait times' a wider problem than VA hospital in Northampton. Daily Hampshire Gazette; 2014. http://www.gazettenet.com/home/12410323-95/kristin-m-mattocks-patient-wait-times-a-wider-problem-than-va-hospital-in-northampton. Accessed 11 Feb 2016.
45. Office of the Under Secretary of Defense (Personnel and Readiness). Review of the effectiveness of the application and enforcement of the Department's policy on homosexual conduct in the military. (13 pp.) Department of Defense; 1998.
46. Gade DM. Where did you serve? Veteran identity, representative bureaucracy, and vocational rehabilitation. J Public Admin Res Theory. 2012;23:267.
47. Yerke AF, Mitchell V. Transgender people in the military: don't ask? don't tell? don't enlist! J Homosex. 2013;60(2–3):436–57. doi:10.1080/00918369.2013.744933.
48. Bowling UB, Sherman MD. (2008). Welcoming them home: supporting service members and their families in navigating the tasks of reintegration. Prof Psychol Res Pract. 2008;39(4):451–8.
49. Witten TM. Gender identity and the military: transgender, transsexual, and intersex-identified individuals in the U.S. armed forces. 2007. http://www.palmcenter.org/files/active/0/TransMilitary2007.pdf. Accessed 11 Feb 2016.
50. Devor H. Witnessing and mirroring: a fourteen stage model of transsexual identity formation. J Gay Lesbian Psychotherapy. 2004;8:41–67.
51. Mosher DL, Sirkin M. Measuring a macho personality constellation. J Res Personality. 1984;18(2):150–63.
52. Frye PR. Transgendered Vet. Breaking the silence…Grethe Cammermeyer. 2004. http://www.cammermeyer.com/board.htm?step= thread&threadid = 244. Accessed 11 Feb 2016.
53. McDuffie E, Brown GR. Seventy U.S. veterans with gender identity disturbances: a descriptive study. Int J Transgend. 2010;12:21–30.
54. Shipherd JC, Maguen S, Skidmore WC, Abramovitz SM. Potentially traumatic events in a transgender sample: frequency and associated symptoms. Traumatology. 2011;17(2):56–67.
55. Gates GJ, Herman JL. Transgender military service in the United States. UCLA School of Law: Williams Institute; 2014.
56. Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. Injustice at every turn: a report of the National Transgender Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force; 2011.
57. Bryant K, Schilt K. Transgender people in the U.S. military: summary and analysis of the 2008 Transgender American Veterans Association survey. Palm Center Blueprints for Sound Public Policy; 2008. http://www.palmcenter.org/files/TGPeopleUSMilitary.pdf. Accessed 11 Feb 2016
58.•• Brown George R. and Jones Kenneth T. LGBT Health. December 2015 doi:10.1089/lgbt.2015.0058. **This study provides key health concerns involving LGBT people**.
59. Lombardi E. Enhancing transgender health care. Am J Public Health. 2001;91(6):869–72. doi:10.2105/AJPH.91.6.869.
60. Stalsburg BL. After repeal: LGBT service members and veterans the facts. 2011. http://www.servicewomen.org/wp-content/uploads/./LGBT-Fact-Sheet-091411.pdf. Accessed 11 Feb 2016.
61. Bliese PD, Castro CA. Role clarity, work overload and organizational support: multilevel evidence of the importance of support. Work Stress. 2000;14:65–73.
62. Castro CA, McGurk D. The intensity of combat and behavioral health status. Traumatology. 2007;13:6–23.
63. Wong L, Kolditz TA, Millen RA, Potter TM. Why they fight: combat motivation in the Iraq war. Strategic Studies Institute, U.S. Army War College: Carlisle, PA; 2003.
64. Kaplan D, Rosenmann A. Unit social cohesion in the Israeli military as a case study of "Don't Ask, Don't Tell". Political Psychology. 2012;33:419–36. doi:10.1111/j.1467-9221.2012.00914.xpo.
65.•• Moradi B. Sexual orientation disclosure, concealment, harassment and military cohesion: perceptions of LGBT former service members. Mil Psychol. 2009;21:513–33. **This study represents a foundational study for what life is like in the military from the perspective of LGBT veterans**.
66. Department of Defense. Anti-harassment action plan. Washington: Author; 2000.
67. Bowling K, Firestone JM, Harris RJ. Analyzing questions that cannot be asked of respondents who cannot respond. Armed Forces & Society. 2005;31(4):411–437.
68. Castro CA, Kintzle S, Schuyler AC, Lucas CL, Warner CH. Sexual assault in the military. Curr Psychiatry Rep. 2015;17:54. doi:10.1007/s11920-015-0596-7.
69. Turchik JA, Wilson SM. Sexual assault in the U. S military: a review of the literature and recommendations for the future. J Aggress Violent Behav. 2010;15:267–77.