20 Lesbian, Gay, Bisexual, and Transgender Service Members: Clinical Practice Considerations

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At the time this chapter is being written, we are at the very center of revolutionary advances for sexual and gender minorities serving in the US Armed Forces. Even before these recent advances in military policy to allow open service by sexual and gender minorities, they have served shoulder-to-shoulder with their heterosexual and cisgender (persons whose self-identity conforms with their biological sex) counterparts in every branch (Pollock & Minter, 2014; Shilts, 1993). With these changes come unprecedented opportunities and challenges for those who provide healthcare in our dynamic military environment. The opportunities and challenges explored in this chapter will focus primarily on those for behavioral health providers given recent changes concerning military service members who identify as lesbian, gay, bisexual, or transgender (LGBT).

This chapter strives to advance the understanding and capabilities of those providing behavioral healthcare to LGBT service members at both individual and population levels. A historical review of sexual and gender minorities in the military will give a contextual backdrop, followed by a brief review of relevant research and theory as it relates to behavioral healthcare practices with LGBT service members. Extending from this is a discussion of the relevance of behavioral healthcare for LGBT service members beyond the military. Lastly, the discussion will highlight possible future directions in research and behavioral healthcare.

In considering groups of sexual and gender minorities, one must acknowledge that individuals who identify as LGBT are not a homogenous group. Worldwide advances for lesbian, gay, and bisexual persons have progressed more quickly than for transgender persons, including the US military. Transgendered persons represent a smaller demographic whose experiences are separate and unique from sexual minorities, but have in the past been lumped in with sexual minorities resulting is less awareness and social advances for gender minorities. As such, it is important to validate the relative dearth of research and data on gender minority service members compared to those who identify as sexual minorities. Where available, we have drawn on prior work with transgender individuals. Our hope is that this apparent deficiency will inspire future research and practice as advances continue.

Estimates of the number of LGBT individuals serving in the US Armed Forces have been difficult to obtain. These were not demographics

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officially surveyed through the Department of Defense (DoD) until recently. Further, there is likely still reluctance on the part of many service members to disclose their sexual orientation or gender identity. Best estimates suggest rates of LGBT individuals in the military are comparable to civilians in the same age range. An estimated 2.2% of the military population (Gates, 2010) and 3.3% of the civilian population self-identify as LGB (Ward, Dahlhamer, Galinsky, & Joestl, 2014). Estimates of the number of transgender service members are also suggested to be representative of the broader civilian population (about 0.3%), where the definition of transgender typically used is discordance with the gender assigned at birth (Gates, 2014). Some estimates suggest that 15,500 DoD service members identify as transgender and are relatively more likely to volunteer for service in the Armed Forces compared to cisgender individuals. Transgender members assigned female at birth are about three times more likely compared to adult women to serve, and those assigned male at birth are 1.6 times more likely compared to all adult men to serve (Gates & Herman, 2014).

The landmark changes in DoD policy affecting LGBT service members mark a movement toward an even stronger military (DoD, 2012). Increasing evidence points to the strength of organizations requiring full employment of the skills, abilities, opinions, and perspectives of a diverse workforce (Fassinger, 2008). As one of the federal government's largest employers, the military has a unique opportunity with recent policy changes to further foster diversity and inclusion. Past experience suggests that increased cohesion and innovation along with new ideas and approaches with the inclusion of LGBT service members will follow. However, if inclusion occurs only at the policy or individual level and not at the organizational level, the benefits will not be realized, and underutilized LGBT service members will seek other career opportunities (Blustein, 2008; Johnson, Rosenstein, Buhrke, & Haldeman, 2015).

Prior to recent policy changes, behavioral health providers were faced with various ethical and legal obstacles in providing efficacious and ethical care to LGBT service members (Johnson & Buhrke, 2006). Providers attempted to manage these obstacles while avoiding harming patients, but providing evidenced-based affirmative care to LGBT service members was not a requirement or even a discussion in most healthcare settings. One concern that cannot be ignored is that, after such longstanding exclusion of LGBT service members, military healthcare providers lack the recent experience and the cultural competence to provide evidenced-based behavioral healthcare to sexual and gender minorities (Johnson et al., 2015; Shipherd, 2015). Broadly speaking, in healthcare there is inadequate discussion and limited cultural competence regarding sexual orientation and gender identity (Petroll & Mosack, 2011; Sherman, Kauth, Shipherd, & Street, 2014; St. Pierre, 2012) despite recommendations from the Joint Commission (2011) and the National Academy of Medicine (formerly the Institute of Medicine [IOM], 2011) that sexual and gender identities be a part of healthcare encounters with all patients given their known impact on health outcomes.

Sherman et al. (2014), found in the Veterans Health Administration (VHA) about two-thirds of gender and sexual minorities reported having never been asked by a provider about sexual orientation and only about one quarter indicated experiencing the VHA as welcoming to LGBT veterans. A potential driver of this lack of discussion could be limited awareness that both sexual orientation and gender identity can have negative impacts on not just mental health (Cochran, Balsam, Flentje, Malte, & Simpson, 2013; Grella, Greenwell, Mays, & Cochran, 2009; Mollon, 2012) but health overall (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; IOM, 2011; Mayer et al., 2008; Ward et al., 2014). This is a topic that needs continued discussion and efforts to create a shift in the culture of not just the US military medicine, but medical and military culture as a whole.

The ending of the military's prohibition of both sexual and gender minorities from serving openly in the US military did not come with clear expectations for how such foundational changes would impact service members, military culture,

or the behavioral health providers working in these settings. Currently, there are more questions than answers regarding how best to address this population in the military from a behavioral health perspective. The changes are exciting and rapid as we continue our efforts to catch up with policy changes and more importantly meet the unique needs of LGBT service members. It is helpful as we begin this discussion to have some knowledge of the history leading up to increased inclusion.

Historical Background

The American LGBT Timeline

To understand the current US military policies regarding LGBT service members and the role of behavioral healthcare for these individuals, first it is important to understand the microcosm of the military culture within the broader context of American LGBT history. The struggle for civil rights for LGBT persons is relatively new, formally tied to a several-day riot starting on June 28, 1969. The setting was the Chelsea District of New York City, and a small bar that catered to LGBT individuals in particular, the Stonewall Inn. After periodic police raids perceived as targeted harassment, the patrons and the larger LGBT community took to the streets, eventually leading to annual celebrations of "Pride," traditionally held around the country in June to honor the leaders at Stonewall (Carter, 2004). To commemorate this seminal moment and the historic site, the Stonewall Inn and the adjacent park was designated a national monument in 2016 (Rosenberg, 2016). Stonewall followed years of subversive and blatant discrimination, such as the McCarthy-era of the 1950s and 60s. During this time, individuals suspected of practicing homosexuality, among other "social deviates," were included in the social repression, and civil servants were purged from government service (Johnson, 2006). The mental health community conformed to the times and offered aversive change efforts in an attempt to undo the effects of homosexuality by use of hormone therapy, aversive conditioning, electroconvulsive therapy (ECT), emetics, and institutionalization along with other more general treatments such as psychoanalysis and psychotherapy (American Psychological Association, 2009). In 1956, a breakthrough psychological study was presented at the American Psychological Association Convention in Chicago in which Dr. Evelyn Hooker offered data based on projective testing with a nonclinical sample of gay men using heterosexual controls showing no higher rate of psychopathology in the gay male sample (Milar, 2011). The depathologizing of homosexuality was placed into diagnostic nomenclature in 1973 when the diagnosis of homosexuality was removed from the Diagnostic and Statistical Manual (DSM) and replaced with Ego Dystonic Homosexuality. The implication of this change was that homosexuality itself was not pathological, but rather the emotional distress that may be associated with this sexual orientation should become the focus (American Psychiatric Association, 1974). The American Psychological Association (APA) passed a resolution in 1975 endorsing the DSM diagnostic change, as well as calling for an end to societal stigma for homosexuals, and instituting an APA antidiscrimination policy (Conger, 1975). Since that time, the APA has been on the forefront of promoting social science data to advance the behavioral health of LGBT persons.

In 1979, the internationally accepted authority on transgender health, the Harry Benjamin Society International Gender Dysphoria Association, later renamed the World Professional Association for Transgender Health (WPATH), instituted its first standards of care for medical and mental healthcare of patients who identify as transgender. Currently, we are working with the seventh iteration of such standards for treating transgender and gender nonconforming patients. WPATH adopted a formal statement depathologizing gender nonconforming expressions and identities in 2010 and published the following: "The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse phenomenon [that] should

not be judged as inherently pathological or negative" (World Professional Association for Transgender Health [WPATH], 2010). In 2013, with publication of its fifth version of the DSM, Gender Identity Disorder was replaced with Gender Dysphoria (American Psychiatric Association, 2013). This change was designed to depathologize persons who held a discordant gender identity from the gender assigned at birth. Instead, the new diagnosis was a recognition that transgender individuals may suffer from psychological distress because of this disparity between identity and assigned gender. While some transgender activists lobbied to strike any diagnostic label, others felt the need to retain a diagnostic label that would allow for a diagnostic code to be eligible for insurance reimbursement purposes.

The mounting progress for LGBT persons was not without opposition and setbacks. LGBT civil rights was struck a blow when Congress passed and President Clinton signed into law the Defense of Marriage Act (DOMA) in 1996, which, in part, defined marriage as the union of a man and a woman (US Congress, 1996). The law was designed to curtail any future federal attempts to promote marriage equality for same-sex couples. Subsequently, several states passed civil union laws, fewer recognized same sex marriages, and most passed State constitutional amendments restricting marriage to heterosexual couples. It was not until the Supreme Court's ruling on June 26, 2015, following nearly 20 years of differential rights granted to same-sex couples that same-sex marriage was legalized nationally. In his majority opinion, Justice Anthony Kennedy wrote, "Their hope is not to be condemned to live in loneliness, excluded from one of civilization's oldest institutions. They ask for equal dignity in the eyes of the law. The Constitution grants them that right" (US Supreme Court, 2015).

The American Military and LGBT Service Members

Reflecting prevailing American culture, the military has formally discriminated against LGBT service members until recently. There is documentation as early as 1778 that a member of the Continental Army was dismissed for sodomy (US Naval Institute, 2016). Articles of War, the Manual for Courts Martial, and (DoD) regulations have formulated procedures for dismissal of LGBT Service Members (Fitzpatrick, 1931). From 1959 to 1982, DoD directives barred homosexuals from military service (US Naval Institute, 2016). In the early 1990s, Congress intended to pass a legislation to reiterate the banning of military service by homosexuals. President Clinton proposed a compromise, commonly called "Don't Ask Don't Tell (DADT)." Passed in 1994, US Code Title 10 sec 654 allowed gay and lesbian service members to remain in the military as long as their sexual orientation was not divulged and brought to the attention of commanders who could process administration separation (US Congress, 1993). Contrary to the intent of the legislation designed to make it easier for lesbian and gay soldiers to serve, there were approximately 1800 soldiers discharged per year for a total of 14,500 discharges over the 8 years DADT was enforced (General Accounting Office, 1992). Transgender service members have been banned from military service according to Army Regulation 40-501 Standards of Medical Fitness 3-35, 2007 and DoD Instruction 6130.03, 2010. Lumped in with a host of disqualifying medical and behavioral health conditions such as personality disorders, factitious disorders, and impulse control disorders, service members diagnosed with a range of "psychosexual conditions" relevant to gender identity could be administratively discharged. This precluded these service members' ability to have their case go before a medical board to assess their fitness for duty and may have had the effect of denying benefits such as eligibility for medical care within the VA system upon discharge. With the revocation of DADT (United States Congress, 2010) open service by LGB service members was ushered in. Since 2013, following President Obama's proclamation recognizing June as Pride Month, the DoD has officially been recognizing this event. Preceding this proclamation, the DoD hosted a panel discussion in June 2012 honoring Gay Pride entitled, "The value of open service and diversity." As of June 30, 2016 the Secretary of Defense has announced a new DoD policy, which will allow transgender individuals to openly serve in the Armed Forces (Carter, 2016b). A phase-in

period over 12 months has been projected which will define policies and offer guidance for commanders relative to dress and grooming standards, eligibility for gender transition medical services, and the ability to change official gender markers in the Defense Enrollment Eligibility Reporting System (DEERS), among other policies (Carter, 2016a). The need for continued discussion regarding sexual and gender minorities does not end with policy changes—it is only the beginning.

Relevant Theory and Research Guiding Behavioral Health Practice

Military service members who identify as LGBT have the same challenges and considerations as civilians in any career field, but also face additional barriers. Like other minority groups subjected to discrimination and victimization, gender and sexual minorities whether civilian or service members experience higher rates of mental health issues (Institute of Medicine, 2011; Mollon, 2012; Quinn et al., 2015). In the military health system, even prior to the repeal of DADT, LGBT service members actively sought behavioral health treatment. As policies continue to progress, thereby increasing avenues for retention and recruitment of well-qualified potential personnel who identify as LGBT, behavioral health providers for the military are likely to see growing rates of LGBT service members seeking treatment. To fully explore each multifaceted area would be impossible within the constraints of this chapter. Highlighted are some relevant clinical concerns (e.g., identity development, the mental health of LGBT service members, and brief discussion related to providing care for transgender service members), as well as use of the Stress Minority Model as a way to better conceptualize the unique experiences of these individuals.

Clinical Considerations

Affirmative Approach The framework recommended for behavioral healthcare of LGBT persons is an affirmative and culturally competent approach (American Psychological Association [APA], 2012, 2015; Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2010, 2013) with the full range of evidence-based practices applied based on a patient's presenting problem and unique needs. All aspects of behavioral healthcare from intake to intervention should occur within an affirmative framework that fosters collaboration, respects autonomy, and choice using a social justice and strengths-based approach (Amadio & Perez, 2008). There are various definitions of affirmative psychotherapy, as operationalized in this chapter it refers to the knowledge, awareness, and skills to address the unique needs of LGBT service members and facilitate coping in a nonaffirming environment using a patient-centered strengths-based approach during all aspects of the clinical encounters. An affirmative approach views variations in both sexual orientation and gender identity as normal and celebrates and advocates for the authentic expression of identity and relationships not just in the individual encounter but also through social justice and advocacy (Amadio & Perez, 2008; Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Heck, Flentje, & Cochran, 2013). Providers are functioning in a heterocentric society with various covert and overt homophobic (Morrow, 2000) and transphobic beliefs and attitudes (Austin & Craig, 2015). This cultural context, along with graduate training that may lag in affirmative attitudes (Pachankis & Goldfried, 2004), creates inherent challenges for behavioral health providers and the patients they evaluate and treat.

An essential foundational element of affirmative practice is examination of one's own sexual and gender identity as well as beliefs and biases related to sexual and gender variations (APA, 2012, 2015; ALGBTIC, 2013; Burnes et al., 2010; Heck et al., 2013; Sue & Sue, 2016). There are various self-assessment tools providers can use to guide self-examination and self-awareness. One must utilize personal awareness as a foundation for professional awareness and skill building. Dillon and Worthington (2003) developed the Lesbian, Gay, Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI)

to measure providers' LGB-affirmative care. The measure looks at advocacy skills, application of knowledge and assessment of unique LGB issues, awareness of one's own attitudes, and building a relationship alliance with LGB patients. As an aspect of ethical and professional practice, behavioral health providers must remember that a component of self-awareness is making appropriate referrals when the limits of his or her experience and training preclude competent service delivery (APA, 2012, 2015; ALGBTIC, 2013; Burnes et al., 2010; Lasser & Gottlieb, 2004).

Increased Suicide Risk In addition to considerations of identity development and coming out, behavioral health providers working with LGBT service members must acknowledge LGBT persons' higher risk of suicide and negative mental health outcomes. The entire military cadre has struggled with an increase in suicide rates since 2005 (DoD, 2011) (See also Ghahramanlou-Holloway et al., Chap. 6, this volume). The DoD has invested resources to understand factors related to self-injurious thoughts and behaviors (SITB), but there has been little attention directed to sexual orientation and gender identity as a possible risk factor. Research with civilian sexual minorities suggests that sexual minority adults are twice as likely as their heterosexual peers to attempt suicide (Bolton & Sareen, 2011; King et al., 2008). The suicide attempt rates for gender minorities suggested by the National Transgender Discrimination Survey (NTDS) are significantly higher (41%) than the general population (1.6%) (Grant et al., 2010). Evidence suggests for veterans in the VHA with gender identity disorder in 2000–2011 had a risk for suicide-related events that was 20 times higher than for the general VA veteran population (Blosnich et al., 2013). In a review of research related to suicide risk in LGBT service members and veterans, Matarazzo et al. (2014) found only one study (Blosnich, Bossarte, & Silenzio, 2012) specific to risk factors for suicide with military members that pointed to decreased support and increased victimization as contributing to increased risk. Given the limited research, they focused on factors in the general LGBT population that could increase risk for LGBT service members such as minority status, substance use disorders, mental health issues, and traumatic experiences. These risk factors are elevated for both gender and sexual minorities (King et al., 2008; Haas et al., 2010).

In a more recent study, Ray-Sannured, Bryan, Perry, and Bryan (2015) looked at a sample of veterans and service members who were sexual minorities with trauma exposure, emotional distress, and a history of SITB. They found those sexual minorities reported more severe depression, posttraumatic stress, and trauma exposure than military personnel who reported only other-sex partners. They also reported higher SITB and suggested this may be due to higher levels of trauma exposure and emotional distress. Awareness of increased suicide risk as well as assessment on initial contact and supplemental assessment for LGBT service members is clinically indicated (Porter & Gutierrez, 2013). Haas et al. (2010) among others, point to the importance of managing behavioral health issues that are typically increased in LGBT individuals as well as increasing advocacy efforts aimed at decreasing violence and discrimination that may contribute to these risks. Other studies provide further evidence of an increased prevalence of negative mental health outcomes for LGBT persons compared to their heterosexual counterparts (e.g., Cochran et al., 2013; Meyer, 2003).

Identity Development for LGBT Service Members

Identity development is a crucial stage between the ages of 17 and 24 (the typical age a service member may enter the military) and, for some, military service may be seen as a rite of passage to becoming an adult. During this phase of life, many individuals begin to gain personal insight into their gender identity and relational affections. These tendencies may have increased to more noticeable levels, and for many, this is their first time experiencing increased independence and freedom to express variations in identity and romantic attractions (Porter & Guiterrez, 2013). For LGBT service members, identity development

may be negatively impacted by overarching military norms associated with heterosexism, cisgenderism, and a traditionally masculinized culture (Allsep, 2013).

Behavioral health providers need to take into account the service member's developmental stage based on traditional lifespan trajectory, as well as with respect to sexual orientation and gender identity. There are different models of identity development for sexual minorities (e.g., Cass, 1979; Coleman, 1981/1982; Grace, 1992; Troiden, 1979), and much less research on gender nonconforming identity models (e.g., Devor, 2004; Gagné, Tewksbury, & McGaughey, 1997; Lev, 2004; Pollock & Eyre, 2012). While these models are helpful, the affirmative approach emphasizes that the experience, pace, and trajectory of the process is unique to each individual. Providers should meet the service member where they are in their identity development and offer interventions appropriate to their development stage and unique needs (Ritter & Terndrup, 2002; Hidalgo et al., 2013) while affirming them as a competent military member (Johnson et al., 2015).

An important aspect of identity development with respect to LGBT persons is the process of "coming out." Despite the changes in policies toward inclusion, this process still has unique challenges for LGBT persons in the military. On the whole, sexual orientation disclosure is associated with positive outcomes, and sexual concealment is associated with negative outcomes (Fassinger, 2008). However, providers should be aware that coming out at work is not always a positive experience and could disrupt relationships, create hostility, and limit career progression and opportunities (APA, 2012; Croteau, Bieschke, Fassinger, & Manning, 2008). For the LGBT service member (SM) in particular, disclosure has historically been associated with negative outcomes (e.g., administrative separation and/or dishonorable discharge). More recently, research suggests that LGBT individuals use both concealment and disclosure to cope with stigma and providers should not view them as all-or-nothing (Porter & Gutierrez, 2013), but as more of a continuum (Moradi, 2009).

The Military Partners and Family Coalition surveyed sexual minorities and found that 55% indicated that, despite the repeal of DADT, they continued to perceive that coming out would put them or their families at risk for negative reactions in the military (Gleason et al., 2012). Johnson et al. (2015) recommends providers working with LGBT individuals recognize that an important task for some service members is making an informed decision about when it is safe or unsafe to come out. The conversation to conceal or disclose should be led by the LGBTSM and should be collaborative and affirming and not be viewed as a determinant of psychological health (APA, 2012, 2015; ALGBTIC, 2013; Burnes et al., 2010; Johnson et al., 2015; Pinto & Moleiro, 2015; Porter & Gutierrez, 2013).

It is not uncommon during periods of identity development and coming out for individuals to experience conflicting emotions including distress, especially given the possible cultural and social challenges. Population data suggests an increased incidence of behavioral health concerns such as depression, obesity, substance abuse, anxiety, and posttraumatic stress disorder (PTSD) in LGBT individuals (Bostwick, Boyd, Hughes, & McCabe, 2010). Cochran et al. (2013) examined behavioral health characteristics of LGBT veterans compared to an existing VA sample and found significantly higher rates of depression, PTSD, and alcohol problems for LGBT persons. However, this distress does not suggest that minority identity is causal and that "reparative" or sexual orientation change efforts (SOCE) are indicated. The APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009) found no convincing evidence that SOCE are effective, especially in the long term. Further, research points to increased psychological well-being when individuals are able to integrate sexual (Levitt et al., 2009) and gender orientation into their identity (Kosciw, Palmer, & Kull, 2015). Research suggests those individuals who seek treatment based on SOCE typically do so based on individual factors such as religious beliefs, fear of implications, pressure from family, and community rejection of minorities (Glassgold, 2008). Given the evidence, the APA

(2009, 2012) suggests an affirmative approach to intervening with service members struggling with desire to change sexual orientation. This approach is described in detail in the APA Task Force report (2009). The components include: acceptance with a client-centered approach, comprehensive assessment that examines all the factors creating distress, and using these factors to inform treatment. Additionally, the affirmative approach requires helping patients develop active coping to manage distress using multiple evidence-based treatments such as cognitive behavioral therapy, mindfulness, dialectical behavior therapy, acceptance and commitment therapy, and religious strategies (APA Task Force, 2009).

Minority Stress Theory

One theoretical framework that has been suggested to help providers conceptualize the experiences of gender and sexual minorities is Meyer's (2003) Minority Stress Theory. The model was initially developed to describe stress in sexual minorities but, as Hendricks and Testa (2012) mention, a majority of the unique stressors experienced by sexual minority individuals are also experienced by gender minorities. Taken together, this theory postulates that LGBT individuals, as members of an oppressed social group, are stigmatized to such a degree that they experience excess stress and negative life events, which in turn can cause or exacerbate behavioral health problems. This model informed Marshal et al.'s (2011) minority stress theory, which hypothesizes that members of sexual and gender minority groups experience chronic stress resulting in part from prejudicial encounters, which contributes to an increase in behavioral health concerns such as suicide, depression, and substance use disorders (Mollon, 2012). This type of stress is unique to marginalized populations (Meyer, 2003) and is perpetuated by a conflict between an individual's self-expectations and the expectations of their social, cultural, and political environments. For LGBT service members, exposure to a heterocentric environment, heterosexist and transphobic stereotypes, microaggressions, limited social support, increased victimization, and discrimination lead to pervasive experiences of minority stress that may contribute to the development of mental health concerns (Balsam, Rothblum, & Beauchaine, 2005; Grant et al., 2010; Quinn et al., 2015).

Research

While the prevalence of LGBT service members' experiences with discrimination and victimization is not known, empirical data support the existence of these stressors in the broader LGBT population. For example, Herek, Gillis, and Cogan (2009) found that approximately 20% of sexual minority women and 25% of sexual minority men reported they had been victims of an attempted or executed sexual orientation-based hate crime, which could include vandalism, robbery, and physical or sexual assault. Mays and Cochran (2001) found that a majority of LGB participants reported having experienced discrimination in some form. Drawing from LGBT individuals' experiences with their families, 34% of gay or bisexual men (Szymanski, 2009) and 36% of lesbian or bisexual women (Szymanski & Henrichs-Beck, 2014) reported being rejected by family members because of their sexual orientation. Further, 49% of men and 48% of women reported being treated unfairly by their family due to their sexual orientation, and 52% of men and 51% of women reported hearing antigay remarks from family members recently. Estimates of discrimination and victimization for transgender people are likely higher than for LGB people (Grant et al., 2010; Grossman & D'Augelli, 2007; Mizock & Lewis, 2008; Nuttbrock et al., 2010). Results from the National Transgender Discrimination Survey (NTDS) indicate that 53% of transgender people report being verbally harassed in a public place (Grant et al., 2010). Such discrimination begins early, as youth that express a transgender identity or gender nonconformity during Grades K–12 report quite high rates of harassment (78%), physical assault (35%), and sexual violence (12%) (Grant

et al., 2010). Thirty-one percent of transgender people report a moderate level of family rejection, and 14% report a high level of family rejection (Grant et al., 2010).

One of the most often studied mental health diagnoses of active duty military personnel is PTSD. While experiences of discrimination or victimization as an LGBT person may or may not meet criteria for PTSD, researchers have contributed to the discussion of a variety of experiences that culminate in a similar symptom picture. Insidious Trauma Theory (Root, 1992), posits that daily experiences of blatant and subtle oppression build up over time to produce trauma, which may culminate in posttraumatic symptoms. While these events on their own may not be considered traumatic, the effects of these events can be severe enough to bring on PTSD symptoms. Neisen (1993) and Balsam (2003) both conceptualized heterosexism, in its broadest form, as an ongoing traumatic exposure that can have an impact on behavioral health. Providing support for a variety of degrees of oppression contributing to similar symptomology, Bandermann and Szymanski (2014) found that sexual orientation-based hate crime victimization and heterosexist discrimination both had direct and unique links to PTSD symptoms.

Behavioral health providers working with LGBT service members should keep in mind that, while policies have created inclusion, these policies are functioning within a culture with conservative gender norms, heterosexism, and sexual stigma (Burks, 2011; Fassinger, 2008; Johnson et al., 2015). Given the barriers to surveying LGBT service members prior to recent policy changes, it is difficult to determine rates of harassment and victimization they may experience. However, some evidence suggests that military rates are similar to civilian rates (Moradi, 2006). Burks (2011) warns that with increased inclusion, victimization of LGBT service members may actually increase related to increased visibility among other factors. In the general population, hate-based crimes toward sexual and gender minorities are increasing (Ciarlante & Fountain, 2010; Shipherd, Mizock, Maguen, & Green, 2011), and given previous evidence of similar rates in the civilian sector and military (Moradi, 2006), the military will likely follow similar trends for increased harassment and victimization. Evidence suggests that the presence of open LGBT service members may actually heighten discrimination (Burks, 2011). Openly serving sexual and gender minorities in the DoD may suffer exclusion, decreased access to advancement, and underutilization of talents (APA, 2012, 2015; Fassinger, 2008) resulting in a range of outcomes including decreased job satisfaction, withdrawal, lowered commitment to the military, diminished self-efficacy, various costs to personal health, and even vicarious traumatization for concealed members (Burks, 2011; Croteau et al., 2008). The clinical outcomes of such victimization often include guilt and self-blame—including intensification of internalized sexual stigma (Herek & Garnets, 2007), and a range of physical and psychological symptomatology including anxiety, anger, depression, and trauma syndromes. This is particularly concerning in the context of high rates of trauma exposure and posttraumatic stress disorder symptoms in the transgender community (Shipherd et al., 2011). On an institutional level, this can reinforce negative beliefs and stereotypes about minority groups by the majority and contribute to internalized social stigma for the minority, which can result in feelings of stress, fear, depression, and anxiety (Hatzenbuehler, Keyes, & Hasin, 2009; Herek, 2007; Herek et al., 2009; Rostosky, Riggle, Horne, & Miller, 2009).

Active and adaptive coping as discussed previously is not always the mainstay of LGBT victims of discrimination. Experiences with facing diversity as an LGBT person may form a predisposition toward negative coping styles, which may be the source of negative psychosocial outcomes. In the face of discrimination or other forms of heterosexism, LGBT persons may experience feelings of helplessness, powerlessness, and confusion, and may become more likely to be passive or engage in maladaptive coping (Szymanski & Henrichs-Beck, 2014; Szymanski & Obiri, 2011). One of these studies (Szymanski & Henrichs-Beck, 2014) theorized that more use of maladaptive coping strategies to deal with

heterosexism will lead to more PTSD symptoms, whereas use of adaptive coping strategies will to lead to less PTSD symptoms. Previous research on coping style's relationships with individuals' mental health indicates that maladaptive coping methods may play a larger role in the development of psychological distress than do even more adaptive coping styles in their ability to ward off such distress (e.g., Bjorck & Thurman, 2007; Nyamathi, Wayment, & Dunkel-Schetter, 1993; Utsey, Ponterotto, Reynolds, & Cancelli, 2000; Szymanski & Owens, 2009). With PTSD already being a target of much intervention with regard to assessment, diagnosis, and treatment among military behavioral health providers, it becomes incumbent upon these providers to be aware of service members' variety of experiences outside of combat trauma, such as those with discrimination that may also play a role in the development of similar symptoms.

More general negative mental health outcomes for LGBT persons have also been the focus of much research. Using Meyer's (2003) Minority Stress Theory as a foundation, Hatzenbuehler et al. (2009) attempted to explain mental health disparities that exist between LGB and heterosexual persons using a psychological mediation model. The study first found that, compared to heterosexual groups, oppression targeted to LGB persons may lead to an increase in negative coping along affective, cognitive, and interpersonal dimensions (e.g., maladaptive coping responses, hyperarousal, rumination, negative self-schemas, and lack or loss of social support) that in turn increase an individual's risk for psychopathology. Secondly, the study found that these negative coping styles play a mediating role in the relationship between external and internalized heterosexist experiences and poor mental health outcomes. Bandermann and Szymanski (2014) further provided evidence for this mediation model that specific negative coping skills (i.e., internalization, detachment, and drug and alcohol use) mediated the link between heterosexist discrimination and PTSD symptoms. As important as behavioral health providers' awareness that discrimination can lead to negative mental health outcomes like PTSD, it also is necessary for these providers to understand that the way a LGBTSM may cope with such oppression may play a role in establishing the symptoms. As such, especially with service members who may face direct oppression such as LGBT service members, behavioral health providers must be aware of not only a patient's symptoms and inciting factors, but also how they have been coping with the oppression.

Clinical Considerations Specific to Transgender Service Members

As previously discussed, the acknowledgment of the lack of homogeneity among LGBT persons is of utmost importance in facilitating treatment. This is especially true of those who identify as transgender. Sexual orientation and gender identity are mutually exclusive. Lesbian, gay, and bisexual persons have encountered more long-standing progress in their desire for social justice than have transgender individuals (for a review, see: Kerrigan, 2011; Yerke & Mitchell, 2013). Gender in the military has typically been viewed as binary such that a person born into a biological sex (natal male or female) is expected to express a gender identity as male or female. Gender identity is how a person personally identifies and gender expression is how a person expresses their gender identity to the others. Gender identity and expression can be a supercontinuum that is both fluid and multidimensional. As such, multiple areas of gender identity exist, including gender nonbinary, gender nonconforming, transgender, transsexual, gender queer, agender, bigender, gender fluid, Two-Spirit, transvestites, cross-dressers, androgynous, intersex, just to name a few (Brown & Rounsley, 1996; Israel & Tarver, 1997; Lev, 2004). The challenge of this venture is that such a vast dimension of identity makes quantitative research and the development of standardized/evidence-based practices more difficult. The strength, on the other hand, both socially and professionally, is that we have the opportunity to remind ourselves as behavioral health professionals that identity is as individual as each person and that, oftentimes, the utility of

categorical approaches is lost as it creates distance between us both interpersonally and therapeutically.

While a transgender identity is not a mental health disorder by any means, individuals who identify as transgender often face systematic barriers to meeting their goals with respect to their gender identity. As such, transgender individuals may benefit from clinical services, advocacy, and multidisciplinary consultation. Clinical psychologists, specifically, are uniquely poised to handle many of these tasks. Johnson, Shipherd, and Walton (2016), specifically with US Veterans, encourage psychologists to play an active role in the care of transgender veterans by, when appropriate, diagnosing and treating gender dysphoria (American Psychiatric Association, 2013), providing treatment for general behavioral health conditions that may otherwise be present, referring to medical services such as gender confirmation surgeries, voice modification, and cross-sex hormone therapies, serving as consultants to other providers, and acting as advocates for addressing systematic barriers and oppression. While these roles represent options for psychologists in the treatment of transgender veterans, it is important to recognize that treatment and the process of acknowledging and accepting gender identity is an individualized process. Thus, it is important not to fully prescribe what the role of the psychologist should be, but rather to highlight the multiple hats a provider may wear during an episode of care.

Austin and Craig (2015) suggest a particular set of skills and interventions that may assist behavioral health providers in facilitating therapy with transgender individuals (Transgender-Affirming Cognitive-Behavioral Therapy; TA-CBT). The team was concerned with the disconnect between the helping professions' guiding principles (APA Task Force, 2009; Burnes et al., 2010; National Association of Social Workers, 2008), as well as research indicating the importance of inclusive, nonpathologizing, and affirming care for transgender individuals (Bockting, Knudson, & Goldberg, 2006; Collazo, Austin, & Craig, 2013; Lev, 2009), as compared to the actuality of current practices with transgender individuals (Barker & Wylie, 2008; Bess & Staab, 2009). Clients have historically viewed the clinician as an adversarial gatekeeper rather than an ally or advocate (Barker & Wylie, 2008; Bess & Staab, 2009; Lev, 2009). This includes transgender veterans (Lutwak et al., 2014). Alternatively, many of the aspects of a transgender individual's care, while calling on the provider to advocate for the patient, incidentally puts the provider in a position of privilege and power. While certain protocols and suggestions for advocacy exist within the standard of care for behavioral health providers working with transgender clients (e.g., conferring an appropriate diagnosis of gender dysphoria, assessing real-life experience, and writing a letter of support), these guidelines inadvertently place clinicians in a position of power, controlling if and when clients would be given "approval" to move forward with various gender-confirming interventions (Bess & Staab, 2009; Levine, 2009). This is especially true and especially troublesome should the provider lack a trans-affirmative perspective, and may even be deleterious to the therapeutic process. All providers must thus balance the desire for advocacy with empowerment, which is a strength of TA-CBT (Austin & Craig, 2015). In addition to basic concepts of CBT, patients undergoing TA-CBT should receive an introduction to the concept of minority stress, have the therapist facilitate understanding of the effects of transphobic attitudes and behaviors on stress as well as the effect of minority stress and transphobic attitudes/behaviors on social relationships, as well as undergo direct work on developing safe, supportive, and identity-affirming social networks (Austin & Craig, 2015).

Intersectionality

Intersectionality, or having the understanding that individuals are more than the sum of each aspect of their identity, is an important concept for those in helping professions to consider when facilitating culturally competent interventions. Research suggests that intersectionality affects important aspects of risk and resilience

(e.g., McFadden, Frankowski, Flick, & Witten, 2013; Singh, 2013). For example, when looking at gender identity and racial identity, women of color who identify as transgender show some of the highest risk levels for several traumatic experiences, including sexual assault, physical crime victimization, and exposure to HIV (Grant et al., 2010). Thus, helping providers should always be cognizant of the breadth of experiences of oppression or privilege an LGBT service member may encounter as a factor of also being a person of color, part of the dominant culture, female, or some other marginalized group (Singh, 2013).

A particular area of interest for this group is the intersection of gender identity and professional identity as a past or present US service member. Though open transgender service is only recently becoming a reality, individuals who identify as transgender have long served in many countries' Armed Forces. In fact, research suggests that transgender people may be especially interested in the military (e.g., Yerke & Mitchell, 2013). At least part of this focus may be the military's emphasis on traditional masculine values (Brown, 1988), and though it may be easy to envision this process for males who identify as transgender, having been assigned female at birth (female-to-male [FTM] individuals), evidence of a similar effect can be found in a variety of transgender individuals, irrespective of their sex assigned at birth. In fact, helping providers with military and veteran populations report higher rates of working with women who identify as transgender, having been assigned male at birth (male-to-female [MTF] individuals; Brown, 1988; Brown & Rounsley, 1996). For FTM individuals, the military's focus on traditional masculinity/hypermasculinity may represent the gender identity developmental stages that include sublimation, or an adaptive expression of one's desired gender identity (McDuffie & Brown, 2010). The hypermasculinity of the military may also appeal to MTF (male-to-female) individuals, given it could represent oppression of the female gender identity or expression and recognizes identity confusion as a stage in transgender identity development which may include attempts to repress questions about one's gender identity. This identity confusion may include attempts to repress questions about one's gender identity. Joining the military is one way that such people can attempt to become "real men" (Brown, 1988). Military personnel, regardless of gender identity, sex assigned at birth, or sexual orientation, are reinforced for displaying masculinity. Prior to transition, female individuals who identify as male may find solace in military service since they are able to express gender behaviors consistent with their gender identity (Frye, 2004). Further, as an individual begins to explore the prospect of transitioning, the military may represent a safe place to engage in at least a partial transition (Yerke & Mitchell, 2013).

For MTF individuals, the desire to serve in the military may arise from an earlier stage of gender identity development. Such theories often include identity confusion stages of development involving attempts to repress a transgender identity or questioning as to gender identity (Devor, 2004; Shipherd, et al., 2011). During such stages, women who identify as transgender, having been assigned male at birth, may attempt to confirm their maleness (Brown, 1988) by engaging in activities that are viewed as masculine or hypermasculine in traditional gender roles. These activities may be associated with danger, excitement, and violence (Mosher & Sirkin, 1984), and the public perception of the military certainly exhibits all of these qualities. This process may be conscious or unconscious, and as such an individual may not gain this insight until long after enlisting or commissioning (McDuffie & Brown, 2010).

Some suggest in relationship to gender identity development that some transgender service members may pursue military service early in the stages of gender identity in an effort to repress experienced gender identity. It is suggested that this may be appealing given the traditional binary gender standards of military uniform and traditional masculine culture of the military. Others have suggested shame and self-loathing may cause an individual to pursue the perceived risks associated with active duty military service, especially those more dangerous parts of the

military (Brown, 1988; Brown & Rounsley, 1996). Such risk-seeking behavior may be seen as passive suicidal ideation, which shows at a higher incidence among individuals who experience depression and hopelessness (Beck, Rush, Shaw, & Emery, 1979; Cleveland Clinic Foundation, 2009), factors many transgender individuals may be prone to experience prior to living consistent with their gender identity (Brown & Rounsley, 1996; Clements-Noelle, Marx, & Katz, 2006; Grant et al., 2010; Israel & Tarver, 1997; Mathy, 2002).

Coordinated Care

WPATH provides Standards of Care (SOC) that assist clinicians with offering evidence-based ethical care to transgender individuals. These SOC are not only limited to mental health interventions, but also assisting in physiological transition (gender confirmation interventions). Transgender individuals coming to terms with a transgender identity may first seek help from a behavioral health provider, or any other discipline, and may be looking to pursue feminizing/masculinizing hormone therapy or gender confirmation surgery. It is important for providers of all disciplines to recognize that caring for transgender individuals is necessarily interdisciplinary, involving a high level of care coordination, many referrals, and cohesive support.

For behavioral health providers who assist with coordinating physiological medical care, the SOC provide criteria to guide clinical decision-making with individuals who are interested in pursuing feminizing/masculinizing hormone therapy and gender confirmation surgery. The SOC first recommends that behavioral health professionals assist transgender individuals to psychologically prepare for such transitions. This involves ensuring that an individual has made a fully informed decision, has clear and realistic expectations, is committed and ready to receive the service, and has included family and community as appropriate. Secondly, the SOC suggest ensuring the individual is practically prepared. As systemic barriers may be present based on the healthcare system (i.e., Tricare), availability of resources, and even location, it may become incumbent upon the behavioral health provider to serve as an advocate as well as a clinician. As to hormone therapy, practical preparation involves being evaluated by a physician to rule out or address medical contraindications to hormone use and ensuring the individual has considered the psychosocial implications of beginning such a transition. As to gender confirmation surgeries, this involves making an informed choice about a surgeon to perform the procedure and arranging aftercare. Prior to initiating physiological interventions younger adults should receive reproductive counseling to consider options such as egg and sperm banking (section IX, WPATH SOC). Gender confirmation interventions can be initiated with a referral from a qualified behavioral health professional. Oftentimes, this referral takes the form of a referral letter written by the behavioral health professional. The recommended content of the referral letter is spelled out by the SOC.

It is absolutely necessary that this work not take place within a proverbial vacuum—both within and between disciplines. Behavioral health professionals should engage in consultation and discuss case conceptualization, advocacy, and case coordination progress with peers who are competent in the assessment and treatment of gender dysphoria. It is also necessary to engage in collaborative consultation with providers across other health professions who have had successful experience in treating transgender individuals. Open communication and cohesive care is necessary from referral, to consultation, to management, and to aftercare.

This section strives to present a theoretical foundation to approach clinical care with LGBT service members as well as introduce particular areas of relevance. This is not exhaustive, and behavioral health providers are encouraged to use this information as a springboard to fill in gaps in competencies (APA, 2012, 2015). Providers should be aware of the guidelines set forth by their professional associations. These include: Competencies for counseling with lesbian, gay, bisexual, queer, questioning, intersex, and ally

individuals (ALGBTIC, 2013); competencies for counseling with transgender clients (ALGBTIC, 2010); guidelines for psychological practice with lesbian, gay, and bisexual clients (APA, 2012); and guidelines for psychological practice with transgender and gender nonconforming people (APA, 2015).

Current Applications in the Military

Given the sheer size of the military and its long-standing traditions, implementing changes to accommodate new practices or categories of service members is monumental. This is certainly relevant to fully utilizing the talents of LGBT service members or integrating pending applicants for military service. For example, despite systemic changes with the repeal of DADT, several years later Mount, Steelman, and Hertlein (2015) found that in a small sample of lesbian Air Force, Army, and Navy service members, there continue to be perceived barriers to accessing behavioral health services. Some of these factors are not unique to LGBT persons, to include a perceived lack of confidentiality and fear of negative repercussions for seeking services. Other barriers are more particular to the LGBT service members, to include widespread heterosexism and transphobia and the fact that gender identity and sexual orientation has played a part in many service members' discharges. Nonetheless, there have been local attempts at providing culturally competent behavioral health and medical services to LGBT service members, which may have system wide implications in the future. The Human Rights Campaign (HRC) implemented the Health Equality Index (HEI) (Human Rights Campaign, 2016a) which is designed to provide a survey for healthcare organizations to establish nondiscriminatory practices relative to sexual orientation and gender identity. The four core criteria for inclusion in the HEI are: patient nondiscrimination, equal visitation, employment nondiscrimination, and training in LGBT patient-centered care. On March 24, 2016, Walter Reed National Military Medical Center became the first military medical facility to achieve the distinction of Leader in LGBT Healthcare Equality, which places it among 114 Veterans Administration Medical Centers that have met the same standard (HRC, 2016b). The promise of the HEI is to offer a template for other medical facilities that wish to offer culturally competent services to LGBT patients consistent with The Joint Commission standards (2011). Also, in the absence of DoD-wide policies for the provision of affirmative LGBT behavioral health servicesLesbian, gay, bisexual and transgender (LGBT) service members:, local policies have sprung up to foster services which extend to clinical, administrative, teaching, and research activities pertaining to LGBT service members and their dependents (Eisenhower Army Medical Center, 2013). Such local policies, once disseminated, also hold the promise of impacting the military healthcare delivery system to provide appropriate services for LGBT service members and their families. This commitment to affirmative behavioral health services at Eisenhower Army Medical Center has led to ongoing LGBT diversity training for staff and recurring didactics for interns and residents and has fostered collaboration with other relevant medical specialties such as endocrinology in advancing the medical care of transitioning transgender service membersLesbian, gay, bisexual and transgender (LGBT) service members:.

Relevance Beyond the Military

The military, while a unique system, is also a microcosm of the US population. The military sample represents a healthy subset of the broader population and presents the federal government with accessibility to outcomes of policy changes. The lessons learned from researching the military's shift from exclusive policies to a more inclusive culture for sexual and gender minorities will provide useful lessons for our society and organizations which wish to mirror these changes. Behavioral health providers in the military have a unique opportunity to facilitate a model for affirmative services not just for LGBT service members but for the wider military culture and even beyond. Behavioral health providers are the

linchpin for promoting awareness of LGBT health issues and highlighting barriers to care through education, research, and policy. With updated DoD policies that allow for advances such as gathering demographic data regarding sexual orientation and gender identity, there is a unique opportunity to create a welcoming and affirming environment for the provision of behavioral health services as well as eliminate healthcare disparities for LGBT service members (Ard & Makadon, 2012).

Elimination of health disparities has long been an overarching public health goal which surpasses the focus of military medicine. Health outcome data point to health disparities for sexual and gender minorities (Quinn et al., 2015; Shields et al., 2012). These disparities occur across a broad range of health outcomes to include cardiovascular disease, diabetes, and asthma (Fredriksen-Goldsen et al., 2013; Mayer et al., 2008; Ward et al., 2014), as well as health behaviors such as smoking (Grady et al., 2014), excessive alcohol use, and obesity (Conron, Mimiaga, & Landers, 2010; Mayer et al., 2008). With the intention of addressing health disparities for the LGBT community, the US Department of Health and Human Services' Healthy People 2020 initiative includes the goal of improving the health, safety, and well-being of LGBT persons. The US military and Veterans Health Administration have an opportunity to begin to implement system-wide policy changes, education at all levels, and research aimed at not just meeting this goal but also providing an example for other healthcare systems to help reach this initiative.

The Military Health System continues to work toward a model of care that is characterized as patient centered and fosters collaboration between the healthcare provider and patient. Patient-centered care requires competence to assess and incorporate sexual and gender identities of service members into their healthcare (Ard & Makadon, 2012). Preliminary research exploring LGBT individuals' experiences in healthcare is very limited within both the VHA and especially within the DoD. Lamda Legal (2010) in a civilian population survey found that over 50% of LGBT patients reported being treated disrespectfully by a provider and/or did not receive the required care. Additionally, LGBT patients reported having been refused care, were blamed for their health status, experienced abusive language with or about them, providers were physically rough, refused to touch them, and/or used excessive precautions. Even within behavioral healthcare, research suggests that during the last several decades many behavioral health providers continued to engage in practices that LGBT clients found to be biased, insensitive, and unhelpful (Herek & Garnets, 2007; Grant et al., 2010; Poteat, German, & Kerrigan, 2013). As an organization and healthcare system that values patient-centered care, the military must lead the way in improving LGBT service members' experiences in healthcare, and this will translate beyond the military.

As a whole, healthcare provider graduate education does not provide adequate training related to LGBT issues (Moll et al., 2014; Rutherford, McIntyre, Daley, & Ross, 2012). For example, Sherry, Whilde, and Patton (2005) found two thirds of psychology doctoral programs required a multicultural class; 29% of these did not incorporate LGBT issues. Only 10% of American Psychological Association members reported that they had been offered a course on LGB clients in graduate school and 28% had no formal training whatsoever (Murphy, Rawlings, & Howe, 2002). Graduate education related to transgender people appears to be even less; in a recent survey of VHA behavioral health providers, over 85% reported a single class or less related to transgender issues and less than 40% reported competence to address transgender issues (Johnson & Federman, 2014). Further, medical training for transgender issues according to a recent study found variability in content, quality, and time related to LGBT topics and very little to no education related to transgender health issues in the curriculum of US medical schools (Obedin-Maliver et al., 2011). Grant et al. (2010) found similar to other reports that about half of all transgender individuals have to educate their medical providers on transgender care. Also reported was that transpeople delay preventative medical care 33% of the time and care for an

illness or injury 28% of the time related to fear of discrimination. Since there is such limited graduate level training for future providers in the provision of affirmative healthcare to LGBT persons, the US military and VHA training programs have a unique opportunity to advance the skill level of its providers who will benefit recipients both within the military and to the broader civilian sector. There is a lack of consensus on required competencies for all categories of healthcare providers (Shipherd, 2015) who care for LGBT individuals. The current policy changes within the DoD offer an unprecedented opportunity to explore the needed competencies and disseminate standards which would have broad applicability to both military and civilian sectors.

Future Directions

Within the past 5 years, the DoD has announced sweeping changes to end or limit discrimination based on sexual orientation and gender identity; yet the list of questions from service members and providers continues to grow. Research just prior to and following the changes in policy, in an effort to justify such efforts, has tended to have a narrow focus on acceptance of LGBT service members, their compatibility within the organizational culture, and the perceived impact of inclusion on unit cohesion, readiness, and effectiveness (Estrada, Dirosa, & Decostanza, 2013). From a behavioral health lens, we have an unprecedented opportunity of witnessing a military cultural shift toward greater inclusion and diversity which promises to transform the organization into a more cohesive, effective, and ready military force. Policy change alone has not translated overnight into a culture of inclusion that eliminates discrimination (Allsep, 2013; Burks, 2011). Victimization, harassment, and discrimination of LGBT service members may well continue and some argue will even exhibit an increase with lessened concealment (Burks, 2011). The impact on behavioral health may follow. While gone are the days where active duty providers may be caught in an ethical conundrum between beneficence to a patient and the call for proof of gender or sexual memories for separation, increasing numbers of our LGBT service members will certainly mean increasing utilization of services. Thus, it becomes incumbent on behavioral health providers to seek out the training and competencies to work effectively with LGBT service members. Research focus should include investigation of the competencies required to provide patient-centered affirming care to these individuals. The DoD has a chance as well to investigate how recent policy changes and provider education impact patient outcomes, with the broader goal of improving the readiness of the combatant.

Effectively addressing individual psychological issues associated with serving as an LGBT service member with culturally sensitive and affirming behavioral health treatment will always be vital and should be informed by evidence-based practices. Given DADT, these individuals have not been well represented in social science research focusing on military populations (Trivette, 2010), and this has left a dearth of research on culturally sensitive evidence-based treatments for LGBT service members. However, until there is increased understanding of the societal or organizational factors that contribute to exclusion and discrimination and factors such as those featured in Meyers' (2003) Minority Stress Model, policy change will not translate into cultural change and individual LGBT service members will continue to experience undue adversity. Research must focus on the population-level factors contributing to exclusion and from there we can begin to address these organizational level factors to fully bring about inclusion and an environment where all service members can fully contribute to the military. Additionally, as mentioned earlier, LGBT individuals are at increased risk for mental health concerns. The National Academy of Medicine recognizes the LGBT community as underrepresented in research (IOM, 2011). The military with movement toward inclusion has opportunity with LGBT service members who have access to medical care to determine possible effective ways to reduce health disparities which subsequently could inform efforts to decrease health disparities on a

broader scale. One health outcome that can no longer be ignored is the increased risk of death by suicide. Efforts toward prevention must start with gathering of information related to LGBT service members who died by suicide and those who experience SITB. Research should continue to determine possible different interactive effects of stressors unique to being a sexual and/or gender minority individuals in the military, such as experiences of discrimination, sexual assault, and concealment to determine how these various experiences mutually interact to influence SITB, mental health, and military service.

As discussed throughout the chapter, gender and sexual minorities are a very heterogeneous group of service members. Research specific to transgender service member in general are almost none. Additionally, as the DoD embarks on implementation of inclusion and forthcoming guidance on affirming service members' gender identity through various possible processes research on implementation, healthcare provider attitudes, impact on service members' quality of life and military readiness, outcomes for transgender service members and the units they are assigned will be vital. Given the dearth of research related to transgender service members, the potential topics are endless and this research is essential to ensure component culturally sensitive care.

One place behavioral health providers are poised to play a role as we move into a future of inclusion is with an increasing emphasis on social justice. The skills a behavioral health provider possesses, knowledge of health and behavioral change, awareness of interpersonal dynamics, and an understanding of social psychology, are just the tools needed to facilitate these cultural shifts. Johnson et al. (2015) encourages those working in the military to move beyond the individual service member and consult with commanders and military policymakers regarding approaches to create a culture of inclusion. Given the nature of the military culture, unless key military leaders at both local and national levels support inclusion, the efforts will likely remain only at a policy level. Providers can point to the broader cultural shifts suggesting more positive attitudes toward sexual and gender minorities. Additionally, post-DADT assessments of unit morale and cohesion indicate that many of the objections to the repeal related to unit cohesion have not been born out (Parco & Levy, 2013). The DoD's Comprehensive Review Working Group reported that 70–76% of military personnel reported repeal of DADT would have a positive, mixed, or no effect on task cohesion, and 67–78% predicted similar effects on social cohesion have not been found (Rostker et al., 2010). Rapid movement toward deliberate integration will likely only strengthen the unit through full access to a diverse force (Fassinger, 2008). Leadership support and system-level support for service members of all ranks as well as positive exposure and relationship development between LGBT and heterosexual, cisgender service members will be one of the most efficient means of achieving genuine integration of LGBT service members.

Conclusion

We are at the very center of revolutionary advances for sexual and gender minorities serving in the US Armed Forces. This chapter laid a foundation for providing behavioral healthcare to LGBT service members. A historical review of sexual and gender minorities in the military gave context to the chapter. A brief review of research and theory related to behavioral healthcare practices with LGBT service members was presented. This included some unique clinical considerations to include: use of affirmative approaches in behavioral healthcare, importance of attending to increase suicide risk, identity development, as well as the use of the Minority Stress Model as a theoretical foundation to better understand LGBT service members. Additionally, a brief discussion of clinical considerations for transgender service members was presented. Lastly, relevance of behavioral healthcare for LGBT service members beyond the military and future directions in research and behavioral healthcare were suggested to advance this exciting area of behavioral healthcare on both individual and broader population level.

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