An examination of stigma in the military

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Stigma of mental health, sexual assault and harassment, women in combat, and LGBT service members is a key problem facing the U.S. military over the coming decade. The purpose of this study is to examine the key literature focused on the impact stigma has on these subpopulations within the military, including barriers to care, attitudes, and impact of stigma on mental health. A multi-dimensional model for reducing stigma is proposed, including organization, societal, and individual interventions. Finally, areas for future research for reducing stigma, discrimination, and prejudice towards these subpopulations within the military are discussed.

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AN EXAMINATION OF STIGMA IN THE MILITARY

A DISSERTATION

SUBMITTED TO THE FACULTY

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TYLER G. RUSSELL

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DOCTOR OF PSYCHOLOGY

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Abstract

Stigma of mental health, sexual assault and harassment, women in combat, and LGBT service members is a key problem facing the U.S. military over the coming decade. The purpose of this study is to examine the key literature focused on the impact stigma has on these subpopulations within the military, including barriers to care, attitudes, and impact of stigma on mental health. A multi-dimensional model for reducing stigma is proposed, including organization, societal, and individual interventions. Finally, areas for future research for reducing stigma, discrimination, and prejudice towards these subpopulations within the military are discussed.

*Keywords:* stigma, military personnel, women in combat, LGBT, military sexual trauma
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An Examination of Stigma in the Military Population

Despite the availability of empirically supported treatments for a vast majority of mental health problems, stigma surrounding mental health prevents many from seeking treatment. Those who do seek treatment often drop out or fail to comply with treatment out of fear of what others will think about them. Several studies have demonstrated that those who have the highest need for mental health care also have the biggest concerns related to stigma (Britt, 2000; Hoge et al., 2004, Kessler et al., 2001). Indeed, those who receive the most benefit from mental health care are the ones most likely to be affected by stigma and are, therefore, the least likely to receive treatment (Wright et al., 2009).

Stigma and discrimination also negatively impact other populations within the military, including members of the LGBT community and women. Generations of discrimination, negative stereotypes, and prejudice have prevented service members from being open with those around them about central characteristics that make up who they are as an individual, but have also prevented them from working in jobs or fields that would otherwise be open to them if they weren’t gay or female.

Problems related to stigma contribute to the barriers for care and wellbeing; keeping thousands of military personnel from receiving the physical and mental health care they need. Recent studies show that one out of every five soldiers returning from Iraq and Afghanistan screens positive for anxiety, depression, or posttraumatic stress disorder (PTSD; Bryan & Morrow, 2011). Stigma surrounding treatment seeking in the military is a significant problem and less than half of those identified with a mental health condition seek out help, primarily due to concerns about stigma, how their units and leaders will treat them once they learn the
individual has a psychological problem, and fears that seeking mental health services will negatively impact their careers (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009).

Efforts in the past aimed at reducing stigma in the military have had some success, especially at reducing stigma surrounding suicide and depression (Knox, Litts, Talcott, Catalono, Feig, & Caine, 2003). Despite these efforts, mental health problems continue to rise (Department of the Army, 2010). The focus of the current study is to examine ways of reducing stigma of mental health care, LGBT issues, women in combat, and sexual harassment and assault in the military.

**Stigma**

Before considering how to reduce stigma, it is necessary to both define and conceptualize stigma. Stigma has been described as an attribute or behavior that works to socially discredit an individual (Goffman, 1963). Corrigan and Penn (1999) defined stigma as negative and erroneous attitudes about individuals and stated that these attitudes are often the result of prejudice and negative stereotypes. Corrigan (2004) further described stigma as four social-cognitive processes: cues, stereotypes, prejudice, and discrimination. As an example, the public can infer mental illness from cues, including psychiatric symptoms (inappropriate affect, bizarre behaviors, and hallucinations), poor social skills, poor personal appearance, and labels (“He’s crazy!”). Corrigan notes that these cues elicit stereotypes or knowledge structures that the public creates and conveys about individuals who may be experiencing mental health problems. Negative stereotypes about mental illness may reinforce prejudicial reactions (e.g., generating negative emotional reactions toward individuals with mental health problems), which leads to discrimination. Corrigan described discrimination as a negative action against the out-group or as avoidance of the group altogether.
Corrigan (2004) further distinguishes between two influential forms of stigma. The first, public stigma, refers to stereotypes held by the general public about those in the minority, which often lead to prejudice and discrimination. Individuals in need of behavioral health services may not seek treatment in order to avoid negative consequences associated with public prejudice and discrimination. This type of stigma is also referred to as enacted or external stigma, or discrimination (Gray, 2002). The second type of stigma Corrigan (2004) identified is self-stigma. Self-stigma refers to the extent that an individual internalizes the public or culture’s beliefs about themselves. Self-stigma is also called felt stigma or self-stigmatization (Gray, 2002). Wright et al. (2009) commented that self-stigma negatively influences treatment seeking due to the impact on the individual’s self-esteem. Self-stigma has also been associated with feelings of shame, inadequacy, and inferiority.

In addition to the specific forms of stigma noted above, stigma on a broad and general level has also been associated with negative outcomes. Gould, Greenberg, and Hetherton (2007) note that stigma may be more devastating, long-lasting, and life-limiting than the primary illness. The authors also noted that having a history of mental illness may lead to feelings of shame and humiliation, denial of life’s essential needs, and negative reactions from others.

Efforts at reducing stigma have been made for many years. In 1996, the World Psychiatric Association (WPA) developed a program to address and work towards reducing the stigma and discrimination of schizophrenia (Sartorius & Schulze, 2005). The WPA suggested that anti-stigma interventions should include four main areas of activities focusing on: public perceptions of mental health, changes in how mental health services are delivered, providing support for users and their families, and education and training in a variety of settings. Corrigan (2004) suggested that efforts to reduce both public and self-stigma should include better
education about mental illness, increased interaction between members of the general public and those with mental illness who are able to hold down jobs or play an active role in their community, and protesting negative views about mental health.

**Mental Health Stigma in the Military**

Barriers to treatment are especially strong in populations where concerns about public and self-stigma are prevalent, such as the military. Military personnel exposed to combat can develop a wide range of mental health problems, including depression, anxiety, posttraumatic stress disorder (PTSD), and suicide (Bryan & Morrow, 2011). Recent studies have estimated that as many as one in four military personnel returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) experience some mental health problems (Bryan & Morrow, 2011; Hoge et al., 2004; Ramchand et al., 2008). Of particular concern is stigma surrounding PTSD, an extremely debilitating disorder that can negatively impact the lives of soldiers that develop the disorder post-deployment (Hoge et al., 2004). Magruder and Yeager (2009) performed a meta-analysis of studies that examine the prevalence rates of PTSD for both deployed and non-deployed military personnel during Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), the Persian Gulf War, and the Vietnam War. The authors found that the estimated prevalence rates for PTSD in deployed military personnel for OIF/OEF ranged between 4.7% and 19.9%, but was lower for non-deployed personnel, between 3.2% and 9.4%. Prevalence rates for PTSD were similar for deployed military personnel during the Persian Gulf War, ranging between 1.9% to 24.0%, and the Vietnam War, ranging between 8.5% and 19.3%.

Despite the high numbers of returning service members experiencing mental health problems, very few seek out mental health treatment post-deployment. Kim, Thomas, Wilk,
Castro, and Hoge (2010) found that among soldiers with mental health problems, only 27% of National Guard soldiers and 13% of active duty soldiers utilized mental health care within 12 months following deployment. Concerns about stigma and other barriers to care are often identified as the biggest contributing factors to low mental health care utilization among soldiers. Pietrzak, Johnson, Goldstein, Malley, and Southwick (2009) found that National Guard and Reservists returning from duty who screened positive for a psychological disorder were more likely to endorse feeling stigmatized and, as a result, reported they would be less likely to seek treatment. The authors identified several factors that contributed to feelings of stigma and barriers to care, including concerns about embarrassment, being perceived as weak, not knowing where to get help, and having difficulty scheduling appointments. Negative beliefs about mental health care, psychotherapy, and unit support were also found to be associated with stigma and barriers to care (p. 1121). Kim, Thomas, Wilk, Castro, and Hoge (2010) reported similar findings among active duty soldiers and National Guard soldiers post combat.

Stigma associated with mental health problems within the military population has a long history. Nash, Silver, and Litz (2009) traced the origins of mental health stigma in the military to the First World War. Prior to World War I, combat stress and PTSD were described as medical conditions, using terms like “soldier’s heart,” “irritable heart,” and “shell shock.” Describing the symptoms of trauma within a medical model implied that military stress casualties should be treated in a similar manner as other physical injuries, which often resulted in evacuation from war zones. Nash et al. (2009) noted that combat stress related injuries among French, British, and German forces were costly, both in the number of casualties and in the monetary cost of treating these shell-shocked veterans. However, skepticism about the physical or medical nature of the disorder grew, as no actual evidence of brain damage was observed in shell-shocked soldiers. To
address this discrepancy, the German Association for Psychiatry held a “War Congress” in 1916. It was decided at this conference that the functional impairment resulting from shell shock could only occur in an individual with hysteria, which was considered a preexisting personality characteristic at that time. As the condition was now considered psychological rather than physical in nature, military doctors were consequently banned from using the term “shell shock” and soldiers were no longer evacuated from the front lines due to combat stress. Nash et al. (2009) noted that the term “hysteria” was intentionally meant to be stigmatizing, as hysteria was considered to be a pre-existing personality weakness at the time typically found only in women.

As the psychological community’s conceptualization of trauma and combat stress developed, initial attempts were made at reducing stigma associated with trauma exposure. When the diagnosis of PTSD was introduced in the DSM-III in 1980, the disorder was thought to originate as the direct result of exposure to a traumatic event “that would evoke significant symptoms of distress in almost everyone” (American Psychiatric Association [DSM-III], 1980) p. 238. This introduced what Nash et al. (2009) describe as a “normalization model”, aimed at reducing stigma associated with trauma responses by framing the response as a “normal reaction to an abnormal event” (p. 791). However, not all who are exposed to trauma develop clinically significant symptoms of PTSD. In fact, the vast majority of those who experience trauma do not develop PTSD, which may further contribute to stigma, with those who do develop symptoms wondering why it is happening to them and not to those who had similar experiences. Nash et al. (2009) contend that the normalization model further contributes to stigma. Those who develop symptoms of PTSD may attribute these symptoms to an internal flaw or a personal weakness, especially when others in their unit exposed to the same potentially traumatizing events do not develop PTSD.
The culture of the military may powerfully reinforce this enacted stigma. Bryan and Morrow (2011) describe a “Warrior Culture” in the U.S. military that places significant value on strength, resilience, courage, and personal sacrifice. Soldiers are indoctrinated with the idea that mental toughness is a requirement, and there is an underlying expectation to “suck it up” and to “shake things off.” Soldiers who return home with their unit and later develop trauma-related symptoms are more likely to self-stigmatize, and regard themselves as being weak and not living up to the warrior ethos. McFarling, D’Angelo, Drain, Gibbs, and Olmsted (2011) further note that from basic-entry training through retirement, service members are conditioned to be strong – both physically and mentally. If treatment for mental health concerns is seen as a weakness, service members may not only be called out by their peers for being weak and not living up to the Warrior Ethos, they are also susceptible to self-stigmatization that may negatively impact their willingness to seek out treatment for not only behavioral health concerns, but for substance abuse and family problems.

Blais and Renshaw (2013) gathered data from 206 National Guard and Reserve service members who had deployed to Iraq and Afghanistan in support of OIF/OEF to assess whether enacted stigma may limit these service members from seeking help. Results from their study demonstrated that those service members reporting greater self-stigma were less likely to seek help for psychological distress. The authors also found that being married was a predictor of increased likelihood to engage in behavioral healthcare, as spouses may have a greater awareness of post-deployment changes in their partners and encourage them to seek help. Finally, Blais and Renshaw (2013) found that anticipation of enacted stigma from unit leaders, unit members, family, and friends, were unrelated to help-seeking intentions. However, it should be noted that
their study was conducted on National Guard and Reservists, who do not typically interact with members of their unit on a daily basis.

Mittal, Drummond, Blevins, Curran, Corrigan, and Sullivan (2013) conducted a focus group with 16 treatment-seeking OIF/OEF veterans with combat-related PTSD. Through the course of these focus groups, the authors identified several themes that may decrease treatment seeking for PTSD among service members. These include awareness of stereotypes that are associated with PTSD, with most often heard labels of those with PTSD as “crazy,” “violent,” “weird,” “numb,” “unstable,” “unreliable,” and “dangerous” (p. 88). Further, the participants reported that they agreed with many of these stereotypes, particularly that those with PTSD are violent and dangerous. The participants also noted that they felt misunderstood by their peers, perhaps further contributing to feelings of self-stigma. Most agreed that they felt more comfortable talking to other veterans who had similar experiences to their own and were reluctant to share their experiences or concerns with friend, family, and even helping professionals out of concerns over enacted stigma or being labeled as “crazy.”

There is some evidence that concerns about self-stigma and barriers to treatment may not be as salient while in a deployed setting. Sudom, Zamorski, and Garber (2012) surveyed 2,437 members of the Canadian Forces who had deployed to Afghanistan from 2009-2010. Participants were invited to complete an anonymous survey that asked questions about perceptions of stigma and mental health treatment during their deployments. Factors related to self-stigma were similar to those found in other studies, including concerns over how others in their unit and unit leadership might perceive them, not wanting to be seen as weak, feeling embarrassed, and potential for harm to career. However, the authors found that stigma was not associated with care-seeking propensity and that structural barriers to care (access to care, interventions
negatively impacting the mission) were a better predictor of whether or not a service member sought care.

A similar study conducted by Kim, Britt, Klocko, Riviere, and Adler (2011) with U.S. service members deployed to Afghanistan or Iraq. Kim et al developed a three factor model to predict barriers to care. These factors include stigma (“It would be too embarrassing,” “It would harm my career,” “Members of my unit might have less confidence in me,” “I would be seen as weak,”) negative attitudes toward treatment (“I do not trust mental health professionals,” “My leaders discourage the use of mental health services,” “Getting mental health treatment should be a last resort,” “I would think less of a team member if I knew he or she was receiving mental health counseling,”) and organizational barriers (“Mental health services are not available,” “I do not know where to get help,” “It is difficult to get an appointment,” “There would be difficulty getting time off work for treatment;” p. 74). The authors found that negative perceptions of others, particularly those in their unit and unit leadership, were the most frequently reported concern, contributing to self-stigma an individual may feel if he or she were to seek help.

The perceived failure to uphold a cultural warrior ethos may be especially salient in service members who experience mental health problems. Britt (2000) examined stigma associated with psychological and medical problems among active duty personnel returning from deployment. Soldiers returning from a peacekeeping mission in Bosnia were required to undergo post-deployment psychological and medical screening. Those who scored above the cut-off point on psychological measures of PTSD, depression, and substance abuse were required to meet with a mental health professional, and those who endorsed medical symptoms were required to undergo physical examination by a medical professional. Britt (2000) found that soldiers admitting to a psychological problem perceived higher levels of stigma than those admitting to a
medical problem, especially since the post-deployment screening was done with the entire unit. For example, 61% of participants felt that admitting a psychological problem would harm their career, as opposed to 45% of participants for a medical problem. Britt (2000) also noted that service members would be less likely to follow through on a psychological referral than a medical referral.

Skoop, Bush, Vogel, Wade, Sirotin, McCann, and Metzger-Abamukong (2012) developed a measure of public and self-stigma to be utilized in a military population in an attempt to better understand the extent to which stigma might negatively impact decisions to seek mental health services, which may result in trickle-down effects, such as decreased retention, reduced efficiency of units, and family disruption. For the development of their measure, Skoop et al recruited 1038 active duty soldiers from a large Army installation. The sample was largely male (93%), the mean age was 26.7 ($SD = 5.9$) years, with around 70% of the sample White/Caucasian, 9.8% Black/African American, 14.9% Hispanic/Latino, 6.1% Asian/Pacific Island, and 1.9% American Native/Alaska Native. The result was a 26-item scale called the Military Stigma Scale (MSS), which demonstrated adequate reliability and validity across demographic variables. The MSS measures perceptions of both self-stigma and public stigma that might inhibit service members from seeking treatment. The authors found significant racial/ethnic group differences in regard to self-stigma, with White/Caucasian service members reporting higher levels of self-stigma than did Black/African Americans. Individuals who had received mental health services in the past also reported lower levels of self-stigma when compared to those who had not received those types of services. These findings will be crucial when examining ways to target and reduce stigma in the future.
Although there has been a great deal of research into attitudes towards mental health, stigma, and barriers to treatment in the military (see Bryan & Morrow, 2011; Greene-Shortridge, Britt, & Castro, 2007; Hoge et al., 2004; Kim et al., 2010; Wright et al., 2009), little research has been published assessing efforts at reducing stigma and barriers to care in the military. Knox, Litts, Talcott, Feig, and Caine (2003) examined the effectiveness of anti-stigma efforts on reducing suicide in the U.S. Air Force. The anti-stigma efforts included implementation of an anti-suicide program, psychoeducation, better involvement of leadership, community-based prevention services, and a critical incident stress management team, which responded to traumatic events on base and completed suicides. The authors found a 33% risk reduction for suicide after the intervention. In light of an increased focus on suicides in the military, efforts to decrease stigma and increase treatment seeking have emerged in an attempt to reduce the staggering number of military suicides each year.

Gahm and Reger (2008) noted that in recent years both active duty and veteran’s suicide rates have increased, especially among veterans with combat exposure. In response, the Department of Defense and the Department of Veterans Affairs have made efforts to improve access to mental health services, increased the number of professional mental health providers on staff, and work with external agencies to provide mental health services to active duty and veterans with mental health problems (Bryan & Morrow, 2011). Despite these efforts, mental health problems and rates of suicide continue to increase (see Department of the Army, 2010).

Further, there is a surprising paucity of literature addressing the efficacy of existing stigma-reduction efforts in the military population. Gould, Greenberg, and Hetherton (2007) published perhaps the only study to date that discusses the implementation or efficacy of efforts at reducing stigma and barriers to care surrounding PTSD in a military population. In their study,
the authors developed a psychoeducational program based on peer-group risk assessment in the British Royal Navy. The aim of the group was to reduce stigma surrounding PTSD, stress, and help seeking through psychoeducation around PTSD and stress reactions. Gould et al. (2007) hypothesized that by utilizing psychoeducation, there would be a reduction in public and self-stigma. The authors found the intervention group had a significant effect on attitudes towards PTSD, stress, and help seeking when compared to a control group that did not receive the psychoeducation. Gould et al. (2007) concluded that psychologically based education and training about stress and PTSD might be an effective way of reducing stigma and increasing utilization of mental health care services.

**LGBT Service Members and Stigma**

Stigma in the military has not only impacted individuals with mental health concerns, but other populations as well. Gay, Lesbian, Bisexual, and Transgendered (LGBT) members of the military have faced both public and self-stigma that was institutionalized in the United States military until just recently. Estrada (2011) reported that gay service personnel have served in every major American conflict dating back to the Revolutionary war. However, it wasn’t until the early 20th century that legal guidelines excluding gay service members were established by the United States. Prior to that time, several service members were dismissed for sodomy, but it wasn’t until the Articles of War of 1916 that a provision for sodomy was included into military law. Article 93 of the Articles of War of 1920 codifies sodomy as a felony crime punishable by court martial (U.S. War Department, 1920).

Shilts (1993) and Herek and Belkin (2005) note that prevailing psychiatric views of homosexuality during the 1920s and 1930s likely led to excluding gay service members due to their sexual orientation, rather than based on sexual behavior alone. Army regulations at that
time declared gay individuals unfit for military service and by 1942, the US War Department began to disseminate guidelines to physicians on how to identify gay men based on their body type, dress, and mannerisms (Estrada, 2011). During World War II, gay service members would be discharged in a number of ways, including being administratively separated honorably, to being court martialed and dismissed dishonorably. Following World War II, the Uniform Code of Military Justice (UCMJ) replaced the Articles of War as the laws governing the US military and it again included sodomy as a court-martial offense. Directives established by the Department of Defense in 1959 effectively barred gay individuals from entering military service and service members discovered to be gay were deemed unfit for duty and were administratively separated from the military (Estrada, 2011; see DoDD 1332.14 and 1332.30). This was the policy of the United States military until 1993, when a new policy was established that service members would no longer be asked about their sexual orientation. This policy, known colloquially as “Don’t Ask, Don’t Tell” (DADT) allowed LGBT service members to enter into the military, but did not allow them to be open about their sexual orientation. The UCMJ and Department of Defense Directives 1332.13 and 1332.30 remained in place to administratively separate LGBT individuals who disclosed – whether purposively or incidentally – their sexual orientation. The National Defense Authorization Act of 1994, the law that codified DADT, states that, “The presence…of persons who demonstrate a propensity or intent to engage in homosexual acts…create[s] an unacceptable risk to the high standards of morale, good order and discipline, and unit cohesion” (10 U.S.C § 654). This fear that allowing openly gay individual service members would negatively impact morale, unit cohesion, and unit readiness was used as justification for the DADT policy. These policies were in place until 2010.
President Barack Obama pledged in early 2010 to repeal DADT (see Obama, 2010). A Military Working Group (MWG) was established to complete a comprehensive review of the potential impact of the repeal of DADT. The MWG concluded that the repeal of DADT would have minimal impact on military readiness and would likely result in short term disruption to unit cohesion and retention, with no indication that that disruption would be long-standing (Department of Defense, 2010). This lead to the United States Congress passing the “Don’t Ask, Don’t Tell” Repeal Act of 2010, eliminating all restrictions and directives that prohibit gay and lesbian service members from serving openly in the U.S. Military. This policy was enacted in September 2011 (Estrada, 2011).

While the lift of DADT provides gay, lesbian, and bisexual individuals the freedom to be openly gay while in the military, the repeal did not apply to transgendered persons. Kerrigan (2012) writes that transgendered persons are banned from serving from all branches of the military and notes that systems are in place to continue with administratively separating these individuals if they are “outed” incidentally or on purpose. Kerrigan cites a study conducted by The Palm Center of the University of California, Santa Barbara in 2008 with 827 transgender service members and veterans. Many reported encountering sexism and discrimination during their time in service. In regard to access to care, transgender service members reported having difficult accessing not only mental health services, but accessing adequate health care. Kerrigan also notes that the Veterans’ Health Administration does not offer sex reassignment surgery.

Attitudes surrounding gay and lesbian service members have varied over the years. In June 1977, 51% of the U.S. public agreed that gay and lesbian service members should serve in the U.S. military (Torres-Reyna & Shapiro, 2002). In 1993, when the United States lifted the ban on the accession of gay and lesbian service members and enacted the DADT policy, a Gallup
poll found that 50% of the American public disapproved of lifting the ban (Wyman & Snyder, 1997). Many cited concerns about morale, unit cohesion, and military readiness, and unit effectiveness (Estrada, 2011). Miller (1994) surveyed 3,700 male and female U.S. Army soldiers between February 1992 and June 1993, asking questions about their attitudes towards allowing openly gay and lesbian service members serve in the military. The results of this survey revealed that at the time of the study, 75% of service men and 43% of service women believed that gay service members should not be allowed to serve in the military. Common reasons why gay service member should be excluded include a belief that homosexuality is immoral; homosexuality undermines military effectiveness, cohesion, and discipline; and that lifting the ban would violate privacy and gender norms.

However, since DADT was enacted in 1994, there appears to have been a positive shift in societal beliefs and attitudes towards the LGBT community, as well as a shift in the attitudes of military personnel towards this population. A poll conducted in January 2000 found that 67% of the U.S. public thought gay and lesbian individuals should be allowed to serve in the military, however that number dropped to 52% when the question was worded to specify whether openly gay or lesbian individuals should be allowed to serve in the military (Torres-Reyna & Shapiro, 2002). A survey of 3,000 active duty personnel conducted by McGarry (2010) found that only 51% opposed open service of lesbian and gay service members. Other studies conducted with active duty personnel, as well as family members of active duty personnel, ranged from 37% to 57% of those surveyed opposing open service (Annenberg Public Policy Center, 2004; Rodgers, 2006).

The Military Working Group (WMG) assigned to assess the impact of the repeal of DADT conducted a number of surveys, small group focus sessions, and larger group forums,
garnering over 115,000 responses from active duty service members (Department of Defense, 2010). In regard to unit cohesion, 70-76% of service members said the repeal of DADT would have a positive, mixed, or no effect on their ability to get the job done and perform as a team. Further, 67-78% of service members surveyed by the MWG said repealing DADT would have positive, mixed, or no effect on social cohesion. The results from the survey found similar numbers in regard to unit effectiveness at completing the mission (80% said positive, mixed, or no effect), unit readiness (67% said repeal would have positive to no effect), and morale (62% said repeal would have positive, mixed, or no effect).

While there have been changes in attitudes towards LGBT service members, there are still many lingering beliefs that serving alongside LGBT service members will have negative impacts on unit cohesion, unit effectiveness, and morale. These beliefs have likely contributed to a perpetuation of both public and self-stigma felt by gay and lesbian service members. However, there is a lack of contemporary research conducted to assess the attitudes of gay and lesbian service members. Prior to 2011, the ban on gays in the military prevented the military, as well as other interested parties, from conducting research on the topic.

Moradi (2009) notes that sexual orientation disclosures, as well as orientation concealment, are strategies utilized by LGBT individuals in order to manage their identities in the face of cultural and organizational stigma against homosexuality. For her study, Moradi surveyed 445 LGBT military veterans regarding hypothesized sexual orientation disclosure, concealment, and harassment and the relationship with unit and task cohesion, and job satisfaction. The sample included individuals from all branches of service, with 24% of participants identified as women, 72% as men, and 3% as transgender, all ranging in age from 19 to 82 years ($M = 45.99, SD = 13.91$). Instruments included measures of general job
satisfaction, unit and task cohesion, sexual orientation concealment and disclosure, and perceived sexual-orientation-based harassment. Results from this study indicate that disclosure of sexual orientation by LGBT service members likely has a positive impact on perceptions of unit cohesion and work satisfaction for those members. There was also some indication that harassment of LGBT service members reduced social cohesion and task cohesion for their units. Finally, concealment of sexual orientation related negatively to perceptions of unit and task cohesion. These findings are contrary to many perceived attitudes that the presence of openly gay service members would negatively impact unit cohesion. However, there are several limitations to this study. First, the study was conducted on veterans and as such does not necessarily reflect the attitudes of active-duty personnel. Second, the study examined hypothesized relations from the perspective of LGBT veterans and does not address attitudes that may be shared by non-LGBT service members in their units.

Negative stigma towards LGBT service members carries other negative consequences as well. Burks (2011) examined victimization of LGBT service members as an unintended consequence of DADT. Burks notes that LGBT service members may have an increased likelihood of sexual victimization, particularly due to the context of the military, a context influenced by sexual stigma, heterosexism, and until recently, mandatory secrecy about sexual orientation. Herek (2004) defines sexual stigma as the negative attitudes, inferior status, and powerlessness that society has traditionally assigned to non-heterosexual individuals or communities. At a societal level, this translates to heterosexism, or a cultural belief system that reflects the dominant heterosexual ideology, and a shared belief that homosexuality is negative and unfavorable. These types of attitudes lead to enacted sexual stigma – overt discriminatory behavior towards non-heterosexual individuals, which includes harassment and victimization –
and internalized sexual stigma – personal acceptance of sexual stigma in one’s own value system. LGB service members who are victims of sexual harassment or sexual assault may be less likely to report or disclose these events out of concern that their sexual orientation may be disclosed, perhaps driven by sexual stigma (Burks, 2011).

Simpson, Cochran, Balsam, Lehavot, and Gold (2013) examined health care utilization in the Veterans Health Administration (VHA) setting among sexual minority veterans. A convenience sample of 416 LGBT individuals participated in a survey that gathered data about the veterans’ military experiences, mental and physical health, health care utilization, and their relationships. Results indicate that VHA utilization for the LGBT veterans was 45.8% \( (n = 163) \), with 28.7% \( (n = 102) \) utilizing their VHA benefits in the past year. For comparison, research based on a Centers for Disease Control and Prevention survey found that 13.1% of veterans typically utilize VHA services in the past year (Nelson, Starkebaum, & Reiber, 2007). Further, Simpson et al (2013) found that around 35% \( (n = 146) \) of respondents indicated that they avoided at least one VHA service due to concerns about stigmatization. Services most commonly avoided were behavioral health services, outpatient medical care, and dental care. The authors also found that LGBT service members were more likely to seek services if they screen positive for PTSD, depression, and one interpersonal trauma. Simpson et al. proposed that future efforts to increase communication about sexual orientation between LGBT veterans and health care providers may reduce stigma and improve outcomes for these individuals.

Wilder and Wilder (2012) examined suicide as another unintended consequence of stigma towards LGBT service members. The authors state that there is a heightened risk for suicide for service members who experience intense stress, social isolation, and discrimination, noting this is especially true for lesbian, gay or bisexual service members, as this population has
a higher risk for suicide when compared to heterosexual peers. However, rates of suicide in LGBT service members are unavailable, as up until 2011, DADT prohibited gathering this type of information. King et al. (2008) conducted a meta-analysis comparing rates of suicide and deliberate self-harm in LGBT individuals. The results indicate that LGBT people are more than twice as likely to attempt suicide as their heterosexual peers [pooled risk ratio for lifetime risk 2.57 CIs (1.87, 3.28)]. Wilder and Wilder (2012) estimate that suicide attempts in LGBT service members may be three to five times that of their heterosexual peers. There are a number of risk factors that may contribute to a higher risk of suicide in LGBT service members. Included in these risk factors is the psychological distress associated with being gay, a function of internalized or self-stigma likely resulting from widespread discrimination against LGBT people and heterosexism in the larger social environment. The authors argue that these public biases become internalized through a lifetime of discrimination, contributing to self-stigma that dictates the way LGBT service members interact with the members of their units. Further, up until 2011, the DADT policy prohibited LGBT individuals from disclosing their sexual orientation, further contributing to feelings of self-stigma.

**Stigma and Women in the Military**

Gender integration in the U.S. military has occurred slowly over the past 65 years. Prior to 1948, women served in roles as nurses, cooks, and seamstresses for service members dating back to the American Revolutionary War ("Early Women Soldiers," 2013). During World War II, women fulfilled roles at factories and in jobs that had been left open by men in order to support the war. From 1941 to 1943, several units were created by the military for women to support the war cause. This included the Women’s Army Auxiliary Corps (which later became the Women’s Army Corps); the Women’s Auxiliary Ferrying Squadron, who were tasked with
delivering aircraft from factories to the Army Air Corps worldwide; the Women Airforce Service Pilots, who assisted with training and delivery of cargo; the Marine Corps Women’s Reserve; and the Army and Navy Nurses Corps (Torres-Reyna & Shapiro, 2002).

Women became an official part of the U.S. military in 1948 when President Harry S. Truman signed the Armed Services Integration Act (Department of Defense, 2010). At that time, women only comprised 2% of active duty personnel in all services, and their role was limited to only a few positions, limiting women to non-combat roles (National Women’s Law Center, 2013). It wasn’t until the 1970’s when the military transitioned to an all volunteer force that further changes were made to allow women to enter the Service academies, and allowing women to serve aboard non-combat Navy vessels and Air Force planes (Department of Defense, 2010). In the 1990s women service members became more visible and 41,000 deployed in support of Operation Desert Storm. In 1994, the Department of Defense created the Direct Ground Combat Definition and Assignment Rule (DGCDAR), which contained a combat exclusion policy prohibiting women from serving in units whose primary mission was to engage in direct ground combat (Boyd, Bradshaw, & Robinson, 2013). An estimated 280,000 women have deployed in support of OIF/OEF (Myre, 2013), with an estimated 153 killed since the start of the war in 2001 (Jean-Louis, Lynch, Fetterhoff, & Hadar, 2013). In January 2013, the Pentagon announced a lift on the ban of women serving in combat roles, paving the way for women to begin serving in combat arms units that have been, for centuries, filled by men (Roulo, 2013).

Attitudes towards women serving in the military have changed over the years. Torres-Reyna and Shapiro (2002) explored attitudes towards women serving in the U.S. military by examining historical data from 1940 to 2002. They reported that during World War II, 45% of the American public supported drafting women into the military, with 69% of the public favoring
the prospect when it was specified that single women would be drafted. With the end of World War II and women volunteering to serve, making up 2% of the military, attitudes towards women serving in the military were not at the forefront of the public. It wasn’t until the end of the Vietnam War in the 1970s, the draft ending, and the move to an all volunteer military, that researchers began looking again at attitudes towards women in those rolls. In March 1979, 50% of the public favored requiring women to enroll in the Selective Service System and being drafted if the U.S. went back to war. That number has remained steady, with the authors reporting that in polling conducted after the September 11, 2001 terrorist attack, only 46% of the public agreed women should be drafted.

Torres-Reyna and Shapiro also examined historic attitudes in the United States regarding women serving in combat. They report that in 1979, 50% of the public agreed women should be drafted. However, of that 50%, only 52% agreed that women should be eligible for combat roles. A similar poll was conducted in 1982 that asked whether women should serve in hand-to-hand combat, with 64% of those polled opposed. Following the Persian Gulf War in 1992, between 65% and 72% of the public agreed that women would serve as an advantage in combat support, as military police, or working in military intelligence and reconnaissance. However, only 41% felt women would be an advantage serving as infantry soldiers. Between 1992 and 2012, public opinion remained divided.

Perhaps one of the primary reasons women would want to serve in combat roles is that serving in a combat role may improve their chances at promotion. In a military that often promotes individuals based on their prior service, their ability to uphold certain values, and their ability to train and lead other members of their teams, experience in combat is looked at as crucial to developing strong leadership skills. Women who do not have that type of experience
may be looked over for promotion and not rise to the same levels within the military as their male counterparts (Congressional Research Service, 2013). Torres-Reyna and Shapiro (2013) note that men and women within the military agree that there is discrimination against women from obtaining what may be considered “top jobs” within the military, perhaps driven by stigma that women cannot adequately fulfill those roles.

Similarly to LGBT service members, women in the military face a number of challenges that may contribute to self-stigma and discrimination. Mattocks, Haskell, Krebs, Justice, Yano, and Brandt (2012) note that as of 2010, 15% of all active duty personnel in the U.S. military are women. While up until 2013 women were not assigned to combat arms units, women serving in the military come under direct fire while deployed and experience combat-related injuries and trauma, and are also subject to sexual assaults and sexual harassment while they are serving their country. For their study, Mattocks et al. interviewed 20 women who had served and deployed in support of OIF/OEF. The women completed a semi-structured interview where they were asked to talk freely about their military experiences, including about their jobs, stressors, and coping mechanisms. For the women interviewed, one of the most stressful experiences, particularly while deployed, was the threat of sexual trauma. One of the women stated, “One of the problems over in Iraq for female soldiers is that there is a lot of sexual harassment and rape is huge…Women serving over there don’t have to be worried about enemy fire. They have to be worried about the guy that’s next to them, you know, that’s supposed to be protecting and taking care of them and a lot of times he becomes like public enemy number one for them” (p. 540). Of note was the prevailing notion that women felt that sexual harassment or sexual coercion were tied to opportunities for promotion and that those women who were promoted, were assumed to have performed sexual favors for those in leadership positions making those decisions. Many of
the women interviewed for the study had significant problems coping once returning from deployment, and faced problems reintegrating back into their lives at home and 32% of the participants had a clinical diagnosis of PTSD, with 11% carrying a diagnosis of depression and a further 11% receiving anxiety disorder diagnosis.

Mattocks et al. (2012) note that an important theme across the interviews they conducted was a sense that the women’s experiences while they were deployed were not understood or accepted by friends and family members when they returned and because their experiences are minimized or misunderstood by those around them, the women themselves tend to minimize their contributions. The women reported that this type of discrimination contributed to feelings of self-stigma, with several stating that they did not feel their experiences were worth enough for them to seek help.

Issues surrounding sexual harassment and sexual assault in the military have recently started to receive more attention, a change from decades of silence and enacted stigma. Military sexual trauma (MST) can range from sexual harassment to “quid pro quo” to unwanted advances or touches and even to completed rape (Middleton & Craig, 2012). LeardMann et al. (2013) surveyed 13,262 women serving in the U.S. military at baseline, then again three years later. Over 10% of participants in the study (1,362) reported at least one sexual stressor during the three years covered in the study. Of those, 80% (1,089) reported being sexually harassed, 8.9% (121) reported sexual assault, and 11.2% (152) reporting having been both sexually harassed and sexually assaulted. Overall, the 3-year cumulative incidence of sexual harassment was 9.4% \((n = 1,241)\) and sexual assault was 2.1% \((n = 273)\). However, women who deployed during the three-year period \((n = 1,193)\) experienced sexual harassment and sexual assault at almost twice the rate of the overall sample, with 20% reporting being sexually harassed \((n = 238)\) and 4%
reporting being sexually assaulted while deployed ($n = 48$). LeardMann et al. note that while deployed, women are not only in more stressful and dangerous circumstances than while at home, but also find themselves in male-dominated environments where perpetrators of sexual harassment and assault may be less concerned about the consequences and less likely to be held accountable for their actions. These women may therefore be less likely to report being sexually assaulted or harassed out of self stigma that they won’t be taken seriously or would end up being ostracized from those around them they otherwise rely on for support in a high-stress and, at times, life-threatening environments.

Miller, Canales, Amacker, Backstrom, and Gidycz (2011) explored the threat of stigma as a possible reason why women wouldn’t report a sexual trauma in a college sample of 144 women. The authors identified four common barriers to reporting: event minimization (e.g. “It wasn’t a big deal,” “It only happened once.”), self-responsibility (e.g. “I thought it was my fault,” “I didn’t say no flat out, so I couldn’t do anything about it.”), stigma threat (e.g. “I figured people wouldn’t believe me,” “I didn’t feel comfortable bringing it up with people,” “I didn’t want my parents to know—it would have caused problems,” “I would have felt ashamed”), and fear of trouble for the perpetrator (e.g. “I didn’t want to screw things up for him,” “I didn’t want to ruin this guys life.”). The authors also found that stigma threat was a predictor of sexual revictimization. These findings may help explain why women in the military would be reluctant to report being the victim of sexual assault or sexual harassment, particularly if the perpetrator is someone in a leadership position who has influence over her career or how she will be viewed and treated by those in her unit. It also highlights the importance of reducing the threat of stigma that surrounds reporting sexual harassments or sexual assaults, as 28% of the Miller et al sample ($n = 40$) was revictimized within 4 months of the study.
As women transition into combat roles within the U.S. military, they will likely face sexism within some of those units, a factor that would contribute to enacted stigma. This may be particularly true for units, such as infantry, armor, and artillery, which have never had women in their ranks. Young and Nauta (2013) examined four forms of sexist beliefs that may precipitate stigma towards women in the military and in combat. Old-fashioned sexism is described as overt discrimination directed towards women. This includes the idea that women may be inferior at performing tasks or jobs that have historically been held by men. Women, such as those who serve in combat arms roles historically held by men in the military, who do not conform to historical gender roles are likely to face this kind of sexism. Another type of sexism described by Young and Nauta is modern sexism. This type of sexism is more covert than old-fashioned sexism, taking a blind approach and denying that discrimination exists. This type of sexism also harbors resentment towards laws or actions taken by organizations to reduce or eliminate sexist discrimination. Sexism was also described as taking on both hostile and benevolent roles. Hostile sexism arises from negative stereotypes and public stigma towards women, resulting in anger towards that group. Benevolent sexism, which also arises from stereotyped beliefs, typically results in women being treated in a kinder, gentler way, following beliefs that women need to be nurtured and protected. This type of sexism may seem more benign than other types of sexism. However, carrying attitudes that women need to be protected because they can’t protect themselves, may foster negative attitudes and stigma directed towards women as they transition into combat roles, particularly when the actions and the tasks required of them may be inconsistent with the views men in their units have about how women should be treated.

Young and Nauta (2013) explored how these types of sexism may be related to attitudes towards women in the military and in combat in military affiliated civilian college students (n =
The results of their assessment revealed that all four types of sexism were negatively associated with attitudes towards women in combat and in the military. The authors hypothesize that this may be the result of two processes. First, those individuals who hold sexist beliefs join or appear to be drawn to the military at higher rates than those who do not. This is consistent with other research suggesting that individuals who join the military bring with them values centering around traditional gender roles (see Robinson Kurpius, & Lucart, 2000). Additionally, Young and Natura hypothesized that service in the military, a historically masculine organization, may increase sexist beliefs and reinforce gender stereotypes, leading to reduced levels of acceptance of women in the military and women serving in combat roles.

Ivarrson, Estrada, and Berggren (2005) explored attitudes and sexism towards women in the Swedish military, where women have served in all military occupations they are able to qualify for, including roles in infantry, artillery, and armor units (those units that up until 2013 excluded women in the United States), since the 1990s. Much like the U.S. military, women in the Swedish Armed Forces face challenges like sexual harassment and assault, discrimination, and enacted stigma. For their study, Ivarrson et al collected survey data from 1,320 male officers serving in the Swedish Armed Forces during 2002, assessing attitudes towards women in the military and perceived conflicts between traditional roles women have filled and roles they may fill in the military, including being involved in armed combat. The authors also asked questions related to classic and modern sexism, including questions such as, “I prefer a male boss to a female boss” (classic sexism), and “Discrimination of women is no longer a problem” (modern sexism). Overall, the authors found that attitudes towards women in the military are generally positive, noting that this finding may not be generalizable across cultures, as historically Swedish society has been more egalitarian toward women in work roles than other nations worldwide.
The authors also found that age and rank were positively correlated with positive attitudes towards women in the military – that is as age and rank increase, respondents were more likely to have positive attitudes towards women in military roles. This was also true for interpersonal contact with women in the military, suggesting that increasing positive contact with women in the military and in combat roles may reduce public stigma directed at women filling those roles and increase overall acceptance. Finally, the authors noted a relationship between both modern and classic sexism directed towards women. They found that those who endorsed higher levels of both types of sexism were less likely to have accepted women serving in the military.

In addition to challenges and stigma associated with sexism, sexual harassment and assault, and many years of discrimination, women in the military also experience mental health problems at a rate similar to men. In a large cohort study conducted at the Veterans Health Administration (VHA), it was found that of 103,788 OIF/OEF veterans seen in the VHA between 2001 and 2005, 13% were women (n = 13,652), 25% of whom received a mental health diagnosis. Over half of those receiving a mental health diagnosis were diagnosed with PTSD (52%), with military sexual trauma (MST), which the VHA defines as sexual harassment and sexual assault that occurs in the military environment, as the main contributing factor for women. (Seal, Bertenthal, Miner, Sen, & Marmar, 2007). Maguen, Luxton, Skopp, and Madden (2012) explored gender differences in exposure to traumatic experiences while deployed. This study was conducted utilizing data gathered during pre- and post-deployment screening with 6697 male and 554 female active duty U.S. Army soldiers who deployed to Iraq and Afghanistan between March 2006 and July 2009. The authors found that men had higher combat exposure than women (66% and 31% respectively). However, 12% of women deployed (n = 66) reported MST as compared to less than 1% (n = 32) men. The authors also noted that women reported
experiencing depression at a higher rate (13%) than men (11%). Dobie et al. (2004) had similar findings, reporting higher levels of depression, eating disorders, and anxiety in female veterans. Finally, Middleton and Craig (2012) conducted a literature review of PTSD among female veterans from 1990 to 2012. Based on their review, they identified the two main trauma experiences that occur in female veterans that may contribute to the development of PTSD as military sexual trauma and combat exposure. The authors also note that men are more likely than women to receive a PTSD diagnosis.

As previously discussed, individuals with mental health problems are at higher risks for both public and self-stigma. Given that women in the military already face the potential for discrimination, sexism, and military sexual trauma, particular attention should be directed toward this population to help reduce stigma in these areas as a potential way to improve treatment seeking, quality of life, and inequality within the military, particularly as women move into and play a larger role in combat units over the next 5 to 10 years.

**Proposal of Reduction in Stigma**

Reducing stigma and discrimination in the military will require a shift in attitudes and behaviors that are deeply engrained, many of which have been in place in the U.S. military for generations. Producing this type of change will require changes at multiple levels, including at the institutional, societal, and individual level, as each one influences the other (Collins, Wong, Cerully, Schultz, & Eberhart, 2012). Therefore, interventions designed to reduce stigma of mental illness, LGBT individuals, military sexual trauma, and women in combat, need to be focused on bringing about changes in institutional practices and policies, social norms, and individual beliefs and actions. By producing change that is mutually reinforced at all levels,
stigma and discrimination can likely be reduced, improving the lives of those populations negatively impacted by that stigma.

Pettigrew and Tropp (2006) conducted a meta-analysis of intergroup contact theory. Intergroup contact theory posits that a reduction in stigma and discrimination comes through social contact between those who foster negative beliefs about a certain group and members of that group. Pettigrew and Tropp suggest that when such contact comes under conditions where there are shared goals, support from individuals in power or authority, equal status, and a lack of competition between groups, positive growth occurs and there is a strong potential for reducing stigma and discrimination. Corrigan and Penn (1999) suggest that interventions directed at reducing stigma and discrimination should include direct, interpersonal contact, as well as education, including factual information directed towards disproving negative stereotypes.

On an individual level, focus should be place on fostering an environment where members of the dominant culture in the military can have positive interpersonal contact with members of the groups experiencing stigma and discrimination. As previous discussed, changes in public policy and law within the U.S. military over the past few years will allow for more openly gay and lesbian individuals, as well as women in combat arms units, to have positive interactions with other members of the military. Education efforts should focus on helping members of the military better understand the potential positive impact each of these groups can have on the overall mission, and on helping dispel myths that women, LGBT individuals, and those with mental illness degrade mission, unit cohesion, and overall morale. Providing a positive and safe environment promotes disclosure of sexual orientation, which will in turn increase opportunities for contact between gay and heterosexual service members and potentially
reduce stigma and discrimination. The same is true for mental illness and women serving in combat arms units (Pettigrew & Tropp, 2006).

Britt, Wright, and Moore (2012) examined the impact of leadership behaviors as predictors of stigma and barriers to treatment. The authors found that the actions of officers and noncommissioned officers (NCO) served as a strong predictor of stigma – that is subordinates look towards the attitudes and behaviors of their unit leadership (officers and NCOs) surrounding mental illness, LGBT individuals, women in combat, and sexual harassment and assault, and cater their own attitudes and behaviors to match. Therefore, a top-down approach may be a key in reducing stigma. Efforts should be directed at training, educating and promoting positive interpersonal contact between groups. Behavioral health professionals, particularly psychologists and social workers in the military, are in a unique position to provide this type of education, as they often have positive relationships with leadership and have the opportunity to provide this type of education and facilitate discussion. This could take the form of small group discussions, one-on-one conversations in side halls, or even briefs given in large groups at initial officer trainings and NCO academies, as there is some evidence that providing educational programs to individuals still in their initial training can bring about positive changes in attitudes. There is also some indication that education and contact can bring about reductions in self-stigma (Collins, Wong, Cerully, Schultz, & Eberhart, 2012).

On a societal level, focus should be placed on shaping and developing positives attitudes within the military community towards LGBT service members and their families, women serving in combat roles, and mental illness. Collins, Wong, Cerully, Schultz, and Eberhart (2012) suggest that mass media campaigns provide an opportunity to deliver educational messages to the larger community and foster positive dialogue and discussion between community members.
Such campaigns within the military should feature those in leadership positions who have themselves experienced stigma. For example, Sergeant Major of the Army, Raymond Chandler has often spoken publically about experiences with PTSD following his deployment to Iraq in 2004, where a rocket exploded in the room where he was. Chandler has also been open about seeking behavioral health services and the positive impact that help had not only on his own mental health, but on the welfare of his family and his unit (Nelson, 2012). Similarly, Brigadier General, Tammy S. Smith, celebrated her promotion to a flag officer in the United States Army by having her wife pin her star to her uniform, becoming the first openly gay general officer in the U.S. military (Wald, 2012). These types of positive, public figures can help to shape positive ideas in society about mental illness and LGBT service members and work to reduce stigma and discrimination.

Johnston (2013) highlighted the importance of fostering communication and dialogue not only between service members and their leadership, but also with the families of service members. Each branch of service within the U.S. military has a Family Readiness Group (FRG), a command-sponsored organization for family members within the unit (see U.S. Department of the Army, 2013). Education and training about mental illness, LGBT issues, and issues women face in the military given at FRG meetings can help create community discussion and directly address stereotypes and discrimination.

Finally, focus should also continue to be placed on enacting change in public policy and laws that may contribute to stigma and discrimination in the military. Over the past several years, the U.S. military has repealed DADT and changed policies allowing women in combat arms units. Recently, the U.S. Army instituted policy changes requiring each officer and NCO to be evaluated each year on their Officer Evaluation Report (OER) and Non-Commissioned Officer
Evaluation Report (NCOER) on their goals and objectives for reducing sexual assault and sexual harassment within their units and the Army as a whole (Rico, 2013). This type of policy change helps hold leadership accountable for enacting positive change and reducing stigma and discrimination. The U.S. military has also, over the past several years mandated formal sexual harassment and assault prevention training be completed by all service members regularly. Secretary of the Army, John McHugh set plans for an Army wide Sexual Harassment and Assault Response Prevention (SHARP) stand down day, where all training and day to day functions will be halted in order for leaders to talk with their soldiers and educate them about the realities of sexual assault and harassment in their units (see James, 2013). Further attention should be given to changing policies giving transgendered service members the same rights and privileges all other service members have, including the ability to be openly transgendered within the military.

**Directions for Future Research and Summary**

One important area of future research would be to examine perceptions of stigma in active duty service members who identify as LGBT, as well as their spouses or partners. As previously mentioned, prior to the repeal of DADT, such research was not able to be conducted. However, studies are underway, including collaboration between the Naval Center for Combat and Operational Stress Control (NCCOSC) and Palo Alto University looking at sexual minority stress and changes in perceived stigma post DADT (Johnston, 2013). Future research may also focus on assessing whether the repeal of DADT has had the negative impact on unit morale and cohesion that was feared for decades, preventing gay and lesbian service members from enlisting and from serving openly within their units.
Another area of future research could examine the effectiveness of current efforts to reduce stigma of sexual assault and sexual harassment. These efforts have included mandatory sexual harassment and assault response and prevention training, stand-down days, and recent changes to officer evaluation reports mandating each be rated on what they have done in their respective units to reduce sexual assault and harassment.

As women move into combat units, future research could focus on assessing the impact that women serving in those units on a number of variable, such as morale, unit cohesion, and impact to mission. Research should also focus on prevention of further sexual harassment and assault within those units, as well as examining the impact of combat related trauma on women serving in combat units.

Finally, research assessing organizational elements within the military that might contribute to stigma would be beneficial. This should include assessment of unit-level influences on perceptions of stigma and discrimination. This type of research could help behavioral health officers and commanders within those units develop and adapt interventions to address stigma within their unit.

Stigma of mental health, women, and LGBT service members prevents those who need help from seeking it and has negative impacts on unit morale and cohesion. Focused efforts to reduce stigma and discrimination within military units need to be directed at organization/institutional, society, and individuals levels. Interventions aimed at providing education and contact with members of these populations will help reduce stigma and increase quality of life for thousands of service members.
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AN EXAMINATION OF STIGMA IN THE MILITARY


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