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Comfort Levels of Active Duty Gay/Bisexual Male Service Members in the Military Healthcare System

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ABSTRACT Before a revision of the "Don't Ask, Don't Tell" policy in 2010, sexual behaviors that lesbian, gay, and bisexual service members disclosed to military healthcare providers (MHCPs) were grounds for discharge. However, after the revision, service members either did not know about the revision, or were still uncomfortable approaching MHCPs. This study examined the comfort levels of active duty gay/bisexual males approaching MHCPs about sexuality/sexual health concerns. Using a quantitative descriptive approach, the 31-item survey developed for this study provided initial research data to inform future studies on this topic. The survey was available to participants from March 2 to April 3, 2012. Analyzing responses from 30 participants, the data revealed a strong correlation between service members' comfort disclosing their sexual orientation to a MHCP and their perception of how the military cares about them as a sexual minority. The data suggested differences in comfort levels among age cohorts disclosing their sexual orientation, in addition to differences between officers and enlisted men concerning the cost of seeing a nonmilitary healthcare provider. MHCPs should understand that establishing a relationship with service members that encourages disclosure can improve their view of the military healthcare system and help address sexual health concerns.

INTRODUCTION

In 2008, approximately 70,781 lesbian, gay, and bisexual (LGB) men and women served in the U.S. military according to a 2010 report from the Williams Institute at University of California, Los Angeles. Of those, it is estimated that 7,216 were active duty men.[1] Before a revision to the "Don't Ask, Don't Tell" (DADT) policy in 2010, the sexual behaviors LGB service members disclosed to military healthcare providers (MHCPs) could be used against them in discharge proceedings.[2] There did exist an exception to this rule in departmental instructions (e.g., SECNAVINST 5300.30D and AR 600-110) concerning epidemiological surveillance and assessment of service members who tested positive for HIV. However, for all other disclosures, the rationale for the exemption of provider–patient privilege regarding sexual orientation was that MHCPs needed to be "free to report information on military necessity grounds."[3] The Department of Defense viewed the health and job performance ability of service members as essential to an effective military. MHCPs were to report any display of health behavior that military officials defined as unfit for service because it could negatively impact the military's mission. The Department of Defense considered homosexuality as incompatible with military service[4]; therefore, MHCPs were expected to report evidence of homosexual behavior. Consequently, LGB service members did not share the same privilege as LGB civilians whose conversations with their healthcare providers (HCPs) were confidential.

Nine percent of patients seeking care at the San Diego Gay Men's Health Clinic between June and August 2002 were male active duty U.S. Navy sailors who had sex with men (men who have sex with men [MSM]) and elected to pay $20 to $50 out of pocket per visit for care rather than receiving free care from MHCPs because they feared being discharged.[5] Researchers concluded that DADT "[bred] distrust between MSM service members and their healthcare providers and this ensures inadequate healthcare with a delay in diagnosis, treatment and preventative counseling for conditions that are more common in this population."[5]

This disparity in care for LGB service members led to the American Medical Association advocating for the ending of DADT in 2009 on the grounds that the policy negatively affected the relationship between providers and patients and jeopardized the healthcare of gay service members.[6] Healthcare problems specific to MSM include having a higher risk than men who have sex with women (MSW) for all bacterial and viral sexually transmitted infections. In addition, MSM are also 17 times more likely than MSW to develop anal cancer related to HPV.[7] Yet, despite the 2010 policy change that protected personal medical information related to the service member's sexual behaviors and healthcare problems from which sexual orientation may be inferred, many LGB service members still said they would

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not disclose same-sex sexual behavior while the remainder of DADT remained in place.[2]

This constellation of factors—a long-standing policy against "open service," LGB service members' distrust of MHCPs, and increased health risks for MSM—prompted the current study. Our interest also included barriers, such as cost, to service members seeking care. MSM service members had previously indicated a preference for nonmilitary HCPs concerning sexual health issues.[5]

The purpose of this study was two-fold: (1) to describe the attitudes and comfort levels of gay/bisexual male service members discussing sexuality and sexual health with MHCPs and (2) to determine barriers those service members may encounter seeking healthcare in the aftermath of the repeal of DADT. This research is timely and relevant since the very recent legislative repeal of DADT, which went into effect September 20, 2011. Before, access to this population for researchers had been difficult to obtain given the consequences to service members disclosing their sexuality. This is evidenced as recently as a November 2012 article published in *Military Medicine* that explored HIV infection rates in the Navy and Marine Corps. Because the data the researchers used was collected between 2005 and 2010 while the DADT policy was still in place, the sexual orientation of the service members studied could not be recorded.[8] Furthermore, the body of literature concerning the health of LGB service members is limited and deserving of more research. Understanding LGB service members' current attitudes, comfort levels, and barriers to sexual healthcare in the post-DADT military is critical because of health disparities that exist in the LGB community, including increased rates of mental health problems, substance abuse, and suicide. These disparities have reached a level that has garnered, for the first time, the attention of the U.S. Department of Health and Human Services in 2011 in its Healthy People 2020 initiative. Outlined in the Healthy People 2020 Topics & Objectives is the goal to improve the safety and health status of lesbian, gay, bisexual, and transgender (LGBT) people.[9] The coexistence of these disparities and the 18-year span of DADT have placed LGB service members at a heightened risk for health problems. Furthermore, the implications of this research can directly impact MHCPs as history takers and health screeners as we strive to reduce these disparities and improve the care we provide to both LGB and heterosexual service members.

METHODS

Participants

We used convenience sampling for participant selection. Partnering with the nonprofit organization, OutServe, we solicited survey respondents through Facebook. OutServe is a nonprofit organization comprising thousands of active duty LGBT service members in the United States Armed Forces. OutServe agreed to provide the web link to the study's survey to members through its "secret" Facebook group pages. Secret groups on Facebook are not visible or searchable to nonmembers. One can only become a member of a secret group by invitation from an existing member.[10] OutServe sent out weekly reminders for one month to its Facebook groups until we reached a sample size of 30.

Inclusion criteria were male gender, self-identified sexual orientation of gay or bisexual, and currently on active duty status in one of the five branches of the Armed Forces. Transgender service members, or the "T" in "LGBT," were not included in this study because the repeal of DADT did not include "open service" for transgender service members.

Research Design

To address the purposes of this quantitative descriptive study, we developed a 31-item survey consisting of 10 demographical items and 21 items exploring the topic of interest (e.g., comfort levels approaching MHCPs about sexuality and sexual health concerns). We used a 5-point Likert agreement scale to measure the responses. The most recent recommendations from the Questionnaire Design Research Laboratory of the National Center for Heath Statistic guided the design of the question asking participants of their sexual orientation.[11]

We constructed the survey using Qualtrics and provided access for responses from March 2, 2012 to April 3, 2012. Thirty-nine individuals attempted to complete the survey, but only 30 respondents met our inclusion criteria. The 9 respondents excluded from our analysis provided one or more disqualifying factors including female gender, status other than active duty, no response for sexual orientation, or incomplete survey. Statistical analysis was conducted using IBM SPSS Statistics. To simplify the data, we collapsed the following response categories: age (from 5-year increments to 10-year increments); pay grade (from individual ranks to "enlisted" versus "officer"); and race (from individual groups to "White" and "non-White").

The University of North Carolina at Chapel Hill Institutional Review Board approved this research study.

RESULTS

Participants were predominantly White, enlisted service members of the youngest age group (18–27 years old). Twenty-eight of the participants self-identified as gay and two as bisexual. The sample included service members from all five branches of the Armed Forces, educational backgrounds from high school diploma to graduate degree, and varying lengths of time served from 0 to 5 years up to 26 to 30 years. No respondents identified as older than 38 to 47 years. Of those who responded to the question regarding race (n = 29), the majority (n = 25, 86.2%) were White, and the remaining non-White respondents were African American or Hispanic (see Table I).

All respondents indicated that they understood that disclosing one's sexual orientation to an MHCP could not be

TABLE I. Demographic Characteristic Breakdown by Pay Grade as a Percentage of the Sample

Characteristic	Enlisted (n = 23)	Officer (n = 7)
Sexuality		
Gay	95.7	85.7
Bisexual	4.3	14.3
Age		
18–27 Years	69.9	14.3
28–37 Years	26.1	57.1
38–47 Years	4.3	63.7
Education Level		
High School Diploma or Equivalent (e.g., GED)	17.4	
Some College but No Degree	34.8	
Associate Degree	30.4	
Bachelor Degree	17.4	14.3
Graduate Degree		85.7
Military Branch		
Air Force	47.8	
Army	17.4	42.9
Coast Guard		14.3
Marine Corps	8.7	14.3
Navy	26.1	28.6
Time in Military		
0–5 Years	56.5	28.6
6–10 Years	30.4	
11–15 Years		28.6
16–20 Years	8.7	28.6
21–25 Years	4.3	
26–30 Years		14.3
	Enlisted (n = 22)	Officer (n = 7)
Race		
White	81.8	100.0
Non-White	18.2	

used against them as a reason for discharge, demotion, or as a means to prevent career advancement since the repeal of DADT. However, when responding to the following statement: "Since the repeal of the military's DADT policy, I am comfortable discussing my sexual identity/orientation and/or my sexual health with my MHCP without fear of punishment or discrimination," only 70% agreed, whereas 23.3% remained undecided, and 6.7% disagreed. A smaller number of respondents (n = 17, 56.7%) agreed with the survey item stating, "I feel that the military cares for my health and well-being, regardless of my sexual orientation." Agreement to the former item strongly correlated with agreement to the latter (r = 0.70, $p < 0.001$) using Pearson correlation (see Figure 1). Respondents also reported they felt that the military had failed to provide resources (e.g., brochures, pamphlets, web sites) specific to their sexual orientation and sexual health.

Because of the sample size, we performed Fisher's exact test comparing demographic groups with items based on response frequencies. For each survey item, we compared the responses of the different demographical subcategories that comprised our sample (e.g., education level, age group, years served, and so on). We consolidated our Likert scale responses to "agree" and "did not agree" to achieve a 2 × 2 cross tabulation. The comparisons revealed enlisted men and officers provided significantly different (p = 0.025) answers to the survey item: "If I see a nonmilitary healthcare provider regarding my sexual identity/orientation and/or sexual health, the cost of that visit is very important to me." Enlisted service members answered overwhelmingly (n = 16, 69.6%) that they agreed, whereas the majority of officers (n = 6, 85.17%) did not agree.

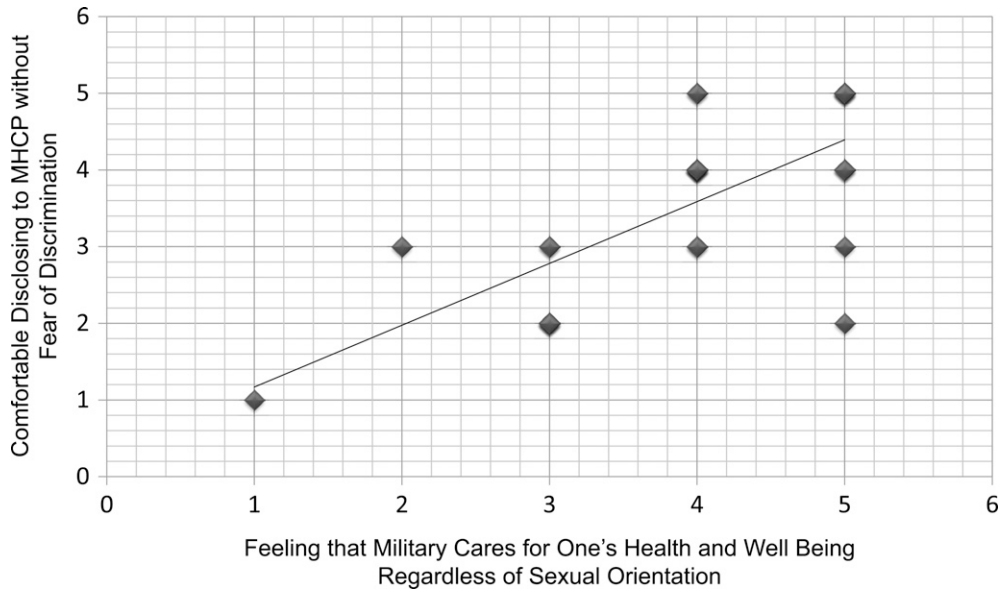

FIGURE 1. Correlation of Disclosure Comfort Level with Perception of Military.

On the issue of disclosure, the responses overall trended toward service members expressing comfort disclosing their sexual orientation, but only if their MHCP asked first. However, when comparing the responses of the three age groups, they noticeably differed, though not significantly. The 18- to 27-year-old and 38- to 47-year-old groups agreed (64.7% and 100%, respectively) that they felt comfortable disclosing their sexual orientation if prompted. Members of 28- to 37-year-old group were less inclined to disclose. Only 40% agreed they would disclose their orientation with prompting, whereas 40% remained undecided, and 20% disagreed. Following up on the topic of comfort level disclosing one's sexuality, only 16.7% of respondents indicated that they would never disclose to a MHCP. Responses to disclosure comfort without prompting by a MHCP were inconclusive.

On the issue of seeking a nonmilitary HCP for questions regarding sexuality and sexual health, 56.7% of participants replied that they preferred a nonmilitary HCP to a MHCP for their questions. Enlisted and officer response rates were nearly the same: 56.5% and 57.1%, respectively.

The remaining survey items did not provide reliable data. The results indicated confusion on the part of the participant (e.g., contradictory responses) or problematic wording with the item itself.

DISCUSSION

All participants responded they knew that their sexuality could not be used against them in their careers, but only 70% felt comfortable disclosing their sexual orientation and/or sexual health with a MHCP without fear of punishment or discrimination. Even fewer, 56.7%, felt the military cared for their health and well-being, regardless of their sexual orientation. The strong correlation between these last two items ($r = 0.70$, $p < 0.001$) indicated that service members who felt comfortable disclosing their orientation to an MHCP without fear of discrimination were likely to feel that the military cared for their health and well-being regardless of orientation. This significant finding warrants additional, in-depth exploration to determine if providing a comfortable environment that encourages disclosure would improve the service members' perceptions of the military and how the military accepts them as sexual minorities.

It is noteworthy that only 70% of respondents felt comfortable disclosing their sexual orientation, even though 100% acknowledged it could not be used against them punitively. This discrepancy supported the findings of Smith (2008) that the DADT policy led to a culture of distrust between LGB service members and MHCPs. It also realized the fears of the American Medical Association (2009) that DADT would damage the relationship between LGB service members and their MHCPs. Exploring whether this attitude is because of prerepeal sentiments, experiences postrepeal, or other reasons could provide measures to improve the trust relationship between the military healthcare system and sexual minority service members.

Officers and enlisted men demonstrated a significant difference ($p = 0.025$) in their attitude about the cost of seeing a nonmilitary HCP. Enlisted men noted that cost was very important to them, whereas officers noted that cost was not important. This is easily explainable: enlisted service members (especially younger members with less time served) earn considerably less salary than officers.[12]

Another trend in the data that suggested the need for additional research is the lack of comfort disclosing one's sexual orientation, as a function of age cohort, to a MHCP. Table II illustrates the response frequencies (consolidated into the categories: "agree," "undecided," and "disagree") of the different age groups to the statement: "I feel comfortable disclosing my sexual identity/orientation to my MHCP, but only if he/she asks about it first." The findings, although not significant, suggested that the 28- to 37-year-old group did not agree that they were comfortable disclosing their sexuality even when prompted. This differed from the youngest age group (18–27 year olds) and the oldest age group (38–47 year olds) who overwhelmingly agreed. However, the oldest age group was small ($n = 3$) and it was not possible to generalize that their answer to this item was representative of all 38- to 47–year-old gay and bisexual active duty men. Regardless, there was a clear difference in the responses to this item between 28 to 37 year olds and the other participants. This could be indicative of the current events during the time that these different age cohorts experienced sexual development and awareness. During adolescence, the 18- to 27-year-old group would have witnessed

TABLE II. Response Frequency by Age Group on Comfort Level Disclosing Sexual Identity/Orientation

			Age Categories		
			18–27	28–37	38–47
I feel comfortable disclosing my sexual identity/orientation to my MHCP, but only if he/she asks about it first	Disagree	Count	6	2	0
		% Within Age Categories	35.3	20.0	0
	Undecided	Count	0	4	0
		% Within Age Categories	0	40.0	0
	Agree	Count	11	4	3
		% Within Age Categories	64.7	40.0	100.0
Total		Count	17	10	3
		% Within Age Categories	100.0	100.0	100.0

legalization of same-sex marriage in parts of the United States and the world, the first-ever acknowledgement of gay Americans by a President-elect in his 2008 election victory speech, and numerous, successful gay and gay-friendly personalities in popular culture.

Respondents who were 28 to 37 years old at the time they took the survey ranged in ages from 7 to 24 years from 1991 to 1999, the decade of their sexual development and likely self-discovery of their sexual orientation. The 1990s saw the creation of the DADT policy (1993) and the Defense of Marriage Act (1996). The nation witnessed the murders of gay military service members Allen Schindler, Jr. (1992) and Barry Winchell (1999) in addition to the high profile murder of Matthew Shepherd in 1998. ABC News/Washington Post polling in 1993 showed that only 44% of Americans felt openly gay service members should be allowed to serve (compared to 75% by 2008).[13] Pew Research Center polling on the topic of same-sex marriage revealed 65% of Americans opposed such unions in 1996 where only 45% opposed and 46% approved by 2011.[14] Societal events and attitudes experienced by an individual of a sexual minority group have been shown to cause excessive stress leading to potentially poorer mental health outcomes than nonminorities.[15] It is plausible that the events of the 1990s that occurred during the adolescence of this study's 28 to 37 year olds had a negative effect on their comfort levels disclosing sexuality to a MHCP even after the repeal of DADT. This finding among this age group needs additional exploration to ascertain the barriers at the root of their lack of comfort. Furthermore, a greater number of 38 to 47 year olds should be sampled to obtain an accurate understanding of their perceptions regarding MHCPs and their comfort levels disclosing their sexual orientation. Efforts should be made to recruit and study gay and bisexual male service members 48 years old and older because they were not represented in this study. Understanding generational differences among subgroups could provide insight as to why one age cohort feels less comfortable than the others.

The difficulty of recruiting participants to take the survey poses a limitation to this research. OutServe was the gatekeeper to the desired population and was relied on to publicize the link to the survey in secret Facebook groups only visible to members of OutServe, thus limiting our ability to control recruitment. Furthermore, leading up to the legislative repeal of the DADT policy, service members took many surveys on the matter, and it is possible that our population had been overexposed to research/opinion surveys in general. In addition, the shadow of DADT is long: many service members may still be uncomfortable participating in any study researching sexuality or sexual health behaviors.

As a result of the difficulty with recruitment, the sample size was small. The number of participants limited which statistical analyzes could be conducted and the generalizability of the results to the larger population of gay and bisexual male service members in the Armed Forces.

These findings indicate a need for MHCPs to address service members' barriers to disclosing sexual orientation in order to discuss sexual health. Conversations between providers and patients about sexual health often occur within the context of illness, or when something has gone wrong, and not as a part of general, overall health.[16] Stigma and marginalization associated with sexual minorities have led to increased rates of self-harm, unhealthy behaviors, and lowered self-esteem.[17] Combining existing literature with these results, MHCPs can tailor their approaches to history taking to ensure that at-risk populations do not go unnoticed. Recognizing that gay and bisexual male service members may be reluctant sharing their sexual orientation should not deter MHCPs from establishing a relationship of trust that encourages disclosure. Through positive, therapeutic, and patient-centered communication MHCPs may be able to bridge the gap of distrust between these service members and the military healthcare system.

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REFERENCES

1. Gates GJ: Lesbian, gay, and bisexual men and women in the US military: Updated estimates. Los Angeles, University of California, The Williams Institute, 2010. Available at http://escholarship.org/uc/item/0gn4t6t3; accessed January 20, 2013.
2. Katz K: Health hazards of "don't ask, don't tell." N Engl J Med 2010; 363(25): 2380–1.
3. Office of the Under Secretary of Defense (Personnel and Readiness): Review of the effectiveness of the application and enforcement of the department's policy on homosexual conduct in the military. Washington, DC, Department of Defense, 1998. Available at http://dod.mil/pubs/rpt040798.html; accessed January 29, 2013.
4. U.S. General Accounting Office: Defense force management: DOD's policy on homosexuality (GAO/NSIAD-92-98). Washington, DC, U.S. GAO, 1992. Available at http://gao.gov/assets/160/151963.pdf; accessed January 20, 2013.
5. Smith DM: Active duty military personnel presenting for care at a gay men's health clinic. J Homosex 2008; 54(3): 277–279.
6. O'Reilly KB: AMA meeting: "Don't ask, don't tell" said to hurt patient care; Repeal urged, 2009. Available at http://ama-assn.org/amednews/2009/11/23/prsc1123.htm; accessed January 20, 2013.
7. Center for Disease Control & Prevention: Gay and bisexual men's health: Sexually transmitted diseases. Atlanta, GA, CDC, 2010. Available at http://cdc.gov/msmhealth/STD.htm; accessed January 20, 2013.
8. Brett-Major DM, Hakre S, Naito NA, et al : Epidemiology of contemporary seroincident HIV infection in the Navy and Marine Corps. Mil Med 2012; 177(11): 1328–34.
9. Healthy People 2020: Lesbian, gay, bisexual, and transgender health. Washington, DC, U.S. Department of Health and Human Services, 2011. Available at http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25; accessed January 20, 2013.
10. Facebook Help Center: What are the privacy options for groups? 2012. Available at https://facebook.com/help/220336891328465/; accessed January 20, 2013.

11. Miller K, Ryan JM: Design, development and testing of the NHIS sexual identity question, 2011. Atlanta, GA, Center for Disease Control and Prevention National Health Statistics Institute. Available at http://cdc.gov/qbank/report/Miller_NCHS_2011_NHIS%20Sexual%20Identity.pdf; accessed January 20, 2013.
12. Defense Finance and Accounting Service: Military pay tables—1949 to 2013. Available at http://dfas.mil/militarymembers/payentitlements/militarypaytables.html; accessed January 20, 2013.
13. Guskin EB: Attitudes toward "don't ask, don't tell" policy radically change. ABC News, 2008. Available at http://abcnews.go.com/Polling Unit/Politics/story?id=5387980&page=1; accessed January 20, 2013.
14. Pew Research Center: Growing public support for same-sex marriage, 2012. Available at http://people-press.org/2012/02/07/growing-public-support-for-same-sex-marriage; accessed January 20, 2013.
15. Meyer IH: Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull 2003; 129(5), 674–97.
16. French K: How to improve your sexual health history-taking skills. Practice Nurse 2010; 40(2), 27–30.
17. Weber S: Parenting, family life, and well-being among sexual minorities: nursing policy and practice implications. Issues Ment Health Nurs 2008; 29(6), 601–18.