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Strength, Resilience, and Resistance Among LGBT Service Members and Veterans: A Clinically-Oriented Content Analysis of the Film *The Camouflage Closet*

by
Maria Heliana Ramirez

A dissertation submitted in partial satisfaction of the
requirements for the degree of
Doctor of Philosophy in Social Welfare
in the
Graduate Division
of the
University of California, Berkeley

Committee in charge:
Professor Kurt Organista, Chair
Professor Paul Sterzing
Professor Adrian Aguilera
Professor Daniel Fisher
Summer, 2017

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Abstract

Strength, Resilience, and Resistance Among LGBT Service Members and Veterans: A Clinically-Oriented Content Analysis of the Film *The Camouflage Closet*

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Maria Heliana Ramirez

Doctor of Philosophy in Social Welfare
University of California, Berkeley
Professor Kurt Organista, Chair

Due to prohibitions against U.S. military service among lesbian, gay, bisexual, and transgender (LGBT) people (e.g., Don't Ask, Don't Tell and the ban on transgender military service), little is known about LGBT service members and veterans. A growing body of research has identified disproportionate medical and mental health problems among LGBT veterans, which are associated with LGBT military minority stressors. The existing literature's problem focus and lack of intervention research, combined with a paucity of culturally competent clinical training, leave social workers ill equipped to provide strength-based care as mandated by the Council on Social Work Education and National Association of Social Workers. This qualitative study uses Grounded Theory to analyze the verbal and nonverbal communication of 9 LGBT veterans featured in *The Camouflage Closet*, a documentary film about trauma and recovery. Considered within the contexts of current political and social climate, and historical representations of veterans, LGBT people, and LGBT veterans in film and news media, this study identifies several new insights into LGBT military minority stressors and strengths. Findings include LGBT military-specific moral injury, post-traumatic growth, love, and the unique ability to communicate experiences of PTSD and LGBT military minority stress and resilience through visual representation. This study concludes with suggestions for strength-based research, policy, and practice with LGBT veterans.

Key Words: LGBT Military Minority Stress, Resilience, Strength-based Practice

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"Perhaps the most valuable thing we can learn in life is how to develop the kind of inner structure that is both sturdy and flexible, solid and adaptable, hardy and responsive, so that we can hold the heart-breaks, bear witness to our struggle and be with the uncertainty of our path."

-Chani Nicholas, *Saturday's Full Moon in Capricorn*

Introduction

The Veterans Administration (VA) promotes the motto “We Serve All Who Served” however little is known about lesbian, gay, bisexual, and transgender service member and veterans’ (LGBT SM/Vs) health status, military experiences, or lives post-discharge (Burks, 2011; Sinclair, 2008). The paucity of information about LGBT SM/Vs’ health and life in the military and civilian society, pose barriers to culturally competent, strengths based social work practice (Ramirez & Bloeser, *in press*). Emerging research suggests an association between service under anti-LGBT military policies and medical and mental health problems, but little is known about LGBT SM/Vs’ strengths and resilience (Johnson, Rosenstein, Buhrke, & Haldeman, 2013; Ramirez & Sterzing, 2017).

Culturally competent, strengths based care for LGBT SM/Vs can draw from LGBT SM/Vs’ significant contributions to the military and society at large. LGBT SM/Vs are credited with the establishment of the United States Military and several of the country’s first LGBT advocacy organizations (Shilts, 1993). Additionally, the Gay and Transgender pride flags flown worldwide today, were designed by Army veteran Gilbert Baker and Navy veteran Monica Helms (Barrios, 2004; Shilts, 1993). Most recently, LGBT veterans’ contributions to civilian society include a lawsuit by transgender veteran Denee Mallon resulting in Medicare coverage of gender transition-related surgery and Marine Corps veteran, Imran Yousuf who saved the lives of 70 LGBT people at the 2016 Orlando gay nightclub massacre (Associated Press, 2014; Holley, 2016).

Stories of LGBT SM/Vs’ heroism and everyday acts of strength and resilience are beginning to surface in documentary films and social science literature (Estes, 2005; Herzog & Orabona, 2013; Nedelman & Ramirez, 2013; Pierson, 2003; Ramirez & Sterzing, 2017; Seefried, 2011; Symons, 2008). Documentary film is increasingly used by social scientists as a secondary data source, by instructors to teach medical and mental health professionals, and mental health activists to reduce stigma among mental health consumers and society at large (Adami, 2009; Chouliaraki, 2006; Erickson, 2011; Goodwin, 1994; Jewitt, 2012; Quinn, Shulman, Knifton, & Byrne, 2011).

The purpose of this study is to identify military minority stressors faced by LGBT SMVs, and the strengths and resilience they used to cope in an exclusionary military environment (Ramirez & Sterzing, 2017). In order to achieve this goal, the first-person narratives of LGBT veterans in the film *The Camouflage Closet* (Nedelman & Ramirez, 2013), are examined as a means to inform culturally competent, strengths-based social work practice and research. Developing a deeper understanding of LGBT military minority stressors and the strengths LGBT SM/Vs generated to survive hostile environments, is critical to strength-based clinical care, especially in a moment of political upheaval at home and abroad (i.e., renewed debate regarding transgender military service in the United States Armed Forces and escalating American military activity worldwide; Bierman & Hennigan, 2017; Frank, 2017; “From Afghanistan to Syria,” 2017).

Significant shifts in LGBT-related military policy and politics have occurred over the past 6 years. On September 20, 2011, the repeal of the Don’t Ask Don’t Tell (DADT) Policy enabled LGB people to serve openly in the military for the first time in American history. The significance of this policy change cannot be overstated for America’s nearly

1 million LGB veterans and 70,500 LGB service members (i.e., active duty, Reserves and Guard; Gates, 2010). For America's 134,000 transgender veterans and 15,500 transgender service members (including active duty, Reserves, and Guard; Gates & Herman, 2014) the July 1, 2016 repeal of the transgender military service ban culminated decades of advocacy and struggle. On January 20, 2017 however, the U.S. Military reported to a new Commander in Chief and many feared his pick for Secretary of Defense, former General James Mattis, signaled a reversal to the LGBT military service gains achieved by the Obama Administration.

While the anti-LGBT military service bans have been repealed, study of stressors and strengths among LGBT SM/V may still be relevant given White House appointments and nominations of people with anti-LGBT track records. In 2016, Gen. Mattis edited the book *Warriors & Citizens: American Views of Our Military*, which asserts that DADT repeal damaged the U.S. Military. This claim runs contrary to findings by researchers of the Palm Center, the U.S. Military Academy, Naval Academy, Air Force Academy, and Marine Corps War College, who report that DADT repeal did not harm military readiness, recruitment, retention, cohesion, or morale (Belkin et al., 2012).

In addition to Mattis' appointment, the anti-LGBT track records of nominees Heather Wilson for Secretary of the Air Force and Mark Green for Secretary of the Army also raise concern among LGBT service members who are skeptical of initial White House claims that LGBT military service bans will not be reinstated (Kheel, 2017; Mitchell, 2017). In fact, a tweet by the current Commander in Chief on July 26, 2017 ordered the military to reinstate the transgender military ban (Lamothe, 2017). Sheri Swokowski, the highest ranking out transgender military leader (i.e., served 34 years as an infantry officer), explains her continued fight for LGBT military service stating that, "as a transgender member of the military, I hid my authentic self for decades to continue serving the country I love. Unlike Green, I was forced to serve in silence the entire time, but I won't be silent now" (Swokowski, 2017).

While it is unknown if and how the 2016 election is affecting LGBT SM/Vs' mental health, increased stress and anxiety are documented among LGBT people during previous anti-LGBT policy debates (Rostosky, Riggle, Horne, Denton, & Huellemeier, 2010; Russell & Bonhan, 2005; Russell & Richards, 2003). For LGBT SM/Vs living with Post-Traumatic Stress Disorder (PTSD)[1], the uncertainty of a rapidly shifting world including news coverage of escalating military activity, terrorist attacks, broadcasts of anti-LGBT commentary (especially LGBT military service debates), may exacerbate trauma-related symptoms such as rumination, paranoia, irritability, insomnia, and depression (Ahern et al., 2002; Herek, 2009; Putnam, 2002; Rostosky et al., 2010). LGBT SM/Vs experiencing worsening PTSD symptoms may be more inclined to seek health care services from the Veterans Affairs (VA), community-based facilities, and the military.

It is unclear however, the extent to which health care providers are prepared to work with military populations in general (Canfield & Weiss, 2015; Frey et al., 2014) and LGBT veterans in particular (Kauth, Meier, & Latini, 2014; Stebnicki, Grier, & Thomas, 2015). A paucity of training on culturally competent practice with military and LGBT populations exists in schools of social work, psychology, medicine, and nursing (Biaggio, Orchard, Larson, Petrino & Mihara, 2003; Bogo, Tsang, & Lee 2010; Braun et al., 2017; Craig et al., 2014; Logie, Bridge, & Bridge, 2007; Obedin-Maliver, et al., 2011; Ruben,

et al., 2017; Shrader et al., 2017; Taylor, Condry, & Cahill, 2017). In a study of VA providers, only 47% had received training in LGBT patient care during their professional education and only 43% had received LGBT clinical training following completion of their professional education (Sherman, Kauth, Ridener, Shipherd, Bratkovich, & Beaulaiu, 2014). This author is unaware of any graduate programs offering an entire course on LGBT SM/V health.[2]

The purpose of the current study is to analyze the strength and resilience that LGBT service members exerted in response to minority stressors experienced while serving under anti-LGBT military policies such as DADT and the transgender military service ban. More specifically, this study addresses the following research questions:

1. What types of minority stressors did LGBT service members experience because of their sexual orientation and gender identity while serving under anti-LGBT military policies?
2. What types of strength and resilience did LGBT service members use to cope with a military environment hostile toward LGBT people?

Literature Review

Recognizing that most social workers will serve military or veteran clients at some point in their career (Pelts, Rolbiecki, & Albright, 2015) and that this work is overwhelmingly cross cultural in terms of military service (i.e., most social workers are not themselves service members or veterans[3]), the Council on Social Work Education published advanced practice competencies for military populations and has encouraged schools of social work to infuse their curricula with military-related content (CSWE, 2010). In 2012, the National Association of Social Workers (NASW) followed suit by drafting standards for social work practice with military personnel and veterans. These standards direct social workers to provide LGBT affirmative services (i.e., non-pathologizing, non-oppressive) and strengths-based care to military and veteran clients (NASW, 2012). Neither the CSWE nor the NASW provide specific clinical suggestions (e.g., interventions) for LGBT SM/Vs. In fact, this author is unaware of any established evidence based practice with LGBT military or veterans (e.g., treatment for substance abuse, suicide prevention, or military sexual trauma that is tailored to address the LGBT military minority stressors associated with the issues for which they seek care; Ray-Sannerud, Bryan, Perry, & Bryan, 2015). To help inform this gap in LGBT SM/V clinical care, the following literature review considers 1) what we know about LGBT veterans, 2) theories related to stress, resilience, and post-traumatic growth, 3) the current state of LGBT Veteran Care, 4) the use of film in clinical education, 5) representations of LGBT veterans in the news media and film industry, and 6) anti-oppressive film analysis.

What we know about LGBT Veterans

LGBT people have served in the U.S. Military since its inception (Sinclair, 2008). Beginning with the formation of the U.S. Military in the American Revolutionary War (1775-1783), Baron Von Stuben, a man who had sexual relations with other men[3] is credited with having drafted the first drilling manual and joining the early disorganized bands of militias into a unified military force (Shilts, 1993; Segal, 2016). Also since the inception of the U.S. Military, LGBT people have been discharged for their sexual orientations and gender identities, although the rates of discharge fluctuated based on the

military's needs (i.e., fewer discharges during war time and in mission critical job functions; Estrada, 2012; Frank, 2004), evolution of various anti-LGBT policies, and development of the profession of psychiatry. Discharges of LGBT people were first institutionalized during World War I (1914-1918) through military laws regarding "the intent to commit sodomy and the act of sodomy," however it was during World War II (1939-1945) that "psychiatry's focus on screening homosexuals from military service… provided an identity and purpose for the profession outside of their well defined roles within the quickly downsizing mental asylums" (Pelts, Rolbiecki, & Albright, 2015; p. 210). While anti-LGBT military policies such as DADT (1993-2011) asserted that LGBT people are a risk to military effectiveness, history suggests otherwise.

In spite of anti-LGBT military policies, LGBT service members have made significant contributions to the U.S. military such as taking on high risk assignments and serving in special operations units like the Navy SEALS (see film *Lady Valor*); saving lives through the design of maps and camouflage and the provision of military medicine (Estes, 2005; Shilts, 1993); providing translation services, participating in the military police force and pastoral care (Estes, 2005; see film *Do Ask*); and raising troop morale through performances of Soldier Shows which brought levity to service members under the extreme stress of combat (Berube, 1999). That these accomplishments were made in a climate where LGBT service members were discriminated against (including physical and sexual assault) is a testament to their strength and resilience (Bloeser & Ramirez, *in-press;* Bosson, Weaver, Caswell, & Burnaford, 2012; Burks, 2011; Pelts, Rolbiecki, & Albright, 2013). The extent to which SM/Vs disclosed LGBT identities in the military differed by war era, service station, and branch of service with some coming out to military colleagues while others went to great lengths to conceal their identities (Curtis, 2014; Estes, 2005).

Little is known about the medical and mental health of LGBT military due to previous anti-LGBT military service bans (Campbell et al., 2017), however it appears that the effects of military service under anti-LGBT military policies may warrant interventions that address the bio-psychosocial domains of LGBT SM/Vs' lives (i.e., interventions regarding physical health, mental health, sexual health, spirituality, family wellness, and community engagement). To begin with, anti-LGBT Military policies created unique barriers to LGBT SM/V's health and access to care. The fear of discharge prevented some LGBT service members from accessing military healthcare and chaplain's services (Aitkin, Alexander, Gard, & Shanahan, 2010; Smith, 2008). Anti-LGBT military policies also generated reluctance among some military physicians to assess service members' sexual histories out of a desire to protect their patients' careers (Aitkin, Alexander, Gard, & Shanahan, 2010; Katz, 2010). Additionally, DADT forced commanders to chose between violating the law and undermining unit cohesion by firing LGBT service members (Aitkin, Alexander, Gard, & Shanahan, 2010). Due to the impact of anti-LGBT military policies on medical and mental health care, it may be particularly important to discuss with LGBT veteran clients, issues of trust with providers and institutions, confidentiality, mandated reporting, and patient rights.

Under DADT, LGBT service members raising children with a same sex parent also faced the LGBT Military Minority Stressor of being denied access to military healthcare and survivor's benefits for their families when registering the child could identify the service member as LGBT (e.g., a benefits form that asks for the name of a

same gender spouse or co-parent; Westcott & Sawyer, 2007). Research also describes challenges with socializing between LGBT service members due to the "guilt by association" of anti-LGBT military policies and widespread investigations, 80% of which, were instigated by an LGBT service member being forced to identity and incriminate other LGBT service members (Shilts, 1993). The interrogation tactic of forcing detainees to identify other people, was also used during the Inquisition, and resulted in anti-LGBT military investigations being labeled "witch hunts" (Shilts, 1993).

The health outcomes associated with serving under anti-LGBT policies include mental health challenges, substance abuse, and risky sexual behavior. Researchers are finding an association between level of sexual orientation concealment and social isolation during military service and the development of depression and PTSD (Cochran, Balsam, Flentje, Malte, & Simpson, 2013). Additionally, alcohol dependence is associated with depression, anxiety, and PTSD symptoms among LGBT service members (Parsons, 2013). While the rates of HIV among LGBT service members is unknown, from 2010 to 2015, HIV sero-conversion rates increased in the military from 21 to 74 per 100,000, with the highest rates in the Reserve and National Guard components (Armed Forces Health Surveillance Center, 2015, as cited in Campbell, Jahan, Bavaro, & Carpenter, 2017). For LGBT SM/Vs, risky sexual behavior is thought to be associated with the pressures of concealing one's LGBT identity under anti-LGBT military policies (Kauth, Meier, & Latini, 2014). Discomfort with LGBT identities and physical disabilities (i.e., beliefs that same sex behavior is a taboo topic for clinical discussion and that people with disabilities are not sexual beings) further complicate LGBT veterans' access to providers who address their sexual health needs (Cameron et al., 2011). It may be that following repeal of DADT and the Defense of Marriage Act, LGBT service members will increasingly come out to military medical providers as 56.7% of gay and bisexual military personnel report a belief that the military health system cares for their health regardless of sexual orientation. Additionally, 70% of LGBT service members report feeling comfortable disclosing their sexual orientation to military medical providers (Biddix, Fogle, & Black, 2013).

LGBT-related investigations were often traumatizing as LGBT service members were followed on and off base with their personal communications intercepted by military investigators and arduous interrogations that lasted hours and at times involved violence and coercion (Shilts, 1993). One of the consequences of anti-LGBT military service bans is LGBT-related victimization in the form of military sexual trauma (MST; Burks, 2011). As compared to heterosexual service members, LGBT service members experienced higher rates of sexual assault (4.5% vs. 0.8%), sexual harassment (22.8% vs. 6.2%) and gender discrimination (8.8% vs. 3.2%) during their military service (Department of Defense, 2017). One study found that transgender veterans experience MST at rates of 19.5% among transgender men and 13.5% among transgender women veterans (Lindsay et al., 2016). Research on LGBT veteran health suggests that stressors of serving under anti-LGBT military policies including MST and forced concealment of LGBT identities, are related to disproportionate medical and mental health challenges (Burks, 2011; Cochran et al., 2013; Johnson et al., 2013). LGBT veterans have elevated rates of PTSD, depression, smoking, substance abuse, histories of sexual assault, suicide, mobility limitations, asthma, high rates of involvement in the criminal justice system (among transgender veterans), and higher mortality from cancer-related illness

(especially among lesbian and bisexual veterans) as compared to heterosexual and cisgender veterans but access healthcare less frequently than non-LGBT veterans (Blosnich, Bossarte, Silver, & Silenzio, 2012; Blosnich, Brown, Wojcio, Jones, & Bossarte, 2014; Blosnich, Mays, & Cochran, 2014; Blosnich & Silencio, 2013; Booth et al., 2011; Brown & Jones, 2016; Kauth, Barrera, Denton & Latini, 2017; Lehavot & Simpson, 2014; Lehavot et al., 2016; Mattocks et al., 2013; McDuffie & Brown, 2010).

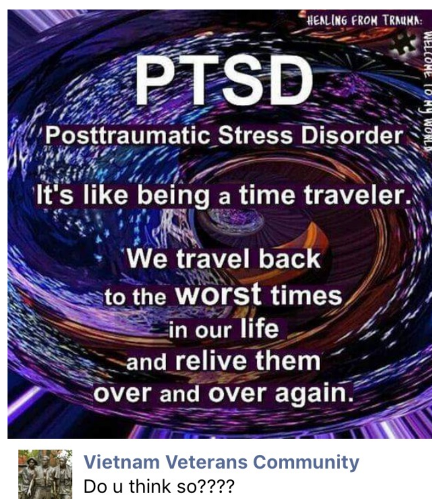
Within group differences in health disparities have been identified between LGBT veterans and civilians, between lesbian and bisexual veterans and their heterosexual women veteran peers, and among LGBT veterans according to social determinants like class. Lesbian and bisexual women veterans have higher rates of mental distress and smoking and three times the odds of poor physical health as compared to sexual minority civilians (Blosnich, Foynes, & Shipherd, 2013). Lesbian and bisexual women who served in OEF/OIF conflicts are also significantly more likely to have experienced sexual trauma during childhood and military service as compared to heterosexual women veterans (MST: 31 % vs. 13 %, $p < .001$; childhood sexual trauma: 60 % vs. 36 %, $p = .01$), engage in hazardous drinking (32 % vs. 16 %, $p = .03$), and describe worse mental health following military service (35 % vs. 16 %, $p < .001$, Mattocks et al., 2013). In addition to the social determinant of gender, class also appears to negatively impact LGBT veteran health in terms of financial barriers to accessing healthcare (Blosnich & Silenzio, 2013). While housing instability and homelessness are associated with health disparities among transgender veterans (Blosnich et al., 2017; Brown & Jones, 2016), geographic location is associated with depression among gay veterans living in rural areas as compared to gay veterans living in urban areas (Kauth, Barrera, Denton, & Latini, 2017).

Due to the potentially immediate lethality of suicide, it is important to note the disproportionately high rates of suicide among LGBT veterans (Blosnich, Bosarte, & Silenzio, 2012; Blosnich, Brown, Wojcio, Jones, & Bossarte, 2014; Herrell et al., 1999; Matarazzo, Barnes, Pease, Russell, Jetta, Hanson, Soberay, & Gutierrez, 2014; Ray-Sannerud, Bryan, Perry, & Bryan, 2015). A 1999 twin cohort study of veterans who served in Vietnam found that 55.3% of male veterans who had at least one male sexual partner in their lifetime reported suicidal ideation, more than twice the rate of veterans who only had women sexual partners at 25.2% (Herrall et al., 1999). A lack of social support is associated with higher rates of suicidal thoughts among LGB veterans (11.48%) as compared to heterosexual veterans (3.48%; Blosnich, Bossarte, & Silenzio, 2012). In terms of gender minority veterans, Blosnich and colleagues (2013) report that veterans diagnosed with Gender Identity Disorder in the Veterans Health Administration (this study was conducted prior to the DSM V diagnosis of Gender Dysphoria), have a 20 times higher rate of suicide-related events (e.g., suicide attempts and plans) than veterans without this diagnosis. Based on a review of suicide among LGBT veterans, Matarazzo and colleagues (2014), conclude that elevated rates of suicidal thoughts and behavior may be due to a combination of "habituation to pain via experiences of victimization" and military and combat training that increases the ability to commit suicide through access to weapons (p. 13).

Similarly to suicide, rates of PTSD are higher among LGBT veterans. In a study of women veterans, lesbian and bisexual women veterans scored positively for PTSD at 39% and heterosexual women veterans scored 32% (Lehavot & Simpson, 2014). In a study comparing LGB veterans to veterans at large in the VA, Cochran and colleagues

(2013) found significantly elevated rates of PTSD among LGB veterans as compared to the VA sample (1.6 points, 95% CI: 1.5–1.7, $p < .001$), with LGB veterans having a five times higher likelihood ($OR_{adj} = 5.8$, 95% CI: 4.6–7.2, $p < .001$) of scores requiring additional PTSD assessment in the VA. Among transgender veterans, PTSD rates were found to be 38.73% among veterans with a transgender related diagnosis as compared to 17.98% among veterans without a transgender related diagnosis (Brown & Jones, 2016). In a review of the literature describing sexual health among veterans, Kauth (2012) describes research findings that PTSD is associated with sexual dysfunction such as reduced libido, sexual satisfaction, intimacy, and dyadic adjustment, which can be exacerbated by medications used to treat PTSD such as SSRIs. In addition to sexual dysfunction, flashbacks or re-experiencing the traumatic event are symptoms described by some veterans living with PTSD as affecting their sense of time as depicted in the below image. Often in a state of hyper-alert, PTSD symptoms also affect veterans' ability to work, care for family and themselves, and participate in society (Seahorn & Seahorn, 2008).

Figure 1: Image from the Vietnam Veterans Community Facebook page (Posted June 6, 2017).



Out of the 48 articles identified by this review, only 3 empirical studies of LGBT veterans were identified that address their strengths and resiliencies. In a study of older transgender people, prior military experience was found related to lower levels of depression and higher quality of life (Hoy-Ellis et al., 2017). The authors state this finding is consistent with research suggesting that military service leads to posttraumatic growth by "fostering resilience through adversity, not despite adversity" (p. S68). Relatedly, Curtis (2014) identified adaptive coping strategies that lesbian and gay military couples developed to manage service under anti-LGBT military policies. Curtis' respondents describe strategies to assess safety such as "reading" (or evaluating) the relative risk of particular military duty stations and colleagues (i.e., the extent to which DADT was enforced and level of anti-LGBT bias in their units) and "testing the water" before disclosing LGBT identity to colleagues (p.62). Additionally Curtis' respondents sought to increase their safety by identifying a "safe person" with whom they could come

out (p. 63). Respondents further negotiated the "camaraderie paradox" created by DADT (i.e., concealing their LGBT identities but still maintaining a sense of camaraderie with colleagues) through "leading a double life" and being "social yet distant" (p. 66). Additionally, respondents protected themselves by communicating with same sex partners in coded language or by changing the partner's name to appear the opposite gender, viewing the deployment as making their relationships stronger, and finding "strength in numbers" through connection with other LGBT service members (p.78).

Trivette (2010) also examines the strategies LGBT service members used to manage the stress of anti-LGBT policies. Trivette concludes from interviews with 24 gay and lesbian veterans, that rather than preventing LGB service members from publicly expressing their sexual orientation, DADT instead fostered an underground queer community where LGB military service members developed distinctly gay military identities and subculture.

Reviews of LGBT veterans' first-person narratives in literature and film, have also begun to identify strengths among LGBT service members including the use of camp/humor, building invisible support systems (e.g., warning one another of investigators), providing couple's mediation following break ups to reduce the number of jilted lovers reporting one another to command, co-opting military resources, radicalized activism, and queering military spaces (Ramirez & Bloeser, *in-press;* Ramirez & Sterzing, 2017). Shilts (1993) highlights TJ Sterben's model of combining strengths from military and LGBT civilian communities to address the mental health needs of service members living with HIV/AIDS. TJ Sterbens was a Marine who lived on the AIDS unit of the Oak Knoll Naval Hospital in Oakland, CA, in the 1980s, which was plagued by rabidly homophobic doctors who quoted scripture damning them to hell during treatment. In response to widespread depression and patient suicides on the ward, Mr. Sterbens rallied the patients to do 7:30 am musters because "they were in the military…[and] needed to act like it" (Shilts, 1993, p. 545). Additionally, Mr. Sterbens invited local clergy to provide AIDS ministry and organize peer support groups. Shilts (1993) credits the combination of calisthenics and group membership of military culture with the peer support and AIDS ministry of the gay community, as having helped raise the spirits of the medical unit.

Just as gay and lesbian civilians and veterans rallied to advocate and care for gay men living with AIDS in the civilian population through groups like ACT UP (AIDS Coalition to Unleash Power; Shilts, 1993), gay veterans also organized amongst themselves through groups such as the Alexander Hamilton Post 448 American Legion in San Francisco, CA. As the nation's only LGBT American Legion, Post 448 members provided care to SM/Vs hospitalized for AIDS related illnesses in the VA and community hospitals, bringing them makeup to cover Kaposi Sarcoma wounds, advocating for their care with medical professionals, providing nurturance and support during hospice, and paying final respects to the families who lost their sons to AIDS in the military (which the military refused to acknowledge; Personal communication with Commander Mario Bentfield, Alexander Hamilton Post 448, Sacramento, CA, 2015). This example demonstrates the military value of "Leave no soldier behind" (Daileda, 2014) and highlights the ways the LGBT military community cared for itself in the midst of an epidemic when the government, military, medicine, and research were at best ignoring them and at worst incarcerating and castigating them to hell (Shilts, 1993). While the

literature is beginning to identify a wide array of traumas and strengths of LGBT SM/Vs in their personal narratives, one of the most striking silences is in regard to their experiences of love.

Perhaps one of the most frequently quoted statements about love by an LGBT veteran is at the gravesite of gay Army Veteran Leonard Matlovich in the Arlington National Cemetery. Mr. Matlovich's tombstone reads "When I was in the military they gave me a medal for killing two men and a discharge for loving one." In terms of love and the military at large, one of the most common images depicts the idea that love of country is what compels military service.

Figure 2: Twitter post by @michaelkeyes on February 11, 2016. Image artist unknown.

While a patriotic love of country compels military service involving "terrible things," romantic love of same sex partners was historically cause for early discharge, suggesting significant complexity in LGBT SM/Vs' experiences of love. For example, while the "terrible things" in the image above are likely assumed to be killing in combat, for LGBT SM/Vs, the terrible things also included living a lie which some took their death (Shilts, 1993), not being able to return home for surgery of a same sex partner, and failing to intercede when they saw an LGBT colleague being gang raped for fear that their own LGBT identity would be questioned (Belkin, 2012; Shilts, 1993; Westcott & Sawyer, 2007). DADT required hiding one's same sex families (i.e., partners and children), which resulted in a violation of the military core values of "honesty and integrity" when completing Emergency Contact, Dependents, and Survivors' Benefits forms (Seefried, 2011; Westcott & Sawyer, 2007).

It is ironic that while LGB service members' same sex love resulted in discharges, harassment, and assault in the military, none of the social science articles reviewed for this study (including those few articles that discuss resilience) specifically address LGBT veterans' love for themselves, romantic or sexual partners, the LGBT community, America at large, or even the US Military. That said, LGBT veterans' love is evident throughout their first-person narratives. The discussion now turns to a few brief examples of LGBT SM/Vs' discussions of love in oral history projects, a qualitative study, and autobiographical essays.

In the preface to "Our time: Breaking the silence of 'Don't Ask, Don't Tell" (2011) editor Air Force Officer Josh Seefried introduces the collection of first-person narratives of LGB service members and veterans by stating,

> The notion that a man is putting his life on the line for his country, but still has to hide his loved ones, is unconscionable to me as an American…Those of us who have been fortunate enough to lead troops never lose our love for our fellow soldiers, nor do we ever stop being thankful for their service. (p. *x-xi*)

Descriptions of love in "Our Time" begin with Staff Sergeant Jim Cauthen recounting his heterosexual military roommate's critical support following a particularly homophobic interaction Cauthen had with his father, which resulted in suicidal ideation. He writes,

> In that hour, Owen saved my life. He held me, a broken man, in his arms and quietly waited for my will to live flow back into me. This one man, who didn't see a wretched, sinful abomination before him, pulled me back from the edge. He didn't care that I was gay. He cared that I was hurt…to this day, I remember what it was like to feel total, unconditional love from another person. (p. 12)

This quote signifies that heterosexual service members have at times provided life saving support to LGBT military colleagues and that unconditional love in the idealized military family, can be particularly healing for LGBT service members. Conversely, however, the rejection of LGBT service members by colleagues at times threatened the very existence of their families back home. For example, Dr. Jamey Burton, a flight surgeon in the Army, writes about her decision to leave the military for the love of her family following an Officer Career Course when an instructor said,

> "Each one of you are challenged on your Army values each and every day," he said and went on to emphasize the importance of integrity, leadership, and trust as an American physician. It was there that the seed was planted: I am living a lie…this struck me to the core. How could I force my wife to stay in hiding for another fifteen years? How were we to have children, then raise them to lie about their mom- "Don't out mommy now, okay?" (p. 14)

Another service member in "Our Time" writes about his love affair with a military colleague that ended abruptly due to DADT,

> "Two guys can't date in the Army," he said. "It is wrong"…I had a short response: "I love you." I won't lie and say I fought back tears. There weren't any to hold back. He'd used a word that both of us had a conditioned response to "soldiers." We were soldiers. Above all else we were soldiers…We had both expected a rough life under "Don't Ask Don't Tell." We didn't expect to fall in love. (p.28)

While same sex relationships were undermined by anti-LGBT military policies, the military also provided opportunities for service members to discover their LGBT identities as they met their first same sex partners (Estes, 2005), and for some, military service strengthened same sex relationships. Curtis (2014) states that each of her 18 respondents (i.e., 9 gay and lesbian couples), reported that deployments strengthened the couple's love for each other. One of the respondents explained,

> I think some of that goes back to discussions we've had...about gay marriage versus straight marriage and the fact that we've kind of had to fight for where we are. When you have to fight for what you have, and who you are, and how you're recognized, I think you probably put more of an investment into it. (p.81)

LGBT SM/Vs also describe unique stressors to LGBT service members' romantic love including a lack of support when a same sex relationship ends and fear of possible death from military service without the ability to have told their partners "I love you" directly (Curtis, 2014; Estes, 2005; Seefried, 2011). For example, LGBT SM/Vs describe elaborate plans to manage the difficulty of not being able to say good bye at public ceremonies with other military families such as hiding their relationships (referring to partners as siblings or roommates) with quick platonic-appearing hugs or watching from the tops of nearby buildings or hills with a view of the dock or tarmac to avoid scrutiny entirely (Curtis, 2014; Estes, 2005; Shilts, 1993).

The stress caused by not being able to express same sex love publicly is countered by the life promoting association of reduced LGBT teen suicides following repeal of the Defense of Marriage Act (DOMA), as state-affirmed same sex marriages may reduce some of the negative thoughts and emotions tied to LGBT youth suicide (Raifman, Moscoe, Austin, & McConnell, 2017). Adult gay men however, have not experienced similar reductions in mental health challenges or social isolation following DOMA repeal (Hobbes, 2017). For gay men who do the arduous and painful work of coming out to themselves and others and then move to a gay community such as the Castro in San Francisco, they may not find a welcoming and unconditionally loving minority community ushering them into their folds. Instead, newly arrived gay men enter a community whose own history of social rejection is re-enacted toward one another through critiques of their sexual attractiveness and gendered behavior performances (i.e., if they are too short, too heavy, too effeminate, not white). Michael Hobbes (2017) writes in a Huffington Post article entitled "Together Alone: The epidemic of gay loneliness" that,

> the closet makes us more likely to concentrate our self-worth into whatever the outside world wants us to be… the social norms in our own community pressure us to concentrate our self-worth even further—into our looks, our masculinity, our sexual performance. But then, even if we manage to compete there, even if we attain whatever masc-dom-top ideal we're looking for, all we've really done is condition ourselves to be devastated when we inevitably lose it.

The unavoidable aging process which is thought to diminish physical characteristics prized as desirable in gay communities, are amplified by online dating apps like Grindr that have replaced gay bars and bathhouses as common places to meet sexual partners (Hobbes, 2017). In these apps, gay men critique one another in devastating ways by informing each other that they are undesirable, which according to Hobbes (2017), is a type of in-group rejection and discrimination, more damaging even than rejection and discrimination by mainstream society. Hobbes explains,

> It's easy to ignore, roll your eyes and put a middle finger up to straight people who don't like you because, whatever, you don't need their approval anyway. Rejection from other gay people, though, feels like losing your only way of making friends and finding love. Being pushed away from your own people hurts more because you need them more.

For LGBT SM/Vs returning to civilian society, rejection in the LGBT community not only includes failure to meet beauty and sexual desirability norms (e.g., rejection of war-related disabilities) but also rejection of their military service itself. LGBT SM/Vs describe being critiqued in LGBT civilian spaces for their military service due to an

historical alignment of the Gay Rights and Anti-War Movements of the 1960s coupled with the belief that a willingness to conceal an LGBT identity for military service, indicates a lack of LGBT pride (Shilts, 1993). For LGBT people who find romantic and sexual love in the military and post-discharge, that love is often developed under hostile conditions.

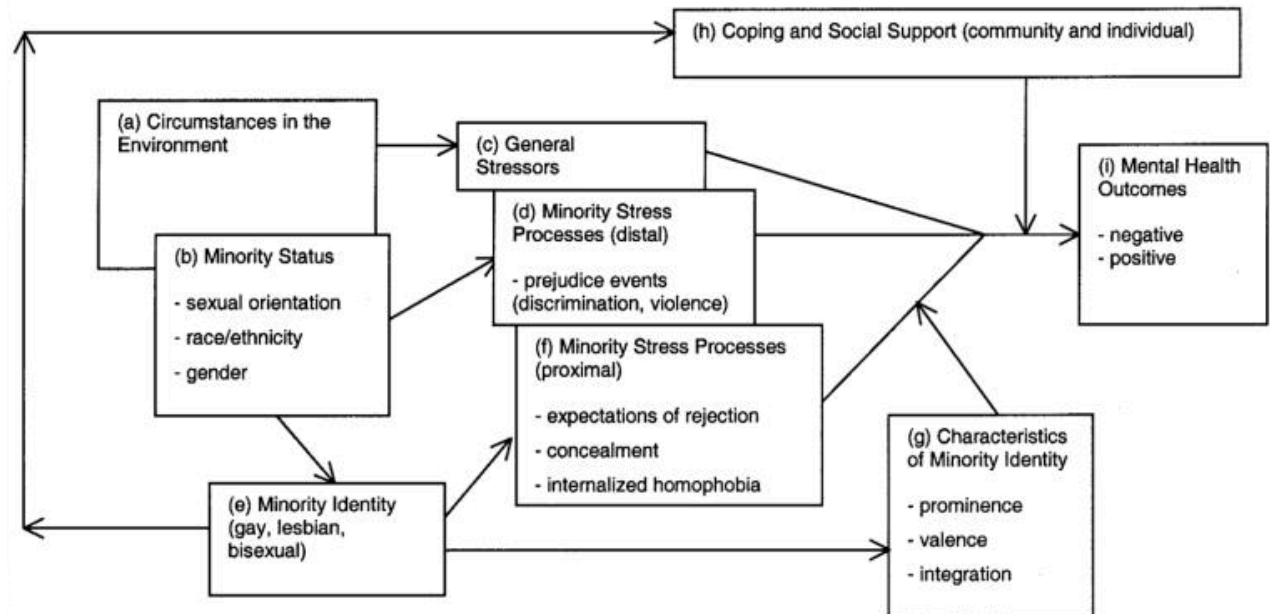
With this review of the stressors during and after military service and LGBT SM/Vs' disproportionate health burdens in mind, the discussion now turns to the Minority Stress Model as one theoretical model that explains the connection between disproportionate health burdens and anti-LGBT stigma (Brooks, 1981; Meyer, 1995).

The Minority Stress Model

While the professions of psychiatry and psychology gained credibility in part by categorizing and pathologizing LGBT people, we now know that LGB status is not a mental illness (i.e., homosexuality was removed from the DSM in 1973; Byne, 2014). Relatedly, transgender people and their allies argue that gender variance is part of a normal spectrum of gender identity and therefor, gender identity diagnoses should be removed from the DSM (Lev, 2006). Elevated rates of depression, anxiety, suicide and substance abuse in LGBT communities are consistent with patterns of "minority stress" (i.e., medical problems resulting from minority based discrimination) and are no longer interpreted as LGBT people being inherently sick (Hamilton & Mahilik, 2009; Testa, Habarth, Peta, Balsam, & Bockting, 2015; Williamson, 2000). The Minority Stress Model postulates that LGBT people experience increased stress from discrimination (e.g., hate crimes, rejection from family and friends, differential treatment at work, healthcare and housing markets) directed at their minority status, which combine with general daily stressors (i.e., stressors experienced by all people regardless of sexual orientation and gender identity) and result in higher rates of health disparities (Meyer, 1995, 2003).

Meyer's (1995, 2003) Minority Stress Model identifies factors of internalized homophobia, stigma, experiences with and expectations of discrimination, lack of access to social support, isolation, and interruptions to the coming out process, as correlated with higher burdens of anxiety, depression, suicidality and substance abuse in LGB people as compared to non-LGB peers.

Figure 3: The Minority Stress Model (Meyer, 2003)

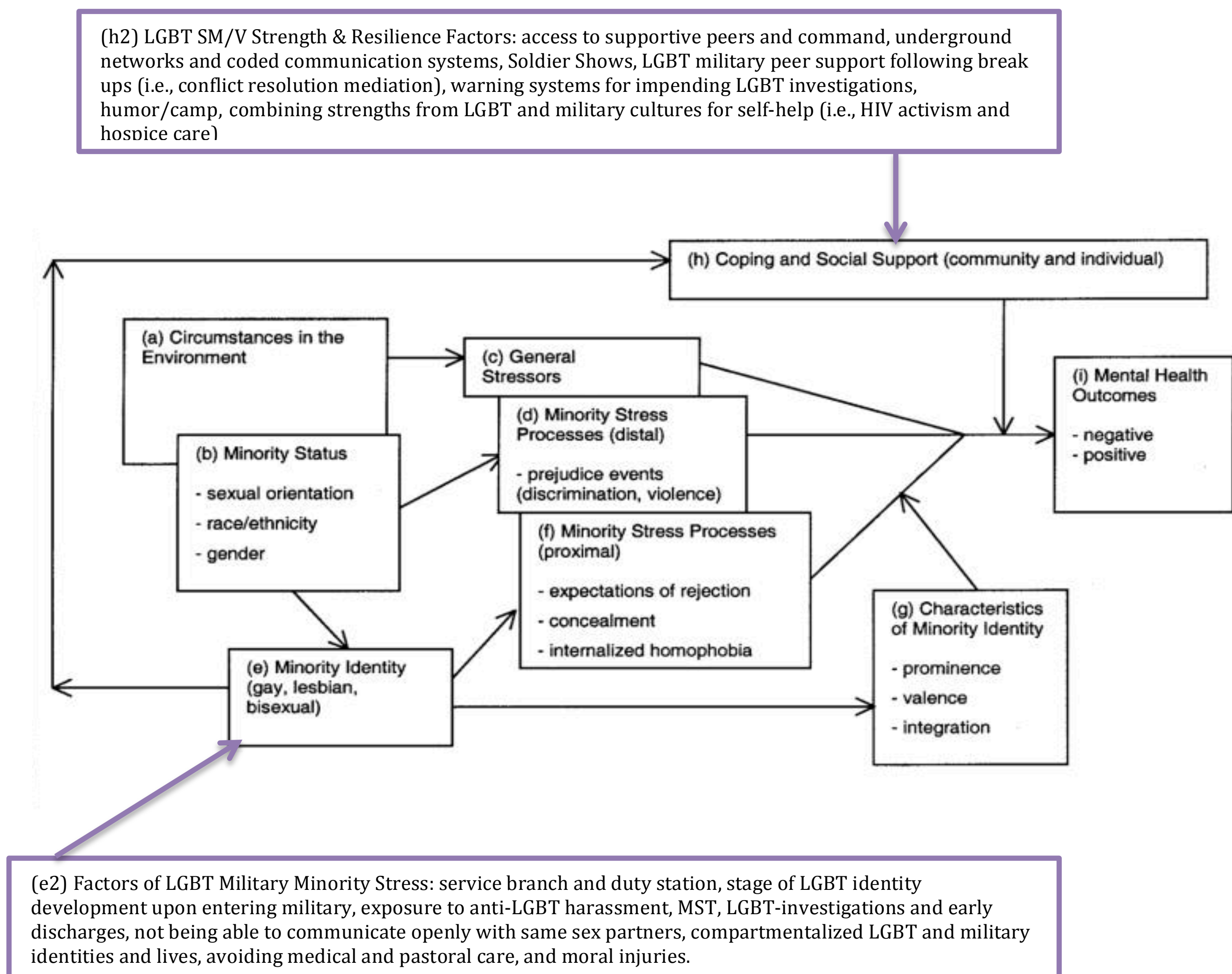


Additionally, Meyer (2015) identified protective factors of coping and social support as mediating the negative impacts of stress, which he more recently, describes as resilience and stress buffering (see Figure 2). Importantly, this model suggests that stressors (c-f) and protective factors (h) are separate constructs.

The Minority Stress Model was adapted to LGBT Military and Veterans who served within the contexts of anti-LGBT military service policies (Ramirez, 2011). This model highlights the unique stressors of gay-related investigations and harassment from military colleagues, HIV/AIDS, military sexual trauma, duty station, and military service branch, as well as the unique protective factors of military service such as underground LGBT military communities and supportive command. Similarly to the Minority Stress Model, the adapted model also conceptualizes stressors and protective factors as separate constructs.

The current study will contribute to the LGBT Military Minority Stress Model by identifying additional stressors and protective factors of LGBT SM/Vs' strength and resilience identified in the documentary *The Camouflage Closet.*

Figure 4: Minority Stress Model LGBT Military and Veterans (Ramirez, 2011)



Resilience

Resilience is defined as “competence despite adversity,” which reduces the impact of stress on health (Meyer, 2015). While resilience is understood as successful coping, it is not the same as coping because coping efforts while related to stress, do not necessarily result in successful adaptation (Meyer, 2015). Additionally, while coping refers to a response to trauma (i.e., typically during the trauma), resilience refers to bouncing back following the traumatic event (Herek et al., 2014; Meyer, 2015). Resilience manifests among individual people as well as communities and in its most effective form, changes the dynamics of power and oppression in society (Meyer, 2015).

While LGBT people’s disproportionate health burdens resulting from discrimination are commonly discussed in the literature, rarely mentioned are the majority of LGBT people who do not have clinically significant mental health challenges (Cochran & Mays, 2013; Fletcher & Sarker, 2013; Herrick, Stall, Goldhammer, Egan, & Mayer, 2014). That most LGBT people do not struggle with mental illness in spite of the discrimination they face at both institutional and interpersonal levels (e.g., anti-LGBT

military service bans and hate crimes, respectively), suggests significant resilience among LGBT people, through the ability to adapt to extreme life stressors (Cicchetti & Garmezy, 1993; Garmezy, 1981; Riggle et al., 2008; Russell & Richards, 2003; Savin-Williams, 2008).

Based on a review of the resilience literature, which until recently has focused almost exclusively on the general population (i.e., samples not differentiated by sexual orientation and by extension largely heterosexual), Agaibi and Wilson (2005) describe resilience as a constellation of an individual's personal resources of (a) personality, (b) affect regulation, (c) coping, (d) ego defenses, and (e) the utilization and mobilization of protective factors and resources to aid coping. Two differences between LGBT resilience and resilience among the general population are that LGBT resilience is often in response to anti-LGBT bias (as opposed to stressors faced by people in general) and draws from protective resources of the LGBT community. In a 2013 review of LGBT resilience literature Kwon describes community resilience as social support that provides individuals increased self-worth and meaning in life, sense of security that they will be able to handle future adversity, buffers against the effects of prejudice, and affirms people's LGBT identities through role models and a sense of belonging. Highlighting the convergence of personal and communal resilience, Ungar (2012) describes LGBT resilience as the ability to access "psychological, social, cultural, and physical resources that build and sustain their well-being, and their individual and collective capacity to negotiate for these resources to be provided and experienced in culturally meaningful ways" (p.17).

While various definitions of resilience have been used in relation to LGBT people and communities, common to most is the concept that resilience is not a birth given trait but rather a process of developing protective factors that change over time (Herrick et al., 2014). Resilience is also described as "stress buffering" and "stress inoculation" as it mediates the effect of minority stress on health (Meyer, 2015). Another area of divergent opinion among researchers of LGBT resilience is in relation to the effects of multiple types of discrimination toward people who have more than one marginalized identity (e.g., LGBT people of color who are living with a disability). In recent years, people with multiple sources of stress such as homophobia, racism, sexism, and ableism have been thought to experience a multiplicative effect such that the stressors of multiple marginalized identities amplify one another, resulting in worse mental and physical health outcomes. This theory is in contrast to studies reporting LGBT people of color to have similar mental health as white LGBT people (Meyer, Dietrich, & Schwartz, 2008; Moradi, DeBlaere, & Huang, 2010).

Conversely to the theory of multiplicative stress is the concept of "steeling" which posits that occasional experiences of surviving and bouncing back from significant stressors creates a sense of mastery and competence, leading to a developed confidence in one's ability to cope with stress that in turn, better equips one to handle the next major life stressor (Rutter, 2012). With multiple marginalized identities it may be that the strengths and resiliencies developed in response to one type of bias can be applied to stressors resulting from another type of bias (Consolacion, Russell, & Sue, 2004).

Meyer (2015) warns that the sole focus on individual resilience results from Western-centric values of meritocracy and individualism, which can result in an attitude of "blame the victim" (i.e., gay people should overcome homophobia) instead of

acknowledging how marginalization (e.g., differential access to education, employment, housing, and medical care) create barriers to resilience. Another significant debate within the study of resilience is in regard to assumptions of successful adaptation and competence. For example, the very assessment of successful adaptation is impacted by the viewer's power and privilege. Reflecting on resilience research with youth, Bottrell (2007) writes that resilience leads to positive outcomes and for marginalized populations, those outcomes might be contrary to the status quo such that resilience manifests as a type of resistance to oppression. Bottrell (2007) warns that when resilience is narrowly defined as *adapting* to systems and situations of inequality, the very concept of resilience can function as a tool of oppression, by reinforcing factors related to health disparities rather than removing barriers to health (Bottrell, 2007).

The careful study of resilience among LGBT military and veteran populations is critical because anti-LGBT military policies largely prevented one of the key aspects of LGBT resilience by disrupting access to social, familial, and community support (Estes, 2005). Meyer (2015) describes identity as being central to LGBT resilience because LGBT communal resilience is directly tied to LGBT identities (e.g., social support through an affiliation with the LGBT community). For LGBT people serving under anti-LGBT military policies, the loss of LGBT peer support as a source of resilience was replaced by a systematic source of stress from LGBT-related investigations, as associations with LGBT military peers resulted in investigations through guilt by association (Shilts, 1993).

Attention to resilience among LGBT SM/Vs is also important in lieu of the existing problem oriented literature, which leaves practitioners ill equipped to provide strength based practice, reinforces the historical pathologization of LGBT people, and contributes to healthcare providers' often unconscious biases (Colpitts & Gahagan, 2016; McWhorter, 1999; Bloeser &Ramirez, *in press*). Typically the problem oriented approach focuses on individual level behavioral change but does not address the structural factors associated with health disparities such as experiences of discrimination, which are related to fewer preventative health screenings (Colpitts & Gahagan, 2016 as cited in Bloeser & Ramirez, *in press*). Conversely, strengths based studies examine the ways interventions can build off of existing strengths and coping capacities to manage stress from discrimination (Herrick, et al., 2014). It appears that interventions which develop and reinforce resiliency rather than changing specific individual behaviors, are more likely to result in long term reduction of health risks associated with discrimination (e.g., HIV risk is correlated with levels of experienced discrimination, such that learning how to properly use a condom may not be enough to prevent risky sexual behaviors linked to issues like poverty and homophobia) (Herbst, Beeker, McNally, Passin, & Kay, 2007).

Additionally, since "deficit-based approaches can help to diagnose what is wrong, but not how to fix it," Herrick and colleagues (2014) point out that "deficit-based approaches" identify problems but not solutions and thus suggest that researchers investigate "pathways to resilience" because resilience will not be evident in deficit focused research (p. 4). Having found the markers for psychological distress to be different than the markers of resilience, Bariola and colleagues (2015) state that mental health interventions should be developed around markers of resilience rather than symptoms of distress. Related to resilience is the construct of posttraumatic growth (PTG).

Posttraumatic Growth

Whereas resilience refers to effective coping in the face of stress, some people who survive trauma, experience growth, which is referred to as posttraumatic growth (PTG; Tedeschi & Calhoun, 2004). Specifically, posttraumatic growth is defined as a positive outcome resulting from a traumatic event such as developing greater meaning in life, deeper connection in relationships, and an increased sense of one's ability to manage personal crisis (Tedeschi & Calhoun, 2004). In a review of the PTG literature, Janoff-Bulman (2004) categorizes PTG research as generally describing: 1) strength through suffering, 2) psychological preparedness, and 3) existential reevaluation. When trauma challenges a person's very notion of themselves and the world around them, the traumatic experience can result in difficulty "understand[ing], mak[ing] decisions, or determin[ing] what will count as meaningful action going forward" (Harbin, 2015, p. 674). It appears that for some trauma survivors, the process of making new meaning in life can lead to PTG (Tedeschi and Calhoun, 2004). For example, one key factor to PTG is "controlled rumination," which moves from automatic processing of a traumatic event immediately after the event, including intrusive thoughts and images, to a more controlled processing of the event through deliberate thinking as time goes on (Lindstrom, Cassie, Cann, Calhoun, & Tedeschi, 2013). As such, trauma survivors can be supported in developing PTG by learning to control their rumination. Without targeted interventions to stimulate PTG, Tsai and colleagues (2015) found in a study of veterans diagnosed with PTSD who access VA services, that 73% of respondents reported at least one domain of PTG.

Viewed through the lens of psychiatric ethics, Harbin (2015) warns that the concept of PTG is vulnerable to harming patients who are expected to experience PTG. In other words, PTG becomes an expected outcome of trauma and people who do not experience this type of growth are pathologized as failing to interpret their traumas correctly. Of course patients who do not experience PTG and receive messages of disappointment from clinicians, may experience worsening symptoms due to feelings of failure at fulfilling their role as a "good" trauma survivor. While a majority of the articles addressing LGBT veteran health that were reviewed for this study describe trauma, few of the articles mention PTG, which may be a factor in the types of health care services LGBT veterans receive. Similarly, few of the LGBT SM/V articles reviewed for this study discuss the impact of military culture on LGBT veterans' willingness to engage in care or their experiences while receiving care. The next section explores the impact of military culture and values on veterans' experiences receiving health care.

Military Culture: Impact on Accessing Health Care

It is important to begin clinically-oriented discussions of military culture by noting that significant variance exists within subgroups of the military according to different service branches (i.e., Air Force, Army, Coast Guard, Marine Corps, and Navy), Military Occupational Specialties (MOS, i.e., job), duty type and stations (i.e., active duty [live and work with the military 24/7], reserves [live and work at home but go to a base for periods during peace time, can be called to service during war], and guard forces; stateside versus foreign service), war eras, and whether service members saw combat and/or had multiple deployments. For example, each branch of the military has its own culture, which can variously impact the level of anti-LGBT sentiment. Further the type of job an LGBT person holds can also affect the level of discrimination they face (e.g.,

women in nontraditional gender roles such as truck driving where there are fewer women, may be particularly vulnerable to harassment; Benecke & Dodge, 1990). Finally, serving stateside in a relatively LGBT-open environment like San Francisco with Hate Crimes protections laws as opposed to conservative societies that condone the state sanctioned murder of LGBT people like Chechnya (O'Hara & Medina, 2017), will obviously involve different levels of potential discrimination for LGBT service members (Bloeser & Ramirez, *in-press*).

In addition to variables like branch of the military and duty location, experiences of LGBT military service differ across service members' diverse social identities in terms of race/ethnicity and class, among other social categories. For example, Ramirez & Sterzing (2017) describe LGBT service members with differential access to places to have sex based on their gender, race, and rank where lesbians and lower ranking gay men tended to have sex in semi-public places on base like utility closets, while higher ranking and typically white men had access to hotel rooms and lived off base.

Differences in LGBT service members' experiences according to race, gender, and class in the military contradict claims that the military is "America's last bastion of social and economic equality" (Luxenberg, 2015). Take for example the function of uniforms in elevating social standing. The military like the police force, trains inductees that once they put on the uniform, their military and/or police service eclipses all other social identities. The experience however of people of color often includes stories of their professional advancement being curtailed by racism in the ranks. Danny Ingram, a white gay veteran states on his Facebook page (3/18/17, shared with permission) that coming out as gay and the loss of privilege that he experienced due to people's rejection of his sexual orientation helped him to understand white privilege. Mr. Ingram states that this awareness of his white privilege is related to his understanding the comment of an African American police officer who stated that when he puts on his uniform "he almost feels white." The idea here being that wearing a police or military uniform protects people of color to some extent from racism, however there are still moments when their racial identities eclipse the power of social elevation afforded by the uniform. To the extent that donning a military uniform, results in more equitable access to job promotions in spite of being a person of color or woman (recall the example "almost felt white"), the uniform may act as a protective factor.

In addition to social demographics, branch of military, duty station, and job type, exposure to combat is another critical variable to veterans' health status (Blosnich et al., 2013; Kauth, Meier, & Latini, 2014; Lehavot & Simpson, 2013). With the increased use of improvised explosive devices on roads and suicide bombings in recent conflicts, OEF/OIF/OND veterans are surviving injuries that claimed the lives of service members from previous war eras and are returning home with polytrauma including traumatic brain injury, PTSD, the loss of limbs, and paralysis (Cifu, McNamee, Gater, Walker, Ericksen, Murphy, & Oliver, 2009; Ramchand, Karney, Osilla, Burns, & Calderone, 2008; Tanielian et al., 2008). The range of physical and psychological injuries from OEF/OIF/OND wars combine with side effects of prescribed medications to affect not only their medical and mental health but also their sexual health (Helmer et al., 2013). Stigma regarding sexuality (of any orientation [i.e., heterosexual or LGB]) among people living with disabilities (be they physical or psychological), often prevents clinicians from completing sexual health histories while medications used to treat war-related injuries

commonly affect sexual desire, physical arousal, and ability to perform sexual intercourse (Helmer et al., 2013). LGBT veterans living with war-related injuries, may face a double burden of ablesim, which sees them as non-sexual people due to their disabilities and as sexual deviants due to homophobia (Sandahl, 2003). Kauth, Meier, and Latini (2014), recommend a sex positive approach to health care that considers sexual health as an integral part of veterans' overall health and wellness.

When LGBT service members and veterans seek health care, they expect services from providers familiar with their unique military experiences and resultant health status, needs, and goals (Lutwak et al., 2014; Ramirez and Bloeser, *in-press*). Canfield and Weiss (2015) highlight significant military cultural values that may impact veterans' feelings about accessing health care. Citing a study that reported 86.2% of active-duty military personnel respondents' most common coping strategy was "thinking of a plan to solve the problem" (p. S129), Canfield and Weiss assert that the military value of problem solving (i.e., focusing on a solution) is in contrast to traditional psychotherapy which typically involves clients describing problems and their reactions to those problems. Also in contrast to the idea of seeking therapy, military personnel are trained that focusing on one's self can result in dangerous outcomes for a military unit that relies upon its members to work in a coordinated manner where each person is focused on the mission of the group as opposed to personal survival (Canfield & Weiss, 2015; Frey, Collins, Pastoor, & Linde, 2014). Combined, the values of problem solving versus focusing on problems, self-sufficiency, and belief that focusing one one's self undermines the mission and military unit, can pose formidable barriers to engaging veterans in care.

The military value of unit cohesion (which is similar to the concept of belongingness) however, may be used to engage veterans in care and bolster therapeutic outcomes. Belongingness, the sense that one is connected to others and part of a group, has been found to protect against depression in LGBT military and civilian populations (Bryan & Heron, 2015; McCallum & McLaren, 2011; McLaren, 2009). Among veterans who served post 9/11, increased belongingness was found to protect against PTSD, perhaps, due to belongingness's protection against depression (Williams, Hagerty, Yousha, & Hoyle, 2002; Pietrzak, et al., 2010; Vogt, Smith, & Elwy, 2011). Conversely, the absence of belongingness (i.e., isolation, low social connection) has been found to contribute to suicidality. Blosnich and colleagues (2012) found suicide among LGB veterans associated with poor mental health and low social and emotional support. Similarly, Matarazzo and colleagues (2014) identified suicide among LGB veterans to be associated with victimization and low social support.

By developing LGBT veteran groups for the purpose of increasing a sense of belonging among peers in terms of unit cohesion, veterans may be more likely to access care and experience reduced depression and suicidal feelings. Bryan and Heron (2015) write that a sense of belonging in the military is similar to the concept of unit cohesion's shared commitment or goal, social cohesion through social-emotional bonds between service members, and collective identity through group membership. Matarazzo and colleagues (2014) agree stating that belongingness is especially important for LGBT SM/Vs because of the value of unit cohesion within the military. For both military service members and LGBT people, the importance of belongingness is tied to survival. For service members, the extent to which a person belonged or fit into and was accepted

by the unit could directly affect their ability to survive combat. For LGBT people, belongingness can be especially important given rejection from family, places of worship, the military, and even the LGBT community itself (Shilts, 1993).

In addition to understanding LGBT veterans' expectations of health care providers and therapy based on their military culture and applying wellness-promoting military values like unit cohesion to health care interventions, treatment can also be tailored to LGBT veterans by building upon their intergenerational strengths. For example, Monin and colleagues' (2017) intergenerational study of LGBT veterans found that younger LGBT veterans had worse mental health symptoms but larger social networks, while older LGBT veterans had more resilience and better mental health but smaller social networks. The authors conclude that intergenerational group level interventions could be particularly helpful for younger LGBT veterans to see models of LGBT resilience from their older counterparts, while the older LGBT veterans would gain a broadened social network (Monin, Mota, Levy, Pachankis, & Pietrzak, 2017).

With this brief discussion of the impacts of military culture on LGBT veterans' willingness to access care, the conversation now turns to the current state of available LGBT veteran care.

The Current State of LGBT Veteran Care

Veterans and their family members, are increasingly seeking mental health care provided by social workers in the VA and civilian society (Savitsky, Illingworth, & Dulaney, 2009; Miller, 2010; Tanielian, et al., 2008). Social workers however, are under-prepared to serve military and veteran populations in general (Frey et al., 2014; O'Donnell, Begg, Lipson, & Elvander, 2011), and LGBT SM/Vs in particular, due to a lack of cultural competence training and evidence based practices (Pelts, Rolbiecki, & Albright, 2015; Sherman, Kauth, Shipherd, & Street, 2014), a limited research literature (Trivette, 2010), and personal biases toward LGBT people and military service (Pelts, Rolbiecki, & Albright, 2015; Ramirez & Bloeser, *in-press*). Clinicians develop stereotypes and assumptions from socialization in their family, community, and academia, which is reinforced by a mostly problem focused literature (Simmons & Lehmann, 2013; Ramirez and Bloeser, *in-press*). Pelts, Rolbiecki, and Albright (2015) only identified 8 articles discussing LGBT veterans in a literature review of 13 primary journals of social work from 1992 to 2013. The authors assert that a limited literature contributes to uninformed practice as clinicians fail to provide culturally specific care to LGBT veterans. For example, the assumption that all veterans are heterosexual or that LGBT veterans should receive the same care as heterosexual veterans, can result in a Type 1 clinical error. This type of error results when clinicians fail to consider LGBT veterans' membership in a minority group and the impact of minority group status on differential risks and health care needs (Pelts, Rolbiecki, & Albright, 2015, p. 216). While tailoring services to minority groups can prevent Type 1 clinical errors, in a study of VA clinicians, 56% of respondents said they do not change their treatment in any way upon learning about an LGB veterans' sexual orientation (Sherman, Kauth, Ridener, Shipherd, Bratkovich, & Beaulieu, 2014).

In a 2014 study, social workers identified educational content they needed to better serve veterans as consisting of physical and mental health care, social and familial relationships, and military life, however, make no mention of diversity issues such as

LGBT identity (Frey, Collins, & Pastoor, 2014, p. 712). This example highlights the insidious nature of biases in clinical care, which manifest as stereotypes about "the Other" but also the absence of consideration for "the Other" in clinical training and service provision. For example, respondents of this study appear to not have even considered LGBT issues in the educational topics they deemed necessary to serve military populations. The absence of LGBT SM/V-specific training leaves practitioners ill equipped to identify problems with LGBT identity development, one common outcome of anti-LGBT military policies, which required compartmentalization of LGBT and military identities and created barriers to LGBT community connection (Pelts, Rolbiecki, & Albright, 2015).

Social work respondents of Frey and colleagues' 2014 study also failed to mention religious and spiritual issues, which, is noteworthy given that spiritual and religious crises often accompany military service (Bica, 1999, 2014; Brock & Lettini, 2012). For example, moral injuries are common among veterans traumatized by what they saw during their service, by violence targeted against them, and/or violence they enacted toward others (Beckham, Feldman, & Kirby, 1998). These experiences can result in crises of faith as people struggle to understand why a higher power did not prevent the suffering. Additionally, moral injuries disrupt a person's sense of fairness in life and trust in the basic goodness of themselves and others, causing "a deep soul wound that pierces a person's identity, sense of morality and relationship to society" (Silver, 2011, para. 6).

For LGBT veterans, the risk of spiritual/religious crisis can be exacerbated if a military clergy member reported disclosure of LGBT identities made during pastoral care. Estes (2007) describes a letter by Major General William R. Arnold in 1945 stating that gay service members should be given immediate dishonorable discharges because he believed them to be a "virulent danger to the Army [whose] immorality exerts a vicious influence" (p. 187). More recently, Paul Dodd, a gay Army chaplain who served from 1967 to 1998 stated,

> Unfortunately there have been chaplains who turned soldiers in who came in and said that they were gay, looking for counseling and help... [in] the executive council of the Chief of Army Chaplains- we were briefed about gays in the military, and the briefer made a comment that some chaplains had actually turned soldiers in because they thought it was in keeping with the welfare of the soldiers as well as the well-being of the Army. (Estes, 2005, p. 201).

LGBT service members who faced combat and also struggled with their LGBT identities due to religious doctrine, may have sought pastoral care in hopes of forgiveness for an LGBT identity prior to battle. Having an LGBT identity reported to command by clergy might lead to severe and complex spiritual/religious crises. Additionally, the LGBT identity concealment required by anti-LGBT policies at times resulted in LGBT service members failing to intercede on behalf of LGBT colleagues they saw being victimized by other service members (Burks, 2011). The moral injury of failing to help an LGBT military peer may result in an LGBT-specific type of survivor's guilt. In this way, culturally competent care for LGBT veterans requires not only awareness of their physical and mental health disparities and strengths, but also the unique types of moral injuries incurred during their military service as well as the ways that clinicians and clergy from whom they sought help, at times actually caused them harm.

The lack of attention to moral injury by social work practitioners is noteworthy not only because moral injuries are common among combat veterans and may uniquely affect LGBT service members, but also because religion and spirituality when incorporated into mental health care, can be sources of support and healing for veterans (Wynn, 2015). While anti-LGBT religious doctrine has caused significant distress among LGBT people, research also suggests that LGBT-affirming religion and spirituality are sources of strength and support for LGBT people (Halkitis, et al., 2009).

Findings from this literature review regarding the LGBT military minority stressors LGBT service members faced and the strengths and resiliencies they used to survive and at times thrive in a hostile environment are listed in Table 1.

Table 1: LGBT Military Minority Stressors and LGBT SM/V Strengths and Resiliencies in the Social Science Literature and Documentary Film

Citation	Military Stressors	LGBT Military Minority Stressors	Strengths & Resiliencies of LGBT SM/V
Cifu et al., 2009; Ramchand, Karney, Osilla, & Calderone, 2008; Tanielian et al., 2008	Combat and war-related injuries		
Canfield & Weiss, 2015; Frey, Collins, Pastoor, & Linde, 2014; Aitkin, Alexander, Guard, & Shanahan, 2010	Military values as a barrier to seeking care (e.g., solution not problem-focus, focusing on self could be dangerous for platoon)		
Brock & Lettini, 2012; Beckham, Feldman, & Kirby, 1998; Silver, 2011	Moral injuries from combat	LGBT Moral injuries (e.g., chaplains disclosing LGBT identity to command & survivor's guilt for not stopping LGBT hate crimes).	
Bowling et al., 2005; Keranen, 2014	Negative media depictions of veterans (e.g., synonymous with PTSD and violence)	Limited representation because until recently, no one could ask and no one could tell.	
Estes, 2005; Seefried, 2010		Concealing LGBT identity and identity compartmentalization	

Citation	Military Stressors	LGBT Military Minority Stressors	Strengths & Resiliencies of LGBT SM/V
Burks, 2011		Military Sexual Trauma	
Shilts, 1993		LGBT-related Investigations	
Shilts, 1993; Berube, 1999		LGBT-related Discharges	
Shilts, 1993		HIV/AIDS: living with and caring for partners and military colleagues living with HIV	
Smith, 2008		Avoiding medical & mental health care for fear of being identified as LGBT	
Curtis, 2014; Estes, 2005; Seefried, 2011;		Inability to tell partner "I love you" by phone and in writing	
Curtis, 2014		No support from colleagues following same sex relationship break up	
Shilts, 1993		Rejection as a veteran in LGBT civilian spaces following military discharge	
McCallum & McLaren, 2011; McLaren, 2009; Bryan & Heron, 2015; Blosnich et al., 2012; Matarazzo et al., 2014		Lack of belongingness or peer rejection is dangerous to physical and mental health	Belongingness and unit cohesion buffer against suicide
Halkitis et al., 2009; Seefried, 2011		Religiously informed discrimination (e.g., on HIV wards in military hospitals, being outed by a chaplain)	Strength and resilience from LGBT affirming-religion and spirituality
Burks, 2011		Moral injuries related to LGBT identity (e.g., MST as an anti-LGBT hate crime and not interceding in an attack on an LGBT military colleague)	

Citation	Military Stressors	LGBT Military Minority Stressors	Strengths & Resiliencies of LGBT SM/V
Russo, 1981		Negative depictions of LGBT people in film	
Ramirez & Sterzing, 2017			Camp and Co-opting Military Resources
Trivette, 2010			Underground Networks
Trivette, 2010			Coded language and underground communication system
Shilts, 1993			LGBT Military Conflict Management during Break Ups
Curtis, 2014; Seefried, 2011			Identifying "safe" colleagues to confide in
Ramirez & Sterzing, 2017			Strategic use of the closet
Berube, 1999			Soldier's Shows
Ramirez & Sterzing, 2017			Combining values and activities from LGBT and military cultures
Symons, 2008; Seefried, 2011			Anti-LGBT Military Policy Activism
Shilts, 1993			Social justice activism in civilian society
Seefried, 2011; Estes, 2005			Opportunity to meet potential partners
Curtis, 2014			Military service strengthened romantic relationship
Shilts, 1993			Uniform can be a social equalizer but is limited by racism and sexism in the military

Recognizing a gap in medical and mental health education and practice, several researchers have called for LGBT veteran clinical training and systems change (e.g., policy change, LGBT Leadership support, and interrupting bias on campus), and cite the VA as an example of LGBT veteran centered care (Alford & Lee, 2016; Johnson & Federman, 2013; Lutwak et al., 2014; Pelts, Rolbiecki, & Albright, 2015; Ramirez & Sterzing, 2017; Sharpe & Uchendu, 2014; Sherman, Kauth, Shipherd, & Street, 2014). As the largest provider of LGBT healthcare in the world, the VA is working toward this goal through a multimodal approach of LGBT cultural competence staff training (i.e., numerous online trainings), LGBT Veteran Care SharePoints (i.e., online platforms where resources like documents and videos are stored and shared), anti-discrimination policies protecting LGBT veteran patients and VA employees, LGBT psychology post doctoral fellowships, Transgender Care E-Consultation, LGBT Veteran Care Coordinators, an LGBT Veteran Research Workgroup, LGBT Special Emphasis Program

for employees, and participation in the Human Rights Campaign's Healthcare Equality Index (Kauth & Shipherd, 2016; Sharpe & Uchendu, 2014).

Like the CSWE and NASW standards of practice however, the VA does not provide specific interventions for LGBT veterans. While the VA provides several online LGBT cultural competency trainings (e.g., how to take a sexual history and general guidelines for LGBT patient care), the VA does not suggest specific interventions tailored for the variety of health issues LGBT veterans seek care (e.g., interventions for substance abuse, depression, PTSD addressing related LGBT military minority stressors and strengths). The paucity of information about LGBT veteran-specific interventions is evident in a literature void of intervention research besides descriptions of two groups, which did not report intervention effectiveness (Maguen, Shipherd, & Harris, 2005; Ramirez et al., 2013). It is important to conduct intervention studies as well as studies that measure resilience (as opposed to problems only) because resilience studies could inform interventions not only to help LGBT people cope effectively but also support communities in resisting and eliminating minority-based oppression (Colpitts & Gahagan, 2016; Riggle, Rostosky, & Horne, 2009; Russell & Bohan, 2005; Savin-Williams, 2008; Wong, 2015). At the most basic level, Dentato and colleagues (2014) assert that strengths based interventions and research, which attend to person in environment and LGBT "affirming models of practice" can help address problems associated with LGBT identity development (p. 324).

Without specific LGBT veteran interventions from the NASW, CSWE, or VA, Dentato and colleagues' (2014) guidelines for a strengths-based and LGBT affirming practice grounded in the ecological model is an important starting place from which to consider new models of LGBT veteran care. As most clinicians were not trained in issues relating to LGBT veterans, they are in need of basic information about this minority military population. One resource for information about the experiences, environments, strengths, and stressors facing LGBT SM/Vs is that of documentary film.

The Use of Film for Health Education

The use of film by social science researchers, medical and mental health educators, and recovery advocates (i.e., anti-stigma activists and health care consumers), dates back to the 1890s with the simultaneous invention of cinema cameras and projectors by Thomas Edison in the United States and the Lumiere brothers in France (Erickson, 2011). The types of research conducted and educational material developed with film, is determined in part, by changes in the size, weight, and portability of recording and, projecting equipment from initial immobile recorders and tripods to contemporary handheld iPhones and camcorders. At first filmmakers were only able to record people they could bring into a recording studio, with the advent of lightweight battery powered cameras, video can be recorded anyplace that is humanly accessible. In 1898 Anthropologist Alfred C. Hadden was the first to use silent cinema film in a study of basket making in the Torres Straits. Over the past 120 years, film and more recently video have been used in diverse settings for clinical training and research purposes including family therapy interviews (mid-1950s), studies of social interaction (i.e., verbal and nonverbal interaction, 1955-56), physician patient interaction videos which were required watching for medical residency training (1970s), clinical supervision in psychiatry and pediatrics residency (1980s), workplace studies (1980s), oceanic

archeological field work (19990s), and household use of space in homes where both parents worked (2000s; Erikson, 2011), to name but a few.

Film is an effective tool in health education (Alexander, Lenahan, & Pavlov, 2005; Downey, Jackson, Puig, & Furman, 2003; Self & Baldwin, 1990). Many clinical supervisors, employee education assistance programs, university faculty, and professional conferences use film for health education (Hillner, 2009). For example, Dentato and colleagues (2014) describe a screening of the film *GEN Silent* about LGBT aging at Loyola University for students, faculty and staff, which was followed by a panel discussion with the film's director and faculty. The authors conclude that the use of film in "educational forums and discussions…such as GEN Silent are necessary to raise awareness and facilitate conversations that may ultimately result in changing attitudes as well as practice behaviors toward" LGBT people (p. 324).

In terms of empirical findings regarding the public screenings of film, an art festival of documentary films created by mental health consumers was found to reduce stigma among audiences (N=415; Quinn, Shulman, Knifton, & Byrne, 2011). Respondents reported that the films inspired anticipated non-stigmatizing behavior change in terms of reduced judgment toward people living with mental illness, increased empathy by listening more and being more understanding of people living with mental illness, and audiences' intentions to change their own health-related behavior (i.e., reduced alcohol use, accessing social support and mental health care; Quinn, Shulman, Knifton, & Byrne, 2011). These changes ranged between films from 11% to 38.5% reductions in stigma among audiences (Quinn, Shulman, Knifton, & Byrne, 2011). The benefits of reduced stigma among audiences of consumer created video narratives appears to be amplified when the people featured in the film engage in dialogue with the audience after the film screening (Holmes et al., 1999; Link & Cullen, 1986; Desforges et al., 1991).

For the average clinical social worker who does not have access to a professional library, the Internet and especially online videos, are likely places to look for education about LGBT Veterans. A Google search on 3/11/2017 of the term "LGBT Veteran Film" generated 700,000 results (https://www.google.com/#q=LGBT+Veteran+Film), with the first entry being the film, *The Camouflage Closet* (www.camouflagecloset.com). Given that this film is the first to appear in a Google search of the term "LGBT Veteran Film," this study's findings could be significant if shared with the film's audiences given its online visibility (i.e. the ultimate aim of this study is to identify how to help audiences see LGBT service member and veterans' strengths and resilience in addition to the challenges they face). Produced through the VideoVoice Methodology (Catalani, Veneziale, Campbell, Herbst, Butler, Springgate, & Minkler, 2012), the veterans featured in this film were trained in the use of video cameras and recorded much of the footage in this 43-minute documentary, which was released in 2013. Directed by Michael Nedelman and produced by this writer, *The Camouflage Closet* includes an original musical score composed by Andrew V. Ly, which like the film itself, was created with veteran participant input.

Approaching the year anniversary of *The Camouflage Closet's* release, The Boise Weekly described the film as "A must-see documentary... The end result is a powerhouse but solution-driven 43 minutes, rarely seen in a documentary short that covers an issue with such heft" (Prentice, 2014). At the time of this writing, the film has been streamed

online 309 times from YouTube, 112 times from Vimeo, and distributed to over 100 VA health care systems, colleges and universities, professional conferences, and Vet Centers across the country (including one international professional conference; Nedelman, 2014). The film has also been screened at several film festivals including the National Queer Arts Film Festival, Veteran Film Festival, and Council on Social Work and Education Virtual Film Festival, and is featured on the Association of American Medical Colleges website (https://www.aamc.org/initiatives/diversity/449810/camocloset.html). On April 5, 2017, The Rocky Mountain Denver VA posted a podcast interview of Mr. Nedelman and this writer as part of its Suicide Prevention Short Takes Series (http://denvermirecc.libsyn.com).

One reason *The Camouflage Closet* is being screened at so many institutions of higher education and health care facilities may be the film's accompanying Educational Resource (Ramirez & Nedelman, 2013; see Appendix A), which summarizes the literature on LGBT Veteran health, provides discussion questions for audiences, and community based resources for LGBT veterans, their care providers, and families. Hastrup (1993) highlights the importance of an accompanying written text to provide additional context for film audiences explaining that while an exhaustive account of an event in a film record is ideal, it is often not possible and thus the accompanying written document enables audiences to gain a more holistic understanding of the filmed event. *The Camouflage Closet* is not meant to represent the experiences of all LGBT Veterans but rather is one representation of 9 specific LGBT veterans' experiences. As such, the accompanying Educational Resource with population data and a review of the LGBT Veteran social science literature is especially important for audiences to gain "contextual enrichment" of a formerly hidden population in a way that reduces stereotypes (Loizos, 1993). For example, while all of the veterans in this film describe their experiences with trauma and recovery, not all LGBT veterans have trauma histories or are living with PTSD as is evident in the Educational Resource highlighting diversity within LGBT veterans' experiences of LGBT-related investigations, early discharges, and MST.

In addition to providing historical context for the film, Loizos (1993) further suggests accompanying documents also provide information about how the film was made so that readers may draw their own conclusions about the extent to which the film was affected by the producer and director (e.g., the extent to which the film reflects the producer and directors' interpretations of LGBT veterans' first person narratives as opposed to veterans' own perspectives). *The Camouflage Closet* Educational Resource only states "The film was created as a community-based participatory art project with the goal of increasing awareness among medical providers, Veterans, and LGBT communities regarding their unique experiences of serving under LGBT-related military policies, such as 'Don't Ask, Don't Tell' (DADT) and the current ban on transgender military service" (p. 1). It is unclear from this statement, the extent to which veterans featured in the film had control over the filming or editing of the film as suggested by Loizos (1993), however in the Rocky Mountain Short Takes podcast, the director and producer describe the veterans as involved in both filming and editing processes (4/5/2017). Given the continued interest in this film by clinicians, veteran service providers, and students, this study explores veteran's personal narratives in an effort to help clinical audiences redirect their gaze from a sole focus on PTSD and trauma, to include LGBT veterans' strength and resilience.

In the current study, the documentary film *The Camouflage Closet* is analyzed as secondary data, which is repurposed to explore LGBT military minority stressors and the sources of strength and resilience LGBT service members developed to manage those stressors. Through an examination of LGBT veterans' own words presented in a participatory digital media project (Catalani et. al., 2012; Wang and Burris, 1997; Wang & Pies, 2008; White, 2003), this study analyzes first person narratives as an established strategy to build knowledge of lesser-known communities (Estes, 2005). In order to contextualize the representations of LGBT veterans in the film *The Camouflage Closet*, it is important to consider the historical and contemporary representations of both LGBT people and veterans in the media (i.e., news and film) in a way that does not (re)pathologize LGBT SM/Vs.

Anti-oppressive media analysis

Given the historical pathologization of LGBT people in psychology and medicine, (Foucault, 1990), and the slow adoption of LGBT affirmative practice across medical and mental health disciplines, it is critically important to interrogate the *type* of LGBT SM/V images presented in the media. Similarly to films about LGBT civilians, producers and audiences of LGBT veteran films may project heterosexism, homophobia, transphobia, sexism, racism etc., from their education and worldviews onto the film screen (Yep, Lovaas, & Elia, 2003; Gamson, 2003).

Medical and Visual Anthropologists offer important frameworks for considering health related issues among stigmatized populations in various media (e.g., news articles, video, Public Health announcements). In terms of the production side of media addressing issues of health, Briggs and Hallin (2016) explain that structural inequities affecting health disparities are communicated through and reinforced by biomediatization, which is co-constructed by numerous professions (e.g., medical professionals, journalists, pharmaceutical companies, politicians, NGOs, and public health officials), that are being changed from the inside out by their growing relationships with one another. In sum, biomediatization is

> the greater interpenetration of biomedicine into other social structures, such as industry, the state, and the mass media, the increasingly central role of science and technology, the proliferation and diversification of flows of biomedical knowledge through public channels, and this process' influence on identities and modes of self-construction (Briggs & Hallin, 2016, p. 3).

Making Health Public (Briggs & Hallin, 2016), describes a performative power of health news and offers "culture-centered critical health communication" as an alternative approach to producing health media. This approach differs from the typical hierarchical production of biomedia (i.e., medical experts educating ignorant masses through a one way dissemination of information) by drawing on "subaltern, postcolonial, and decolonial studies in criticizing the Eurocentric bias of dominant approaches and the exclusion of health knowledge produced by populations targeted by top-down health communication approaches" (p. 9). For the purpose of this study, queer theory is used to illuminate the heterosexist, cisgender, and ableist assumptions that form the Matrix-type (i.e., invisible, interconnected, movement of power across dense socio-political networks that maintain the status quo) backdrop of the biomediatization of LGBT veteran health. For example, queer theory rejects the notions of "normal" and "natural" resulting from an invisible web

of sexism, heterosexism, and cisgenderism, which assert that gender is necessarily binary with the only options being male or female and that LGBT identities are unnatural and sick (Yep, 2014). Additionally, this study pays particular attention to the extent to which LGBT veterans control the images of themselves that are portrayed in film as an indicator of culture-centered critical health communication.

Following Brigg's and Hallin's (2016) example of analyzing media representations of communities of interest, news articles regarding LGBT veterans were reviewed to identify themes and narratives regarding this population. An informal review of 13 news articles identified from a Google search of the term "LGBT veteran news article" generated a picture composed largely of victimization, illness, and medical disengagement. It should be noted that this search was not meant to be exhaustive but rather provides a glimpse at recent news coverage of issues relating to LGBT Veterans (i.e., the first 10 articles identified in the search were reviewed). In addition to this Google search, 3 news articles from the research assistant's personal library were also reviewed (i.e., these articles were collected in a personal library of the research assistant prior to this study). Importantly, LGBT veterans do not typically have control over representations of themselves in news articles written by journalists. While people described in news articles may request changes to facts or quotes, they typically do not have editorial control unless they have written an Op-ed piece (i.e., opinion piece; Personal communication with a producer at a large news network who wished to remain anonymous; June 7, 2017).

Anti-LGBT military policies feature prominently in the small, convenience sample of LGBT veteran news articles considered in this review. Journalists describe LGBT veterans' humiliation, embarrassment, and shame from gay-related discharges (Spinell, 2017) and having "two separate personalities" due to the compartmentalization of military and LGBT identities required by anti-LGBT military policy (Siebrase, 2017). News stories also highlight elevated rates of suicide, sexual trauma, substance abuse, obesity, anxiety, depression, and other medical and mental health challenges as compared to non-LGBT veterans (Zachariah, 2015; Friedman, 2016; Black, 2015; Caiola, 2017). LGBT Veterans are further described as experiencing anti-LGBT discrimination in the military, VA, and civilian society (Miller, 2015). LGBT identity concealment is described in news articles as a tool LGBT veterans use with VA providers to mitigate anticipated discrimination where they access healthcare (Black, 2015; Boyle, 2013; Bustamante, 2016; Grady, 2016). Exceptions to this negative narrative include portrayals of LGBT veterans as having achieved success in military service including promotion to higher ranks and fighting for LGBT rights within the VA (Froelich, 2016; Indiana University Press Release, 2017), increasingly coming out to VA providers (Miller, 2015), having the courage necessary to demand appropriate healthcare in spite of institutional barriers (Black, 2015), being "an integral aspect to our human capital" within the VA (Lutey, 2015, no pagination in the online news article), and serving in community leadership roles (Fagan, 2013).

One positive example of LGBT SM/Vs was printed in 1940's news coverage of The Amputettes (Serlin, 2003).

Figure 5: The Amputettes

This dance ensemble of men who used prosthetic legs and performed in drag (i.e., women's clothing), were described by journalists as "'high kickers on artificial legs,' [who] did dance routines with Rockette-like precision in Carmen Miranda-inspired outfits or in full 'Gay 90s' regalia" for audiences in 1945 at the Walter Reed Army Hospital in Washington D.C (Serlin, 2003). The Amputettes are part of a larger gay military tradition of Soldier Shows where gay actors communicated in coded language to gay audience members (Berube, 1999). In this way, The Amputettes' performances fit squarely between military soldier shows and live performance by gay Crip artists (i.e., artists who resist stigma toward people who are living with disabilities) like Greg Walloch and his show *White Disabled Talent* and Robert DeFelice's show *Crippled, Queer, and Legally Blond(e*) (Sandahl, 2003, p. 31). The Amputettes aside, it appears that social science research and to a lesser extent, news media regarding LGBT SM/V, focus on victimization often instead of the ways they resisted, organized, or fought for social justice. As will be discussed in the next section, representation matters and in film, the consequences of stereotypes are amplified when projected onto audiences who internalize the negative narrative about themselves and others. The discussion now turns to LGBT, veteran, and LGBT veteran representations in film.

Representations of LGBT People, Veterans, and LGBT Veterans in Film

Representations of LGBT people in American cinema over the past 130 years were initially few and far between, with images historically limited by the Hollywood Production Code, to characters that audiences laughed at, pitied, or feared (Russo, 1981). In *The Celluloid Closet: Homosexuality in the Movies* (first published as a book in 1981, and later a documentary film in 1995), Russo explains the importance of those few and injurious images, as being the only images available at that time. The impact of these negative images is significant as "Hollywood taught straight people what to think about gay people and gay people what to think about themselves. No one escaped its influence" (see the film, *The Celluloid Closet*). Actor and writer Harvey Fierstein states that, "There are lots of needs for art, the greatest one is the mirror of our own lives and our own

existence. That hunger that I felt as a kid looking for gay images was to not be alone." For LGBT people, if the few available images are negative, the impact can be an internalization of anti-LGBT bias, experienced as self-loathing. Self-loathing of an LGBT identity is described as internalized homophobia and internalized transphobia, and is associated with a host of physical and mental health problems (Herek et al., 1998). Importantly, *The Camouflage Closet* presents both trauma and recovery among the LGBT veterans featured in the film and as such, offers audiences a more balanced representation than historical stereotypes of LGBT people as inherently sick and socially deviant (Foucault, 1990; Russo; 1981).

Contrary to internalized homophobia and self-loathing, LGBT people also occupy the very site of their invisibility and pathologization and queer it (i.e., take power from and get off on the bias/stereotype) through disidentification. Carlos Munoz (1999) describes disidentification as a resistance strategy used by LGBT people of color to recycle oppressive images, into images of sexiness and desirability. Munoz provides the disidentfication example of lesbian comedian Marga Gomez who recalls being a teenager sitting on a couch next to her mother watching a TV talk show about lesbians who were dressed in heavy disguise. Gomez pretended to be disgusted by the lesbians for the sake of her mother, while secretly finding their wigs and dark glasses intriguing and erotic. As will be discussed, disidentification is a strategy used by veterans in *The Camouflage Closet* to manage LGBT military minority stressors.

As the sexual revolution of the 1960s swept the nation, so too did LGBT representations in film become more visible, and politically sexualized. In the 1970s with the rise in Feminism(s), Gay and Lesbian Studies, and the Civil Rights Movement, film makers and scholars began to pay increasing attention to filmic representations of socially marginalized groups and the impact of those representations on the communities being represented. More recently, a genre of independent films by LGBT filmmakers called New Queer Cinema emerged with representations of LGBT people imbued with a critically political lens (Chin, 2005). One example of films grappling with social discrimination are those regarding the military's anti-LGBT service bans such a *The Camouflage Closet* (Nedelman & Ramirez, 2013) and *Ask Not* (Symons, 2009*)*.

Veteran images in film. Similarly to stereotyped images of LGBT people in film, images of veterans in film have also been dominated by stereotypes of illness and social marginalization. In a study of films depicting veterans and PTSD, Keranen (2014) describes veteran *myths* (Keranen's emphasis), which are created and reinforced through a cyclical process, resulting in a conflation of veteran status with PTSD. By analyzing the performative aspects of myth making resulting in what Foucault describes as a discourse unity (i.e., the interplay between news stories of veterans including photos and reports from professional experts like psychiatrists and popular images in film), Keranen concludes that the media's discourse on veterans, is comprised of a "naturalized" idea of *veteran*, *combat veteran*, and *PTSD* which tie "dominant discourse about combat-related PTSD to outdated or outmoded notions that significantly affect our attitudes about and treatment of veterans" (emphasis by Keranen; p. vii).

One example Keranen offers of veteran *myths* is news coverage of Benjamin Barnes, a veteran who shot a woman and then died while hiding from police in a forest. While this man's health record did not contain a diagnosis of PTSD, the newscasts about him quickly began suggesting that he had combat-related PTSD and that this illness was

the cause of his having shot the woman, even though psychiatrists stated that "there is no direct, causal link between combat-related PTSD" and Mr. Barnes murder of the woman (Keranen, 2014, p. 29). In fact, as it turns out, there is no record of Mr. Barnes having served in combat at all but there is a record of a troubled youth who was expelled from school prior to entering the military. Additionally, Keranen argues that photographic depictions of Barnes reinforced and were reinforced by a veteran discourse of the socially isolated, law breaking, and combative veteran (i.e., trained killer) based on ideas that his tattoos, photos of him with large guns, and photos where he looks like other young men (i.e., clothes covering tattoos), combined to suggest that while he can disguise himself to look like other young men, inside he is actually a violent time bomb waiting to go off. Keranen is ultimately concerned that the myth of veterans as "disturbing or perhaps disturbed" men, influences society and health care providers' perceptions of all veterans.

Reviewing films from World War I and II and Vietnam, Keranen identifies myths of criminality, psychosimplicity (i.e., veterans would heal from war traumas if they simply put their minds to it, by choosing to forget and move on), and unrecoverability (i.e., inability to recover from PTSD associated symptoms of reliving/re-experiencing the trauma, numbing/avoidance, and hyper-arousal). Keranen's analysis of Post 9/11 veteran representations in film identifies psychostasis (i.e., a state in which there are no options for healing or recovery). The myth of psychostasis is particularly evident in the HBO film *Wartorn: 1861 - 2010* (John Alpert, *Director* and *Producer*, 2010), which details veterans' experiences with trauma, PTSD, and the effect of PTSD on veteran families, however makes no mention of treatment or sense of hope that veterans can achieve any type of recovery from PTSD or trauma. *The Camouflage Closet* breaks from these veteran myths through representations of LGBT veterans accessing and healing from art and trauma-related therapy as well as relationships with peers and same sex partners.

LGBT veteran images in film. The first representation of erotic behavior between same gendered military personnel in film is *The Dickson Experimental Sound Film* (directed by William Dickson and released in 1894/1895 by the Eddison Laboratory). This film also happens to be the first film produced with synchronized sound. In this short film Dickson is playing the song "Cabin Boy" on a violin into a recording horn, while two Navy sailors dance together (see Figure 6, below). Unlike *The Camouflage Closet*, where veterans self-identify as LGBT, the men dancing in *The Dickson Experimental Sound Film* are not presented with labels regarding sexual orientation or gender identity. While Vino Russo (1981) describes this film sequence as "The Gay Brothers" in *The Celluloid Closet*, Professor Ron Gregg argues, that such an interpretation is a projection of our current understanding of same sex attraction and sexual behavior, onto a time period when the concept of homosexuality did not exist (YaleUniversity YouTube video entitled "Teaching LGBT Studies at Yale: Ron Gregg, Senior Lecturer in Film Studies and American Studies"). Gregg asserts that this film can however be interpreted in terms of there being spaces in the 1890s where men felt freer to be close and affectionate in public such as on Naval ships where there were few if any women.

Figure 6 Frame from The Dickson Experimental Sound Film (1894/1985)

Unlike Dickson's film, recent films featuring LGBT military and veterans directly identify the film subjects' sexual orientation and gender identities such as *Lady Valor: The Kristin Beck Story, Ask Not,* and *Soldier's Girl*. These films address the experiences of self-identified LGBT people serving under anti-LGBT service bans and advocating for the ability to serve openly. *Lady Valor: The Kristin Beck Story* (produced by HBO and directed by Mark Herzog and Sandrine Orabona, 2014), presents Kristin Beck reflecting on her military service in the Navy SEALS, gender transition, and re-entry into society (it is unclear what if any influence Ms. Beck had over the film's production). *Soldier's Girl* is a documentary directed by Frank Pierson (2003) about the true story of Private First Class Barry Winchell who was murdered by military colleagues for dating a transgender Navy veteran, Calpernia Adams. *Soldier's Girl* depicts the murder of Barry Winchell who was beaten to death in a "blanket party" by colleagues who held down the edges of his blanket and beat him with a baseball bat. The film's website suggests that Calpernia Adams was involved in the film production, however it is unclear to what extent she had editorial control of the film. The film *Ask Not*, was produced and directed by Johnny Symons in 2008 about the efforts of military personnel and civilians to overturn DADT. This film features the stories of 1 current and 3 former gay service members, 3 of whom are highly skilled and accomplished in their military service. It is unclear the extent to which the people featured in this film, contributed to or had control over the film's production. In sum, these films present LGBT veterans as heroes and patriots who took on high-risk assignments (*Lady Valor*), targets of lethal anti-LGBT discrimination in the military (*Soldier's Girl*), people who are able to form deep and loving relationships in an exceptionally hostile environment (*Soldier's Girl*), activists fighting to repeal DADT (*Ask Not*), and everyday military service members who concealed their LGBT identities to serve the country that they love (*Ask Not*). Of the 3 films, veteran health is most directly addressed in *Lady Valor*, with Ms. Beck describing a variety of war related injuries, psychological stress of hiding her transgender identity during service, and the bias she faced regarding her gender transition.

Just as filmmakers and film scholars are drawing from queer theory to break from traditions of pathologizing LGBT people in film, so too are researchers employing queer theory to inform research agendas, projects, and analysis in ways that affirm LGBT peoples' strengths (Goss & McInerney, 2016). The theme song "Seasons of Love" from

the musical *Rent*, offers a unique direction for qualitative studies of LGBT populations by asking how one measures a year in "the life" (i.e., the life of LGBT people). The song's chorus asserts that the lives of LGBT people should be measured in love. Relatedly, researchers Goss and McInerney (2016) propose that research be guided by a "queer hermeneutic of love" through the stance of threshold research. Threshold research is described as taking a mindful, anti-oppressive approach to the position of being between two worlds or on the cusp of an identity binary (Goss & McInerney, 2016). For example, the hermeneutic of love as a driving principle in research on LGBT veterans takes care to avoid re-stigmatizing a population historically characterized as sick and pathological both as LGBT people and as veterans (i.e., the linking of veterans and PTSD as "natural" and LGBT identities with mental illness and sexual deviance). The current study explores what becomes visible when researchers shift their attention from LGBT veterans' problems and challenges to their pursuit of love (of self and others) and development of strengths and resiliencies.

Methods

Study Design

This study is a qualitative inductive analysis, guided by Grounded Theory (Glaser & Strauss, 2009), to identify themes of LGBT military minority stress and strength represented in the film *The Camouflage Closet*. The personal narratives of nine LGBT veterans featured in this film were coded for verbal and nonverbal communication events.

Qualitative studies of video data differ from studies of written text in several ways. First, qualitative film analysis benefits from inferring meaning not just from the words respondents say but also from their tone of voice, body language, and the rapidity or slowness of speech as well as issues related to "the elusive quality of the relationship" between researcher and subject (Loizos, 1993, p. 60). Paulus, Lester, and Dempster (2013) assert that video provides greater reflexivity and transparency of research decisions through systematic reflection on the researcher's own social location and filming and editing technique, which enable identification of how the researcher's biases, perceptions, equipment, and editing style influence the data collection and analysis processes. Analysis of edited films (i.e., versus raw footage) is increasingly used as a "re-purposing" of videos in service of social science research (Adami, 2009; Chouliaraki, 2006; Goodwin, 1994).

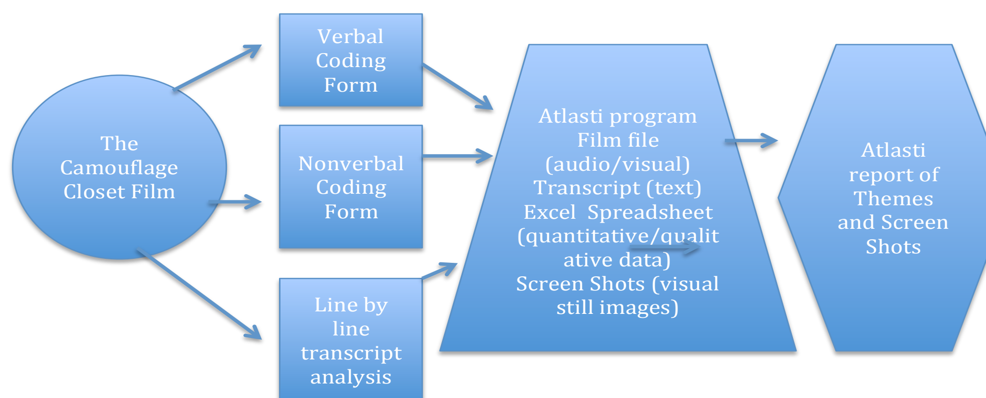
Film background. Participants of *The Camouflage Closet* were recruited through the Veterans Affairs Palo Alto Health Care System (VAPAHCS) LGBT Veteran Support Group by the film producer. The purpose of the LGBT veteran support group is to provide peer support for the range of bio-psychosocial needs and life goals of LGBT veteran participants (Ramirez, et al., 2013). Veterans were informed that the film project's goal was to create an opportunity for LGBT veterans' to present their experiences with trauma and recovery, that the project was artistic in nature (i.e., not a clinical mental health intervention), and participation in the film was voluntary (i.e., choosing not to participate would not affect their access to VA services). *The Camouflage Closet* was produced with the VideoVoice methodology (Catalani, 2009 and 2012), which involves film participants using video cameras to record their own personal stories. Veterans were involved in every step of the film's development: veterans recorded their own video footage; viewed, discussed and provided feedback regarding their peers' recordings and interviews collected by the film director and producer; provided archival

photographs; and veterans listened to iterations of and provided feedback on the musical score written by the film's composer. Veterans reviewed and approved all aspects of the film prior to its release.

While this study's investigator founded the support group and participated in the film's production, the film was not created for the purpose of research and was determined exempt from IRB approval by both the VAPAHCS Research and Development Committee and Stanford Research Compliance Office because it did not meet the criteria for research (i.e., the artistic film project was part of routine care). This study only considers the publicly available final film (e.g., unused video footage collected but not included in the final film, group meeting discussions, and audience feedback forms are not reviewed in this study). This study repurposes the completed art project as a collection of first-person narratives. While excluded from analysis, the Audience Feedback Forms prompted this writer to consider the importance of helping audiences attend to veterans' strengths, resiliencies, and resistance in addition to the trauma and challenges discussed in the film. The current study applies the analytic lenses used by Ramirez and Sterzing (2017) to examine LGBT military minority stressors and acts of every day strength and resilience from first-person accounts of 9 LGBT veterans in *The Camouflage Closet*.

Analysis of data. Analysis was systematically recorded on Data Collection Forms through the use of codes, which were sorted by themes emerging from the codes (often through direct quotes), while memos were kept to track ideas generated during data entry and code analysis. Memos were also used to record the methodological and thematic evolution of the study (e.g., changes to tracking forms and study questions). Atlas.ti, a qualitative analysis software program was used to track the codes in relation to specific moments in the film and written transcript, capture still images of the logged events in the film, generate code reports combing qualitative, quantitative, and visual data, and to keep a log of memos. Additionally, codes were entered into an Excel spread sheet for simple descriptive statistical analysis. Quantitative and qualitative data from the Excel spreadsheet were entered into a report of codes and themes generated by Atlas.ti as depicted in the below diagram. The film's transcript, data analysis codes, themes, and memos are presented as Appendices C through F. Figure 7 below, provides a diagram of the data analysis process.

Figure 7: Data Analysis Process Diagram



The research team coded the film using line-by-line analysis of the film transcript and 2 coding sheets for verbal and nonverbal statements and behavior in the film. Constant comparison was used to combine the coded verbal and nonverbal data from the two data collection sheets and line-by-line analysis into themes which were entered into Atlas.ti (Glaser & Strauss, 2009). For the verbal coding of Strengths and Stressors, tally marks were used to delineate each event on the Verbal data collection sheet. Nonverbal events were coded on a separate data collection sheet with the fields "Voice" (i.e., changes in volume and tone), "Eyes" (e.g., direction of gaze, eyes closed or opened wide), "Hands" (e.g., gestures and touching self or others), "Posture/Body Movement," "Smiling/Laughing," "Tears/Crying," and "Other" (e.g., Mouth: Biting tongue while discussing PTSD). With the nonverbal sheet, tally marks were made in the column associated with the behavior (e.g., smiling) or type of comment made in the event (e.g., Strength & Resilience), notes explaining the tally mark of the event, when the event happened in the film, and which research team member logged the event.

The current study was designed from the premise that verbal and nonverbal communication work in tandem with one another so this study coded both and analyzed them in relation to one another (Knofler & Imhoff, 2007). There has been limited investigation of LGBT people within the field of Communication Studies. A common theme in the existing LGBT-related Communication Studies is investigation of the effects of nonverbal behaviors on identification of gay and lesbian identity with the assumption that gay men act in an "effeminate" manner and lesbians act in a "masculine" manner (Yep, 2014). Knofler & Imhoff's study (2007) suggests that lesbian and gay people tend to display gender-neutral behaviors while heterosexual women display the most stereotypic female behaviors and heterosexual men display the most masculine behaviors. No research was identified that analyzes the communication patterns of LGBT military, thus, the analysis of nonverbal communication in this film considers nonverbal communication irrespective of the combined sexual orientation and military cultural communication patterns of LGBT veterans.

The film is 43 minutes long (including introductory text, credits, and a list of LGBT Veteran resources). The research team watched the film 3 times each (once with each other and twice by themselves). The research team consists of this writer, a licensed independent social worker who has 20 years of experience working with LGBT populations and 11 years of experience working with LGBT Veterans and a research assistant, a transgender veteran and community leader who served from 2002 - 2003 in the Army. The research assistant's military service was completed under DADT and the transgender military service ban as a Drill Instructor. Since he served prior to his gender transition, the research assistant served in a gender-segregated women's unit of the Army. The research assistant also served as Secretary of the LGBT veteran advocacy group Sacramento Valley Vets and is the current Vice President of the national Transgender American Veterans Association and board member of the American Military and Veteran Partners Association. The research assistant was trained in use of the coding sheets through a didactic explanation of video analysis of verbal and nonverbal cues as well as qualitative analysis of a written film transcript in the method of constant comparison. The research assistant was given an opportunity to practice coding a sample transcript and the first time the research assistant watched and coded the film, he did so with this writer and asked questions about coding and use of the coding sheets as needed during the coding

session. Prior to coding the film, the research team engaged in discussion of personal and ideological factors that can influence data analysis as described in the next section.

Procedures

At the first face-to-face meeting, the research team discussed the anthropological concept of reflexivity which refers to the ways decisions made during the filming and editing process can affect the film and its analysis (MacDougall, 1997). Additionally, the research team also discussed (in the very broadest sense), a Criticalist approach to qualitative research, which acknowledges that knowledge is subjective as it is influenced by one's social identities and lived experiences (Kincheloe & McLaren, 2011). The research team discussed how their own personal and professional experiences, identities, and perspectives in a society stratified by race, class, gender, sexual orientation, disability, and other factors, might affect their analysis of the film. As a mixed race, white complected, middle class, queer Chicana Social Worker, this writer seeks to identify ways that systemic forms of oppression (i.e., racism, sexism, homophobia, transphobia, classism, ableism, and other "isms") impact people, their opportunities to achieve their own goals, and their health. This writer's perspective is limited as she has never served in the U.S. military and has only worked with LGBT veterans who access VA care. This client population history is relevant given that LGBT VA access appears to be affected by institutional versus interpersonal discrimination in the military with LGBT veterans who survived institutionalized discrimination (i.e., LGBT-related investigations and discharges) accessing the VA less frequently than LGBT veterans who experienced interpersonal discrimination (e.g., MST and gay-related hate crimes, Simpson, Balsam, Cochran, Lehavot & Gold, 2013). The writer is biased by the belief that many health and economic disparities result from unequal access to resources, minority-directed harassment, and discriminatory policies rather than intrinsic deficits of marginalized individuals and their communities.

The research assistant is a White, transgender man, and U.S. Army veteran who is living with disabilities. The research assistant considers himself biased toward outcomes that benefit the health and wellbeing of LGBT veterans. His perspective is limited to his lived experiences of social identity (e.g., he has not lived as a transgender woman or person of color), particular military service (i.e., he has not worked in any military branches other than Army, only served stateside, did not experience combat, is permanently disabled and empowered by and proud of his service), and physical and mental health experiences (i.e., living with a service connected physical disability and PTSD).

This study consists of video recordings of first person narratives of 9 LGBT veterans in the documentary film *The Camouflage Closet*. This film is a combination of recordings made by the veterans and interviews of the veterans conducted by the film director and producer. Participants agreed to create a film exploring the main question, "What are LGBT veterans' experiences with trauma and recovery?"

Human Subjects

This study of *The Camouflage Closet* was found exempt from University of California, Berkeley Institutional Review Board, as the data is a publically available film (i.e., there are no human subjects because only the publically available film was

analyzed, see Appendix B). This study involves no deception or coercion and strives to satisfy the principle of "Justice" by sharing the results of the project with healthcare providers serving LGBT veterans in the VA, military, and community with a focus on veterans' strengths and resilience as opposed to a sole focus on their victimization, social disenfranchisement, and mental health challenges.

Results

Analysis of *The Camouflage Closet* sought to answer the research questions 1) What types of minority stressors did LGBT service members experience because of their sexual orientation and gender identity while serving under anti-LGBT military policies? and 2) What types of strength and resilience did LGBT service members use to cope in a military environment hostile toward LGBT people? This section begins with background characteristics of participants followed by findings regarding LGBT military minority stressors and LGBT military minority strengths. A detailed discussion of reflexivity in terms of the ways the camera, filming process, and various social locations of the film director, producer, and veterans may have impacted the film and this analysis, is included as Appendix H.

Background Characteristics of Participants

As can be seen in Table 2, the veterans in this film are diverse in terms of race/ethnicity, sexual and gender identity, and military era. 8 of the 9 veterans in this film used their real names and one veteran used a pseudonym signified by quotations (all veterans were given the choice to conceal their identities as desired). The combined military service of these veterans spanned a 40-year period from 1967 to 2009. In terms of branch of military service, 5 veterans served in the Army (i.e., Christine, John, Caroline, Peni, and "Ruben"), 3 veterans served in the Marine Corps (i.e., Andrew, Lani, and Merina) and 1 person served in U. S. Navy (i.e., Billy). Participants' ages range from 26 to at least 67 years old. Veterans use various terms to describe their sexual minority identities including gay (i.e., Andrew, John, and Billy), lesbian (i.e. Peni), bisexual (i.e., Caroline), LGBT veteran (i.e., Merina), and an LGBTXYZ ex-military woman (i.e., Christine). Two veterans identify as transgender in the film but do not identify their sexual orientations (i.e., "Ruben" and Lani). The seven participants who identify their sexual orientations do not identify their gender identity, presumably because they do not identify as transgender.

Table 2: Veteran Demographics

Gender		Sexual Orientation	
Female (5 cisgender, 1 transgender)	6	Gay	3
Male (2 cisgender, 1 transgender)	3	Lesbian	2
		Unidentified	2
Military Service Era		Bisexual	1
Vietnam War	6	LGBTXYZ ex-military woman	1
OEF/OIF	2	**Race/Ethnicity**	
Desert Storm	1	Caucasian	4
Military Branch		African American / Black	2
Army	5	Latina	1
Marine Corps	3	Native American	1
Navy	1	Japanese American	1

Analysis consisted of the research team viewing the film 6 times (3 times per team member), which generated a total of 628 codes. Removal of repeat codes, resulted in 214 unique codes which were sorted into Parent Categories of Stressors and Strengths and were found to reflect a total of 19 themes (See Table 3). For a more detailed description of this sorting process including a list of the 19 themes, please see Appendices I and J.

Table 3: Coding Theme Frequencies

LGBT Military Minority Theme Counts	Strength	Stress
Military Sexual Trauma = 31	6	25
Love: Affection, Attraction, Agape= 18	13	5
PTSD: What it feels like, what living with PTSD entails, impact of treatment=15	7	8
Mental Illness & Recovery = 17	7	10
Unique Transgender Experiences= 16	10	6
Healing Power of Art= 14	13	1
Power of Peers & Community = 14	12	2
Investigations= 13	3	10
Resistance: Socratic Questions, Flipping the Script, Irony, Humor, Reframing, Repurpose, Disidentification = 10	8	2
Disclosure: Coming Out, Concealment, Compartmentalization Military/LGBT identities= 9	5	4
Treatment Gone Right and Wrong= 8	2	6
Intersectionality = 8	6	2
Prescribed Medication = 7	3	4
Pride=7	6	1
Military is not what I expected = 5	1	4

LGBT Military Minority Theme Counts	Strength	Stress
Sex in the Military= 5	2	3
Things that bring joy, happiness, strength= 5	5	0
Enlistment = 4	3	1
Military Mind: DADT Mentality & Military Behaviors= 4	1	3
Post Discharge and Community Integration Challenges= 4	1	3
TOTAL = 214	**114**	**100**

LGBT Military Minority Stressors

18 of the 19 themes identified in this analysis (see Table 4 above), included at least 1 construct coded as a stressor, except for the theme "Things that bring joy, happiness, and strength" which only included items coded as strengths. The themes with the greatest number of stressor codes are "Military Sexual Trauma" (N=25), "Investigations," (N=10), "Post Discharge Problems" (N=6), Mental Illness & Recovery (N=8), Harmful Treatment (N=6), "PTSD" (N=8), and Compartmentalization (N=4) as discussed below.

Military sexual trauma (MST). Examples of MST codes categorized as stressors include coercion by commanding officers and sexual assailants who threatened to ruin the service members' careers if they reported the MST (i.e., Christine), being gang raped by a group of men thought previously to be friends (i.e., Andrew), living and working next to the person who committed the rape (i.e., Caroline, Andrew, and Christine- this code was generated by a memo which interpolated that they were forced to continue serving next to the assailants), being sexually assaulted at the beginning of basic training which affected the entirety of the military career (i.e., Caroline), and due to anti-LGBT policies, not being able to "rally" sizable groups of LGBT service members to protect one another (i.e., Caroline and Christine).

One of the subthemes that developed from the theme of MST events coded as stressors is the idea that MST can be so disruptive to one's sense of safety and other people's trustworthiness, that people targeted by MST end up unable to trust anyone and are constantly on guard. This major loss of trust is an example of the previously mentioned moral injuries. Peni states of her experience with PTSD,

> When you have to constantly, every minute of every day, be on the alert—every minute—I am never not aware of what is going on around me, or who is behind me, and I wish I didn't have to live like that. When any feeling of safety or security that you may ever have felt in this life is just stripped away from you, you never get it back.

Relatedly, Andrew describes a complete loss of trust following MST enacted against him by a group of men he had considered friends. "It was always an unmentionable for me for many years. To be violated like that. And these were guys that I trusted. No more. Anyway, that's that." The finality of Andrew's statement suggests a complete loss of trust he does not hope to regain.

A related subtheme in the MST stressor codes is the idea of lost safety. Christine describes choosing to enter the military as a means of escaping a violent relationship, she states,

> I decided that I needed to get out. I didn't see a way out. I had no skills. I was poor, just out of high school, 19 years old. And I saw a commercial that said "Be all you can be." And I thought, "I'm not being all I can be in this life right now. I need help." And I chose the military for direction, discipline, a job, college education, money for a house, all the great things that they promised me. One thing they didn't promise me was safety.

Believing the military was an escape to safety, Christine instead experienced military sexual trauma (MST) during her service. Christine explains,

> It happened in basic training, and it just so happened that my superior NCO [noncommissioned officer] set me up on a date rape. I was told that I would be ruined if I said anything to anyone. So it was this really mixed emotion, collusion thing. I had no idea that this would happen to me in the military. I was naive, I was 19, I didn't know very much about the world. And I just kind of went along with this date thing and it ended up that the person decided they would rape me instead.

In the preceding examples, the betrayal by people believed to be trustworthy (i.e., friends and a commanding officer), resulted in an inability to trust people and a lost sense of safety throughout their military service and following discharge. This lost trust and sense of safety manifested in hyper vigilance common among people living with PTSD (Seahorn & Seahorn, 2008). Peni describes hyper vigilance while asserting that most people do not understand the impact of MST, "nobody sees you 24 hours a day, so they don't know really the dark hours, the terror of the nightmares, the constant being on the alert. Nobody knows those things unless they experienced it, and I hope to God they don't." This comment is particularly noteworthy as Peni is speaking in the context of a therapist who discouraged her from engaging in trauma work because she was coping adequately without therapy addressing the trauma. Peni's statement "nobody knows," suggests that simply being educated about MST and PTSD do not provide clinicians enough information for true understanding of these experiences, which is critical to effective and non harmful care (i.e., if the therapist understood "the terror of the night mares" and "constantly being on the alert," she might not suggest a client should to resign to coping with these symptoms).

LGBT-related Investigations. Similarly to MST, LGBT-related investigations also resulted in a permanent state of hyper vigilance. The experience of being permanently altered by traumatizing investigations is evident in Billy's description of the conclusion to her investigation in the following, "In the end, they decided that NIS [Naval Investigative Service] didn't have enough information, and my administrative hearing just went away. At least on the legal side. Mentally it's still there. And I'm still looking over my shoulder." That Billy's military service ended in 1979 and 34 years later she is still looking over her shoulder, demonstrates that the disruption to her sense of safety from the investigation (which she knows is over), was so severe that the her sense of safety in the world was permanently altered by the experience. The manifestation of Billy's hyper vigilance, is also reflected in Peni's assertion that LGBT-related investigations leave a permanent stain on a person's reputation. Peni states,

> When they started investigating me, I held my own. I loved the military and I wanted it to be my life and my career, but one day, one of the central intelligence people said to me: "It won't matter if we don't get you. If we don't prove it, if you

> don't disprove it, none of it matters, because even if you stay in there will be a dark cloud over you for the rest of your career. What need did I have to stay then? None. My mother always said, 'Why would you wanna be somewhere you're not wanted?"

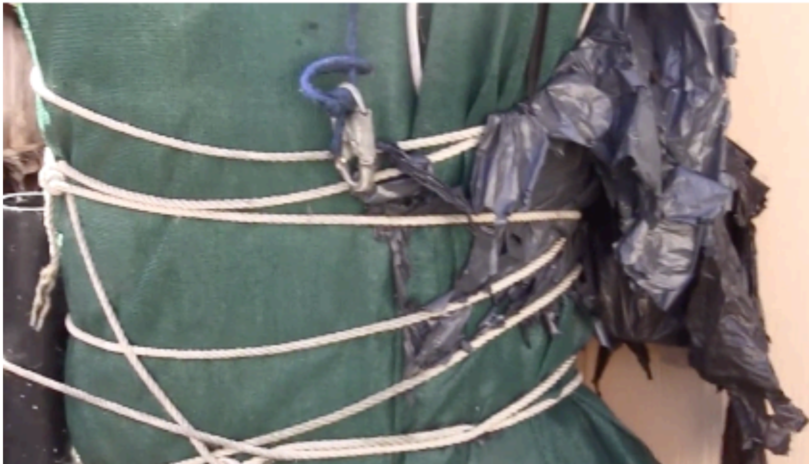
In addition, to hyper vigilance, another subtheme of investigations, which were coded as stressors was the theme of being swept up in an investigation based on associations with other LGBT people. John explains,

> And then the guy that I had sex with told me that he was getting discharged from the Army. He'll show me the papers that he's getting discharged. And I said, "Oh my God, he went ahead and told that we had sex. I'm gonna get in trouble." Thought I'd get kicked out of the Army.

The fear of guilt by association created for some LGBT veterans, a specific type of hyper vigilance where they were not just looking over their shoulders for investigators but also looking at their own sexual partners and peers with suspicion and fear.

Post traumatic stress disorder (PTSD). Subthemes that emerged in analysis of PTSD constructs coded as stressors, include disorientation, a collapsed sense of time when people are triggered by traumatic memories, and difficulty communicating these visceral experiences solely through spoken word. Veterans' descriptions of the PTSD they experienced following MST and investigations is communicated in *The Camouflage Closet*, perhaps most poignantly through a combination of both spoken word and imagery. The effectiveness of this multimodal communication may be due in part to the impact of trauma which when triggered, creates biological and psychological processes that are difficult to describe with words alone. For example, Christine uses an image of a water heater bound in a blanket and rope to describe her experience serving under an anti-LGBT ban.

Figure 8 Screen shot of Bound Water Heater, *The Camouflage Closet*



Christine explains the metaphor of this water heater as, "PTSD is post-traumatic stress disorder. It becomes a disorder when it's chronic, and the violence against me was chronic. This is how I felt sometimes as an LGBT-XYZ, ex-military woman." To this

writer's knowledge, "LGBTXYZ" is not an actual acronym but rather a statement about the ever growing list of sexual and gender minority identities.

Veterans were particularly effective in creating images that were unsettling in ways that mirror the experience of PTSD such as disorientation. For example, Caroline recorded a dirt wall with the sound of keys jingling, a vehicle turning on, and the camera backing away from the dirt wall, which combine in a disorienting audio-visual moment until it is clear what is happening in the scene.

Figure 9: Screen shot of dirt and roots, *The Camouflage Closet*

Likewise, in the the following image recorded by Caroline, the shot creates an effect of tunnel vision, which is described by some people living with PTSD in their recollections of traumatic events and/or triggered memories of their traumas.

Figure 10: Screen shot of a storage unit lot, *The Camouflage Closet*

Christine's filming is particularly interesting in her use of space with several continuous shots of herself talking to the camera while walking outside, one moment with the camera facing her and capturing a portion of her head and other moments, with the camera facing

away from her recording what Christine is seeing. When Christine faces the camera toward herself and captures a portion of her head, the automatic zoom feature in the camera focuses on Christine and her surroundings become blurred and nearly unrecognizable. Thus, the audience is given neither a complete picture of Christine nor her surroundings, which can also be disorienting. Similarly to disorientation, people living with PTSD also experience a collapse of time, which can be interpreted in a reflection of the camera's viewfinder in the lenses of Christine's glasses. This reflection provides the audience a three dimensional representation of the moment being filmed (i.e. Christine is filmed by the camera [1st dimension], the image of Christine is visible in the camera viewfinder [2nd dimension], the image of Christine in the camera viewfinder is reflected in Christine's glasses [3rd dimension]).

Figure 11: Screen shot of Christine's title slide, *The Camouflage Closet*

This arrow points to the reflection of Christine in the camera's viewfinder.

This three dimensional image is most visible on a large screen as opposed to a computer screen or the above screen shot. The three dimensional image can be interpreted as a visual representation of the experience of being triggered by a current event which conjures the physical experience of the original trauma in a way that creates a simultaneous hyper awareness of the past and present as described by Christine in the following reflection. Christine states that while recalling her traumas during the film project that,

> I feel fists beating me on my back, but I know that that's not now. I know that what I'm doing now is going to benefit clinicians, and vets, and hopefully artists, and young girls to know that every story is important.

In this quote Christine's description of telling her trauma story is like the first dimension of awareness (i.e., the current moment), the feeling of fists on her back is the second dimension of awareness (i.e., historical moment of trauma), and the thought of her story helping others is the third dimension of awareness (i.e., imaging a future outcome of the film on audiences). Considered in this way, the experience of being triggered can

collapse a sense of time such that people are aware of and physically experiencing multiple moments in their lives simultaneously in relation to their trauma. Similarly, Caroline's use of imagery presents a collapse of time as well. Caroline's filming of art that she created prior to experiencing MST and PTSD, is juxtaposed with the self-description of being a "broken soldier" stating "I was an artist from the time I was really young, but I lost that after I got sick and after I got PTSD."

Figure 12: Screen shot of Caroline's art, *The Camouflage Closet*

By describing herself as a "broken soldier" who lost the ability to create art, while showing the above artwork and below collage of photographs of herself prior to her MST and PTSD, the audience gets a sense of the magnitude of her loss due to PTSD.

Figure 13: Screen of a collage of photographs of Caroline as a youth, *The Camouflage Closet*

Caroline explains this loss in numerous aspects of her life as she films a storage unit where she keeps her military memorabilia stating the following,

> Somewhere in the back of all of this are my military uniforms. Although I feel pride when I look at them, I also feel very upset. So I decided I'd better put them away, along with all the remnants of my life that I've had to put away. All the loss in my family. Me getting sick and losing my house. And losing my Army family.

Figure 14: Screen shot of Caroline's storage unit, *The Camouflage Closet*

This event is coded as a stressor in that while she feels pride when she sees her military uniform, she is also reminded of the trauma she experienced in the military and the losses that followed due to her multiple illnesses. While Caroline exerted agency in determining for herself a way to manage the physical representations of her memories (i.e., a form of coping), placing these items in storage (i.e., compartmentalizing) meant not only that she was kept from reminders of stress but also reminders of prideful and happy times in her life. Similarly, Caroline's "I Love Me Book" was also coded as a stressor because while representing her numerous successes during her service in spite of MST and resultant PTSD, her description of the book, suggests the most prominent feeling she experiences when looking at it is stress.

Caroline's multimodal expression of spoken word and images, collapses time in a way that can be both uncomfortable and illuminating. The images of her pre-trauma art work and collage of photographs represent a vibrant and creative youth, which is interrupted by trauma resulting in a broken soldier who can no longer create art, however the entire story is being told/shown in a film that she has contributed to, which is itself a form of artistic expression.

Harm from treatment. Veterans describe multiple stressors resulting from care that is insensitive to their particular experiences as LGBT veterans. For example, "Ruben," states "It's a long way from having an endocrinologist say, 'I'm not gonna treat you 'cause I don't approve of your lifestyle,' to finding one who's actually said, 'Oh, yes, I've done studies on female-to-male transitions.'" In addition to insensitive or outright discriminatory care, LGBT veterans also discuss problems from pharmacotherapy. Christine states that while anti-anxiety medications helped her manage increased PTSD

symptoms during the filming,

> Some of those medications have horrible side effects, like gaining 50 pounds. For women, that's not a joke. It's like, "oh, big deal." well, it is a big deal, 'cause we have to carry around that weight and that weight represents the trauma. So I really hope someday I'm not gonna be on medication, but I don't know.

Medication side effects mentioned in this film also include complications from over medication and drug interaction problems (e.g., anaphylaxis [the term anaphylaxis was not used by Caroline but rather referred to when Caroline shows an epi pen and states "medications that can kill me with other medications"]), driving long distances to access a VA with LGBT services, harm from insensitive treatment (e.g., being told they could not have experienced trauma as women in the military because they did not see combat, being discouraged from addressing their traumas, and being told the provider does not agree with their "lifestyle"), and harm from chemical exposures from nonmilitary sources during military service (i.e., Caroline's exposure to chemicals from nearby Monsanto). One memo developed during analysis is the need for LGBT veterans to drive long distances to access LGBT veteran care when they are prescribed medications that cause drowsiness or other side effects that can be dangerous when driving (i.e., due to higher rates of medical and mental health challenges, LGBT veterans may be taking medications, which can have adverse effects on driving, an issue of particular concern for LGBT veterans in rural areas where there are few if any LGBT veteran services).

Figure 15: Screen shot of medicine in a drawer, *The Camouflage Closet*

Post-discharge problems. The theme of "Post Discharge Problems" is comprised of the 3 subthemes of 1) realizing the military is "not what I expected," 2) an internalized "military mindset," and 3) challenges reintegrating into community following military discharge. Several veterans describe stress in realizing the fallacy of their initial beliefs of what military service would be like and how they would benefit from this service. Andrew explains that social inequity in civilian society also haunted military society in the following, "The first thing I heard in boot camp from my drill instructor is that: 'The

only color we see here is green. Marine Corps green.' But that wasn't the case..." Just as Andrew finds that racism exists in the military in spite of claims that the military is colorblind, Christine also learned that while she expected the military to be a safe place from the sexism she experienced as a civilian, she found sexism to permeate the military as well. As previously mentioned, Christine describes the realization that the military while providing her an escape from an abusive relationship and educational and career opportunities, did not protect women soldiers from being raped by male colleagues. In addition to realizing that the military was not immune to racism and violent misogyny (e.g., MST), veterans also recall the loss of their dreams of military careers. Merina and Peni both describe "loving" the military and a deep sadness upon realizing they could not achieve their dreams of military careers due to anti-LGBT military bans. Merina explains how the devastating loss of her dream of a military career, haunted her post discharge in the following,

> The Marine Corps was my life. Then one day, it was all gone. I couldn't fit back into the civilian workforce. With my bipolar, and with my trauma, and with the PTSD—all that combined, I was very sick when I got out of the military. The only road that I could face was a road of recovery. I hit my bottom when I got out of the military, as they say in the AA world.

The trauma of being forcefully separated from their military careers and having had to conceal their LGBT identities, posed unique challenges to community reintegration following discharge. Caroline describes that her sense of having to hide her bisexual identity in the military followed her into civilian life and affected her access to VA services in the following "I didn't know that I could get support for it even at the VA when I got out because my 'Don't Ask, Don't Tell' mentality just went on." Merina describes the military mentality she had to unlearn which "affected every aspect of [her] life" in the following,

> I couldn't go back to work. I failed at my relationships. And cosmetically, I would still tie my shoelaces and tuck them into my boots like I did in the military. I would still do that to my shoes. I wouldn't wear anything girlish. No colors. I wouldn't show any emotions in public. I had to learn to get out of that, and it's taken a lot of years.

For several of the veterans in this film, substance use and abuse was a coping strategy they used to deal with the difficulties transitioning back into civilian life. Andrew describes alcoholism leading to homelessness, Peni describes substance abuse as a means of numbing the terror of PTSD, and Lani describes alcoholism following military discharge as well. In addition to self-medication, substance use among LGBT veterans also resulted from frequenting gay bars, which were one of the only places LGBT veterans could be around other LGBT people in public and because of their challenges integrating back into society post-discharge. John states,

> I interacted with other gay men after I got out of the military. In fact, one of my comp and pen [compensation and pension] evaluations asked me what I spent with my money. I said, "I go to gay bars." They said, "Oh, so you get your disability money and you spend it in a gay bar? You don't go to college? You don't work or anything like that?" The thing of it is, I couldn't get a job and I couldn't get to college because I didn't have work history so I couldn't get hired,

> and they wouldn't allow me into college 'cause I was mentally ill. So, what else could I do?

This description of living with mental illness, which prevented John from entering college and the workforce, is powerfully juxtaposed by his DD214 (i.e., military discharge papers), which highlight numerous significant military accomplishments, including an honorable discharge. In the film, John reads the following from his DD214 "Declarations, medals, badges… Commendations, citations, and campaign ribbons awarded or authorized: National defense service medal, Vietnam service medal, Vietnam campaign with 60 device… Purple heart, sharp-shooter badge M14 with rifle bar..." The next section discusses LGBT military minority strengths identified in this study of *The Camouflage Closet.*

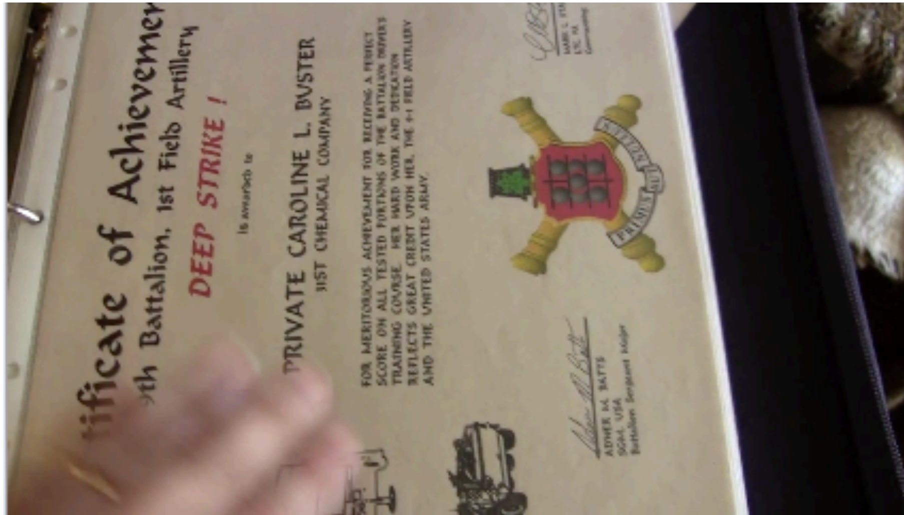
LGBT Military Minority Strengths

Themes with the greatest number of "Strengths" are "Love" (N=13), "Healing Power of Art" (N=13), "Resistance" (N= 8), "Recovery from Mental Illness" (N= 7), and "Pride: Military and LGBT" (N=6).

Love. The construct of love as used to code *The Camouflage Closet* describes love for one's self, love for romantic partners, love for the LGBT community and military at large. One common subtheme in this category is pride as a manifestation of self-love and love for community. One of the most explicit examples of self-love in *The Camouflage Closet,* is Caroline's "I Love Me Book," which holds her awards, commendations, and certificates (Caroline created this book prior to filming *The Camouflage Closet)*. Caroline's I Love Me book represents accomplishments that she feels personal pride in and self-love for. The act of self-love following rape is a remarkable experience in part because one effect of trauma is the internalization of negative messaging about rape survivors (e.g., stereotypes that she invited the assault) exemplified in Caroline's description of herself as a broken soldier. Caroline states while flipping through this book,

> I have every award paper I've ever gotten, page after page. But what's odd about it is that while I was doing all of this, I had a pretty rough time in the military. I was a victim of MST, military sexual trauma. I had PTSD very early on. My chain of command sent me for help. So the entire time I was doing all of this, I was actually considered a broken soldier. I was tested all the time.

Figure 16: Screen shot of a Certificate of Achievement, *The Camouflage Closet*



As Caroline remembers "how sick" she was at the time she was earning these certificates of achievement, that fact that she saved and organized these awards also suggests she is a talented, hardworking soldier, who takes pride in her work. By organizing and preserving these awards, Caroline is performing an act of self-love by reflecting on and acknowledging her accomplishments.

Similarly to self-love, the love for a sexual partner involves a healing of the psychological wounds from having served under anti-LGBT military policies. Merina's description of her military mindset as manifested in an inability to express emotions in public and choice to wear subdued colors for years following her discharge, is offset in the film by her expressing love publicly toward Peni and allowing Peni to paint her toe nails bright pink. At the beginning of a joint interview with Merina and Peni, the two women exchange "I love you's" and during a group video meeting, Merina places her arm around Peni in a loving embrace.

Figure 17: Screen shot of Peni & Merina holding hands, *The Camouflage Closet*

Figure 18: Screen shot of Merina with an arm around Peni, *The Camouflage Closet*

Images of Merina wearing bright pink clothes, allowing Peni to paint her toenails pink, and public displays of affection, represent her love and acceptance of herself and the love she shares with Peni. These moments in the film suggest a healing effect of her relationship with Peni- where she unlearns a military mindset that disrupted her life following discharge from her clothes and public demeanor to an inability to "fit back into society."

Examples of love for community include community service, mourning the loss of peers from LGBT investigations, refusing to succumb to suicidal ideation, and gaining strength from the peer support they received while participating in the film's production. John's service on a VA Veteran Advisory Council (figure 48), represents not only his love for community through his service in this volunteer capacity but also the return love of the community toward John. That John as an out gay man, was selected by his peers and VA leadership to serve on this council suggests that he is valued and respected by them- a noteworthy about face to the rejection he received from would be employers and universities following discharge as a veteran living with mental illness and no work history.

Figure 19: Screen shot of a Veteran Advisory Council Pin, *The Camouflage Closet*

In addition to community service, love for community is also expressed through mourning the loss of colleagues to LGBT discharges (Billy) and suicide (Christine, Peni, Billy). Peni's explanation that suicide while "tempting" is not an option due to the impact suicide has on "the people left behind," suggests a love so profound for others that she choses to endure the "terror" of PTSD to prevent others from suffering her early death.

Finally, love for community is indirectly described in terms of the powerfully healing and uniquely supportive encouragement they received from their LGBT veteran peers. Several veterans describe the peer group as being critical to their interest in and ability to get through the video project as described by Caroline in the following "I keep coming back because of the group. I wouldn't have wanted to do it without the group." Christine explains part of why the peer-based aspect of this project was so powerful by stating "My fellow veterans that are doing this understood what I was trying to say" and "Ruben" who states "I like being around other veterans. Sometimes, only another veteran can understand you and what you're going through."

Love was also evident in the care taking LGBT veterans provided one another. For example, John describes providing hospice for his partner of 15 years during his AIDS-related illnesses. Additionally, Andrew describes the way that gay people were treated in the ghetto during his military service as a form of "respecting your last wishes" and sharing of dresses from men who were returning to the US, because "dresses were hard to come by in Okinawa." Communal love or affection is visually represented in images of Andrew and other men casually touching one another in photos taken in public were the men are leaning on one another's shoulders.

Figure 20: Archival photograph of Andrew leaning on another man, *The Camouflage Closet*

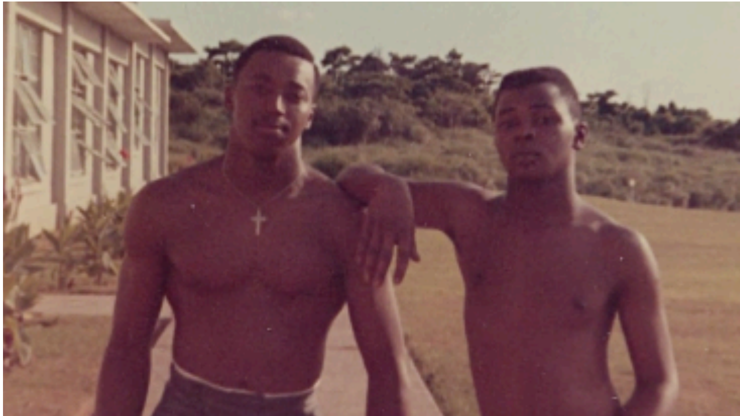


Figure 21: Archival photograph of Andrew standing with other men, *The Camouflage Closet*

Healing power of art. Veterans describe art as being critical to their healing and survival. Peni states, “All of my therapy, all of my counseling has been wonderful. But bottom line for me, though: this video class and my art therapy have actually done more for me faster, I think, in getting to the inside. The outside we’ve been treating for years.” Relatedly, Christine states, “Art saved my life. If I couldn’t do art, I wouldn’t be here.” In terms of the healing potential of artistic expression available through video, Christine explains,

> You know, a lot of times we can’t see ourselves, and then you see yourself on camera and you hear yourself speak, and you have all these really good thoughts. Then you hear them and you see it. It’s healing. It makes me feel like, “Hey, I don’t have to be agoraphobic. Hey, I don’t have to isolate. It’s okay. Yeah, yeah, there’s people that wanna know your story. It’s okay, you can tell ‘em. You’re not gonna get hurt.” That’s the scary part for a lot of people.

Similarly to the multimedia representations of PTSD symptoms, the inclusion of visual art in *The Camouflage Closet*, communicates unique aspects of veterans' healing beyond what is possible with spoken word alone.

In addition to artistic expression such as Christine's drawings, Caroline also shares her paintings and describes herself as "a belly dancer and a medieval recreation living reenactment enthusiast." Just as Caroline expresses herself artistically through her own body in terms of belly dancing, other veterans use their bodies as canvasses of artistic expression through tattoos (Caroline) and make up such as finger nail polish (Lani and Merina). Lani's introduction to the film combines special nail painting and a white index card trope. The film begins with Lani holding 3x5" white index cards in front of her face so that all that is visible are the words on the cards, her fingers holding the cards, and the top of her head. The fingernails on her right hand are painted blue while the fingernails on her left hand are painted pink. A male gender symbol is painted in white on the pink nail of her left index finger while the female gender symbol is painted in white on the blue nail of her right index finger. With these cards, Lani introduces herself to the audience as a 26-year old Marine who is "also male to female transgender."

Figure 22: Screen shot of Lani holding index card with text "I'm also male to female transgender," *The Camouflage Closet*

Lani's use of her body as a canvas extends beyond nail polish to the way she takes up space in another image where she is filmed in both male and female clothing and stereotyped posture. As shown in figure 19 below, Lani is seated on the left side of the screen in male or gender neutral clothing (i.e., a t-shirt, hair pulled back) and on the right side in a woman's blouse with her hair down. The idea for this shot originated with Lani and was recorded and edited by Mr. Nedelman according to Lani's direction.

Figure 23: Screen shot of Lani's title slide, *The Camouflage Closet*

Considering the previously mentioned Communication Studies examining gendered posture, it is interesting to note that Lani depicts herself in male or gender neutral clothing not only through her clothing and hair style, but also in terms of her body position and use of the chair (i.e., the masculine/gender neutral image is seated backwards on a chair with legs spread wide, while the feminized image is seated in a way that is turned inward, looking down, and occupying minimal space).

Resistance. The theme "Resistance" includes the subcategories of Socratic Questioning, Humor/Irony, Disidentification, and Intersectionality. While Intersectionality as defined by Crenshaw (1991) describes the intersection of multiple marginalized identities, in this analysis Intersectionality is inverted to mean the intersection of multiple sources of strength and resilience. In addition to inverse intersectionality, several veterans used Socratic questioning in regard to LGBT-related investigations and with medical providers. Socratic questioning is a tool of critical thinking drawing from the way Socrates posed questions to identify hidden assumptions, inconsistencies in arguments, and previously unknown options (Williams, 2012). As such, Socratic questioning can be used to equalize or illuminate power differentials. For example, Lani's notecard introduction includes cards stating "I'm just tired of taking pills just to be…'NORMAL'" followed by another card, which asks "What is normal?" It is unclear if Lani is referring to medications for gender transition, for mental health (e.g., depression and/or PTSD), and/or non gender-related medical problems. By asking what is normal however, Lani challenges the audience to consider societal assumptions of normalcy and in so doing, asserts that her experience is also normal and/or that there is no such thing as normalcy. In this example, Lani may be drawing from resilience developed in response to stigma toward her as either a transgender person or as a person living with PTSD, and as such is an example of both Socratic Questioning and inverted intersectionality.

Similarly to Lani, Billy poses a Socratic question regarding LGBT service members discharged due to their sexual orientations and gender identities while filming a pile of empty plastic water bottles with a voiceover stating, "How many quality people did the military lose just because they searched? How many hours of training and millions of dollars? For some, the dreams are ended. For some, it's just a trash heap." In this example

Billy's questioning of the lost talent and cost of anti-LGBT policies implicitly questions the rationale of those policies as strengthening the military. Billy also uses a type of Socratic question regarding the end to her investigation by stating "I was accused of being a latent homosexual. They never quite got me to understand what they really meant by that. How could they find me guilty of being a homosexual if I was latent?" This question highlights the ludicrousness of the investigations, especially accusations of latent homosexuality. The facial expressions Billy makes throughout this scene add to the sense of her incredulity toward the concept of latent homosexuality.

Figure 24: Screen shot of Billy, *The Camouflage Closet*

Christine also uses Socratic questioning with a doctor who asserts that she could not have PTSD because she did not experience combat, to which Christine responds "Wanna bet? What is a battle?" In this question, Christine is referring to the MST orchestrated by her commanding officer. Also regarding investigations, Peni describes her decision to abandon her dream of a lifelong career in the military with the Socratic Question, "Why would you want to be where you are not wanted?" Each of these examples were coded as a strength because the veterans acted in resistance to specific stressors. Similarly to resilience, the resistance of their Socratic questioning only has meaning in relation to the stressor they are resisting.

Resistance. Similarly to Socratic Questioning, veterans in *The Camouflage Closet* used an element of irony, surprise, and humor to deliver their resistance to LGBT military investigators (Peni), medical providers (Christine), and peers (Ruben). Peni describes playing tricks on investigators in the following,

> They just followed us everywhere. We would actually pull into cul-de-sacs. There's no way out. We would meet them going in as we were coming out. And we'd just wave at them. I'm sorry, please don't show all that heavy laughing. When we stopped at restaurants to eat, they wouldn't come in. They'd sit in the car, so we'd take them out coffee. "Let us know if we get too far ahead of ya'!" Oh god. We had to do something. If we hadn't treated it that way, it would've been even more awful on us. The emotional load and turmoil.

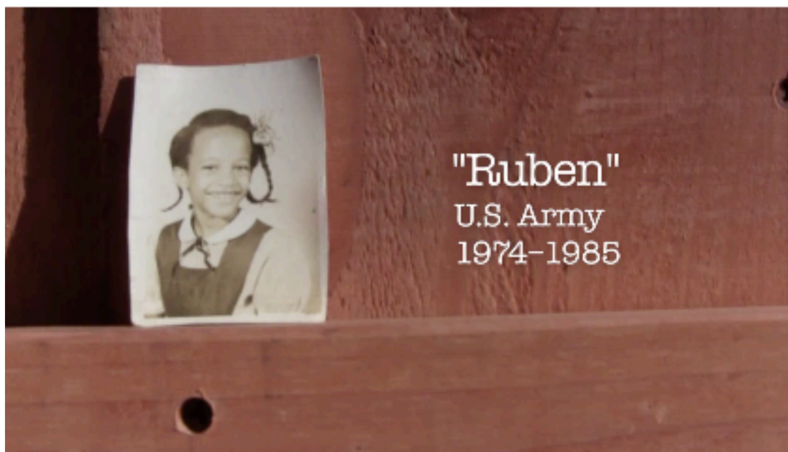
Christine and Peni both resisted comments made by medical providers as previously mentioned (i.e., Peni resists the idea that she should not engage in trauma work because

she was “coping” while Christine resists the ideas that weight gain medication side effects are not a big deal and that women veterans could not have experienced combat because MST is a type of combat).

Ruben also used resistance to internalized homophobia when responding to stereotypes about women service members. “Ruben’s” choice to join the military was coded as a source of strength as an example of disidentification:

> This is a story about a little boy. Well, looks like a little girl, but actually it's a little boy. He wanted to be in the army when he grew up. And that was not popular in the '50s for someone built like him, to want to go out and fight in the army…. One of the things that really appealed to me about joining the military was the fact that I wouldn’t have to wear a dress. Fatigues and boots looked a whole lot better than heels and stockings. So I finally got up enough nerve to follow my dream and join the army. I was, needless to say, strongly discouraged from joining the military. The common philosophy in those days was no one went into the army but lesbians and whores, so I liked to tell ‘em I was a whorish lesbian.

Figure 25: Screen shot of “Ruben’s” title slide, *The Camouflage Closet*



This quote was coded as an example of strength regarding “Ruben’s” disidentification (Munoz, 1999) as he rejects internalized homophobia by embracing and delighting in the stereotype that women in the military were either lesbians or whores by labeling himself a whorish lesbian. Additionally, this example was also coded as a strength because he used self-determination to get himself into a work environment where he was permitted to wear clothes in which he felt most comfortable.

In addition to Socratic Questioning and disidentification, intersectionality (i.e., the interconnected impacts of multiple and overlapping minority experiences; Crenshaw, 1991, 1991) was another common strength as it helped veterans in the film cope with the LGBT military minority stressors they faced during and following their military service. For example, Lani’s choice to join the military was directly related to her transgender identity by enlisting as a form of “overcompensation” hoping to find her “true identity.” Lani states,

> Others have described my life like the stages of a butterfly. Before the military, I had no idea who I was. Somewhere along the way, I tried to overcompensate [by

> acting more masculine] —of course, by joining the military—hoping that I would find my true identity. Of course, it wasn't how I expected, but still. Being in the military was like I was trapped in my cocoon. My whole life had to be put on hold. But then, when I got out of the military, I decided it's time for me to live my life. And I think that's the final stage. I have emerged from my cocoon. Then I come out the butterfly that I want everybody else to see—that I know I am.

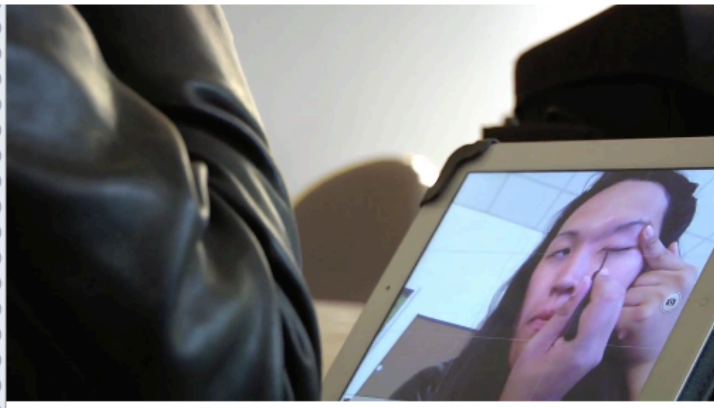
Lani's experience as a Japanese American transgender Marine is a site of intersectionality which she adeptly uses to make meaning of and survive the challenges of PTSD resulting from her military service. Lani uses the lessons learned and the strength developed in response to one type of oppression, to manage another type of life challenge. She states,

> My closet is pretty much divided. I have my male clothing on one side, and my female clothing on the other. So of course my room is getting a little bit cramped. Having to keep that hidden all the time, it's like how when you have PTSD. When you have those bad memories, you just want to keep them locked away.

Whereas Crenshaw, 1991 (1991) developed the term intersectionality to describe the amplified oppression of intersecting marginalized identities, the term is used here to elucidate the amplified resilience available from the experience of surviving multiple and intersecting types of oppression or challenge.

Lani explains how she "improvises" to hide her transgender identity by keeping a change of clothing and makeup in her car because the family she lives with, do not know that she is transgender (i.e., she wears men's clothing at home). She also improvises by using technology to assist her getting dressed in her car. Instead of sitting in front of a mirror in a bedroom or bathroom to apply makeup and do her hair, Lani uses an iPad.

Figure 26: Screen shot of Lani using an iPad to apply makeup, *The Camouflage Closet*



Lani exemplifies the healing that LGBT veterans living with PTSD can experience through a combination of trauma focused care, VideoVoice or other art projects, and coming out to a community of affirming peers as an LGBT veteran. *The Camouflage Closet* visually represents a transformation or transition of Lani from a tough looking male Marine into a smiling and vibrant woman veteran.

Figure 27: Archival photo of Lani during military service, *The Camouflage Closet*

Figure 28: Screen shot of Lani smiling, *The Camouflage Closet*

Similarly to Lani, "Ruben" draws on his multiple cultural identities as an African American transgender male veteran by combining the African American tradition of Gospel Music with images of troops marching in the following combined statement and musical interlude,

> That's a song I've always liked. I decided to end with the troops marching to the background of Mahalia Jackson and Dinah Shore singing, "I Ain't Gonna Study War No More." I didn't have a sword and shield. I did have a 45. So I'd just like to say, I emptied my 45, and I emptied my M16, and I ain't gonna study war no more.

Pride. Veterans also recorded images signifying the importance of their military and LGBT cultures (i.e., their pride in the military service and LGBT pride). In terms of their military service, veterans filmed their military gear (i.e., Merina, Andrew, Caroline, John), military branch flags and seals (i.e., Andrew and Caroline), military awards (i.e., Caroline), video of soldiers marching in formation (i.e., "Ruben"), a veteran motorcycle club vest (i.e., "Ruben"), and a Veterans Affairs Veteran Advisory Council pin (i.e.,

John). Of particular note is the continued pride in and association with their military service in spite of the MST, LGBT-related investigations, and early discharges they experienced. Veterans displayed their LGBT pride by displaying public affection (Peni and Merina), tattoos (Christine), LGBT pride flags and imagery on their walls (Andrew), and in statements such as Andrew's "I am a proud gay Black Marine. Simple as that."

Figure 29: Screen shot of a District 13 American Legion motorcycle vest, *The Camouflage Closet*

Figure 30: Screen shot Andrew in front of a flag, *The Camouflage Closet*

Recovery from mental illness. Comments regarding recovery from mental illness are frequent and multifaceted throughout *The Camouflage Closet*, communicating the messages that treatment is available, healing is possible, and LGBT veterans' lives can improve when they engage in healthcare and self-care (i.e., Peni, Christine, Lani, Merina, and Andrew). For example, Merina describes her healing process as "Learn to like myself. Learn to accept my trauma. Learn to accept my time in the service. And learn to face that world as an LGBT Veteran." This quote also depicts the identity integration process combing previously compartmentalized aspects of her separate military and LGBT lives. Caroline describes the following regarding accessing care "Coming to the

LGBT group here and getting some support was a huge release, a huge open valve. It took so much stress away." Many of the veterans specifically name the VA as critical to their healing. Andrew states, "I am in deep gratitude to the VA hospital for saving my life. Better still, when I got pulled into the emergency room from the streets, they took care of me. They nurtured me."

Posttraumatic growth. Military sexual trauma was coded as a strength when it suggested posttraumatic growth, such as Christine's comment that "I was a target, not a victim of MST." This comment is coded as a strength because her assertion that she was a target and not a victim indicates that she is engaging in a process of self definition regarding the trauma that includes her own personal agency and power. Christine goes on to state that "the MST, what it gave me was, going through the healing journey told me that I have the strength to come out the other side, and it's my responsibility to take care of the young ones that are coming up and help them through their trauma." In this way, Christine's reflection of her MST suggests posttraumatic growth as the trauma has resulted in new meaning in and purpose for her life and trauma history. Additionally, Christine's description of self-talk that she uses to calm herself during triggering moments of trauma-related work such as discussing her MST, was also categorized as a strength. She states,

> I took extra anxiety pills in order to be calm around it [the film]. It triggered some flashbacks. I have to use a lot of my "tools" to get through it. And yet, on the other side, it's beautiful.

This quote demonstrates how reflection on traumatic histories such as experiences of MST can be very painful and disturbing (e.g., re-experiencing of physical sensations from traumatic events), however when successfully worked through, can result in benefits to the person (i.e., Christine sees her own strength and resilience in the film and learns that she can engage other people without getting hurt) and other people (i.e., Christine is using her trauma history to help younger veterans, artists, and clinicians).

Discussion

This study examined LGBT military minority stress and strength among 9 LGBT veterans who served under anti-LGBT military policies as represented in the documentary film *The Camouflage Closet*. This section discusses the study's main findings in relation to the existing LGBT Veteran literature, followed by recommendations for LGBT Veteran research, policy, and clinical practice, and concludes with study limitations.

Analysis of *The Camouflage Closet* suggests that contrary to veterans portrayed in films depicting *psychostasis* (Keranen, 2014), LGBT veterans can and do getter better with the right combination of treatment and social support. Main findings suggest that PTSD may be best articulated through a combination of verbal and artistic communication and that trauma work with LGBT SM/Vs should include attention to post traumatic growth and moral injuries. Finally, LGBT SM/Vs who have additional marginalized identities such as being people of color or living with a disability, may be able to use strengths and resiliencies from one aspect of their lives to manage discrimination and challenges toward other parts of their lives.

As represented in the LGBT veteran literature, veterans in *The Camouflage Closet* described the following stressors: military sexual trauma (MST, Belkin, 2012), anti-

LGBT investigations and discharges (Shilts, 1993, Berube, 1999), abandoning the goal of a lifelong career in the military due to anti-LGBT institutionalized and interpersonal bias (e.g., gay-related investigations and harassment by peers, Seefried, 2011; Estes, 2005), fear of being outed by former lovers (Shilts, 1993), having command who abused their power (e.g., being set up on a date rape by a commanding officer), being sexually assaulted by people considered trustworthy (i.e., military peers who were considered friends, Belkin, 2012), using alcohol and illicit drugs to manage mental and physical health problems, and difficulty integrating into civilian life following discharge from military service (Seefried, 2011).

This analysis of *The Camouflage Closet* identified several LGBT military minority stressors absent from the LGBT Veteran social science literature. The new stressors identified in this study include interruptions to one's ability to produce art due to trauma, medication side effects of weight gain which represent trauma, driving long distances to access a VA with LGBT services and potential complications with medication, harm from medical and mental health treatment, moral injuries, and harm from chemical exposures from nonmilitary sources during military service.

Table 3: LGBT Military Minority Stressors & LGBT SM/V Strengths & Resilience

Literature Review	Current Study	LGBT Military Minority Stressors	LGBT SM/V Strengths & Resilience
Ramirez & Sterzing, 2017	X		Humor/Camp
Shilts, 1993	X		Resisting LGBT investigations
Shipherd et al., 2012; Ramirez et al., 2013	X		Engaging in treatment
Shilts, 1993; Ramirez & Sterzing, 2017	X		Success in military career (i.e., awards and commendations)
Trivette, 2010	X		Peer support & communicating in coded language
	X		Benefits of Intersectional Resiliencies
	X		Use of art for healing, self expression is particularly helpful for LGBT veterans given DADT and includes unique potential for processing traumatic memories.
	X		Posttraumatic growth from MST
	X		Healing potential of love for self, partner, LGBT community, and the military

Literature Review	Current Study	LGBT Military Minority Stressors	LGBT SM/V Strengths & Resilience
	X		Mental health treatment is available and recovery is possible
	X		Disidentification
	X		Socratic Questioning used to resist anti-LGBT military policies and problematic heath care
	X		Artistic group level project can help heal compartmentalized LGBT veteran identities
Belkin, 2012	X	Military Sexual Trauma	
Shilts, 1993; Berube, 1999	X	Anti-LGBT investigations and discharges	
Estes, 2005; Seefried, 2011	X	Abandoning goal of a military due to anti-LGBT military policies	
Shilts, 1993	X	Fear of being outed by former romantic partners	
Shilts, 1993; Belkin, 2012	X	Being sexually assaulted them by command and colleagues	
Seefried, 2011	X	Using alcohol and drugs to manage LGBT Military Minority Stress	
Shilts, 1993	X	Harm from mental health treatment	
Seefreid, 2011	X	Difficulty transitioning into society following discharge	
Shilts, 1993	X	HIV/AIDS	
	X	Medications side effects (especially an issue for LGBT veterans living in rural areas)	
	X	Driving long distances while taking prescribed medications that cause drowsiness	
	X	Loss of ability to produce art due to trauma	
	X	Chemical exposure during military service	
	X	Moral injuries	

Analysis of *The Camouflage Closet* identified several strengths, which are discussed in the literature: use of humor/camp (Ramirez & Sterzing, 2017), resisting investigations (Shilts, 1993), engaging in treatment (Shipherd et al., 2012; Ramirez, et al., 2013; Sullivan, Mills, & Dy, 2016), achieving success in the military such as promotions and

awards (Seefried, 2011), peer support, and communicating with LGBT service members through code or other signals (Curtis, 2014). Further, this analysis identified the following new LGBT military minority strengths: benefits of inverted intersectionality, the use of art for healing, posttraumatic growth from military sexual trauma (MST), the construct of love, mental health recovery, disidentification, and the use of Socratic Questioning to resist anti-LGBT military policies and problematic health care. Additionally, memos developed during this analysis also identify artistic expression as being particularly helpful for LGBT veterans to communicate experiences that are difficult to communicate solely through spoken language (e.g., how it feels to live with PTSD and to serve under anti-LGBT policies). For example, Peni states that after years of psychotherapy, the film project and art therapy were more effective in helping her deal with her trauma by getting to the deepest wounds as opposed to "treating the surface." These new LGBT military minority stressors and strengths can be used to inform both strengths based research, policy, and practice.

The implications of this study for medical and mental health clinicians working with LGBT veterans are potentially significant because findings may lead to a more balanced understanding of LGBT veterans by broadening our awareness of the strengths and resiliencies they manifested to manage LGBT military related minority stressors. As such, findings may assist social workers required by the professional standards of National Association of Social Workers and Council on Social Work Education, to provide strengths-based, culturally relevant and LGBT-affirming practice.

Research. The lack of empirical intervention studies (as opposed to descriptive articles) in the LGBT Veteran social science literature, suggest that intervention studies of LGBT veterans are critically important (Ramirez & Shapiro, *under review*). Intervention research would do well to consider constructs that may simultaneously function as both stressors and strengths in LGBT SM/Vs' lives such as peer engagement. While most constructs identified in this study fit within the Minority Stress Model's framework of distinct stressors and strengths, some events had an element of both strength and stress. For example, while social support is a major source of resilience for LGBT people, socializing was dangerous when LGBT service members were forced by investigators to identify their LGBT peers (Kwon, 2013; Shilts, 1993). As such, having relationships (platonic or sexual) with other LGBT service members while serving under anti-LGBT military policies, provided both the potential for peer support which is a strength, but also the risk of being discharged due to guilt by association which is a stressor. Another example is Caroline's "I Love Me" which was coded as both a strength and stressor because while she "felt pride" looking at it, she also felt distress.

Particular strength-based research topics that are uniquely relevant to LGBT SM/Vs include the concepts of belongingness/unit cohesion, community service, and pride. For example, now that the social science literature has identified LGBT-related investigations and discharges as disrupting LGBT SM/V's connection to the military and civilian LGBT communities, and community support has been identified as a key factor in LGBT resilience, how might interventions informed by the above support LGBT SM/Vs' health and wellness? Given that the above values are also held within the LGBT civilian population and some LGBT SM/Vs experience rejection from LGBT civilian communities, how might LGBT civilians and veterans be brought together around these shared values? Importantly, while the VA is increasingly offering group level

interventions for LGBT veterans, how might a referral to such a group be important to identity integration and also feel potentially dangerous for LGBT veterans who experienced peer connections as risky given LGBT-related investigations?

With LGBT SM/Vs who communicated through code in the military as a means of self-protection, it may be particularly helpful to video tape sessions to allow researchers and clinicians to reflect on LGBT SM/Vs' communication several times before drawing conclusions about conscious and unconscious aspects of communication. That is, considering that LGBT service members were conditioned to hide same sex partners, a lesbian or gay veteran couple in family therapy who do not show affection through touch or eye contact, may reflect the conditioning to conceal same sex relationships as opposed to a lack of connection or warmth in their relationship (i.e., when alone or among LGBT SM/V peers, the couple may engage in more casual touching, eye contact, and use of terms of endearment). It may be that such couples have developed ways of expressing affection in public that are nearly imperceptible to others. As such, clinicians and researchers may have to listen and look very closely (and perhaps differently) to register public displays of affection among LGBT veterans and avoid pathologizing their concealment survival skills.

The veterans in this film unprompted by project staff, repeatedly stated having found the artistic, peer-based film project to be particularly helpful in processing their traumas and experiences as LGBT service members and veterans. This study is not an intervention study and as such did not measure the extent to which the film project impacted participants, however the veterans' spontaneous (i.e., unprompted) and overwhelmingly positive reflections of the project described in the film itself, suggest that VideoVoice may serve as an intervention worth studying with this population.

In addition to intervention research, there is also a great need to conduct research on LGBT veterans' strengths and resiliencies in addition to their traumas and diagnoses. Importantly, this study suggests that as clinicians and researchers, we see that which we are looking for, a particularly problematic dynamic when working with communities historically pathologized based on their social identities. In other words, if we are only looking for challenges and diagnoses, we are likely to miss strengths and resiliencies, especially among marginalized groups historically defined as inherently sick. Additionally, research on posttraumatic growth among LGBT veterans is greatly needed given the high rates of trauma to which they are exposed before, during, and after military service. Finally, the total loss of trust and sense of safety described by several veterans suggests that research regarding moral injuries among LGBT veterans may also be an important area for future study.

Given that the most commonly coded theme in this film is military sexual trauma (MST), it would be helpful to research what if any impact MST has on LGBT service members who were targeted because of their LGBT identities (Burks, 2011). In particular, it would be helpful to look at issues of LGBT identity development such as identity foreclosure and consolidation (Floyd et al., 1999) to see if MST targeting LGBT people based on their sexual and gender minority identities interrupts the LGBT identity development process, which is often already disrupted by the forced concealment of LGBT identities within military service under anti-LGBT military service bans.

Finally, given that it is common for LGBT veterans to drive long distances to access LGBT veteran-specific care and their elevated rates of medical and mental health

challenges are commonly treated with pharmacotherapy, it is critically important that researchers and clinicians begin to assess the extent to which those medications may be impacting LGBT veterans' ability to drive, especially among rural LGBT veterans who live far from LGBT veteran-specific care (Kauth et al., 2017). Additionally, alternative forms of treatment that do not require travel to the VA such as telemedicine and online therapy are also are an area of needed study (Mustanski, Newcomb, DuBios, Garcia, & Grov, 2011).

Clinical Practice. Given the significant positive impacts veterans spontaneously identified in the peer-based aspect of this project, peer-based group level interventions may be particularly helpful for LGBT SM/Vs. For example, considering the important place John found in gay civilian spaces following discharge, and the meaning Christine found in helping younger women veterans by sharing her story of trauma and recovery, one suggestion of a new type of group work entitled "Seasons of Love," is to combine LGBT people of different ages and military statuses (e.g., service members, veterans, and civilians). Based on the theme song from the musical *Rent* (music, lyrics, and book by Johnathan Larson, 1993), "Seasons of Love" asserts that the lives of LGBT people and those living with HIV/AIDS, is best measured in love. In this way, a Seasons of Love group not only centers the idea of love as a shared and central construct across LGBT people (i.e., there is strength and resilience in love for self, love for family, and community), but also the idea that seasons of life when combined (e.g., young adults and seniors and military service members, veterans, and civilians), can be sites of strength and healing.

A Seasons of Love group could be constructed to help LGBT veterans reintegrate into civilian society following military discharge while also educating LGBT civilians about the experiences of LGBT service members. This group could highlight specific ways that LGBT civilians can offer support to both community reintegration and identity integration processes (i.e., integrating LGBT and military identities from compartmentalization to a unified whole and from military service to civilian life). In particular, such work could involve the use of artistic expression and build upon military values that promote health and wellness such as unit cohesion and working as a unified force toward a group goal. Given the value of community service in the military, an example of a group goal could be a beautification project for the LGBT community highlighting the contributions LGBT military and veterans have made to LGBT civilian society through murals of prominent LGBT SM/Vs like Gilbert Baker and Denee Mallon. Such works might increase the sense of belonging LGBT SM/Vs feel in the LGBT civilian community, and inspire the respect they deserve among civilians for the positive contributions they have made to the military and civilian society.

Additional suggestions to support the integration of LGBT and military identities include attention to compartmentalization and the connection between military pride and LGBT pride. One suggestion for individual or group work is the intentional and mindful use of compartmentalization. Drawing from Caroline's description of placing her military memorabilia in storage, clinicians could work with LGBT veterans to critically analyze avoidance strategies that reinforce isolation and compartmentalization.

Clinicians and LGBT veterans can also critically analyze the contexts within which avoidance (i.e., placing military items in storage) functions as a strength when they are not ready to do trauma work (e.g., during times of high stress such as prior to a major

surgery), and as a stressor if they are placing military items that represent both bad and good memories in storage, when the good memories could support their active trauma work. Additionally from Caroline's example, clinicians can support LGBT veterans' identity integration in creating "I Love Me" books that combine images and memorabilia of both their military service and LGBT identities. Finally, writing and other artistic expression (e.g., collage making, poetry, painting, digital storytelling) for LGBT veterans reflecting on the concepts of moral injury, posttraumatic growth, love, and similarities and differences between pride in military service and pride in an LGBT identity, may also be helpful to their pursuit of health and wellness (Ramirez & Shapiro, *under review*).

Given the military ethos of showing no weakness or emotion, it may be particularly important for clinicians to look for moments when the nonverbal communication that is typically rejected in military culture (e.g., crying and tears, physical affection between same gender people) surfaces in work with LGBT veterans. When identified, these moments can be used as examples of strength and healing from the conditioning of military training that prevents SM/Vs from accessing their emotions and expressing same gender attraction. Finally, the willingness of Peni and Merina to express physical affection to one another in public suggests that LGBT veterans given the right environmental factors, can unlearn the instinct to hide their same gender love. That LGBT veterans can unlearn such self-policing is a significant strength that could be used in other contexts such as unlearning other types of hypervigilance.

Policy. This study's findings suggest that LGBT military minority stressors not only affected access to care in the military, but also veterans' access to care, even decades after discharge. As such, health care systems serving LGBT SM/Vs could make great strides by instituting policies requiring clinicians to factor LGBT status into clinical care. Whether it is considering the unique needs of being informed about confidentiality or the implications of a referral to a group level intervention, clinicians can acquire LGBT veteran clinical training in treatments tailored to LGBT veterans' needs and strengths. Additionally, medication management policy can be used to screen LGBT veterans who live far from VA medical centers to assess if medication side effects are affecting driving and if remote access LGBT veteran services could be of use. Finally, ensuring that all group level intervention, waiting areas, residential and inpatient services are LGBT affirming by posting anti-discrimination policies and enforcing these policies, could increase LGBT veterans' comfort accessing VA care. Perhaps most importantly, the deleterious impacts of serving under anti-LGBT military policies documented in this study and the literature, unequivocally suggest that anti-LGBT policies should not be reinstated in the U.S. Armed Forces.

Study Limitations. While video affords many benefits, there are particular limitations as well. People at times act differently in front of a camera due to feeling shy and therefor hesitant to speak or feeling self-conscious about how they will appear resulting in internal editing of what they say. In VideoVoice projects (Catalani, 2009 and 2012), participants control the camera and thus have an opportunity to review their own footage, erase and re-record video for a more favorable video clip. While qualitative research does not purport to be representative of the population or phenomenon studied, it is important to consider what if any biases in the data result from the people not included in film projects (i.e., the VA enrollment eligibility criteria used in *The Camouflage Closet* necessarily excluded veterans outside of the VA whose experiences may differ from the

veterans featured in this film). On the other hand, VideoVoice methods can be liberating for participants who find the medium conducive to personal disclosure and general self-expression.

An additional limitation is that only one of the two coders is a veteran and the civilian's perspectives might have limited or skewed her interpretation of the veterans' video recordings. On the other hand, the other coder's lived experience as a transgender veteran who also happens to have communicated with several hundred LGBT veterans over the past 7 years in his LGBT veteran leadership positions, is a major strength for this study's analysis in terms of cultural awareness. Of course the opposite may have also been true, if the research assistant's personal experiences in the military or with trauma and recovery were triggered by the material in the film, this closeness to the subject matter could have skewed his analysis of other people's experiences by interpreting them as if the experiences had been his own. Hopefully, such potential biases are balanced out by the positionality of the two coders.

Contrary to previous representations of veterans, *The Camouflage Closet* exemplifies not only the existence of treatment, but also the potential for healing among LGBT veterans. Through the VideoVoice methodology, LGBT veterans produced a film that provides a more holistic and hopeful representation of themselves than is found in the social science literature, news media, and Hollywood-produced films. Audiences of students and clinicians who watch *The Camouflage Closet* with an eye and ear toward strength, will walk away with an appreciation for the significant and multifaceted resiliencies LGBT SM/Vs have developed to survive and thrive in a hostile and exclusionary world. Just as LGBT veterans' at times painful trauma work results in posttraumatic growth as exemplified in *The Camouflage Closet*, so too have the community organizing efforts of LGBT service members and veterans resulted in major successes for the military and society at large. As the final edits are made to this dissertation, Mark Green withdrew his acceptance of the nomination as Secretary of the Army and in a news conference at the Pentagon, General Mattis stated that plans to reinstate the transgender military service ban are now on hold (Lamothe, 2017[1,2]). In the illustrious battle cry of the United States Marine Corps, Green's withdrawal is met with an "Oorha," a "Hoorah" from the United States Army, Navy, and Coast Guard, and from the former and wildly popular Commander in Chief, President Barak Obama, "Yes we did!"

Notes

[1] The University of Southern California School of Social Work offers a Military track to prepare clinicians for military and veteran social work practice (http://bit.ly/USCMilitary) and for the past 3 years one lecture on LGBT Military and Veteran Care has been included in the Stanford University School of Medicine's student-run seminar "Queer Health and Medicine," (Ramirez, 2014, 2015, and 2016, Stanford University, School of Medicine).

[2] Post traumatic stress disorder according to the Diagnostic Statistical Manual V is diagnosed in adults according to the following criterion: a) directly experiencing or witnessing a traumatic stressor (e.g., death, sexual trauma, combat), b) intrusion symptoms (e.g., intrusive memories and traumatic nightmares), c) avoidance, d) negative alterations in cognition and mood, e) alterations in arousal and reactivity, f) symptoms lasting longer than a month after the traumatic event, g) significant symptom related distress or functional impairment, and h) disturbance is not due to medications or physical ailment.

[3] The exception to cross cultural social work practice with military populations, are social workers who provide clinical services within the military, because the social worker is military service member unless they are a contractor to military. In 2011, the NASW reported that there are over 500 social workers providing mental health care to the military.

[4] The concept of homosexuality was not created until the late 19th century and therefor it would be inaccurate to refer to Baron Von Stuben as "gay."

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