Understanding and Mastering Risk Management: A Comprehensive Guide

CAPT Delmy M. Robinson, USN, MBA
Commandant

Daniel P. McDonald, PhD[2]
Director

MAJ Roshonda Gilmore, USA, MBA[2,3]
Department Head

Dr. Richard Oliver Hope Human Relations Research Center
Defense Equal Opportunity Management Institute
366 Tuskegee Airmen Drive, Patrick Space Force Base, FL 32925

1. JHT Inc.
2. Dr. Richard Oliver Hope Human Relations Research Center, DEOMI
3. Applied Science & Analytics, DEOMI

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Prepared by

Troy Yamaguchi, BS[1]
LT Jayson M. Rhoton, USN, PhD[2,3]

With contributions from

Kathrin Blair, MS[1]
Courtney Burns, MA[1]
Dillon Caldwell, PhD[1]
Courtney Howell, PhD[1]
Tiffany Lemmo, BS[1]
Royce Simpson, PhD[1]

Contents

Risk Management

Overview

Senior and strategic leaders for the Department of Defense (DoD) are expected to manage several aspects of risk management related to diversity, equity, and inclusion (DEI). Some common examples of DEI-related risks include harassment and discrimination toward individuals, which can be detrimental to both individual health and performance (Rice and Young, 2021; Sumner et al., 2021). These individual-level risks can create and exacerbate broader organizational risks, which can threaten both organizational health—via higher turnover rates and the creation of a toxic work environment—and organizational performance (Bergman et al., 2012; Chiocchio & Essiembre, 2009). This document outlines some of the common DEI-related risks that DoD leaders can expect to encounter and their consequences to individual and organizational wellbeing, as well as opportunities for mitigation and training.

Definitions

Risk Management

The phrase "risk management" is typically used in the context of financial acquisitions, but has applications in many technical fields. DoD Instruction 5000.85 establishes policy and prescribes procedures regarding major defense acquisition programs, and briefly outlines the role of project managers in identifying, prioritizing, and mitigating programmatic risks during acquisitions. In 2003, the Defense Acquisition University published a number of expanded guidelines for risk management, including risk management techniques, sample plans, and typical obstacles one may encounter (DoD, 2003). That document outlines the applications of

risk management to various fields, including engineering and information management, and defines risk as "a measure of the potential inability to achieve overall program objectives within defined cost, schedule, and technical constraints" (DoD, 2003). Risk management, then, is the practice of planning for, assessing, and handling risks. The Defense Acquisition University recommends operationalizing abstract risk into concrete "risk events" (the individual situations in which "things go wrong") to help clarify both the assessment and the management of risk (DoD, 2003).

Risk management can apply to a DEI context. DEI-related risk in this context refers to a total constellation of individual risk events related to issues of DEI (henceforth: DEI-related incidents) and the negative outcomes these incidents produce. Major types of DEI-related incidents tracked and studied by the military include racial and ethnic discrimination, and sexual assault and harassment. However, this is by no means an exhaustive list of categories; other types of DEI-related incidents include the negative effects of hazing, bullying, and ostracization based on race, ethnicity, sexuality, or beliefs. Significant negative outcomes (risks to individuals and risks to the organization) caused by DEI-related incidents include reduced individual and unit performance, posttraumatic stress disorder (PTSD), physical disability, and suicide.

DEI-related Risk: Racial and Ethnic Discrimination

In order to mitigate DEI-related risk, U.S. military policy defines, describes, and prohibits discrimination in the Services. Specifically, DoD policy prohibits the following:

> Discrimination, including disparate treatment, of an individual or group on the basis of race, color, national origin, religion, sex (including pregnancy), gender identity, or sexual orientation that is not otherwise authorized by law or regulation and detracts from military readiness. (DoDI 1350.02, 2020, p. 40)

Likewise, the DoD also prohibits advocating for such discrimination:

> Advocating widespread unlawful discrimination based on race, color, national origin, religion, sex (including pregnancy), gender identity, or sexual orientation for unlawful discrimination is prohibited as unlawful extremist activity. (DoDI 1325.06, 2021, p. 10)

These policies reflect DoD recognition of the risks (for individuals and the organization) posed by discrimination that occurs within the Services.

As one deterrent to this behavior, DoDI 1350.02, entitled DoD Military Education Program, requires training to include an overview of the nature, consequences, and effects of prohibited discriminatory behavior. DoDI 1350.02 further mandates training to address fostering a command climate that does not tolerate prohibited discrimination, and one that encourages individuals to intervene and prevent potential incidents of prohibited discrimination, whether in person or online, to include social media misconduct and inappropriate electronic communications. An additional tool to deter DEI-related discrimination is consequences, and the directive also mandates that training include information regarding available disciplinary options, whether administrative, judicial, or else.

DEI-related Risk: Sexual Harassment and Sexual Assault

The proliferation of sexual harassment in the military has received high visibility in recent years (e.g., Vanessa Guillen). The DoD reported that in Fiscal Year 2021, 29% of women and 7% of men in the military indicated experiencing sexual harassment in that year alone, with the figure representing a rise for female Service members (as targets), and about one fifth of alleged offenders being identified as someone in the target's chain of command (2022). Similar to other forms of harassment, sexual harassment can occur in a variety of contexts, including in person, in writing, or over social media (DoDI 1020.03, 2022). Sexual harassment involves

"unwelcome sexual advances, requests for sexual favors, and deliberate or repeated offensive comments or gestures of a sexual nature" (DoDI 1020.03, p. 22). Typically, such conduct either involves a power dynamic wherein rejecting such advances might adversely impact an individual's career path or job security, or interferes with job performance and contributes to a hostile work environment (DoDI 1020.03). As with other forms of harassment, the DoD defines sexual harassment as behavior that "is so severe or persuasive that a reasonable person would perceive… the environment as hostile or offensive." Under this "reasonable person" standard, evidence of physical or psychological distress is not required to constitute sexual harassment; rather, any behavior that would produce the negative effects described above for a "reasonable person" is considered to be sexual harassment (DoDI 1020.03).

Sexual assault is a form of sexual harassment. DoDD 6495.01 defines sexual assault as "intentional sexual contact characterized by use of force, threats, intimidation, or abuse of authority or when the victim does not or cannot consent" (DoDD 6495.01, 2012, p. 19). The trauma caused by experiences of sexual harassment and sexual assault while serving in the military can be referred to generally to as military sexual trauma (MST).

Risk Policy

DoD policies that address risk and risk management typically do not do so with specific attention to DEI-related risk. However, because risk management frameworks are applicable to a variety of contexts—including engineering, business project management, medical care, information technology security, and more—it may be possible to apply the practices espoused in the extant DoD risk management policies as they relate to matters of DEI. For example, DoDI 8510.01—entitled "Risk management framework for DoD systems"—discusses how the

principals of risk management should be applied to maintaining the integrity of the military's cybersecurity infrastructure (DoDI 8510.01, 2022). This document asserts that military organizations must follow a six-step risk management framework for assessing new information technology systems:

(1) Describe the characteristics of new risk management solutions;

(2) Select a risk management solution;

(3) Implement the risk management solution;

(4) Assess the risk management solution;

(5) Authorize the risk management solution; and

(6) Monitor the risk management solution (DoDI 8510.01, 2022).

This same framework could be applied to the management of DEI-related risk. Guidance from the DoD's DEI Strategic Plan could be applied as a foundation for a DEI-risk management strategy, ensuring any goals and solutions presented are in alignment with the overall mission. For example, the six-step risk management framework applied for assessing a new program or procedure for addressing racial discrimination may look something like:

(1) Describe the characteristics of new procedures for addressing racial discrimination (i.e., "We have noticed that Service members have discrimination complaints, but are confused on how to file official reports. We would like to develop a new, simpler reporting procedures.")

(2) Select a new procedure for addressing racial discrimination (i.e., "Based on our previous analysis, we have decided that X new system meets our needs better than the alternatives and existing systems.")

(3) Implement the new procedure for addressing racial discrimination

(4) Assess the new procedure of addressing racial discrimination (i.e., "We have surveyed Service members on their interaction with the new procedure, and they have reported that they would be more likely to complete the new procedure as compared to the old one. On this basis we can expect that the new procedure will meet our needs better than what was in place prior.")

(5) Authorize the new procedure

(6) Monitor impacts of the new procedure (including continuous improvement efforts)

Given that the DEI needs of the DoD can change as quickly as the population of the nation itself, the assessment and monitoring steps will measure strategy success and identify gaps. Monitoring and assessment efforts must be evidence-based so that solutions and adjustments can be data-driven and informed by research. Nonetheless, the implementation plan detailed in DoDI 8510.01 may help provide structure and criteria for risk management solutions.

Because of the lack of specific guidance available, clear, documented procedures must be established when identifying and addressing matters of DEI-related risk. DoDI 1020.03 requires that DoD hold all leaders accountable for fostering a climate supportive of diversity—free from various dimensions of harassment, and the negative effects thereof—and a systematic and effective program to manage all aspects of DEI-related risk is necessary to best meet that requirement (DoDI 1020.03, 2022).

Impacts of DEI-related Risks on the Individual

Physical Health Consequences

DEI-related risks have been shown to negatively impact the physical health of Service members, with the bulk of research illustrating the deleterious effects of military sexual trauma

(MST). In 2019, the yet largest study on the effect of MST on health outcomes (with data from over 500,000 female veterans) found that MST was associated with higher rates of numerous physical health issues—including myocardial infarction (30% greater odds), cerebrovascular disease (23% greater odds), and congestive heart failure (23% greater odds) (Sumner et al., 2021). Experiencing MST was also associated with higher rates of multiple co-morbidities, a long-standing issue among veteran populations that makes treatment more difficult, less effective, and more expensive (Agha et al., 2000; Sumner et al., 2021).

These effects of MST can compound with everyday stressors and continue to disrupt veterans' lives post-Service—resulting in more pronounced effects with age. A cohort study of about 800 women veterans, for example, found that the exposure to MST lowered self-reported quality of health ratings for all veterans in the cohort; however, middle-aged veterans (45-65) displayed the greatest disparity in health quality among all cohorts involved (Gibson et al., 2015). This effect of poorer outcomes being most pronounced among middle-aged veterans can have lethal outcomes. Another cohort study on suicide mortality among veterans found that over the course of a four-year period, men that had screened positive for MST had a 69% higher suicide rate than men that did not, and women that screened positive for MST had a 129% higher suicide rate than women that did not (Kimerling et al., 2015).

In addition to issues related to MST, physical health disparities are pervasive among active Service members. The 2015 DoD Health-related Behaviors Survey found that Black and Hispanic Service members reported higher rates of physical symptom severity, with 25.6% of Black Service members and 23.4% of Hispanic Service members reporting a bothersome physical issue (e.g., back pain, headaches, dizziness), as compared to 18.8% of White Service members (DoD, 2015). Black and Hispanic Service members also reported higher rates of low

sleep (four hours or less) and lower rates of sleep satisfaction (DoD, 2015). In addition, DoD surveying techniques currently categorize American Indian, Alaskan Native, Native Hawaiian, and Pacific Islander Servicemembers as "Other." Service members placed in this "Other" category were more likely than White Servicemembers to report deployment-related injuries, report post-concussive symptoms, and screen positive for traumatic brain injury (TBI) (DoD, 2015).

On the subject of TBI, an important distinction must be made between screening positive for traumatic brain injury and being diagnosed with (and therefore receiving treatment for) one. Studies in civilian populations have shown that patients of color that screen positive for traumatic brain injury are significantly less likely than White patients to be referred for follow-up care—regardless of their insurance status (Asemota et al., 2013). Accordingly, studies have shown that although Black and Hispanic Service members are equally as likely to screen positive for traumatic brain injury as White Service members, they are significantly less likely (27% lower for Black Service members, and 33% lower for Hispanic Service members) to receive an official traumatic brain injury diagnosis (Kysar-moon & Mustillo, 2019). This can have lethal consequences. In 2006, the 48-month mortality rate for Hispanic veterans seeking VA care for traumatic brain injury was measured to be 231% higher than non-Hispanic Whites (Egede et al., 2012). DEI-related risk is not limited to harmful incidents perpetrated by antisocial elements in the military, such as sexual harassment and racial discrimination; risks can also be borne from procedural inefficiencies and unintended consequences, such as the disparate, sometimes unconscious treatment of minorities when accessing health services as discussed above, which often results in worse health outcomes including death.

The effects of DEI-related risks on physical health are currently understood to be the effects of an increased stress burden, and these effects are not limited to sexual trauma alone. Cohort studies among general populations have found that persistent verbal abuse in the workplace is associated with increased rates of fatigue, musculoskeletal injury, and sleep disturbances (Meyer et al., 2008; Gale, 2019). In addition, individuals experiencing regular racial or ethnic discrimination also experience higher rates of hypertension, obesity, and disease—consistent with findings on sexual trauma (Coughlin 2021). While the negative consequences of DEI-related risks extend throughout the lifetime, and become more pronounced with time, DoD has the responsibility to manage risk during active Service. Addressing DEI-related risks provides an incredible opportunity to decrease health-related risk for Service members and veterans, both reducing costs and improving quality of life in terms of health outcomes.

Mental Health Consequences

Due to the higher stress burden, DEI-related risks also negatively affect Service members' mental health. Disparities in health outcomes of LGBTQ+ (lesbian, gay, bisexual, transgender, queer, questioning, and other identities) persons in the general population are reflected and even exacerbated amongst LGBTQ+ Service members. An analysis of the most recent Health Related Behaviors Survey (HRBS) found that LGB Service members are significantly more likely to report feelings of psychological distress (30.5% compared to 15.5% for non-LGB Service members), more symptoms of PTSD, and increased likelihood of experiencing suicidal thoughts than their average peer (Meadows et al., 2018). Depression, alcohol abuse, and PTSD are also greater for LGB veterans relative to nonminority veterans (Cochran et al., 2013).

Racial discrepancies in rates of suicidal ideation and suicide attempts can also be found among active-duty military personnel. Non-White Service members actually reported significantly lower rates of suicidal ideation than White Service members (with Black Service members 38% less likely than Whites to report suicidal ideation, and Hispanic Service members 43% less likely than Whites to report suicidal ideation) (Wong et al., 2021). This finding, however, seems directly at odds with findings regarding suicide attempts. On that same survey, Black Service members were 128% more likely than Whites to report a suicide attempt since joining the military; Hispanic Service members were 23% more likely; and Asian Service members were 279% as likely (Wong et al., 2021). It is important to note, however, that while active-duty non-White Service members are substantially more likely to attempt suicide since joining the military than White veterans, White veterans still have higher much suicide rates than non-White veterans overall (33.6 suicides per 100,000 for White veterans, as opposed to 14.5 per 100,000 for Black veterans) (Veteran Affairs, 2021). The emergence of uncharacteristically high rates of suicide attempts for non-White Service members upon joining the military indicates a high degree of DEI-related risk, and bears further investigation.

When controlling for other stressors—including combat exposure—identity challenges, assault, and military sexual harassment resulted in significantly higher rates of psychiatric symptoms among Veteran Health Administration (VHA) survey respondents (Murdoch et al., 2010). Not only do targets of racism and discriminatory behavior experience higher rates of mental illness, but the severity for these populations may be higher as well. An analysis of patient-clinician interactions among veterans receiving treatment for psychotic disorders found that Black veterans began treatment with significantly higher baseline levels of psychosis than their White peers (Ali et al., 2017). Additionally, although both Black and White veterans that

experienced poor patient-clinician interactions demonstrated poorer recovery outlooks than their peers with positive patient-clinician interactions, the effect was more pronounced in Black veterans (Ali et al., 2017). The interaction between race and clinician impact indicates a need for awareness of DEI-related risks throughout the treatment process.

Related to disparate outcomes of those seeking psychiatric treatment are inequities in incidence of PTSD, one common mental health consequence of DEI-related risk (Solomon et al., 2021). A study on a national sample of military reservists found that veterans who experienced sexual harassment reported significantly higher rates of both PTSD and depressive symptoms than their similar peers (Bell et al., 2014). Just as racialized experiences can play a role in the treatment of psychotic disorders, racialized experiences can play a role in the treatment of PTSD. A study of about 2500 White, Black, and Latino veterans found that disparities in clinician assessments (e.g., ratings of clinician affect, approachability, skill in managing treatment, personal investment in treatment, etc.) were responsible for significantly lower treatment retention among non-White veterans as compared to White veterans (Spoont et al., 2017). The effect was attributed to higher rates of conflict between patients and clinicians; Black veterans were more likely than White veterans to discontinue treatment if they deemed their clinician incapable of managing medication, and Latinos discontinuing treatment in 99% of cases where they deemed that their clinician "did not care" about treatment (Spoont et al., 2017).

As illustrated, DEI-related risks can have negative impacts on Service member mental health, and the arena of mental health treatment is fraught with additional risk, which, if mismanaged, can affect individual Service members, their units, and the mission as a whole. Currently, even effective PTSD treatment strategies can have high rates of adverse effects within sessions. An analysis of trauma-focused treatment techniques utilized by VHA found up to a

28.6% incidence rate of within-session symptom exacerbation during treatment for PTSD (Larsen et al., 2016). Managing DEI-related risk, therefore, must extend throughout the continuum of a DEI-related incident: focusing on prevention while ensuring good outcomes throughout intervention and subsequent treatment.

Behavioral Consequences

DEI-related incidents can cause a suite of deleterious behavioral consequences in individuals. In general populations, workplace racial and ethnic discrimination has been associated with increased rates of tobacco and alcohol use (Chavez et al., 2015). Veterans who have been targeted by MST also have been shown to have higher rates of obesity (Pandey et al., 2018). Within veteran populations, there have been conflicting findings on the effects of sexual harassment on rates of physical activity. Smaller early studies on veterans found that sexual trauma was associated with lower rates of physical activities (Lang et al., 2003). This is consistent with findings within general populations, which have observed sexual trauma and other antecedents to PTSD to be associated with depressive symptoms—including decreased physical activity (Godrey et al., 2013). However, larger, more recent analysis of veteran data has found experience with MST to be associated with significant increased rates of vigorous physical activity, with postulations that veterans are more likely to use exercise as a coping mechanism (Thomas et al., 2019). The effect of DEI-related incidents on physical activity, substance abuse, and other behaviors is of a particular interest for military populations—owing first to the positive effects of exercise on PTSD symptoms (Oppizzi et al., 2018), and second to the importance in the physical health of veterans and reservists for Service readiness. The consequences of these effects can be seen in behavioral data among active military personnel. Gay and lesbian Service members, for example, are 60% more likely than heterosexual Service members to smoke, and

45% more likely to binge drink (Wong et al., 2021). These effects are exacerbated beyond disparities seen in gay civilian populations as compared to heterosexual civilian populations, which indicates military status as a risk factor (Wong et al., 2021).

Relatedly, behavior consequences for individuals who are targets of a DEI-related incident include significant effects on their engagement with health services. A review of 29 studies investigating the effects of racial and ethnic discrimination on health outcomes found that exposure to discrimination—even outside of a clinical context—can have negative effects on patients adhering to medical regiments for the treatment of mental health issues, and lower overall levels of care satisfaction (Williams et al., 2019). Regarding the effect of DEI-related incidents on healthcare utilization, VHA is one of the few large organizations that actively screens for sexual trauma as part of routine care. Analysis of VHA data has found that veterans living with MST used about 50% more health services than those that did not, with the highest discrepancies observed for VHA mental health services and substance use programs (Brignone et al., 2017). It is, however, unclear if this higher rate of health service utilization is sufficient to meet the higher mental health treatment needs of veterans who experienced MST; VHA data on health Service utilization tracks only veterans that are already engaged with a healthcare system, and does not provide a full picture of potential impacts of MST on care-seeking behavior and voluntary involvement with VHA generally.

Impacts of DEI-related Risks on the Organization

Performance Consequences

DEI-related incidents have been shown to be disruptive to organizational effectiveness in both civilian and military contexts. Among general populations, racial and ethnic harassment in

the workplace has shown significant negative associations with employee satisfaction with work, employee satisfaction with supervisors, and employee retainment—all qualities required for an organization to succeed (Bergman et al., 2012). Regarding supervisors, instances where DEI-related incidents are perpetrated by individuals in positions of power can poison organizational culture. Studies of general population workplaces have found that high-level supervisory abuse and negative affectivity can bring about lower levels of employee organizational-based self-esteem, or the degree to which individuals feel they are capable and significant contributors to an organization (Rice & Young, 2021). DEI-related incidents, therefore, run the risk of damaging the performance of even those who are not directly involved in negative incidents. Studies on the effects of workplace bullying, for example, have found that employees who witness abuse can experience "vicarious abuse," and exhibit the same suite of deleterious effects as those experiencing abuse directly (Kenneth et al., 2013). Indeed, organizational inability to address sexual harassment violations was associated with higher rates of military officer turnover, with officers targeted by sexual harassment also scoring 40% lower on measures of organizational commitment (Sims et al., 2005).

Regarding military contexts, a study on how open disclosure of individual lesbian, gay, bisexual, and transgender (LGBT) status affects the cohesion of military units found that open disclosure of identity was associated with significantly improved ratings of both unit social cohesion and unit task cohesion (Moradi, 2009). Sexual-orientation-based harassment and abuse, however, were associated with significantly lower ratings of both of these measures (Moradi, 2009). Thus, DEI-related risks impact unit cohesion, and measures of unit cohesion have been shown to have direct significant relations to unit performance, with the most powerful effects observed during high-complexity tasks (Chiocchio & Essiembre, 2009). Low unit

cohesion has also been shown to have impacts on the long-term retention of Service members. A study of active-duty Service members found that upon completion of Service commitment, LGBT Service members were about twice as likely as non-LGBT Service members to be undecided about their future military career—with lower unit cohesion being significantly associated with disengagement from the military across all Service members, regardless of LGBT status (McNamara et al., 2021). This may be due, in part, to lower feelings of peer support and camaraderie reported by LGBT Service members, as compared to non-LGBT Service members (Carey et al., 2022).

Recruiting and retaining qualified enlisted personnel has long been a struggle for military organizations, and remains a risk to organizational health today (General Accounting Office, 2000). Thus, preventing and mitigating the risks associated with DEI are in the best interest of the Services, as they also serve to address department's concerns and goals regarding the recruitment, retention, and promotion of qualified personnel (DoD, 2022).

Antecedents

DoD's conception of and approach to managing DEI-related risks has changed greatly over the past half-century. When DEOMI was originally founded in 1971, military leaders commonly identified "racial militancy" as a premier risk to be solved in the wake of growing social unrest (Burgin, 2014). Indeed, DEOMI training was often discussed in such terms, including accusations that it was making students "too militant" on topics related to DEI (Johnson, 1995). DoD's understanding of DEI-related risks has evolved even further in recent years to expand beyond race and gender into areas including neurodiversity and accessibility,

and continues to adjust to a changing social climate and the evolving needs of national security (DoD, 2022).

In 1995, the Government Accountability Office (GAO) published a total review of DoD-sponsored research into inequity and DEI-related risks, identifying 72 studies produced since 1974. GAO found that 25 of these studies (35%) were concerned with racial equity; 15 (21%) addressed equitable training; 10 (14%) addressed sexual harassment; 9 (13%) addressed equitable promotions; 7 (10%) addressed inequitable rates of discipline; and 6 (8%) addressed recruitment efforts (GAO, 1995). Three DoD-sponsored studies (included in the above totals) could not be located by the Defense Technical Information Center at all.

Analysis of these studies shows a progression of themes as well as a progression of accountability efforts. Reports on sexual harassment, for example, did not emerge until 1988, but quickly became a major area of concern as its negative effects came to light. Early DoD reports also rarely contained specific recommendations for actions, or if they did, the recommendations were sometimes disregarded; in events where recommendations were well received, documentation for actions taken was often not collected (GAO, 1995). Overall, 38 of the 72 studies (53%) during this time period contained process-improvement recommendations; the appropriate military Service took action on these recommendations in 26 of these 38 cases (68%). Ergo, only 26 of the 72 studies conducted by military organizations between 1974 and 1994 (36%) resulted in specific process changes—though DoD asserts that the views expressed in these studies were "primarily those of the authors, and may have never reached the general acceptance of those who requested the study be conducted" (GAO, 1995). Focused structures for recommendations and goals with regular follow-up have since become a cornerstone for DoD's

DEI-related risk management strategy, forming the backbone of such documents as the Diversity, Equity, Inclusion, and Accessibility Strategic Plan (DoD, 2022).

Regarding strategies to conceptualize risk itself, DoD currently utilizes a risk assessment matrix to categorize other tactical threats to mission success, as seen in Table 1 (DoD, 2018). This same model can be adapted to conceptualize DEI-related risk. In addition to threats to mission success, the impacts of a given DEI-related risk on an individual or organization's wellbeing can be utilized to generate assessments of severity. By DoD's definitions, catastrophic risks to individuals are those that result in death or total disability when realized; frequent risks are those that are "known to happen regularly," and so on (for a complete breakdown of definition, see Appendix A). Special care should be given to adapting the definition of risk to suit the physical and mental health consequences of DEI-related risk. For example, the official definition of a "critical" as compared to a "marginal" risk to individuals leaves a wide discretionary gulf for topics of mental illness (i.e., the distinction between a critical and a marginal risk falls to the length of symptoms suffered—specifically whether or not symptoms exceed exactly three months). Application of this matrix to DEI-related risks should follow careful review of its original context as well as specific risk and protective factors in the populations being evaluated.

Table 1: DoD Risk Assessment Matrix (DoD, 2018)

Frequency / Severity	A Frequent	B Probable	C Occasional	D Seldom	E Improbable	F Eliminated
1 Catastrophic	High	High	High	Serious	Medium	N/A
2 Critical	High	High	Serious	Medium	Medium	N/A

3 Marginal	Serious	Serious	Medium	Medium	Medium	N/A
4 Negligible	Medium	Medium	Low	Low	Low	N/A

Under this model of risk conceptualization, risk management strategies should focus on reducing both the severity and frequency of risks. High ratings of severity must always be seriously considered, even if the events in question are improbable. Likewise, frequent DEI-related risks, no matter how negligible in severity, should always be given attention. An example of a high-severity, but improbable, DEI-related risk is a military coup on the basis of ideological extremism. An example of a frequent but low-severity DEI risk is 'benevolently intended' name-calling.

Risk Factors

Qualities of Targets of DEI-related Incidents

Veterans with racial, gender, and sexuality identities that do not conform to the majority military culture (White, cis-male, and heterosexual) are more likely to be targeted for DEI-related incidents. In 2019, a survey of active Service members found that within the Army, 31% of Black Service members, 22.3% of Asian Service members, and 21% of Hispanic Service members reported racial discrimination, harassment, or both—as compared to 14% of White Service members (Office of People Analytics, 2017). A DoD-sponsored study on sexual assault and harassment during military Service found that LGBT Service members were 26% more likely to experience stalking than non-LGBT Service members; 21% more likely to experience sexual harassment, and 90% more likely to experience sexual assault (Schuyler et al., 2020).

Despite this higher exposure to sexual assault, LGBT Service members were less likely to officially report sexual assault to authorities (Schuyler et al., 2020). Women in the military are targeted for sexual harassment and assault at rates over four times as high as men (Acosta et al., 2021).

Beyond demographic qualities, certain adverse life experiences seem to predispose individuals to later harassment. Veterans who experienced adverse childhood experiences (e.g., witnessing/experiencing domestic abuse, neglect, poverty) have been found to be significantly more likely to also experience military sexual trauma (Doucette et al., 2022). The interaction between deployment, combat, and rates of sexual harassment and assault—and the later somatization of stress incurred by both combat and MST—is another topic of interest. Studies on Millennium Cohort data have found that women veterans deployed for combat alone did not experience sexual harassment or assault at higher rates than their non-deployed peers; however, being deployed and experiencing combat was associated with a 120% increase in the likelihood of reporting sexual assault or harassment (Leardmann, 2013). Consistent with prior findings on the effect of adverse life experiences on rates of sexual assault and harassment, previous diagnosed mental illness, previous experiences of sexual assault or harassment, and recent divorce were all also risk factors identified as significant (Leardmann, 2013). Therefore, because targets of previous DEI-related incidents are more likely to continue to be targeted when placed in vulnerable situations, it is imperative that efforts to address DEI-related risks protect those with known histories of adverse life experiences.

The exact role of combat stress—and whether or not combat stress is a risk factor that moderates the relationship between MST and the development of PTSD—is hotly debated, and yet to produce consistent, conclusive findings. Studies both in the United States (Cobb Scott,

2014) and abroad (Fontana and Rosenheck, 2000) have asserted that combat exposure can cause higher rates of PTSD symptoms in veterans who also experienced MST; however, separate studies have also found no interaction between combat exposure and MST on rates of PTSD development (Gross, 2019), or have found that when controlling for stressors outside of combat exposure and MST, the moderating effect of combat exposure on development of psychiatric symptoms in targets of MST lost validity (Murdoch et al., 2010). In summary, an association exists between previous life adversity and experiencing MST. It therefore behooves military organizations to have a strong understanding of their troops' lived experiences, and devote additional resources to understanding how these factors interact with DEI-related risk.

Qualities of Ineffective DEI Risk Management: Fear of Retaliation

Having procedures in place ready to address DEI-related risk is not sufficient alone to ensure success; these procedures must be evaluated for effective implementation. DoD reporting systems for racial and ethnic discrimination, for example, tend to have low satisfaction ratings for individuals who reported an incident. In 2017, only 25% of respondents who reported racial or ethnic discrimination indicated that they were satisfied with the reporting process overall; 34% reported that they were neither satisfied nor dissatisfied; and 40% reported that they were dissatisfied with their experience (Office of People Analytics, 2019). Rates of satisfaction tended to be similar between White and non-White Service members on various specific dimensions of satisfaction; however, non-White Service members were more than twice as likely to report dissatisfaction with "the degree to which privacy was protected," when reporting DEI-related risk, with 31% reporting dissatisfaction (as compared to 14% of White Service members) (Office of People Analytics, 2019). This perception of a lack of privacy protection represents a severe issue. In this same survey, 41% of non-White Service members reported some kind of

retaliation following their report; in addition, only 16% of all Service members indicated that their discrimination report resulted in action taken against the perpetrator (Office of People Analytics, 2019). Ergo it was more reasonable for Service members to assume that they would endure retaliation for reporting discrimination than it would be for corrective action to occur.

Responses to DEI-related risk must address the fear of retaliation for reporting incidents. In 2021, 67% of women and 84% of men who received unwanted sexual contact did not make a report on the incident (Office of People Analytics, 2021). A Servicemember may have legitimate reasons for declining to report unwanted sexual content (e.g., they did not believe the offense to be severe enough to report, or they handled the situation through other means, without initiating a report). However, an examination of actions taken following a report of sexual harassment shows reasonable distrust of current risk management strategies. Among reserve component respondents, 33% of women reporting a sexual harassment complaint indicated that the perpetrator stopped their upsetting behavior; however, 35% of women were "encouraged to drop the issue," and 34% of women indicated that coworkers began treating them worse, ostracized them, or blamed them for the problem (Office of People Analytics, 2021). Additionally, 30% of women and 36% of men reported that the person they told took no action; and 25% of women and 32% of men were discouraged from filing a complaint (Office of People Analytics, 2021). As such, current programs for handling DEI-related risk in the military do not seem to communicate good risk-reward propositions for targets of DEI-related incidents. This can reasonably result in a culture that does not value—or actively advises against—reporting DEI-related incidents. As a result, communicating support for those that report DEI-related risk is necessary to generate greater transparency and more reliable information in pursuit of solutions.

Mitigation and Training

Improved Initiative Tracking Systems

Effective management of DEI-related risk is predicated upon a good understanding of the risks in question and the concrete, iterative solutions proposed from this understanding. Early attempts to study and manage DEI-related risks often did not include concrete goals and recommendations, or struggled to document efforts undertaken. The same might be said about individual efforts to handle DEI-related incidents. The aspect that Service members were most dissatisfied with when reporting DEI-related incidents was "being kept well informed about the progress of the report" (34% dissatisfied) (Office of People Analytics, 2019). Therefore, improved structures to collect and publish information on DEI-related risks can have benefits for to both organizational clarity and Servicemember satisfaction. Previous assessments on military organizations have advised establishing official systems to track action or non-action on proposed recommendations to ensure effectiveness (GAO 2021; Helmus et al., 2021). If it is the case that the views of researchers do not reach "general acceptance" within their sponsored organization, this fact—and the rationale for the determination—should be recorded, and a label of "non-concur" be applied so that there can be accountability. When organizations concur with recommendations, the implementation of these recommendation should be tracked and evaluated until completion, or until significant changes in context or knowledge calls for the recommendation to be reevaluated.

Analysis of Outcomes of Current Risk Management Efforts

Ineffective efforts to manage DEI-related risks can themselves be assessed for risks. In other words, it is possible to apply risk analysis (assessments of severity and frequency of risk)

to some of the negative outcomes associated with current DEI-related risk management efforts. Some current negative outcomes include unit retaliation, non-strategic non-action, administrative error, privacy violations, and more (Office of People Analytics, 2019). By creating an inventory of known threats to effective DEI-risk management, programs can take efforts to reduce their severity and frequency, resulting in more effective solutions.

Training and Communication

Currently, Service members report high rates of training satisfaction and training effectiveness on DEI-related incidents, and even assert that they "feel safe reporting offensive situations;" in a recent publication by OPA (2019), only 2% of Service members indicated otherwise; and 93% indicated they "know how to report" violations of policy. However, DEI-related incidents continue to occur and go unreported at high rates; in instances where incidents are reported, there can still be negative outcomes. This indicates that while training efforts may be effective at imparting the necessary skills to navigate DEI-related risk, it is more difficult to affect culture and climate within and beyond a unit.

Training should place an emphasis on the immediate supervisors' role in facilitating a supportive environment for targets of DEI-related incidents. This can be difficult, as Service members have differing opinions on the importance of addressing DEI-related risks, with 31% of White Service members reporting that the military places "too much attention" on harassment and discrimination, whereas 19% of non-White Service members indicate that the military places "too little attention" on these same issues (Office of People Analytics, 2019). However, 92% of White and 84% of non-White Service members asserted that their direct supervisors placed "the right amount of attention" on these same issues, indicating a degree of approval for these individuals over the military, generally (Office of People Analytics, 2019). While it is possible

that supervisors may place too much or too little attention on DEI-related risks—while receiving approval from their fellow Service members—the rate of approval of supervisors' discretion indicates that an emphasis on their role in seeing effective solutions to DEI-related incidents may be key to military management of DEI-related risks.

References

Agha, Z., Lofgren, R. P., VanRuiswyk, J. V., & Layde, P. M. (2000). Are patients at Veterans Affairs medical centers sicker? A comparative analysis of health status and medical resource use. *Archives of Internal Medicine, 160(21), 3252–3257*. https://doi.org/10.1001/archinte.160.21.3252

Ali, M. K., Hack, S. M., Brown, C. H., Medoff, D., Fang, L., Klingaman, E. A., Park, S. G., Dixon, L. B., & Kreyenbuhl, J. A. (2018). Racial differences in mental health recovery among veterans with serious mental illness. *Journal of Racial and Ethnic Health Disparities, 5(2), 235–242*. https://doi.org/10.1007/s40615-017-0363-z

Asemota, A. O., George, B. P., Cumpsty-Fowler, C. J., Haider, A. H., & Schneider, E. B. (2013). Race and insurance disparities in discharge to rehabilitation for patients with traumatic brain injury. *Journal of Neurotrauma*, 30(24), 2057–2065. https://doi.org/10.1089/neu.2013.3091

Bell, M. E., Street, A. E., & Stafford, J. (2014). Victims' psychosocial well-being after reporting sexual harassment in the military. *Journal of Trauma & Dissociation, 15(2), 133–152*. https://doi.org/10.1080/15299732.2014.867563

Bergman, M. E., Palmieri, P. A., Drasgow, F., & Ormerod, A. J. (2012). Racial/Ethnic harassment and discrimination, its antecedents, and its effect on job-related outcomes. *Journal of Occupational Health Psychology, 17(1), 65–78*. https://doi.org/10.1037/a0026430

Brignone, E., Gundlapalli, A. V., Blais, R. K., Kimerling, R., Barrett, T. S., Nelson, R. E., Carter, M. E., Samore, M. H., & Fargo, J. D. (2017). Increased health care utilization

and costs among veterans with a positive screen for military sexual trauma. *Medical Care, 55(9), 70–77*. https://doi.org/10.1097/MLR.0000000000000767

Calhoun, P. S., Schry, A. R., Dennis, P. A., Wagner, H. R., Kimbrel, N. A., Bastian, L. A., Beckham, J. C., Kudler, H., & Straits-Tröster, K. (2018). The association between military sexual trauma and use of VA and non-VA healthcare Services among female veterans with military Service in Iraq or Afghanistan. *Journal of Interpersonal Violence, 33(15), 2439*. https://doi.org/10.1177/0886260515625909

Carey, F. R., Jacobson, I. G., Lehavot, K., LeardMann, C. A., Kolaja, C. A., Stander, V. A., & Rull, R. P. (2022). Military Service experiences and reasons for Service separation among lesbian, gay, and bisexual individuals in a large military cohort. *BMC Public Health*, 22(1), 1-13. https://doi.org/10.1186/s12889-021-12420-1

Chavez, L. J., Ornelas, I. J., Lyles, C. R., & Williams, E. C. (2015). Racial/ethnic workplace discrimination: Association with tobacco and alcohol use. *American Journal of Preventive Medicine, 48(1)*, 42–49. https://doi.org/10.1016/j.amepre.2014.08.013

Chiocchio, F., & Essiembre, H. (2009). Cohesion and performance: A meta-analytic review of disparities between project teams, production teams, and Service teams. *Small Group Research, 40(4), 382–420*. https://doi.org/10.1177/1046496409335103

Cobb Scott, J., Pietrzak, R. H., Southwick, S. M., Jordan, J., Silliker, N., Brandt, C. A., & Haskell, S. G. (2014). Military sexual trauma interacts with combat exposure to increase risk for posttraumatic stress symptomatology in female Iraq and Afghanistan veterans. *The Journal of Clinical Psychiatry, 75(6), 637–643.* https://doi.org/10.4088/JCP.13m08808

Coughlin, S.S. (2021). Racism and discrimination in the military and the health of U.S. Service

members. *Military Medicine*, *186*(5-6), 147. https://doi.org/10.1093/milmed/usab037

Department of Defense. (2003). *Risk Management Guide for Acquisition*. https://apps.dtic.mil/sti/pdfs/ADA437820.pdf

Department of Defense. (2015). *2015 Health-Related Behavior (HRB) Survey - Active Duty Service Members*. https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Survey-of-Health-Related-Behaviors/2015-Health-Related-Behavior-Survey-Active-Duty

Department of Defense. (2018). *Department of Defense Independent Technical Risk Assessment Framework for Risk Categorization*. https://aida.mitre.org/wp-content/uploads/2018/07/2018-ITRA-Framework-June-2018.pdf

Department of Defense. (2021). *DoD Instruction 1325.06. Handling protest, extremist, and criminal gang activity*. https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/132506p.PDF

Department of Defense. (2022). *DoD Instruction 1020.03. Harassment prevention and responses for DoD in the armed forces*. https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/102003p.PDF

Department of Defense. (2022). *DoD Instruction 8510.01. Risk management frameworks for DoD systems*. https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/851001p.pdf?ver=2019-02-26-101520-300

Department of Defense. (2022). *Diversity and Inclusion Strategic Plan 2022-2023*. https://media.defense.gov/2022/Sep/30/2003088685/-1/-1/0/DEPARTMENT-OF-

DEFENSE-DIVERSITY-EQUITY-INCLUSION-AND-ACCESSIBILITY-STRATEGIC-PLAN.PDF

Department of Defense. (2022). *Department of Defense Annual Report on Sexual Assault in the Military: Fiscal Year 2021.* https://www.sapr.mil/sites/default/files/public/docs/reports/AR/DOD_Annual_Report_on_Sexual_Assault_in_the_Military_FY2021.pdfDoucette, C. E., Morgan, N. R., Aronson, K. R., Bleser, J. A., McCarthy, K. J., & Perkins, D. F. (2022). The effects of adverse childhood experiences and warfare exposure on military sexual trauma among veterans. *Journal of Interpersonal Violence, 38(3-4), 3777–3805*. https://doi.org/10.1177/08862605221109494

Egede, L. E., Dismuke, C., & Echols, C. (2012). Racial/Ethnic disparities in mortality risk among US veterans with traumatic brain injury. *American journal of public health, 102(2), S266–S271*. https://doi.org/10.2105/AJPH.2011.300176

Fontana, A., Litz, B., & Rosenheck, R. (2000). Impact of combat and sexual harassment on the severity of posttraumatic stress disorder among men and women peacekeepers in Somalia. *The Journal of Nervous and Mental Disease, 188(3), 163–169*. https://doi.org/10.1097/00005053-200003000-00006

Gale, S., Mordukhovich, I., Newlan, S., & McNeely, E. (2019). The impact of workplace harassment on health in a working cohort. *Frontiers in Psychology, 10*. https://doi.org/10.3389/fpsyg.2019.01181

Gaska, K. A., & Kimerling, R. (2018). Patterns of adverse experiences and health outcomes among women veterans. *American Journal of Preventive Medicine, 55(6), 803-811*. https://doi.org/10.1016/j.amepre.2018.06.029

General Accounting Office. (2000). *First-term recruiting and attrition continue to require focused attention.* https://apps.dtic.mil/sti/pdfs/ADA373796.pdf

Gibson, C. J., Gray, K. E., Katon, J. G., Simpson, T. L., Lehavot, K. (2015). Sexual assault, sexual harassment, and physical victimization during military Service across age cohorts of women veterans. *Women's Health Issues, 26(2), 225-231*. https://doi.org/10.1016/j.whi.2015.09.013

Gilmore, A. K., Brignone, E., Painter, J. M., Lehavot, K., Fargo, J., Suo, Y., Simpson, T., Carter, M. E., Blais, R. K., & Gundlapalli, A. V. (2016). Military sexual trauma and co-occurring posttraumatic stress disorder, depressive disorders, and substance use disorders among returning Afghanistan and Iraq veterans. *Women's Health Issues: Official publication of the Jacobs Institute of Women's Health, 26(5), 546*. https://doi.org/10.1016/j.whi.2016.07.001

Godfrey, K. M., Lindamer, L. A., Mostoufi, S., & Afari, N. (2013). Posttraumatic stress disorder and health: A preliminary study of group differences in health and health behaviors. *Annals of General Psychiatry, 12(1), 30*. https://doi.org/10.1186/1744-859X-12-30.

Government Accountability Office. (1995). *DoD Studies on Discrimination in the Military.* https://www.gao.gov/assets/nsiad-95-103.pdf

Government Accountability Office. (2021). *DoD Should Address Data Reporting Deficiencies, Training Limitations, and Personnel Shortfalls*. https://www.gao.gov/assets/gao-22-104066.pdf

Gross, G. M., Cunningham, K. C., Moore, D. A., Naylor, J. C., Brancu, M., Wagner, H. R., Elbogen, E. B., Calhoun, P. S., Mid-Atlantic MIRECC Workgroup, V., & Kimbrel, N. A.

(2018). Does deployment-related military sexual assault interact with combat exposure to predict posttraumatic stress disorder in female veterans? *Traumatology, May 2018*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6128291/

Helmus, T. C., Byrne, H. J., Mallory, K. (2021). Countering Violent Extremism in the U.S. Military. *RAND Corporation*. https://www.rand.org/pubs/research_reports/RRA1226-1.html

Johnson, J. (1995). A preliminary investigation into DEOMI training effectiveness. https://apps.dtic.mil/sti/pdfs/ADA300958.pdf

Harris, K. J., Harvey, P., Harris, R. B., & Cast, M. (2013). An investigation of abusive supervision, vicarious abusive supervision, and their joint impacts. *The Journal of Social Psychology, 153(1), 38–50*. https://doi.org/10.1080/00224545.2012.703709

Kysar-Moon, A., & Mustillo, S. (2018). Race/ethnicity and traumatic brain injury: Are there disparities in positive screenings and diagnoses among Service members returning from Afghanistan and Iraq? *Armed Forces & Society, 45(1)*. https://doi.org/10.1177/0095327X18761852

Kim, J., Kim, J., & Park, S. (2019). Military hazing and suicidal ideation among active duty military personnel: Serial mediation effects of anger and depressive symptoms. *Journal of Affective Disorders, 256, 79–85*. https://doi.org/10.1016/j.jad.2019.05.060

Kimerling, R., Makin-Byrd, K., Louzon, S., Ignacio, R., McCarthy, J. (2015). Military sexual trauma and suicide mortality. *American Journal of Preventative Medicine, 50(6), 684-691*. https://doi.org/10.1016/j.amepre.2015.10.019

Kintzle, S., Schuyler, A. C., Ray-Letourneau, D., Ozuna, S. M., Munch, C., Xintarianos, E., Hasson, A. M., & Castro, C. A. (2015). Sexual trauma in the military: Exploring PTSD

and mental health care utilization in female veterans. *Psychological Services, 12(4), 394–401*. https://doi.org/10.1037/ser0000054

Larsen, S. E., Wiltsey Stirman, S., Smith, B. N., & Resick, P. A. (2016). Symptom exacerbations in trauma-focused treatments: Associations with treatment outcome and non-completion. *Behaviour Research and Therapy, 77, 68–77*. https://doi.org/10.1016/j.brat.2015.12.009

Leardmann, C. A., Pietrucha, A., Magruder, K. M., Smith, B., Murdoch, M., Jacobson, I. G., Ryan, M. A., Gackstetter, G., Smith, T. C., & Millennium Cohort Study Team. (2013). Combat deployment is associated with sexual harassment or sexual assault in a large, female military cohort. *Women's Health Issues: Official Publication of the Jacobs Institute of Women's Health, 23(4), e215–e223*. https://doi.org/10.1016/j.whi.2013.05.002

McNamara, Kati & Gribble, Rachael & Sharp, Marie-Louise & Alday, Eva & Corletto, Giselle & Lucas, Carrie & Castro, Carl & Fear, Nicola & Goldbach, Jeremy & Holloway, Ian. (2021). Acceptance matters: Disengagement and attrition among LGBT personnel in the U.S. Military. *Journal of Military, Veteran and Family Health, 7(1), 76-89*. https://doi.org/10.3138/jmvfh-2021-0017

Meadows, S. O., Engel, C. C., Collins, R. L., Beckman, R. L., Breslau, J., Bloom, E., Dunbar, M. S., Gilbert, M., Grant, D., Hawes-dawson, J., Holliday, S., Maccarthy, S., Pedersen, E. R., Robbins, M. W., Rose, A. J., Ryan, J., Schell, T. L., Simmons, M. M. (2018). 2018 Department of Defense Health Related Behaviors Survey (HRBS). *RAND Corporation* https://www.rand.org/pubs/research_reports/RR4222.html

Meyer, I. H., Schwartz, S., & Frost, D. M. (2008). Social patterning of stress and coping: Does disadvantaged social statuses confer more stress and fewer coping resources? *Social Science & Medicine*, 67(3), 368-379. https://doi.org/10.1016/j.socscimed.2008.03.012

Millegan, J., Wang, L., LeardMann, C., Miletich, D., & Street, A. E. (2016). Sexual trauma and adverse health and occupational outcomes among men serving in the U.S. military. *Journal of Traumatic Stress, 29(2), 132–140*. https://doi.org/10.1002/jts.22081

Moradi, B. (2009). Sexual orientation disclosure, concealment, harassment, and military cohesion: Perceptions of LGBT military veterans. *Military Psychology, 21(4), 513–533*. https://doi.org/10.1080/08995600903206453

Murdoch M, Pryor JB, Polusny MA, Wall MM, Ripley DC, Gackstetter GD. (2010). The association between military sexual stress and psychiatric symptoms after controlling for other stressors. *Journal of Psychiatric Research*. doi: 10.1016/j.jpsychires.2010.09.009.

Office of People Analytics. (2019). *2017 Workplace and gender relations survey of military members*. https://apps.dtic.mil/sti/pdfs/AD1113643.pdf

Office of People Analytics. (2022). *2021 Workplace and gender relations survey of military members*. https://apps.dtic.mil/sti/pdfs/AD1113643.pdf

Oppizzi, L. M., & Umberger, R. (2018). The effect of physical activity on PTSD. *Issues in Mental Health Nursing, 39(2), 179–187*. https://doi.org/10.1080/01612840.2017.1391903

Pandey, N., Ashfaq, S. N., Dauterive, E. W., MacCarthy, A. A., & Copeland, L. A. (2018). Military sexual trauma and obesity among women veterans. *Journal of Women's Health (2002), 27(3), 305–310*. https://doi.org/10.1089/jwh.2016.6105

Rice, D. B., & Young, N. C. J. (2021). Integrating ethics and inclusion: How and when upper-level managerial leadership impact supervisory inclusiveness. *Current Psychology*. https://doi.org/10.1007/s12144-021-02460-6

Sims, C., Drasgow, F., Fitzgerald, L. (2005). The effects of sexual harassment on turnover in the military: Time-dependent modeling. *Journal of Applied Psychology 90(6) 1141-52*. Doi: 10.1037/0021-9010.90.6.1141

Solomon, D. T., Combs, E. M., Allen, K., Roles, S., DiCarlo, S., Reed, O., & Klaver, S. J. (2021). The impact of minority stress and gender identity on PTSD outcomes in sexual minority survivors of interpersonal trauma. *Psychology & Sexuality*, *12*(1-2), 64-78.

Spoont, M., Nelson, D., van Ryn, M., & Alegria, M. (2017). Racial and ethnic variation in perceptions of VA mental health providers are associated with treatment retention among veterans with PTSD. *Medical Care, 55(9), S33–S42*. https://doi.org/10.1097/MLR.0000000000000755

Sumner, J. A., Lynch, K. E., Viernes, B., Beckham, J. C., Coronado, G., Dennis, P. A., Tseng, C. H., & Ebrahimi, R. (2021). Military sexual trauma and adverse mental and physical health and clinical comorbidity in women veterans. *Women's Health Issues: Official Publication of the Jacobs Institute of Women's Health, 31(6), 586–595*. https://doi.org/10.1016/j.whi.2021.07.004

RAND Corporation. (2021). *The Behavioral Health of Minority Active Duty Service Members*. https://www.rand.org/pubs/research_reports/RR4247.html

Williams, D. R., Lawrence, J. A., Davis, B. A., & Vu, C. (2019). Understanding how discrimination can affect health. *Health Services Research, 54(2), 1374–1388*. https://doi.org/10.1111/1475-6773.13222

Wong, E. C., Meadows, S. O., Schell, T. L., Chan, W. Y., Jaycox, L. H., Osilla, K. C., Schuler, M. S., Roth, E. (2021). The Behavioral Health of Minority Active Duty Service Members. *RAND Corporation*. https://www.rand.org/pubs/research_reports/RR4247.html

Appendix A

Military Risk Assessment Matrix Definitions

Frequency

- Frequent: Occurs very often, known to happen regularly.
- Likely: Occurs several times, a common occurrence.
- Occasional: Occurs sporadically, but is not uncommon.
- Seldom: Remotely possible, could occur at some time.
- Improbable: Can assume it will not occur, but not impossible.

Severity

- Catastrophic: Complete mission failure or the loss of ability to accomplish a mission. Death or permanent total disability. Loss of major or mission-critical systems or equipment. Major property or facility damage. Severe environmental damage. Mission-critical security failure. Unacceptable collateral damage.
- Critical: Severely degraded mission capability or unit readiness. Permanent partial disability or temporary total disability exceeding three months' time. Extensive major damage to equipment or systems. Significant damage to property or the environment. Security failure. Significant collateral damage.
- Marginal: Degraded mission capability or unit readiness. Minor damage to equipment or systems, property, or the environment. Lost days due to injury or illness not exceeding three months. Minor damage to property or the environment.
- Negligible: Little or no adverse impact on mission capability. First aid or minor medical treatment. Slight equipment or system damage, but fully functional or Serviceable. Little or no property or environmental damage.

Appendix B

Example Small-group Discussion Topics on DEI-related Risk Management

(1) Can DEI-related risk (including racial and ethnic discrimination, sexual harassment, and sexual assault) pose a legitimate threat to your unit? Why or why not?
    a. If so: how might the target of a DEI-related incident be affected? How might a DEI-related incident affect your unit's teamwork?

(2) What do you think are the major obstacles to managing DEI-related risk? Why do military organizations still have difficulty with these topics?
    a. Have you witnessed or heard about a DEI-related incident? What was done in response? Do you agree with the outcome?

(3) In 2017, 31% of White Service members, and 14% of Service members of color thought that the military was spending "too much attention" on DEI-related risk (Office of People Analytics, 2019). Do you agree with this assessment?
    a. What—if anything—should military organizations focus on going forward?