

# Toward Optimizing Mental Health Care for Sexual and Gender Minority Veterans

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Studies examining physicians' knowledge, attitudes, and perceptions of their clinical competence have revealed that many are, or perceive themselves to be, poorly prepared to address the needs of sexual and gender minority (SGM) patients as well as military veterans. In this article, the authors examine these findings as they pertain to mental

health care and identify the areas of cultural and clinical competence necessary for psychiatrists and other mental health professionals to provide high-quality care for SGM veterans.

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Multiple studies have revealed deficiencies in clinicians' readiness to provide optimal care to patients who identify as sexual and gender minorities (SGMs), including but not limited to those who identify as lesbian, gay, bisexual, transgender, nonbinary, queer, or questioning (1, 2). Consequently, SGM individuals may avoid health care, including mental health care, because they anticipate or have experienced stigma in health care settings or believe that clinicians lack the training to meet their needs (1, 2). Similarly, questions have been raised about the readiness of community-based providers to address the mental health needs of veterans (3, 4). At the same time, federal legislation has increased access to care in the private sector to veterans because of insufficient capacity of the U.S. Department of Veterans Affairs (VA) hospitals to meet the needs of the large veteran population (5, 6). Thus, community mental health providers need to be prepared to address the needs of patients who are SGMs, veterans, or both.

This article begins by briefly reviewing the current status of clinically and culturally competent mental health care for SGM individuals, which is addressed more fully by other articles in this issue of *Focus* devoted to SGM populations (7, 8). The current status of culturally and clinically competent mental health care for veterans is then reviewed, followed by a discussion of the mental health care needs of individuals who are both SGMs and veterans. Recent enhancements in SGM veteran health care by the VA are described, and the article concludes with recommendations for optimizing the mental health care for SGM veterans, whether it is provided by the VA, provided by the private sector, or coordinated between both. Sources for guidance in key areas of SGM veteran mental health care are also identified.

## STATUS OF CULTURALLY AND CLINICALLY COMPETENT SGM MENTAL HEALTH CARE

Studies have consistently concluded that SGM individuals experience poorer mental health compared with their heterosexual and cisgender counterparts (1, 2, 9). Considerable evidence links these mental health disparities to SGM stress, that is, the stresses of having a stigmatized identity together with the experiences of living in a society with deeply embedded heterosexist and anti-SGM attitudes (8, 10). Highly relevant to the present discussion, SGM individuals often experience stigmatization in health care settings (1). Stigmatization in mental health settings can be enacted through failure to assess a patient's sexual orientation and gender identity, undue focus on the patient's SGM status when it is not related to the presenting complaint, as well as adherence to outdated pathologizing theories of sexual and gender variance, including engaging in efforts to change sexual orientation or gender identity (11, 12).

Although accepting attitudes toward SGM individuals have increased in recent years, anti-SGM bias remains in society at large and persists within health care systems (13). The American Psychiatric Association did not declassify homosexuality as a mental disorder until 1973, and homosexual behavior was not decriminalized throughout the United States until 2003 (12). Lesbian, gay, and bisexual individuals could not serve openly in the military until 2011 (12). Moreover, gender dysphoria, which is highly associated with transgender identification, continues to be classified as a psychiatric disorder in *DSM-5*. Same-sex marriage was not available in all states until 2015 (12). At the

time of this writing, most U.S. states do not explicitly prohibit employment discrimination on the basis of sexual orientation or gender identity, there is no federal protection against employment discrimination on the basis of sexual orientation (14), and efforts aimed at changing sexual orientation (also known as sexual orientation conversion efforts) or gender identity in minors have yet to be banned in most states (15). Conversion therapies are premised on the assumption that same-sex attractions and gender variance are pathological, and the damaging effects of these treatments are described elsewhere (12). In light of these circumstances, SGM patients may avoid psychiatric care or approach it with trepidation (11, 12).

Compared with their heterosexual and cisgender counterparts, SGM individuals have increased utilization of mental health services (16) but are less likely to report satisfaction with their mental health care (1). They are also more likely to report negative experiences in receipt of this care and to believe that their clinicians lack the training necessary to provide them with optimal care (1). Their impression of inadequate training is supported by a survey of U.S. and Canadian medical school deans, which found the median amount of time dedicated to SGM topics in medical school was about 5 hours (17). Similarly, a survey of U.S. psychiatry residency program directors found that most programs offered less than 5 hours of SGM-specific training (18).

## GENERAL CONSIDERATIONS WITH SGM PATIENTS

Mental health professionals should seek to understand how SGM stress affects the psychological health of their SGM patients both developmentally and currently. However, they must balance this need against the need to focus on patients' current chief complaints and limitations. Undue focus on SGM status can be not only inadvertently stigmatizing but can also result in increased time in treatment and financial burden to the patient. Next, we briefly describe common issues encountered in working with SGM individuals, which are covered in more detail elsewhere (12, 19).

Coming to the realization that one belongs to a stigmatized minority and accepting one's membership in that group can be filled with conflict that may never be fully resolved (11, 12). It is, therefore, often important for the mental health professional to explore the emergence of the patient's awareness of SGM status and its effects over time on self-esteem, sexual and gender identity (including resistance to identification as a member of a stigmatized minority), coming out to others, relationships (including interpersonal, romantic, and social), and mental health (including assessment for depression, suicidality, and substance abuse). The experience and impact of SGM-associated stigma should also be explored from childhood to the present, including experiences of punishment, bullying, and rejection by parents, siblings, or peers as well as discrimination in any sector, including employment and health care

(11, 12). Individuals who express uncertainty regarding their sexual and gender identity should be supported in finding authenticity in their sexual and gender identities and expression. For some patients, the uncertainty of which identity labels are "correct" for them can be a source of considerable anxiety. Introduction of terms such as "questioning" and "gender questioning" may help the patients because it provides them with labels that fit their experience.

The mental health professional's role in working with individuals with gender dysphoria is addressed in detail elsewhere (11, 19–22). Briefly, this work entails assessing the following: the history, development, and manifestations of gender dysphoric feelings and gender nonconformity; the effects of any associated stigma; management to date (what has helped and what has not); support from family, friends, and peers; and contact with others from the gender diverse community. In addition, the mental health professional should provide the following or make appropriate referrals so that they are addressed: psychotherapy to address the gender concern; psychopharmacology, if indicated, to address any coexisting psychiatric disorder; assessment of eligibility for gender transition services, if requested; and provision of the necessary psychoeducation and preparation for requested transition services as specified in the most recent Standards of Care of the World Professional Association for Transgender Health (22). It is important that the patient and therapist understand that gender transition addresses gender dysphoria and that coexisting psychiatric disorders are likely to persist after transition, although stress-related symptoms may be diminished in severity (11, 21).

## STATUS OF CULTURALLY AND CLINICALLY COMPETENT VETERAN CARE

The RAND Corporation surveyed the readiness of mental health professionals to address the needs of veterans and their families using the Institute of Medicine's definition of high-quality care as care that is evidence based, effective, safe, patient centered, timely, efficient, and equitable (3). The ability of clinicians to deliver such care to veterans was assessed by a web-based survey and conceptualized as including both cultural competency and the capacity and inclination to deliver clinically appropriate, evidence-based care. Participants in the survey were 522 mental health providers working in community-based settings, of whom 35% had experience working in either a military setting or the VA, and 30% were registered in the TRICARE network. TRICARE is the civilian care component of the Military Health System and provides civilian health benefits for U.S. Armed Forces military personnel, military retirees, and their dependents, including some members of the Reserve component.

Cultural competency was defined as "the degree to which providers are sensitive to the unique needs and relevant issues of concern within the veteran population." Cultural

competency was assessed by participants' self-ratings related to proficiency in military and veteran culture, comfort in working with veterans and their families, and self-reported measures of proficiency and training. When these ratings were compiled into an overall military cultural competency score, 70% of those working in VA or military settings met the study's threshold criteria for high competency compared with 24% of those who were TRICARE affiliated and only 8% who were neither ( $p < 0.001$ ).

Assessment behaviors were assessed by participants' reports of how often they implement a variety of relevant screening and assessment practices, including military and veteran status; stressors of military life or being a veteran; suicidal ideation and risk; past traumatic events, including those experienced in the military; and using validated screening tools to detect problems known to have increased prevalence among veterans, including posttraumatic stress disorder (PTSD), major depressive disorder, alcohol and substance use, and sleep problems. Of VA providers, 46% endorsed doing all of these assessments compared with 13% of community providers (3).

Overall readiness to care for veterans was operationalized as receiving a high score on the measure of veteran/military cultural competence together with having received training in, and having used, evidenced-based treatments for both PTSD and major depressive disorder. Only 13% of participants met this readiness criterion, with those who worked primarily in a military, VA, or TRICARE setting more likely to meet the readiness criterion than others (3).

### GENERAL CONSIDERATIONS WITH VETERAN PATIENTS

The most common mental illnesses among veterans are major depressive disorder, PTSD, substance use disorders, and anxiety disorders (23). The RAND Corporation, therefore, has recommended that all veterans be screened for PTSD, major depressive disorder, as well as alcohol and drug misuse, suicidal ideation and risk, past traumatic events (including while in the military), and sleep problems (3). Use of validated screening instruments is recommended (3). Given the elevated gun ownership (24) and risk of suicide in the veteran population (25), it is also important to inquire about gun ownership, such as with the following screening question: "Are any firearms kept in or around your home?" (26). Depending on the answer and the situation, the clinician might ask additional questions about whether the gun is stored loaded, whether it is locked, or whether there are small children in the home. Appropriate means restriction is an important aspect of risk reduction for those who might be at risk for suicide or violence (27).

The VA has prepared a downloadable Military Health History Pocket Card for Clinicians to assist with the first clinical interviews with veterans (28). This card includes screens for conditions that are increased in frequency among veterans, including those conditions that often present with

psychiatric complaints, such as traumatic exposures and head injuries. Example questions for querying veteran status and related experiences adapted from this card are shown in Box 1.

### SPECIAL ISSUES WITH SGM VETERANS

Despite the historical prohibitions against SGM service in the U.S. military, SGM individuals have served from the Revolutionary War to the present (29, 30). The impact of SGM status will vary depending in part on the veteran's era of service, branch and arena of service, deployment history, rank, military role, and discharge status. For example, World War II veterans may have been aware of same sex attractions before enlistment, which may have been due to involuntary inscription, but may have come to view themselves as SGM only after encountering other SGM individuals in the military (31). In either case, they were subject to less than honorable discharge if found out or court martial if accused of acts of sodomy (32).

Those who were identified as SGM may have enlisted voluntarily out of patriotism or declined to divulge their SGM status when registering for the draft because of the societal repercussions of being excluded on that basis. This occurrence was perhaps particularly true for those living in rural areas and small towns where there may be less anonymity. The same was true for many serving during the Vietnam War era. In addition, during the Vietnam era, antiwar protests in large cities with sizable SGM communities have been credited with creating a schism between SGM youths opposed to the war and older homophile groups that refrained from taking a stance against the war (33). For example, a contingent of Vietnam veterans was not allowed to participate in the 1980 San Francisco Pride parade amid sentiment that returning veterans should be tried as war criminals (34). Such strong antiwar sentiment and shunning of returning soldiers by the SGM community created a need for some returning SGM veterans to conceal their veteran status within the SGM community, just as they had concealed their SGM status while serving. This particularly poignant example shows how SGM veteran experience is influenced by the era during which one served.

In 1993, after unsuccessfully trying to end the ban on gay men and women in the military, President Clinton announced a compromise policy, "Don't Ask, Don't Tell" (DADT), permitting lesbian and gay Americans to serve in the military as long as they remained closeted (32). The policy, however, arguably increased harassment and attempts at outing of service members thought to be lesbian or gay, resulting in more than 1,300 service members being discharged under the policy before its repeal by the Obama administration in 2011 (32). Thus, the need to conceal their identity while in the military should be explored with SGM veterans of any era of service, but it often has particular salience for those who served before and during DADT. There has been increased institutional openness for SGM

**BOX 1. Example questions for military history**

1. Have you ever served in the military?
2. Have you separated from service?
  - a. If yes, when and under what circumstances?
  - b. What was your discharge status?
3. When did you serve?
4. What was your branch and rank?
5. What was your job?

Before continuing, ask the veteran for permission because you will be asking potentially emotionally charged questions. The veteran can decline to answer.

6. Were you deployed? If so, where?

7. Did you ever see combat?
8. Did you have exposures to things such as chemicals or infectious agents?
9. What about gun blasts, explosions, excessive heat, radiation, vehicular accidents? Any other exposures?
10. Did you witness or were you exposed to traumatic events, including deaths or physical or sexual abuse?
11. Were you ever a prisoner of war or hostage?
12. What else should I know about your military experiences?

Extracted from the U.S. Department of Veterans Affairs Military Health History Pocket Card (28).

persons in the military since the repeal of DADT (35), including access to health care within the military medical system related to gender dysphoria (36). Nevertheless, the need for concealment remains important to explore regardless of era of service given the vulnerability of inclusive policies to change (37) and the fact that inclusive policies cannot end all abuses.

Despite the repeal of DADT and the changes in the military's transgender policy, both sexual harassment and assault are experienced with greater frequency by SGM individuals relative to their cisgender and heterosexual counterparts (38). VA refers to sexual assault or harassment experienced in the course of military service as military sexual trauma (MST) (39). MST includes any sexual activity that occurs against a service member's will, sexual activity that results from pressure or threats, unwanted sexual touching or grabbing, threatening and offensive remarks about a person's body or sexual activities, as well as threatening and unwelcome sexual advances (39, 40).

In a study comparing SGM and non-SGM service members (38), SGM women were 3.5 times as likely to report sexual assault compared with non-SGM women. Compared with non-SGM men, SGM men were 11.7 times more likely to report sexual assault. SGM service members were also more likely to report having experienced sexual harassment compared with their non-SGM counterparts, with the prevalence increased by a factor of 1.5 for SGM women and 4.6 for SGM men (38). The small number of transgender individuals in that study did not allow analyses to be stratified by both sex assigned at birth and current gender identity; however, a study of returning veterans from the Iraq and Afghanistan conflicts found that nearly one in five transgender men and one in seven transgender women screened positive for MST (40). Whereas the high prevalence of MST found among transgender individuals is similar to the ranges reported in other studies, the prevalence of MST found among transgender women veterans is much higher than that among cisgender women (38). It is imperative that veterans with MST receive supportive, evidence-based, culturally competent treatment to address the impact of victimization on their psychosocial adjustment.

**TOWARD CULTURALLY AND CLINICALLY COMPETENT SGM VETERAN CARE**

The first step toward optimizing care for SGM veterans is to query veteran status, sexual orientation, and gender identity during the first encounter with all patients if not already unambiguously documented in their record. In our recent experience working with resident and fellow trainees in psychiatry, most report competency in eliciting sexual orientation and gender identity during intake interviews but report not doing so routinely for fear of offending patients who are not SGM. Collecting these data and letting patients know that they are collected from everyone as matter of routine ensures that this important information is gathered in addition to preventing patients from wondering why these questions are being asked of them. Electronic health record systems are increasingly including data fields for sex assigned at birth, current gender identity, and sexual orientation (41); however, these data may not be stored in fields available to providers.

Questions for querying sexual orientation and gender identity have been studied in an effort to develop routine questions for incorporation into electronic health record systems, which is a requirement of electronic health record software to be certified under Meaningful Use guidelines (41). Studies have verified that such questions are acceptable to most individuals regardless of their gender identity or sexual orientation (42) and that most patients understand their importance and would be willing to answer them in person or on a registration form or kiosk (43). Example questions adapted from Cahill et al. (43) are shown in Box 2. When eliciting these data, clinicians should not challenge a patient's self-label for their sexual orientation or gender identity but may need to clarify how the patient defines their label(s) when that information is clinically relevant. In situations in which it is important to assess a patient's sexual behaviors, it is important to realize that one's gender label poorly predicts their sexual identity label and assumptions about one's sexual behaviors should not be based on either label (12, 44).

As a show of respect, it is important to address gender minority individuals using their requested and gender-affirming

names, pronouns, and honorifics regardless of their transition status. This status can be clarified by asking, “What are your pronouns, and how would you like me to address you?” Of note, gender minority individuals may not wish their gender-affirming names, pronouns, and honorifics to be used in all situations (e.g., situations in which using them would place the patient at risk by revealing their identity to unaccepting others). SGM patients should also be informed of the current affirmative stance of the psychiatric profession in which sexual and gender variance are viewed as valued aspects of human diversity, not targets to be changed by treatment.

### Recent Progress and Current Status of VA SGM Health Care

Given the number of patients receiving care through VA hospitals throughout the country, the VA may be the largest single provider of health care for SGM individuals in the United States (4). However, many SGM veterans, especially those who served before the repeal of DADT, may be reluctant to come out at the VA by requesting SGM-related services. They can be assured, however, that the VA never had a policy of discriminating on the basis of sexual orientation or gender identity, that DADT never applied to the VA, and that in recent years the VA has taken tremendous strides to provide respectful and culturally sensitive care to SGM veterans as described next.

In response to known SGM health disparities, the VA implemented a lesbian, gay, bisexual, and transgender (LGBT) Health Program to develop policies supporting the provision of affirming care to SGM veterans. The program became fully national in 2016 (45). To support policy implementation, an LGBT Veteran Care Coordinator (LGBT VCC) Program was launched in 2016, requiring every VA facility to appoint at least one clinical staff member to serve as an LGBT VCC (46). SGM veterans who do, as oppose to those who do not, use the VA tend to be older, are more ethnically diverse, have less income, and tend to be less public about their SGM identity than nonusers (47, 48). VA users and nonusers have not been found to differ on depression, anxiety, alcohol use, or tobacco use; however, VA users tend to have more physical limitations and chronic medical conditions and lower health literacy than nonusers (47).

In a 2014 study, approximately 66% of veterans reported that none of their VA clinicians had specifically asked about their sexual orientation, and 24% indicated that they had not disclosed their orientation to any VA clinician (48). Although some veterans reported wanting clinicians to initiate these discussions, some also expressed fears about disclosure and its possible adverse consequences. Further, only 28% of SGM veterans surveyed experienced the VA as welcoming, and they reported varied opinions about the appropriateness of routine assessment of SGM status (48). A study of VA clinicians also published in 2014 reported that many were

### BOX 2. Queries for sex assigned at birth, gender identity, and sexual orientation

#### Sex Assigned at Birth

What sex were you assigned at birth on your original birth certificate?

Male

Female

Decline to answer, please explain why \_\_\_\_\_

#### Current Gender Identity

What is your current gender identity? Check all that apply.

Male

Female

Female-to-male (FTM)/transgender male/trans man

Male-to-female (MTF)/transgender female/trans woman

Genderqueer, neither exclusively male nor female

Additional gender category or other, please specify \_\_\_\_\_

Choose not to disclose

#### Sexual Orientation

Do you think of yourself as \_\_\_\_\_?

Lesbian, gay, or homosexual

Straight or heterosexual

Bisexual

Something else, please describe \_\_\_\_\_

Don't know

Choose not to disclose

Adapted from Cahill et al. (43).

reluctant to raise the issue of SGM status, believing that veterans would raise the issue if it were important to their care, and about half reported that they never assessed sexual orientation (49). More recently, most SGM VA users have reported feeling welcome at their facility and comfortable disclosing their SGM status to their clinicians (47). Compared with the earlier studies, the positive experiences reported more recently by SGM VA users suggest that the VA's LGBT Health Program and staff training efforts have been successful (47). To date, no studies have compared the VA and non-VA health care experiences of SGM veterans.

### Optimizing Care for SGM Veterans

Although it is possible for SGM veterans to obtain outstanding state of the art care in either the VA or civilian sector, especially if financial concerns are not a factor, some veterans may be able to optimize their mental health care by using both VA and civilian resources. In particular, the RAND Corporation's study suggests that the VA may outperform the civilian sector in some areas, such as PTSD, traumatic brain injury, and the physical ailments common among veterans (3); similarly, the VA may also outperform the civilian sector in group modalities for veterans, such as those that target veteran-specific issues related to suicidality and MST (50). Gender minority veterans seeking hormonal

treatments and referral letters for gender-affirming surgical treatments may find that they can obtain them more expeditiously and at lower out of pocket cost through the VA than other health care settings. The gender-affirming policies and clinical services provided by the VA are specified by Veterans Health Administration directive 1341 (Providing Health Care for Transgender and Intersex Veterans) (51). The directive specifies that the VA strives to provide an atmosphere free of harassment in which veterans are addressed by their self-identified gender and preferred name, including in conversations and clinical notes. Care includes gender-affirming mental health and endocrine services. Although mental health services include evaluations and provision of referral letters for gender-affirming hormones and surgeries, the VA does not currently provide or pay for gender-affirming surgeries (51).

SGM veterans who are not aware of the VA's SGM affirmative policies and services may be reluctant to seek care through the VA. Additionally, those who were discharged under DADT may assume that they are ineligible for VA services. As noted earlier, the VA may outperform the civilian sector in addressing particular mental health issues related to military service. To assist SGM veterans in obtaining the highest quality and affordable health care, civilian sector providers should ideally be able to direct them in investigating their VA eligibility and relevant available clinical services. In general, a veteran may receive VA health care benefits if they served in the active military, naval, or air service and did not receive a dishonorable discharge. If they enlisted after 1980, they must have served 24 continuous months on active duty. If they were discharged under DADT, they may appeal to change their discharge characterization to the Board for Corrections of Military Records and Discharge Upgrades, whose website has links to information specific to each branch of service (52). Veterans can verify their eligibility for VA services and apply online (53). As noted earlier, the VA has made major efforts in recent years to create a welcoming environment where SGM veterans can receive affirming state of the art medical and mental health services. A publicly available website (54) allows anyone to check what SGM services are available at any VA medical center in the country. The website also links to contact information for the LGBT VCC at each VA facility.

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