Gay Mental Healthcare Providers and Patients in the Military

Personal Experiences and Clinical Care

Elspeth Cameron Ritchie
Joseph E. Wise
Bryan Pyle *Editors*

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Editors
Elspeth Cameron Ritchie
Department of Psychiatry
Uniformed Services University
of the Health Sciences (USUHS)
Silver Spring, MD, USA

Bryan Pyle
Walter Reed National Military Medical
Center
Bethesda, MD, USA

Joseph E. Wise
Walter Reed National Military Medical
Center
Bethesda, MD, USA

ISBN 978-3-319-66025-7 ISBN 978-3-319-66026-4 (eBook)
https://doi.org/10.1007/978-3-319-66026-4

Library of Congress Control Number: 2017955371

Printed on acid-free paper

This Springer imprint is published by Springer Nature
The registered company is Springer International Publishing AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

Foreword

This book is about the personal experiences of lesbian, gay, and bisexual (LGB) mental health providers in the military and cultural changes regarding homosexuality in the military and society. While I have read several books about the military bans on same-sex behavior and LGB identity disclosure (e.g., *Conduct Unbecoming* [1]) and the personal experiences of LGB service members (e.g., *Barrack Buddies and Solider Lovers* [2]), I can think of none that have presented the experiences of LGB mental health providers in the military. The stories in this volume help to tell the larger painful history of how homosexuality and LGB people have been viewed in this country. It also describes lessons learned in taking care of gay service members and veterans.

I am not a veteran. Nor have I worked for the Department of Defense (DoD). But for 25 years, I have worked as a clinical psychologist in the Veterans Health Administration, Department of Veterans Affairs (VA), and provided clinical care to LGB veterans. I've heard innumerable personal stories from many LGB veterans who served during peacetime and in every military conflict involving this country, from World War II to wars in Iraq and Afghanistan.

These veterans often described horrific, terrifying events, such as physical violence or sexual assault, and feeling of inability to report the event without being victimized further. Many reported living with the constant terror of being found out. Some resorted to pretending to be straight. I also heard countless touching stories of secret same-sex intimacies and relationships. But I have talked with few LGB healthcare professionals about what it was like living and working in the military under "Don't Ask, Don't Tell" (DADT) or previous anti-gay bans.

My connection to LGB veterans and military policies began in 1991, before DADT, which wasn't enacted until 1993. I was invited to present as a doctoral student (along with my mentor, Dan Landis, at the University of Mississippi) at the American Psychological Association meeting in San Francisco. APA had organized a symposium on DoD policy, which flatly asserted that "homosexuality is incompatible with military service." My talk, "Ethnic Minority and Gender Integration: Lessons Learned," contrasted opposition to integration of African-Americans and women in the military with opposition to gay and lesbian service members. (In those days, transgender service members were rarely mentioned.)

This was very exciting! I loved thinking about how government policy affects the lives and mental health of veterans. At the presentation, I met an ex-Navy officer

who left the Navy after learning that a fellow sailor who was under investigation had named him as a potential homosexual. The Navy sued the veteran to recover the cost of his education, as they did with others; eventually, the Navy lost.

After completing a predoctoral psychology internship at the New Orleans VA Medical Center, I stayed on as a staff psychologist in the HIV clinic. I enjoyed treating veterans and saw stability and career opportunities at the VA. Although the VA did not have anti-gay policies like DADT, I worried about how I would be treated as a gay man. I'm happy to say that I have not experienced overt anti-gay attitudes or behaviors during my VA career. Nonetheless, I was told that my scholarly work in LGB sexuality and sexual health had little application in VA and I should focus on more "relevant" veteran health issues.

Things changed dramatically in 2011 when VA issued a national healthcare policy on transgender care. I was tapped to lead (along with Jillian Shipherd) the development of staff training on implementation of the new policy. With the pending repeal of DADT, Jillian and I became the point people in VA for questions about lesbian, gay, bisexual, and transgender (LGBT) veteran health issues. We leveraged that position into a formal national office in 2012 – the LGBT Health Program – where both Jillian and I now serve as directors.

Since then we have delivered training on LGBT veteran health issues to thousands of VA providers and established an LGBT Veteran Care Coordinator at every facility whose job is to train staff and address the clinical needs of LGBT veteran patients. With more than a thousand VA healthcare facilities, more than 200,000 providers, and about six million patients annually, there is always room for improvement. But I am so gratified when I heard that an older veteran cried when informed that the VA won't take away his healthcare benefits because he's gay, that a lesbian veteran came out to her doctor after seeing an LGBT poster in the clinic, or that a transgender veteran learned from our website that she can get hormones from the VA.

Attitudes about homosexuality and LGBT people have improved over 25 years. On the military side, DADT ended in 2011, allowing openly LGB service members to serve, and the ban on transgender service members ended in 2016. These social changes are a result in part of humanizing stigmatized minorities – by getting to know them and by listening to their stories. However despite advances, considerable challenges remain.

This volume by COL (ret) Elspeth Cameron (Cam) Ritchie, MAJ Joseph Wise, and CDR Bryan Pyle presents a unique, compelling set of personal stories from LGB mental health professionals in the military before DADT, during DADT, and after DADT. Clinical lessons learned are also presented. These stories honor the service of so many gay and lesbian Service members, and we should not forget their sacrifice.

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Washington, DC, USA Michael R. Kauth
Houston, TX, USA

Contents

Part III Clinical Lessons Learned

Contributors

James R. Batterson, MD, DFAPA, DFAACAP Division of Developmental and Behavioral Sciences, Children's Mercy Kansas City, Kansas City, MO, USA

UMKC School of Medicine, Kansas City, MO, USA

Katharine Bloeser, PhD, MSW Silberman School of Social Work at Hunter College, The City University of New York, New York City, NY, USA

The War Related Illness and Injury Study Center at the Washington, DC VA Medical Center, Washington, DC, USA

Martin Chin, MD Department of Psychiatry, Palliative Medicine, Sinai Hospital of Baltimore, Baltimore, MD, USA

Daniel W. Hicks, MD, DLFAPA, FAPM Georgetown University Medical Center, Washington, DC, USA

Bruce S. Hill, MD Substance Abuse Rehabilitation Program, Washington DC VA Medical Center, Washington, DC, USA

Department of Psychiatry, Georgetown University, Washington, DC, USA

Edmund G. Howe III, MD, JD Professor of Psychiatry, Professor of Medicine, Director, Ethics Programs for Medical Students, Senior Scientist, Center for the Study of Traumatic Stress (CSTS), Uniformed Services University of the Health Sciences, Bethesda, MD, USA

Monica Ormeno, DO Naval Medical Center San Diego, San Diego, CA, USA

Heliana Ramirez, PhD, MSW VA Palo Alto Health Care System, Palo Alto, CA, USA

University of California, Berkeley, CA, USA

Elspeth Cameron Ritchie, MD, MPH Chief Mental Health Community Based Outpatient Clinics, Washington, DC VA, USA

George Washington University School of Medicine, Washington, DC, USA

Howard University College of Medicine, Washington, DC, USA

Georgetown University School of Medicine, Washington, DC, USA

Uniformed Services University of the Health Sciences (USUHS), Silver Spring, MD, USA

Jackson Taylor, PhD Medical Service Corps, United States Navy, Washington, DC, USA

Clifford Trott, PhD, MPH Veterans Healthcare Administration, VA Maine, Portland, ME, USA

Steven J. Tulin, PhD Howard University Hospital, Washington, DC, USA

Joseph E. Wise, MD Medical Corps, US Army, Walter Reed National Military Medical Center, Bethesda, MD, USA

Part I

Background and Introduction

Introduction

1

Elspeth Cameron Ritchie

This volume has many points of origin. Various chapters in this volume will have their own narratives with a beginning and perhaps an end. This introduction will lay groundwork for the following chapters. On my part, I will start for now with the American Psychiatric Association meeting in San Francisco in 2013. A symposium there was titled, "Bringing the Uniform out of the Closet: Artistic and Clinical Perspectives of Gay Military Life Before and After 'Don't Ask, Don't Tell'" [1].

I was asked to speak because of my role participating in the Pentagon work group to examine the repeal of "Don't Ask, Don't Tell" (DADT). That work group was convened in 2010 to examine how and if to repeal the DADT policy. There my main contribution was pushing the DoD group to move past discussion of fears of battlefield transmission of HIV, to the positive effects of service members not having to live in fear of exposure of their sexual identity.

On that afternoon in San Francisco at the APA, we spoke of the experiences of military gay psychiatrists, in and out of the closet. It was a wonderful and moving panel. Even more dynamic were the personal stories of many participants, including COL (ret) Jim Rundell, a military psychiatrist and friend of many years.

He spoke of being an Air Force psychiatrist for a career, rising to a high rank, including being in charge of all medical issues at Landstuhl Army Medical Center in Germany. Yet, despite being accepted and admired by his medical and line colleagues, he lived in fear of being "outed." He eventually turned down the chance for a star (making General) over concerns about the necessary security clearance.

E.C. Ritchie, MD, MPH (✉)
Chief Mental Health Community Based Outpatient Clinics, Washington, DC VA, USA

George Washington University School of Medicine, Washington, DC, USA

Howard University College of Medicine, Washington, DC, USA

Georgetown University School of Medicine, Washington, DC, USA

Uniformed Services University of the Health Sciences (USUHS), Silver Spring, MD, USA
e-mail: elspethcameronritchie@gmail.com

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_1

Other participants had a range of tales of being gay in the military, some being in a welcoming and nurturing atmosphere (especially in medical settings), with others having to live in constant fear that their careers could be easily ended.

We talked afterward about doing a volume on the personal experiences of gay psychiatrists, before, during and after "Don't Ask, Don't Tell." The initial title of this volume was "Passing with Flying Colors." However, some felt that that was too incorrectly identified with African American issues. As the volume has evolved, so has the title, into the current one: *Gay Mental Healthcare Providers and Patients in the Military: Personal Experiences and Clinical Care*. The volume has also expanded to include other mental health disciplines, including social work and psychology.

One thing we as editors and authors have struggled with is that many active duty clinicians do not want to reveal publically their sexual orientation, even years after "Don't Ask, Don't Tell" has ended. They were still legitimately worried about career implications. If you are still in uniform, how much do you personally reveal?

We were similarly interested in the experiences of gay civilian providers working with the military and both gay and straight providers working with gay patients from the military community. So, the focus has broadened to include issues for treatment of both gay service members and veterans. By veterans we mean people who have served in the US military but are no longer on active duty. We also include those in the Guard and Reserve, who may go back and forth between active duty and civilian life.

Of course the strands have gone back much further than the APA symposium. Personally, I have served with many gay psychiatrists and other mental health clinicians throughout my military career. I have been troubled numerous times about the burdens they face. I have also been impressed by their resilience and professionalism despite the obstacles they faced.

One clarifying note, the first editor (myself) is not gay. Perhaps I can be called a "gay ally" or perhaps just a soldier who appreciates the contributions of my gay and transgendered comrades in arms. But as a female soldier, I do see many parallels between the struggles of women and gays to obtain recognition in the military [2]. Now the issues of transgender persons are prominent, as is covered in other chapters later is this volume.

Purpose

This volume has several purposes. It first seeks to tell some of the personal story of gay psychiatrists and other mental health clinicians in the military. The timeline is organized into sections about the bad old days ("pre-Don't Ask, Don't Tell," "DADT"), the not good days of DADT, and the maybe better but not perfect days post-DADT.

We also seek to pass on lessons learned of how to provide mental healthcare for service members and veterans who may struggle with issues about being gay in the

military, many times in addition to other traumas associated with service in war zones.

We will briefly address the various military policies across time and its effect on the mental well-being of gay individuals who have or are currently serving. Finally, we hope to translate lessons learned in the military for transgendered service members and veterans.

Background

Gay service members have long been an important part of our nation's military. They were closeted for many years, subject to harassment, bullying, and involuntary separation. Prior to 1993, when "Don't Ask, Don't Tell" was implemented, they could be involuntary separated simply for being homosexual.

After the "Don't Ask, Don't Tell" policy was implemented, life was supposed to get better, but in many cases it did not. Thousands of service members were involuntarily separated under this policy.

"Don't Ask, Don't Tell" was repealed in 2011. In recent years, gays have been officially accepted in the military, with allowance of same sex marriages and partner benefits provided. However considerable stigma still remains. The legal issues related to homosexuality in the military are an important part of the overall narrative but will not be the focus of this volume [3]. Please see this link for a summary of the legal issues [3].

The Early Years

Another important part of the story relates to the AIDs epidemic. In the late 1980s, all service members were screened for HIV, then known as HTLV *human T-cell lymphotropic virus*. (I will use the term HIV here for consistency, rather than the older term.) In 1985, a gay soldier hung himself in the stairwell of the old hospital of Walter Reed, after having been found in bed with another man. The command at Walter Reed decreed that there should be no more suicides.

Shortly thereafter (in 1986) the screening of all troops for HIV began, across the Army [4]. If they tested positive, they were informed by their company commander, uprooted from their military and other support systems, and put on a plane to a major medical center for further testing. Plane loads of just-diagnosed Soldiers arrived at Water Reed Army Medical Center several times a week. They were scared, both of having tested positive for the disease and being outed for being homosexual. Back then, of course, AIDS was considered a death sentence.

Part of my job as a third-year psychiatry resident was to screen them on arrival (often in the wee hours at about 2 AM) for suicidal ideation. It was a challenge to "screen" seven individuals at that hour, for the effects that a diagnosis of presumptive AIDs had on them, and whether they were suicidal.

The soldiers stayed on Ward 52 at Walter Reed Army Medical Center. Ward 52 was actually a very warm and welcoming place for them. Psychiatrists were assigned to the ward, including Dr. Dan Hicks and Rob Stasko. The chapter by Dr. Dan Hicks and Dr. Steve Tulin covers Ward 52 in more detail.

My first research project was a survey of these newly diagnosed individuals and what were their stress and support systems. Unsurprisingly those from conservative Hispanic backgrounds had the greatest stigma [5].

Other pivotal experiences for me included a deployment to Somalia in support of Operation Restore Hope in early 1993. I went with the 528th Combat Stress Control detachment, out of Fort Bragg. There were four psychiatrists on the mission, two were gay. When DADT was announced, it precipitated a homophobic wave on the sands of Mogadishu. My fellow psychiatrists were scared, but nothing serious happened to them. In other Army bases, gays were not so lucky. There were many episodes of hazing and some murders.

Recent Years

The United States has been at war since September 11, 2001, first in Afghanistan, then Iraq, and now still in Afghanistan. Approximately 2.7 million service members have been deployed to the theater of war. This prolonged war, the longest in our country's history, has brought to the forefront the mental health consequences of combat and warfare.

Alongside the other troops, gay military mental health workers—psychiatrists, psychologists, social workers, occupational therapists, and others—delivered mental healthcare and combat stress control principles throughout the theaters of war. These include, of course, Iraq and Afghanistan as well as humanitarian efforts after natural disasters. Recent efforts include West Africa during the Ebola virus.

Mental health clinicians have been treating service members for the psychological consequences associated with their experiences in battle, including killing enemy combatants, seeing wounded and killed civilian casualties, losing their friends in combat, and potentially dealing with their own physical injuries from being shot or blown up.

Compounding the battlefield stressors has been home front issues. Unlike earlier wars, most soldiers are married and have children. With a world that is globally connected through the Internet and cell phones, the news of problems back home is not shielded from the soldier on the front lines. Common ones include spouses wanting a divorce, children struggling in school, financial difficulties, and parents with health problems.

For gay members the stresses were both the same and different. They have pretended they were in heterosexual relationships, because of worries about being outed. The early chapters in this book will provide more personal accounts of these issues.

Conclusion

The focus in this book initially will be on the personal stories of gay-uniformed providers who have served throughout the last 30 years. Clinical and policy issues for active duty service members will follow.

There are many providers who have worked with gay veterans. Veterans have the advantage of not having to conceal the sexual orientation and can openly concentrate on both routine mental health issues and sexual identity matters.

The volume also offers clinical advice to military and civilian clinicians working with gay military and veterans on how and what to ask and how treatment may be affected by sexual orientation.

This book will highlight lessons learned and survival strategies for gay mental health providers not only deploying in support of US military operations but to any austere and dangerous environment for a prolonged period of time. Lessons learned will be relevant for the transgendered service members and veterans.

What is striking is the resilience of the gay men and women who have served in the US military. Despite all the obstacles contained in the accounts herein, they have performed heroically.

It is not a perfect, or comprehensive, volume. Good research data is sorely lacking. Many of the chapters are anecdotal. Some potential authors felt they could not expose themselves and their sexuality in such a public forum. We hope to draw a "line in the sand," setting forth what we do know and asking for further exploration of the topic.

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Risk and Resilience: A Review of the Health Literature of Veterans Who Identify as LGBT

2

Heliana Ramirez and Katharine Bloeser

LGBT people have served in the US military since its inception; however anti-LGBT military service bans, including gay-related investigations and discharges, rendered this population all but invisible [1]. Despite policies prohibiting their service, LGBT people served in every branch during every war era and received accolades and commendations for their bravery, leadership, and sacrifice [2–4]. Contrary to the rationale of anti-LGBT military policies, claiming that LGBT people undermine unit cohesion and are a security threat if blackmailed by the enemy [5], LGBT people make major contributions to the military. These include performing their regular duties as well as the production of lifesaving maps and camouflage, uplifting troop morale through soldier's shows, critical intelligence work such as language translation, and in special operations units like the Navy SEALs [2, 4, 6, 7].

The nascent state of social science literature limits our understanding of LGBT service members and veterans in terms of the total population size and diversity of this population (e.g., race/ethnicity, military service branch, socioeconomic status, and religion/spirituality). Additionally, the existing literature on LGBT service members and veterans is largely dedicated to struggle. The literature often focuses on problems and does not examine resilience and successful coping, which this chapter will highlight.

H. Ramirez, PhD, MSW (✉)
VA Palo Alto Health Care System, Palo Alto, CA, USA

University of California, Berkeley, CA, USA
e-mail: heliana.ramirez@va.gov

K. Bloeser, PhD, MSW
Silberman School of Social Work at Hunter College, The City University of New York, New York City, NY, USA

The War Related Illness and Injury Study Center at the Washington, DC VA Medical Center, Washington, DC, USA

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_2

In a review of LGBT literature Savin-Williams (2008) describes an "irresistible and overpowering attention to the problematic nature of same-sex oriented populations, rather than a focus on their capacities to adjust, thrive, and lead exceptionally ordinary lives" ([8], p.137). The tremendous strength and resilience we have seen in our clinical work with LGBT service members and veterans are not immediately evident in the literature. Most research is focused on disproportionately high rates of medical and mental health challenges and discriminatory experiences (e.g., gay-related military investigations and discharges, military sexual trauma, posttraumatic stress disorder, and suicide).

We do not deny the gravity or power of the existing research. Many of these influential papers describe the painful consequences of oppression and discrimination resulting from anti-LGBT military policies. This is critical to our understanding of the challenges for which LGBT service members and veterans seek clinical care and the resilience that bolsters their healing. For clinicians aspiring to provide strength-based practice, the paucity of discussion on LGBT service members and veterans' strengths and resiliencies poses unique challenges [9, 10].

This chapter explores both risk and resilience in LGBT veteran populations beginning with the decision to serve. Next, we discuss life under anti-LGBT policies and the consequences of these policies, in the form of health disparities. We examine the historical and theoretical context in which these consequences can be viewed. Finally, we define a resilience lens and illustrate examples of resilience in response to anti-LGBT military policies. First, we present a brief comment on terminology.

Terms, Definitions, and Their Limitations

While we use the acronym LGBT throughout this chapter, human experience often defies labeling. For example, the labels gay, lesbian, and bisexual assume that gender is binary—either male or female. This male/female dichotomy erases the experiences of people who are androgynous or otherwise outside of the gender binary [11]. The term transgender includes a variety of people whose gender is different from the gender assigned them at birth, including people who make permanent changes to their bodies (e.g., through hormone therapy and gender confirmation surgeries). This term also includes people who do not alter their bodies but rather express their gender identity through clothing, name changes, etc. The term transgender is also limiting in that it does not include other gender minorities like people who are intersex, those born with atypical anatomy and/or chromosomes.

Additionally, some cultures use terms other than LGBT, such as "Two Spirit" in Native American communities and "Down Low" in African-American communities [12]. Finally, terms like LGBT do not capture the same-sex behaviors of people who identify as heterosexual, reminding us that sexual orientation refers to a self-ascribed identity only, not necessarily sexual behaviors, fantasies, or romantic relationships.

We are learning from people who are outside of current labels that gender and sexuality exist on a spectrum. Sexual behaviors change over lifetimes and in certain

situations. People hold romantic love for those of their same gender at different times in their lives. People may at times cross dress but not identify as transgender. Thus, definitions can limit research as labels reduce the richness of the human experience to definable behaviors [13]. Responding to the need for inclusive definitions, this chapter uses the term sexual and gender minority and reverts to LGBT when describing specific research literature that uses this nomenclature.

The Decision to Serve

LGBT people enlist in a work environment that prohibits their participation at rates higher than heterosexual people for a variety of reasons [14, 15]. LGBT service members join the military for reasons common to heterosexual service members, such as patriotism, following in the footsteps of previous generations of family members, to meet new people, international travel, to get away from home, and increase educational opportunities [3, 16]. While some sexual minority veterans knew their sexual orientations prior to the military, many did not realize they were gay, lesbian, or bisexual when enlisting. Others joined the military as a means of escape from their LGBT identity, violence at home or in the community, or from societal expectations. Despite the reason to join the military, LGBT service members' identity development may have been a powerful part of their service.

In the article "Veterans Speak Out: A Collection of Essays from the Documenting Courage Project," Nick Marulli retired Petty Officer First Class, US Navy (active duty 1977–1997), explains "I enlisted in the Navy right out of high school. As a son in a military family, it was the natural thing to do" and began to accept his "homosexuality on my last tour" ([17], p. 481).

Marulli continues stating:

> Those years were difficult. I couldn't seek counseling because I had to use military medical facilities and I didn't know who I could trust. Before I retired, my best friend- an army officer who was also struggling to accept his homosexuality- committed suicide. I had to cope with the pain alone, in silence, lest I risk being discovered myself. After all I had given to the Navy, living in fear of losing my career or my pension seemed like an unjust reward.

For some people, joining the military may be a "flight into hyper-masculinity" [18] they attempt to join the ranks of society's arguably most masculine group as a means of proving that they are not gay or transgender. Service members may also be asserting that gay men can be masculine or join as a way to escape questions about their gender identity and/or their desire to transition from the gender assigned to them at birth [3, 19–22]. McDuffie and Brown suggest that some transgender women enlist in the military as an attempt to "purge the desire to become feminine by enlisting in an organization that rewards and cultivates exaggerated masculine behaviors: high risk taking, stoicism, controlled violence, heterosexuality, athletic prowess, and contempt for physical/emotional weakness" ([22], p. 23). The authors note that formative stages of transgender identity development surface at the age of typical military enlistment [22].

Brown describes the premilitary experience of one transgender woman veteran in the following case study:

> L.B., a 37 year-old, single Caucasian, biological male…showed an interest in cross-gender activities throughout childhood, including doll play and extensive non-fetishistic cross-dressing behavior at age 6. He was the object of ridicule by boys his age, especially when he wore unisex clothes to school. Adolescence was particularly tumultuous and after graduating high school, he enlisted in the Air Force. He believed basic training 'would make a man out of me' and 'make my [adoptive] father proud of me.' [18]

Leonard Matlovich, an Air Force sergeant who received a Purple Heart, explained his choice to enlist as a gay man as trying "to prove that I was just as masculine as the next man. I felt Vietnam would do this for me" ([3], p. 185).

Escape also took the form of freedom from society's traditional norms. For lesbian women, the military provided a career that deflected questions about marriage and children, while offering access to career opportunities unavailable to women in civilian society [23]. For example, from 1954 to 1978, the Women's Auxiliary Corps headquarters at Fort McClellan, Alabama, had "an entirely female chain of command" ([23], p. 130–131).

A transgender man in the film *The Camouflage Closet* [24] states he joined the military prior to his gender transition because "wearing boots and pants to work was a lot better than heels and stockings." For yet another group of LGBT people, enlisting under LGBT bans was the next civil rights frontier in the US military.

Sinclair states that:

> Many homosexual men and women have [entered the military] in order to justify their existence and demonstrate that they are worthy of the same rights as others. Just as women and African Americans eventually earned their status as equal members of society and proved their worthiness to serve in the military, homosexuals are now trying to achieve the same. ([16], p. 14)

Regardless of reasons for enlistment, military service affected the sexual and gender minority identity development processes for service members who had no contact with similar people, at times causing identity foreclosure [1, 3, 5]. In a study of 208 online lesbian, gay, and bisexual respondents, Sinclair [16] examined Cass' six stages of LGB identity development (Table 2.1) and career orientation, finding respondents represented in all six stages of identity development, with the majority (60.9%) being in stages 1, 2, and 6. Sinclair states that people in stages 4 and 5 "(acceptance & pride) are the most closely connected to a homosexual identity and thus are most likely to choose a community-centered preference", versus a military career that would have required concealment of their LGBT identity ([16], p. 82). Additionally, 75% of respondents said anti-LGBT military policy "influenced how they conduct(ed) themselves while in the military" ([16], p. 75).

Table 2.1 Cass' six stages of lesbian, gay, and bisexual identity development

Stage 1: Identity confusion Begins with the person's first awareness of their sexual orientation	Task: *Who am I?* Accept, deny, or reject this identity
Stage 2: Identity comparison The realization that identification as lesbian, gay, or bisexual may result in feeling alienated from others who are not gay	Task: *How will I cope with this feeling of isolation?*
Stage 3: Identity tolerance The individual seeks out other people who identify as lesbian, gay, or bisexual but maintains two separate identities or images	Task: *How do I find people who are like me? How do I cope with heterosexism?*
Stage 4: Identity acceptance The individual begins to share their sexual orientation with others	Task: *How do I bring my public and private self together?*
Stage 5: Identity pride The person feels anger and pride which may be channeled into activism	Task: *How do I contend with the anger I feel about heterosexism?*
Stage 6: Identity synthesis The individual moves away from a dichotomous	Task: *How is my sexual orientation one part of my identity?*

Data from Cass [25]

Life Under Anti-LGBT Policies

The decision to serve brought with it tremendous risk including fear of harassment and violence and investigation and discharge. It is noted throughout this text that service as a sexual and/or gender minority meant added stress in an already stressful occupation. At the same time, resilience was still present in the ways LGBT service members persisted and often times thrived.

In an online survey of 445 LGBT veterans, Moradi reports the majority were "generally satisfied with their military service" and had "moderately high levels of active sexual orientation concealment" and "low levels of sexual orientation disclosure" ([26], p. 521). Respondents reported that within their military units, there were "moderately low levels of sexual-orientation harassment" ([26], p. 521). At worst, LGBT military personnel worked in environments wrought with isolation and harassment including anti-LGBT marching calls, "blanket parties," undercover agents at gay bars, blackmail, military sexual trauma, and witch hunts [3, 5, 23, 27, 28].

Lack of privacy in the military caused unique stress for LGBT service members. Those on active duty worried about their LGBT identity being discovered in "things as mundane as phone calls and personal mail (which can be tapped or opened in the military, depending on the circumstances, as well as simply being accidentally overheard or found)" in addition to breaches of confidentiality by military mental health practitioners or chaplains ([1], p. 217).

Further, LGBT veterans describe stress about the military finding personal materials like photos of family or friends, gay-related literature, periodicals or pornography, or gender discordant clothing like undergarments in surprise searches of the barracks. LGBT veterans also tell of fears of being seen while entering LGBT-related spaces like bars or parties [3, 24]. The fear of being discovered as LGBT is described as causing "a great deal of paranoia and stress around having to keep quiet about being gay" ([1], p. 219). Another veteran explained, "It's a slippery slope. Once one person finds out that you don't trust, you're done. So there goes all your mental security and safety and sanity until you either change duty stations or get out" ([1], p. 219).

This fear of being discovered as LGBT was well founded. The Servicemembers Legal Defense Network reports that over 14,000 service members were discharged under DADT between 1994 and 2011 [29]. In an online survey of 445 LGBT veterans, 36% were investigated for their sexual orientation, 15% were reported isolation due to sexual orientation, 11% were forced to participate in a psychiatric evaluation related to their sexual orientation, and 2% were incarcerated for their sexual orientation. Additionally, 16% ($N = 71$) received gay-related discharges, which made them "more likely to avoid Veterans Administration Services due to their perception of how they would be treated" [26].

Some LGBT service members accessed civilian healthcare due to a lack of confidentiality required of military healthcare providers under anti-LGBT policies [30, 31]. In a study of 11 active duty US Navy sailors seeking treatment at a community-based Gay Men's Health Clinic in San Diego, Smith reports that each of these patients expressed fears of being discharged as the reason for seeking care outside of the military [30]. Also highlighted were unique concerns about military patients transferred to new duty stations being lost to clinical follow-up by community-based clinics. Due to the transient nature of military populations, leaving a safer space like San Diego may mean that a service member also left access to needed medical care. These strategies highlight the desire to serve despite this tremendous risk. This risk associated with LGBT identity intersected with race, class, and gender.

Diversity Among Military Service Members

Race, class, and gender differently affected LGBT SGM's military experiences. For example, service members of color and women often socialized and had sex in different places than white gay men who had the financial resources and social ability to frequent a variety of hotels and bars during World War II. People of color were relegated to segregated bars, and women, who could not afford hotels, had sex in semipublic spaces on military bases like closets [2]. Additionally, in the 1980s and 1990s, people with more financial resources had greater freedom to move off base where there was less surveillance of their daily lives. Having a car enabled service members to travel between community-based housing and the military base. White gay men who passed as heterosexual (i.e., masculine appearance and demeanor)

enabled career mobility not available to people of color and effeminate gay men (Ramirez, *in-production*).

Investigations also resulted in women accused of being lesbian losing custody of their children to grandparents so they would not be raised by women deemed to be socially and moral unfit [23]. In summary, these experiences and clinical needs are affected by diverse experiences including sexual health, problems related to trauma, parenting, race, and gender.

Military and Veteran Families

The effects of policies like DADT extended to LGBT service members' families. Wescott and Sawyer's analysis of interviews with lesbian, gay, and bisexual veterans highlights how these policies created barriers to access for medical benefits, pay and housing allowances, and survivors benefits for thousands of military families [32]. Reporting minor dependents and spouses in the Defense Enrollment Eligibility Reporting System (DEERS), which is required to access military benefits such as the TRICARE medical system, could have violated DADT if the spouse was of the same sex or if children were being raised by a same-sex spouse. Similarly, LGBT families were often not even notified when an LGBT service member passed because they were not enrolled in the Emergency Reporting System [31, 32].

The authors also discuss the impacts of DOMA and DADT as having "forced a choice between [the] military career and family" ([31, 32], p. 1132), such as for both Army Staff Sergeant Jeffrey Schmalz and Army Lieutenant Colonel Peggy Laneri, who chose early military retirement for legal marriage to their same-sex spouses in Massachusetts. Additionally, the impact of DADT on children is discussed in terms of Air Force Major Scott Hines' four children who received differential access to military and veteran benefits based on the gender of their other parent [31, 32]. Hines' children from a former marriage to a woman received military identification cards, medical care, and were eligible for survivor's benefits, while the two children adopted by Hines and his same-sex partner did not receive these benefits.

Research on the Health and Mental Health of Sexual and Gender Minority Veterans

The literature on service members and veterans who identify as sexual and gender minorities is in an emergent state. Over the past decade, researchers consistently report health disparities in this population. Several studies compared sexual and gender minority veterans to heterosexual and cisgender (i.e., people who are not transgender) veteran populations, reporting a higher prevalence of mental health concerns among LGBT veterans. When compared to women veterans who identify as heterosexual, lesbian and bisexual women have higher odds of reporting poor physical health [33]. Identification as lesbian or bisexual is also associated with

higher odds of intimate partner violence among women veterans who are enrolled in the VA [34]. Lesbian and bisexual veterans are also more likely to report physical violence as civilians and while in the military, depression, PTSD, and alcohol misuse [35]. Mattocks and colleagues report lesbian and bisexual women veterans are more likely to have survived childhood sexual abuse than heterosexual women veterans [36]. These women are also more likely to report negative mental health after deployment. Sexual assault is disproportionately associated with lesbian and bisexual identity at all periods of life (e.g., prior to, during, and after the military) as 73% of the lesbian and bisexual veteran respondents reported a lifetime history of rape as compared to 48% of heterosexual women veterans [37].

Sexual and gender minority veterans are twice as likely to report smoking as heterosexual veterans [38], and sexual minority status among veterans is significantly associated with suicidal ideation [39]. Among veterans diagnosed with gender identity disorder (GID), research found the rate of suicide attempts, gestures, and/or plans is 20 times that of the general VA patient population [19]. Veterans who use VA and have a diagnosis of GID or gender dysphoria report higher rates of depression and PTSD [22, 40]. In addition, 80% of transgender veterans reported a history of homelessness and incarceration in comparison to 65% of veterans who were not identified as transgender [40].

Historical Significance of the Minority Stress Model

This research suggests sexual and gender minority veterans are disproportionately diagnosed with mental illness. There is a theoretical causative mechanism behind this disproportionality that is important to explore given the past context of research with sexual and gender minorities in general. Historically, gender identity and sexual orientations that differed from the *norm* were pathologized.

Until 1973, homosexuality was considered a disorder in the *Diagnostic and Statistical Manual* (DSM; [41]). Some would argue that the inclusion of gender identity disorder (GID) in the 1980s was a way of labeling behavior inconsistent with the gender binary norm as deviant [41, 42]. Perceiving sexual and gender diversity as perverse and pathological is detrimental in numerous ways, and it has been disproven [12, 43–45].

The minority stress model identifies factors associated with risk for and buffering from mental distress among LGBT individuals [44–46]. While developed for lesbian, gay, and bisexual people, the framework has been applied to transgender people as well [47]. Minority stress is the cumulative effect of stress on stigmatized populations resulting from prejudice and discrimination and the stress of daily life we all face. Experiences of violence and discrimination perceived as related to one's identity, internalized homophobic attitudes, and perceptions of stigma combine with everyday stressors, resulting in higher rates of mental distress [45, 46, 48]. In one study of lesbian, gay, and bisexual veterans, discrimination based on sexual orientation in the military was associated with disparities in the diagnoses of PTSD and depression. These conditions were exacerbated by higher levels of concealment of sexual orientation [49].

Person *and* Environment: Resilience Among Service Members and Veterans

The existing literature about sexual and gender minority people rarely highlights the vast majority who do not have clinically significant mental health challenges [50–53]. That most sexual and gender minority people do not struggle with mental illness, in spite of the systemic discrimination they face at both institutional and individual levels, suggests significant resilience among these individuals and communities [8, 54, 55].

The study of resilience has its roots in child psychology and stress theory and has increasingly been explored in LGBT populations [56]. Resilience in LGBT populations is often discussed in tandem with the minority stress model [45, 53, 57–61].

Meyer states that LGBT resilience should be conceptualized in terms of individual resilience and community resilience (e.g., resources provided by the community that help individuals cope, such as role models). Meyer warns that a sole focus on individual resilience reflects Western-centric values of meritocracy and individualism. A focus on individual resilience can result in an attitude of victim blaming instead of acknowledging how "social disadvantages limit individual resilience" ([62], p.211).

Individual or personal resilience includes self-acceptance, self-esteem, the "ability to accept and process emotions in an insightful manner," hope, and optimism ([58], p. 372). Kwon describes community level resilience as social support that provides individuals with "greater self-worth, security, meaning...positive role models…a sense of belonging…lowers reactivity to prejudice…[and] affirms people's sexual orientation" ([58], p. 372).

While various definitions of resilience have been used in relation to people who identify as sexual and gender minorities, common to most is the concept that resilience is not an inherent trait but rather a process of developing protective factors that change over time. These then enable a person (or community) to *bounce back* after a traumatic or stressful event [63]. In this way resilience is similar to coping in that both are responses to stressors; however they diverge as resilience is time specific to *bouncing back* following a stressful event, whereas coping is enacted when one is faced with a stressor [52, 62]. Resilience is also described as *stress buffering* as it refers to a process that mediates the health effects of minority stress [55].

The disease- and problem-oriented slant of the current health literature leaves practitioners ill equipped to provide strength-based and evidence-informed practice [64, 65]. The disease/problem approach also reinforces the historical pathologization of sexual and gender minority people [66] and healthcare providers' often subconscious anti-LGBT stereotypes. For example, high rates of HIV can be described in ways that reinforce stereotypes of promiscuity among gay and bisexual men. In addition it may be assumed that because LGBT service members actively concealed their identity, they must not have LGBT pride [23, 67]. Typically the disease/problem approach focuses on individual level behavioral change but does not address the structural factors known to be associated with health disparities.

One example is evidence that experiences of discrimination result in fewer preventative health screenings [64]. Conversely, "learning how [LGBT people's] strengths evolve could improve prevention efforts by capitalizing on the skills that already exist" among LGBT people ([63], p. 3). This is coupled with the expectation that developing and reinforcing resiliency rather than changing specific individual behaviors are more likely to result in long-term reduction of discrimination-related health disparities.

Here we can look at literature showing the correlation between HIV risk and levels of experienced discrimination. Learning how to properly use a condom may not be enough to prevent risky sexual behavior because these behaviors are linked to larger systemic issues like poverty and homophobia [68]. Additionally, since "deficit-based approaches can help us diagnose what is wrong, but not how to fix it," researchers should "intentionally look for potential pathways to resilience, [because] they may find crucial variables that cannot be derived from exclusively deficit-based models" ([63], p. 4).

Another area of divergent opinions in the LGBT resilience literature is in relation to the effects of multiple types of discrimination toward people who have more than one marginalized identity. For example, what might be the lived experience of sexual and gender minority people of color or those living with a disability? The question researchers ask is whether or not additive stress makes one more at risk or more resilient. In recent years multiple sources of stress, such as homophobia, racism, and sexism, have been conceptualized as additive such that people with multiple marginalized identities face more stressors and are thus expected to have worse mental and physical health outcomes. This theory has been disproven in studies where LGBT people of color were found to have similar mental health as white LGBT people [69, 70].

Importantly, Meyer has asserted that the theories of resilience and minority stress are antithetical to one another as minority stress anticipates an increase in negative health outcomes with rising levels of minority stress while resilience defies minority stress in studies where LGBT people of color have the same rates of mental health challenges as white LGBT people, even though they face two minority stressors [12].

Contrary to the theory of additive stress is the concept of *steeling* which posits that occasional experiences of surviving and bouncing back from significant stressors create a sense of mastery and competence. This is developed through one's ability to cope with stress thus making us better equipped to handle the next major life stressor [71]. The theory of steeling and the related theory of stress inoculation help explain why African-American sexual and gender minority people, while experiencing racism in addition to homophobia, do not have worse health outcomes than white people [12]. One study demonstrated that socialization in a racist society prepared black lesbians to face heterosexism [72]. For many individuals, a sense of belonging in communities attenuates the effects of rejection from family members [73]. In a study of women who identify as lesbian or bisexual women of color, African American, Hispanic/Latina, and Asian American reported lower LGBT community connectedness but higher collective self-esteem than white lesbian and bisexual women [74].

Coupled with resilience is the notion of posttraumatic growth (PTSG). Posttraumatic growth was developed to explain the phenomenon of spiritual or existential growth and/or flourishing following traumatic events [75]. This is not a rare occurrence that is separate from PTSD. In one study, 72% of veterans who met criteria for PTSD also reported PTSG [76]. In the literature on sexual and gender minorities, the concept of stress-related growth has emerged. Research has linked stress-related growth to positive health and mental health outcomes including reduced internalized homophobia and strong sexual identity [77]. This concept must not focus solely on the resolve of the individual but must also take into account the structural and institutional barriers that inflict pain and stress [78].

Resilience Under DADT

While the authors of this chapter identified only one article examining resilience among sexual and gender minority military and veteran populations, analysis of this phenomenon is important [10]. One of the key aspects of resilience is the role of social, familial, and community support [58]. One of the greatest stressors inherent to anti-LGBT culture is the prevention of social and community support. For many sexual and gender minority people who served prior to the repeals of DADT and the transgender military ban, anti-LGBT military policies prevented them from identifying themselves and other sexual and gender minority people in the service. This removed a major source of potential support.

This support was replaced instead with a systematic source of stress in the form of LGBT-related investigations and discharges commonly known as *witch hunts* [23]. Given that 80% of DADT-related discharges were instigated by a service member being forced to incriminate LGBT friends and lovers, the LGBT-related investigation tactics turned potential sources of resilience (i.e., LGBT peers) into sources of risk [23].

For LGBT service members, social support was largely limited to underground networks [4]. LGBT identity is "especially important in the area of resilience…because so much of the community resilience social support depends on people affiliating with their sexual orientation and gender identity groups" ([62], p. 210). For LGBT military service members, access to LGBT-affirming social support ranged from virtually no support to hidden support. Service members worked and lived in a violently homophobic environment where LGBT people are at times sexually assaulted [67]. Some service members were killed by colleagues such as Private First Class Barry Winchell who was murdered while asleep on base (see *Soldier's Girl* film by Pierson, 2003). Despite this threat, social support for some developed and thrived in underground LGBT military communities like the Coalition of Gay Service People (CGS; [23]).

The existing literature largely does not address what helped sexual and gender minority veterans survive and at times flourish in this hostile environment. A handful of military-specific strengths have been identified in first-person narratives. In terms of factors related to resilience, a review of personal narratives in social science literature and film [10] identified five strength-based strategies LGBT service

members use "to manage a hetero- and gender-normative military culture" (p. 10): co-optation or queering of the military, tactical use of the closet to manage oppression, creation of underground military networks, the use of humor and camp, and becoming engaged activists fighting publicly for their rights. Our review of the literature also identified coping strategies to manage anti-LGBT interpersonal and institutional barriers.

LGBT service members employed a wide variety of strategies to maintain secrecy of their sexual orientations and gender identities. These included the creation of fictitious stateside relationships with opposite gender partners, feigned interest in opposite sex people in public, and wearing uniforms that did not correlate with their internal sense of gender [4, 5, 23, 79]. LGBT veterans' descriptions of their military service often included communicating with same-sex partners in code whether by phone, email, or letters [3]. Additionally, some LGBT service members also changed one letter of the name of their spouse to appear an opposite-gendered partner in mandatory military-dependent reporting systems [32]. LGBT service members described the opportunity to frequent LGBT-related spaces during their service that were not available or accessible at home [3]. Many reported traveling long distances to access LGBT social spaces or healthcare services, far from base [23]. Finally, LGBT veterans, organized across LGBT subgroups in bar raids by having two lesbians and two gay men at a table, pretend to be women on dates with men, instead of each other [3]. This resistance in the face of tremendous risk shows how LGBT veterans epitomize the concept of resilience.

Conclusion

The literature on sexual and gender minority service members and veterans and their service is growing rapidly. We have learned much about the struggle facing sexual and gender minorities in the service and look forward to learning about the diversity and strengths of this population. We can take care to be mindful of disparities in access to care as well as diagnoses within populations of sexual and gender minority veterans especially mental health conditions like PTSD and depression. With posttraumatic stress however, there is posttraumatic growth. Given this history, how do we integrate resilience and the need for adequate, responsive, and culturally competent care to sexual and gender minority service members, veterans, and their families? If we were to follow a client or patient through the doors of our clinical space, what would they hear? What would they see? How would their perceptions of our facilities and clinical interactions affect their health outcomes?

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"I Can Finally Be Me…Why Did It Take So Long?" A History of US Military Policy Regarding Sexual and Gender Minority Service

3

Andrew's Story

It had been "one of those days" – one where I found myself accidentally double-booked with patients, all of whom were in newly found crises. By noon, I swore that I could feel the heat through my boots from all of the metaphorical brushfires I had stamped out. As I walked my last patient to the front desk and made a beeline to the galley, hypoglycemia and exhaustion were starting to give way to delirium. So when I smacked directly into Petty Officer L.V., I was just happy I didn't knock her completely to the ground.

Petty Officer L.V. (not her real initials) was the first transgender service member my team had treated. She had finally felt comfortable "coming out" shortly after Secretary of Defense Ash Carter's 28 July 2015 memorandum that effectively banned the administrative separation of service members based on their gender identity [1]. *In the year that followed, my team and I worked with her extensively to treat her gender dysphoria at that bizarre time where we could acknowledge her identity but could do little else. Indeed, we likely learned more from her than we could have ever done for her over those twelve months.*

Although she was a bit shaken from my hunger-induced body check, the smile never left her face as she clutched tightly to her copy of Department of Defense Instruction (DODINST) 1300.28 – "In-Service Transition for Transgender Service Members" [2]. *After accepting my mumbled apology, she excitedly handed me the stack of papers. "It's here, Doc! We're finally here! I can finally be me! I guess the only thing that bothers me is the question I always ask you…why did it take so long?" We set up an appointment for the next week to discuss the future directions of her treatment after I had an opportunity to read through the instruction. It wasn't until after lunch as I was flipping through the sheets, their edges crumpled by her hope-filled clutching, that I realized that she and I had the same exact question – why* ***did*** *it take so long?*

With the introduction of open transgender military service in the United States, we look back at the history of both the participation by and regulation of LGBT service members in America. In doing so, we hope to trace the path that led to the end of transgender service prohibition through DODINST 1300.28. We conclude with a brief discussion of this instruction to help military mental health providers going forward.

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_3

Revolutionary War to Operation Desert Storm (1775–1992)

The first Army Judge Advocate General Corps Archivist and Historian, Fred Borch, posited that American culture's strong Judeo-Christian roots permeated through its military since its inception, particularly regarding concepts of appropriate and/or moral behavior [3]. Citing scripture passages used throughout history to prohibit any deviance from heterosexual monogamy – including *Leviticus* 18:22 [4] and I *Corinthians* 6:9 [5] – Borch argues that American society, and, therefore, American military culture, "has been anti-homosexual and anti-bisexual for most of history" [3]. This sentiment has been shared by other military scholars [6].

Nevertheless, sexual and gender minority service members have defended the United States since the formation of the country. In his final book before his death, the late journalist Randy Shilts chronicled the history of LGBT service members in the United States. He noted that Baron von Steuben, who was integral to the United States' victory in the Revolutionary War, was only convinced to join the Continental Army after persistent rumors regarding his homosexuality destroyed his credibility among the European Gentry [7]. Although Steuben is widely credited with turning the tide of the Revolutionary War and served without impediment, homosexuality remained prohibited in the Continental Army. Indeed, the first court-martial for homosexuality in America occurred shortly after Steuben's arrival. Shilts told the story of Lieutenant Gotthold Enslin, who was accused of engaging sodomy with a Continental Army soldier in 1778:

> *…on March 10, [Lieutenant Colonel Aaron] Burr presided over Enslin's court-martial, in which the lieutenant was found guilty of sodomy and perjury… According to General Washington's general order of March 14, Enslin was '…to be dismiss'd with Infamy. His Excellency the Commander in Chief approves the sentence and with Abhorrence and Detestation of such Infamous Crimes orders Lieutt. Enslin to be drummed out of the Camp tomorrow morning by all the Drummers and Fifers in the Army never to return.…* [7]

Honorable military service rendered by LGBT Americans continued after the Revolutionary War, and it is believed that LGBT service members have participated in every American military conflict since [3, 7–9]. Shilts and Sinclair both document gay soldiers serving alongside Custer during the so-called American Indian Wars and gay sailors and naval officers during the Civil War [7, 8]. Furthermore, primary source documents from the late nineteenth-century record male sailors cross-dressing multiple times during a deployment. Notably, the historian who examined these documents reported that these descriptions were written "without irony or explication…" [9] Although this appears to give the impression of tacit approval of sexual and gender minorities, scholars also document multiple discharges of American service members for these deviations from heterosexual and cis-gendered norms [3, 7, 8]. Nevertheless, there were no specific regulations governing homosexuality or gender identity until after the First World War with the codified prohibition of sodomy added to the Articles of War (AW) in 1920 [10]. Borch notes that until this time, LGBT service members were charged under Article 62, the *General Article* in the AW, for crimes including sodomy [3].

It was also during this interwar period in the United States that a newly introduced branch of medicine, psychiatry, had a significant impact on how the country and the military viewed homosexuality and transgender identity. As the field of psychiatry developed in the early twentieth century, its leaders considered homosexuality and gender-nonconforming identity to be signs of severe psychopathology – including their inclusion under the heading ***Sociopathic Personality Disturbance*** in the first *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published in 1952:

> ***Sociopathic Personality Disturbance*** *– Individuals to be placed in this category are ill primarily in terms of society and conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals. However, sociopathic reactions are very often symptomatic of severe underlying personality disorder, neurosis, or psychosis, or occur as the result of organic brain injury or disease…*
>
> *…*
>
> ***Sexual Deviation – This diagnosis is reserved for deviant sexuality which is not symptomatic of more extensive syndromes, such as schizophrenic and obsessional reactions… The diagnosis will specify the type of pathologic behavior, such as*** *homosexuality, transvestism, pedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation).* [11]

Although the first DSM was not published until after World War II, psychiatry's influence on the military's belief that homosexuality (in particular) represented a mental illness that was unfitting for military service is evident as early as 1923, when it was included in the Army's accessions manual as a "sexual pathology" and barred homosexual men from service [3]. Borch notes that this classification as psychopathology was also integrated into the Army's separations manual, which "gave commanders the basis to administratively discharge gay men who had already enlisted…" [3] Indeed, historians estimate that over 5000 service members were discharged during World War II for homosexuality, either via court-martial or administrative separation without honor [3, 12]. Further legitimacy was lent to the notion that homosexuality was a treatable medical illness with the development of a multi-tiered classification of homosexuality [3, 7–9, 12]. In this system, those placed lowest tier – having homosexual without having "confirmed" homosexual acts – could be treated and "reclaimed" in service or honorably discharged [3, 12].

In the decades that followed World War II, public opinion and medical science regarding homosexuality shifted away from it being rooted in sociopathy. This is reflected in the American Psychiatric Association's decision to replace homosexuality with "sexual orientation disorder" in the 1973 update to the DSM-II (originally published in 1968) and eliminated it altogether with the publication of DSM-III in 1980 [3, 8, 12]. Alongside a number of landmark court cases in which separated homosexual service members were reinstated (the interested reader is directed toward the opinions rendered in *Watkins v. United States Army* and *Ben-Shalom v. Secretary of the Army*), many were hopeful that the Department of Defense (DoD) would reverse course on its policies toward homosexuality and gender identity. This would not be the case. Although language regarding homosexuality as a mental illness was removed from DoD and service-specific regulations, the prohibition of

open service continued on the basis that LGBT service members undermined military discipline, adversely affected mission accomplishment, and caused an unacceptable level of risk national security and secrets [3, 12]. DoD Directive 1332.14, published 28 January 1982, governed enlisted separations and summarized these concerns as justification for separation from the military:

> *Homosexuality is incompatible with military service. The presence of such members adversely affects the ability of the Armed Forces to maintain discipline, good order, and morale; to foster mutual trust and confidence among the members; to ensure the integrity of the system of rank and command; to facilitate assignment and worldwide deployment of members who frequently must live and work under close conditions affording minimal privacy; to recruit and retain members of the military services; to maintain the public acceptability of military services; and, in certain circumstances, to prevent breaches of security.* [13]

As such, approximately 17,000 service members received administrative separation for homosexuality from the years 1980–1990. Although it would have been impossible to accurately estimate, scholars believe that the individuals separated represented only a small percentage of actual number LGBT individuals that served clandestinely during these years [3, 8, 12].

"Don't Ask, Don't Tell" (1993–2010)

> *The issue is not whether there should be homosexuals in the military. Everyone concedes that there are. The issue is whether men and women who can and have served with real distinction should be excluded from military service solely on the basis of their status. And I believe they should not.—President Bill Clinton (29 January 1993)* [14]

> *Open homosexuality is the problem.—General Norman Schwarzkopf, U.S. Army (Ret.) (11 May 1993)* [15]

The aforementioned 1982 revision to the DoD prohibition of open homosexual military service held until late 1993, when it became supplanted by Title 10 of the United States Code, Section 654 (10 U.S.C. § 654) – better known as "Don't Ask, Don't Tell" (DADT) [3, 12, 16, 17]. Signed into law by President Bill Clinton on 30 November 1993, further detailed in DoD Directive 1304.26 on 21 December 1993, and enacted on 28 February 1994, DADT was considered to be the compromise between President Clinton's campaign promise to end the ban on homosexuals in the military and the opposition he faced by legislators and high-ranking military leaders – all of whom argued that allowing homosexuals to serve openly would destroy morale, good order, and military effectiveness [3, 8, 12, 16–18]. These arguments against open service remain evident in the text of 10 U.S.C. § 654:

> **§ 654. Policy concerning homosexuality in the armed forces.**
> (a) Findings.—Congress makes the following findings…

(7) One of the most critical elements in combat capability is unit cohesion, that is, the bonds of trust among individual service members that make the combat effectiveness of a military unit greater than the sum of the combat effectiveness of the individual unit members.

(8) Military life is fundamentally different from civilian life in that…

(B) the military society is characterized by…numerous restrictions on personal behavior…

(13) The prohibition against homosexual conduct is a longstanding element of military law that continues to be necessary in the unique circumstances of military service.

(14) The armed forces must maintain personnel policies that exclude persons whose presence in the armed forces would create an unacceptable risk to the armed forses' high standards of morale, good order and discipline, and unit cohesion that are the essence of military capability.

(15) The presence in the armed forces of persons who demonstrate a propensity or intent to engage in homosexual acts would create unacceptable risk to the high standards of morale, good order and discipline, and unit cohesion that are the essence of military capability. [17]

Military historian Fred Borch argues that DADT was "[the codification of] the pre-Clinton policy on homosexuals in the Department of Defense—thereby preempting Clinton's authority as Commander-in-Chief to lift the ban on homosexuals in uniform." [3] Indeed, DADT placed into law that which had already taken place in the US military since the Revolutionary War – the ability to serve one's country so long as sexual orientation and expression of sexuality remained hidden [8]. While this technically barred the ability of military leaders to inquire about sexual orientation, many researchers report that this practice went undeterred – leading to the continued administrative separation of many homosexual and bisexual service members [8, 19, 20]. Additionally, consistent with the argument made by some scholars that gender identity is regularly conflated with sexual orientation, many transgender service members report being regularly questioned by military leaders if they were homosexual – often leading to their separation from military service as well [21–23].

DADT Repeal and Open Transgender Service (2010–Present)

Society has changed, and the military has changed.—Former Senator Sam Nunn, D-GA (10 December 2010) [24]

By the late 2000s, public opinion in the United States regarding homosexuality and open military service had shifted so significantly that DADT was widely panned by the majority of American citizens and American ally countries (many of whom already allowed for open service) [24, 25]. Opposition to this military policy had become so severe that President Clinton's primary opponent and DADT's architect, former Senate Armed Services Committee Chairman Sam Nunn, went on record in 2010 stating that he would support repeal if he were still a senator [24]. Despite earlier failed attempts, the 111th Congress passed Public Law 111–321, the "Don't

Ask, Don't Tell Repeal Act of 2010" on 18 December 2010. It was signed by President Barack Obama on 22 December 2010, rendering 10 U.S.C. § 654 obsolete effective 20 September 2011 [26, 27].

Widely hailed as a victory by human rights organizations and LGBT advocacy groups, the repeal of DADT continued to have critics from Americans, both in and out of the military, many of whom continued to argue that open homosexual military service would erode discipline, cohesion, and efficacy [19, 24, 27]. To that end, the University of California's Palm Center undertook an extensive study (which included outreach to over 500 flag officers and employed 10 separate research methodologies) of US military readiness 1 year after DADT's repeal. It concluded that there was *no negative impact* to military readiness, cohesion, recruitment, retention, assaults, or harassment. Further, the study concluded that there was *no net impact to unit morale*, though it noted individual variations among service members ("Morale rose for some, fell for others with no net, overall change.") [27].

Although the repeal of DADT – and its demonstration that it had no effect on military readiness – was a sea change for the rights of homosexual and bisexuals in the United States, it was a shock to many that it did not allow for the open service of transgender or gender-nonconforming (TG/GN) service members [19–22]. A careful reading of 10 U.S.C. § 654 will demonstrate that DADT, despite public belief to the contrary, *never applied to transgender individuals* and only barred homosexuality and bisexuality [27, 28]. Indeed, there has never been any Federal law regarding the prohibition of TG/GN individuals from military service. Rather, this service ban existed in DoD and service-specific *medical* regulations as an unfitting psychosexual condition – where homosexuality was relegated until the 1970s–1980s [3, 20–23, 27–29].

Public opinion of TG/GN individuals in the United States remains substantially less positive than LGB individuals, but support has rapidly grown in the last decade [21, 28–31]. Despite softening opinion and the success of DADT's repeal, many in and out of the military balked at the idea of open TG/GN service and the use of taxpayer money to provide gender-affirming treatment to service members. In addition to the same arguments made by detractors of open LGB service – degradation of unit cohesion, morale, and mission accomplishment – many voiced concerns about the cost of gender-affirming treatment and the medical risks involved with hormone and surgical therapies [21, 28–30, 32]. Despite this opposition, advocacy for open service for the estimated 15,500 active and reserve TG/GN service members clandestinely serving (per the oft-cited 2014 Williams Institute study [33]) continued undeterred. Proponents were emboldened by data demonstrating the negligible cost of gender-affirming treatment [32], the demonstrable safety of treatment [29], a wealth of best practices from the 18 ally nations that allowed open transgender service [34], and landmark studies from the United Kingdom and Canada demonstrating that TG/GN service caused *no negative effect to military readiness* [35, 36].

To that end, Secretary of Defense Ashton Carter effectively allowed for open TG/GN military service with the 28 July 2015 memorandum stating that "no Service member shall be involuntarily separated or denied reenlistment or continuation of

active or reserve service on the basis of their gender identity, without the personal approval of the Under Secretary of Defense for Personnel and Readiness…" [5] The memorandum also created a working group to pave the path forward for the full implementation of TG/GN service, including operational capabilities, records management, and gender-affirming treatment. With the input of the working group, DoD Instruction 1300.28 – "In-Service Transition for Transgender Service Members" – was released on 30 June 2016 and became effective on 01 October 2016 [2].

Department of Defense Instruction 1300.28

> *Any medical care and treatment provided to an individual Service member in the process of gender transition will be provided in the same manner as other medical care and treatment. Nothing in this issuance will be construed to authorize a command to deny medically necessary treatment to a Service member. –DoD Instruction 1300.28* [2]

DoD Instruction 1300.28 and the Don't Ask, Don't Tell Repeal Act of 2010 represent the decades-long efforts of LGBT activists to end discriminatory treatment of service members in the US Military. As this regulation (at the time of this writing) is less than 6 months old, a brief overview of the instruction for military mental health providers is appropriate. This is particularly so in light of the military-specific idiosyncrasies involved in gender-affirming treatment that need not be considered in the civilian setting.

Per this instruction, "[g]ender transition begins when a Service member receives a diagnosis from a military medical provider indicating that gender transition is medically necessary, and concludes when the Service member's gender marker in DEERS is changed and the member is recognized in the preferred gender." This is significant as service members undergoing gender-affirming treatment *must continue to use the berthing, toileting, and showering facilities of their birth-assigned gender (that of their natal sex)* until transition is complete. Furthermore, service members undergoing treatment will also *be held to the physical fitness, grooming, and uniform standards of their birth-assigned gender* until transition is complete [2].

DoD Instruction 1300.28 further delineates the roles of each stakeholder in a service member's gender-affirming treatment:

1. The service member must secure a diagnosis of a medical condition whose medically necessary treatment is gender transition, develop a transition treatment plan with their medical providers, and seek approval in writing from their commanding officer.
2. Military medical providers must make such a medical diagnosis when appropriate, advise both the service member and their commanding officer on treatment planning and treatment completion, and provide the medically necessary care per a service member's care plan.

3. Commanding officers are tasked with reviewing gender transition requests made by service members within 90 days of request receipt. It is important to note that the commanding officers, if in possession of a service member's complete and medically appropriate treatment plan, *may not deny a request for gender transition.* However, such an approval may be delayed if determined to be absolutely necessary based on deployment, operational considerations, or critical skills availability needs.
4. Military departments will develop service-specific regulations consistent with DoD Instruction 1300.28, ensure transitioning service member's continued fitness for duty, and ensure service member's gender marker is appropriately changed after transition is complete – thereby allowing that service member to be held to the standards and use the facilities of their affirmed gender [2].

The above summary of this instruction is, very clearly, an incomplete one. Readers are strongly encouraged to familiarize themselves with all aspects of DoD Instruction 1300.28, including the differences in treatment planning for active and reserve component members, special considerations for initial entry training, and the protection of service members' privacy. Furthermore, it is necessary for readers to familiarize themselves with their service-specific regulations, which continue to be developed and released at the time of this writing.

Conclusion

Honorable and effective LGBT military service in the United States is as old as the country itself. As public opinion continues to shift toward a more welcoming attitude toward LGBT individuals, the contributions of LGBT service members continue to evolve and grow. With the integration of transgender and gender-nonconforming service members, we stand at the crossroads of a new era in American military history. As military mental health professionals, it is our responsibility and our privilege to understand this rich history. Doing so ensures our ability to best treat and advocate for our population of patients that, finally, need not be silent any longer.

Disclaimer The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the US government.

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Part II

Personal Experiences

The Reservist Perspective: Service Before and During "Don't Ask, Don't Tell"

4

James R. Batterson

The Reserve Forces Prior to Desert Shield

The US Army Reserves I joined in the early 1980s was different in many ways from what I hear about the experience of reservists today. Gay or straight and regardless of job title or rank, reservists in this former time period shared one common belief: that they would not be called to active duty or at the very least the chances of this were remote. The line of thought shared by most of us was that if we went to war, it would be with the Soviet Union and it would involve nuclear weapons. That sort of war would most likely end human civilization, meaning the reserves would be useless. If there were smaller battles such as the action in Grenada, we theorized that the cost of calling us up would be too great to make it worth it.

Given all of this, reserve drills were largely free of any tension about actual active service. A number of issues that would have been addressed differently in an active duty unit were let go in the more relaxed 1980s reserves.

One of the medical units in which I served had a policy that surgeons didn't even have to show up for weekend drills. Our scales were set to weigh us all about 10 or 15 pounds lighter because our commanding officer was a bit more round than standards might have wanted.

Our 2 weeks of annual training basically turned into a typical rotation for the medical students. The reservist attending physicians staffed the hospital, thus allowing the active duty docs to take their vacation.

My father was in the reserves for 30 years. His experience was much the same as mine, with little reason to ever worry about being called up. He spent a lot of time

J.R. Batterson, MD (✉)
Division of Developmental and Behavioral Sciences, Children's Mercy Kansas City, Kansas City, MO, USA

UMKC School of Medicine, Kansas City, MO, USA
e-mail: bbatterson@cmh.edu

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_4

during drills hanging out with buddies, and his 2-week annual training (AT) were described as pretty much just guy time away from home where he also got paid.

My father had so much fun and had made so many friends in the reserves, when he heard they were recruiting medical students, he suggested I join. This was not the scholarship program where medical students incurred active duty commitments but rather one where we were direct commissioned as second lieutenants and were paid for drill attendance and ATs only.

Becoming Part of the Reserves

I joined for two very basic reasons, to please my father and to try to make myself into a heterosexual-conforming person. My father was near the end of his career in the reserves when I joined and was also the West Point recruiter for our region. He had been in a Civil Affairs unit for most his service but was promoted out of a position. His buddies found another slot for him in recruitment, solidifying how much he loved the reserves.

When he first brought it up, I was not particularly keen on the idea of joining the reserves. Like many of my father's activities, including his fraternity experience, it all sounded good if one were straight, but how was I going to deal with being gay in the Army? I knew they were going to ask if I were gay and that I would have to say no.

What would I talk about while we were standing around? What would happen if I were attracted to someone in my unit? I had a strong feeling that my experience would not be like my father's because I wasn't good at idle chatter, especially if I had to talk about being attracted to women.

Being gay for me was not a welcome fact. My family was probably fairly typical of the era in being at least moderately homophobic. Both of my parents were from backgrounds that did not foster understanding of gay people. My father talked about a fraternity brother who got kicked out for being gay as an expected outcome of "choosing" that lifestyle. Also, as an only child, I wanted to continue my family by having children of my own.

I felt internal pressures as well to conform and not to let others know about my shameful and abnormal attraction to other guys. Our church didn't preach heavily against sin, but many members during that time were Anita Bryant supporters in her effort to push back against gay rights. If the Army could get rid of the gay for me, I was all for it.

There was a question on the health form that asked if I were homosexual and having to answer it bothered me greatly. That question was going to be answered in the negative or else I would not get in the reserves. Lying on government forms was new to me. I had not done that knowingly in the past, and it didn't seem like a good idea to be untruthful. I rationalized this away however by telling myself I was joining so that I would not be gay. Therefore I was not fully a homosexual, and this is how I mislead myself as well as the US Army.

By today's standards, I am sure it sounds atrocious to some that a gay person would bother to support an institution that did not support them. One has to reflect back however on a different era where basically all institutions treated gay people the same as the military.

For example, a friend in my medical school class told me that after his sexuality became more obvious, he was called to the dean's office and informed that he had to make a choice between being gay and being a physician. He quoted a high authority figure at the school that reportedly told him he could not be both.

I talked to a psychiatrist in my reserve unit in Kansas City about the question on the form after filling it out. He turned out to be gay himself and told me that in his opinion, so many people answered untruthfully on that question that they would never prosecute us all. This was cold comfort for me but was typical of life in the 1980s for gay and lesbian Americans.

That psychiatrist became a mentor of mine toward the end of medical school. He led a closeted life. He told no one at work about his personal life and was quite clear with me that coming out at work would be career suicide. Sadly, he had experienced training in an era where homosexuality was considered to be a disease, and when he started practicing, coming out would have ended his career.

Life in the Reserve Forces

The monthly weekend drills at the General Hospital Reserve Unit in Kansas City were consumed initially by assisting with physicals on new recruits and then with running an orientation for new members of the unit. I was promoted from second lieutenant to captain after medical school graduation, and with a move to Charleston, South Carolina, I moved to a new unit blocks away from my house.

They engaged me to teach the med techs in the unit some basics about psychiatry. I worked with a nurse in our unit who ended up as a confidant of mine, and I came out to her. She worked in my primary training hospital so we saw each other frequently, and it would have been difficult to keep it from her. We also had several gay members of the unit and at least one of them had served in Vietnam.

I introduced my father to a nurse in my unit who was also a Vietnam Veteran, and my dad was quite taken with him and his stories about serving in that conflict. The subject of his sexuality was not broached in the conversation, though it would have been impossible for my dad not to know that he was gay. Since I was not yet out to my father, I was anxious during the conversation that I would be outed.

Other than a few select individuals, I did not come out to my reserve unit. At the same time however, I was completely out at work and took my partner to any and all functions. It was a bit odd looking back that I could get away with this double life because Charleston is not a large town and our unit was made up of a great number of physicians and nurses from the university health system where I was training.

Romance in the Reserves

I tried to stay away from romantic situations in the military, as did most of my friends who were gay. Army regulations were on our side in that romantic relationships were off limits or seen as highly problematic despite the soldier's gender, but homosexual relationships were decidedly illegal.

One way I found to achieve this was to stay professional on weekend drills and not talk about members of the unit inappropriately. It was tempting to do this to cover up being gay but that could be filled with problems. This worked fine for drill weekends, but the 2-week annual training experiences presented larger challenges. In these situations as well as at longer courses such as basic and advanced training, people were living away from home, and sexual tensions and energies were more intense.

I had several uncomfortable situations where I had to deal with females who were attracted to me and I had to manage to not out myself or embarrass them. I often failed to see that a woman was attracted to me until it was too late. Since I did not share their attraction, it made it harder for me to appreciate that something was happening of that sort. If there were any fellow male officers interested in me, I didn't recognize it either. In one of the large medical units where I was a member there were rumors of quite a lot of heterosexual liaisons at ATs which served to increase my anxiety.

My template for AT was my father's reserve unit, which was all male and filled with daytime training and evening drinking. If there were any extracurricular activities, it was not advertised and would seem unlikely from the folks I knew around my father. Considering that this was my template for what AT was all about, I was not prepared for what happened in that unit.

The Impact of Deployment

August 22, 1990 was a watershed moment for the United States Reserve forces. After more than two decades with an absence of reserve call-ups, President George HW Bush along with Dick Cheney, then Secretary of Defense, announced that the Reserve Forces would be activated. Within just a few days, my unit was called to augment the medical staff of the hospital at Fort Stewart near Savannah Georgia following the mobilization of the 24th Infantry to Kuwait.

Suddenly, I was dealing with a whole new set of issues. I had a partner and a dog in Charleston, not to mention my training in psychiatry of which I was in my last year. I was at a meeting of the South Carolina Psychiatric Association in Myrtle Beach the weekend we were called up.

The hospital operators at MUSC knew about my call up before I did. They told my chief resident, and she called me out of the meeting to let me know. My mother and father were in a state of shock when I told them the news since this was way off script.

I was called to my unit a few days later separately from the other soldiers along with a few other residents. We were told that the military did not see us as an asset since our training was not completed, so amazingly, we were off the hook. We were not permanently relieved of duties however and were placed in the Individual Ready Reserve. Once our medical training programs were over, we were to report for active duty.

Since the war was so short lived, we didn't get called up and instead served by going to our 2-week ATs at Fort Stewart. I worked the psychiatry unit, and in those first few months of reserve call-ups and mobilizations of active duty units that had not been deployed in years unearthed some interesting pathology. We had a few reserve soldiers admitted for evaluation of dementia and had been kept on in their units so they could get retirement.

One of my patients was evacuated from the theatre of action because his cross-dressing interests had come to light both at home and in the theatre. It was no Corporal Klinger situation from *M*A*S*H*, and instead my patient loved his military career which was now over which caused a massive depression with suicidal ideation.

Gay and lesbian soldiers could probably more easily keep their identity cloaked in the reserves as opposed to active duty because they only served for 1 weekend per month and 2 weeks per year. If my experience were any guide, there were about the same number of LGB soldiers as would be expected based on population statistics.

We joined, even though not welcome, because we weren't really welcomed anywhere. With the onset of the Gulf Wars and increasing activation of reserve units, the theoretical became reality, and reserve units had to pay much more attention to the reality of mobilization.

Gay reservists had to consider the true cost of staying in a system that was more likely to enforce rules. There was a story about some gay army translators who were kicked out around the first gulf war and they apparently had some expertise in Arabic. That sent a chill through me and others because we figured those guys were in high demand yet removed for being gay, and we wondered, what could happen to us.

Service in the Reserves Following Desert Storm

After Desert Storm I moved to Providence, Rhode Island, for child psychiatry training and joined a unit in the Boston area. I noticed that drills became more serious and so did people serving. There was some soul searching on the part of reservists. People who had hung around in the reserves for years to get a pension or because they thought they looked cool in a uniform had to consider the possibility of going to war.

Reservists who had family or business obligations had to face the real possibility of getting mobilized. The CO of my unit in South Carolina was an Allergist who reportedly declared bankruptcy after the war because he had a large staff and he was

not there to generate cash flow. Gay soldiers as well had to face the possibility that the double life they had enjoyed would be much more complicated to continue.

With my South Carolina unit's mobilization, the thought did occur to me that I might have a "get out of the war FREE card" by saying that I was gay. Being gay was clearly prohibited, and I could state that I had come to the realization after answering that hideous question on the medical form years before. I was too much of a conformist and too worried about the implications of that to play the card, and I wasn't entirely sure it would work. It made me wonder how other gay soldiers handled this possibility and if any did play that card.

The Impact of Increasing Societal Tolerance

The fact of my service in the reserves met more dismay in my New England gay friends than it did in South Carolina. I suspected that this was in part due to varying attitudes about the military in the South and the Northeast, but time was moving along as well, and in the early 1990s, the LGBT community was making slow but noticeable progress toward equal rights.

There were towns and cities passing antidiscrimination ordinances, and more and more people came out. The concept of supporting companies or business that supported our community was in its infancy, but the idea of protesting a business by not patronizing them was alive and well. The efficacy of boycotts is the source of continuous debate, but it was a tool of the 1980s and 1990s, and it made us feel like we were doing something. Was that feeling stretching to the reserves and military overall? Were LGBT people starting to feel as though they could not support an institution that treated them so poorly?

Decision Process on Continuing in the Service

The 1992 presidential campaign was historic because for the first time, a candidate openly courted the gay vote. There were hopes among my gay friends in the reserves that this might put an end to the ban on gay people serving. My own service was starting to be put into major flux.

I was at that time aged 30 and had served at least 7 "good" service years. I had missed a year with my moves because of delays getting processed into new units. I now had a lot of questions I had to answer for myself. In 1992, I was 1 year away from graduating from my child fellowship, and I had to decide where in the country to go. I also had to figure out what kind of practice I wanted to have and specifically whether I wanted to be employed by an organization or do private practice.

The choices were seemingly endless as child psychiatrists were in such demand. I could basically have my pick of places and work lifestyles. I also had to decide if I were going to stay in the military. My 8-year commitment was close to being met, and I could then drop at any time. I was wholly unsure about what to do with any of these life decisions.

If I chose a private practice, which did intrigue me because I liked clinical work, I also knew that military service would be a problem. There is no time off in private practice, and time spent away means money lost. The reported bankruptcy of my former CO weighed on me. Presenting a much greater problem was the military stance on gays. I was becoming much more resistant to being involved with organizations that did not support me or where I had to hide my sexual orientation.

I did not put up with discrimination where I did my residency and enjoyed the freedom of an out lifestyle. I didn't go to church in places that would not accept me either, and I got a little charge out of boycotting businesses that were publicly anti-gay. I actively chose not to hang out with people who were not accepting. The reserves started to become the one and only part of my life where I was putting up with discrimination.

Every time someone asked about whether I had a girlfriend or assumed I was married, I burned with irritation where in the past I had felt ashamed. I also began to think about what it would be like to live that life on a daily basis in active duty. Since mobilization was now a more likely possibility, I had to consider that it would be part of my future if I continued to serve.

With Bill Clinton's election in November 1992 and assumption of office in January 1993, there was an expectation in the gay community that there would be action on the issue of military service. There was opposition to gays serving, and we knew it would be an uphill battle, but I did not anticipate the backlash from conservatives on the issue and how effective it might be.

At the same time, I was interviewing for jobs in the Midwest where I was from and in the South and Northeast where I had trained. A 5-year relationship had ended a year earlier, and while I was free to look where I wished, I did not want a completely new city where I had no affiliations. I was most drawn to return home to Kansas City. My time there had been good, and I felt increasingly a Midwesterner.

I continued to "out" myself on all my interviews to make sure that being gay would not present a problem for me or any of my future colleagues. I ended up liking a private practice group the best. My fellow psychiatrists were accepting, kind, and well respected. The office staff was good, and they were expanding.

My reserve status however was not going to work well with this practice given their high volume of patients. I had heard additional stories of psychiatrists who got mobilized and basically lost all of their patients and had to start over. I felt that if I wanted to stay in, I would have to look at other options for my job, and frankly those options just weren't that appealing. It appeared I was headed to private practice and that put my future reserve service in doubt.

Another watershed moment occurred for me in 1991 when I finally came out to my father. I had done this with my mother in 1987 but had waited to tell my dad. He had gotten depressed previously just figuring out I might be gay, and he asked me just to not tell him. By 1991 I couldn't really function well with that secret and keep any sort of relationship going.

He got depressed with my news, and it took months for him to speak to me. He didn't come and visit for the 2 years I was in Rhode Island and sent me letters on the

joys of celibacy for several years as well. Now that I was out to him, there was no point staying in the reserves to please him or to use it to keep up the farce that I was straight.

The Last Few Months of Service

With the decision to enter a private practice and no reason to please my father by staying in, I had made a decision to ask for a discharge from the Army, but there were four things pending that would keep my final decision in play until the summer of 1993.

Those four things were the continuing national debate on gays serving, the Gay March on Washington, DC, in late April, advanced training scheduled in the early summer in San Antonio, and my attendance at the American Psychiatric Association Annual Meeting in San Francisco where I would end up meeting my future husband.

With the debate on gays serving in the military starting to fire up, there was anger among the marchers in Washington in late April. We turned our heads when marching past the White House to symbolize the administration turning away from us by not taking action sooner on gays serving. I met the gay psychiatrist group at the march and walked with them. Two people were required to carry the banner for the Association of Gay and Lesbian Psychiatrists, and I was one of the banner carriers off and on throughout the walk.

Unbeknownst to me, I was photographed by someone with connections with *Psychiatric News,* which was published by the APA. Our group photo with me carrying the sign was placed on the front page of the paper (Fig. 4.1). With that, I had openly violated military policy. I was not in uniform, nor did it say anywhere that I was representing the military, but I was clearly making a statement.

I also could have defended myself, if it came to that, by saying that I was simply expressing my first amendment rights and it had no implications on my sexuality. That would have been at the very least misleading, and I think now that I was making a clear statement to myself and to anyone who cared to listen that I was gay and that was that. The march changed me further by solidifying by already strong feelings that I would no longer put up with discrimination.

Since the military discriminated against me, my interest in serving dropped even further. It was less and less fun hanging out with people that would turn their back on me if I were to come out, and that is how I experienced my military family—that they were not really my family. I may have underestimated them however as I never really gave them a chance.

After the March on Washington, I was to head for my advanced training, which would be necessary to move upward in rank if I were to stay in the reserves. We were housed at Trinity College in San Antonio, which rented space to the Army during the summer. We were not alone on campus as they had also booked a weeklong seminar of the reparative therapy support program known as Exodus.

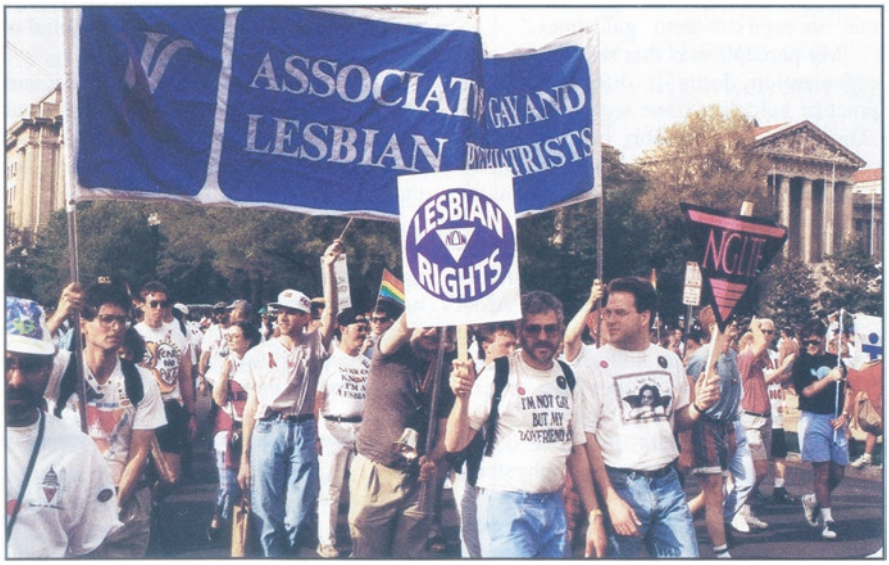

Fig. 4.1 The author is pictured second from the right, carrying a pole for the banner for the AGLP in the 1993 March on Washington (From *Psychiatric News*, Volume 28, Number 10, May 21, 1993, with permission)

As I arrived on campus, I was struck by the number of gay men and women and wondered if they were military members, only to find out later that they were part of this group. The juxtaposition of a group of gay and lesbian people trying everything they could to get rid of their sexual orientation and a military organization that wished to push the whole issue under the carpet was my final sign that it was time to go.

It seemed to my military cohorts and me that the people we met in Exodus were a sad and damaged bunch of souls. I did not want to have to go that route to be able to serve my country and stay in the reserves. If they kept their policies of disallowing my service, I would either have to change or leave.

Don't Ask, Don't Tell

With the passage of DADT in 1994, a compromise had been reached, but the closet door remained shut for members of the military. DADT looked like familiar ground to me from what I had been living before I had come out. I was also on the front of the *Psychiatric News* with a gay banner in my hand, so it appeared to me that I had already violated the policy.

DADT to me represented a move by the military from being anti-gay to being tolerant. DADT did not represent acceptance however, and that is what I now required of people and institutions around me. I no longer would accept the idea that I had something of which to be ashamed in the form of my sexual orientation.

When I wrote to ask for discharge, I elected not to mention any of this, as I didn't want publicity or legal issues, I just wanted out. I received my discharge easily and have remained forever a former reservist.

My husband and I are now serving as a volunteer sponsor for foreign officers in the Command and General Staff College at Fort Leavenworth Kansas, and in this role we have hosted the first foreign out gay officer to bring a spouse for the course. Our officer is in the British Army, and while both countries militaries have moved far on this issue, it seems that his sexual orientation has at the very least remained a point of discussion here and in the UK.

My sense is that a gay psychiatrist in the US Army Reserve now would be welcomed and accepted. With the removal of DADT, there are no official barriers left. There will however be continued work to do as we remain a minority, and some members will struggle to see us as right and proper members of the service.

Being Discharged Under Don't Ask, Don't Tell

5

Martin Chin

Joining the Military

In high school, all students took a military aptitude test. After the test, I was approached by a recruiter and was encouraged to apply for an ROTC scholarship. I was awarded an Air Force ROTC college scholarship. While on active duty, I received tuition assistance for a masters' degree and attended the Air Force Institute of Technology and received an additional masters' degree. After acceptance to medical school, I was awarded a Health Professions Scholarship (HPSP) and received residency training on active duty. A bachelors' degree, two masters' degrees, a medical degree, and two residencies create a considerable sense of indenture.

Reconciling Joining the Military with Being LGBT

I was 16 when I underwent the induction physical exam. I recall the question on the paperwork asking if I was gay and struggling about how to answer. I don't think I knew the consequences of answering that I was gay. My apprehension in answering the question stemmed from being unsure of the answer. At the time, I'd had thoughts that I now recognize as gay but at the time had not had sexual experiences of any sort. At that time, I hadn't even masturbated for the first time.

M. Chin (✉)
Department of Psychiatry, Palliative Medicine, Sinai Hospital of Baltimore, Baltimore, MD, USA
e-mail: mchin@lifebridgehealth.org

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_5

Being "Outed"

After finishing a combined psychiatry/internal medicine residency at Walter Reed in 2003, I accepted an assignment to an Air Force hospital in Japan. As a psychiatrist, internist, and flight surgeon, I was involved in many areas, both clinical and administrative. I was even able to fly a few CCATT (Critical Care Air Transport Team) missions. As a result of deploying other physicians to other missions, I was often filling multiple roles simultaneously.

One of the more challenging cases involved a soldier who had crossed the DMZ and defected to North Korea in the 1960s. In the late 1970s and early 1980s, North Korea abducted many Japanese citizens. These Japanese were studied and forced to teach the Japanese language to North Korean spies. The soldier married one of the abductees, and they had two children.

In 2002, North Korea acknowledged the abduction of many of these Japanese citizens, one of whom was the soldier's wife. She was allowed to return to Japan, but the soldier remained in North Korea. He became ill and required medical care that could not be provided in North Korea. He arranged to join his wife and children in Japan.

The status of forces agreement (SOFA) between the USA and Japan requires the return of deserters who land in Japan. The Japanese government feared that the soldier would be executed and requested pardon for the soldier.

As the acting medical executive officer (SGH[ER2]) of my hospital, I was involved in determining the soldier's medical needs and the ability of the US military's resources in Japan to meet those needs, as well as the feasibility transporting him back to the USA. This role involved interactions with the three-star commander of US Forces Japan (USFJ) and the US Ambassador to Japan.

After working on the case for several months, the hospital commander approached me. She said, "Let me be clear. I'm not asking you anything, and I'm ordering you not to tell me anything." She went on to say that there was something about my personal life that was a cause of concern. She felt that if this became known, I would be exposed as a liar, causing embarrassment to the Air Force. Because she did not want embarrassment for the Air Force, she told me to remove myself from the case. I would continue to serve in my other clinical and administrative roles.

She also said that she would make sure that I was never promoted again. She filed a Promotion Recommendation Form (PRF) with the recommendation of "Do Not Promote." Because I was meeting the promotion board below the zone, no narrative supporting her recommendation was required or provided.

As a commissioned officer, my reaction at the time was to comply with her instructions. Salute smartly and carry on, as the saying goes. I had agreed to separation from my partner for the 2-year duration of the assignment to Japan. As the only psychiatrist at the hospital, I had a full clinical load yet agreed to see internal medicine and flight medicine patients, as well as to fill in during the deployment of the SGH. While I made these agreements willingly, benefited greatly from the experiences, and anticipated recognition at the promotion board, the personal sacrifices I made were substantial.

After thinking about it, I realized that I'd been called a liar and an embarrassment to the Air Force. I felt that I was neither. I was angry and resentful. The prospect of completing the assignment so far away from home and then completing my service obligation without promotion was unbearable. Because I wasn't "asked," there would be no recourse under the provisions of Don't Ask, Don't Tell (DADT) unless I "told." I decided to write a coming out letter to my squadron commander, which would force the Air Force to separate me.

Military Issues About Being Gay

The arrival of an unaccompanied male of a certain age is a conspicuous occurrence in many situations but particularly so in the military. The awkwardness is unavoidable: "You're so good looking, why are you single?" "I have a friend I want you to meet." "Where is your girlfriend?"

This phenomenon is not unique to LGBT situations, but for the LGBT, it can be more difficult to provide an acceptable answer. Being asocial, caustic, or otherwise unmarriageable is often an insufficient explanation and in a situation such as a remote/foreign assignment can result in an undesirable isolation.

For a closeted LGBT, the line of questioning will likely persist and become intrusive and sometimes prejudicial. To this day, I don't know exactly how my commander found out that I was gay, but I suspect it was as a result of an interaction along this vein.

At the time LGBT members seemed to be accepted in the medical community. I expect the climate was similar in larger organizations and more urban locations. I don't think I encountered any other military members in Japan that I knew were LGBT.

As I came to realize and accept my homosexuality, I was in the process of leaving the military for medical school. In returning to the military after medical school, the environment seemed to be accepting. I was aware of the prohibition on LGBT service in the military but didn't feel the need to hide my sexuality among my friends and colleagues.

I took this attitude with me to Japan and probably didn't realize that the situation was different until the conversation with the hospital commander. At that point, I realized it was too late to reconcile my sexuality with continued military service.

Separation

The process of separating from the Air Force in this manner was very slow. Despite the assistance of the Area Defense Counsel, the process dragged on. I gained weight. I was irritable. I was angry. I entered the window for reassignment and arranged to return to CONUS. I looked forward to leaving Japan. It seemed that there was some light at the end of the tunnel.

Then I learned that my reassignment had been frozen because of my pending separation. I was not eligible for reassignment from Japan. There was no estimate of a final separation date. I was stuck. I would be in Japan beyond the 2 years of the original assignment.

I remember being at my desk in the Life Skills (mental health) Clinic, picking up the computer mouse and throwing it as hard as I could. It struck a framed picture, shattering the glass. The clinic staff came running. I was back home and out of the Air Force in about a week.

Leaving the Air Force

My feelings about leaving the Air Force are mixed. I can't imagine serving out my time after what happened. To qualify for retirement, I would have had to continue another 8 years, a long time to go without promotion. As I see my peers advance in the military or retire with pensions to pursue civilian careers, I feel a sense of loss. I miss the affiliation with the military and the people. I miss the sense of accomplishment of completing my service obligation and achieving the status of a retiree.

Rationally, I understand that by continuing to care for patients, I continue to serve and fulfill my obligation. I will always be grateful to the military for the education, experience, and relationships that I've gained.

Leaving the Air Force under these circumstances forced me to become involved with organizations such as the Servicemembers Legal Defense Network. I hope that in some small part that my support and work in this area contributed in the repeal of Don't Ask Don't Tell.

In Retrospect, What Would I Have Done Differently?

At this stage of my life, there have been so many decision points along the way that I have relitigated. Would I have accepted the ROTC scholarship? Would I have gone to medical school if I weren't in the military? Would I have chosen different specialties? Would I have stayed in after stepping away from the deserter case? Would I have waited until my next assignment to decide? Would I have been as active in the movement to repeal Don't Ask, Don't Tell?

I'm comfortable saying that I think things have turned out all right for me. A different decision at any point might have led me to a worse place, and, in that sense, I wouldn't change anything.

Working for the Military as a Civilian

I had the benefit of 5 years in the civilian world before returning to work for the military as a civilian. I very much enjoyed renewing the connections with colleagues from residency, working with military residents, and other civilians. I think my military experience informed my practice with service members.

It was a good fit until my personal circumstances took me elsewhere. I was seriously injured after being struck by a car when I was bicycling to work. The supportive environment at Walter Reed was exactly what I needed as I returned to work. I don't think that any other organization would have been as accommodating of me at that time.

After recovery, I realized I needed to leave. I needed a fresh start. It's funny. It's only as I write this that I realize that this "fresh start" is really just a continuation of my military experience. I was recruited for this position as a result of the recommendation of a military residency colleague, and another colleague from our training program is working with us now as well. Everything is connected. Everything happens for a reason.

A Gay Psychologist's Account of Serving in the Army Reserves and National Guard During Don't Ask, Don't Tell

6

Clifford Trott

Before Joining the Army

On March 21, 2002, I raised my right hand and became a member of the US Army (Reserves). I was also required to sign a form as an attestation that I had not been asked if I was gay and I had not told anyone I was gay. I paused a little before signing this form, thinking of all the struggles in the journey in coming out personally and professionally. I came to the conclusion that, based upon what I thought to be a solid, healthy gay identity, I could join an organization that did not allow me to live openly.

A year prior I had found myself in what I considered to be a fortunate point in life. I was living in a beautiful city and working in a field that gave me fulfillment, challenge, and gratitude. I began to explore ways that I could give back to others. My first thought was Doctors Without Borders. However, I had too much student loan debt to go one full month without income.

I had all but given up on the idea of giving back, until I met a friend of a friend at a Labor Day barbecue. He was a gay nurse serving in the US Army Reserves in Boston. He spoke with me of the ease he felt in being gay and serving his country.

I remember him saying "I don't really talk about my personal life with coworkers anyway, so it doesn't matter to me." He also shared that he felt the medical fields were far more accepting of gay soldiers than other branches. I hadn't considered the Army as an option, but his description made it seem possible for a gay man to serve without personal distress.

That next week I called a medical recruiter and began the process to join the military. I had concerns about going back in the closet, as I considered it. I did not feel I could share this decision-making process with my friends and family, fearing that

C. Trott, PhD, MPH (✉)
Veterans Healthcare Administration, VA Maine, Portland, ME, USA
e-mail: clifford.trott@va.gov

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_6

they would not understand my considering the military. So, I pondered the decision on my own.

My reflections included all of the personal and professional work I had done up to that point: I was out to my family and friends; my dissertation investigated efficacy in working with gay clients; I was writing policy for gay, lesbian, bisexual, and transgender advocacy organizations; and I was out as a gay psychologist at work. I felt as though I was secure enough in my identity to handle the "one weekend per month and two weeks per year" commitment required by the Army Reserves.

Pre-deployment

Upon joining the Reserves, I was assigned to the 1908th Combat Stress Control Medical Detachment out of Topeka Kansas. I was attached to the National Army Medical Augmentation Detachment (NAAD) out of Georgia. In the Spring of 2003, I was brought to Georgia for an orientation and then sent to Officer Basic Course (OBC) in San Antonio, Texas, for 2 weeks. It seemed like so much information to learn and integrate. I recall being asked, "Are you married?" I simply replied, "No," rather than say, "I'm not allowed to marry."

My OBC training involved receiving a military orientation, very basic weapons familiarity, and basic land navigation. I was tested on how to disassemble and reassemble an M-16 and 9-Mil, two weapons commonly used by Army officers. This was my first time ever handling and firing a weapon. I remember the trembling of my hand the first time I pulled the trigger. We were also tested to insure we could all don our gas mask within the required 9 s time limit. I recall one officer had donned her mask upside down during the simulation exercise. The training officer said, "That's not going to work too well, ma'am, now is it?"

As part of my OBC training I met with an amazing psychologist. She and I briefly spoke of a psychologist we both knew and she shared some of her experiences stationed at various stateside bases. However, we did not speak of potential deployments, which were looming at this point in 2003. I remember feeling completely ill-prepared for being a psychologist in a combat zone after this 2 week training.

March of 2004 was when I received "the call." My unit in Topeka phoned to tell me to be in Kansas in 7 days. This required quite a bit of work, as I had a private practice and needed to transfer clients to different clinicians in the community (so much for the "termination phase" of therapy). Fortunately, all of my colleagues were able to schedule the clients in a timely fashion.

Once I arrived in Kansas, my unit quickly transitioned from the Armory in Topeka to conducting convoy trainings and weapons qualification at Ft. Riley. During weapons qualification, it took me many attempts to hit the minimum of 23 out of 40 targets. One sergeant put a couple of extra rounds in my magazine and said, "Sir, this ought to help out." They did help and I qualified. This sergeant would later become the noncommissioned officer on my team.

It was during this training phase that we learned we were deploying "in support of Operation Iraqi Freedom." Less than 30 days from receiving the mobilization call from my unit, we were "boots on ground" in Iraq. My head was spinning from all I had learned and all that I realized I did not know. I had an anxious anticipation about what awaited me and my unit.

In-Country

Our unit was responsible for providing behavioral health support to all service members from Bagdad to the Kuwait border. I was placed as team leader and assigned three mental health technicians. Our team mission was to support five forward operating bases (FOBs) and be a mobile support as needed to units in the area.

Initially there was no time to think of my personal life and the impact of serving under don't ask don't tell (DADT). We were far too busy trying to establish contact with all of the units in our catchment area. These units needed to have access to our services. While there is stigma around receiving mental health care within the military, we were fairly busy right from the start.

The evaluations we conducted always involved recommendations to the command. The technicians on my team were good, but as they were enlisted, I provided all of the consultations and recommendations back to the command.

Our team was providing a mobile mission that necessitated traveling via convoys. While having a mental health technician would have been nice, it was not essential. Convoys were attacked, and bases were rocketed and mortared; thus the fewer members from my team on the road the better. Consequently, I solely provided much of the mobile support during the year.

While the convoys were exhausting, both mentally and physically, I enjoyed the opportunity to get to escape to forward operating bases (FOBs) where people did not know me as well. On these FOBs there were no soldiers from my unit, the soldiers I had deceived and lied to in an effort to not violate DADT. It was during these times when I was apart from people who knew me that I could relax and not have to worry about the deception. It was during these times that I was at greater peace. I kept to myself and preferred it that way.

I had a great team during my year in Iraq. I counted on them and leaned on them for professional support. However, I never shared this important aspect of my life. My personal life was off-limits for conversation; this was an unstated and understood rule.

I spoke in generalities and fabricated a "girlfriend" named Jess rather than disclose my boyfriend named Jeff. There were times when this felt like it created a canyon between me and them. However, day in and day out, it didn't really matter though. We supported each other and we got our job done, or at least that's what I wanted to believe.

I did meet two gay soldiers on my deployment. I was authorized a pass to Qatar. While there I met a lesbian soldier with the Virginia Army National Guard. Being

out of the chaos in Iraq for a couple of days was nice, but meeting her and being able to speak openly about our lives were far more beneficial to my well-being.

I also met a gay physician at one of the FOBs. He had been transferred to the base for his last 30-day in-theater. I initially suspected he was gay by his choice of pronouns in describing his partner as "they." One day I decided to ask, "they?" He proceeded to come out to me and I to him.

For me, this experience was like an exhale after having held my breath underwater for a very long time. I could relax around and be comfortable with him. He and I formed a friendship that consisted of working out and eating together when we could. We spoke of the challenges that the deployment was having on our families and partners back in the States. I was relieved from some of the stress by knowing another gay male officer was serving alongside me.

Welcome Home

My team had conducted several reintegration briefs while in Iraq. I thought I knew all about the challenges facing service members coming home. I assumed it would be easy for me. I did not realize how naive I was to the challenges to the reintegration process. After returning home, I decided to take several months off before looking for work. I had saved money and this seemed like a good idea.

I returned to my home and slept on the floor, using the same camp pillow and poncho liner I had used while traveling to-and-from FOBs in Iraq. For whatever reason, this felt comfortable to me. I tried to convince myself, and friends who noticed, that I did not need all of the material things that I used to value.

I now valued drinking lots of alcohol while trying to make sense of everything that had happened over the past year: the service members' stories, the attacks, the isolation, and just how different it was "over there" compared to life in the States. However, I became overwhelmed by all of the action and commotion in ordinary places, like supermarkets. I adjusted my life and habits to avoid these periods of overload. For example, I found a 24-h supermarket and discovered that I could manage shopping at midnight.

I had a difficult time adjusting to what was now important back in the USA: celebrities, fashion, and voyeurism through reality programing. I was coming off a year of helping individuals make sense of some of the most intense situations, and I could not "lighten up."

My reintegration into the gay community was equally complicated. Prior to deploying I had a strong network of gay men and lesbians who knew me well. I went to gay bars, gay parties, and gay resorts. I had a gay life. When I returned from Iraq, my gay friends said I had changed. Friends would use such adjectives as "angry" and "distant" to tell me how I had changed.

One of my best friends asked me "what was the worst thing that happened over there?" I proceeded to tell him one of the moments from my year in Iraq. Two weeks after I shared this with him, he told me, "I wish you wouldn't have told me that, I've been having nightmares ever since." I decided to not share any more of my "stories" from Iraq.

The Career After

Professionally, I found employment within the Veterans Healthcare Administration in Cleveland, Ohio. I did well with the structure of this job. That structure ended when I accepted a position with the Veterans Healthcare Administration in Vermont to provide outreach to veterans of the National Guard and Reserves in Vermont. This position involved a lot of time on the road, traveling from location to location. It was an exhausting job.

I soon realized that this job was too similar to what I was doing in Iraq. It left me feeling extremely fatigued, and I just wanted to get away from everything. I tried to find another deployment, but I had switched to the National Guard, and my state wasn't willing to release me to another state for a deployment. I found a mobilization detail in Washington, DC, with the Army National Guard Bureau. I applied and was accepted.

This position kept my mind busy. I had a sense of being a part of something, rather than feeling alone and isolated. While I was certainly still integrating and reconciling experiences from Iraq, it was somehow comforting to work alongside people who had deployment experiences of their own.

In 2009 my unit was placed on a mobilization list. I felt a duty to deploy with them. My boss at the Army National Guard Bureau told me, "You've already done your duty, you don't have to deploy again. We need you here." I instead returned to my home state and prepared for a deployment to Afghanistan.

Round Two

On this deployment I served as the brigade psychologist. The mobilization phase involved conducting psychological evaluations on soldiers and determining their fitness for deployment. During the mobilization phase, the brigade command moved my position from the medical company to the brigade headquarters. It was unclear to me why he had made this shift. I later learned of the role the commander envisioned for his mental health asset.

Once we arrived in Afghanistan, the work was very familiar to me. I knew how to counsel service members in distress. I knew how to work with acute stress reactions. I knew how to consult with commanders and write reports. However, I did not know how to handle toxic leadership.

Within 3 months of arriving in Afghanistan, the brigade surgeon informed me that our brigade commander wanted me to produce a document containing protected health information (names, diagnoses, social security numbers, and units) of soldiers I had seen professionally. I consulted with a medical JAG officer who concurred with my concerns and advised me to not release the information.

My refusal was not well received. My command launched in a 15–6 investigation on me for not documenting sessions. I was found to be in violation of improper documentation of clinical encounters. I was following a theater-wide standard operating procedure (SOP) of not needing to document incident debriefings and

encounters that did not warrant a psychiatric diagnosis. The command dismissed this SOP. I tried to fight these charges, showing the SOP to the JAG officer leading the investigation, but it did no good. Ultimately, I was sent home from Afghanistan early and received a general letter of reprimand in my permanent personnel record.

Before being sent home, I had formed an amazing friendship with a lesbian medical officer who helped me cope with the stress of this ordeal. She helped me to feel fully heard and supported. She knew that I was being railroaded and suspected it was because of my sexual orientation.

Prior to deploying, the brigade surgeon had said that he believed gays and lesbians should not be serving in the Army. A fellow Vermont Guard Officer had disclosed my sexual orientation to this brigade surgeon, not knowing his views on gays serving in the military. I believe that individuals felt more free to intimidate, harass, and bully me because my sexual orientation was known. They knew my "secret."

Home Again

When I returned home, I was very fatigued. Without realizing it, I had become exhausted from the work of being a psychologist in the military. I do not know whether it was the clinical work, the experiences on my deployments, or the stress of concealing my identity that caused the exhaustion. Perhaps it was a combination of all three.

I sought out therapy for the mental fatigue. I pursued and completed a graduate degree in public health, focusing on policy.

Out of the ending of one career, a new one has taken root. I now consider the letter of reprimand I received to be a gift that helped me realize the necessity for this career transition.

Due to non-selection for promotion, I was scheduled to leave the military. My commander recognized my commitment and dedication and was also aware of the negative experience I had in Afghanistan, asked if I wanted to stay for a retirement. I queried her and learned that I could become an enlisted soldier.

In March 2015, I resigned my commission and again raised my right hand to become an enlisted soldier in the Army National Guard. That same lesbian who provided support to me in Afghanistan swore me in as an enlisted soldier. My husband was by my side.

I needed to select a military job. Based on my interest in policy and public health, it was an easy decision to become a preventive medicine/public health specialist (68S). I completed this training in April 2016 and graduated on the Dean's List.

While in school I met another absolutely amazing lesbian, enlisted soldier. She had been working as a mechanic and was changing her MOS. She was completely open about her wife and who she is. It dawned on me that she hadn't served under DADT. I learned so much from her during the 16-week training course. My first drill back I was asked by the lieutenant of my section if I was dating. I replied, without fear, "I have a husband."

Conclusion

I am truly proud to have served my country as a psychologist in the US Army. Serving under DADT took a toll on me. Prior to joining I was naive to the stressors that serving as a closeted gay man would present. Working for an organization that did not acknowledge who I am fully caused me to feel isolated, detached, and not a part of the whole. I missed out on the full sense of camaraderie that is an essential part of the military.

I have learned over the 14 years of my military service that a sense of belonging is essential to well-being. The years that I spent hiding a part of myself from the men and women I served with kept me disconnected from the vital support I needed. It is only when I am able to be honest and authentic with those around me that I can begin to form true connections with others. This connection was missing when I returned from Iraq and from Afghanistan.

I did not feel a strong bond with my unit members. I didn't feel that I could tell them about my struggles and challenges. Likewise, I didn't feel that I could speak with my non-military friends about deployment experiences. I had unknowingly created two separate, incompatible worlds in which I was living. This took a toll on me.

I now serve as a gay member of the Vermont Army National Guard. This ability to serve openly and without fear is essential to me. I feel connected, a part of our unit, and camaraderie is developing among my fellow soldiers.

Despite the challenges of being a gay member of the military, I am proud to continue to serve my country. Gay, lesbian, and transgender service members are a tremendous asset to this nation. I often reflect on the gay and lesbian medics, doctors, mechanics, infantry men, and many others I've met over the years. I am grateful that so many of sisters and brothers have had the courage to serve, sometimes times in places and in organizations that are inhospitable.

Does Anybody Have Anything They Want to Say?

7

Joseph E. Wise

"Does anybody have anything they want to say?" This was said as a joke—or, at least it seemed—a cruel one, from one of the senior physicians and impromptu leader of this small band. It was breakfast with the medical staff—a sustaining informal ritual among the doctors of the "Cash" CSH (Combat Support Hospital). I was in Iraq—it was 2010, just prior to the repeal of the policy of "Don't Ask, Don't Tell." Such comments didn't faze me, and I had come to expect it such insensitivity. Ironically, I had grown up watching "MASH," sitting beside my father on the couch.

There's a certain situational irony in gay man watching an anti-Vietnam, though set during the Korean War, military medical drama and then years later living that out as a closeted gay man. Within the institution that had legally forbidden tolerance for being gay, how could I not expect such ridicule? In addition to these institutional barriers, I had, like many LGBT people, also internalized the societal prohibitions of a gay lifestyle—feeling internally, even unconsciously, there is something wrong with me. I had internalized that I have a problem (similar to other marginalized minority groups, internalizing the oppressor). At breakfast that morning in Iraq, it would have been humiliating and shaming to speak up and "tell." But, this was an instance of being on the cuff of official policy change—still far from a welcoming environment.

The nights prior, I had watched the Senate debate and then the vote in Congress to repeal DADT. It was another irony that I was deployed to combat, as a closeted gay, working as the only psychiatrist—one of the busiest providers on the medical staff, due to concerns about PTSD, mTBI, and suicide. Yet, despite all of that

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J.E. Wise, MD (✉)
Medical Corps, US Army, Walter Reed National Military Medical Center, Bethesda, MD, USA
e-mail: wiseje01@gmail.com; joseph.e.wise.mil@mail.mil

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_7

service, I was watching the Congressional debate from a combat zone to see if I could declare openly my sexual identity.

In the personal narrative that follows, I endeavor to share anecdotes of personal, professional, clinical, and organizational experiences during DADT and immediately post-DADT.

Deployment

The "does anyone have anything to say?" story above was during deployment. Luckily, I was also not alone, as I was connected with other LGBT service members who communicated on an invitation only Facebook website called OutServe. I had been invited by a gay nonmedical officer whom I knew from West Point and who had been separated from the Army in the mid-2000s.

There was also a sub-rosa group of gay men on this larger forward operating base (FOB) who would meet (via word of mouth) to watch TV, mostly Glee. (It was the type of connection that automatically existed, at the time of DADT, just for being LGBT.)

My sense is that it would have been open for other types of comforts, but I was too frightened by the prospects of fraternization, though I don't think others had the same reservation. (In a similar way, in my residency, prior to my deployment, I had later discovered that within the medical staff there was several who had "hookup"-type relationships despite the limits of medical hierarchy.) During these times, there was quality of a small tribe, secretly joined together. Bucking the rules of fraternization can be understood as a type of reified moral confusion, in that how can one choose which rules with which to selectively comply when at the same time the same authority sets immoral rules barring one from disclosing a fundamental aspect of identity.

Being in the shadows, with others, when they were discovered, such as unexpectedly at a gay bar, led to an immediate closeness and group cohesion from the us-versus-them mentality during DADT. The exception was when someone was in trouble for something or turned in—there was no public support lest the others get outed.

While deployed, I had also Skype calls to Servicemembers Legal Defense Network (SLDN) without giving my name (consistent with my anxiety of that time) to discuss options if the DADT policy had remained in place. If the policy had not changed, my idea is that I would come out officially to my commander upon return, and they would have been moved to an administrative discharge process. Having seen others separated for being gay, to do so would have brought humiliation for me, but I was willing to do so, to be open and free about my identity. For me, like many, the humiliation of potential separation under DADT would have been doubly humiliating for my parents and family, who were very proud of my, their son's, service to the country.

In my anonymous Skype calls to SLDN, from Iraq, my questions had to do with how much debt I would owe given that the Army had paid. I was also interested in

whether I might be charged criminally and whether since I was being kicked out rather than quitting whether my debt might be forgiven. In retrospect, it seems quite silly, but the fact that I would not give my name speaks to how it was at the time.

While I was deployed, to Iraq in 2010, my best friend was a Navy social worker. She was my constant companion, and many presumed we were dating, but we were just platonic—two that found each other in the desert. We once talked about physical intimacy—it followed since we were such great friends, and flirtatious with each other, but it was clear that it would not work—despite all my efforts to be straight: I'm gay and that happens to be the way it is. But, we continued to have our meals together and watch movies every night. In some of the psychosexuality and homoeroticism of everyday life, my hospital colleagues, including this social worker (upending gender stereotypes), enjoyed many a cigar together in the dusty Iraq night—a tradition among military men, which I first learned at West Point.

West Point

I had started West Point at the urging of my parents and beginning my time with the military. (Notably, I also had a family tradition, in that all of the many relatives had served. They were not career military but had essentially done an enlistment. I, surprisingly, felt like it was a "normal" thing to do—to be in the military for a few years.) Not only could they avoid paying for my education (which was a major objective), but they could be rest assured that I was bathed in traditional masculine straight culture.

Consciously, I do not think they knew, at that time, about how I am gay, and I most certainly was not out. But, I think, out of their awareness, unconsciously, they believed it would "cure" me of my homosexuality—a flight to hyper-masculinity. And, it's true, in many ways; it did make a man out of me, but not a "straight" man, especially graduating just after 9-11.

But, of course, I went there when I had just turned 18, literally, 9 days after. So, I was doing my best to consolidate my identity, as is developmentally appropriate, for late teenagers and early 20s. (We cannot forget that the brain is still myelinating up until age 24.) In this way, I can resonate with many military patients who are in their early 20s and have left home not that long ago. They are still in their separation and individuation stage of early adulthood and solidifying their identity post-family of origin.

Residency

There was one sort of occurrence during my psychiatric residency, in an unfortunate instance of a quarreling couple—not that uncommon, especially developmentally for psychiatric residents, in their mid-20s, and often doing a great deal of dating. My coresident was turned in by the intimate partner. This led to an investigation and the awful experience of this person being dragged through the mud and basically

publicly ridiculed. There's a certain irony since this psychiatric resident has deployed for an extended period to a combat zone, led a BH department at a major troop location, and otherwise had exemplary service. It goes to show how professional performance is linked to abilities and dedication, rather than elements of core identity.

"Coming Out"

During DADT, the coming out (to each other) was very peculiar. I remember "walking on eggshells" with this discussion. It was often initially discussed in a disguised way, a "roommate" or a "best friend," which I would later learn was a lover. I remember going through this several times, and it was often after the suspense, a way to come clean. (In group therapy, we might say that "coming out" is a way of "coming in" to the community as one's true self.) But, in the days of DADT, there was no joining the community in a true, open way—it was wrong, deviant, illegal, and disgusting to be gay.

On 20 September 2011, DADT was officially repealed. At the time, I was almost a year back from the deployment mentioned above. Intervening, there was essentially a moratorium on chapter separations. When I returned I was named chief of the outpatient Behavioral Health Clinic—the main psychiatric clinic on Ft. Campbell.

On that day, I happened to be at a several-day training at the Beck Institute in Philadelphia on Cognitive Therapy for combat PTSD and similar conditions. I also had a meeting with one of the experts, in CBT for PTSD, from the University of Pennsylvania who was helping me formulate a "PTSD track" in our clinic. It was there, at the Beck Institute, that I had gotten up on 20 September 2011 and made an announcement before the first session. It was the first time I had declared myself openly as not only a gay man but as a gay man in the Army and a psychiatrist no less.

I learned later this small moment of unabashed honestly was welcomed and found to be quietly brave, when others were just content to be not under scrutiny any longer. I had also sent a note to my chief, who was very open in these matters. Since I was away, I also sent out, via email, a similar type of announcement—the actual email is included below:

Good morning ABH staff,

As we all learn, who work for the Army and military, it is a unique organization with its own set culture and rules.

Today is somewhat historic for the military community, as "Don't Ask, Don't Tell" (DADT) is officially repealed throughout the military.

For those of us who work with patients, this comes up from time-to-time, as patients try to better understand who they are. Of course, for us, the clinical struggle will continue, but, perhaps, the organizational and legal hurdles will be less, as individuals are better recognized for who they are and what they do, rather than other issues.

I would also like to make it clear that it is a joyous day for me, as I, too, can join the ranks openly.

Thanks
Joe Wise

I had decided that if the government did not repeal, I would have turned myself in to be separated. (Sometimes, I wonder if that would have made my future life easier in many respects, if I had turned myself in earlier, when there were frequent separations, but I felt a strong sense of duty to do a deployment tour at the very least and practice psychiatry since there was such a shortage.)

For the email announcement, I remember I chose my words carefully since I did not want to seem too political but rather taking a clinical stance but noting the historic significance for our patients and the Army, as an organization. Anticipating a backlash, I had sent a warning email to my supervisor, the department chief. It was a good move, because, I later learned, the hospital command and lawyer later commented on complaints from employees who felt I was promulgating some kind of agenda. Luckily, the controversy soon died down, though it was disheartening to learning that many in the clinic, which I led, were opposed to the change (and hence made complaints about my announcement).

Finally "Gay" and in the Army

Emboldened by the policy change, I do wonder if my attempt at being "loud and proud" ran the risk of being more foolish than otherwise. My primary task of running a psychiatric clinic and practicing psychiatry might have been halted had there been more complaints—it was not, but I don't know if it would have been worth the risk.

I also learned, several years later, from one of the clinic psychologists, who ended up leaving civilian government service, that my sexuality was frequently a focus of gossip during the time leading up to the repeal: is he or isn't he? Do you know he has a boyfriend? Luckily, the psychologist in question, let me know—and I fully believe him—that he would respond by saying something to the event that, regardless of the sexuality, I was a good work and doing a good job, imagine that, valuing performance, rather than identity.

Relatedly, the long tradition of civilian oversight has been important in these matters. As a member of the military, looking from inside but also somewhat outside, as a medical corps officer, and then as it relates to this volume, as a gay man, separated and silenced during DADT, my experiences bely an organization resolute, including implicitly/unconsciously, in its culture and policies.

Movement to change from within are taken as assaults (terminology noted, given the military mission) and quickly squelched (often implicitly as well, subtly, and without awareness). The most prototypic example was the catastrophizing and negative prediction regarding gays in the military, as voiced, by then USMC General Martin Amos. None, of which, have of course come true.

The religious/moral character of military leadership cannot be denied either. The conservative forces spill over (often silently or even out of awareness) into unwritten norms regarding these matters, where matters of identity become colluded with matters of morality and therefore inseparable and not left to the choices of individuals.

Lessons Learned

In the current culture, this story becomes applicable in addressing the wrongs of DADT in the context of transgender changes. That is, consistent with psychoanalytic ideas of multiple function and overdetermination, as applied to organizations, the efforts to integrate transgender may take on a character of righting the wrongs of prior oppressive policies, potentially with over-permissiveness or unclear lack of accountability. In this hyperrational, stereotypically masculine, and orderly culture of the military, the ramifications for transgender policy are significant. This approach is set up for gender as binary, which is simpler in that it keeps it orderly and neat but orderly since there is no fluidity. Does a gay member have to act gay and be in a helping or logistical branch? It's one thing for the company clerk or medic or linguist or something like that—the organization already sees them as outsiders, not 11B Infantryman. Relatedly, what does it mean to act gay? And, given the conformity culture of the military, what would that mean exactly? Would it mean the same to say that a soldier could "act" the part of any number of minority communities: Black, female, Latino, etc.? In my experience, this seems to happen more after hours, in which small groups will come together, in "civvies," and free of the uniform, to be more themselves, as might happen in a greater society, or "back on the block," as sometimes comes out in Army cadences.

It does beg the question, then, what greater culture is pervasive. It seems to me that a kind of masculine self-sufficient aloofness pervades. It has its root in the larger culture of heteronormative independence and unemotional (except flashes of anger), Western European Protestant and otherwise hyperrational Stoic origins, which is seen as the only root to a warrior ethos. Note, there is no nod to openness, vulnerability, or emotional expression, which might take a great deal of "personal courage" (one of the seven Army values), though that is not part of what is generally meant by "intestinal fortitude" or "steely eyed" warriors.

How does one reconcile the value seemingly placed on impenetrable masculinity, when gay psychologists and psychoanalysts have asserted homosexuality is characterized by erotic passivity in relationship to other men. The challenge is that gay identity, though not illegal or oppressed, as in DADT, simply remains unacknowledged and otherwise marginalized. Since this is a personal reflection, I am "out" at work but not "open" and certainly not "loud and proud." My fear is that greater cultural surround would just be too uncomfortable. I therefore remain my aloof self, "straight acting," as a gay psychiatric patient of mine has pointed out.

We cannot forget that for a military member, unlike every other segment of society, the daily comings and goings are very much up to the particularities of the chain

of command and local supervisors—and, of course, in the military, one cannot just up and quit—so I have taken to a style of not ruffling any feathers until I know I am among allies.

In places where I was stationed (when DADT ended, Ft. Campbell, KY, home of the 101st Airborne Division), it's not uncommon to see people actually stand up for Lee Greenwood's "Proud to Be an American" rendition. It's better because it's legal now, but it's still not proud to be a gay American.

My behavior is not necessarily different in nonmilitary culture. I also don't openly hold hands with my partner except in places like New York City or other gay-friendly areas. Be it explicitly condemned in laws or not, there is an implicit bias against this unsanctioned behavior. From a psychoanalytic perspective, we understand how this external behavior is internalized, such that internalized homophobia continues to exist even outside of awareness (unconsciously), to continue to limit free expression.

Even after DADT was overturned, for the first few years when I was stationed at a predominantly infantry division post, I would not take my partner to events. I would often ask my deputy department chief to go in my stead—since he was decidedly straight and had a wife with a young child—what I felt the Army leadership was most comfortable dealing with.

Clinical Work

For patients who I am likely to treat over the long term, I reveal my homosexuality early on in the treatment relationship. Since there remains a tacit, in my experience, disparaging of homosexuality in the military, I do not want my patients to come upon my identity from other sources and be startled by it. Likewise, if the patients were to be prejudicial, I would assist them in finding another doctor. Other than to patients, I am cautious in who I reveal this information to.

As a psychiatrist, there were a few times I was asked to see gay men during this time. When the only reason was that shared identity, I don't think it ever turned out well; somehow I was on the same shaky ground as they were: exposed but not able to be exposed.

I had the unfortunate duty of being called by the senior headquarters of a nearby reserve unit needing a Command Directed Evaluation (CDE). As per protocol, I called them back. I could not believe it when they suggested a CDE to separate someone for transgender behavior. How is it that a gay man just out from under DADT could evaluate someone for separation for being transgender? As the psychiatrist at this location, assigned for CDEs, especially the sensitive and complex one, I had no choice but to continue to see where this might lead.

Most of the CDEs are related to gathering collateral history from the Command and helping to refine the consultative question. This one was different since all available collateral, from the service members commander, were excellent functioning. I remember making my best case about superb function and "occupational"

problems rather than psychiatric illness. The Command ultimately gave me an ultimatum: gender dysphoria or not? I answered yes, and the individual was separated.

This story highlights the need for civilian policy regarding military matters. There was clearly no aggression directed toward this person, rather a somewhat simple-minded attempt to conform to current policies. Clearly the individual in question was functioning fine. This was just strict, unfortunately thoughtless, compliance with existing policies. This is why the civilian authorities and greater civilian societal norms must monitor military policies—the military is great at compliance, so much so that it is often unthinkingly so.

There were several other times that this came up, but the other intervening psychiatric situations (such as suicidality or hospitalization) seemed to trump the gender identity questions. (Or, perhaps had we had done a better job of affirming identity and assisting identity consolidation, there would have been much less suicidality.)

A New Generation: 5 Years Post-DADT

In the present period, 2016, the changes since DADT repeal are quite amazing. I recently (2014) attended a "dining in"—a formal dinner event, steeped in military history. There were several gay couples—amazing given that it had only been 3 years. But, I suppose, one thing about the military is there is very rapid turnover. I remain amazed, in awe, that they brought their partner or gay boyfriend to a military event.

Many enlistments are just 3 years. So, there can be significant organizational turnover in just a few years. (There is a certain irony in this for a psychoanalytic psychiatrist, in which treatments can last years—very different from many of my colleagues who think in terms of 30 minutes of mainly psychopharmacological appointments.) That's why, ostensibly, I do not think sexual orientation is much of an issue now, at least, in a manifest way. I do think implicit bias remains. Moreover, in a military culture that values the Warrior Ethos, how can it actually embrace homosexuality, without significant changes to the social unconscious, since homosexuality, in men, is erroneously equated with passivity or femininity?

One would think that gay recruits would not even consider joining the military. That would be logical, but the military, now and for many years, has been a place of social mobility for lower socioeconomic status. The lure of a job and education is enough practicality to make many choose the entrepreneurial side of their personality, rather than the side aligned with identity. Additionally, for some, especially those struggling with identity, the military gives structure and regimentation, when the fundamental questions of life are unclear, the structure can be salvo. Likewise, the respect afforded by military, nowadays, is likewise stabilizing in the context of the whirlwind of identity questions.

Residual Effects

What are the residua or hanging detritus of an oppressive policy, in which one class, based on a fundamental aspect of identity, is labeled as not capable in a fundamental element of citizenship, protecting the homeland? In so doing, this group of citizens gets cast out, and labeled, yet again as less than, or not capable, or disturbed, or not desirable, or not worth associating with. How does a group of people or how do individuals in this group keep going in an organization and society, since we are talking about an aspect of citizenship?

One way would be to collude in the outcast status and defy the rules of the society. This most certainly happened in the sub-rosa gay culture of military bases in which sleeping around, regardless of rank, was not uncommon.

Yet another way would be to identify with the aggressor, to take in parts of these oppressive views and make it part of oneself. To internalize that one is in fact less than, not worthy, and to keep these parts of oneself walled off and secret. It is a "if you can't beat them, then join them" strategy of survival.

As editors, this was our experience in trying to find contributors to this volume. We had a terrible time getting authors. When we did get authors, the chapters were very slow in coming, making me think this story is too painful. This was felt to be too personal, private, not that important, or that here is no story to tell. As we know for psychoanalysis, it is narrating the story, in the presence of others in a relationship, that leads to integration—the walled off, pushed away, and secret parts get brought back in, laid open, examined, looked at, and then taken back inside in a less secretive way. In a sense, in telling the stories in this volume, we hope to do the same thing as an organization and not just for individuals.

In the military, it is, of course, more common than not to become numb to trauma, including organizational trauma like this. It's a way of coping, dealing, and managing the unmanageable. I am in no way comparing oppressions of gays in the military to combat PTSD, but the phenomenon is the same—detaching and becoming numb as a way of rationalizing the irrational. (In this analogy, anger would be another way of responding, but it seems it is much more common to direct anger, due to the power structure in the military hierarchy, inward rather than outward.)

Organizationally, it might have been nice to have acknowledged for service, against all these odds, at sort of rapprochement, but maybe that was just too much to ask for, and now it feels a bit late.

Conclusions

I hope this narrative can add to our common memory of this time in history when DADT was in place, during the time around the DADT repeal, and the few years thereafter. In a sense, I tell my story as a medical officer during this time, but I also chronicle some of the stories of those who came to see me as a psychiatrist. I hope also to have conveyed the greater organization and societal dynamics of this time.

Lastly, we can consider the DADT story in light of continued changes with military policy regarding other minority groups, most especially sexual minorities.

So, "does anybody have something to say?" I do, in fact, have something to say, though it has taken a long time for it to feel safe enough for me to say it. I hope you can hear it in what I have written. For it is through speaking that human beings come alive as a subject.

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"Family": Surviving the Don't Ask, Don't Tell Years

8

Monica Ormeno

It turns out writing about yourself is not as easy as I had thought it was going to be. When I first heard about this project, I immediately fell in love with it. The idea of writing about the trials and tribulations I experienced while serving in the Navy as a lesbian during "Don't Ask, Don't Tell" sounded so appealing. I love talking about it at parties and gatherings, so writing about it should be a piece of cake.

The thing is, in order to write about it, I had to examine those first 13 years of my Navy career. Once I started doing that, I realized very quickly that I didn't have it as hard as most of my fellow LGBT service members had it. I really didn't. Yes, I had some shitty times. Yes, I was scared that my career could end any day, but I still remember those years fondly. Maybe, my brain has chosen to erase all the anxiety and anger I felt during those years, or maybe it really hadn't been that bad for me.

Making Friends to Make Do

After several weeks of self-examination (I don't like the word procrastination, it has a bad connotation), I still couldn't come up with the reason why I now feel that the days of DADT weren't that bad. And then, something reminded me of why my DADT days were not as hard as they could have been. I recently transferred from being stationed on shore in a hospital to being stationed on a ship. Anyone that has ever been stationed on a ship or any other operational command will tell you that when you're operational, everything is about "the hookup."

The "hookup" culture is universal to any time the military places people in the middle of nowhere with limited resources and supplies. You have to learn to make do with the little you have, and you have to learn to make friends who would give

M. Ormeno, DO (✉)
Naval Medical Center San Diego, San Diego, CA, USA
e-mail: mormeno2007@gmail.com

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_8

you supplies when you need them and no one else has them. On a ship, real estate and supplies are very limited.

I was starting a pilot program: a psychiatrist on a ship was something new in the Navy. I was one of four psychiatrists starting this program in the Navy. So, I needed a space to work, and I needed office stuff: a desk, a computer, computer access, a desk chair, a couch for patients, etc.

As part of this pilot program, I was assigned my own personal behavioral health technician. my own personal psych tech. He and I were team mental health for three ships and one Marine expeditionary unit. My psych tech had deployed several times before, and I had a couple of deployments under my belt. I was able to secure a space for us to work from, but we needed furniture.

I sent my psych tech on a quest to find everything we needed to set up our office. In a matter of hours, I had everything. I was surprised how quickly he had gotten everything set up. I asked him how he got things so quickly, and his answer reminded me of what kept me sane during the days of DADT. "I just find the gay sailors and I tell them my boss is family and they hook it up!" he said.

I busted out laughing when I heard his answer. I am completely out to everyone I work with and my psych tech had met my wife at command gatherings. I had never thought that being gay on a ship gave me an advantage. I guess 13 years of serving under DADT got me used to thinking about being gay as a burden. My psych tech reminded me of the importance of "family" and he's not the first one to do it. "Family" is the reason why all my memories from the DADT days are not so bad.

Early Years

Making friends during DADT was difficult. Imagine getting to know someone and not being able to discuss this huge part of being a person: your romantic life. I was "raised" in the fleet. My first duty station was a ship in Norfolk, VA. I was enlisted at the time and all I cared about was becoming an officer. So, during the first 5 years of my Navy career, I avoided people, I did my job, and I went to school.

I have few friends from those years because I was on a mission: I wanted to be a Naval medical officer. I didn't have time for friendships because making friends wasn't my priority. I think it also helped that during those years, I was a closeted bisexual. So, I hadn't admitted anything to myself to be shared with any friends I could make.

I graduated college in 2003 and was accepted into a commissioning program (Health Professions Scholarship Program). The 4 years of medical school are a total blur. I remember just being busy trying to survive (both financially and academically). By the end of medical school, I had come out to some friends and relatives about being bisexual. Just like in college, romantic relationships were not a priority for me during my medical school years. The internship year was a very busy year, but I had more time to date and I realized that I was just a lesbian hiding under the umbrella of bisexuality. Great! I finally had achieved my ultimate goal of being a Naval medical officer, and now it was all going to be gone because I was gay.

I had to protect my career, so I spoke little about my romantic life, which led to my coresidents believing that I was a very promiscuous person. I really wish I knew how people made that connection. I guess men are promiscuous when they talk about their conquests, and women are promiscuous when they don't.

I don't like labels, I think we have too many already. But, I do feel that the fact that I am a "lipstick" lesbian helped people believe the rumors of me enjoying the single gal life. I was actually happy that people thought I was sleeping around with guys all over town. Because as long as people felt that way about me, no one knew who I was really sleeping with.

Outing Myself

Eventually, it's almost impossible to keep a secret from everyone. A couple of months into my second year of residency, I accidently "outed" myself to someone at work. My best friend from college was also in the military, and she was deploying to a combat zone. I would send her care packages every so often while she was out there. She is bisexual, so I wanted to send her movies and shows that she would enjoy.

I know what you're thinking and the answer is: no, I wasn't trying to send gay porn to my friend while she's in a combat zone. I was just afraid of sending her gay-themed movies and shows to a place where everything she got was strictly checked. One of my coresidents told me that one of our ward psych techs had helped her pass prohibited items to some of her friends who are deployed. So, I asked this psych tech for her help.

All I wanted was to send some DVDs of shows with gay content. I was expecting to pay for the services my psych tech was going to provide, but instead, she helped me and said: "No worries, ma'am. We're family." I just thought she was being nice, she's probably talking about all of us being a big Navy family who help each other. I knew what "family" meant in the LGBT community; I just didn't think that was the type of family she was referring to.

But within a couple of days, something strange started happening. I would walk around the hospital and different women (both enlisted and officers) who I had never met before would wave and smile at me in a caring way.

It's hard to explain. I have always been a big fan of female college basketball and had season tickets to the local female college basketball games. I started noticing the same women who were now acknowledging me in the hospital were also attending these games. Before I knew it, I was running into these women at games, bars, restaurants, having conversations with them, and making friends with them.

As I got to know them, I learned that some of them had been with their partners for their entire Naval career: some of these couples had hidden for decades. They are Navy nurses and doctors, Navy chiefs, and Navy and Coast Guard officers. They had deployed to combat zones and seen their friends get kicked out for being gay before DADT. They told me stories about witch hunts prior to DADT. I heard about all the sacrifices they had made while serving in silence.

It was thanks to my brand new family that I was introduced to clandestine organizations that were lobbying for the repeal of DADT and advocating for our families to be fully recognized and have benefits. I would have never thought that accidently "outing" myself to a psych tech would have led to me finding my "family."

Having family with me made me feel protected. I had a group of people who took care of me. Every department had them and we all knew who we were. I never asked how they found out about me. I was just so happy that I had finally found a group of people that I could relate to. Having family with me gave me courage to come out to others.

By the end of my third year of residency, I had come out to some of my straight friends. Coming out to someone who is also a service member during DADT was tricky. You had to trust that they were not going to turn you in. You were asking someone to lie for you. Naval officers don't lie, cheat, or steal (or get caught).

My straight friends were all super supportive and understood the repercussions of knowing I was gay and stood by me. Some of them even contributed to the rumors of my heterosexual promiscuity to help me appear as straight as possible. Yes, my friends are great: they would make sure people thought I was a whore before they thought I was a lesbian.

It was good to have family around me because dating during DADT was not fun. Online dating was out of the question; I didn't want to run the risk of someone else seeing me on a dating site looking for women to date. I had to meet women the old fashioned way. But when I met them, I couldn't immediately tell them I was gay and interested in them. I had to play so many games in order to find out about if the women I was interested in would date me.

Of course, the other problem was that when dating someone during DADT, I had to ask them to be in the closet. Coming out is so hard: once you're out, no one wants to go back in. So, my options were limited to women who would be willing to be in the closet with me. Everyone I dated during DADT was in the closet (to everyone: relatives, friends, sometimes even themselves). The problem with dating someone who is in the closet is that you can't really imagine a future together. I always wanted to be a mom; how was that going to work out when all the girls I was dating didn't even want to publicly admit they were in love with me: a woman?

Hanging out with other gay officers was not risk-free. I needed those rumors about sleeping around with guys, because going out to bars and restaurants with "family" meant that people could also spread rumors about me being gay.

The benefits of having family in the hospital by far outweigh the risks. Especially when under DADT, almost weekly I would hear a homophobic comment made by a colleague or a patient. I feel that DADT allowed service members to be openly homophobic.

Homophobic comments from patients are easier to handle; but they still hurt. They were easier to handle because patients are supposed to tell us their darkest thoughts. Homophobic comments from patients always confused me; it's harder to care for someone who hates something about you that you can't change. So, I handle them the same way I handle any hateful comment about something I can't change.

I was born and raised in Peru; I look Hispanic, I have an accent; English is my second language. I've had several patients make comments against Hispanics, immigrants in general and nonnative English speakers. Each time, I dealt with them accordingly.

Homophobic comments are a bit different because patients can tell when they meet me that I am a Hispanic immigrant who learned English as a second language. People can't really tell that I am gay, just by looking at me. So, confronting patients as part of a therapeutic process about their homophobic comments was not an option. Plus, confronting a patient on a homophobic comment would have meant "outing" myself to the patient.

Homophobic comments from colleagues hurt me because I expect more from educated people. I want to believe that homophobia is based on ignorance and not hatred and that educated people are less ignorant about the world. I guess, in my heart, I want to believe things that I know, in my head, are not true.

The End of DADT

Before the Republican Presidential campaign of 2016, my colleagues wouldn't say racist things in front of me. But, during DADT, they had every right to make homophobic statements, and I couldn't confront them. Not everyone was an open homophobe during DADT; it was always a relief to find a heterosexual fellow officer, who didn't know I am gay, who would openly talk about the need to repeal DADT.

I wanted to be a child and adolescent psychiatrist since my third year of medical school when I shadowed a Navy captain who became my mentor. He was the Director of Mental Health at the Naval Medical Center Portsmouth when I worked for him. During my child and adolescent psychiatry rotation, I attended a resident case presentation with my mentor. The case was about a gay sailor.

During the Q and A part of the presentation, the topic of what to do if we found out that a patient is gay came up. Some of the active duty psychiatrists argued that as Naval officers, we were required to report gay patients to their chain of commands. My mentor emphatically disagreed. He then was questioned on what he would do if he found out that one of the officers under him was gay. His answer was priceless: Can he or she still see patients?, he asked. The audience chuckled and answered: "Of course." He then proceeded to say that if being gay doesn't preclude the officer from doing his work, he didn't care. "You're here, you're queer, get to work!" was how he ended his answer. A Navy captain, a Naval Academy alumnus with 20+ years in the Navy, a Christian man from the South, didn't care if his sailors were gay; he only cared that they were able to do their job. Hearing his answer gave me hope that, one day, DADT would be repealed because the repeal wasn't just good for gay sailors; it was also good for all service members.

For most of the world, December 2010 was just another month. I don't think I slept for that whole month. It was the last month of a democratic majority senate, and the Obama administration was trying to pass the defense budget, which included

the repeal of DADT. I was glued to C-SPAN, CNN, and Facebook, constantly trying to get updates on the latest news.

I wanted DADT to be repealed, I needed DADT to be repealed. I needed to be able to date someone who I didn't have to hide with and I wanted to have a family one day. Finally, on December 22, 2010, DADT got repealed. I felt that all the anxiety, all the fear, or the uncertainty that I had felt at different times in my career was gone. I no longer had to live thinking that any day I could lose my career. It was really a feeling that I can't describe with words.

I cried, I called my relatives, I celebrated with my family. My friends who knew I was gay congratulated me for the repeal of DADT as if I had won the lottery. And it felt like I had won something: I was ecstatic. I didn't care that I still had to wait until September 2011 to be completely open about being gay. But, the wait for the implementation dragged. It was my last year of residency, and while waiting I still couldn't be open about who I was, but there was light at the end of the tunnel.

I met the woman who is now my wife in my intern year. She doesn't remember meeting me. I remember everything about that day. I remember who introduced us, what she was wearing, who she was sitting next to. I remember she had a drink in her hand, and I remember thinking she was stunning. I also remember that every time we would run into each other at the hospital after we met, she always smiled at me and waved. Each time I saw her, I always thought she was so beautiful.

My wife and I went to the same medical school. She finished 2 years ahead of me; we had some common friends in medical school and we were often at the same parties, but we weren't formally introduced to each other until my intern year (even if she doesn't remember). We did our residency (she's ob-gyn) in the same hospital. Again, during residency, just like in medical school, we shared common friends and found ourselves hanging out in the same places. Because of DADT, neither of us knew the other person was gay.

I arrived in Guam, my first duty station after residency, in July 2011. My wife's best friend and I arrived together. Once again, I was introduced to my future wife, this time in Guam, while we were both staff attending Physicians. Yes, I also remember every detail of meeting my wife for a second time and this time she remembers meeting me.

Shortly after we meet, we all started hanging out; as I got to know her, I learned she was gay and about a week after the DADT repeal was officially implemented, we started dating. My wife was the first person I dated openly in the military and it's been awesome! Of course, we have challenges, just like every relationship. But, through all our challenges, we have continued to have our "family" by our side.

The word "family" for me has now so many meanings. I am blessed with wonderful, loving, and supportive blood relatives. I adore my parents and their 10 siblings who produced over 40 first cousins for my only child self. I don't want to bore you with how close I am to my mom's second cousins' kids (we grew up together spending our summers running around chasing cows and rabbits in the Andes). I have an incredibly large group of people distributed all over the world that I am related to by blood. These people have been amazingly supportive and loving to me, to my wife, and to our daughter and son. My wife went from having 3 first cousins

in America to having over 100 people in Peru, Australia, Italy, and Germany who now call her "Prima." My blood relatives are part of my family. But my family is so much bigger than just the people I share some DNA with.

My wife and I dedicated our wedding toast to our guests. Our guests were the people that hid our secret during DADT and called us super excited to congratulate us after DOMA got repealed. They were the people who sent me care packages when I was in Afghanistan or took my wife out drinking while I was in Afghanistan. Our wedding guests were our "family." Our "family" helped us survive two deployments, my fellowship, three moves, having our first child in the middle of a move, and expecting our second child while I was deployed.

This family has grown exponentially since DADT was repealed. All the clandestine organizations we were part of during DADT are now nationally recognized. Organizations like the American Military Partner Association (AMPA) and OutServe now have chapters in every duty station where soldiers, sailors, airmen, and Marines serve. New organizations, like Gay, Lesbian, and Supporting Sailors (GLASS) and Sparta, are also recognized and supported by the military. My family members are not only gay, lesbian, bisexual, and transgender; they're heterosexual people who have been fighting by our side for years.

As I finish writing this chapter, I find myself thinking about how much better my life is after the repeal of DADT. However, as I finish writing this chapter, I am reminded that there's still a lot of work to be done. I was recently flown to evaluate patients on one of the ships I serve. One of the patients I saw was a young gay Marine who was struggling with depressive and anxiety symptoms due to being physically and verbally abused by his peers for being gay. How could this be? Didn't this all end after DADT got repealed? Once again, in my heart, I want to believe things that I know, in my head, are not true. And as I try to help this patient, I am navigating (literally and figuratively) through several parts of the military legal system. Numerous e-mails exchanged trying to help this patient, multiple meetings with senior enlisted and officers in charge of making things happen in order to stop this patient from being bullied for being gay. I am finishing writing this chapter when I got an e-mail from one of the senior enlisted females who was helping me coordinate care for the gay Marine. She ended her e-mail telling me how nice it was to have a family onboard. I've been walking around with a huge smile in my face since I read that e-mail. I trust my gay patient will be cared for after I leave the ship; he has family onboard who will make sure he's safe.

My family is the reason why I felt safe during the DADT years. I am so glad I accidently "outed" myself to a psych tech 10 years ago. An accident that could have ended my career turned out to be a path to meeting amazing, caring people who I now call family. And with my family, I feel stronger to continue to fight for acceptance and respect.

Here/Queer/Used to It: An Account of a Post-Don't Ask, Don't Tell Mental Health Provider

9

Jackson Taylor

In this chapter a personal account of a queer-identified mental health provider who commissioned and served in the Medical Service Corps of the United States Navy after the repeal of Don't Ask, Don't Tell is provided. Reflections on entry into service, training, and early career are included with regard to personal significance and professional experience. Insights are offered to advance our understanding of the lives of LGBTQ service members and further improve the mental health care they receive. The views expressed here are that of the author alone and do not represent the views of the Department of the Navy or the Department of Defense.

Arriving

At the time of the repeal of Don't Ask, Don't Tell, I was enrolled in graduate school at the Derner Institute of Advanced Psychological Studies, Adelphi University. Having recently completed college, I thought I would be in New York City forever. I had my sights set on developing as a practicing psychologist and envisioned a full practice in an office with good light, packed bookshelves, and carefully curated art. Among the subtle variations of this fantasy, I had not even the faintest idea that I might soon find myself in a military uniform on the other side of the world.

Five years later, I am an active duty Navy psychologist at the US Naval Hospital Okinawa in Japan. My schedule is full. My office has good light. The fast pace at which I moved throughout my training has met its match in this setting, although the streets at night are far quieter and the air fresher than that of New York City.

I commissioned through the Health Professions Scholarship Program (HPSP) in 2012. I learned about HPSP while searching the Internet for scholarships, grants,

J. Taylor, PhD (✉)
Medical Service Corps, United States Navy, Washington, DC, USA
e-mail: jacksontaylorphd@gmail.com

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_9

and fellowship programs at the tail end of my first winter break of graduate school. The program was impressive and afforded tremendous opportunity. I felt compelled by the significant mental health needs in the military, and my interest piqued at the consideration of the unparalleled settings in which military psychologists operate. Suddenly my fantasy office in Greenwich Village seemed to be, well, pretty basic.

I may have been a lot of things at age 22, but basic was not one of them. I came of age in the city, where I made a home there among a community of passionate, talented people. These people—many of whom were some kind of queer—were ripe with intellectual proclivities and trying (at times desperately) to figure out how best to live. I kept myself surrounded and was always the available listener. I was full of life but too skinny. Hungry, it seems, for some other way of being. So in considering a career as a military psychologist I took what I knew from my past, from my education, and from my New York City gumption, and I did what came naturally to me: I went for it.

A month after my initial inquiry to the HPSP program manager, I sat in the passenger seat of my recruiter's car outside of a Military Entrance Processing Station (MEPS) in Brooklyn about an hour and a half before it opened. Hurried and waiting, we talked about his divorce, my schooling. Later, I crawled around in my underwear with a bunch of teenagers as a doctor assessed who knows what. *Someday when I am not a specimen, I will look back on this experience and laugh*, I thought. At the time, I was too disoriented to locate the humor. (At least at MEPS, crawling around in your underwear is made explicit. In graduate school it just feels like that.)

Shortly thereafter, I was flown out to San Diego for an interview with a trio of Navy psychologists. I recall being asked a few stark questions about my training, my relationship to authority, and whether or not I would "feel comfortable being thrown in there with a bunch of marines." Calmly setting aside my host of associations, I replied, "Absolutely." The interview went well.

Countless others had asked such questions, although generally not so explicitly. The prospect was exciting. With DADT repealed, it felt as though the military was something of which I could be a part. Still, its history, along with mine, gave me pause. It should come as no surprise that a gay boy's entry into service involves a question of masculinity. The same could be said of any entry into service, I think, although the queer variant just presses the issue. Semiconscious of the conflict I had around my experience of gender and its expectations, I knew enough to appreciate the nuance. Sometimes aggressing, sometimes receding, the question of masculinity is perpetual [1].

I considered military service of LGBT people to be a bold move, an indicator of agency and action. It struck me as a distinct strand of bravery that was previously subversive, gradually became progressive, and is destined for the new normal (the kind of new and the kind of normal that was always there and already that way). I thought of LGBT service members as people I wanted to know. I imagined them as people to look up to, which can be a bit of a hide and seek in the gay community. *Come out, come out, wherever you are.*

Poking and prodding at MEPS behind me, I did my best during the application process to get a sense of what being in the military would actually mean. To build an understanding, I started with the most available sources: private past experience, literature, and art.

Private Past Experience

The military was not entirely foreign to me. One of my sisters and her husband attended the United States Military Academy at West Point (USMA), and few were held higher in my esteem when I was growing up. I also recalled stories about late family members who served during times of war, although they were largely unknowable to me.

I tried to focus on what I knew. In 2007, during my senior year of high school, I cared for my infant nephew while both of his parents were deployed. I recalled the way distance distorts a milestone in the memory of broadcasting some of his first steps via webcam to his parents in Iraq, albeit pixilated and delayed. I thought about the precarious joy in this arrangement, the feeling of being faraway, and the ever-present dread of dropped connections. *Are you still there?*

Around that time, my first relationship with a man began. He was a combat veteran stationed several states away. It was a different joy, a different faraway feeling, a different dread. The relationship progressed quickly (as is common among service members of a certain stripe), but we never managed to disassemble the shame we carried as an accessory to our relationship. With time and under pressure, we blew up.

For a couple summers in college I had worked at USMA doling out standard-issue items to the incoming class of cadets, counting and labeling supplies, and setting up and dismantling seating for graduation. These were odd and at time quite dull but necessary jobs, supportive functions. Amidst the quotidian, a certain mystique exists at any institute of considerable tradition. Among the new cadets, I observed the pairings of merit and boredom, courage and fear, camaraderie and solitude. I was drawn in.

I read the critical journalism and the fiction. I attended lectures and art events in which veterans told their stories. "There is no such thing as a hero," I remember someone telling me. She was someone I admired, and I felt compelled by these stories, mesmerized even. I read up on moral injury and the ways in which the psyche is bruised and battered in the line of duty. I watched the documentaries. I read related poetry, too. I underlined E.E. Cummings' line: "true wars are never won" (Cummings, a poet, served when the world was at war).

Perhaps I heard "the call," but my siren song was not tales of victory or heroism. I did not watch those movies. It was not the romance of the American soldier. It was his private experience, her inner world. It was longing, loneliness, loss, and reckoning. In these themes, I felt gripped. Perhaps it was an extension of the struggle I had with my sexuality, perhaps it was a function of the human condition. I did not quite

know, but I realized this was both my way in and a way of coming out. I sought to make something of my associations with war, with loss, with reckoning. In "the call" I heard a song of myself.

At the end of the semester I received an excited text message from my recruiter, *BIRTHDAY CAME EARLY!!!!!!*, and from that I learned I was one of five psychology doctoral students in the country offered the HPSP scholarship. The following week, a sweaty, makeshift commissioning ceremony ensued in a vacant room at my graduate school clinic as an intermission of sorts between some of my first therapy sessions.

On Training

A year after I commissioned, I shipped off to Officer Development School (ODS) for 5 weeks in Newport, RI. (Too brief and too picturesque for a "real" boot camp, my sister chided.) I imagined training would include early morning workouts, high volume, and a lot of polyester. I would learn to walk and talk again to shape up into the archetypal American man: rugged but dignified, fearless, noble…fierce haircut.

I was pretty sure I would not be a natural but believed I had what it took. I was fit. I could hurry up and wait with the best of them. If dancing behind closed doors was any indicator, I could execute sharp and vicious movements. I could march for the imagined audience. The Star-Spangled Banner gave me goosebumps; I could proudly hail. I could salute.

At ODS I was neatly outfitted in a khaki uniform: my corners were strapped down, tucked in, and creased like a parcel. I felt like a piece of mail.

Training had its challenges but in comparison to our noncommissioned counterparts, the commissioned officers had it made. While we struggled to collapse our independence into the battle buddy system, the officer candidates quite literally crawled from place to place at the command of their superiors. We thought it was a tall order to feed fully in 7 min while they performed an orchestrated mealtime ritual I am not sure I can even describe. Perhaps no more clear a difference than the humbling fact that at the end of the day, our stripes were already sewn while theirs were not yet ordered. Indoctrination is developmental, I learned, and respect for your shipmates is an early and easy developmental achievement.

Still, despite the apparent advantages, a pulsing out-of-place feeling seemed to accompany me through each and every evolution. I tried to view it as a typical growing pain—worry as a placeholder until some certainty told hold. I tried to chalk it up to the chow (a term that still does not sit well with me), but the food was just fine. I thought it might have something to do with two identities I had already grown into and was quite fond of: an intellectual, a pacifist. (Truth be told, answering commands with a holler of the word "Kill!" in unison made me queasy. Can we think about this for a minute?!) I was no stranger to feeling different, though. So naturally, I figured it had something to do with not being straight.

Although prior to basic training I considered the concepts of fortitude and endurance, I had not thought much about the kind of durability needed to brush up against

the confines of a new, standard issue identity and emerge unscathed. Others filled out the uniform better than I. But resiliency doubles as the capacity to adapt. I carried on. I ironed, I starched. Still the specimen, I hurried, I waited.

I took to thinking the uneasy feeling I was carrying might link me with the sexual minority service members that came before me. *What am I doing here? What if who I really am is revealed? Who am I kidding?* Certainly not unique to sexual minorities, these were familiar questions in the internal dialog of difference.

My attention drifting from memorization of the general orders of a sentry, I considered the pros and cons of blending in, of "passing." This particular page from the socialization playbook was worn and torn, but it had been awhile since I had turned to it.

Albeit a lonely dwelling, the proverbial closet can foster an intense sense of closeness and even its own (gated) community. This is something known to those who find reprieve in the discrete, people comfortable "on the down low." Those who are decidedly not out are afforded a certain degree of choice: to stand alone or allow another in. I considered the 11th general order: "…challenge all persons on or near my post and to allow no one to pass without proper authority."

Those who reside in the closet are in the dark most of the time—stumbling, fumbling, and either feeling around or just trying to keep still, which, coincidentally, is not unlike basic training. Perhaps this is why LGBT people are particularly apt at navigating military service.

In a training command or other environment where an individual is virtually never alone, privacy is precious, sacred even. Only very recently could an out LGBT person stand at ease in the US military. Accordingly, doing so is a particular honor. But being out in the military requires not only presence in the command structure and community but also adapting to the local cultural surround, be that a military base, a training command, a vessel, a detachment, a deployment, or a host nation. In other words, when you are out in the military, you are way out. The fact that I could be out at the time of my commission brought with it a strange question: Did I want to be?

Perhaps no more clear a sign of progress than when the previously invisible subsequently choose to go unseen. More or less closeted until graduate school, going unseen was familiar for me. It felt like home. But home was not a place I returned to often.

Coming to terms with gay identity in a straight world is a challenge. Queer identity is one way I continue this formative process. Once a common derogatory term, "queer" has been revived in reclamation. It houses a strand of social criticism in academia (queer theory) and the term has been embraced as a symbol of perseverance and solidarity in the ultimate classroom—the real world. For me, queer is an indicator not only of my sexual identity but also of my thoughts on identity in general and sexual and gender identity in particular (thoughts informed by Bersani, 2001, among others) [2]. Although I use gay as a synonym (shorthand, a local equivalent) when a conversation about identity politics seems well, fruitless, I identify as queer not to be exceptional but to bring the value of difference back into the fold. Queer is a way of looking at the world in addition to a way of being in it. It is a way of creating a home I can live in.

Insofar as I can choose to pass, I choose to be out. Of course it helps that I serve during a time in which the Department of Defense formally recognizes Pride Month and commands throughout the world serve colorful sheet cakes in celebration. It is a time at which transgender service members are visible and gender identity is the subject of service-wide trainings. It is a time when a biannual drag show is hosted on a US military base in Okinawa, and it sells out. The pioneers of the gay rights movement likely never dreamed today's gay pride events would be draped in corporate sponsorships. In this era, when I stop at the commissary to pick up a few things on an otherwise unremarkable evening, I notice I am in the company of not one but three junior enlisted lesbian couples. "You know I don't eat fruit unless you pack my lunch!" I overheard a marine tell her wife in the produce section. I smile and wish we could be friends, feeling out and proud among the apples and oranges.

Yet it is also a time of staggering juxtaposition. Bachelorette parties flood gay dance floors, unapologetically. Drag culture is popularized and co-opted, often with little understanding of from where it came. And in the political arena, motions that seek to reverse the social progress that has been made in America continue to be pushed. Prejudice and discrimination persist stateside, and LGBT lives remain in grave danger around the world. At present, American society at large is more keyed in to the importance of diversity, yet efforts toward respect and understanding are parodied as the phrase "politically correct" meets criteria for pejorative in heated (usually cyber) conversations. It is a time when some kinds of people, some perspectives, and even some lives matter more than others.

I can only speak from mine. Despite my sexual minority status, I am privileged as a highly educated, white, middle class, cisgender male. I matter. I am aware that my experience may not map onto that of a great many others. In my brief tenure as an out officer, any marginalization I might experience in the military is similar to that of nonheterosexual people in the civilian sector. (Gay may be okay, but it is largely still considered the exception to an otherwise straight and narrow rule.)

Unlike some of the accounts of LGBT service members I have heard, my supervisors and chain of command were not fazed by my sexual orientation. In fact, to say they were "supportive," or "accepting," or even "tolerant" of my sexuality would imply a pause was placed on that aspect of my identity, and I do not believe there was such a moment. As a military mental health professional, I am subject to more slightly concerned looks in response to my theoretical orientation (psychodynamic) than I am as a sexual minority. This is progress.

As is the case for many occupational specialties in the military, I was neither the first sexual minority in my field nor the only LGBT person in my training cohort. Far from it, in fact: I stand among a number of out clinicians, a proud number I can say is many more than a few. The fact that this path was well trodden was refreshing, although it made me feel less bold. This, I think, is the experience of a post-DADT officer: a sense of relief to simply fall into the ranks mixed with an odd envy of the actual pioneers. (We salute you.)

The Struggle

The increasing public acceptance of same-sex love and visibility of LGBT lives does not mean our work here is done. Great strides were taken in the years leading up to my entry into service, and it is my hope that we will continue to keep the pace. Mental health professionals are particularly well suited to lead the charge, given their training and, ideally, their background experiences that cultivate understanding of self and other (personal therapy is a good place to start). It may be that LGBT people in the military have an easier time than they used to—I think that they must—but still, it is not easy for many. The struggle persists, and colloquially speaking, the struggle is real.

The struggle of LGBT service members is apparent as we brush (or bash) up against vestiges of homophobic and oppressive aspects of heteronormative ideology in the daily grind. Mental health needs of service members remain high as our LGBT troops face not only the exigencies of military life and its associated stressors but are also tasked with combating stigma and navigating modern identity and identity politics. As clinicians, our minds need be tuned to the impact of background experiences, developmental hurdles, technological contexts, and the sometimes dangerously shallow dating pools in which LGBT service members find themselves.

It is also important to note that LGBT issues are not exclusive to the LGBT-identified. Children of heterosexual service members are exploring and questioning their identities. Parents, sometimes taken aback when a child comes out, may seek guidance. Some heterosexual service members are children of LGBT homes. They too have gay brothers, lesbian sisters, queer peers, trans neighbors, questioning friends, and sometimes nonconforming nemeses.

Although DADT was repealed at the national level, the individuals that comprise the armed forces may have sympathies, allegiances, and identifications with family systems, histories, and state or local governments that espouse discriminatory policies, laws, actions and attitudes. Even a cursory glance suggests that the sentiment of DADT appears to be a standard operating procedure in many families and communities that service members call home. It is, of course, hardest to repeal policies of invisible instruction.

Purported locker room talk or otherwise, we cannot close our ears to the continuous use of "gay" as a synonym for stupid, or pretend not to notice how "faggot" equals loser (see Corbett, 2001 for a clinical analysis of this phenomenon) [3]. So much more need be done when a service member is up in arms about her recent haircut being shorter than she had wanted and states with outrage, "I don't want people to think I'm a dyke!" The work is not simply that of gay visibility, it is of straight recognition, consideration, and care.

As LGBT advocates, mental health professionals, and agents of social change, it is important to observe the ways in which discriminatory practices or marginalization might recapitulate even within the LGBT community. The oppressed and marginalized are not immune to perpetrating similar injustices. For example, I recall

feeling deeply troubled by the solicitation of support for "dropping the T" from the LGBT community on a private social media group for LGBT officers prior to the lift of the ban on the military service of transgender people. There exists the view of trans people as disordered and disorderly—shame and rejection projected onto what might be a perceived lower hanging, stranger fruit. Of course I was not alone in the outrage at such a motion, but it was a reminder that however strong the correlation might be, sexual orientation and a value system based upon inclusion and equality are not always partnered.

I also recall feeling flabbergasted when a colleague unintentionally referred to the 2016 tragedy in Orlando as "the greatest shooting in US history" ("You mean the worst?" I asked.) And I was disheartened by the "no prancing around" directive issued by a peer in the command LGBT pride group at a meeting prior to the local pride festival (notably, a meeting called to discuss reactions to the Orlando nightclub shooting). No prancing around as if it were a motion to be ashamed of, a limp wrist when a situation demands a proper rendered salute. Lest we forget the limp wrist is a salute of another kind, even a potential monument. But as preferred, passable forms of homosexuality remain prioritized, femme queens vogue butch.

These kinds of exchanges stayed with me because they made visible the roots of stigma and unearth areas for continued growth. The band plays on; there is more to cultivate. By and large, we are still educated in a system wherein LGBT history is at best an elective, if not an entirely individualized study. It will be challenging for the next generation to learn about and from the lives of LGBT people if the history is not taught. This is precisely the reason the US Navy vessels USNS Harvey Milk (T-AO-206) and RV Sally Ride (AGOR-28) carry such a significant weight. (For an in-depth history of gays and lesbians in the US military, see [4].) Similarly, sexual health of LGBT people remains at elevated risk when sexual health education (when and where available) considers same-sex sex unmentionable. We are here (and have been), we are queer (et cetera), and we would like to say hello.

Onward and Upward

I was fortunate to complete my clinical training in the Hampton Roads area of Virginia, an area with a tireless LGBT pride organization and community. Many people in the area were attuned to the needs of the community, even if they themselves were not card-carrying members. My colleagues sought consultation on LGBT-related topics, attended local events, or simply inquired earnestly about aspects of the culture, such as the origin and definition of "Yas kween." Although it holds the potential to be intrusive or burdensome, these kinds of consultations were welcomed, even if sometimes I would subsequently text a friend to say, "Gurl, get this…"

It is crucial to have trusted colleagues to turn to and lean on as needed when navigating these situations or others that may present in the context of general military training or clinical care. Like, *Gurl, get this: Mandatory online training now includes information about Pre-exposure Prophylaxis to help people lower the risk of HIV infection—we betta werk.*

Or, *Gurl get this: A devout Christian patient sexually involved with another young man reported his most recent fainting episode occurred immediately upon viewing a rainbow after his lover invited him outside following a thunderstorm. Unreal!* In short, to have in your corner a boon who understands the distinct joy of queening out to a pop diva through your headphones while working out at the base gym among the stone-cold heterosexual is imperative.

During my training, I also had the opportunity to co-facilitate a support group for transgender service members. Establishment of the group was a courageous effort from both the small team of professionals who put forth the initiative, the department leadership, and perhaps more importantly, the group members. Each member struggled to stand in the space of uncertain but forward motion regarding transition process, keeping an individual posture while managing their workplace duties and their personal lives. You can imagine the kind of overwhelming rush felt by a group member who had never met another trans service member, let alone a half dozen all at once. Or the glow exhibited by a retired chief transwoman who presented in a manner consistent with her gender identity on a military installation for the first time after over 20 years in service. As Rihanna would say, they shined bright like a diamond.

The repeal of the ban on transgender service members was met with excitement, joy, relief, and impatience, confusion, and frustration among group members. For some, impatience triggered the next logical questions: So what now? And what next? It was a blank stare in the direction of authority for some guidance on a way through this. For others, the repeal called for celebration as they experienced recognition and inclusivity: You can, in fact, sit with us.

The group took to considering themselves "trailblazing guinea pigs" a metaphor that captures their pioneering and playful spirit and also embodies the unfortunate comparison to something other than human (albeit a cute, domesticated comparison). It is our task as mental health professionals to foster the resilience and provide a space to feel and be more simply human than otherwise.

The path for lesbian and gay service members is more clearly trodden. Outstanding out service members are visible across branches, and these role models hold and have held important leadership positions. Further down the ranks, the token LGBT service member may be presumed to be seriously sharp, culturally competent, left leaning, and in all other ways absolutely fabulous. This is not an unfortunate assumption when it fits the bill, but it may open a dangerous vulnerability for those who were simply not born that way.

It is important to note the potential for LGBT people early in the identity development process to seek to meet if not exceed extraordinary expectations, no matter the cost. I am reminded of a news clip popularized on YouTube of newscaster announcing the impressive feat of a man whom had scaled Mount Everest, "But, he's gay!" It was a slip she instantaneously corrected to indicate the man was visually impaired. It is as humorous as any exposure of human fallibility, and it also reveals an underlying sentiment that LGBT identity is perceived, at times, as a qualifier that necessitates impressive, perhaps compulsive compensatory action. I recall the Sailor of the Quarter nominee who nursed a drinking problem in an otherwise

painfully empty closet and an Iron Woman soldier with disordered eating and little in the way of a romantic relationship history. People will sometimes go to extreme lengths to gain approval, LGBT people are no different.

Such lengths might be in the form of minimizing visibility, and we ought also to try to understand same-sex attracted people who seek to maintain a straight image. It is not uncommon to respond to people who engage in homosexual relations but do not identify as LGBTQ with doubt, exasperation, or worse. We have much to learn from those who manage intricate dynamics of nontraditional forms of mating and relating, just as these people have much to learn about themselves. This learning process will continue as more people experiment with various dimensions of gender and sexuality, suffer-related conflict, and are willing to discuss it in therapy.

As a field (and society) we are finally taking LGBT people seriously, but even gay mental health professionals can at times fail to recognize the intersection of other identities, and/or inadequately consider people who do not fit neatly into existent labels and nomenclature. The negotiation of nontraditional identities, relationship structures, and intimacies form a knowledge base many are curious about. We also need to be mindful of the kinds of identity conflicts that manifest within a matrix of intersecting values and nuanced identifications such as race, ethnicity, gender, religion, sexuality, and politic. Of course, sexual identity need not be a presenting problem for sexuality to enter the discussion. Most often it is not.

It is important for helping professionals to consider the diverse sexual histories and practices of LGBT-identified and straight-identified people alike. Sexual identity, sexual orientation, marital status—these markers of identity are not necessarily static. He might identify as gay and have several young children from a previous, heterosexual relationship. She might be married to a man but a history of romantic relationships with women. He might be married for a decade and taking pains to conceal concurrent same-sex sexual encounters. Or they might be a single, never married parent happily cohabiting with their partner. Do ask, do tell.

Conclusion

The personal account offered in this chapter provides a glimpse of my experience as an officer in the US Navy, an early career psychologist, and a proud queer man. Inspired by LGBT service members and encouraged by the repeal of DADT, I have fallen into the ranks with relative ease. My entry into service was both a way in and a way out: an in into the psyches of our service members and an expression of what Sedgwick [5] terms the constantive work of coming out. Just as therapy is a practice, being LGBT is always a process of becoming.

Although they may struggle at times, LGBT people exude considerable resilience, and they have accomplished much in and for the US military. This volume supports efforts to improve mental healthcare for this population, and it will be of significant use as the next chapters of the military service of LGBT people are written. We have a history to learn and a future to shape. As we continue to support diverse service members, we are presented with a pronounced need for the lessons

learned from pre-DADT clinicians. Previously silenced, we are now fortunate to hear these pioneers speak out. In moving forward, we look not only to the leaders of the repeal of DADT and current leadership but to the service members charting their course and sharing it with us in the clinical situation. As mental health professionals, we must also be mindful of those from whom we have not yet heard. We can always stand to become better listeners. In doing no harm, we are tasked with protecting liberty and justice for all. When that is the mission I am not only out but proud to serve.

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Part III

Clinical Lessons Learned

Ward 52: A Haven for HIV-Positive Military Personnel

10

Daniel W. Hicks and Steven J. Tulin

In 1985, the military began testing all its active duty personnel for HIV, in order to protect the blood supply and also to identify persons who may be immunocompromised and at medical risk. If a person tested positive during enlistment, they were refused entry. If they tested positive on active duty, they were sent to one of the stateside military centers for evaluation and disposition, such as Walter Reed Army Medical Center (WRAMC) in Washington, D.C. It was unclear at the beginning of the testing if being HIV positive would lead to discharge or exactly how these troops would be handled administratively.

At that time, there was no effective treatment for HIV, and this diagnosis was basically thought of as a death sentence, often after a prolonged illness. The only question seemed to be how long one might survive. It certainly was a disruption to the person's life: they could no longer be deployed overseas, often had to change their MOS (military occupational specialty), had to inform their spouse, and decide whether to tell others, such as partners, family members, and colleagues, or to live with the secret.

There was tremendous stigma about HIV at the time, and the diagnosis often caused a great deal of anxiety, depression, and distress. The assumption at that time was that if you were HIV positive you were homosexual or a drug addict. Persons testing positive were abruptly sent to a medical center, with little support to help them deal with being HIV positive and the nightmarish scenarios that many people faced. If the person was gay or assumed to be gay because of being HIV positive, they faced discrimination and possible discharge. In January 1986, with the initial group of inductees who tested HIV positive, one service member was abruptly

D.W. Hicks, MD, DLFAPA, FAPM (✉)
Georgetown University Medical Center, Washington, DC, USA
e-mail: dr.danhicks@verizon.net

S.J. Tulin, PhD
Howard University Hospital, Washington, DC, USA
e-mail: sjtulin@verizon.net

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_10

brought to WRAMC for evaluation. With limited support and much uncertainty about his health and his future career, he committed suicide.

In response to this crisis that mandatory HIV testing caused in their troops, the Army, Navy, and Air Force established units in their medical centers where persons who recently tested positive would be brought in for support, education, and further evaluation and testing [1, 2]. Ward 52 at WRAMC was one of these places where soldiers came for support and comfort.

Ward 52 had been an ambulatory unit in the hospital and now became the place where the patients who tested positive were brought in for evaluations and support. They were physically and psychologically evaluated as well as educated about their disease, prognosis, and transmission. Walter Reed's infectious disease service developed a diagnostic system with stages 1–6, from asymptomatic to full-blown AIDS, based on the CD4 blood count, as well as measures of immunocompetence and the presence of opportunistic infections. This system was later adopted by other medical programs outside the military (the Walter Reed HIV Staging system).

At the same time, the Henry M. Jackson Foundation military research program came on board to study this new epidemic and help to find a cure, as the Army had found for yellow fever. There were intense efforts to find a vaccine to prevent or cure the disease, and military personnel could sign up to be part of the study and return every 6 months for further evaluation and study even after they left active duty.

In addition, it was known that HIV affected the central nervous system as well as the immune system, and this was being studied by the new field of psychoneuroimmunology, the interaction between the brain and the immune system. An increased incidence of depression and mood changes was thought to be due to the virus, and it was also clear that there could be progressive cognitive and neurological changes over time. Dr. Lydia Temoshok, a world-renowned researcher in this area, was hired to study psychological and cognitive parameters of these soldiers and follow them over time. They were monitored with a battery of psychological and neuropsychological tests.

History of Ward 52

Ward 52 was established after the soldier who tested positive committed suicide, because it was clear that more education and support was needed. It was established under the medicine service, specifically infectious disease, but with a strong psychiatric component. Milieu principles were utilized in how the ward was managed, under the management of a general medical officer who reported to the head of Infectious Disease. In addition, there was a military head nurse, noncommissioned officer (NCO) as ward master, and civilian physician assistants, nurses and aides, and infectious disease nurse specialists.

For the mental health component, there were two civilian psychiatrists and a civilian psychologist for evaluation and treatment as necessary, social workers to provide support for the troop and family and establish support in the community, as

well as art therapy, recreational therapy, substance abuse education and counseling, and chaplains for spiritual support [3]. When the patients were brought in, they were oriented to the milieu and expected to follow their schedule for the week.

Nursing assessments were done and a physical examination by the physician assistant. There were blood tests and anergy panels placed early in the week to be read later when seen by their ID physician. If there were medical or psychiatric concerns, the appropriate steps were taken. There were rarely psychiatric emergencies on the ward requiring the patient to be transferred to a psychiatric ward. Occasionally, medical illnesses might require transfer to a medical floor for more intensive observation and treatment if they could not be managed on the ward.

Structure of Ward 52

Treatment goals were the following:

1. Medical evaluation: HIV staging, medical treatment if needed, and disposition
2. Research: to support the military goal for further understanding and treatment of HIV and subsequent opportunistic infections through the Henry M. Jackson Foundation
3. Education: to educate the patient about HIV, its prognosis, treatment, transmission, and to help them to learn to live safely and productively with their disease
4. Psychiatric/social support: to provide effective psychosocial support and treatment if needed to the patient and their family to maintain the highest quality of life and ensure supportive follow-up

Besides the medical evaluation and treatment, the patients were involved in structured activities on the ward. These included support groups twice a week, art therapy sessions to help them express their feelings, and recreational activities to provide safe outlets and promote a healthy lifestyle. There were educational groups to provide information about living with HIV, including transmission, disease progression, and treatment. There were also groups on spirituality, on substance abuse education, on sexuality, on stress reduction, and relaxation. The social workers discussed the medical board process so that they would be prepared for medical retirement when needed and facilitated appropriate aftercare. The protocol nurses met with the patients to discuss the research option and sign patients up for appropriate protocols.

This comprehensive evaluation and treatment were not only to provide the optimal medical care but also to provide support for patients dealing with an unknown illness, in an environment that stigmatized those with HIV and could cause ostracism from friends, family, and colleagues. Because the military prohibited homosexuality, it forced troops to stay in the closet or possibly face discharge. The ward provided a milieu where people could talk more openly about their sexuality. There were no incidents of these discussions leading to discharges over their sexuality because the information was handled confidentially.

Research

The ward was comprised of active duty personnel, infected spouses, and civilians who had retired but returned for research protocols. There were multiple protocols involving trials of medications for HIV, including vaccine studies, as well as medications for prophylaxis and treatment of opportunistic infections. In addition, because HIV was known to involve the central nervous system and could cause cognitive and neurological deficits, there were studies involving complete neuropsychological testing to chart the course of the illness and help to determine if someone was no longer fit for duty.

If the person was on active duty, they returned for regular staging visits once a year until they left the military, usually annually but sooner if clinically indicated. Civilians could return regularly for visits if they were in the research protocols, where they were brought back every 6 months to 1 year.

Benefits of Ward 52

Dr. Hicks' Perspective

I had been working with HIV patients in Indiana since the beginning of the AIDS epidemic, treating patients individually but also beginning and running support groups. I also had helped organize a full psychosocial community support program called the Damien Center, based on similar programs in San Francisco, New York, and Boston. When I decided to move from Indianapolis, a colleague, Dr. Rob Stasko, told me about a position as a civilian psychiatrist on Ward 52 at Walter Reed where he worked. I interviewed for the position and was hired. It was interesting that several of the psychiatrists, psychologists, and other personnel were gay. Maybe it was because gay clinicians had more experience working with AIDS patients, or maybe it was felt that the troops would be more comfortable talking about their sexual behavior with supportive civilian staff, since the military policy prohibited homosexuality.

We tried to help patients be open about their risk behavior so that they would be more willing to take precautions and be responsible to prevent transmission. As civilians, we were under no obligation to report their sexual risk behavior and were accustomed to confidentiality around mental health issues. Even with this support, many persons never did admit to same-sex behavior or what their exposure may have been. As our chief medical officer would say about troops coming from Germany, "They come in blaming a prostitute named Helga for their infection, but I suspect it was Helmut."

The staff of Ward 52 as well as others involved in caring for HIV-positive troops were so involved that they made quilt panels to represent the patients for the national AIDS quilt. The panels were displayed near Ward 52, and a rendition of "The Way We Were" sung by one of the patients who had been treated on the unit played

nearby. One of the authors of this chapter, Dr. Tulin, noted, "I was struck when I heard the song play. I knew the patient well, but I did not know that he had such a beautiful voice. The themes of the song, with reminiscence of happier days now gone, were so touching to me, and I suspect to others as well. Given the tragedy, sadness, and loss that both patients and staff had lived through and were continuing to experience, the emotions were understandable, and may have helped us to cope. In reality, in some ways we had developed into a family, supporting each other in a world that may have included others who were not accepting or even hostile towards us and the struggle that we shared."

Many staff members from Ward 52 also volunteered to walk with patients in the annual AIDS Walk to help raise money for AIDS organizations. They were dedicated in their compassion and care for their patients and provided a compassionate and nurturing environment.

Case 1

A middle-aged Latino man, who was very angry and guarded, never discussed his HIV risk exposure and was aloof and sullen on the ward. He asserted that he was not gay but would not divulge his risk behavior. He was not very open to socializing with others on the ward or listening to staff. Because he was asymptomatic and in an early HIV stage, he went back to duty. We heard he was court-martialed for having unprotected sex and not informing his partners.

If service members were healthy and in early stages, they would return to duty with regular ongoing follow-up. They could no longer serve overseas, nor in Alaska or Hawaii, but had to be stationed stateside. Some of them had to change their job description or MOS (military occupational specialty), because they could no longer fulfill the duties, which was very hard for many of them who identified with their positions. Once their disease progressed to Stage 3 or beyond, the person could be medically discharged. If they were asymptomatic, some chose to stay on duty until symptoms or an opportunistic infection occurred. If there were significant psychiatric symptoms, they could receive a medical discharge for psychiatric reasons, even if their HIV disease was in early stages.

Case 2

A young Caucasian man came from a troubled childhood with divorced parents and had problems with learning disabilities, as well as drug and alcohol use. He came into the service as a means to straighten out his life and avoid legal trouble. He was stationed in Germany where he continued to party and use drugs and alcohol. When he tested positive, he became despondent and suicidal. He swore he never had homosexual sex or used IV drugs. He was started on antidepressant medication and psychotherapy, but due to the extent of his depression, he received a medical discharge. His HIV disease was in an early stage. He had a tough adjustment to civilian life, continued to battle depression and suicidality, but eventually he stabilized, his physical health remained stable, he became sober, and he maintained a long-term stable relationship.

Sometimes patients responded well to the supportive environment of the ward, and although they may have been very depressed, they improved enough to return to duty instead of being retired.

Case 3

A young African-American man came from a poor rural background, with little education or career options. He had done well in the military, had achieved status in his family and community, and was devastated when he was diagnosed as HIV positive, thinking his career and future were over. He was afraid he would have to go back to his community with no real job options and tell his family. However, his diagnosis was early, he was asymptomatic, and with the support and the education from the staff and the unit, his mood improved and he could continue with his military career and come back for regular check-ups.

Course of Care

If returning to active duty, we coordinated care with preventive medicine and mental health clinicians at their local posts, so that they would receive supportive care or follow-up, especially for treatment of depression or anxiety if needed. If they were on the research protocols, they also were brought back regularly for reevaluations as part of the research. Over time, we got to know many of the patients very well, and it was gratifying to see that some of them benefitted from the support and treatment. They were able to adjust to their diagnoses and have happy and productive lives, either in the military or civilian life. If they were separated, we tried to arrange follow-up care in local VA hospitals or community systems.

Case 4

There was a young African-American male from a deprived background, who became an administrator in the medical field while in service. He was very responsible, discreet in his private life, and was a role model for younger people in his family. After he tested positive, he continued to work in the medical field on active duty, was a very good leader, and was able to teach to others who became positive. Eventually he had a medical discharge due to his HIV but continued to work in health care as a civilian. He could be more out and open about his sex life and partner and became involved in HIV prevention and education in the community.

Informing Partners

If the infected soldier was married, they were required to tell their spouse about their diagnosis within a certain time frame. If they did not, preventive medicine contacted the spouse and offered testing for them and any children who may have been exposed. The spouse also was offered support and education and could be

brought to WRAMC for evaluation initially. If they signed up for research, they could return regularly for follow-up.

Case 5

A young Caucasian woman who was married to an active duty soldier came to Ward 52. She had children from a previous relationship who were healthy, but she had become infected by a partner prior to her current marriage. She was very depressed and suicidal due to her diagnosis, fearing her husband would desert her or she would not be able to see her children grow up. Her husband remained supportive and committed to the relationship. She was asymptomatic and stayed healthy. Her depression was treated and she benefitted greatly from the program, eventually becoming a great role model and advocate for others with HIV in the community.

Case 6

Ms. M was a young Latina, infected by her active duty husband, probably before testing started, but fortunately her children were uninfected. She stayed in the marriage, worked and cared for her children. Because she was involved in research protocols, she came back for regular check-ups. Unfortunately, her disease progressed rapidly and she died.

If the soldier was not married, they were strongly encouraged to tell their sexual partner or partners, whether male or female or both, but there was not the same legal requirement to inform them. Because we had an opportunity to provide support and form a relationship with the soldier, they often could be encouraged to inform their partner(s). If not, the local health department could be informed of the HIV status anonymously and approach the partner. An emphasis was made by the entire staff of Ward 52 to educate the troops about transmission and effective use of safe sex practices. In the military, there were serious legal consequences if a soldier was accused of not informing a sexual partner of their HIV status, and some served time in prison.

Case 7

Mr. B was a middle-aged African-American man, formerly in the Army in Germany for years, who came to WRAMC for follow-up. He came to us after being imprisoned for several years in Europe where he was accused of having sex without informing his partner he was positive. He came back to the ward regularly for research protocols and was a kind and compassionate man, who was an excellent role model and helped educate others.

Policy Issues

The military's prohibition against homosexuality added a huge burden to many of these people who had been good soldiers and performed well but lived hidden lives regarding their sexuality. The HIV diagnosis had the potential to completely disrupt

their futures. The LGBT professionals working on Ward 52 and with the Jackson Foundation research team were acutely aware of the deleterious effects of this policy on the people we were caring for, with the potential to lead to suicide and other disastrous results. When Bill Clinton ran for president, one of his promises was to lift the military ban on homosexuality. Soon after he was elected, he began working on this, and Congress was tasked with considering changing the policy. But it was not a popular decision at that time, especially with the military establishment.

Several of the psychiatrists involved with Ward 52 were called to testify before a house committee hearing on our view of the effects of the military policy and how changing it would affect the military environment. We all testified that psychiatry's position about homosexuality had changed and was in favor of nondiscrimination in all aspects of society for better mental health for all. We also felt that if the military changed their policy, it would be similar to what happened with racial integration: once the military made the change at the command level, it is carried out at all levels and had a massive effect on changing society's standards.

Unfortunately, whenever Congress or the government gets involved in a project, things become very complicated and compromised. Despite our best efforts and those of our mental health organizations, the policy which emerged was not to lift the ban but what became known as Don't Ask, Don't Tell (DADT). People could remain on duty as long as they did not talk about their sexuality, and their command was not supposed to ask them directly. This may have seemed better, lessening the "witch hunts" which sought to uncover people engaging in homosexual activity, like going to bars. In reality, the effect of the policy was probably worse for most LGBT active duty people who lived in fear of being accidentally discovered and discharged. It would take 20 more years before gays were allowed to serve openly in the military.

Case 8

A service member who was a patient on Ward 52 was apparently observed entering his barracks room with another male. A more senior service person who had either observed this or was informed about it unlocked the door and saw the soldier and the other male asleep in each other's arms. Dr. Tulin heard about the incident and was concerned that the person would be discharged from the Army.

Sometime later, however, Dr. Tulin saw the service member entering Ward 52 and asked to talk with him. Dr. Tulin stated that he had heard about the incident and asked what had transpired. When questioned about being gay, he stated, "Us, gay? No, we just fell asleep!" As he stated this he smiled, and his tone suggested that he had portrayed himself as innocent and surprised by the accusation. His response also conveyed that he was understood and accepted by Dr. Tulin and the Ward 52 staff. He was not discharged and continued on active duty and in treatment on Ward 52.

Dr. Tulin's Perspective

Before returning to graduate school in clinical psychology in 1985, I had volunteered as a "buddy" with Whitman-Walker Clinic in Washington, D.C. I wanted to do what I could to help those who had unexplained illness attributed to the disease or had become sick and had an AIDS diagnosis. It is difficult to remember the frightening times when our friends, partners, or ourselves were becoming sick, before the HIV virus had even been identified. For someone who was not a provider in the medical field, serving as a buddy to help people who had AIDS to complete daily activities and to provide them with peer support appeared to be a way to offer some assistance.

The impact of the crisis on gay men living at the time is also hard to reimagine. Some of my friends gave me a party in July before I left to go to California. Two guys met at the party and began dating. But by the holidays that year, one of them had been diagnosed with AIDS and died soon after. His parents were very uncomfortable about his diagnosis and only told his one sibling of his situation 2 days before he died. Within several months of my departing for school, my two closest friends were diagnosed with AIDS, as many others would be in the years to follow. We all experienced repeated traumatic losses like this that had been unimaginable to us a few years before. To me, attempting to help offered the only consolation available. I knew that I had to do my part, and I was unhappy until I again had the opportunity.

I began my studies and I was then accepted in the psychology internship at VA Medical Center Los Angeles, where I was able to work in providing psychotherapy and neuropsychological assessment to HIV patients as part of my training.

While completing a postdoc in neuropsychology, I heard about a position working to take care of HIV patients at Walter Reed. It sounded like just the kind of job I wanted, and I was elated to get the position. I was asked to do evaluations of patients who were returning to the ward for follow-up, to determine how they were coping with their situation, and to provide individual and group psychotherapy to service members who lived near enough to Walter Reed to come to regular visits. I also did neuropsychological testing on patients who appeared to be having changes in cognitive functioning due to the impact of the virus or opportunistic infections that impaired these abilities.

When I started at Walter Reed, I quickly felt as though I had become part of a very different sort of treatment program. Patients who had been there before sometimes acted like they were returning to see close friends when they encountered staff upon entering the unit. A psychologist whom I was speaking with at my postdoc told me that she often asked potential interns, "Would you ever hug a patient?" I knew that she was looking for the answer to be "no" or they would be rejected from acceptance to the training program. But when patients returned to Ward 52, they often embraced staff who embraced them back. I knew that for those with HIV or AIDS, this closeness, prohibited as a "boundary violation" by others in the mental health field, would be seen as another rejection. They felt very close to staff, who had chosen to work on Ward 52 and whose feelings and behavior were in total

contrast with many others in society. But this was part of why Ward 52 was a very special place, where those who were stigmatized in society at large, and in the Army, could learn that they could be safe, welcomed, and supported without judgment.

My work included meeting with returning patients to discuss how they were coping emotionally, as well as helping to evaluate service members coming to Ward 52 for the first time. I also ran groups, sometimes with a focus on the use of medications or on coping with HIV in general. Staff decided that it perhaps would be helpful to offer a group that would encourage positive attitudes, as the work of David Spiegel [4] and others had suggested that group therapy could actually extend the life of patients with breast cancer. Attempts to replicate this study later showed no survival benefit [5] but did show definite improvements in emotional functioning and quality of life. I always think that others who are in the same situation are most able to help others in a group, and I think that our patients did just that in a way that conveyed that they really understood the challenges of being HIV positive.

Service members could stay on active duty until their health began to decline and then entered a "window" during which they could retire with benefits before having an AIDS diagnosis. The health status criterion for retirement was that their T-cell count had to measure below 400 and be found to remain below 400 on retesting within 6 weeks.

One service member had decided that he would like to retire and pursue his civilian life, and his T-cell count tested below 400. When he came in for retesting, I told him that his T-cell count had been measured at 399. He was very relieved, and we shared a sense of the irony of the moment. A conservative Congressman later attempted to have all HIV-positive service members removed from the military, but his attempts were scuttled by others in Congress.

Conclusion

The military response to HIV was not only an important infection control measure, but it also recognized the stigma around the diagnosis of HIV and AIDS at that time. Besides the poor medical prognosis, there were tremendous psychosocial consequences. The person could not serve overseas and faced involuntary discharge if their medical status warranted it but often had a major career change depending on what their duty was. It also caused disruptions in families when one of the partners was found to have been infected by sexual behavior outside the relationship or possibly IV drug use and sometimes even transmission in utero to children if the status had not yet been discovered.

The diagnosis led to the suspicion that the person was homosexual or engaged in homosexual activity, which itself causes stigma, even though we know sometimes people were exposed through heterosexual activity or through fluid contacts that might have happened medically or through occupational exposure. For some persons, this led to overwhelming distress, shame, anger, and suicidal thoughts. It was important to have an environment where these feelings could be expressed and

worked through in a safe, supportive manner. In addition, HIV's effect on the brain seemed to cause and increase in depression and emotional dysregulation. Ward 52 and similar psychosocial programs provided a safe place for people to get help and treatment if needed, to be educated about their illness, to be cared for and supported, and to achieve their highest quality of living.

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Creating Safe Spaces: Best Practices for Clinicians Working with Sexual and Gender Minority Military Service Members and Veterans

11

Heliana Ramirez and Katharine Bloeser

People who identify as sexual and gender minorities (i.e., lesbian, gay, bisexual, and/or transgender) have a rich history of service in the US military [1, 2]. Research suggests that this community of veterans faces unique stress associated with their LGBT identity and military service. LGBT veterans, when compared to cisgender and heterosexual veterans, endorse a higher prevalence of conditions like posttraumatic stress disorder (PTSD), depression, suicidality, and physical health concerns [3–6]. Providers in the VA, DoD, and community-based healthcare facilities should be prepared to address these unique healthcare needs. At the same time, the ample strength and resilience of this population should not be ignored as they offer tremendous benefits to improved health. In clinical practice we have seen that LGBT veterans also have incredibly rich and creative forms of resilience that can be useful to clinical interventions [7]. While sexual orientation and gender identity are clinically relevant for preventative screenings and for sources of existing strength, oftentimes, patients and healthcare providers alike often do not discuss them. The following is offered as a guide for providers to create a welcoming environment for veterans who identify as sexual and gender minorities.

H. Ramirez, PhD, MSW
VA Palo Alto Health Care System, Palo Alto, CA, USA

University of California, Berkeley, CA, USA
e-mail: heliana.ramirez@va.gov

K. Bloeser, PhD, MSW (✉)
Silberman School of Social Work at Hunter College, The City University of New York, New York City, NY, USA

The War Related Illness and Injury Study Center at the Washington DC, VA Medical Center, Washington, DC, USA
e-mail: kb1568@hunter.cuny.edu

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_11

Accessing Care

Providers in all practice settings are likely to work with veterans who identify as sexual and gender minorities [8, 9]. Disclosing sexual and gender minority identities to clinicians can maximize the benefits of healthcare [10]. Unfortunately, in part due to anti-LGBT military service bans, sexual and gender minority veterans may not feel safe sharing their identity with clinicians and face unique barriers to care [11]. Among veterans who identify as sexual minorities, only 33% report disclosing their sexual orientations with their VA providers [12].

Male-to-female transgender veterans are more likely to seek mental health services outside the VA. They cite barriers to care that include finding providers versed in transgender health needs [13]. In one study, only 28% of LGBT respondents perceive the VA as a welcoming environment [14]. Institutional victimization may further contribute to veterans avoiding VA care. Simpson et al. report that veterans who experienced *interpersonal* anti-LGB harassment (e.g., from a colleague such as military sexual trauma or gay bashing) while in the military were almost twice as likely to access VA care as veterans who experienced *institutional* anti-LGB discrimination (e.g., investigations, LGB-related discharges) [12].

Creating Safer Space in Healthcare for Military Personnel and Veterans

Providers can take concrete steps to increase sexual and gender minority veterans' comfort in sharing their identity while accessing healthcare. Creating safe space in healthcare begins at a systems level with policy and employee training. One example of LGBT responsive systems level change is the Human Rights Campaign's (HRC) Healthcare Equality Index (HEI). To achieve the HEI designation as a Leaders in LGBTQ Healthcare Equality, facilities are required to provide evidence of four core criteria. First, facilities must demonstrate patient nondiscrimination policies that include the terms "sexual orientation" and "gender identity" [15, p. 17]. These must be communicated to patients by posting them on clinical walls, in patient magazines, on electronic information boards, or websites. This information must also be available to staff through mechanisms like all employee emails, employee training, or employee newsletters.

Second, facilities must demonstrate visitation policies granting equal visitation to sexual and gender minority patients' loved ones and communicate these policies to patients and staff. Third, facilities must adopt and communicate to the public employment nondiscrimination policies using the terms "sexual orientation" and "gender identity" [15, p. 17]. Finally, facilities are required during the first application, to complete a three-part training series entitled "LGBTQ Patient-Centered Care: An Executive Briefing" by at least one senior manager from each of the following five areas: Organization Leadership (e.g., CEO,COO, medical director, or other "C-suite" leader), Nursing Management, Patient Relations/Services Management, Admitting/Registration Management, and Human Resources Management. Additionally,

facilities must also acquire 25 h of LGBT Patient-Centered Care training by staff throughout the facility during the first and all subsequent application cycles. The importance of staff training cannot be overstated as clinicians receive little to no education on clinical care for LGBT populations in medical and graduate schools [16–20]. Additionally, it is critically important that training address the needs and strengths of LGBT patients as well as clinicians' own conscious and unconscious biases toward LGBT people [21, 22].

The VA, through efforts of the LGBT Veteran Care Office in Patient Care Services, has worked diligently to improve care and culture in its 168 medical centers and thousands of outpatient clinical sites [23]. Thanks to the Veteran Health Administration's Office of Health Equity and the efforts of medical centers [24], 84% of VA Medical Centers now participate in the HEI. [14, 23].

Policies Addressing Healthcare Needs

Providers should be aware of healthcare policies that impact sexual and gender minority veterans and service members. VHA Directive 2013-003 asserts transgender and intersex veterans are entitled to VA care. The policy grants access to gender-specific VA healthcare including hormone replacement therapy, care prior to and after sex reassignment surgery (i.e., VA will not cover gender confirmation surgery), medical care that is not deemed cosmetic (e.g., electrolysis is considered a cosmetic treatment), and mental healthcare. None of these services requires a diagnosis of gender identity disorder (GID) or gender dysphoria (GD). (This policy was written prior to the transition from gender identity disorder (GID) to gender dysphoria (GD) in the DSM-5). By 2017, the VA will change the "Sex" and "Gender" markers in medical records to "Birth Sex" and add "Self-Identified Gender Identity." All veterans accessing VA will be asked to choose from the following responses: Male, Female, Transmale/transman/female-to-male, Transfemale/transwoman/male-to-female, Others, and Individual chooses not to answer [24]. The significance of this change is that veterans will be able to change their gender marker without medical or government documentation as the marker is of "Self-Identified Gender Identity."

On June 30, 2016, Secretary of Defense Carter lifted the transgender service ban in the US military. In October of 2016, the DoD completed rule making around medical care, training, and policy and procedures. Under these guidelines, the Military Health System (MHS) requires that service members receive all care regarding confirmation of their gender through that system. Service members are eligible for care related to gender transition (e.g., hormone therapy) including gender confirmation surgery that is deemed medically necessary. They may also change their gender marker in the personnel data system [28]. Beginning in July of 2017, all armed services will begin to accept eligible transgender individuals into the military (i.e., transgender people will be held to the same enlistment standards as people who are not transgender). On August 25, 2017 however, The White House ordered the Pentagon to implement an indefinite halt to military enlistment by transgender people. Additionally, while this directive has reversed plans to allow transgender

people to serve openly in the U.S. Military, it is unclear at this time, how General James Mattis will decide which existing transgender service members may be permitted to continue their military service and be allowed to continue receiving gender-related medical care from the U.S. Military [25].

Guidance for Initial Clinical Interactions and Rapport Building

Creating safe clinical spaces for sexual and gender minority service members and veterans requires staff training at every level of the organization. For example, clinicians and other staff including admitting and benefits office staff should be trained regarding culturally appropriate forms of addressing transgender veterans and asking about their Self-Identified Gender Identity and Birth Sex. Providers of family therapy should be trained on issues unique to sexual and gender minority families [27, 28]. Inpatient staff should be trained on hospital visitation policies allowing veterans to name anyone they wish for visitation, irrespective of blood relation and state-issued marriage licenses.

In other examples, recreation therapists should be trained on unique issues that can arise when leading contact sports, such as hormones administered topically in a gel or patch that can rub off on other peoples' skin. For overnight trips, providers might consider the need for sharps containers for syringes used to administer injectable hormones. Police should be trained on bathroom access issues facing transgender people. Bathrooms are uniquely unsafe spaces for transgender people, and police are often called when cisgender people are concerned about a transgender person in a shared bathroom, as described in the film *Toilet Training* [29].

Training on LGBT-related healthcare is available through the VA (http://www.patientcare.va.gov/LGBT), the National LGBT Health Education Center, a program of the Fenway Institute (www.lgbthealtheducation.org), and the Center for Affiliated Learning (The CAL) (www.hrc.org/hei/hei-training-on-the-cal). Most of these organizations provide continuing education credits and support to practitioners.

The discussion now turns to common interactions in healthcare settings that may help improve care for veterans who identify as LGBT.

Scenario 1: I'm Not Sure What Gender Pronouns to Use with This Service Member/Veteran

Gender is not readily apparent for some people. Being referred to by the wrong gender can be uncomfortable and may contribute to dysphoria [30]. A good rule to follow is to avoid using gendered pronouns (e.g., he/she, him/her, his/hers) [15]. An alternative is to use they/them/theirs if the veteran uses plural pronouns. Staff can ask, "It is important that I address veterans per their preference, how would you like to be addressed?" and should be careful if the name the veteran uses differs from the name in their medical chart. It is preferred to ask "Would the record be under a different name?" instead of "What is your real name?" [31].

Mistakes are common when addressing transgender people. The best way to maintain clinical rapport is through acknowledgement (e.g., "I apologize, I just

Table 11.1 Creating a safe space: best practices for LGBT clinical interactions

Phrase or question	Alternative
How may I help you, sir? Miss Smith, the doctor will see you now. Dr. Hines, he has been waiting to see you. What is your "real" name?	How may I help you? Excuse me, the doctor will see you now. Dr. Hines, this service member/veteran is ready to see you. Could the record be under a different name?
Are you married?	Do you have a significant other or a partner? Who do you live with? Who would care for you if you were sick?
Is your husband/wife with you?	Would you like to involve your partner or a friend or family member in your care?
When you referred to that veteran as [slur or term] it was really homophobic and uncalled for. Our forms only offer the veteran or service member the choice of male or female. That reinforces a binary gender identity.	I know you really care about veterans and what you just said isn't consistent with that. Those terms can be really hurtful and I know you wouldn't want to harm a veteran. We're such a well-regarded clinic or service here in the hospital. How about we change the form to include other gender identities? This way we can maintain the inclusiveness and customer service we're known for.

referred to you as he but know that you use the female pronoun. This was a mistake on my part"). Acknowledging mistakes is critical because without an explanation, the transgender client may wonder if the mistake was intentional. Making a direct and brief apology demonstrates respect for and understanding of the importance of the client or patient's gender identity.

Table 11.1 provides some examples of affirming, gender-neutral questions for and means of addressing sexual and gender minority clients or patients developed from Fenway Institute resources [31].

Scenario 2: I'm Not Sure What This Service Member/Veterans' Relationship Is with Their Visitor or Companion

There are many reasons why sexual minority veterans do not disclose same-sex relationships in healthcare settings. Historically, individuals with same-sex partners did not have the same rights to visit their loved ones or make decisions for them at VA, military, and civilian hospitals, and the meaning and process of coming out has shifted over time [1, 32].

The role of historical context in the lives of LGBT people who are older cannot be overstated. While "coming out" in the 1930s described a person's first same-gender sexual experience, in the 1940s it described a communal identity and way of life as military service enabled increased social contact with LGB people in cosmopolitan areas [2]. Known as the *pre-Stonewall* generation, those who came out before the gay liberation protests of 1969 are more likely to be guarded or less open about their sexual orientation [33]. For veterans, the forced concealment under anti-LGBT military policy can further contribute to a lack of disclosure in healthcare settings [34, 35]. Members of dually marginalized groups such as LGBT people of color may be reticent to disclose their sexual orientation due to the intersection of racism, sexism, and heterosexism or homophobia in their lives [36].

One way to increase SGM clients' sense of safety and identity disclosure is through the display of nondiscrimination policies, LGBT-friendly posters, and pride flags in waiting and clinical areas. Additionally, it is important to not make assumptions in clinical care (e.g., gay people are not parents) and to review clinical forms for assumptions of heterosexuality. It is also important to understand the difference between sexual orientation and gender identity. Transgender people can be heterosexual, lesbian, gay, bisexual, asexual, or any other sexual orientation (i.e., the term transgender refers to how one feels about their own gender and sexual orientation refers to whom one is sexually attracted).

Scenario 3: My Male Patient/Client Identifies as "Straight" or Heterosexual but Has Sexual Relationships with Other Men

Sexual histories are an important piece of a clinical assessment; however, many providers do not discuss sexual orientation or gender identity with their patients or clients. Some clients avoid disclosure fearing that providers' behavior will change in adverse ways [37]. For example, a provider may focus exclusively on HIV/AIDS testing or a discussion about safe sex rather than the client's presenting concern [38].

Conversely, providers avoid discussions about sexual orientation, especially among older LGBT individuals [39, 40]. Providers can normalize same-sex behavior and increase client comfort. Providers can state, "It is important to understand my client's sexual behavior because it can impact health. I want to remind you that this information is confidential. In your lifetime, have you had sex with men, women, or both?" For people who engage in same-sex behavior but do not identify as LGB, a provider's focus on behavior versus labels allows people to disclose same-sex behavior with less fear they will be mislabeled. Considering people who only have same-sex behavior when opposite gender partners are unavailable (i.e., "situational sex" in prison, the military) [41], it is very important to only refer to clients with the terms clients use for themselves.

Explaining the limits of confidentiality (e.g., LGBT identity is shared with other healthcare staff on a need-to-know basis and what is recorded in patients' medical charts) can be especially important for LGBT veterans who served under anti-LGBT military service bans. Anti-LGBT military policies resulted in military clinicians and chaplains reporting service members' LGBT identity disclosures made in clinical or pastoral care to command, despite the confidentiality typically afforded to patient/provider and congregant/chaplain relations [1]. This conflict between military employment and professional licensing (e.g., mandates of clinical confidentiality) resulted in several mental health, medical, and legal associations authoring statements disavowing support of Don't Ask, Don't Tell [42–46].

Scenario 4: I Overheard My Colleague or Another Patient or Client Say Something Homophobic or Transphobic

Clinicians must address anti-LGBT comments made by veterans and colleagues in the VA and DoD alike [47]. While directly addressing discrimination can be uncomfortable, confronting bias and bigotry also garners significant clinical rewards.

For LGBT veterans who hear homophobic slurs or transphobic dialogue in a clinic waiting area or witness staff's nonverbal cues of disgust toward LGBT people, seeing their clinician address the discriminatory behavior directly can cement their rapport and trust in the provider and increase their sense of safety on VA campuses. Additionally, other people who witness the discriminatory and corrective comments can benefit from seeing the clinician model effective strategies to confront bias.

Research suggests that when confronting discriminatory language, using a calm and open approach is most effective [48]. *Calling people in* to warm and accepting behaviors then happens instead of *calling people out* on hurtful behavior [49]. How might this look? If someone says something trans- or homophobic, you might say that this contradicts what you know about them—that they are an advocate for others or that they are a kind person. For example, in response to a statement about "those people" one might say, "I know you to be a great advocate for veterans. You referring to someone like that is not consistent with your dedication to veterans." Often people are appreciative of the correction of language they didn't realize was discriminatory or harmful. Here in response to an outdated term, one might say, "I recently heard a friend or family member say that term is hurtful. I know you did not want to hurt anyone when you made that statement." Brief interactions made in a warm engaging way have been shown to be effective in changing people's core beliefs about transgender individuals specifically [48].

Clinicians also have an ethical duty to confront discrimination both through anti-discrimination policies like those at the VA and those held by professional organizations. Interrupting anti-LGBT discrimination in healthcare settings thus is not just because anti-discrimination policies require this but also because healthcare providers are required to do so by their professions. Recognizing that discrimination results in adverse health outcomes, the professional organizations of social workers, psychologists, nurses, and physicians require clinicians to address anti-LGBT discrimination [50–52].

Sexual Health

Sexual health is a frequently overlooked but critically important aspect of veteran healthcare that may have been complicated by DADT. The benefits of sexual health include closeness with others, intimacy, increased relationship satisfaction, stress release, physical and psychological pleasure, and reproduction [53, 54]. For veterans living with disabilities, "healthy intimate relationships and secure emotional attachments add meaning to life in the face of substantial loss and can contribute to recovery from physical and mental trauma" [55]. Some sexual and gender minority veterans remain fearful of sexual health discussions with clinicians, even decades after discharge, which may hinder access to essential aspects of good clinical care [56, 57].

Tepper asserts that "all combat-related serious injuries" can result in sexual health problems "whether they are characterized as a primary, secondary, or tertiary effect or as direct physical effect, a psychological effect on the individual or relationship, a

treatment effect, or a combination of some or all" [55]. Reflecting on their work with recently returned veterans from Afghanistan and Iraq, Cameron and colleagues write that sexual and gender minority veterans with both psychological and physical disabilities "navigate the double-barreled taboo against disability and sexuality that pervades our society" [58]. Physiologically, PTSD has been linked to erectile dysfunction (ED) through mechanisms within the sympathetic nervous system [59]. Sexual health should be included within treatments addressing the needs of veterans living with physical and mental disabilities, including PTSD, traumatic brain injury, polytrauma, spinal cord injuries, amputations, and severe burns [56, 58].

Higher survival rates of recent military conflicts are contributing to sexual health issues including "intimate partner violence, child abuse, divorce, partners taking on care giving roles, higher incidence of risky sexual behavior among single veterans, and special challenges faced by women and gay and lesbian soldiers" [60]. Comprehensive sexual healthcare requires clinicians throughout the veteran and military healthcare community, working together across disciplines, in service of safe and satisfying sexual relationships for optimal health of all veterans and service members [55–58].

Guidance in Assessing for Strengths, Resilience, and Resistance

Clinical Assessments of Sexual and Gender Minority Veterans' Years Prior to the Military

In a strengths-based assessment, veterans can be asked about experiences of trauma prior to the military and related coping tools, awareness of sexual orientation prior to military service and stage of identity development, reasons for enlistment and whether or not they have needed to defend those reasons, and the impact of being drafted. Veterans can be asked the extent to which their family's religious/spiritual values impacted their LGBT identity development, the impact of cultural values on their decision to enlist, and what benefits, if any, they expected to garner through military service.

Clinicians can ask veterans who were drafted about religious/spiritual issues and how their life trajectories were changed by the draft. Finally, veterans can be asked about role models and experiences of coming out to accepting people prior to the military. Veterans who report coming out as youth or having others suspect their identity should be asked about rejection, violence, harassment, and homelessness as well as coping skills such as connection to communities of support. Veterans of color should also be asked about race-based discrimination experienced in childhood and early adulthood and, if so, what, if any, impact that discrimination had on their mental and physical health and military service. Additionally, LGBT veterans of color and women veterans can be asked about coping skills they developed in response to racism and sexism, as some of these skills may be transferable to experiences of homophobia and transphobia [61].

Clinical Assessments of Sexual and Gender Minority Veterans: During Military Service

In 2012, the National Association of Social Workers established guidelines for social work practice with veterans and service members based on a life-span approach informed by clients' strength and resilience [62]. In a strengths-based assessment, clinicians may inquire about veterans' experiences in the military workplace and living spaces. This might include connection to underground networks or other supportive people. Clinicians are encouraged to inquire about isolation, harassment, violence, investigations, military incarcerations, involuntary military psychiatric hospitalizations, early discharge, and impacts of service on partners and family. Veterans should be asked about experiences of seeking mental and physical healthcare and religious/spiritual counseling both on and off base.

It may also be important to assess the stage of identity formation during their service, any pride developed from their service or the service of other LGBT military personnel, and conflicts of the military ethics of honesty and integrity with the mandate of hiding their identity. Veterans should also be asked about any colleagues they may have lost to suicide as well as suicidality they personally experienced during their military service.

For veterans of color, it would be important to ask if they experienced race-based discrimination while in the military, and women should be asked about gender-based discrimination and any impacts this discrimination had on their health and career trajectory. Finally, from a strengths-based perspective, it is important to ask veterans to what they attribute their success in navigating employment under LGBT-related military policy.

Clinical Assessments of Sexual and Gender Minority Veterans: Post-military Discharge

A comprehensive assessment can explore veterans' feelings about their military service. Some veterans recall patriotic pride and a profound sense of camaraderie with military peers, while others experienced trauma from colleagues and confusion over US military policies [1, 63]. It is also helpful to assess veterans' current stages of identity development and connection to or isolation from peers and social support. It is important to be aware that risk of suicide can increase around the process of coming out to others, in part due to increased discrimination at work and in the community [64].

Many veterans may have waited until after their military discharge to affirm their gender identity or come out. Clinicians may consider assessing veterans' experiences seeking healthcare in terms of disclosing identity to healthcare providers and experiences with acceptance and culturally relevant care or rejection, be it active or passive. Using a more passive example, veterans may feel clinicians are satisfying their own curiosity in discussing identity or behavior rather than engaging in a clinically relevant endeavor (e.g., inquiring if a transgender person has had gender confirmation surgery when the veterans' genitals have nothing to do with their presenting clinical concern). Veterans should be asked about post-military experiences of trauma and discrimination including in employment and housing related to sexual

orientation, gender identity, and race/ethnicity. Veterans should also be asked about alcohol and drug use.

It is critical to assess suicide with veteran clients, and this is extremely important with veterans who identify as sexual and gender minorities. Clinicians should inquire about veterans' sexual health, being mindful of the ways that PTSD, TBI, medication side effects, and disabilities impact sexual activity and relationships.

When providing care to sexual and gender minority veterans raising children, it may be helpful to consider the following issues. Research on LGBT families has found that anti-LGBT discrimination trickles down to children through pressures to appear "no different" than the children of heterosexual parents [65–67]. Due to anti-LGBT discrimination toward their parents, children of LGBT families are at times scared that lower grades in school or mental health challenges will be used by anti-LGBT politicians as an argument against same-sex marriage [67]. A review of the literature on children of LGBT parents unequivocally finds that these children have similar social and educational outcomes as children of heterosexual parents [66]. While LGBT parenting skills are similar to those of heterosexual parents, it appears that LGBT parents also provide unique strengths and resiliencies [66]. LGBT parents may be more likely to teach their children about respect for diversity and provide examples of more egalitarian households (e.g., nontraditional gendered division of labor). Additionally, children of LGBT families may benefit from seeing their parents' skills in managing discrimination directed at them in society.

Clients can be asked whether or not homophobia and substance abuse are impacting their family. For LGBT families with children from an opposite gender partner and a same-sex partner, a clinician may inquire if their family had differential access to military benefits. It may also be helpful to inquire about the impact of their coming out or not disclosing their sexual orientation and/or gender identity to children and opposite sex partners [68]. Veterans with children can be offered contact information for organizations serving LGBT families such as COLAGE, a resource for children, youth, and adults with one or more LGBT parent (www.colage.org).

Integrating Military and Veteran Sources of Strength and Resilience in Treatment

Veterans who identify as sexual and gender minorities develop adaptive strategies to manage minority stress. These can be assessed and accessed to improve clinical practice. For veterans involved in LGBT communities working on advocacy issues, the associated skills and social connections can be drawn upon as resources. Community organizing skills, increased socialization and reduced isolation, and achievement of civil rights on par with heterosexual and non-transgendered people can all result from involvement in social advocacy.

Clinicians are often unaware of the history of LGBT service members who have taken on high-risk assignments and received high accolades throughout the military [69]. Engaging in heroic and successful activism to repeal anti-LGBT policies, such as Eric Alva, Miriam Ben-Shalom, and Leonard Matlovich, can assist LGBT

veterans developing pride in and integrating their sexual or gender minority and veteran identities. In fact the very establishment of the US military is credited to a man who had male sexual partners, Baron Von Steuben, whose tombstone reads "Indispensable to the establishment of America."

The Life-Span Approach

The LGBT resilience literature frequently discusses the evolving and changing nature of resilience over time [70]. The life-span approach is a framework for organizing experiences that people have over their lifetime [71–73] and is particularly relevant for veterans who often describe their lives chronologically to experiences before, during, and after their military service. This historical approach examines differences across various developmental life stages such as childhood, adolescence, and adulthood. This allows for identification of the ways in which life events, now resurfacing as presenting clinical concerns, impacted the client. Conceptualizing histories by periods of life in relation to military service (1) reflects the range of data provided in the research articles regarding LGBT veterans, (2) adapts the life-span approach to veterans in terms of their stages of sexual orientation and gender identity development, (3) organizes the impact of military service on sexual and gender minority veterans' healthcare needs, and (4) permits identification of sources of culturally specific support, strength, and resilience across time.

The life-span approach also coincides with LGBT identity development theories as well as LGBT military-specific concepts like the flight into hypermasculinity [74]. Since studies of LGBT veterans' military experiences are based on recall and memories may be elicited in reference to significant points in time (e.g., when a person enlists in or discharges from the military), the life-span approach is particularly well suited to LGBT veteran research and clinical assessments.

It is important to consider that sexual and gender minority service members and veterans served through enlistment or draft, despite various bans prohibiting their service. The stress of military service was in addition to everyday experiences of heterosexism, homophobia, and transphobia both within and outside the military. In his book, *Ask & Tell: Gay & Lesbian Veterans Speak Out*, Steve Estes publishes the story of Paul Dodd, a Southern Baptist preacher and pastoral psychotherapist who served in the US Army from 1967–1998. Dodd states of his service and that of other gay service members:

> I truly don't believe my sexual orientation affected the quality of my military service one way or the other, and I know in my heart that our soldiers now who happen to be gay or lesbian are serving honorably and courageously even though they are serving sometimes under hostile conditions and hostile regulations. Nevertheless, they are doing it and I think it's a great act of courage and patriotism and honor. [75]

This shows the tremendous resolve LGBT veterans demonstrated toward their service. The decision to serve in the military despite entrenched attitudes of heterosexism, homophobia, transphobia, and traditional mores of masculinity stands as a great act of courage. While many researchers examine the negative effects of trauma, a distinct body of literature has examined how people grow after experiencing a

negative event [76]. Posttraumatic growth or transformational coping is a way of defining this phenomenon. While the authors are not aware of research that has examined this explicitly, the resolve and courage exercised by sexual and gender minority service members and veterans suggests that transformational coping may be an important aspect of their experience.

Fostering Posttraumatic Growth Through Encouraging Social Support

Themes of resilience may be closely associated with identity and fostering connections to communities of peers can build resilience and posttraumatic growth [76–78]. It may in fact be that sexual and/or gender minority identity is also protective. Studies of LGBT people suggest that community belonging can help to mitigate the effects of prejudice and discrimination [79, 80]. This highlights the importance of asking each individual about their multiple identities, which can be protective and may not be associated with sexual orientation, gender identity, veteran, or military status. Someone may state that their identity as a member of Alcoholics Anonymous, as a person who identifies as Latino or Asian, or as a parent is a tremendous source of strength.

Support Groups

Support groups may help SGM veterans move out of isolation through connection to other veterans as suggested by Maguen et al. [81] and Ramirez et al. [7]. Maguen and colleagues describe the management of issues like confidentiality, goal setting, and topics for discussion in a structured eight-session support group for transgender veterans. These sessions include childhood, identity and development, military service and young adulthood, personal safety, employment, housing, social support, family issues and parenting, medical issues (e.g., hormone maintenance, surgeries, and healthcare), disclosure, passing and socialization, and body issues and intimate relationships.

Ramirez et al. [7] describe an evidence-informed LGBT veteran support group based on ongoing clinical assessments and a review of LGBT veteran research. Ramirez and colleagues also provide examples of culturally responsive strategies to increase participation among LGBT veterans from diverse backgrounds and suggestions to improve healthcare services based on discussions of VA care. Of particular note are the utility of fact sheets provided transgender group participants in Maguen and colleagues' article [81] and Ramirez and colleagues' description of a veteran-only online peer chat group established by LGBT veterans outside of the veteran support group [7].

A compelling argument can be made for intergenerational support groups of older and younger LGBT veterans. Monin and colleagues found that younger LGBT veterans had higher rates of PTSD and depression than older veterans. However, the older veterans reported more resilience and thus fewer mental health challenges but had smaller social support networks than younger veterans [82].

Veterans Service Organizations

A history of military service appears to provide some protection against depression and a higher quality of life for transgender older adult veterans as compared to transgender older adult civilians [83]. While we are aware of no research that examines veteran identity as a protective factor for LGB veterans, there are numerous veteran service organizations (VSOs) dedicated to serving LGBT veterans and service members. OutServe-SLDN, American Veterans for Equal Rights (AVER), SPARTA, Transgender American Veterans Association (TAVA), the Alexander Hamilton Post 448 in San Francisco, and other organizations served countless service members and veterans. These groups are credited with contributing to the policy changes allowing open LGBT military service and to improve VA care. Connecting individuals with these groups that work toward social equity may speak to Ramirez and Sterzing's findings that becoming engaged in political action is a form of resilience among some sexual and gender minority service members and veterans [84].

Supporting Military Families

Family membership may also be a protective factor associated with posttraumatic growth for veterans. To this end, it is vitally important to support family members of LGBT service members and veterans.

The VA did not recognize same-sex marriage until January of 2016, 3 years after it was recognized by the DoD. This is important when considering the benefits paid to veterans and their dependents (including spouses) by the Veterans Benefits Administration as a result of illness or injury incurred while in the military. Veterans must apply for these benefits, which oftentimes means retelling stories of military trauma that resulted in the bodily and/or psychiatric harms for which they seek VA benefits. VA claimants may request back pay for claims where a spouse was denied benefits because the marriage was not recognized, but these are limited and the maximum allowed year of back pay is 2013 [85].

Organizations like the Military Partners and Families Coalition (MPFC), which has served military families since 2011 (www.milpfc.org), and the American Military Partner Association (militarypartners.org), which has over 45,000 members and supporters, can help families access resources and advocate for change. These organizations provide advocacy, cultural competency training, and resources for LGBT military families. Any time of transition can produce stress for families. Gender transition can be both a celebration and a time of stress for families. To this end, there is a marked lack of research and resources for families with a member who undergoes gender transition or confirms their gender identity [86].

Fostering Posttraumatic Growth Through Clinical Practice

Clinicians can aid clients in developing posttraumatic growth through clinical practice. Witnessing without judgment the anger LGBT people can feel regarding experiences of homophobia or transphobia and the true weight of "macro-level forces

[that] shape [the client's] feelings, attitudes, and behaviors," clinicians can support healing critical to posttraumatic growth [87]. Clients might be asked, "How have [your] identities and how have [your] understandings of [your] own life narratives been changed?" [88] as a result of their experiences.

Positive psychology also has a great deal that it can provide to this discussion. Case conceptualization, assessment, and interventions should take into account all individual and community level strengths the client or patient brings to treatment [89]. Through identifying and fostering these strengths, we can "amplify the strengths rather than repair the weaknesses" of our clients [90].

Conclusion

This chapter discussed numerous ways that healthcare providers and systems can create safer spaces for sexual and gender minority service members, veterans, and their families. In summary, clinicians may benefit from training that addresses the health disparities facing this population, the unique strengths they developed to manage stress, attention to clinicians' own biases, and strategies to interrupt bias in healthcare facilities.

Sexual and gender minority veterans may benefit from examples of LGBT military and veterans who have made great contributions to the military and civilian society at large. Resilience and theories of posttraumatic growth can help guide our practice toward strengths in addition to the challenges our clients and patients face. We can tailor assessments through the addition of questions specific to veterans' experiences prior to, during, and after military service.

In 2018 the US Navy will commission a new ship bearing the name of Harvey Milk, the civil rights pioneer and US Navy veteran [91]. We can learn a great deal from LGBT people who served in the military, like Harvey Milk, especially in terms of their distinctive cultural strengths and resiliencies.

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Treating LGBT Veterans with Substance Use Disorders: A Gay Psychiatrist's Experience

12

Bruce S. Hill

In recent years, American citizens who were identified as lesbian, gay, bisexual, or transgender (LGBT) have enjoyed increasing recognition, including protection against discrimination regarding employment, legislation surrounding hate crimes, and finally the opportunity to marry officially. LGB military service members also benefitted from the repeal of Don't Ask, Don't Tell (DADT) in 2011. However, because of DADT, clinical research and epidemiological data are not readily available for this population; this could be due to fear of termination of service for identifying as LGBT or possibly editing of the data, such as had been done by the US Census to change same-sex couples to opposite-sex couples or unmarried partners [1, 2]. In line with the Department of Veterans Affairs mission to provide compassionate respectful care for LGBT veterans [3], I wanted to share my experiences treating LGBT veterans with substance use disorders.

Understanding the challenges that LGBT veterans diagnosed with substance use disorders (SUDs) face is complex. Data from the civilian LGB population shows higher frequency of mental disorders. Other studies show increased prevalence of substance use disorders in LGBT population [4–6]. One major specific concern is the increased frequency of post-traumatic stress disorder (PTSD) noted in LGBT population [7].

B.S. Hill, MD (✉)
Substance Abuse Rehabilitation Program, Washington DC VA Medical Center, Washington, DC, USA

Department of Psychiatry, Georgetown University, Washington, DC, USA
e-mail: bruce.hill2@va.gov

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_12

Post-traumatic Stress Disorder as Comorbid

PTSD is often comorbid with substance use disorder [8]. Data from the Veterans Health Administration show a gradual increase in numbers of veterans diagnosed with co-occurring PTSD and substance abuse/substance use disorders, reaching 26.5% in fiscal year 2013 [9].

Given an estimated incidence of PTSD in 5–15%, up to 17% of returned veterans from Iraq and Afghanistan [10], combined with increased prevalence of PTSD and substance use disorder (SUD) [59], treatment of SUD in LGBT veterans could pose special challenges already at risk for or diagnosed with PTSD from non-military trauma as well as war-related traumatic exposures. PTSD is the number one mental health diagnosis in returned veterans.

The criteria for PTSD in DSM-5 include the following:

The person is exposed to an initial traumatic experience of actual or threatened death, serious injury, or sexual violation. The experience is distressing and debilitates the individual for at least 1 month; reexperiencing the scene, avoidance of external or internal cues, negative mood and cognitions, and hyperarousal may all follow the initial traumatic event [11]. For veterans and civilians alike, avoidance includes not seeking care or help for their distress, not discussing prior traumatic events or feelings *even when asked about them*, and arriving late for appointments at times.

Although not all veterans with PTSD present with substance use disorder, it is not uncommon to hear veterans report an increase in regular and/or escalating substance use upon returning from deployment. Psychodynamic understanding of substance use disorders suggests that substances are used in part to relieve painful and overwhelming emotional or affective states [12]. These emotional states can be linked to traumas (death, injury, or sexual events) experienced during active military duty or added to traumatic events from childhood or adolescence. In addition, there is much attachment to substances of choice as emotion regulators [12] and subsequent reinforcement of behavior due to neurological adaptation [13]. As a result of these factors, frequently there is denial and an overly self-reliant stance [12].

Other Comorbid Conditions

Although avoidance and hyperarousal in PTSD can trigger use of substances of abuse, veterans with SUD can present with multiple other psychiatric diagnoses, which may also interfere with assessment and treatment. SUDs are strongly associated with comorbid mood disorders, such as major depressive disorder (MDD), and other anxiety disorders, notably social anxiety disorder [14]. Social anxiety disorder is quite frequent among veterans with PTSD [15] and is more common among gay non-military individuals than heterosexuals [16, 17]. Individuals with depressed mood can have difficulty concentrating to relate their history; gay veterans suffering with social anxiety may have trouble talking about social situations and sexual and

romantic relationships, which can relate directly to their problematic alcohol or illicit drug use.

Personality disorders (PDs) are also associated with SUD in the general population; current studies suggest 55–60% of patients with active or lifetime diagnosis of SUD have a personality disorder [18]; antisocial PD and borderline PD had the highest prevalences [19]. Comparing Vietnam veterans to matched civilians, antisocial personality disorder was more prevalent in male veterans [20]. Multiple PDs were noted in a smaller series of veterans with PTSD [21]; paranoid PD, obsessive-compulsive PD, and avoidant PD, all were more frequent than borderline PD or antisocial PD. Clearly, multiple clinical conditions that concur with SUD may pose significant clinical difficulties in talking to and treating LGBT veterans.

Case Studies

The following cases are comprised of composite material, in order to maintain confidentiality of the veterans.

Case 1: VJ

One of the first LGBT veterans I saw in my work at the Washington DC VA Medical Center, VJ, age 53, began treatment in our intensive outpatient program for stimulant use disorder with "crack" cocaine of 30-plus years' duration. His intermittent compulsive binges had necessitated multiple inpatient and outpatient treatment episodes in the late 1980s and 1990s, tapering to only two episodes of outpatient treatment in the last 10 years. One of these programs started with residential treatment for intranasal and "crack" cocaine abuse. His cannabis use had been more incidental to cocaine usage.

Treatment began unremarkably with timely progression through the admission and substance abuse education phase. He briefly relapsed in the second phase of the program, which focuses on relapse prevention. He had been prescribed with trazodone and sleep hygiene for improvement of his sleep regimen; he also continued on long-standing treatment with aripiprazole for presumed bipolar depression. Nicotine replacement as well as a short course of bupropion assisted with his tobacco use disorder later.

Understanding and reframing his brief relapse, I noticed and validated his persistent efforts to become abstinent and remain in recovery in supportive psychotherapy, including praise for subsequent negative urine toxicology screens. I found out after the second visit that his partner of 33 years was male, and I began to ask questions about him. The recognition of this part of his life led to more open communication; he was able to talk about how his partner had been supportive over the years.

By the next visit, he had brought in poems just written during his recovery. He asked to read them aloud to me, and I listened. As he rapped out his inspirational verses, I smiled. But then I wondered to myself, "I've never done this with any patient before." As an early-career psychiatrist, I thought about what the appropriate boundaries were and how this fit with what I was taught. My support leaned to the

side of his renewing strengths and his creativity and trust in our treatment relationship. He successfully completed the intensive program and started an aftercare extension program. He relapsed after 3 weeks and dropped out. Only later did I learn about the chronic relationship tension and irritation he had experienced decades ago, which had been pivotal triggers in his binges on cocaine in the past.

Importance of Therapeutic Alliance

Meeting less frequently, as is common in aftercare settings with less intensive treatment, may have been one significant factor in his relapse; more frequent meetings can serve to build an alliance with LGBT clients and provide support for their trust and emerging creativity. More confidence in the therapeutic relationship often translates into more sharing of their history; this therapeutic alliance has a positive impact on outcome, both for patients in psychotherapy and for those receiving medication [22]. Patience is important. There is guilt and shame to work through, associated with substance abuse, with shame being the more powerful factor [23]. In addition, there is also the shame of internal homophobia brought on by social stigma.

Attention to Internalized Homophobia

Internal homophobia has been discussed since the 1980s [24] as an important factor in the lives of LGBT individuals. It is defined as the taking in, or internalization, of cultural bias, community prejudice, and harsh judgmental attitudes toward themselves, as LGBT children. This usually leads to significant mental distress due to the resulting punitive attitudes and shame about one's self [25]. Shame then fuels isolation to avoid others' judgments as well as feeling undeserving and even worthless. Having less social support and lacking gay role models in the family and in the community can lead to avoiding discussions about problems and seeking help. Although boundaries are important, helping our LGBT clients to express themselves in artistic and creative ways not only builds trust in a treatment alliance but also helps to overcome the "double shame" of substance use and homophobia.

Case 2: BR

Working with psychiatry resident physicians gives me great enjoyment with opportunities for teaching and for learning from enthusiastic young professionals.

Noting this veteran's referral for alcohol use disorder, psychiatry resident Dr. R spoke with Mr. BR, a 46-year-old African-American gentleman with a past psychiatric history of adjustment disorder with depressed mood and related past medical history of chronic back pain and back injury sustained during active duty 22 years ago.

After hearing the resident's initial presentation, I noticed a very poised well-dressed African-American man with meticulous grooming. We reviewed his current

difficulties with alcohol and the DUI charges he was actively addressing in court. He had not mentioned another previous DUI to the resident in the initial interview. As we progressed in the conversation, topics turned to his personal life. He was enjoying his work as a nursing technician, having completed 3 of his 4 years.

It was easy to talk about his relationship with his mother and the military family in which he grew up. He also mentioned his two sons but avoided talking about his life partner. He couldn't acknowledge the gender of his partner, referring to him as "they." Only later did I find a reference to him. It was in a note from 1½ years prior—an encounter with a tele-mental health provider; there was one line: "Male companion, 'he is understanding.'"

Empathy

I mulled this over, struggling with it, thinking about all the social progress of today's world, both in society and in my own life. Now with same-sex marriage rights in every state, it was tough seeing it from his perspective, but I then tried to understand—active military experience for a gay African-American soldier in the 1990s. During that time, an AIDS diagnosis was essentially a death sentence; in 1991 only two medications were available for HIV treatment: AZT and ddI. Generally speaking, the gay community was felt to be the primary vector for virus transmission. However, awareness was growing that HIV could spread through drug use with needles. There was much cultural hysteria which required education. As medical students, we participated in an AIDS education outreach program; I'll paraphrase the recurring question from several seventh graders in Birmingham Alabama schools: "If a mosquito bit Magic Johnson, and then bit me, would I get AIDS?" The lack of understanding, the morbid fear, and even the outright hostility of those times reminded me of what lay before me as I myself had struggled to come to terms with who I was and where I fit in. As these fragments of remembrance came together in my mind, I was able to empathize and accept his avoidance and defensive discussion, knowing the many stages required to progress to self-acceptance.

Therapist's Self-Disclosure

Initially I thought about telling him my orientation as a gay clinical professional; then, however, this might not respect the truly adaptive measures he had been taking for years. Being able to avoid feelings of shame, sadness, and memories of isolation can be very protective, allowing someone to continue to function productively—for a period of time. We were not meeting in the context of weekly or more intensive psychotherapy, so gradually working through these emotions would not be possible right now. Perhaps my silent support would help him more with gradually coming to terms with his gay military and veteran experience, more than pushing an intimate discussion of his life in *this* setting. We could focus more on his acute substance use history and treatment. And yet, identifying and involving the supportive

and drug-free persons in a patient's life are critical in treatment of substance use disorder [26–28], as well as the treating primary care physician [29]. Indeed, the Substance Abuse and Mental Health Services Administration (SAMHSA) includes home and community as two of the four major dimensions of recovery, with a home offering safe and stable housing and a community providing relationships and social support [30].

The timing of self-disclosure of therapist's or physician's personal life is important. With the advent of online profiles and accessibility, more therapists are "screened" by their patients than ever before [31], so they may already have preconceived notions about the therapist's sexual orientation. Either explicit revelation or implicit supportive stance by a LGBT therapist or mental health professional or psychiatrist can be equally as valuable [32]. It has become clear that many therapeutic interventions, both medication and psychotherapy, depend in part on the quality of trust in the relationship with the patient.

Case 3: SL

Mr. SL came to our clinic for treatment after a relapse with binge drinking and MDMA (Ecstasy) in recent months. This 58-year-old now unemployed gay African-American male presented with past psychiatric history of depression, anxiety, and PTSD, in addition to previous amphetamine abuse. His medical history included hypertension, low back pain, and successfully treated prostate cancer and recently treated hepatitis C with apparent total resolution. Earlier in the year, he was employed as a teacher in a nearby county in Maryland. Apparently a student had seen a picture of his young boyfriend on his cellular phone; this led to accusations from the administration of "inappropriate sexual behavior" after this student reported. He was initially suspended and ultimately dismissed from the position.

Feeling betrayed, depressed, and angry, he then intermittently binged on MDMA and alcohol—Long Island Iced Teas—with more regular use of smoking marijuana. After a while, he began feeling out of control and started attending 12-step meetings again. However, when group members discovered the sexual allegations against him, Mr. SL reported that the group put additional restrictions on him, relating to his group interactions. He felt this was undeserved and demeaning; he again returned to drinking heavily and smoking marijuana.

After Mr. SL recounted his ups and downs of late, we talked more about his interpersonal and sexual past. He was born in the Southern United States and had experienced childhood physical abuse, including corporal punishment with switches. There were some dim memories of sexual mistreatment as a child. He married his wife 31 years ago and has four children; he still lives with his wife and daughter, as well as his young grandson. He enlisted in the Navy and served for 27 years.

Now, for the first time ever, he said he has been able to talk more about his sexual history. Although he has been with his wife for 31 years, he considers himself gay. He came out to himself within the last year. He loves his children very much; he no longer feels attracted to his wife. He has discussed his feelings and sexual

orientation with her; she has accepted it at some level. So just this year, he met a man and started a relationship with him.

Mr. SL shared with me that for many years, he never felt free to express his sexual orientation and desires as well as enormous anger and frustration. Even knowing my orientation, which we never explicitly discussed, he had difficulty talking about a sexual trauma in the Navy; he was raped and never talked about it to anyone until this year. He stated that this was normal for him—normal to avoid talking about his sexual life—normal because he had been not talking for so long and normal because he was ashamed of what happened. During active duty, he couldn't discuss anything that might lead to discovery of his sexual orientation. He felt there was no other choice: hide, suppress, and ward off his sexual and angry feelings. In addition, he had been the target of teasing and slurs; these only reinforced the "no talk" pattern over his lifetime.

We continued his psychotropic medications, which included bupropion and buspirone; he participated in the intensive outpatient program. More importantly, he attended a 90-day residential program for PTSD and military sexual trauma (MST) in Salem, Virginia. He shared that he had mixed feelings of relief and anxiety, sharing for the first time in a group setting about feeling betrayed, abused, and confused by a person who was supposed to fight with him, not against him.

At his follow-up visits, he was more relaxed when talking and said he felt different, compared to when he started treatment. He had remained abstinent with no cravings for alcohol or illicit substances. He expressed his gratitude for all the help he had received through the Washington DC VAMC Substance Abuse Rehabilitation Program and other programs; he was freer to be himself, to explore his gay identity. However, he still had no close friendships, only his children, and his relationship with his wife was understandably strained by his open relationship with his boyfriend. Forming other new relationships evoked anxiety and continued hypervigilance about his sexual identity. Indeed, he brought me some gifts to thank me ostensibly for my help; I wondered if there was also anxiety about being himself. Did he think he had to buy my continued assistance? We talked about all the gifts he brought and decided that one small item was enough to show his thankfulness.

Anxiety and Gifts

Feelings of anxiety and hypervigilance about sexual identity continue, *even after stated self-acceptance or coming out*; unwavering acceptance from a therapist and other significant relationships is key. It is important for physicians and therapists to be aware of the ways in which LGBT veterans or any clients may feel they need to placate or please those who care for them. Accepting excessive gifts or making other exceptions may undermine the trust and alliance, in which boundaries are vital to security and growth into their identity. Understanding the patient's motivation for giving [33] and its possible effect on the treatment help inform the decision on whether to accept it [34].

Additionally, LGBT veterans suffering from PTSD may feel alone and isolated, unable to trust any relationship. Professional relationships with doctor or therapist may offer more stable connections than previously experienced. Giving a gift might signal a need to solidify this. The felt isolation may be especially true for married gay men who have come out later in life and find less support from the gay community, many of whom have never been married (to a woman); however, societal shifts in acceptance of gay men in heterosexual marriages and bisexual individuals may change responses in the future [35].

Treatment for SUD

Current treatment for substance use disorders includes a multitiered approach with multiple modalities: intensive outpatient treatment; individual and group counseling; case management; medication for certain SUD, especially alcohol and opioids; inpatient and residential treatment as well as peer support; and 12-step fellowship meetings [30]. This may also include a sequential treatment track for PTSD predicated on the clinical premise of more stability or an integrated treatment track such as *Seeking Safety* by Lisa Najavits [36].

Challenges for treatment providers include the support and respect of the initiative and persistence of the patient balanced with the denial and inevitable relapses intrinsic to the addiction process; these are well understood as part of a cycle in Stages of Change as described by Prochaska and Diclemente [37–40]. Motivational interviewing [41, 42] grew out of understanding of the readiness to change [43].

Challenges for LGBT Therapists

This is no less difficult for LGBT providers; they have firsthand knowledge and can easily empathize with their patients' challenges in coming out and self-acceptance [44]. On the other hand, an overly affirming gay or lesbian therapist can experience problems if compassionate understanding is not accompanied by realistic appraisal of the client's capacity for change and sense of agency. Countertransference reactions can result from issues not fully worked through in his own mind and life, like residues of his own internalized homophobia [44]. Any therapist may feel the need to cure or rescue the client through caring in an overinvolved way, defensively pity them, and/or blame herself during a relapse [45]. Additionally, negative feelings toward SUD patients can accumulate during a treatment episode [36]. To offset these, successful therapists have been shown to use qualities, such as high empathy, confidence, hope and low wishes, to be in control [46].

Women Veterans

Women veterans make up about 10% of all veterans and slightly more at 11.6% in veterans who served in the recent era (Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn); however, only about 32% of women veterans had enrolled in VA services in 2009 [47]. Updated estimates from the 2008 American Community Survey and General Social Survey [48] show women comprising 14% of all active military personnel and LGB men and women making up about 2.2% of the total. Lesbian and bisexual women represented >40% of the LGB service members. [49]. However, it is unclear how many lesbian veterans currently access VA care. It is generally understood that women veterans have lower rates of substance use disorders than male veterans [50]. However, younger female veterans now are reaching or surpassing the rate of their male veteran peers, with prescription drug misuse [51]. However, given higher prevalence for SUD in LGB population, lesbian veterans with SUD remain at risk [3]. VA clinicians may not be as familiar with lesbian veterans' patterns of substance use; however, routine screening using the Alcohol Use Disorders Identification Test (AUDIT) in primary care clinics and other settings in VA medical centers has been shown to have less gender and ethnic bias than earlier methods [52, 53]. They continue to remain an important part of our veteran community that requires both understanding of prevalence and patterns of substance use and sensitive compassionate care as deserved by all who have served their country.

Transgendered Veterans

Despite their dedication and service, the current environment is still in flux for transgendered veterans, as society struggles to accept our transgendered siblings in the family [61]. However, the Veterans Health Administration has committed to increased attention to and treatment for transgendered veterans per VHA Directive 2013-003 [3]. This directive has drawn more clinical focus to needs of transgendered veterans in very recent years [54]. This is good news for our transgendered patients, considering that transgendered persons may be more likely to have served in the military than the general population [55, 56].

Conclusion

At long last, the tone is hopeful. Twenty-five years ago, it would not have been thinkable to me, as a closeted freshman medical student, that society would not only work to end discrimination against LGBT individuals in various settings but would eventually work actively to end an AIDS/HIV epidemic, allow LGBT service members to serve openly, and finally allow and support the recognition of marriage rights

across the nation. This willingness to "see" LGBT citizens parallels the work of seeing LGBT patients, both civilian and veteran. The current status of identifying percentages of LGBT veterans and recognizing their unique needs in treatment of SUD should include willingness to work with them creatively, in the context of recognized researched treatments for SUD. Continued recognition of the "coming out" process for veterans who served under DADT and the dedication we bring as LGBT clinicians to understanding and development of treatment relationships with previously un-"seen" LGBT veterans will lead to more understanding and inevitably more questions for research. In telling these stories of LGBT veterans with SUD, we had to "see." Now, more than ever, we can ask, and they can tell.

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"At Least 'Shipmate' Is a Gender-Neutral Insult": A Military Psychiatrist's Introduction to Transgender Military Service

13

Andrew's Story

As a physician, I pride myself on my strong stomach. No matter what specialty a physician chooses, they will invariably have at least one story where they ruined a meal for their friends or family because they are so excited to share what they learned about an organ system or disease state (it was dermatopathology for me). In fact, I can think of only one thing that is guaranteed to turn my stomach without fail – when someone tries to make a joke about financial disclosures at the start of any academic presentation. It is the same routine every time, with an exaggerated "I wish someone would pay me!" and a stock photo of an empty wallet on the PowerPoint slide. Much like the retail employee who cannot stifle their disappointed groan at the classic "joke" made at the register ("Not scanning? That means it's free, right?"), a wave of nausea comes over me whenever the empty-pocketed Monopoly man clip art is projected on stage. I acknowledge how minor this is, but its irritant properties never seem to subside.

You may be asking yourself right now why I decided to start my story this way. Is my distaste of bad PowerPoints and corny, tired jokes unique? Probably not. Is it important? If you look only superficially, the answer would be a resounding no. All you now know about me is that I have a curmudgeonly attitude toward people trying to make light of the necessary evils in academic presentation. That information does not exactly bathe me in a flattering light; nor is it particularly related to the theme of this chapter or book as a whole. If you examine it a bit closer, however, the importance of the statements above starts to show. You now know something about me you did not know before – a *disclosure***.** It is through author disclosure that you are better able to understand and judge their work. Despite my exasperation with jokes around them, I greatly appreciate and value the importance of financial disclosures in presentations and medical literature. Indeed, many young physicians have been swept up into the clouds after reading about a new drug in a journal article that

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_13

makes it sound like a true panacea. It is only after they read that the authors are financially tied to the drug's manufacturer can they return to terra firma. Disclosure gives us the necessary context. As it were, my journey as a military transgender ally and advocate started with a personal disclosure shortly before former Secretary of Defense Ash Carter composed his historic memorandum in July 2015 [1].

To understand what I mean by that, I must tell another story. Early in my medical school clinical rotations, I angered a nurse. It was a small infraction of the unspoken rules of the hospital (I sat at her computer to type a note), but it was the most educational experience I had on that rotation. For my transgressions, I was a persona non grata in a short white coat. Whenever I needed a chart, she always seemed to have it. When an opportunity to do a procedure arose on a patient she was caring for, she made it a point to tell my classmates before me. I had no idea what I did wrong, but I knew something was amiss. My resident at the time let this go on for a few days before she sat me down and explained to me all the things they don't teach you in medical school – in particular, the hatchet-burying properties of bagels (this nurse in particular loved blueberry cream cheese, the resident stressed). I left that rotation with an inordinate amount of respect toward the difficult job nurses have, and I resolved to never become *that* doctor that disrespects, belittles, or berates any member of the healthcare team. Indeed, I am proud to report that I have lived to that standard ever since – except one time.

In June 2015, Ms. X has been sitting silently in front of me for the last 20 min. She was an active duty male-to-female (MTF) transgender service member on my inpatient psychiatric unit, admitted there after a suicide attempt related to being ostracized for her gender identity. After 3 days of rapport building, Ms. X had finally started to talk to me, and I felt like we were getting somewhere. However, all she did today was fidget with the freshly changed bandage on her wrist like she did on the day of admission. Finally, she spoke up: "Are you going to fucking call me 'bro' now, too? How about 'dude'? I bet you're just another close-minded asshole like the guy who changed this gauze. Just call me 'shipmate', okay? At least 'shipmate' is a gender-neutral insult."

I think Ms. X saw in my face that I was confused and slightly hurt what she had just said to me. She softened her tone and explained that the wound care nurse that came to the ward to check her stitches told her to "man up" when she flinched and ended their conversation by saying "see you tomorrow, bro." Ms. X said she would have tried to ignore it as an innocent assumption (her face was unshaven, and her hair was within male grooming standards) had she not told him the day before about her female gender identity. The government-issued tissues did little to soak up the tears streaming down her face.

I rushed out of the treatment room to see if this individual is still on my floor – he was. I am not proud of just how loudly and angrily I let him know just how I felt about his behavior. I am similarly embarrassed when I think back to that day and remember how he cried harder than Ms. X when I was finished. In the moment, however, I could do little else – all my work with my patient was destroyed, and I

did not know if I could ever recoup those losses (for the record, I made sure that the bagel shop included a tub of blueberry cream cheese when I apologized the next day).

Returning to the treatment room, red faced and out of breath, I turned to Ms. X and did something that my mentors trained me to never do – self-disclose. "I am a cis-gender, heterosexual man," I told her, "I have almost as many letters after my name as I have in my name and more student loan debt than some people will earn in their entire lives. Yet, I sit here with you and I have never felt more stupid in my entire life." The face that she made rivaled the one I had made earlier. However, she was making eye contact with me for the first time that day. I continued, "I don't understand what you are dealing with and I feel completely powerless to help you. But I am here, I want to be here, and I want to help you. Tell me how I can do right by you." I didn't know what I had hoped to accomplish by telling her this, but I know I didn't want the initial response she gave me – she started to cry even harder.

Now I've done it; I thought to myself, *now she'll never trust me or any doctor ever again.* How could I not think that? The culture of medicine remains one where omnipotence is considered a minimum standard of competency, and yet, I just admitted to being completely ignorant to a patient and her plight. My mind was racing as she cleared her throat and started to speak – *she is going to fire me as a doctor. How am I going to tell my attending? How did they let me graduate medical school? Why did I open my stupid mouth? I am clearly a fraud, and this patient has figured it out.* "Thank you," she said, "for being honest with me."

To this day, I still hate the financial disclosure jokes made at the start of every presentation. I've attempted to sublimate this anger in the form of teaching by making disclosures during that slide that, while perhaps not funny, are at least original. In my lectures, my colleagues have learned various facts about me. They know that I have lived in the South for over 4 years and I still don't know what pimento cheese is. They know that I was such a neurotic kindergartener that my parents had to find a new home for my first puppy within a week because she made me so anxious (a Jack Russell terrier named, originally, "Jackie"). It may not lead to a career in stand-up, but it appears to disarm the crowd somewhat and put my mind at ease.

Shortly after Secretary of Defense Carter's 2015 memorandum, which was the de facto end to the ban on open transgender military service [1], I was invited to give departmental Ground Rounds on the role of the mental health provider in the treatment of gender dysphoria. I immediately accepted this offer; I learned so much from and made so many unintentional errors with Ms. X and the transgender patients that followed. It was important for me to pass this knowledge on. On the day of the presentation, I noticed a few of my friends in the audience look up as the "disclosure" slide came on the screen – they were curious to know what silly thing I would say about myself today. What they got instead was the second important disclosure I had ever made as a physician:

> I am a cis-gender, heterosexual man. I have almost as many letters after my name as I have in my name and more student loan debt than some people will earn in their entire lives. Yet, I stand here in front of all of you and I have never felt more stupid in my entire life. I don't

truly understand what I am about to present and I feel completely powerless. But I am here, I want to be here, and I want to share what I know with you today. We can and we must do right by our patients.

A Military Psychiatrists' Introduction to Transgender Military Service

When we set out on the task of writing this chapter, it became very readily apparent that a full discussion of transgender military service – or even simply the military mental health provider's role – was well beyond the scope of a single book chapter. Indeed, an entire volume would be unlikely to suffice. We were left, therefore, with a difficult question: how do we proceed? Contained in this book's other chapters are the personal stories of some of the greatest minds in military mental health. Further, our esteemed coauthors in this volume have written about their struggles and successes as sexual and gender minority service members. As such, we intentionally started with the long-winded, but necessary, set of disclosures above. We write this chapter as outsiders looking in, trying to understand, so we can better serve *all* of those who serve our country.

We cannot truly understand the struggles of the transgender service members we treat. However, does that not hold true for many cultures and situations our patients face beyond those with sexual and gender identities from ours? Indeed, we remain successful in our ability to treat patients that are strikingly different from us. We believe that we are best able to do so when we appreciate the unique sociocultural contexts of our patients. We may not be able to walk a mile in our patients' shoes, but learning the terrain on which they walk builds understanding and trust and leads to effective clinical relationships. To that end, we will now discuss the three major psychological concepts that have helped us develop our cognizance, as outsiders, of the unique transgender military experience – the military as a total institution, self-determination theory, and the minority stress model. We will conclude by proposing, for the first time, a merged model to build mental health providers' sociocultural competence in the care of transgender service members. We consider this model, although it remains in its infancy, to be revolutionary not only as it unifies these major theoretical frameworks but that it is the first to account for the distinctive idiosyncrasies of modern military culture.

Starting from Scratch: Knowledge Gaps in Transgender Physical and Mental Health

The practice of medicine and service in the military has many similarities. Of these, the emphasis on preparation and training often stands out beyond the rest. Indeed, such a large investment of time and energy in practice often pays dividends for the members of both professions. In being able to revert to one's training, solutions and successes are often found even when faced with new and unfamiliar situations. Such

an approach is poignantly ineffective when one's training is inadequate or even nonexistent, however. This is certainly the case for physicians when it comes to adequately understanding and addressing the healthcare needs of transgender and gender nonconforming (TGGN) individuals.

Despite calls for unique healthcare needs of lesbian, gay, bisexual, and transgender (LGBT) individuals to be better integrated in undergraduate medical education, a landmark 2011 study demonstrated that they have gone unheard in many US medical schools [2]. This study, which examined curricular content in 150 medical schools, demonstrated that the median time spent on LGBT topics was 5 h *over the entire 4 years of undergraduate medical education.* Furthermore, the primary focus of these instructional hours was devoted to sexual identity – not gender identity or TGGN healthcare needs. Although slightly over 70% of medical schools reported teaching about gender identity, only about 30% report providing *any* training regarding gender-affirming treatment [2]. Although increased attention has been paid to TGGN issues in the media, even in the few years that have passed since this study, there is little indication that undergraduate medical education has responded. A 2016 Canadian study given to medical students at nine medical schools demonstrated that 24% of students felt TGGN issues were sufficiently taught to them [3]. With less than 10% of respondents feeling adequately prepared to address TGGN healthcare needs upon graduation, it is clear that these significant gaps in knowledge remain unfilled [3].

Psychiatry residency training does not appear to fair much better. Although we could not locate any studies that examined TGGN curricular inclusion in psychiatry graduate medical education (GME) programs, a 2015 study examined LGBT inclusion on the Psychiatry Residency In-Training Exam (PRITE), an annual assessment test taken by all psychiatry residents in the United States [4]. The authors reasoned that through its ubiquity amongst trainees, questions on the PRITE can be viewed as a barometer for topics considered essential for psychiatrists. With an average of less than one question related to any LGBT topic annually from 2009 to 2013, this may represent a trend similar to that in undergraduate medical education [4]. Beyond the poor availability of formal training opportunities for TGGN-specific healthcare needs, research and education disseminated in the peer-reviewed literature have only started to accelerate in the last few years – particularly regarding psychiatric and psychological aspects of TGGN care – leaving providers who want or need to self-study with little ability to do so.

Overall, these significant gaps in training and knowledge amongst healthcare providers regarding TGGN individuals and TGGN-specific healthcare issues have significant and deleterious effects on both the physical and mental health of TGGN individuals. Of the research that does exist, poor provider knowledge, provider-committed microaggressions, and feelings of stigmatization rooted in provider ignorance of TGGN matters are pervasive in the US healthcare system [5–9]. Further, these manifestations of poor education and training are consistently cited as primary reasons for medical treatment avoidance [10–12] and the use of "black market" and unsafe methods of gender affirmation by TGGN individuals [12–16].

There are few places in the United States where this gap in our knowledge is more apparent than within the military. Although there were an estimated 15,500 TGGN service members clandestinely on active duty in 2014 [17], the ban on open service essentially obviated the need for most military medical professionals to be knowledgeable on the topic. With the repeal of the TGGN service ban in 2016, however, military medical professionals are at even larger disadvantage than their civilian counterparts in providing competent and compassionate care to TGGN individuals. Indeed, even research regarding the interplay between TGGN-specific healthcare needs and military-specific stressors is essentially nil. The few studies that do exist prior to the repeal of open service prohibition were performed clandestinely, had very few participants, and remain limited in their generalizability. Research amongst TGGN veterans receiving their care from Veterans Health Administration has been somewhat more robust. Although these data from veterans are beneficial, they cannot completely account for the day-to-day needs of TGGN service members on active duty by virtue of veterans' physical and temporal separation from the specific cultures, operational tempo, and regulations of military service.

The Military and Military Culture as Total Institutions

In light of this dearth of both training and extant knowledge regarding TGGN military service, we must adapt previous theoretical frameworks to our current situation. We believe that the best way to accomplish this starts with assessing military culture from a broad sociological context – a view we admit can often be missed by healthcare professionals during day-to-day medical care provision and military operations.

In 1961, sociologist Erving Goffman presented a paper at the Walter Reed Army Institute of Research wherein he coined the term *total institution*. The total institution, he stated, was a societal institution "which seems to be encompassing to a degree discontinuously greater than the ones next in line" with a "total character… symbolized by the barrier to social intercourse with the outside that is often built right into the physical plant: locked doors, high walls, barbed wire, cliffs and water, open terrain, and so forth" [18]. In addition to limiting or eliminating the ability of a person inside such an institution to communicate with those outside of it, a total institution's raison d'être is to control most, if not all, facets of a member's life to achieve a specific purpose [18, 19]. Certainly, military service meets these criteria. Starting at the moment they arrive at initial entry training, military recruits are stripped of nearly all aspects of their individual identities. In place of their individuality, recruits absorb the identity of the group to ensure the achievement of a common goal – defending the Constitution of the United States against all enemies, foreign and domestic. Upon graduation from initial entry training, the now freshly minted service members are able to regain some aspects of their individuality. However, they remain beholden to exacting standards of dress, grooming, conduct, and attitude for the entirety of the military careers [18, 19].

Dietart and Dentice [19] argue that although modern society has induced changes to the military total institution, the strict requirement for compliance remains. Further, the authors argue that this compliance is not limited to regulations and standards but compliance to cultural aspects as well. Within military culture is a strict adherence to Western and Judeo-Christian concepts of the gender binary – visible in the military's uniform, groom, fitness, and occupational standards. Dietart and Dentice argue – and we agree – that the military's adherence to these gender binary concepts is further reinforced by the elevation of and emphasis placed on the male attributes contained within this construct [19]. Hypermasculinity, defined as "an ideology that expresses exaggerated, extreme, and stereotypic masculine attributes and behaviors that include the hatred of femininity, strict adherence to gender norms, dominance, control, aggression, and violence" [19], sets the stage for a significantly toxic environment for TGGN service members [19–21].

Conversely, this deference to hypermasculine ideals *may also be an extremely attractive component* to military service, with TGGN individuals estimated to be *twice as likely to serve in the military* compared to age-matched cisgender Americans [17]. Indeed, one of the first known studies to examine TGGN military service in the United States – published in 1988 and included three TGGN individuals serving clandestinely on active duty – notes that the military afforded transwomen with both a "last ditch" attempt to conform to their chromosomal sex (XY) and a means to hide their transgender identity from others [21]. This "flight into hypermasculinity" has been seen as an impetus for TGGN military service since that time. More recent studies note that it is also an attractive aspect of military service for transmen as well – allowing them to be immersed in an occupational and cultural environment where acting in manners consistent with their gender identity is valued (as opposed to experience reprisal for not behaving in manners consistent with their chromosomal sex of XX) [19, 21, 22].

Self-Determination Theory

In searching for a model to fit the military experience of TGGN service members, we found self-determination theory (SDT) to be of great benefit. Developed in the 1980s by Deci and Ryan, SDT and its applications have evolved exponentially and continue to play a critical role in modern industrial/organization psychology [23]. One overarching premise of SDT, as defined by its creators, is that *(emphasis ours)*:

> [A]ll humans need to feel **competent, autonomous, and related to others**. Social contexts that facilitate satisfaction of these three basic psychological needs will support people's inherent activity, promote more optimal motivation, and yield the most positive psychological, developmental, and behavioural outcomes. In contrast, social environments that thwart satisfaction of these needs yield less optimal forms of motivation and have deleterious effects on a wide variety of well-being outcomes [24].

These three basic psychological needs – autonomy, competence, and relatedness – can help to develop an understanding of TGGN individuals' specific needs in

the setting of a military context. Indeed, this theory has been successfully applied to TGGN military service in a study published shortly before SECDEF Ashton Carter's 2015 memorandum on open service [25].

Autonomy, defined as the perception that "one's activities are endorsed by or congruent with the self" [26], is generally in short supply in the military. Consistent with the concept of the total institution, serving in the military limits a substantial amount of autonomy and individual decision-making [18, 19, 25]. However, Levy et al. note that autonomy can be somewhat preserved in the manner by which individuals achieve mission completion [25]. While it may hold true for TGGN service members, autonomy is more limited than their cisgender counterparts in light of the loss of choice in gender expression by way of the strict adherence to the gender binary and gender-specific regulations contained therein [19, 25]. Even with the release of DODINST 1300.28, gender expression remains limited both before and during the time that a service member is receiving gender-affirming treatment ("gender transition").

Competence, defined as "the experience that one can effectively bring about desired effects and outcomes" [26], forms an interesting dilemma in the case of TGGN service members. Levy et al., in their interviews with TGGN service members serving clandestinely (all conducted prior to 2015), noted that the fulfillment of competence is perhaps higher in this population versus their cisgender counterparts [25]. However, this does not necessarily imply positive outcomes. Indeed, the TGGN service members in this study used competence as a means of protection and cover to prevent their commands from discovering their gender identity and the consequences therein (including administrative separation from service) [25]. Even with DODINST 1300.28 and open military service, a heavy emphasis on competence to buffer against discrimination or abuse remains a critical component of this model in our opinion. We suspect that competency will continue to be used as a survival mechanism and subsequently increase the risk of burnout while simultaneously decreasing availability and resources for social support and adaptive coping mechanisms.

Relatedness, defined as "feeling that one is close and connected to significant others" [26], can be thought of as the polar opposite of autonomy in the military context; the total institution essentially trades autonomy for vast amounts of relatedness that goes well beyond one might find in many – if not all – civilian settings [18, 19, 25]. However, Levy et al. argue that this may only be superficially so for TGGN service members. Remembering that this study was performed prior to the current era of open service, they found that relatedness was not achieved for TGGN service members. Rather, relatedness was severely limited for the TGGN service members studied, having connections to those with whom they served alongside in the cisgender façade they presented to others while at work [25]. Fearing reprisal if their true self was discovered, many eschewed relatedness and strove to quickly return to their homes and genuine identities as quickly as possible when each workday ended [25]. Although we suspect that this may be mitigated somewhat with open TGGN military service, we believe that fear of discrimination and reprisal will likely persist, thus limiting the ability to achieve the level of relatedness necessary to fulfill this basic psychological need.

Minority Stress Model in the Military Context

Certainly, thinking in terms of SDT has been beneficial to our understanding and ability to provide compassionate and effective mental health treatment. However, we felt that it was insufficient on its own as it pertains to helping us better appreciate the effects of fear and discrimination that are experienced by TGGN service members. To that end, we have found great benefit in applying the concept of the minority stress model to this context.

The minority stress model was conceived by Meyer in 1995 from his graduate work with gay men in New York City during the AIDS epidemic of the 1980s and 1990s [27]. Meyer defined minority stress as "psychosocial stress derived from minority status" and that minority groups are "subjected to chronic stress related to their stigmatization…and such stress leads to adverse mental health outcomes" [27, 28]. Further, these minority stresses are in addition to (and, in some cases, multiplicative with) the daily stresses experienced by all in a society, even those in the majority [27, 28]. Although developed for LGB populations, it has been applied to TGGN populations with a great deal of success [29, 30].

Minority stresses can be further broken down into external minority stresses and internal minority stresses. External (sometimes referred to as "distal") minority stresses include overt discriminatory events perpetrated by others as well as physical, psychological, verbal, and sexual abuse committed by others as a direct result of minority status. Internal (sometimes referred to as "proximal") minority stresses, however, have a significantly wider scope and include internal expectation of discrimination and rejection, internalized self-stigmatization, and identity concealment [27–30]. It is the internal minority stressors that are beginning to be recognized as the more severe in many cases and indeed may be the more significant etiological factor in the development of mental illnesses, particularly in TGGN minority populations [29, 30]. When we apply the minority stress model to the TGGN military service experience, we note that there are even more external and internal stressors that are unique to the military and for which we must account.

External Minority Stresses

In addition to overt discriminatory events, we consider the external manifestations of gender binary adherence in the military as very significant. Notably, TGGN service members experience external minority stress in being required to dress, groom, and even exercise to standards consistent with their chromosomal sex as opposed to their gender identity, both before and during their gender-affirming treatment. This has been noted in previous studies that examined TGGN service members as highly discriminatory, distressing, and psychological abusive [19, 25]. One study also noted that TGGN officers, who are addressed as "sir" or "ma'am," experience high levels of distress secondary to this constant (albeit inadvertent) misgendering on a daily basis [25].

Internal Minority Stresses

In keeping with the military-as-total-intuition construct, the indoctrination and adherence to gender binary and elevation of hypermasculinity have the potential to cause significantly greater levels of internal minority stresses for TGGN individuals

compared to civilian occupational settings. As TGGN service members are immersed and educated within this hypermasculine military culture, internalization of and compliance with these cultural norms induce development and growth of self-stigmatization and internalized transphobia. As previously discussed, preexisting internalized transphobia is often an impetus to join the military in the first place – to attempt to rid themselves of or hide from their self-stigmatized gender identity and minority status. However, studies that have examined this have concluded, unsurprisingly, that the entry into military service does the opposite by reinforcing one's own self-directed transphobia [19, 21]. Leading to avoidance of social relationships, medical professionals, and healthy outlets to cope with all forms of stress, it is clear that internal minority stresses are highly detrimental to quality of life and emotional well-being, especially when those in the minority group are part of an organization like the military that actively fosters these stresses in its members [19, 21, 27–30].

Putting It All Together

As we wrote this chapter, we could not help but notice that it is often felt as though we were repeating ourselves at every turn. Upon further reflection, we found that – while certainly far from perfect – the concepts of the total institution, SDT, and the minority stress model fit together extraordinarily well. It was through the combination of these theoretical frameworks that we felt best able to provide the highest standards of compassionate and competent psychiatric care to our TGGN service members. As such, we conclude by present a schematic that synthesizes these three concepts in a military mental health context (Fig. 13.1).

Acknowledging the realities of general life stress and military/operational stresses, we propose that TGGN service members have significantly higher rates of stress and negative mental health outcomes via external/internal minority stress, especially when viewed through the lens of decreased autonomy in the military. Although minority stresses (particularly internal minority stresses) may be mitigated to some degree by increasing one's competence, this can be stymied by both burnout and being overly preoccupied of building competence at the expense of losing social relationships and opportunities for healthy coping. Lastly, we believe that relatedness directly affects mental health outcomes but also in an indirect manner by limiting opportunities to build adaptive coping mechanisms to all stresses as well as decreasing ability to foster social support systems.

We acknowledge that this proposed model remains both incomplete and untested with any degree of scientific rigor. Although we are currently developing a study to examine this model in further depth, it has been anecdotally a very useful tool for us as we strive to serve *all* who serve this country with respect and dignity they deserve.

Disclaimer The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the US Government.

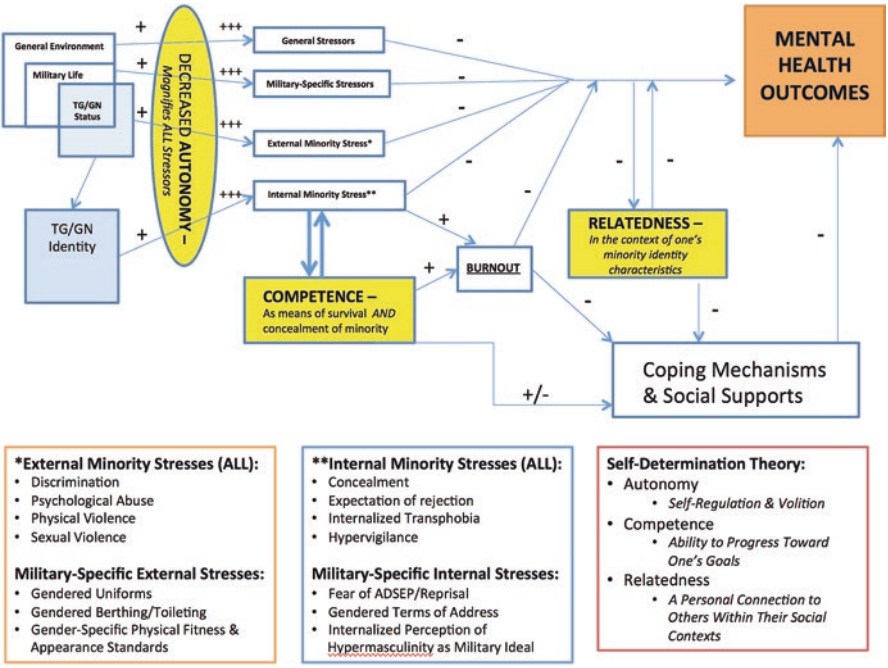

Fig. 13.1 A schematic that synthesizes concepts of care in a military mental health context for transgender and gender nonconforming individuals

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Ethical Issues Regarding LGBT and Intersex Service Members

14

Edmund G. Howe III

The military has recently welcomed lesbian, gay, bisexual, and transgender service members into its ranks. In June 2016, Secretary of Defense Ash Carter lifted the military's ban on transgender persons serving in the military, and on October 1, 2016, gender transition processes were begun [1]. Policy for this members in the near future will , however, again change. If these members can't be dployed, for example, it may be that they will not be able to serve in the military. It is estimated at this time that there are now between 1320 and 6630 transgender persons within the 1.3 million members in the military [2].

In this chapter, I shall discuss ethical issues that may arise for military providers treating these individuals. Since some policies and practices for transgender members are just now being developed, many ethical questions that may arise aren't yet known. For example, transgender members needing some treatments may go to special centers. If so, approaches will be needed to protect these members' confidentiality.

The military's recent integration of members who are lesbian, gay, and bisexual has taken place over a short time [3, 4]. Its capacity to change rapidly and enforce these changes can help make this transition successful. The military can, for example, provide mandatory training, and if members discriminate against fellow service members, the military can apply sanctions.

I shall present here core ethical issues military providers may encounter when they treat LGBT and intersex persons – those born with ambiguous genitalia. I shall

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The opinions or assertions contained herein are the private views of the authors and are not necessarily those of the AFRRI, USUHS, or the Department of Defense. The funders had no role in study design, data collection, analysis, and decision to publish or preparation of the manuscript.

E.G. Howe III, MD, JD (✉)
Professor of Psychiatry, Professor of Medicine, Director, Ethics Programs for Medical Students, Senior Scientist, Center for the Study of Traumatic Stress (CSTS), Uniformed Services University of the Health Sciences, Bethesda, MD, USA
e-mail: edmund.howe@usuhs.edu

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4_14

discuss issues which involve, first, lesbian, gay, and bisexual service persons; second, transgender persons; and, third, intersex persons.

In this first section involving lesbian, gay, and bisexual members, I shall discuss past events in the military that are relevant to transgender members now. I shall then discuss current concerns.

In the second section involving transgender members, I shall address especially ethical priorities military providers should consider and needs these members may have that these providers should know of.

In the third section, I shall consider concerns regarding intersex children and adults. Since some of these children have suffered profoundly tragic medical outcomes in the past, I shall discuss how military providers can best avoid these.

I shall suggest overall that the military can provide these members the highest standard of medical care. Further, the military can model this care for other institutions here and in other countries.

Lesbian, Gay, and Bisexual Service Members

The military's past policies and practices involving gay, lesbian, and bisexual persons have radically changed. Its initial, long-standing policy of exclusion of these individuals illustrates the importance of the military's basing its practices on sound assumptions. I shall review here key points in this past history and then discuss their relevance to these same groups now.

Historical Precedents

The US military's prior exclusion of lesbian, gay, and bisexual service members has occurred also in other countries [5]. Here, at one time, commanders sent investigators on "fishing expeditions" to look through patients' medical charts for information that might suggest that they were gay [6]. Subsequently these patient records gained greater protection. Commanders had to give their reasons for wanting this information, and military lawyers were the firewall protecting these records. These lawyers would give commanders then only information necessary for their missions.

This history is relevant to the treatment of transgender members today. When it was illegal in the military to be gay, providers sometimes tried to protect these patients by writing euphemisms in their medical charts. They believed that other providers would understand these euphemisms but that investigators would not or at least could not use them against these patients. The phrase providers often used was that their patients showed "psychosexual confusion."

Transgender members now too may want what they disclose to be kept private, particularly now, as a new policy which will exclude some transgender members in the near future will be implemented. Thus, providers may again have to consider what to write in these persons' charts. They should be wary of assuming that what they write will be understood only by other providers.

The military at one time also had to change its policy of excluding gay members. This need arose when HIV first appeared. This occurred in 1987, years before the "Don't Ask, Don't Tell" policy [6]. Then, there was no way to treat HIV. Thus, the military needed to know how within its ranks HIV was being spread. To do this, the military had to know which members were gay. If, however, members who disclosed that they were gay would be excluded, they would not acknowledge this. Thus, the military adopted this new policy allowing these members to remain in the military.

The speed with which the military initiated this new policy illustrates its exceptional capacity to change its policies and practices quickly. This example illustrates why the military can now respond ideally to transgender members.

The military may also justifiably adopt inconsistent values to maximally further both its missions and members' interests. An example most commonly practiced is when gay members were excluded. Though possible, the military did not seek to discern and exclude these members as vigorously as it could have.

Ethically, its practice was then inconsistent. Inconsistency is common and justified in many contexts. This is because it may alone allow the maximal net gain of mutually exclusive ends. Speed limits and police enforcement of these limits are an example. Rarely, if ever..., are these limits strictly enforced. This frees police to engage in more important pursuits while these limits still deter speeding.

Military providers' two core roles are to keep members healthy and to be able to inform their commanders accurately regarding the units' health. To be able to do this, though, they must retain these members' trust [7]. Thus, when gay members were excluded from the military, providers often kept this information to themselves.

Military psychiatrists who believed that they had a duty to inform their commanders if they learned that a patient was gay frequently did not. Rather, they informed these members before they divulged that they were gay that if they divulged this, they would have to report them [6].

Some psychiatrists would add how they could not divulge that they were gay but have therapy at this time. They would tell them that they could relate this problem to them as the problem of a friend [6]. If they did this, these psychiatrists would then not know that they were gay. They would thus not have to report them.

Military lawyers had at this time different views as to what military law required. Some lawyers said that providers were required to report and others that they were not. Despite this discrepancy, neither these lawyers nor military providers knew of a case in which a provider not reporting a gay patient had undergone severe sanctions [6, 7].

Ethical Questions for Lesbian, Gay, and Bisexual Service Members Now

Some problems gay members have still may need to be optimally resolved. I shall examine, here, two of them.

The first involves lesbian, gay, and bisexual partners who want to start families. The other involves providers having decided whether to prescribe for these members a medication known as PrEP. This medicine is a combination of drugs that reduces the risk of acquiring HIV as by engaging in unprotected sex.

Lesbian, Gay, and Bisexual Couples Wanting Children

There are several ways in which same-sex partners can have biologically related children. Providers may in some instances ask psychiatrists to approve this. Providers may do this, for example, when they fear that a patient may have a psychosis or be severely depressed.

Providers may, though, hesitate to proceed for other reasons that they may not be aware of. They may believe that if children have LGBT parents, this will not be best for these children. Thus, they may not approve these members acquiring these interventions, themselves, in part for this reason.

I shall note later that transgender persons may be depressed because they haven't yet had the hormones or surgery that they want. Likewise, same-sex partners wanting children may be depressed not for other reasons but because they want to have children and are having difficulty bringing this about.

Military providers should know that this belief that LGBT persons are likely to be less adequate parents is erroneous [8, 9]. They may, in fact, as a group, be better parents than average parents [10]. If so, this may be because they have suffered more than most parents. This may enable them have greater empathy for their children. When their children hurt, they may be able, therefore, to better and more deeply understand.

Providers generally should be wary of similar, negative countertransference responses. These feelings may affect them outside their awareness. They, too, may, as a result, make unwarranted clinical decisions. Transgender persons may, for example, want top, bottom, and contouring surgeries, as I shall shortly discuss. They may be depressed, because, as I have said, they haven't had this surgery. They may then still experience the daily stress that results from this.

Prescribing PrEP

Now, civilian medical providers differ in regard to whether or not they should prescribe PrEP to gay men. PrEP is a preexposure prophylactic (PrEP) medication that significantly reduces the incidence of HIV in people who engage in unsafe sex [11–14]. It is an oral, antiretroviral, fixed-dose combination tablet that contains tenofovir disoproxil fumarate and emtricitabine.

PrEP is much more expensive than condoms, and condoms offer greater protection. Providers' greater concern is, however, that if they give patients this medication, these patients may believe, rightly, that they will be at less risk of acquiring HIV if they engage in unprotected sex and thus take this risk more than they do now [15].

Also, civilian patients wanting to take PrEP also have reported that they fear asking their providers to prescribe this to them. They fear that their providers may respond to them in a negative way. They fear that providers will assume that they are asking for PrEP so that they can engage then more safely in unsafe sex.

The extent to which persons using PreP will in fact engage in unsafe sex more is unknown. Studies have suggested that this may not be the case. The validity of this finding is, however, uncertain. Those reporting their behavior may not state accurately what they do. Those who do report may also not represent most others.

This question of whether or not to prescribe PrEP is particularly important for military providers because of the exceptional importance of their gaining members' trust, as noted above. This trust may be increased if military providers can prescribe PrEP.

Military providers' optimal response to these members might be for them to discuss these concerns with them. If they are unable to prescribe PrEP and personally regret this, they might say this, as well. Their saying that they personally disagree with the military's policy might especially convey to these members how much they care.

Transgender Service Members

Providers in the military may see members, retirees, and dependents who have changed their gender, want to, or are considering this [16]. The ethical questions I discuss here are of two types: those that primarily involve transpersons' trust and those that will most meet these persons' needs. I shall discuss both in this same order.

Eliciting and Maintaining Transpersons' Trust

In the above paragraphs, I have referred to transgender persons as persons, not patients. This is because persons wanting to change or having changed their gender do not have, based on this alone, a medical or emotional disorder. Thus, they may not be patients.

There are several other important points providers also should know to maximally gain transgender persons' trust. Transgender persons' greatest two needs and desires may be, for example, to live as the gender they are and to be able to interact with others as most others can. This is to be able to meet and interact with them without their appearance being what all others first see.

This second need involves primarily how transgender persons appear. Thus, to be able to interact normally, they may need hormones, top surgery, and contouring surgery, as later I shall discuss.

For some, being able to live authentically and interact means appearing as persons of the gender they are. For others, however, this may mean also living in nonconforming ways. They may, for example, want only to take hormones and stop short of surgery. They may choose to have only top, not bottom, surgery. Providers should know of and respect these choices [17].

Providers should also know that while these persons may have no disorder, they also may be anxious, depressed, or emotionally distressed because their bodies are

still the wrong gender [18]. It may be, then, that if they can change their bodies, their dysphoric feelings may remit.

Persons who want to change their gender may alternatively, however, deny this to themselves. Thus, men who want to be women may join the military and seek particularly dangerous roles, such as those of Rangers or Seals, to affirm for themselves their masculine identity. If they volunteer for exceptionally high-risk missions, they may, then, be more vulnerable to physical and emotional harms, such as PTSD.

Military providers also should know that transpersons' desire to change their gender is different from their sexual orientation [19]. Their sexual orientation refers to the persons to whom they feel sexually attracted. Being transgender is not then the same as being lesbian, gay, or bisexual. Transgender persons' sexual interests, further, may change over time.

Their sexual feelings may change, for example, when they take gender-changing hormones [20, 21]. This may or may not alter their sexual orientation. Providers knowing about these changes can inform transpersons that they may occur. Then, these persons can know better what to expect.

Military psychiatrists may be asked to approve these persons receiving hormones and/or surgery. One study estimated that transpersons in the military over a year's time will need between 30–140 new hormone treatments and 25–130 new gender transition-related surgeries per year [2].

Military providers should know also about these persons' more subtle needs. "Men" who choose to be women may, for example, still have facial hair. If their facial hair goes untreated, its daily growth may much impair the quality of their lives.

The point here bears repeating. Transpersons may want, more than anything else, to be able to walk down the street and be greeted and treated like anyone else. They may not want others to look at them intently or to look away.

Transgender persons must also continually ask themselves whether they should disclose to others that they are transgender. This question will continue to arise for them, of course, throughout their lives.

This decision may be important to them even in regard to their providers. That is, in some medical contexts, they may not want their providers to know that they are transgender. Providers should know and respect this, though they may expect that their patients will share all personal information with them.

A final important issue is for military providers, as all providers, to use the right pronouns and names with these persons [22]. Transpersons face exceptional burdens when changing their names and gender identities, and the steps they must take differ in different contexts [2]. These steps are different, for example, for a driver's license and medical records.

Most important also of course is how providers respond to transpersons nonverbally. Some providers have religious beliefs that oppose persons changing their gender [23]. They may, then, struggle with what they should do. Other providers not having this problem may help providers that do.

They can ask those with religious scruples, for example, whether they might be willing to discuss with them what they feel are the deepest spiritual tenets of their religious beliefs. They can share with these providers that they might find this question useful, because asking this question has helped other providers feeling similarly conflicted to resolve their ambivalence.

Why might this work? These providers may discover then that the deepest tenet of their religion is to love their neighbor. Having unearthed this, they may then want to treat these people on the basis of this deeper underlying value.

Other providers who oppose treating transgender persons for moral or spiritual reasons may find that once they have a chance to come to know a transgender person better, they may no longer have their initial judgmental view. Becoming closer may melt negative personal bias better than anything else [24]. Other providers encountering conflicted providers may again help them, this time by telling them also that they may change in this way.

Providers so informed may then ask whether ethically they should tell transpersons they would see about their personal conflict when they first meet them. To respect these transpersons' autonomy and show them respect, this answer would have to be, "Yes." Only this candor would enable these transgender persons to choose whether or not they want to continue to see this provider.

Providers having this conflict may, however, hope that by getting to know such a transgender person better, they will change and lose this conflict. They may fear though that if they share with this person that they have this conflict initially, they may miss the opportunity to get to know him or her better, because this person may then not want to see them.e

A possible approach that may most maximize transgender persons' autonomy while giving providers the best chance of possibly getting to know these persons is to discuss their conflict with them. These transgender persons then can decide.

Medical Needs About Which Providers Should Know

If providers know about transgender persons' likely needs, they can raise them for discussion. An example I raised earlier is transgender persons wanting to have biologically related children. Their ability to do this is more medically problematic if they take hormones for a longer time, as for more than a year. This possible complication exemplifies the kind of medical knowledge providers can bring to these persons' attention if they are sufficiently knowledgeable.

In the last part of this section then, I shall accordingly discuss some important needs transgender persons may have that are more subtle.

Ethical Questions that Arise When Psychiatrists Have Two Roles: Treating and Preapproving Hormones and Surgery

An important ethical question particularly military psychiatrists may confront is what they should do when they have two roles. They may be treating transgender persons with psychotherapy and at this same time be asked to clear them for an

intervention, such as hormones or top or bottom surgery [25]. It is estimated that over a year's time, 25–130 transgender members will seek new hormone treatments and 10–130, gender transition-related surgeries [2].

Guidelines for approving these interventions may justifiably differ, depending on transgender persons' individual circumstances. A common guideline used is transgender persons having enough time to live as the gender they are, before they undergo such procedures as irreversible surgery. Some of these persons may face circumstances, however, which make this more difficult. They may be precluded from doing this, for example, because of too great, negative costs to themselves.

Some transgender persons also may have already lived as the gender they are for some time prior to meeting the provider tasked with making this assessment. These providers, accordingly, might optimally tailor the criteria they use to these transgender persons' individual needs.

A sometimes greater problem transgender persons may encounter is when they are seeing a psychiatrist for therapy and this psychiatrist is asked to preapprove them for hormones or surgery. These persons may then have to ask themselves how they should err. Should they say to their therapist what they believe they need to say in order to gain the most out of their therapy? Or should they say what they think will most enhance the likelihood of their having the medical intervention that they want?

Providers having this dual and conflicting role have several options they may consider. One is to request that they have only one role. This requires deferring the approving role to another. If this is not possible, they may at least share this bind they have with the transgender person. Together they may be able to arrive at a solution that works best for them.

Providers Acting as Transgender Persons' Advocates

Providers may sometimes benefit transgender persons by serving as their advocates. As I noted, persons wanting to change their bodies to become women must, for example, have a way to eliminate their facial hair. Providers may help support them in this endeavor.

There are, of course, many other examples. Transgender persons wanting to change their bodies to women's may need, for instance, to change their voice to a higher pitch and reduce a too prominent Adam's apple.

They may have other needs less well known for which providers can similarly advocate for them. Here are two examples: Women who become men may find the contours of their chest inadequate [26]. Thus, they may benefit most substantially from having chest surgery that renders their chest contours more like those of other men.

Likewise, men who become women may find that the female hormones they take do not sufficiently result in normal-looking female breasts [27]. Thus, they too may need breast implants in addition to female hormones. Only this may enable them to not draw unwanted attention to themselves. This attention can be highly stressful.

The rationale for both the above contouring surgeries thus bears repeating. These surgeries may be necessary to enable these persons to stand in line to pay at a

supermarket or merely walk down the street without others responding to them, initially, solely because of how they appear.

Ethically, military providers may also want to consider whether the principle of compensatory justice might apply. This principle might suggest, for instance, that since all service members may risk their lives and limbs for their country, they deserve some compensatory gains in return.

Compensatory benefits for transgender members may be the military's being willing to freeze and save their sperm and eggs in the event that they might want to for a time continue to take hormones but later might want to have children [28, 29]. Otherwise, if they stay on hormones too long, this may adversely affect their later ability to have children.

Intersex Children and Adults

Intersex persons refers to persons who are born with ambiguous or mixed genitalia. There are numerous causes of this condition [30]. I shall discuss here initially one of these causes, complete androgen insensitivity syndrome (CAIS). I shall use this as a paradigmatic example of how military providers, as other providers, might optimally respond when they see these individuals [31].

I shall next and at last discuss the more general, most critical questions these children will face: Should they have genital surgery, and if they should, what surgery and when and who should decide? As I shall elaborate below, some children have experienced most tragic outcomes in the past.

Complete Androgen Insensitivity Syndrome (CAIS)

CAIS used to be called testicular feminization. This term is no longer used, because it is implicitly too stigmatizing. Persons with these conditions have an XY or male karyotype, but their cells are unresponsive to testosterone. Thus, they develop in most respects as women. They cannot, however, have children. They also do not have menses, may have a shortened vagina, and have embryonic testicular remnants within their bodies that may become cancerous if they are not removed.

These people's needs do not usually raise exceptional concerns in the military. Persons with CAIS may present, however, to providers in the military both when they are children and as adults, and they may not know that they have this condition.

Their learning for the first time that they have this condition and are genetically the opposite gender may be most difficult at any age. Thus, providers should plan beforehand how they would want to respond if this occurs. Since what such providers say may be especially important with children, I shall begin this discussion with them.

Children

When a military provider is the first one to diagnose an intersex child, it is, of course, especially important that this provider responds in a way that will most preserve this child's present and future self-esteem.

One provider's way of responding is for this reason particularly worth noting. This provider told a young girl after she discovered that she had CAIS that her condition was just like a wonderful pile of building blocks that merely had been mislabeled. This provider then also showed this girl a film depicting an obviously joyous family. In this film, two parents were pushing their child on a swing, enjoying every minute of this. The film indicated that this child was adopted.

This second intervention was intended to convey to this child and others like her that she could look forward to a wholly happy family life. Her life could be just like the family in this film. She would just not be able to have her own children.

Adults

Providers in the military may also be the first one to diagnose CAIS in adults [32]. These women may come in with their husbands, years after having been married. They will know, perhaps only, that they have not been able to have children.

When providers inform these women or couples that they have CAIS, they must do this with the same care they would give to a child. This wife and husband may face quite a challenge adjusting to the new knowledge that this woman and wife genetically is a male.

It is worth also noting that throughout this discussion I have referred to women with CAIS as women and as unequivocally so as possible. This is the right and only pronoun to use in this instance. This careful choice of words here is as important as this is when providers are seeing transgender persons.

Whether and When to Perform Genital Surgery

Providers should know, more generally, that in the past, the question has been posed whether children with some intersex conditions should have genital surgery. This surgery would result in their genitals being more wholly female or male.

The assumption was made then that once this surgery was carried out, the psychological makeup of these children would follow suit. Their gender identity would, it was believed, over time become the same as their genitals. Tragically, this wasn't always the case.

Providers, accordingly, now knowing this, should advise these children's parents to review all their child's options fully before they decide what to do or not do [33]. One option may be, for instance, for them to do nothing, but rather wait. This surgery may then wait until these children are old enough to decide what they want for themselves. Ethically, this may be preferable to these parents deciding on irreversible surgery for their child at an earlier time.

Conclusion

Presently, lesbian, gay, bisexual, transgender, and intersex members serve in the military. This chapter has some optimal approaches that the military providers may take when seeing these persons.

These approaches included providers acting as these members' advocates when they want to have biological offspring and when they seek interventions that will enable their bodies to appear more unequivocally as the gender they are. The discussion includes also optimal approaches providers may take when they discern for the first time that children and adults have intersex conditions.

Throughout this discussion, military providers gaining and then maintaining these persons' trust are emphasized. Optimal approaches include their using the right words when seeing these persons, especially when they are children.

It has been recently reported that LGBT advocates applaud the steps that the military has taken with transgender members so far [1]. Providers can know what these persons most need, and the military can both change quickly and enforce what it enacts. With the right efforts, military providers should be able to provide for all these groups the highest medical and ethical standards of care.

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Index

E.C. Ritchie et al. (eds.), *Gay Mental Healthcare Providers and Patients in the Military*,
https://doi.org/10.1007/978-3-319-66026-4