

# INCLUSION AND READINESS: IN SUPPORT OF LGBTQ-AFFIRMING MILITARY HEALTH CARE

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*Author's Note: For the purposes of this paper, the acronym LGBQ (lesbian, gay, bisexual, queer) is used to discuss policy that does not specifically address transgender service members. The acronym LGBTQ (lesbian, gay, bisexual, transgender, queer) is used when individuals who identify as transgender are impacted by the policy or culture discussed. As the author, I recognize and respect that even LGBTQ does not incorporate all sexual orientations and gender identities.*

Mercurial policy shifts concerning the gender identity and sexual orientation of individuals serving in the United States military have adversely affected the quality of health care offered to service members who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ) directly impacting unit readiness. A lack of LGBTQ-affirming services within the military health care system compromises the health and well-being of LGBTQ service members, which is symptomatic of the exclusionary, heteronormative culture fostered by decades of discriminatory policy. The historic inequity within the military and its impact on the relationship between LGBTQ service members and military health care providers (MHCPs) must be addressed to rectify the ongoing health care disparity. Moreover, policies and LGBTQ-affirming practices that empower service members and foster inclusivity must be implemented to strengthen the military as a whole.

## THE HISTORY OF LGBTQ SERVICE POLICY

During World War I, the U.S. military criminalized sodomy and explicitly prohibited “homosexual conduct” by service members (Connell, 2017). The first outright ban of LGBQ service members was imposed during World War II, when the surgeon general of the U.S. Army classified homosexuality as a justification for disqualification from military service (Bérubé, 1990; Bailey & Barbato, 2011). After World War II, lesbian, gay, bisexual, and queer (LGBQ) service members were discharged under a pseudo-psychological pretext known as a “blue discharge” (Bailey & Barbato, 2011). At this time, the military did not address transgender identity in its policies. In 1962, a new policy facilitated the discharge of service members based on assumed homosexual identity, regardless of whether they had engaged in sexual activity with a member of the same sex (Connell, 2017). The discharge of service members was left to the discretion of commanding officers. Beginning in 1981, the Department of Defense’s standard protocol

was to discharge all service members who engaged in homosexual acts (Connell, 2017).

The Don't Ask, Don't Tell (DADT) policy, an effort to promote inclusivity within the armed forces, was enacted in 1994, despite fierce opposition from the Senate and military leadership (Bailey & Barbato, 2011). DADT allowed LGBQ individuals to serve in the military, provided that they did not disclose their sexual orientation. This repeal did not apply to individuals that identify as transgender. In actuality, discharging service members remained common practice upon reveal of their actual or perceived nonheterosexual orientation (Bailey & Barbato, 2011; Goldbach & Castro, 2016). This policy bred a "witch-hunt" mentality, in which service members could report to superiors any service member suspected of being LGBQ (Bailey & Barbato, 2011). This practice negatively impacted unit cohesion because it undermined the value of teamwork inherent to the military. The Don't Ask, Don't Tell Repeal Act of 2010 overturned DADT and allowed LGBQ service members to serve openly, meaning they were able to be honest about their personal lives with their units. Prior to this repeal, service members would often have to lie about their social lives, live off-post, and avoid bringing partners to military functions. This repeal did not apply to service members who identified as transgender. Shortly thereafter, the Department of Defense began offering family benefits to same-sex spouses (Department of Defense, 2013).

### **CURRENT POLICY**

The ongoing debate regarding LGBTQ service policies specifically impacts the transgender community. In 2012, the Department of Defense released formal instructions barring individuals with a history of psychosexual conditions, "including, but not limited to, transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias" from enlisting in the military (Department of Defense, 2012). This ban on transgender service was officially repealed in 2016 by the Obama administration, which emphasized that transgender individuals are fit to serve and already do so in other countries (Connell, 2017). The Department of Defense is actively recruiting, training, and retaining transgender service members despite continued efforts to prohibit their service, including the Trump administration's efforts to reinstate the ban (Shane, 2018). Transgender individuals enlist at twice the rate of their cisgender counterparts, which some researchers and personal accounts attribute to a desire to embrace the societal construct of masculinity (Connell, 2017; Goldbach & Castro, 2016; Herzog & Orabona, 2014; Kemp & Del Monte, 2017). The reinstatement of the 2012 ban would limit which transgender service members are permitted to serve based on the length of time each individual has identified as transgender and on potentially necessary medical accommodations related to gender identity (Seck, 2018).

Opponents of the ban question the justification for its implementation. Some high-level military leaders, bolstered by pseudoscience, claim that the inclusion of LGBTQ service members has a negative impact on morale (Bailey & Barbato, 2011). Contrary evidence shows that, in fact, a ban on transgender service would adversely affect unit morality, retention, and readiness, as evidenced by the “witch-hunt” culture during the period of DADT (Barnes, 2018; Bailey & Barbato, 2011). This policy battle has perpetuated confusion among the ranks regarding the state of current regulations and has created a daunting environment for transgender service members. For instance, service members who identify as transgender and who have recently disclosed their gender identity may fear negative repercussions if the Trump administration were to reinstate the ban.

### **IMPLICATIONS FOR HEALTH CARE**

Though DADT has been repealed, LGBTQ service members’ distrust of military health care providers (MHCPs) remains. MHCPs serve in the dual roles of clinicians and officers. As officers, MHCPs are required to report medical findings that disqualify patients from service eligibility. Under the DADT policy, if a patient informed a MHCP of their LGBTQ identity, the MHCP was required to report the patient and, in some instances, to classify them as unfit for service (Biddix, Fogel, & Black, 2013). Considering that the ban on transgender service may be reinstated, it is likely that many transgender service members will be reticent when interacting with MHCPs, as being open about their gender identity can disrupt their ability to serve (Goldbach & Castro, 2016). In a study examining comfort levels of LGBTQ service members with regard to the military health care system, 30% reported feeling discomfort when discussing their gender identity, sexual orientation, or sexual health with their MHCP (Biddix et al., 2013). The study found that 44% of gay and bisexual male participants believed sexual orientation was a factor in the care they received from the military (Biddix et al., 2013).

Many LGBTQ service members waited several years after the repeal of DADT to come out to their units, for fear of bullying, denial of promotion, or discharge (Bensahel, 2012). One notable study revealed that 45% of LGBTQ service members chose not to disclose their sexual orientation to MHCPs and 75% believed that their MHCP presumed that they were heterosexual (Stebnicki, Persko, & Thomas, 2015). Many LGBTQ service members also reported that they avoided seeking health care for fear of discrimination (Stebnicki et al., 2015). Notably, LGBTQ service members are likely to have poorer physical and mental health—including increased risk of conditions such as depression, posttraumatic stress disorder, and alcohol and/or other substance use—than the health of their heterosexual and cisgender counterparts (Stebnicki et al., 2015; Shrader et al., 2017). Further, LGBTQ service members attempt suicide at a rate 2.5 times higher than non-LGBTQ

service members (National Defense Research Institute, 2010).

New recruits may be drawn to enlist because of the alluring, comprehensive military health care benefits to which they are entitled during and after service. However, until the repeal of DADT, service members who were entitled to full retirement benefits—accrued over 20 years of service—but who were discharged for being LGBTQ would have to reenlist to receive benefits. Likewise, if a ban on transgender service is reinstated, transgender individuals who lose their active duty or reserve status would be denied military health insurance until a policy change allows them to reenlist. The nature of their discharge may also negatively impact their right to receive lifelong health coverage from the Veterans Health Administration (VHA) (Bailey & Barbato, 2011). Should the military continue to employ transgender service members, LGBTQ-affirming measures must be expanded to cover all LGBTQ service members, both active and veteran, across all military facilities.

### **RECOMMENDATIONS**

Transgender service members face unique barriers in receiving quality health care. An estimated 250,000 LGBTQ service members and veterans utilize VHA services, including roughly 5,000 who identify as transgender (Kauth & Shipherd, 2016). In 2018, the Veterans Administration (VA) issued a directive to use inclusive language, providing more deferential care to veterans who identify as transgender or intersex by addressing patients by their preferred names and gender pronouns (Department of Veterans Affairs, 2018). Though this policy cannot completely assuage the discomfort of many LGBTQ service members in VHA environments, it is a step in the right direction and should be adopted by the entire military health care system in order to support and care for LGBTQ service members (Stebnicki et al., 2015).

MHCPs and military social workers play an integral part in changing the way the military supports LGBTQ service members; both roles have the unique capability to engage at multiple levels of the military and to positively change how LGBTQ service members receive care. Military social workers are trained to provide necessary support, counseling, and education to military personnel and their families; however, there is room for improvement in how to sensitively and effectively work with LGBTQ service members. While seminars and ethics training may provide a foundation, LGBTQ service members deserve care from those who are specifically trained to meet their needs. Stebnicki et al. (2015) provide several suggestions that can be adapted specifically to social work supervision, including seeing LGBTQ patients regularly during internships and post-education training, ensuring that supervision includes discussions about LGBTQ experiences, and learning directly from those who have been

the recipients of this care in the past. A standard of care should then be established to ensure that all service members are receiving the highest possible level of support, regardless of where they are stationed.

MHCPs and social workers must then address the distrust between LGBTQ service members and MHCPs. The therapeutic alliance between clinician and service member must be rooted in mutual trust, which has been eroded in the military by the former policies that mandated MHCPs to report evidence of LGBTQ identity. Moving forward, in order to provide affirming care, MHCPs must acknowledge the historically problematic power dynamics of the relationship and allow this awareness to shape the ways in which they interact with and provide care for LGBTQ service members. For example, not assuming service members' sexuality or gender identity and changing the language around health care can provide a more welcoming hospital environment and thus healthier LGBTQ service members. Each unit of MHCPs should also include a subject matter expert on anti-oppressive practice to allow for direct peer-to-peer education.

Furthermore, improving health care outcomes for LGBTQ service members may also occur outside of the medical department. Due to social work officers' unique position within military structure, they are able to engage directly with unit leadership. They should take the initiative to conduct anti-oppressive trainings for these leaders, therefore prioritizing and normalizing the inclusion of LGBTQ service members. Educating all members of the military in anti-oppressive best practices could help to mitigate negative mental health outcomes for LGBTQ service members that are rooted in living and working in environments that contain unaddressed stigma, stereotyping, and homophobic undertones (Stebnicki et al., 2015). If both commissioned and enlisted leaders incorporate inclusive language into their daily lives, the rest of the unit, and thus the culture, will follow.

## **CONCLUSION**

In conclusion, vacillating policy changes have had negative effects on readiness and inclusion within the U.S. military. The whims of politicians should not negatively impact the health care provided to service members and veterans, regardless of their sexual orientation and gender identity. While society at large has made great strides toward acceptance and inclusion of the LGBTQ community since the DADT era, the military community and government policy still lag behind. Under the Obama administration, the military took steps toward greater inclusivity with the repeals of both DADT and the ban on transgender service, yet current political leaders are working to revert to an earlier era by reenacting previous bans that were discriminatory and detrimental. However, there is hope for the future of LGBTQ service members. VHA health directives prioritize inclusivity and work towards providing the care that veterans may

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not have been able to access during their active duty service, and continuous advocacy by military social work officers can help to change military culture both within and outside of the medical tent. Perhaps the next administration, alongside Congress, will ally with this rising generation of social workers to facilitate the establishment of a more inclusive military, propelled by health care professionals who are educated and committed to LGBTQ-affirming practices and sustained by those who will never stop fighting for the care they deserve from the country they love.

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