The Camouflage Closet:
LGBT Veteran Educational Resource

This curriculum was created as an accompaniment to *The Camouflage Closet*, a short documentary film about trauma and recovery among nine Lesbian, Gay, Bisexual and Transgender (LGBT) Veterans. The film was created as a community-based participatory art project with the goal of increasing awareness among medical providers, Veterans, and LGBT communities regarding their unique experiences of serving under LGBT-related military policies, such as "Don't Ask, Don't Tell" (DADT) and the current ban on transgender military service.

At this time, *The Camouflage Closet* has screened at a variety of venues including the National Queer Arts Festival, the San Francisco Veterans Film Festival, the Department of Veterans Affairs, Stanford University, and the Gay and Lesbian Medical Association (GLMA). Audience feedback at these screenings has suggested that prior to seeing this film, viewers felt they had limited knowledge about LGBT Veterans. It is our hope that the foregoing curriculum will support a deeper understanding of the needs and strengths of LGBT Veterans. This document includes:

The views expressed in this document do not represent the Department of Veterans Affairs or any other institution. Please feel free to contact the production team with questions regarding the information in this educational resource.

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1. Overview of LGBT Servicemembers and Veteran Research

Estimates, Reasons for Enlistment and Experiences of Physical and Mental Health

Estimating the size of LGBT military and Veteran populations has long been compounded by the fact that neither the Department of Defense (DOD) nor the VA collect self-reported information on sexual orientation or gender identity among servicemembers or Veterans. Based on population data, Gates (2004) estimates that **"nearly one million gay and lesbian Americans are veterans"** (p. iv), and an additional **71,000 lesbian, gay, and bisexual people are active duty military personnel**, including the guard and reserves (Gates, 2010). No estimates have been published for the number of transgender servicemembers or Veterans based on population data such as the U.S. Census or American Community Survey.

Estimating the size of the LGBT population is also challenging in part due to the complex definitions of sexual orientation and gender identity. The American Psychological Association (APA) defines sexual orientation in terms of sexual attraction (i.e. toward men, women, or both), a sense of personal identity based on that attraction, sexual behavior, and participation in a community of others who have the same sexual attractions (APA, 2008). The APA's definition of transgender refers to an internal sense of gender identity that is different from the gender assumed by others at birth based on genitalia (APA, 2008). Gates (2012) points out that the APA definition of transgender does not specify the degree to which a behavior makes one transgender or not; while some people choose to have sexual reassignment surgery and hormone replacement, others do not. The fluidity of these definitions is further obfuscated by countless studies and surveys that conflate the internal sense of sexual orientation or gender identity with external behavioral characteristics (Gates, 2012). Like the APA's, these definitions highlight a unique issue for LGBT servicemembers who, because of policies like Don't Ask Don't Tell (DADT), were prevented from expressing certain behaviors and from participating in a community of other LGBT people—both key aspects of LGBT identity development.

Under previous anti-LGBT military policies, we might wonder why LGBT people ultimately chose to enlist and why lesbian, bisexual, and transgender women may enlist at rates higher than gay men and heterosexual, cisgender[1] people (Gates, 2010, Brown, 1988, Shiperd et al., 2012, Blosnich et al., 2013). **LGBT people report a variety of reasons for enlisting.** On one hand, many of these reasons mirror their non-LGBT counterparts—a desire to serve their country; following in the footsteps of military family members; accessing educational scholarships and home loans. On the other hand, many also report LGBT-specific motivations for military enlistment (Berube, 1990; Estes, 2007; and Frank, 2004). One theory that has been proposed to explain why some gay men and transgender women enter the military is known as the **"flight into hypermasculinity"**; as a means to deflect suspicions that they may be gay or transgender, many seek refuge in a characteristically masculine institution like the military (Brown, 1998). **Escape from sexual assault** is also cited as a possible reason for enlistment among lesbian and bisexual women, who report higher rates of sexual abuse in pre-adulthood when compared to heterosexual women servicemembers (Zinzow et al., 2007, Dichter et al., 2011, Schultz et al., 2006). While some LGBT Veterans assert that they intentionally subverted bans on LGBT military service, others maintain they did not know they were LGBT when they enlisted.

[1] C*isgender*, the opposite of transgender, refers to people whose internal sense of gender is concordant with the gender ascribed to them by others based on genitalia.

Stages of Sexual Orientation and Gender Identity Development

The most frequently cited model for sexual identity development is Cass's (1979) **Six Stages of Homosexual Identity Formation:** confusion, comparison, tolerance, acceptance, pride, and synthesis. Conversely, transgender identity development is described by Maguen et al. (2005) not as "a linear process but often a complex, intricate, and convoluted journey" (p. 479). People often enter the military in their late teens and early twenties. For many LGBT servicemembers, this corresponds with the first two stages of Cass's Model, identity confusion and comparison—at the same time they may be developing an early awareness of their sexual orientation or gender identity.

What may logically follow anti-LGBT military policies, then, are challenges to identity integration, such as identity foreclosure or forestallment. That is to say, identity development may prematurely end or temporarily pause during military service.

Minority Stress Model

Given disproportionate rates of negative health outcomes among LGBT people as compared to non-LGBT people (Institute of Medicine, 2011), the Minority Stress Model is important to LGBT-affirmative practice. In contrast with the difference-as-deficit model—the incorrect assertion that higher rates of negative health outcomes result from simply being LGBT, the Minority Stress Model explains disproportionate health problems among LGB people in terms of the additive stress of being a sexual minority in a homophobic society (Meyer, 2003).

The Minority Stress Model was first created for lesbians by Brooks (1981) and later adapted by Meyer (1995, 2003) to describe how LGB people's experiences of homophobia and heterosexism can result in higher baseline levels of chronic stress, which can lead to poorer mental and physical health outcomes.

In Meyer's model, LGB people experience distal (objective) and proximal (subjective) stress processes. Whereas distal stress results from external stressors (e.g. hate crimes) that are visible to others, proximal stress refers to internal processes (e.g. perceived stigma, expectation of future harassment) based on past experiences of victimization, internalized homophobia, and efforts to remain closeted. While this model did not initially include transgender people, emerging research suggests that they are similarly affected by stigma related to their gender identities (Bockting et al., 1998; Nemoto, et al., 2003 and Grant et al., 2011), and the model has since been adapted to the experiences of transgender and gender non-conforming people (Hendricks and Testa, 2012). Research also suggests that stress and mental health challenges increase for LGBT people during times of anti-LGBT policy debate (Levitt, et al., 2008), which is potentially significant given that DADT debate lasted from 1993 to 2011, and LGBT military personnel from that era are now seeking VHA health care services.

LGBT Veteran Military Experiences

Many LGBT Veterans thrived in the military, professionally and socially. Some of these Veterans found themselves among colleagues to whom they were comfortable coming out. Others, however, describe cases of **social isolation, severe and brutal harassment, and physical and sexual assault due to their sexual orientation and gender identity** (Moradi, 2009, Burks, 2011, Trivette, 2010, Frank, 2004, Estes, 2007, Cameron et al., 2011). Additionally, these Veterans also recall significant **stress concealing their sexual orientation and gender identities** from people with whom they worked, lived, ate, and recreated, and from whom they received medical treatment, men-

tal health services, and spiritual counsel (Estes, 2007; Trivette, 2010). This **stress was amplified by military investigations** into their sexual orientations and gender identities that included extensive surveillance of their private lives off-base—a tangle of undercover officers, interception of personal communications, and invasive questioning of family and friends back home, collectively known as "witch hunts."

In an online study of 445 LGBT Veterans (27.2% female, 64.7% male, 8.1% transgender or other), 36.2% were investigated for their sexual orientation, 14.8% reported being isolated due to their sexual orientation, 11% were forced to participate in psychiatric evaluation, and 2% were incarcerated for their sexual orientation (Santa et al., 2007). Additionally, 16% were discharged from the military due to their sexual orientation. These Veterans as a whole are "more likely to avoid Veterans Administration Services due to their perception of how they would be treated," highlighting a potential impact of these experiences on healthcare later in life (Santa et al., 2007).

LGBT servicemembers who found themselves in hostile environments employed a variety of **creative strategies to survive the stress of these military settings**. Some corresponded in code with same-sex partners or created fictitious, opposite-sex partners at home. Some established a Gay Underground Network (GUN) where they could be openly LGBT with a group of trusted peers (Trivette, 2010; Frank, 2004; Estes, 2007). In mandatory dependent-reporting systems, many LGBT servicemembers subtly changed the name of their partner to appear as someone of the opposite gender, often by changing a single letter to appear as a typo in a court of law (Wescott & Sawyer, 2007). LGBT servicemembers have also described opportunities to visit LGBT spaces that they were afraid to access at home, while others reported traveling long distances to access LGBT social spaces and healthcare services, far away from base (Estes, 2007). Finally, LGBT Veterans were known to have organized in bar raids by having two lesbians and two gay men at a table, pretending to be on heterosexual dates (Estes, 2007).

LGBT servicemembers experienced unique **challenges to the formation of cohesive service units**—ironically, a key justification championed by DADT's supporters, who claimed that preventing LGBT people from serving openly would create a safer work environment for heterosexual servicemembers and increase unit cohesion. Instead of increasing unit cohesion, DADT impeded the ability of many LGBT servicemembers to bond with heterosexual personnel (Estes, 2007); those who could not share seemingly mundane aspects of their lives with colleagues may have been seen as private and withdrawn (Frank, 2004). Another unique minority stress affecting LGBT military personnel under DADT was the **ethical strife between the military code of ethics—which called for honesty and integrity—and the compulsory requirement to withhold the truth** about one's sexual orientation or gender identity (Frank, 2004).

Sexual Assault

Burks (2011) asserts that **"DADT has served to increase LGB victimization [and] decrease victim reports and help-seeking,"** which was amplified by a unique mixture of "sexual stigma, conservative gender role beliefs, and sexual prejudice" within military culture (p. 604). In a computerized phone interview–based study of 1,004 Midwestern Veteran women under 51 years old, Booth et al. (2011) report that 11% (N=74) of respondents identified themselves as being in relationships with women or with women and men. Of these respondents in same-sex relationships, **reports of lifetime rape were higher (73%) than heterosexual respondents (48%).** The authors note concern about **higher rates of childhood sexual assault among these women service-**

members, who also face continued higher rates of sexual and physical assault in the military as compared to heterosexual women servicemembers (Booth et al., 2011).

Higher Risk-Taking

The literature also suggests that **LGBT people engage in higher-risk assignments** in the military as a means of proving their masculinity or to deter questions about their sexual orientation (Estes, 2007). It appears alcohol and drug use are common in LGBT military social spaces (e.g. parties and bars off-base), which might also lead to higher risk-taking behaviors (e.g. sex without condoms, reckless driving).

Accessing Medical Care while on Active Duty

Some LGBT servicemembers chose to **access civilian healthcare over military support systems due to the confidentiality breach required by DADT** (Smith, 2008; Johnson & Buhrke, 2006). The years preceding the repeal of DADT saw much open discussion among military psychologists regarding the ethical dilemma of **DADT mandating the report of LGB Veterans who disclosed their sexual orientation in therapy—a breach of APA ethical codes of patient client confidentiality**. In a study of active-duty U.S. Navy sailors seeking treatment at the community-based Gay Men's Health Clinic, Smith (2008) explains they "all expressed fears of being discharged" as the reason for seeking care outside of the military. Smith goes further to underscore unique epidemiological concerns for military personnel who are unable to complete a course of treatment, or who are transferred to new duty stations and lost to clinical follow-up.

Disparities in LGBT Veteran Health

LGBT Veteran research suggests that **anxiety about concealment, PTSD, and substance abuse are more prevalent among sexual minorities** (Cochran et al., 2013, Dobie et al., 2004, Escalona et al., 2004). Suicidal thoughts and behavior are found to be higher among LGBT Veterans as compared to heterosexual and cisgender Veterans (Blosnich et al., 2012, Herrell et al., 2007, Blosnich et al., 2013, Grant et al., 2011).

Depression, anxiety, frequent mental distress, sleep problems, low satisfaction, isolation and lack of social support, military sexual trauma, combat trauma, childhood and lifetime sexual abuse, poor physical health, smoking, and being overweight are also noted as key issues facing LGBT Veterans (Blosnich et al., 2012, McDuffie and Brown, 2010, Blosnich et al., 2013, Blosnich and Silenzio, 2013, Zinzow, 2007, Kelly et al., 2011, Lehavot et al., 2012, Shen & Sambamoorthi, 2012, Booth et al., 2011, Burks, 2011).

Sexual Health Issues

PTSD is associated with sexual problems including sexual interest, erectile dysfunction, premature ejaculation, poorer orgasmic function, and lower overall sexual satisfaction (Cosgrove et al., 2002; Letourneau et al., 1997). Cameron et al. (2011) write, "Veterans who acquire psychological or physical disabilities during their service and then subsequently cope with concerns about sexuality have to navigate the double-barreled taboo against disability and sexuality that pervades our society" (p. 290). The authors conclude by proposing that **sexual health interventions be added to the treatment of PTSD and TBI** in order to focus on positive sexual expression, health, and safety among Veterans.

Similarly, Satcher et al. (2012) explain that recently returning soldiers are experienc-

ing higher survival rates than Veterans from previous conflicts, resulting in 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" (p. 6). The authors add that "**healthy intimate relationships can contribute to a person's recovery from physical and mental trauma**, while a lack of them can contribute to ongoing mental health problems and even suicide."

LGBT Servicemembers and Veterans' Familial Relationships

DADT and other LGBT-related military policies caused particular challenges for LGBT servicemembers' same-sex partners and children raised by same-sex partners as they were prohibited from reporting their partners and children in the Dependent Enrollment Eligibility Reporting System and Emergency Reporting System. Without reporting partners and dependents, the families of LGBT servicemembers would not receive a range of benefits such as medical care, military housing, survivor's benefits or even death notifications (Wescott and Sawyer, 2007). Additionally, DADT in combination with the Defense of Marriage Act (DOMA) forced LGBT servicemembers to choose between their military careers and families with some servicemembers opting for early military retirement in order to legally marry their same-sex spouses in states like Massachusetts (Wescott and Sawyer, 2007).

Gender Differences

In a literature review of articles regarding LB Veterans, Lehavot and Balsam (2013) conclude that they face a "host of unique issues when accessing health care, including fears of insensitive care and difficulty disclosing sexual orientation to Veterans Health Administration (VHA) providers." In addition, the authors highlight DADT's differential impacts by gender, with women representing 14% of the military but 30% of DADT discharges. "This group violates cultural norms with respect to both gender (by virtue of being in the military) and heterosexuality." For LB women Veterans, "especially those who may be butch (e.g. present with a more masculine gender style), discrimination may be a result of gender nonconformity prejudice that is intertwined with anti-gay prejudice." This has manifested in a type of sexual assault called "corrective rape," which is enacted with the intention of making the victim "'act' more like their gender" (Lehavot et al., 2013, p. 5 and 6). Gender presentation also appears to affect health care service utilization differently across LB Veteran women with "butch and more masculine LB women… significantly less likely to have routine gynecological exams and report worse treatment in health care settings, putting them at potentially greater risk for uterine or cervical cancer" (Lehavot, et al., 2013 p. 7).

LGB Veteran VHA Service Utilization

In a study of 356 LGB Veterans who answered an online survey, 45% reported having used VHA services in their lifetime and 29% in the past year (Simpson et al., 2013). Additionally, **LGB Veterans' decision to access VHA health care service was predicted by service connection (i.e. the percentage of health benefits earned due to injuries accrued during military service), PTSD, depression, and interpersonal trauma related to sexual**

orientation while in the military. The Veterans who accessed the VHA reported that 33% discussed their sexual orientation with providers and 25% of the entire sample reported that fear of stigma caused them to avoid at least one VHA service. It is particularly worth noting that LGBT Veterans with a history of institutional oppression (e.g. DADT) were those less likely to access VA care in the first place, as opposed to those who experienced interpersonal oppression (e.g. MST, gay-bashing), who were more likely to approach the VHA (Santa, 2007).

Even though DADT technically had no bearing on Veterans accessing the VA when their discharges did not include DADT, some Veterans may have feared that disclosing their sexual orientation to the VA might cause them to lose a wide range of benefits—such as health care, retirement, and burial benefits. Furthermore, for Veterans accessing VA services who wanted to retain the ability to enter the Reserves or National Guard, the DOD's access to VA medical records may have prevented their participation in health care services or VA-sponsored research related to sexual orientation or gender identity (Terp, 2011).

Resilience among LGBT Veterans

LGBT Veterans develop **adaptive strengths and strategies to manage minority stress**, which can be reinforced in and contribute to the efficacy of clinical practice. Some Veterans use their skills and social connections to get involved in LGBT communities working on Veteran advocacy issues. For all the obstacles they have faced, LGBT servicemembers have a long history of taking high-risk assignments, receiving numerous military honors and decorations, and engaging in heroic and successful activism to repeal anti-LGBT policies—as evidenced by figures like Dan Choi and Leonard Matlovich. These members of the LGBT Veteran community can be crucial to other Veterans in integrating, and taking pride in, their LGBT and Veteran identities—a critical stage in LGBT Veteran identity development.

LGBT Veteran Support Groups

LGBT Veteran support groups have had success in **helping some LGBT Veterans out of isolation** through community-building with LGBT Veteran peers, information sharing, and psychoeducational methods like CBT that encourage thought-checking, grounding techniques, and other stress management tools (Maguen et al., 2005; Ramirez, et al., 2013). In addition, given the high rates of isolation among LGBT Veterans and the critical buffering role the LGBT community can have in mediating the effects of discrimination and internalized homophobia, support groups have great potential in the context of the VA, as well as community-based clinics serving LGBT Veterans and civilians alike.

Maguen et al. (2005) offer suggestions on managing issues in a transgender Veteran support group like confidentiality and goal setting in a structured 8-session format that covers childhood, identity and development, military service and young adulthood, personal safety, employment, housing, social support, family issues and parenting, medical issues, disclosure, passing and socialization, and body issues and intimate relationships. Ramirez et al. (2013) discuss how to create an evidence-based LGBT Veteran support group with ongoing clinical assessments, culturally-relevant strategies to increase participation, and other measures to improve health care services for LGBT Veterans. Of particular note are the fact sheets provided to transgender group participants in Maguen et al.'s (2005) article, and the development of a Veteran-only online chat group established by LGBT Veterans outside of the support group described by Ramirez et al. (2013).

2. Evidence-based Suggestions for LGBT Veteran Culturally Relevant Care

This section applies the biopsychosocial assessment (BPS) to the unique experiences of LGBT Veterans before, during, and after the military. In doing so, it seeks to draw together LGBT Veteran research findings, insights from Veteran participants in The Camouflage Closet, and the author's own experience providing LGBT Veteran mental health care services.

BPS Prior to the Military

Clinicians may want to begin by inquiring about Veterans' experiences of trauma prior to the military; coping mechanisms; stage of identity development (e.g. awareness of sexual orientation prior to enlistment); experiences coming out to family and friends; impact of culture on their thoughts about their sexual orientation; and reasons for enlistment.

1. Did the Veteran experience trauma prior to the military? If so, what coping strategies did the Veteran use?
2. In which stage of identity development did the patient enter the military? Prior to enlistment, what was their awareness of their sexual orientation or gender identity, and what was their level of engagement with the LGBT community?
3. To what extent did their family's religious, spiritual, and/or cultural values impact their thoughts about their own sexual orientation or gender identity? What impact, if any, did these values have on their decision to enlist?
4. What benefits did the Veteran hope to achieve by joining the military?
5. Did the Veteran have any LGBT role models?
6. What, if any, experiences did the Veteran have coming out prior to the military? Did the Veteran experience rejection, violence, harassment, or homelessness?

BPS During the Military

Clinicians are encouraged to inquire about Veterans' experiences of workplace climate, socializing, accessing care, recreating on and off base, LGBT identity formation, and any suicidal thoughts or actions— both personally and among their LGBT colleagues.

1. What was their experience like at work in the military?
   A. Were they able to be open with any colleagues about their sexual orientation or gender identity?
   B. Did they feel isolated and compelled to conceal their identity? To what extent did they avoid discussing romantic relationships or family life?
   C. Did they create fictitious relationships or feign interest in people of the opposite sex around colleagues? If they concealed or misrepresented their sexual orientation or gender identity, did this cause any conflicts with military codes of ethics requiring honesty and integrity?
2. How safe did they feel on base? Did they personally experience or were they aware of other servicemembers experiencing harassment, violence, sexual trauma, military investigations, involuntary psychiatric hospitalizations, military incarceration, or early discharge due to sexual orientation or gender identity?
3. Did their identity impact their access to medical care, mental health services, or spiritual counsel?
4. What impact, if any, did DADT and other LGBT-related military policies have on their families and romantic relationships?
5. Did they experience suicidal thoughts or actions while in the military? Did they know any LGBT servicemembers who at-

tempted or committed suicide?
6. Did they know they were LGBT before entering the military? To what extent did their military service impact their self-awareness of and feelings about being LGBT?
7. What makes them proud to be an LGBT Veteran?

BPS After the Military

Clinicians are encouraged to explore Veterans' feelings about their military careers; discharges; current stages of LGBT identity development; relationships with LGBT peers and other social support; experiences coming out to medical and mental health providers; trauma and discrimination post-discharge; current substance use; thoughts regarding self-harming behaviors, including suicide and unsupervised hormone use; and any effects of mental health issues on their sexual health.

1. How do they feel about their military service (e.g. positive, negative, mixed)?
   A. To what extent do they identify as a Veteran and feel comfortable being around other Veterans?
   B. How do they feel about their discharge? Was it related to sexual orientation or gender identity? If related to sexual orientation, would they like to apply to upgrade their discharge?
2. How do they feel about being LGBT?
3. Do they have a social support system of family, friends, and colleagues with whom they can be open?
   A. To what extent do they identify with the larger LGBT community?
   B. To what extent do they tell other LGBT people that they are a Veteran?
   C. To what extent do any religious or spiritual leaders in their lives know they are LGBT?
4. To what extent do they tell their medical and mental health providers they are LGBT? To what extent do they feel their medical and mental health care addresses their needs as an LGBT patient?
5. To what extent do they feel safe in their current homes, jobs, and communities as LGBT people?
6. Are drugs or alcohol being used to manage negative feelings about sexual orientation or gender identity?
7. Are there any suicidal thoughts or feelings associated with their sexual orientation or gender identity?
8. Would they like to discuss the pros and cons of coming out as LGBT to family, children, friends, colleagues, etc.?
9. Are transgender Veterans using hormones to feminize or masculinize their bodies? If so, are they using hormones as directed by a doctor or are they accessing hormones and injection equipment from an outside source?
10. What effects, if any, do mental health issues like PTSD and TBI have on their sexual health? If sexually active, are they engaging in safer sex practices and getting regular tests for HIV and other sexually transmitted infections?
11. Would they be able to make use of a list of LGBT-affirming and knowledgeable health providers to whom you can make referrals? If you work at the VA, are you familiar with the scope of VA care for transgender and intersex Veterans? For example, the VA currently provides hormones prescribed by an outside doctor, as well as pre- and post-surgical care, but not sexual reassignment surgery itself.
12. Are there any health services the Veteran needs but is avoiding due to fears of stigma from providers or personal discomfort (e.g. transgender woman having a prostate screening)?

Recommendations for Health Care Systems Serving LGBT Veterans

Ramirez et al. (2013) offer the following list of suggestions for health care systems to become culturally responsive to LGBT Veterans:

1. Provide educational resources for LGBT Veterans, which may decrease isolation and increase knowledge and pride about LGBT Veterans in history.
    a. LGBT Local Resource Binders
    b. Video Library
    c. Safe VA Space Campaign
    d. LGBT Veteran Support Groups
2. Provide resources for Staff
    a. Trainings to VA staff in accordance with key issues facing LGBT Veteran health as outlined in research.
        - addiction treatment
        - trauma recovery
        - biopsychosocial impacts of DADT
        - upgrading DADT discharges,
        - LGBT-affirmative practice,
        - History and Current Best Practices of LGBT Mental Health Care
        - Minority Stress Model
        - LGBT Related VA Directives
        - LGBT Veteran Culture and Sources of Resilience
        - "Get Your Questions Answered About Sexual Orientation and Gender Identity from Colleagues Not Clients"
    b. Community Guest Presenters (e.g. Transgender Law Center, Swords to Ploughshares)
    c. Gay Straight Alliance
    d. Nursing Patient Care Recommendations (e.g. assessments, discharge planning, engaging care givers and family members)
    e. List of LGBT-affirming practitioners throughout the VA
5. Plan LGBT Veteran field trips.
6. Encourage the establishment of an LGBT Veteran online social network.
7. Reduce costs and transportation barriers to LGBT services.
8. Give special consideration to substance use/abuse and psychiatric diagnoses, which have been shown to be more prevalent among LGBT people, when drawing up eligibility criteria for treatment programs.
9. Use Veterans' own terms regarding sexual orientation, gender identity, partners, and family in both conversation and charting
10. Provide LGBT-affirmative couples and family counseling.
11. Respect LGBT partners with the full range of accommodations given to heterosexual partners in hospital situations.
12. Add opportunities for Veterans to come out to medical providers.
13. Conduct VA outreach online and at community pride events.
14. Conduct an LGBT-Affirmative VA Public Relations Campaign, targeting Addiction Treatment Services, the Trauma Recovery Program, mental health clinics, and other relevant programs.
15. Create an LGBT Veteran Peer Support Program
16. Review all departments within the healthcare system for unique needs of LGBT Veterans.
17. If you are concerned that community members may be upset about an LGBT group at the VA, seek support from campus administrators and police to ensure that the group is not interrupted or harassed.
18. Ask participants when and where they would be most comfortable and able to attend an LGBT group.

Additionally, this review suggests that Veterans who have experienced suicidal ideation and sexual assault might benefit from targeted VHA public relations campaigns acknowledging that it provides quality care for LGBT Veteran survivors of MST by trained clinicians. Psychiatrists and other staff—including admitting and benefits office staff—would benefit from training about documentation required for changing gender identity in the Computerized Patient Reporting System (CPRS). Inpatient staff can be trained on hospital visitation policies that allow Veterans to name anyone they wish for visitation, including same-sex partners and children of same-sex partners, irrespective of blood relation.

In the 2011 report, "Reaching All Who Served: An Analysis of Department of Veterans Affairs Health Policies," the National Coalition for LGBT Health concludes much work is needed to develop LGBT-related policies and resources in a variety of areas. In 2013, the VA made significant strides when 80% of VA Medical Centers (n=120) participated in the Human Rights Campaign's Health Care Equality Index, a tool used by civilian public and private health care providers to identify and rate healthcare systems' responsiveness and cultural relevancy to LGBT patients. To be rated a "Leader in LGBT Healthcare," each medical center was required to advertise LGBT anti-discrimination policies protecting patients and staff, adopt equal hospital visitation policies, and train executive leadership in LGBT culturally competent healthcare. Of the 120 participating VA Medical Centers, 91 (76%) achieved the distinction of being rated a "Leader in LGBT Healthcare Equality."

3. Policies Related to LGBT Culturally Relevant Care

The past three years have seen a period of rapid change for LGBT Veterans. In addition to the repeal of DADT, 2011 also witnessed a lawsuit filed by lesbian and gay Veterans against U.S. Attorney General Eric Holder, Secretary of Defense Leon Panetta, and Secretary of Veterans Affairs (VA) Eric Shinseki. In McLaughlin et al. v. Panetta et al., LGBT Veterans sought access to VA benefits for their families, which were denied by the Defense of Marriage Act (DOMA). Also in 2011, VHA adopted the groundbreaking transgender and intersex Veteran care policy (VHA Directive 2011-024), which protects transgender and intersex Veterans from discrimination, directs VA staff to refer to Veterans with the pronoun and name of their choice, outlines services for gender transitioning provided within the VA, and delineates the process for changing a Veteran's gender designation in patient medical records.

In 2012, the Pentagon designated the month of June as the first official observance of Gay Pride Month while the Department of Defense (DOD) allowed military personnel to march for the first time in uniform at the San Diego Gay Pride Parade (Watson, 2012). On April 16, 2012, a VHA LGBT Health Equity Workgroup submitted to the VA Principal Deputy Undersecretary of Health a report entitled, "Recommended Actions to Impact Health Equity for LGBT Veterans" which included participation in the previously mentioned Healthcare Equality Index. The VHA Health Equity Workgroup is tasked "to help ensure VHA takes immediate and coordinated action to advance the health and well-being of lesbian, gay, bisexual, and transgender (LGBT) Veterans." The VHA National Leadership Council, through endorsement of the Workgroup's Recommendations, has committed to providing LGBT Veterans "culturally competent, equitable healthcare," which they maintain is "essential to effective healing."

On June 26, 2013, the repeal of DOMA in the United States Supreme Court granted "1,100 protections and responsibilities of marriage" under federal law to legally married same-sex couples with differential impacts on servicemembers and Veterans (Freedom to Marry, 2013). For married same-sex servicemembers, the DOMA repeal was heralded by Secretary of Defense Chuck Hegel's assertion that "it is now the department's policy to treat all married military personnel equally"—including equal access to military benefits for same-sex spouses such as the ability to live on base with a military ID card, access to medical care and surviving spouse benefits. For married same-sex Veterans, access to VA benefits following DOMA repeal remained complex due to the VA's statutory language of "spouse," which is defined in terms of a man and a woman, and differed from the key phrase of marriage in the now-defunct DOMA. Nevertheless, on September 4, 2013, Attorney General Eric Holder wrote in a letter to Speaker John Boehner that "continued enforcement [of the statutory language of 'spouse'] would likely have a tangible adverse effect on the families of veterans and, in some circumstances, active-duty servicemembers and reservists, with respect to survival, health care and home loans, and other benefits." As such, Veterans in state conferred same-sex marriages now have equal access to these federal VA benefits.

4. LGBT Resources for Veterans and Clinical Staff

Resources for LGBT Veterans

1. American Veterans for Equal Rights (AVER)
   http://aver.us/
2. OUTServe/Servicemembers Legal Defense Network (SLDN)
   http://www.sldn.org/
3. Knights Out (LGBT West Point Alumni)
   http://knightsout.org/
4. USNA OUT (UC Naval Academy Alumni)
   http://usnaout.org/
5. Blue Alliance (LGBT Alumni US Air Force)
   http://blue-alliance.org/
6. The American Military Partner Association
   http://militarypartners.org/
7. Service Women's Action Network
   http://servicewomen.org/
8. The Gay Military Signal
   http://www.gaymilitarysignal.com/

LGBT Veteran Resources for VA Staff

1. LGB Education SharePoint
   http://vaww.infoshare.va.gov/sites/LGBEducation
2. Transgender Veteran Educational SharePoint
   http://vaww.infoshare.va.gov/sites/pcsclipro/trer/default.aspx
3. LGBT VA Inclusion Initiatives
   http://vaww.vha.vaco.portal.va.gov/sites/OHE/Pages/LGBT.aspx
4. VHA Office of Health Equity SharePoint
   http://vaww.vha.vaco.portal.va.gov/sites/OHE/Pages/Default.aspx
5. VHA Diversity and Inclusion SharePoint
   http://vaww.wmc.va.gov/Diversity/default.aspx
6. VA Diversity and Inclusion SharePoint
   http://www.diversity.va.gov/programs/lgbt.aspx

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6. Discussion Questions for Screenings of The Camouflage Closet

1. Did the Veterans in this film say anything that was surprising or inspiring to you?
2. Did the Veterans describe anything that reminded you of your own military service?
3. What did you hear or see the Veterans talk about that seemed to help them in their recovery process?
4. How do you think medical and mental health providers can best support LGBT Veterans given what you heard and saw in this film?
5. Is there anything you will do differently in your interactions with LGBT Veterans or take into consideration after watching this film?
6. What do you think these LGBT Veterans can feel proud about, given their history of military service and health journeys over the years?