Gender Dysphoria in United States Veterans and Military Personnel

Historical Context and Current Policies

Individuals with gender dysphoria are at risk for a variety of mental health sequelae, including mood disorders, substance use, anxiety, interpersonal trauma, and suicidality (Valentine & Shipherd, 2018). *Gender dysphoria* is defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*), as clinically significant distress that occurs due to an incongruence between an individual's sex assigned at birth and their true, experienced gender identity (American Psychiatric Association, 2013).

Gender dysphoria disproportionately impacts U.S. Veterans and military personnel when compared to the general population, with rates as high as 22.9 per 100,000 persons in the Veterans Health Administration (VHA), compared to estimates of 4.3 per 100,000 persons in the U.S. general population (Blosnich et al., 2013), and an estimated total of 150,000 transgender active duty service members, Veterans, and reservists (Ahuja et al., 2019). In addition, approximately 50% of U.S. Veterans with gender dysphoria have been diagnosed with a mood disorder, and approximately 25% have been diagnosed with posttraumatic stress disorder (Blosnich et al., 2013).

Sociocultural factors, including social support (or lack thereof) and access to gender affirmation care appear to influence trajectories among Veterans with gender dysphoria, with high levels of experienced discrimination associated with increases in suicidal ideation in this population (Carter et al., 2019; Tucker et al., 2019). *Discrimination* can be defined as "unfair treatment by outgroup members [i.e. non-LGBT individuals] experienced due to an individual's minority group membership" (Morrison et al., 2019, p. 549).

The purpose of the current article is to describe the historical context of transgender discrimination within the U.S. military and Veteran population, and to highlight current policies that continue to perpetuate transgender discrimination within the VHA. In addition, as the VHA is the largest employer of nurses in the United States, implications for nurses will also be outlined.

HISTORICAL CONTEXT

Despite recent sociocultural progress and acceptance, lesbian, gay, bisexual, and transgender (LGBT) individuals have historically faced health and social disparities on the basis of their sexual or gender orientation. Military culture is reflective of this trend, as evidenced by federal policy evolution beginning more than 2 decades ago with the onset of "Don't Ask, Don't Tell" (DADT) legislation in 1993. DADT prohibited military recruiters or application documents from inquiring about an individual's sexual orientation but barred openly gay or lesbian individuals from serving. Undoubtedly, this legislation failed to offer adequate protections for the LGB community. In 2010, the directive was repealed, which ultimately allowed for openly LGB individuals to serve (Under Secretary of Defense, 2011). Increased protections and regulations followed, including reapplication eligibility for those previously discharged under DADT and the prohibition of LGBT discrimination in 2011 and 2014, respectively (Department of Labor, 2014).

Although DADT focused on sexual orientation alone, gender identity in the U.S. military has remained a contentious issue. Those with gender dysphoria have historically faced additional barriers in military recruitment and retention (Harrison-Quintana & Herman, 2013). In fact, transgender individuals were prohibited from military service until 2016, after a 6-month study found no negative outcomes related to transgender military service (Department of Defense, 2016). Unfortunately, eligibility of transgender service members at the time of this article remains ambiguous and litigious. Although the current number of transgender U.S. military service members is unclear, it is estimated that ≥12,000 transgender service members may be impacted by current and ongoing policy changes regarding their service eligibility (Belkin, 2015). Since 2017, the current U.S. administration has sought to end eligibility for transgender military members. The administration's efforts have been challenged by various advocacy organizations, including the National Center for Lesbian Rights (NCLR) and GLTBQ Legal Advocates and Defenders (GLAD). At the time of this article, the legality of the ban on transgender military service members continues to be challenged throughout courts in the United States.

CURRENT EVIDENCE REGARDING TRANSGENDER MILITARY SERVICE

A study conducted by the RAND Corporation (Schaefer et al., 2016)

evaluated evidence from foreign militaries regarding the effects of openly transgender individuals serving in the military. When evaluating the militaries of Australia, United Kingdom, Canada, and Israel, all of which allow openly transgender individuals to serve, there was no evidence that transgender individuals had any negative impact on cohesion, operational effectiveness, or readiness (Schaefer et al., 2016). Furthermore, a ban on transgender military service members would result in a cost of $960 million annually, based on an estimate that replacing each of the 12,000 transgender service members would cost approximately $75,000 (Belkin et al., 2017). Based on these data, a ban on transgender military service members seems discriminatory. This type of policy is not derived from or supported by current evidence, and places unnecessary barriers on those with gender dysphoria when compared to their non-transgender peers. It is critical to understand that discrimination and discriminatory policies act as social determinants that influence health outcomes. A study that evaluated 1,640 Veterans with gender dysphoria found that those who resided in states with employment non-discrimination protection had a significantly lower prevalence of mood disorders, self-injurious behavior, and suicidality (Blosnich et al., 2016).

It is estimated that there are >150,000 transgender active duty service members, Veterans, and reservists (Ahuja et al., 2019). Although the future of transgender military policy remains to be seen, it is critical to understand that individuals who identify as transgender will continue to serve in the military, but some may conceal their gender identity during their time in the service due to fear of discrimination (Tucker et al., 2019). Nonetheless, transgender individuals will seek care at the VHA following their time in the military and should be supported in achieving optimum health outcomes.

CURRENT VHA POLICIES

Prior to the initiation of transgender military acceptance in 2016, transgender service members existed but could not and did not express their gender incongruence until post-discharge from the military for fear of expulsion and retaliation. It was only in 2011 that the VHA began treating those with gender dysphoria, yet treatment options remain limited. VHA Directive 1341, most recently updated in 2019, outlines policies regarding the health care delivery to transgender Veterans eligible for VHA care. Specifically, the Directive states that the VHA will provide financial coverage for both VHA and non-VHA care for the following: hormonal therapy, mental health care, preoperative evaluation, and medically necessary postoperative care following gender affirming surgeries. This policy explicitly states that gender affirming surgeries cannot be performed or funded by the VHA, on the basis that such interventions are excluded from the medical benefits package (VHA, 2019).

Evidence has emerged that demonstrates gender-affirming surgery improves mental and physical health of patients with gender dysphoria, and various professional organizations have endorsed gender-affirming surgery as medically necessary (Byne et al., 2012; Committee on Health Care for Underserved Women, 2011; Hembree et al., 2009). Over the past decade, the insurance industry has begun to reimburse for gender-affirmation surgeries as deemed medically necessary, including Blue Cross Blue Shield, Kaiser Permanente, Medicare, and Medicaid (Kuzon et al., 2018). Nonetheless, the VA has reaffirmed their position that such care will not be financially covered, highlighting a major health and social inequity impacting Veterans with gender dysphoria.

Those who experience gender dysphoria are at a significant risk for psychiatric symptomatology and ultimately suicidality, with estimates of >65% of those with gender dysphoria experiencing suicidal ideation in their lifetime (Bradford et al., 2013). Given the high rates of suicidal ideation in transgender individuals with a significant overlap in suicide risk among Veterans (Zivin et al., 2007), a reexamination of the VHA's transgender health policy, including coverage of gender affirming surgery, is worthy of consideration. Various studies also support that hormonal therapy in conjunction with gender affirmation surgery significantly reduces the negative psychiatric sequelae associated with gender dysphoria and that, ultimately, these modalities are lifesaving (Colizzi et al., 2014; Heylens et al., 2014; Murad et al., 2010; Smith et al., 2005).

A recent qualitative study explored Veterans' perceptions of gender-related care within the VHA; Veterans reported satisfaction with some services, including hormonal therapy and endocrine treatment, but expressed distress at lack of access to gender affirmation procedures (Dietert et al., 2017). One participant in the study reported that access to gender affirmation procedures would be helpful in reducing mental health symptoms and believed that the "cost [of gender affirmation procedures] would outweigh the costs of treating the individual for a number of suicide attempts and mental health issues" (Dietert et al., 2017, p. 41). Another Veteran reiterated her belief that Veterans should have access to the full spectrum of transgender health care (Dietert et al., 2017).

Another qualitative study described similar findings; lack of gender affirmation procedures is detrimental to the mental health of Veterans with gender dysphoria (Chen et al., 2017). One participant reported that, due to lack of gender affirmation surgery: "I will never feel whole as a woman" (Chen et al., 2017, p. 67). Other participants described lack of access to gender affirming surgeries, and the high costs associated with private gender affirming health care, resulted in high levels of mental health issues.

Based on the aforementioned evidence, Directive 1341 may contradict the VHA Mission: "To honor America's Veterans by providing exceptional health care that improves their health and wellbeing" (Department of Veterans Affairs, 2019, p. 1). Evidence points to gender affirmation surgery as a cost-effective modality, with the cost of productivity loss related to dysphoric symptoms and subsequent psychiatric symptomatology, in conjunction with health care costs to treat psychiatric symptoms, outweighing the cost of gender affirmation surgery and postoperative treatment (Stroumsa, 2014). The cost of gender affirmation surgery, in conjunction with hormonal therapy and preoperative psychological evaluation, is estimated at upwards of $100,000 (Dasti, 2002); however, costs of gender dysphoria left untreated are accompanied with not only financial burdens (e.g., through inpatient psychiatric hospitalizations, substance use treatment), but also through societal costs, such as unemployment, homelessness, or death and productive years of life lost. A study by Padula et al. (2016) elucidated a significant cost savings when comprehensive transgender health care coverage is provided that accounts for a reduction in associated sequelae and their respective costs. Coverage of gender affirmation surgery would allow for a significant cost savings within the VHA, but also assures ethical and dignified treatment of Veterans with gender dysphoria.

CONCLUSION

As the VHA is the largest health care system in the country (Department of Veterans Affairs, n.d.), the organization often acts as a trailblazer for policy change. The VHA is the largest employer of nurses in the United States and, as previously mentioned, the prevalence of those with gender dysphoria is likely higher among Veterans than their civilian peers. Subsequently, it is inevitable that VHA nurses will encounter individuals with gender dysphoria and must be adequately prepared to provide therapeutic and comprehensive care. Nursing staff throughout the VHA currently account for >90,000 individuals, and one of every four RN students will complete a clinical rotation at the Department of Veterans Affairs. An understanding of the psychosocial needs of this population is imperative if nurses are to act as advocates for transgender patients. Furthermore, it is critical that VHA nurses, and nurses in general, are prudent to familiarize themselves with best practices in transgender care to reduce systematic and structural barriers and stigma, ultimately improving care for transgender Veterans who face doubling disparities per their Veteran and gender minority status.

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