Letter from the Chair

My step-brother, Bob, a U.S. Army veteran, died not long ago. Bob served in Vietnam, and came away from the war with conditions that made him dependent on the Veteran’s Administration for health care and mental health services for the rest of his life. Fortunately, Bob took advantage of those services to remain productive and a respected and fulfilled member of his community.

Like many veterans, Bob built deep and lasting friendships with other veterans, in a bond of commonality that only veterans can enter, and these relationships were essential to Bob’s moving ahead in life.

I don’t know what my family would have done had that safety net of services provided not been there for Bob. Social workers played an essential role in reorienting Bob from the battlefield to his new life. My family is beyond grateful. The calling of social work has touched and bettered many lives, including mine and those in my intimate family circle.

Rabbi Dennis S. Ross, MSW, LMSW, LCSW
Social workers play an important role in health care settings. We are often the ones called on when someone is in crisis or when problems arise. We lend an ear when someone doesn’t feel heard and speak up when someone’s voice isn’t acknowledged. When we assess a patient and gather initial information, it is imperative that we do this in an efficient, thorough way, and this can prove to be a difficult balancing act.

It is estimated there are more than 1 million lesbian, gay, bisexual, transgender, and queer (LGBTQ) veterans (Gates, 2010). However, a recent study showed 62 percent of Veterans Health Administration (VHA) providers do not ask about a veteran’s sexual orientation or gender identity (Sherman, Kauth, Shipherd, & Street, 2014). As social workers, we have the chance to engage patients, gain trust, and see the bigger picture. Being mindful of someone’s sexual orientation and gender identity will open up opportunities to identify health care disparities, build rapport, and provide excellent patient-centered care—without assumptions.

Many within the LGBTQ community have avoided getting medical attention because of previous negative interactions with medical providers. These negative experiences may include but are not limited to: health care professionals refusing to touch.
patients; providers using harsh or abusive language; patients being blamed for their health care status; or medical professionals being physically rough or abusive (When Health Care Isn’t Caring, 2010).

A great way to frame a positive and embracing environment is to make sure intake paperwork has inclusive language. Creating a comprehensive section for sexual orientation and gender identity is important for a first impression. If your clinic does not have gender identity included on intake paperwork, it’s okay to ask the patient. When addressing someone by name, ask him or her how he or she would prefer to be addressed. Assumptions can set the tone for a negative experience.

Open-ended questions also provide space for the patient to give an answer they feel comfortable with, without putting such answers into a predefined box. It is also always important to reflect the language your client is using. Consider the following example: A man who is gay refers to the man sitting next to him as his “partner.” It can be disrespectful for the provider to refer to his partner as his “boyfriend” or as anything other than his preference. Having a partner of 20 years—someone whom you may not have been able to legally marry until recently—is much different than dating someone for a few months.

Why else is it so important to talk about sexual orientation and gender identity? Providing a safe space without judgment is a great way to build trust with patients and get honest answers about their lifestyles. It creates a better experience for them, and as providers we are better equipped to give patients the best possible care. Going into a health care setting puts patients in a vulnerable situation.

It is important to create a welcoming environment.

The LGBTQ veteran population has additional concerns that providers need to understand. Most recently, Don’t Ask Don’t Tell (DADT) was a law that did not allow LGBTQ members of the military to be “out.” If military members were outed or even accused of “homosexual acts,” they received an “Other Than Honorable” discharge and were removed from the military. Not only does this discharge shame someone for his or her sexual orientation, it also ends careers and limits earned benefits. While in the military, those serving alongside you are supposed to be your brothers and sisters, people whom you may have to depend on in life or death situations. Although we have made great strides with the repeal of DADT, transgender individuals are still restricted from being “out” in the military. While research is still limited, studies have shown that LGBTQ enlisted military personnel have experienced higher rates of military sexual trauma and harassment than have officers and non-LGBTQ enlisted military personnel (Buttice, 2014).

This culture of victimization, hypermasculinity, fear, and mistrust within the LGBTQ military and veteran community creates many barriers to engaging veterans and building rapport. Engaging new patients can be difficult—especially with the time and resources we are allotted. When we serve minority populations, there are even more aspects of a person’s life to consider. What past experiences have shaped their opinions and beliefs? What kinds of discrimination and victimization have this person faced?

How many times have those within the LGBTQ military and veteran community been told that something (or someone) was safe only to have it (or that individual) prove to be dangerous later? We have the opportunity to provide excellent care. Social workers need to make our space safe for everyone, not just by telling them it is safe but by showing them it is safe. We can show them with our demeanor, how we ask questions, and how we react, and we can show them by being respectful of their experiences and of who they are. We have the opportunity to pick up the pieces others have dropped.

Jessica Homan, MSW, LISW, is currently the LGBTQ Care Coordinator and Enrollment Social Worker at Chalmers P. Wylie VA Ambulatory Care Center in Columbus, Ohio. She has led LGBTQ advocates at the Columbus VA, and she holds the first position of its kind within the region. Jessica has been instrumental in creating programming, awareness, and training for the inclusion of LGBT care within the Columbus VA, and she has influenced efforts on a regional level as well. Jessica earned her MSW from The Ohio State University and her BA in sociology from Bowling Green State University. She can be reached at Jessica.Homan@va.gov.

REFERENCES


RESOURCES


Many individuals who leave their military careers have a difficult time adjusting to civilian life and finding a sense of belonging. This issue is particularly important to me, as my husband retired from the United States Air Force (USAF) after 20 years of service. After so many years of a structured and stringent career, he thought retirement to a civilian world, with its more flexible rules and greater opportunities for individualism, sounded wonderful. This turned out not to be the case at all!

Once a discharge date is set in the military, there is a regimen of classes intended to “prepare the soldier to transition to the civilian world.” But this training proved to be of little help. Although information was presented on what needs to be done to discharge and online sources were identified to assist with job hunting, there was not much discussion about the personal changes the retired soldier would go through.

While writing his résumé for a civilian job, my husband had many people to talk to who understood him and the military lifestyle: working long hours, passing physical exams, respecting others as well as demanding respect, being ready to help other military families at any time. It was very hard for him to understand why people were not like this in the civilian world; at times, this is still is trying for him. My husband, like many, worked long, hard hours once he was discharged; he constantly wanted to go on vacations, try new hobbies—do anything he could to find out who he was and where his place was outside of the military.

An estimated 2.6 million troops served during the Afghanistan and Iraq wars. Whether they were in combat or a support position, more than half (51 percent to 64 percent) of these soldiers claimed a feeling of disconnection from civilian life upon their return. What they missed most about active duty was the camaraderie. Among those who are no longer in the armed services, 33 percent of them think about wartime daily and 29 percent think about it weekly (Saslow, 2014, p. 3).

According to the Pew Research Center, one variable that affects ease of transition is exposure to a traumatic event—this is true for 32 percent of those service members who have been deployed. Of those exposed to traumatic events, 56 percent have PTSD, which includes nightmares, feelings of detachment, anger, anxiety, flashbacks, and depression.

Many of those who were married while enlisted (48 percent) had a harder time adjusting to being a civilian. While it would seem that being married would make the transition easier—due to having someone to talk to and a family support system in place—those who were married found it difficult to ascertain their function in the marriage. Of those married service members, 61 percent experienced marital difficulties once after transitioning back to a civilian. Lastly, veterans who have religious faith and attend services weekly (24 percent) found it easier to transition (Morin, 2011, p. 4).

These figures highlight the need for more programs to help those soldiers—and their families—who will soon transition to civilian life. Mentoring is certainly needed during this transition. I noticed a bit of ease come over my husband when he spoke to his friends who had found jobs in the civilian world; this gave him hope. Although we watched as many marriages fell apart after departure from the military, we never understood what could have happened until we experienced our own separation. Had we had some insight on how...
military separation would affect him psychologically, I would have been more prepared to help him get through the rough times of feeling lost and alone. My role as a psychotherapist and all the training I’ve had in PTSD and with veteran clients did not prepare me for the changes that were to come into my own life.

Classes on transitioning out of the military need to address these psychological changes, and families should be brought in. It would be of tremendous benefit to veterans if they could be taught how to recognize the differences that exist between the civilian and military thought processes, between the expectations that exist in the civilian and military settings, and between the behaviors that are deemed acceptable in the two spheres. The classes should also acknowledge that there is often a lack of support and understanding once these individuals are no longer in the military. Although it’s normal in the military to have friends come and go, due to relocation orders or loss during deployment, there is still a connection. Sometimes soldiers move to other bases and run into old friends, furthering that sense of belonging. Something as simple as seeing someone in uniform helps to give a sense of belonging.

One preventative measure that could be taken to ease the transition is increasing the amount of time between deployments. A large number of veterans come home from deployment and sign up to deploy again as soon as possible, because they are not adjusting well to being home. But they are never asked—even those with families are never asked—why they wish to deploy again so soon. There is a short briefing to discuss what occurred while deployed but no true assistance to acclimate the veteran to being home again. While the veteran was deployed and immersed in the military world consisting of his or her military family, all of whom cared for one another and went through an array of emotions and experiences, his or her home life, and actual family, changed in ways that would allow it to continue to function while the veteran was gone.

When veterans come home from war, they bring with them an intense array of emotions and experiences that they have shared with other veterans, and often they don’t wish to discuss their military time with anyone who hasn’t been there—it can make for a very distressing sense of self at times. Clearly, more research needs to be done on addressing these and the other aforementioned issues in order to better assist with this transition.

Michele Graffam, LCSW, works in an outpatient mental health agency in North Carolina. She has worked with the military population for many years, with both individuals and families, as well as being a military spouse. She can be contacted via email at michelegraffam@yahoo.com.

REFERENCES

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- Administration/Supervision
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- Child Welfare
- Children, Adolescents, and Young Adults
- Health
- Mental Health
- Private Practice
- School Social Work
- Social and Economic Justice & Peace
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For submission details and author guidelines, go to SocialWorkers.org/Sections. If you need more information, email sections@naswdc.org.

Did You Know?

Children under 18 years of age represent 24.9 percent of the total population, but account for 35.2 percent of people in poverty.