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Sexual Dysfunction: Providers' Willingness to Ask LGBQ Veterans About their Sexual Functioning

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DISSERTATION

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This dissertation is dedicated to those who served in silence or were judged by their sexual identity rather than their ability as service members. This research is for you.

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Abstract

The prevalence of sexual dysfunction (SD) in veterans is high when compared to the general population because of its relationship to physical and mental health issues endured while serving their country (Hosain, Latini, Kauth, Goltz, & Helmer, 2013). Research has mainly concentrated on male, heterosexual veterans with SD and very little research has explored lesbian, gay, bisexual, and queer (LGBQ) veterans' experiences. This is concerning considering research indicates that LGBQ veterans' sexual minority status adds unique stressors such as fear of disclosing identity, fear of stigma, and internalized homophobia in addition to the stresses that occur from being in the military (Cochran, Balsam, Fientje, Malte, & Simpson, 2013). These stressors cause LGBQ veterans to be more susceptible to mental health issues, which can affect sexual functioning. The focus and purpose of this dissertation was to examine if Veterans Health Administration (VHA) clinicians are asking about their LGBQ veterans sexual functioning. This research was conducted by giving VHA clinicians a Demographic and Experience Questionnaire and responses were analyzed through frequency chi-squared analyses. The primary aim of this dissertation was to examine the barriers to asking LGBQ veterans' about their sexual functioning, especially when research has proven that this is an issue that many LGBQ veterans suffer with. Results revealed a significant relationship between provider's willingness to assess for sexual functioning and whether they have received training in that area. Other barriers included being on a time constraint as well as a lack of relevance to the treatment. Implications, limitations, and suggestions for future research are explored.

Keywords: LGBQ veterans, sexual functioning

Sexual Dysfunction: Providers' Willingness to Ask LGBQ Veterans About their Sexual Functioning

The visibility of lesbian, gay, bisexual, and queer (LGBQ) individuals in the United States Military continues to grow after the repeal of Don't Ask, Don't Tell (DADT), a policy that banned openly LGBQ and transgender individuals from serving (Cochran et al., 2013). The repeal of DADT has made LGBQ veterans more likely to seek Veterans Health Administration (VHA) care now that their jobs are not at stake if they choose to disclose their sexual identity (Kauth, 2012). However, even after the repeal, there is a lingering fear about disclosing one's sexual identity, which impacts LGBQ veterans' mental health. The research on health disparities among LGBQ veterans suggests that the relationship between sexual minority status and military service place these individuals at even greater risk for sexual dysfunction (Kauth, Meier, & Latini, 2014). It is possible that LGBQ veterans' concealment of sexual identity contributes to this sexual health risk, however, very little research has been dedicated to this issue and limited training has been provided to VHA clinicians who are likely to work with a LGBQ veterans suffering from a sexual dysfunction.

To address these gaps in literature, the current study explored if VHA clinicians are asking LGBQ veterans about their sexual functioning and if they are not, what are the barriers to them doing so. Understanding clinicians' general hesitations for not asking these questions is necessary because these reasons can be appropriately addressed in training or educational settings. These research findings can contribute to the changes that may need to be made in VHA training or possibly the graduate school curriculum. Addressing these barriers and making crucial changes in the training setting would be beneficial to LGBQ veterans who need access to competent, trustworthy clinicians.

Key Constructs

Sexual dysfunction. Sexual dysfunction (SD) is defined as "Disturbances in sexual desire and in the sexual-response cycle, which significantly impacts an individual's mood, self-esteem, interpersonal functioning, and overall life satisfaction" (Hosain et al., 2013, p. 516). Numerous factors contribute to SD including general health status, specific diseases and conditions, medications to treat conditions like depression or PTSD, psychosocial dysfunction, physical and psychological trauma, and more (Helmer, 2015). The sexual-response cycle, which includes arousal, maintenance, and climax, is largely under the control of the autonomic nervous system. Helmer stated that when a veteran is diagnosed with PTSD, this changes the functioning of the autonomic system and negatively affects an individual's sexual performance. Psychological trauma is only one cause of impairment in sexual functioning among military veterans. Additionally, severe combat-related physical wounds, such as spinal cord injury and loss of limbs, present multiple, complex barriers for engaging in sexual activity (Kauth, 2012). Sexual health issues are documented in about 25% of recent combat veterans seeking care at VHA facilities, which is alarming considering the impact SD has on intimate relationships and quality of life (Helmer et al., 2013; Kauth, 2012).

Differentiating LGBQ veterans' mental health issues. It is important to distinguish the unique mental health issues LGBQ veterans endure when compared to heterosexual veterans. In general, veterans are exposed to stressors that are unique from the general population such as combat, war zones, and military sexual trauma (MST), which increase their risk for PTSD (Cochran et al., 2013). Other mental disorders like depression, substance abuse, and anxiety are also overrepresented among the veteran population (Cochran et al., 2013). However, there is strong evidence that both LGBQ veterans and the LGBQ general population are at elevated risk

for mental health problems when compared to the heterosexual population. In a study that collected data from online surveys of 409 LGBQ veterans, Cochran et al. (2013) found that LGBQ veterans were more likely to screen positive for PTSD, depression, and alcohol problems than heterosexual male veterans. The anxiety around concealment of one's sexual orientation while in the service was related to current depression and PTSD symptoms. Myer's (2003) minority stress theory posits that concealment of minority sexual or gender identities is one of the major stressors for individuals with such identities. Though concealing one's sexual identity may be a risk factor for mental health issues, being out in the military also puts an individual at risk for overt discrimination and in the past, possible discharge from service.

U.S. Military culture. When exploring the experiences of LGBQ veterans with a SD, it is crucial to take into consideration the U.S. Military culture that created an environment where LGBQ and transgender citizens were not welcome for over 225 years (Golbach & Castro, 2016). Historically, the U.S. Military has promoted traditional gender roles and social norms; additionally, they have enacted policies that punished or excluded individuals that deviated from these norms. The hypermasculine environment promoted traditional gender roles, which could explain why lesbian and bisexual women were disproportionately discharged under the DADT policy when compared to gay and bisexual men (Kauth et al., 2014). Even after the repeal of DADT, many in the military believe LGBQ service members should not be allowed to serve, or they have personal, moral, or religious beliefs condemning it (Golbach & Castro, 2016). Research by Saltsburg found that nearly 80% of active duty service members reported hearing offensive language, jokes, and derogatory statements made about LGBQ and transgender service members within the past year and more than one third reported witnessing harassment based on perceptions of sexual identity (Saltsburg, 2011 as cited in Golbach & Castro, 2016). This overall

heteronormative culture and microagressions send the message to LGBQ and transgender service members that their identity does not align with military tradition. The U.S. Military upholds core values of selfless service, respect, loyalty; feeling excluded from this culture or perceived as betraying these values can be detrimental to LGBQ and transgender service members' mental and sexual health.

Keeping the Transgender Experience Separate

In literature and society, it is common for individuals to reference sexual minorities using the acronym LGBTQ+. In this study, I have made the decision to not include transgender individuals for two reasons: (a) to support the transgender movement that states that sexual identity and gender identity should be recognized as separate and not paired together, and (b) transgender individuals have unique sexual difficulties when compared to lesbian, gay, bisexual, and queer individuals that should be examined through separate research.

As society continues to slowly progress in the equal rights of sexual minorities, it has become apparent that transgender individuals, in comparison to gay, lesbian, and bisexual individuals, can be neglected in this movement. Curry (2017) writes that often, transgender individuals are considered an obscure or misunderstood subgroup of the gay community rather than a unique group that requires its own specific agenda. There have been several petitions that call for separating the "T" from LGBT to convey the separate fight transgender individuals have to partake in to achieve equality. Though transgender and lesbian, gay, and bisexual individuals share some of the same inequalities, such as marriage and employment discrimination, transgender individuals are often subjected to many more injustices (Curry, 2017). The Center for Transgender Equality (as cited in Curry, 2017) has shown studies to support that transgender individuals are three times more likely to endure police violence and are more likely to live in

poverty or be homeless. Transgender individuals also can be inappropriately sexualized in the media and experience derogatory comments about their genitalia (Curry, 2017). There is a difference between sexual orientation and gender identity, and this study intended to acknowledge and support that these major differences do exist.

Transgender individuals also can experience unique sexual difficulties when compared to the LGBQ population. Nikkelen and Kreukels (2018) examined the transgender-specific sexual difficulties of 325 male-to-female and 251 female-to-male individuals and found that gender confirming treatment (GCT) such as hormonal treatment and genital surgery can have significant impacts on transgender individuals' sex lives. For example, participants reported a direct impact from genital surgery on their sexual pleasure and their motivation to masturbate. Also, GCT medications such as testosterone impacted general sexual behaviors and feelings (Nikkelen & Kreukels, 2018). Aside from physiological differences, some participants reported dissatisfaction in their body appearance and genitals as a result from GCT (Nikkelen & Kreukels, 2018). Taking into consideration the unique difficulties of the transgender population, it would not be fair to group them in a study that also explores the LGBQ experience and assume that the results can be generalized.

Theoretical Framework

Biopsychosocial model. The biopsychosocial model (BPS) is vital to use when addressing matters of sexual health in the LGBQ veteran community. George L. Engle created this scientific model to address the missing dimensions of the biomedical model, which conceptualizes SD as an issue with biological functioning (as cited in Berry & Berry, 2013). Hosain et al. (2013) suggested that SD is the result of a complex interaction of biological, psychological, and social factors. McCarthy and McDonald (2009, as cited in Berry & Berry,

2013, p. 2627) agreed that sexuality is a multi-causal, multi-dimensional, complex phenomenon that warrants the consideration of an individual's biological, psychological, and social functioning. Providers that treated SD used to mainly examine an individual's biological functioning and sought to treat the dysfunction with only medication. Medical providers used to only prescribe phosphodiesterase type 5 inhibitors (PDE5Is) to men who had an erectile dysfunction, but typically, the problem persisted in the majority of patients (Berry & Berry, 2013). Engle believed that the whole person must be considered when creating a treatment plan (as cited in Berry & Berry, 2013). Much of the training for VHA healthcare professionals focuses on the disease rather than the health. Helmer (2015) notes that, "This can result in disproportionate attention to the biomedical aspects of health and biomedical solutions with a relative disregard for the context" (p. 3). When treating LGBQ veterans with SD, biological and physical factors are important to consider; however, psychological and social aspects also need to be addressed when treating the disorder.

In the BPS model, the psychological aspect takes into consideration mental disorders, mood disorders, anxiety, and trauma that are contributing to SD (Berry & Berry, 2013). LGBQ veterans are at a higher risk for mental health disorders because of their military career and by identifying with a sexual minority population. Mental disorders are highly correlated with SD and interfere in ways that biology, alone, cannot explain. Lastly, an individual's social aspects are examined by exploring their professional stressors, gender, sexuality, and socioeconomic status (Berry & Berry, 2013). Identifying as LGBQ in an institution that promotes heteronormativity—where prejudice still exits—and fear of disclosing one's sexual identity is still present may be contributing to LGBQ veterans' SD and must be considered when treating this population.

Implications to Clinical Psychology

Applied importance for clinicians in training. It is estimated that about one million veterans have a same-sex partner and approximately 70,000 of these veterans are currently serving (Kauth et al., 2014). Research by Simpson, Balsam, Cochran, Lehavot, and Gold (2013) who surveyed 356 lesbian, gay, and bisexual veterans, found that less than 50% used VHA services and more than 25% of the participants avoided at least one VHA service because of concerns about stigma. Individual counseling and general outpatient medical care, two important services needed when treating someone with a SD, were the services most frequently avoided due to concerns about stigma. It is difficult for LGBQ veterans to receive proper care when they fear judgment or are uncomfortable discussing issues of sexual identity because they do not know if it will be well received (Sherman et al., 2014). If clinicians are properly educated and informed about the social stigma against LGBT individuals, the responsibility is on them to create a comfortable environment as well as initiate conversations about sexual matters to normalize the experience.

Can clinicians properly assess for SD in LGBQ veterans? In general, sexual health issues are prevalent in veterans seeking care. However, patterns in VHA documentation indicate that either veterans are not reporting their symptoms or clinicians are not addressing the issue or asking the right questions (Helmer et al., 2013). Helmer (2015) found that veterans, in general, do not report matters with SD because they do not feel comfortable initiating the discussion, do not know how to adequately describe their symptoms, or feel they will be ignored or laughed at. Helmer et al. states that, “Given the strong relationship between mental health issues and sexual dysfunction and psychoactive medication, mental health providers are at the forefront of detecting and initiating treatment of sexual health issues” (p. 5). Since veterans fail to report or

underreport sexual health issues out of embarrassment or lack of information about normative functioning, the clinician has a responsibility to initiate the discussion (Helmer et al., 2013). Often, mental health providers do not discuss sex or sexual identity because of the lack of time they have with their patients, inadequate knowledge or training, fear of offending the patient, or lack of awareness of sexual issues (Kauth et al., 2014).

Mental health providers often avoid conversations about sexual identity which is concerning considering LGBQ veterans may be more prone to sexual health issues and that SD is more than just a biological issue. Research by Simpson et al. (2013) found that providers in civilian settings were often uncomfortable addressing sexual orientation and when LGBQ clients sensed this discomfort, they reported they most likely stopped seeking the providers' services. Sherman et al. (2014) indicated in his study of VHA care providers, that half of the 202 individuals did not assess sexual identity with their patients and did not alter their treatment plans even if they knew their patient was lesbian, gay, or bisexual. A study by Biddix, Fogel, and Black (2013) examined the comfort levels of 30 active duty gay and bisexual males approaching VHA care about sexuality and sexual health outcomes. It was reported that these service members felt comfortable disclosing their sexual identity only if their provider asked first. If mental health providers fail to recognize or ask questions about their client's sexual identity or sexual health, they are doing their clients a disservice and are potentially affecting the quality of their therapeutic relationship.

Clinicians may not have the training or knowledge to understand the risks LGBQ veterans have for a SD. There may be educational gaps in the basic understanding of LGBQ veterans' lifestyles and their specific health care needs (Mattocks et al., 2013). Additionally, clinicians may not know how to effectively communicate about sexuality and gender variance

(Mattocks et al., 2013). If clinicians are not inclined to alter their treatment plans when they are aware that their client identifies as LGBQ, they may not understand the risk sexuality identity has on SD. To understand the relationship between sexual identity and SD, clinicians should be informed of minority stress theory. This theory can explain why stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental and physical health problems (Meyer, 2003). The theory also explains how societal persecution and chronic victimization can lead to significant distress for LGBQ individuals resulting in poor physical and mental health, and subsequently SD. When a clinician does not ask about a client's sexual identity or, in general, when a LGBQ veteran feels the need to conceal their identity, this can also affect health outcomes and immune functioning (Meyer, 2003). If a clinician is knowledgeable about minority stress theory, then they may be more prepared to ask certain questions about social stressors that add to SD, such as possible rejection from others, concealment of identity, or internalized homophobia. When clinicians ask their clients about sexual identity, it conveys a message of respect and safety to discuss matters freely and without judgment.

Research Questions and Hypothesis

In order to better understand a VHA clinician's experience of assessing for sexual dysfunction, the following questions will be asked:

1. For those who ask their LGBQ veterans about sexual functioning, what makes you comfortable asking these questions?
2. For those who do not ask about sexual function, what are the major barriers of asking about sexual functioning?

3. What is the relationship between clinical experience and willingness to ask about sexual functioning? Furthermore, what is the relationship between exposure to classes/training on sexual disorders and willingness to ask about sexual function?

It is my belief that VHA clinicians are more likely to ask about their LGBQ veterans about sexual functioning when they have more training in this area and more experience in the field. VHA clinicians will be less likely to ask about sexual functioning when they do not feel competent in this domain, are uncomfortable talking about sex in general with their clients, or assumed a medical provider has already assessed for these issues.

Literature Review

High Prevalence of Sexual Dysfunction in Veterans

Every day, military veterans are returning home from war with a variety of problems. These include adjusting to civilian life, problems with mental health, and issues surrounding SD. In 1989, researcher Kaplan observed Vietnam veterans who had a well-functioning sex life before going to war but noticed severe problems in this area upon return (Bentsen, Giraldi, Kristensen, & Anderson, 2015). Researchers have replicated these findings of severe sexual problems in veterans. A systematic review conducted by Bentsen et al. analyzed the results of 123 studies concentrating on SD among veterans with PTSD. They found there was a high prevalence of SD with male veterans who had PTSD, specifically erectile dysfunction (ED) and decreased sexual desire. For those who had been diagnosed with PTSD, their likelihood of having a SD was between 8.4% and 88.6%. Compared to between 20 and 30% of the general population experiencing SD, these statistics are significantly high.

Negative Mental Health Outcomes Correlated with Sexual Dysfunction

SD is defined as disturbances in the sexual-response cycle and sexual desire, which severely affects overall life satisfaction, self-esteem, mood, and interpersonal functioning. This is a result from a complex interaction of biological, psychological, and social factors (Hosain et al., 2013). SD is commonly found in patients with psychiatric illness. This could be related to symptoms of the mental disorder itself or the undesirable side effects of the psychotropic medication prescribed (Clayton & Balon, 2009). In a systematic review, Clayton and Balon analyzed the published literature on sexual dysfunction in patients with psychiatric illness and/or taking psychotropic medications. A commonality throughout the majority of the literature is that there is a positive association between two variables: (a) mental health disorder, and (b) sexual dysfunction. This is especially true for patients using medication. Many of the psychotropic medications affect sexual dysfunction because it interferes with the neurotransmitters that a play a crucial role in sexual functionality. An example of this would be dopamine and serotonin (Clayton & Balon, 2009).

In their large epidemiological study published in 1999, 43% of women and 30% of men had sexual complaints (as cited in Clayton & Balon, 2009). The number is doubled in patients with mood disorders not on medication with complaints mainly on arousal and desire (as cited in Clayton & Balon, 2009). In another study concentrating on combat veterans, Cosgrove et al. (2002) compared the prevalence of sexual dysfunction in veterans with and without PTSD. The International Index of Erectile Function (IIEF) and a health and demographic questionnaire were administered to both groups. The results for the veterans who had PTSD, the rate of erectile dysfunction was 85%. In the group without PTSD, showed the rate of erectile dysfunction was 22% (Cosgrove et al., 2002). This study supports that the rate of sexual dysfunction in

individuals with PTSD is significantly higher and the presence of a psychiatric illness can affect sexual functioning.

LGBQ Community has High Rates of Mental Health Issues

Several population-based studies established that the LGBQ population has an elevated risk for a mental health diagnosis (Cochran et al., 2013). This high risk may be explained by the minority stress hypothesis, which states that those who are greatly exposed to stress, such as discrimination or victimization, can have their mental well-being affected. Research has shown that some mental disorders such as anxiety and substance use are influenced by the effects of social stress (Cochran, Sullivan, & Mays, 2003). LGBQ individuals are still widely stigmatized and despite society becoming more accepting, many individuals still report histories of victimization and discrimination (Cochran et al., 2003). Some studies have shown higher rates of depression, suicide attempts, and anxiety disorders when compared to the heterosexual population (Cochran et al., 2003). Cochran et al. (2003) conducted a study that collected data from the surveys of gay, lesbian, bisexual, and heterosexual individuals. One of the purposes was to observe the difference in mental disorders and psychological distress. What they found was gay men were three times more likely to meet the criteria for major depression and 4.7 times more likely for a panic disorder than a heterosexual male. About 20% of gay men overall, were comorbid for two or more mental disorders. Gay men also reported higher levels of current and past psychological concerns. For lesbians, researchers observed that there was a high prevalence of generalized anxiety disorder when compared to heterosexual females (Cochran et al., 2003).

In another study lead by Mays and Cochran (2001), 73 gay or bisexual individuals and 2,844 heterosexual individuals were surveyed. They also phone interviewed 70% of the households containing an eligible respondent. The results showed that gay and bisexual

individuals frequently reported lifetime and day-to-day discrimination, and approximately 42% say this because of their sexual orientation (Mays & Cochran, 2001). About 76% reported having a personal experience with discrimination. Data revealed that perceived discrimination was positively associated with harmful effects on quality of life and indicators of psychiatric morbidity (Mays & Cochran, 2001). These studies show a strong correlation between mental health disorders and the LGBQ community but do not address the area of sexual health or the sub-area of LGBQ veterans.

Sexual Dysfunction and the Veteran Population

Sexual dysfunction hits the veteran population particularly hard because research has shown that this population has high rates of psychopathology and unique stressors compared to the general population. There is an elevated risk of a mental health diagnosis among veterans, which can be explained by their exposure to combat, MST, and other stressors (Cochran et al., 2013). In a meta-analysis, researchers found that veterans have a 1.5 to 3.5 greater likelihood of developing PTSD compared to the general population (Cochran et al., 2013). At the start of the Iraq and Afghanistan conflicts, over 2 million individuals served in the war and approximately half received a mental health diagnosis, most commonly PTSD (Breyer et al., 2014). A mental health diagnosis, especially PTSD, is highly correlated with SD. In a study by Letourneau et al. (as cited in Bryer et al., 2014), 90 combat veterans were surveyed and 80% reported experiencing ED or premature ejaculation.

Breyer et al. (2014) conducted a cohort study on 405,275 male veterans who entered VA healthcare. Even after adjusting their data for confounding variables, they found that a mental health diagnosis, particularly PTSD, was independently associated with SD. Even though research supports that psychopathology is highly correlated with SD, these studies give little to

no insight beyond the male, heterosexual experience. Helmer et al. (2013) directed a qualitative study that explored the perspective of eight heterosexual men who screened positive for SD. They reported that their SD was due to their exposure to combat, aging, and medication side effects. One reported that SD is not routinely assessed in primary care or mental health encounters, which is a key issue. In addition, patients do not expect medical doctors or clinicians to ask so problems with SD often go unnoticed.

Studies in general are reporting on the young, male, combat exposed veteran experience with SD and are often neglecting to explore the female veteran population, let alone the female, lesbian or bisexual experience. Cohen et al. (2015) recognized that in the military, women are the fastest growing population of new recruits and an increasing amount of women are being exposed to combat or physical trauma related to combat. Women veterans also have high incidences of MST; both combat and sexual trauma can lead to issues with sexual functioning. Cohen et al. also noted that the majority of women active duty members are primarily of the reproductive age. In a study that examined the VA chart data of 71,504 female OEF/OIF veterans, Cohen et al. found that women with a diagnosis of PTSD were 4.88 times more likely to have a diagnosis of female genitalia pain. Also, they were six to ten times more likely to be diagnosed with SD. In addition to female genitalia pain, other diagnoses included dyspareunia and dysmenorrhea. It should be noted that for the women veterans who experienced MST, they are often avoiding SD screenings or gynecologist appointments due to triggering aspects of the diagnosis process which can impact diagnosis and treatment of this often-overlooked population in research.

LGBQ Veterans Unique Position

Despite the current positive political and media attention about gay, lesbian, bisexual, and queer in the service, the military has a notorious history of its lack of acceptance of this community. SD in veterans mainly occurs because of mental and physical health issues endured while serving their country. Recent combat veterans may be vulnerable to SD due to their deployment-related health issues such as mental health conditions, prescription medication use, and psychosocial challenges (Helmer et al., 2013). Mental health conditions such as depression and PTSD may yield impairments in an individual's sexual functioning through decreased libido or raising barriers to interpersonal relationships. Among studies of U.S. civilians, it was found that 20.7% of men aged 30–79 experienced sexual dysfunction (Hosain et al., 2013). When studying same-aged Vietnam veterans who suffered from PTSD, 80% of the surveyed population experienced sexual difficulties (Hosain et al., 2013). Specifically, individuals with PTSD voiced problems with intimacy and high levels of anxiety, anger, and irritability (Hosain et al., 2013). The intrusive thoughts and avoidance practices of veterans diagnosed with PTSD affected their ability to focus on sexual activity in the moment and made it difficult for veterans to become intimate with their partners (Kauth et al., 2014). Several cross-sectional studies have suggested that PTSD and depression are associated with SD not only because of the psychological symptoms but also because of the adverse effects of medications prescribed to treat these conditions (Hosain et al., 2013). There are also medical conditions such as diabetes, vascular disease, and other challenges stemming from a Traumatic Brain Injury (TBI) that may contribute to underlying mechanisms of sexual functioning (Helmer et al., 2013).

The studies that have explored the prevalence of SD in veterans have primarily concentrated on male, heterosexual veterans. For the few studies that have explored LGBQ

veterans, a common theme arises: LGBQ veterans have to endure the hardships of war along with their sexual minority status in an environment where they were previously excluded. In 1993, President Clinton signed off on the DADT policy which prohibited people who "demonstrated a propensity or intent to engage in homosexual acts" from serving in the U.S. Armed Forces (Mattocks et al., 2013). Simply put, self-identifying as gay or lesbian alone was sufficient grounds for discharge. During the 18-year history when this policy took place, approximately 14,000 service members were discharged (Mattocks et al., 2013).

For those who served under DADT, the policy created unique stressors such as facing discharge or fear of discharge, feeling isolated, experiencing harassment, or needing to conceal personal information to continue one's service (Cochran et al., 2013). Those who criticized DADT indicated that it silenced LGBQ service members with regard to their identities and reinforced the fear that revealing of one's sexual identity will result in immediate discharge from service and the loss of veteran benefits (Cochran et al., 2013). Concealment and anti-LGBQ discrimination may have taken a negative, psychological toll on LGBQ service members and created a general distrust in the VHA care system (Cochran et al., 2013). These added stressors unique to LGBT veterans, in addition to the adversities of war, make this population extremely vulnerable to mental illness, which can negatively affect their sexual health. Given that this population is at-risk for SD, clinicians and healthcare providers may have a responsibility to initiate conversations about sexual health matters and be required to have the tools and competence to properly assess for SD.

Intersections with Critical Topics

Social justice. Often, LGBQ individuals and veterans have been afraid to seek mental health services because they fear being stigmatized or are afraid that their clinician will not

understand their experiences with sexual dysfunction. In addition, LGBQ service members have to worry about privacy violations and fears of military readiness due to lower morale and unit cohesion (Golbach & Castro, 2016). The BPS model addresses these others factors beyond the biological roots of SD and allows clinicians to become aware of LGBT veterans' whole experience. Constantine, Hage, Kindaichi, and Bryant (2007) believe a clinician must become knowledgeable about the various ways oppression and social inequalities can be manifested at the individual, cultural, and societal levels in order to promote social justice (p. 25). This cannot be accomplished if the clinician does not consider the psychological and social difficulties LGBQ veterans' experience as a marginalized population in the U.S. Military. Sherman et al. (2014) also recognized that sensitivity training for clinicians about the biological, psychological, and social aspects of LGBQ veterans' experiences can also empower providers to work effectively with and provide tailored care for this population. The Institute of Medicine (as cited in Sherman et al., 2014, p. 434) recommended that research continue to explore provider attitudes, education, and ways in which mental health providers can improve their care to this marginalized population. In order to promote social justice, Constatine et al. (2007) indicated that clinicians should explore their own biases and be aware of their own privilege. Even if the clinician also identifies as LGBQ, he or she is in a position of power that can be intimidating for LGBQ veterans seeking services so recognizing this privilege is important. Through this exploration, clinicians might be able to start using more inclusive language and addressing the social and cultural stressors that the heterosexual veteran population might not be exposed to.

Diversity. LGBQ veterans are a minority population within an institution that historically has promoted heteronormativity. Even after the repeal of DADT, many LGBQ veterans still have concerns over continued persecution, lack of acceptance by unit leaders and other service

members, and impact on their military careers if they were to ever disclose their sexual identity (Golbach & Castro, 2016). Research by Lambda Legal (2010, as cited in Golbach & Castro, 2016, p. 434) who surveyed 4,916 LGBQ service members revealed that 50% reported having been treated disrespectfully by a health care provider and/or did not receive the care they needed because of their sexual identity. In these surveys, they cited incidents of being refused care, being blamed for their health status, professionals using abusive language, and providers being physically rough, refusing to touch them, or using excessive precautions. To help LGBQ veterans who come from a marginalized group within the U.S. Military and in the general population, clinicians must understand the hesitancy LGBQ veterans might have in discussing matters of sexual behavior and dysfunction. Using the BPS approach, clinicians can take into considerations the unique stressors that can contribute to their patient's SD and understand how these stressors can deter their LGBQ patients from seeking care.

Ethics. Competencies specific to working with the LGBQ population are found when reviewing the American Psychological Association's Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (2017). These guidelines are a good frame of reference when treating this population. There are 21 guidelines for psychologists to follow when working with LGBQ individuals. These guidelines include a framework for therapists about attitudes towards homosexuality and bisexuality, relationships and families of LGBQ clients, and issues of diversity both within the context of the larger population and within the LGBQ community. The following guidelines are considered best practices in working with LGBQ community according to APA's Division 44:

1. Psychologists understand that homosexuality and bisexuality are not indicative of mental illness.

2. Psychologists are encouraged to recognize how their attitudes and knowledge about lesbian, gay, and bisexual issues may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated.
3. Psychologists strive to understand the ways in which social stigmatization (i.e., prejudice, discrimination, and violence) poses risks to the mental health and well-being of lesbian, gay, and bisexual clients.
4. Psychologists strive to understand how inaccurate or prejudicial views of homosexuality or bisexuality may affect the client's presentation in treatment and the therapeutic process.
5. Psychologists strive to be knowledgeable about and respect the importance of lesbian, gay, and, bisexual relationships.
6. Psychologists strive to understand the particular circumstances and challenges facing lesbian, gay, and bisexual parents.
7. Psychologists recognize that the families of lesbian, gay, and bisexual people may include peoples who are not legally or biologically related.
8. Psychologists strive to understand how a person's homosexual or bisexual orientation may have an impact on his or her family of origin and the relationship to that family of origin.
9. Psychologists are encouraged to recognize the particular life issues or challenges experienced by lesbian, gay, and bisexual members of racial and ethnic minorities that are related to multiple and often conflicting cultural norms, values, and beliefs.

10. Psychologists are encouraged to recognize the particular challenges experienced by bisexual individuals.
11. Psychologists strive to understand the special problems and risks that exist for lesbian, gay, and bisexual youth.
12. Psychologists consider the generational differences within lesbian, gay, and bisexual populations, and the particular challenges that may be experienced by lesbian, gay, and bisexual older adults.
13. Psychologists are encouraged to recognize the particular challenges experienced by lesbian, gay, and bisexual individuals with physical, sensory, and/or cognitive/emotional disabilities.
14. Psychologists support the provision of professional education and training on lesbian, gay, and bisexual issues.
15. Psychologists are encouraged to increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation.
16. Psychologists make reasonable efforts to familiarize themselves with relevant mental health, educational, and community resources for lesbian, gay, and, bisexual people. (APA, 2017)

These sixteen guidelines ensure that psychologists are not only practicing within their realm of experience, but provide a sufficient outline for programs that are attempting to infuse more LBGT affirmative practices within their curriculum.

Competence. When working with LGBQ veterans, it is important that clinicians are competent in their work, especially if proper training has not been provided to them, to ensure

that they are not harming their client (American Psychological Association [APA], 2010). With the repeal of DADT, it is possible that more LGBQ veterans are seeking VHA care for their needs however, in order to welcome them into the VHA care system, it is important that clinicians understand those needs (Golbach & Castro, 2016). In Golbach and Castro's study that surveyed 202 VA providers, only 47% received professional training about LGBQ issues and only 43% received education on the topic since completing their professional training. Many providers have indicated that LGBQ health issues are rarely discussed in VHA clinical staff meetings; ethically, the responsibility is on the clinicians to gain knowledge and understanding about their LGBQ clients and their SD (Golbach & Castro, 2016). Mayer et al. (2008) indicated that, "…clinicians and service providers need to be sensitive to the potential stressors of coming out and the process of forming a positive identity as an [LGBQ] individual, and should be prepared to answer questions about making referrals" (p. 992). The BPS model suggests that a clinician consider those other potential stressors unique to the LGBQ veteran's experience such as minority stress theory and U.S. Military cultural attitudes when conceptualizing their clients.

Confidentiality. Clinicians have a primary obligation to protect the confidential information of their client, but when working in a VHA care system, clinicians are put in a unique bind that forces them to answer to their ultimate client: the U.S. Military (APA, 2010; McCauley, Hughes, & Liebling-Kalifani, 2008). Clinicians must struggle between their therapeutic relationship with their clients and the military, which poses a huge dilemma. When DADT was in place, service members who disclosed sexual behavior to military healthcare providers were immediately discharged which created a significant amount of distrust between veterans and their providers (Golbach & Castro, 2016). Despite the change in policy, that distrust still exists and LGBQ veterans are cautious about what they disclose. Patients' records are

technically property of the government and are often shared between departments to ensure that service members are able to effectively carry out military operations (McCauley et al., 2008). Again, it is the clinician's responsibility to inform their patients about the limits of confidentiality and initiate conversations about the distrust that may exist. These open conversations can comfort LGBQ veterans and allow them to more openly discuss their sexual health without fear of judgment.

Social. The BPS model suggests that social stressors must be considered when treating LGBQ veterans' SD. One of the social stressors is stigma, a social concept highly related to poor mental health. According to Erving Goffman (1963) stigma is, "…an attribute that extensively discredits an individual, reducing him or her from a whole and usual person to a tainted, discounted one" (p. 3). Though LGBQ veterans may find solace knowing they belong to a LGBQ group, they are also cognizant that they are different than the majority of veterans who identify as heterosexual. Studies suggest that stigma leads to LGBQ persons experiencing alienation, lack of integration with the community, and problems with self-acceptance (Goffman, 1963; Meyer, 2003). This creates a dilemma for the U.S. Military, which bases its success on interpersonal connection, support, and trust among unit members (Helmer, 2015; Moradi, 2009). It also interferes with factors critical to combat effectiveness including unit morale and unit cohesion (Moradi, 2009). Clinicians have the ability to address this sigma that may be contributing to the core of LGBQ veterans' SD. When stigma and its relationship to social isolation are addressed, clinicians create an inclusive environment within the VHA care system where clients feel comfortable to disclose information and understood in their experiences.

Research Design and Methodology

The following is a discussion of the methodology and the design that was used to conduct research concerning the aforementioned research questions on VHA clinicians and their experience assessing for SD in LGBQ veterans.

The model for this study is a survey with frequency and chi-squared analysis. The design allows one to see the relationship between years of experience, training in sexual disorders, and willingness to assess for sexual functioning.

Participants

Participants were recruited from two Veteran's hospitals in the VISN 1 district: (a) the Edith Nourse Rogers Memorial VA hospital in Massachusetts, and (b) the Manchester VA in New Hampshire. Participants were also recruited through the Division 19 Military Psychology chapter of American Psychological Association (APA). This email included a request to participate in the study, information about confidentiality, and a link to the survey hosted by SurveyMonkey.com, a survey approved by the VHA organization. In order to qualify to complete the survey, participants must work at a VA and provide direct individual and/or group therapy or psychopharmacology services to the veteran population and also, the to best of their knowledge, provide services for LGBQ veteran(s). It was expected that the participants are English speaking as the survey was only available in English. I expected to receive at least 52 participants to achieve a medium effect size but a total of 35 participants completed this survey and were included in the data analysis.

Measure

I constructed the online survey, the Demographic and Experience Questionnaire (Appendix A) which consists of 15 questions from three categories: (a) 10 questions regarding

demographics, information about graduate school, status of graduate training, degree, and any licenses received; (b) four questions regarding participants experience in the mental health field, training in matters of sexual functioning, and details of their current case load; and (c) 1 question assessing if the participants ask their LGBQ veteran about their sexual functioning with an opportunity to rate statements of relevance to describe their answer. Questions consist of a combination of Likert-type, multiple choice, and fill-in-the-blank response choices.

Procedure

After permission was obtained from the Antioch University New England Institutional Review Board (IRB) and the Union representatives from both Veterans' hospitals, the Human Resources department forwarded an email to the directors of the mental health clinic to disperse to those who qualify for the study. I also contacted the head of the Division 19 Military Psychology chapter who sent an email to the Division 19 community explaining qualifications to fill out the survey, information about confidentiality, and a link to the survey. Providers who chose to participate in the study clicked on the provided link and were directed to the informed consent page. The informed consent form covered the participant's rights to choose to participate in the process and information regarding possible risks of the study. All survey responses were anonymous. Data provided to me from SurveyMonkey was stored on my password-protected computer. The stored data had no identifiable information and I will keep it for seven years, at which time, I will destroy the data to ensure privacy and confidentiality. I collected data over a four-month period, specifically from the beginning May 2018 to the end of August 2018. I conducted analyses using R software.

Data Analysis

The initial area of analysis is descriptive statistics on the participant demographic data to provide a larger picture and description on those who were sampled. This information was gathered from the first 10 questions of the Demographic and Experience Questionnaire.

The first two research questions of this study were addressed by Question 15 of the Demographic and Experience Questionnaire where participants have the opportunity to rate statements that best describe their reasons for assessing or not assessing for sexual functioning in their LGBQ veterans. From this data, I conducted a frequency analysis to determine what statement participants endorsed most frequently. This analysis could also inform future directions for training or other research.

The third research question asks about the relationships between experience working in the mental health field and willingness to ask about sexual functioning. It also explores the relationship between training received about sexual disorders and willingness to ask about sexual disorders. This data was interpreted by performing a chi-squared analysis.

Results

The purpose of this study was to better understand a VHA clinician's experience in assessing for SD in their LGBQ veterans. Specifically, for those who ask their LGBQ veterans about their sexual functioning, what makes them comfortable in doing so and for those who do not, what are the major barriers that get in the way? Another purpose of this study was examine the relationship between clinical experience and a VHA clinician's willingness to assess for SD. In addition, this study examined the relationship between a VHA clinician's exposure to classes/training on SD and their willingness to assess for SD in their LGBQ veterans.

There were multiple hypotheses proposed before data collection. One hypothesis was if a VHA clinician has more training in the area of SD then they are more likely to assess for sexual functioning. It was also hypothesized that if a VHA clinician has more years of experience in the mental health field, then they are more likely to assess sexual functioning. Lastly, it was hypothesized that if a VHA clinician did not feel competent in the area of SD, was uncomfortable talking about sex in general, or assumed another provider had assessed for SD, then they were less likely to ask their LGBQ veteran about their sexual functioning.

Demographic Characteristics of Sample

Table 1 provides numerical representations of the demographic characteristic as reported by the participants (N=35). When participants were asked about age, 2.9% (n=1) reported being between 18–24 years old, 48.6% (n=17) reported being between 25–34 years old, 31.4% (n=11) reported being between 35–44 years old, 11.4% (n=4) reported being between 45–54 years old, 2.9% (n=1) reported being between 55–64 years old, and 2.9% (n=1) reported being 65 years old or older. In terms of gender identity of the participants, 75.3% (n=26) reported being female, 22.9% (n=8) reported being male, and 2.9% (n=1) reported being non-binary. Regarding sexual orientation, 65.7% (n=23) reported being heterosexual, 22.9% (n=8) reported being bisexual, 8.6% (n=3) reported being queer, and 2.9% (n=1) reported being asexual. In regards to ethnicity of participants, 94.3% (n=33) reported being White and 5.7% (n=2) reported being Black or African American.

When reporting about what state participants were raised in, what state they receive(d) training, and what state they are currently working in, participants chose from a drop down list of all 50 states in the U.S. I organized these states by their respective region: Northeast, Midwest, South, and West. In regards to state participant grew up in, 74.3% (n=26) reported growing up in

the Northeast, 2.9% (n=1) growing up in the Midwest, 17.1% (n=6) reported growing up in the South, and 5.7% (n=2) reported growing up in the West. Regarding state participant receive(d) training in, 75.6% (n=25) reported receiving training in the Northeast, 21.2% (n=7) reported receiving training in the South, and 3.0% (n=1) reported receiving training in the West. When asked about state participant is currently working, 85.3% (n=29) reported working in the Northeast and 14.7% (n=5) reported working in the West.

When responding to highest degree achieved, 2.9% (n=1) reported having their BA, 2.9% (n=1) reported having their MA, 20% (n=7) reported having their MS, 51.4% (n=18) reported having their PhD, 14.2% (n=5) reported having their PsyD, and 8.6% (n=3) reported Other. In terms of how far along a participant is in their graduate school training, 2.9% (n=1) reported being a practicum student, 14.7% (n=5) reported being an Intern, 17.7% (n=6) reported being a Postdoctoral Fellow, and 64.7% (n=22) reported N/A. Regarding licenses and certifications, 5.7% (n=2) reported being an APRN, 2.9% (n=1) reported being a LMFT, 62.9% (n=22) reported being a Psychologist, 2.9% (n=1) reported being a LICSW, and 25.9% (n=9) reported having no licenses or certifications.

Experience and Caseload

Table 2 provides data of the participants' experience, caseloads, and training as reported by the participants (N=35). When describing how many years of experience participant had in the mental health field, the mean score was 11.0 (*s*=7.05). When reporting the percentage of their caseload that identifies as LGBQ, 25.7% (n=9) reported having less than 10%, 31.4% (n=11) reported having 10%, 25.7% (n=9) reported having 20%, 14.3% (n=5) reported having 30%, and 2.9% (n=1) reported having 40%. When describing the percentage of individuals in their

caseload that identify as male, the mean score was 73.4 (*s*=17.4) and for the percentage that identifies as female, the mean was 26.2 (*s*=17.6).

Training in Sexual Functioning

When asked if participants received any training on sexual functioning, 45.7% (n=16) reported "yes," 48.6% (n=17) reported "no," and 5.7% (n=2) reported they were "not sure." For the participants that answered "yes" (n=16) they were assessed for how many hours of training they received, the last workshop they attended, if it was mandatory or voluntary, and how many classes they took in their graduate training. In terms of the number of hours of training they received, participants reported a mean score of 58.2 (*s*=124.6). Regarding the last workshop participants attended, 25% (n=4) reported it being within the last year and 75% (n=12) reported it being within the last 5 years. When asked if they trainings were mandatory or voluntary, 25% (n=4) reported it being mandatory and 75% (n=12) reported it being voluntary. Regarding how many classes a participants took in graduate school about sexual functioning, 31.3% (n=5) reported taking "0," 62.5% (n=10) reported taking "1," and 6.3% (n=1) reported taking "3."

Willingness to Ask

When asked if participants ask their LGBQ veterans about their sexual functioning, 31.4% (n=11) reported "yes" and 68.6% (n=24) reported "no." Once participants provided an answer, they were asked to rate the following variables on a Likert scale from one to five, one being "not at all" and five being "all the time." Table 3 and Table 4 represents more details about how participants rated the following the statements of relevance.

Comfort in asking. For those who answered yes, they rated the following statement, "I personally feel comfortable" ($\bar{x}$=4, *s*=1). For those who answered no, they rated the following statement, "I personally do not feel comfortable" ($\bar{x}$=1.6, *s*=1.1).

Requirement to ask. For those who answered yes, they rated the following statement, "My place of practice requires me to ask" ($\bar{x}$=2, *s*=1.9). For those who answered no, they rated the following statement, "My place of practice does not require me to ask" ($\bar{x}$=2.4, *s*=1.5).

Training and education in SD. For those who answered yes, they rated the following statement, ""I am trained in this area" ($\bar{x}$=3.5, *s*=1.3). For those who answered no, they rated the following statement, "I am not trained in this area" ($\bar{x}$=3.2, *s*=1.5).

Relevance to overall treatment. For those who answered yes, they rated the following statement, "It was relevant to the treatment" ($\bar{x}$=4.1, *s*=1.0). For those who answered no, they rated the following statement, "It was not relevant to the treatment" ($\bar{x}$=3.4, *s*=1.5).

Fear of being offensive. For those who answered yes, they rated the following statement, "I am not afraid to offend my client" ($\bar{x}$=3.6, *s*=1.2). For those who answered no, they rated the following statement, "I am afraid to offend my client" ($\bar{x}$=1.3, *s*=0.8).

Proper referrals. For those who answered yes, they rated the following statement, "I know where to refer my client for treatment" ($\bar{x}$=3, *s*=1.5). For those who answered no, they rated the following statement, "I do not know where to refer my client for treatment ($\bar{x}$=2.3, *s*=1.5).

Time constraints. For those who answered yes, they rated the following statement, "I am not under a time constraint" ($\bar{x}$=2, *s*=1.6). For those who answered no, they rated the following statement, "I am under a time constraint" ($\bar{x}$=2.7, *s*=1.6).

Other providers asking. For those who answered yes, they rated the following statement, "I am the only provider asking these questions" ($\bar{x}$=1.6, *s*=1.7). For those who answered no, they rated the following statement, "Another provider has already asked these questions" ($\bar{x}$=2.1, *s*=1.3).

Relationship Between Training and Willingness to Ask

A chi-squared test was conducted to assess the relationship between a participant's willingness to ask their LGBQ veterans about their sexual functioning and if they have received any training in SD or sexual functioning (e.g., classes, seminars, workshops, etc.). The results were found to be significant, X^2 (1, N = 35) = 4.04, p = 0.04. The results suggest that there is a significant relationship between a participant's willingness to assess for sexual functioning and their training in that area.

Relationship Between Years of Experience and Willingness to Ask

A chi-squared test was conducted to assess the relationship between a participant's willingness to assess for sexual functioning and the years of experience a participant has in the mental health field, specifically since starting graduate training. The results were found to be not significant, X^2 (13, N=35) = 6.15, p = 0.94. This suggests that there is no significant relationship between willingness to assess for sexual functioning and years of experience in the mental health field.

A chi-squared test was also used to assess the relationship between a participant's willingness to ask their LGBQ veteran about their sexual functioning and their status as a trainee. Specifically, if a participant identified as a practicum student, intern, or postdoctoral fellow or if the participant was out of that phase of training. The results were, again, found to not be significant, X^2 (1, N=35) = 3.18, p =1. The results suggest that there is no significant relationship between trainee status of a participants and willingness to assess for sexual functioning.

Discussion

Descriptive and inferential statistics were used to investigate the research questions. Specifically, why VHA providers are comfortable asking questions about sexual functioning as

well as the barriers of doing so. Also, does training or years of experience have any relationship to asking LGBQ veterans about their sexual functioning? It was hypothesized that providers will be more likely to ask if they have been trained in sexual functioning or have more years of experience as a clinician. Providers will be less likely to ask if they do not have training in this area, are uncomfortable to talk about sex, or assumed another provider has already assessed for sexual functioning. In the next sections, the results are discussed which is followed by limitations of the study, ideas for future research, and discussion of concluding thoughts.

Significance of Results

Research has supported that, in general, clinicians are hesitant to inquire about their patient's sexual health and/or sexual orientation. The situation is amplified when in VHA context with LGBQ veterans where there are other variables at play such as, but not limited to, the after effects of DADT and the overall heteronormative culture of the U.S. military. The results of this study support the current research that the majority of VHA clinicians sampled in this study are not asking their LGBQ veterans about their sexual functioning. Approximately 68.6% reported that they are not assessing for sexual functioning in their LGBQ veterans and only 31.4% are asking these crucial questions. This is concerning especially with all the literature about how vulnerable LGBQ veterans are to sexual health issues and how they often expect their provider to initiate this type of conversation.

Reasons of assessing for sexual functioning. When examining the participants that reported that they ask their LGBQ veterans about their sexual functioning, the majority of them endorsed feeling comfortable asking and not being afraid to offend their client. However, about 27.3% of participants rated the statement *I am not afraid to offend my client* a "2" which may reveal some general hesitations of talking about sex with their client. Despite these natural

hesitations, participants still asked these important questions about sexual functioning which could be attributed to their level of training on why it is still crucial to ask or they understand the relevance of doing so despite this fear of being offensive. It is natural for a provider to not want to risk damaging the therapeutic relationship by asking something that may offend their clients but for these participants, it appears they still ask because they see the benefit of doing so.

A large indicator of whether a person feels comfortable asking is their exposure to training. Of the people that reported assessing for sexual functioning, about 45.5% rated the statement *I am trained in this area* either a "4" or a "5" and 36.4% rated it a "3." More than half of participants agreed with this statement and the chi-squared analysis also showed a significant relationship between assessing for sexual functioning and exposure to training. It should be noted that there was no significant relationship between assessing for sexual functioning and experience in the mental health field or status of trainee. The relationship existed between exposure to training and willingness to ask. Simply put, there is power in knowledge. Being trained on how to assess, diagnosis, and treat SD, as well as understand how a veterans sexual identity can be important when considering treatment options, may give VHA clinicians confidence in their ability to provide the correct care. It can be argued that confidence can come with years of experience or how far along someone is in their graduate school career but the results suggest that receiving training about SD is more salient of a factor than having 30+ years in the field. These data highlight the importance of giving graduate students or current VHA clinician's access to trainings because it gives individuals confidence and competence which translates to better care for LGBQ veterans.

This study found that participants ask LBGQ veterans about their sexual functioning because it was relevant to their treatment. Approximately, 81.9% of participants rated the

statement *It was relevant to the treatment* either a “4” or “5.” Providers are asking these questions because they determined the usefulness of this intervention. There are many variables as to why a provider feels asking about sexual functioning is relevant. Some possibilities are that it was part of the referral question, the veteran specifically voiced their concern about their sexual functioning, or providers were given knowledge on why assessing for sexual dysfunction in the LGBQ population is so crucial. Regardless of the reason why, this research emphasizes that out of the 35 participants that were administered this survey, an alarmingly small percentage found assessing for sexual functioning to be relevant to the treatment. This is extremely concerning especially when research suggest that LGBQ veterans are particularly vulnerable to these issues and are likely expecting their provider to ask them.

It is possible that providers are asking questions about sexual functioning because they are responsible for treating SD and do not have a place to refer them to. About 45.5% rated the statement, *I know where to refer my client for treatment* a “2” suggesting that they are responsible for assessing and treating SD. Also, the majority of participants reported that other providers in the VA are assessing their LGBQ veterans for sexual functioning but still take matters into their own hands and ask. In addition, the majority of participants reported that they are under a time constraint. This data brings to light the overall culture of a VA system of how VHA providers are often put into a position to wear many hats and are under a time constraint to see many clients. Despite these circumstances, these participants still see the importance of assessing for sexual functioning but this data represents some of the difficulties of doing so in a VA system.

What are the barriers? About 68.6% of participants in this study reported that they are not asking their LGBQ veterans about their sexual functioning. Helmer (2015) stated that

clinicians are not asking their clients about sexual functioning because there is a lack of time, inadequate knowledge and training, they are afraid to offend their clients, or there is a lack of awareness about the issue. The following results support the majority of Helmer's findings with the exception of one. The overall consensus of participants that do not assess for sexual functioning reported that it had nothing to do with their personal comfort or their fear of offending their client. As many as 54.6% rated the statement *I am afraid to offend my client* a "1" and 81.8% rated the statement *I personally do not feel comfortable* a "2" or lower. This data could suggest that society is becoming more open to talking about sex and individuals are considering this topic to not be as taboo. It is also possible that in any survey based on self-report, people have a tendency to make themselves look more favorable, and it may not be easy to reveal that the reasons of not asking have to do with their own discomfort. Nevertheless, these findings state that people are not afraid to talk about sex with their client but may need more education on why they should.

Another important aspect to consider is that though the majority of clinicians are not afraid to ask their clients about their sexual functioning, what messages are they sending by not asking? The silence or avoidance about the topic could convey the message that they are uncomfortable or unaccepting of their veteran's sexual identity even if that is not their intention. Current research shows that when LGBQ people seeking mental health services sense discomfort from their provider, they will likely stop treatment and not return. The avoidance of this topic could be pushing away potential LGBQ veterans that are suffering. This demonstrates a need not only for trainings about sex but also cultural competence when working with sexual minorities.

Fifty percent of participants who do not assess for sexual functioning in their LGBQ veterans rated the statement *I am not trained in this area* a "4" as a reason why they choose not

to ask. This supports the hypothesis that when providers are trained, they will be more likely to ask. This seems to be a major influencer in people's competence, confidence, and overall action in assessing. Research supports that LGBQ veterans are at high risk of developing a SD and its possible that these providers are unaware of this vulnerability or they are aware but are afraid to ask because they would not know how to asses, diagnosis, or treat their client. Regardless, this is translating into possible inappropriate care for the LGBQ veteran and highlights the absolute need for access to more training.

The data also suggested that participants not assessing for sexual functioning because they do not see it being relevant to the treatment. Again, it is important to consider the definition of relevance and why participants do not believe assessing for sexual functioning could be relevant when treating an LGBQ veteran. Participants could be basing relevance on the referral question or their clients' goals but it is difficult to ignore that this question of relevance could be addressed with more education about SD and the LGBQ veteran population. Research shows that LGBQ veterans' willingness to disclose issues with sexual functioning is low and are often looking to the clinician to initiate the discussion. It is difficult to assess the relevance of the situation if the provider is not getting the full picture of their client.

Another barrier that participants reported was a problem with time. About 45.5% rated the statement *I am under a time constraint* a "4." This data suggests that participants may feel that they do not have enough time with their LGBQ veteran to assess for sexual functioning and are choosing to concentrate on other parts of the treatment that they perceive to be more pressing. Since there is an issue of time and many providers are basing their decision to assess on relevance to treatment, they may be only treating their LGBQ veteran based on their self-report of the problem. This is concerning because the literature purposes that LGBQ veterans may have

mistrust in their providers which leaves the responsibility on the VHA clinician to ask the questions.

Similarly to the participants that ask their LGBQ veterans about their sexual functioning, participants that do not ask reported that they do not know where to refer their client if they are experiencing symptoms of SD. Since there is not a clear place for a LGBQ veteran to be referred, the responsibility relies on the provider to treat this individual if they express a concern with their sexual functioning. If the VHA provider does not feel equipped to do so because they are not trained, do not have time, or do not see the relevance, they may make the decision to not assess. These reports suggest a lack of resources within the VA system to address issues with SD in the LGBQ veteran population. In research conducted by Johnson and Federman (2013) who assessed barriers in the VA to care for LGBT veterans, they also concluded that there is a major lack of resources to correct care for this population. They identified staffing, programs, financial support for educational opportunities outside the VA, and consultation availability around LGBT veteran care to be the main resources that are missing (Johnson & Federman, 2013). The need still exists and becomes even more crucial as the LGBQ veteran population continues to grow.

The importance of training. A chi-square analysis found a significant relationship between training and a VHA providers' willingness to ask their LGBQ veteran about their sexual functioning. For the 45.7% of participants that reported having some form of training in sexual functioning, 75% of those participants stated that it was within the last 5 years and 75% reported that it was done voluntarily. Therefore, either the participants' graduate school or the VA they work in are not requiring this training and they are seeking it out for themselves. Since the opportunity is not readily available for all VHA providers, they are likely using their own time and money because they recognize the importance of seeking out this training. Participants in

Johnson and Federman's (2013) study also explicitly noted that their training about LGBT issues was obtained outside the VA. The participants also expressed that it would be beneficial to have training on subjects such as assessment and documentation (Johnson & Federman, 2013). This, again, suggests the dire need and demand for readily available training so VHA clinicians feel supported when treating the LGBQ veteran population and possible SD.

Limitations

A major limitation of this study is the low number of participants. It was expected that at least 54 responses to the on line survey however only achieved 35 responses. It could have been beneficial to have kept the survey open for longer than four months or recruit from more VHAs in the VISN 1 district. The low number of participation in this study could have also been influenced by the sensitivity of asking VHA mental health providers about their LGBQ veterans' sexual functioning. Research suggests that the topic of sex may still be uncomfortable for providers. Furthermore, all data collected for this study was based on self-report. It is possible that participants could have over-reported or underreported about training experience or the characteristics of their caseloads. In addition, participants who filled out the survey may have reported socially desired response when asked about their willingness to ask about sexual functioning. It is possible that participants are reluctant to report that they are not asking their LGBQ veterans about their sexual functioning especially if they are uncomfortable to do so.

Another major limitation of this study is participants who completed the survey may not have accurately represented the overall demographics of the population thus, population bias could affect the validity of the results. First, 75.3% of the participants are female; though the majority of the psychology field is female, the male experience is underrepresented in this study. Second, the majority of participants were raised, trained, and work in the Northeast. The limited

geographic scope of this sample leaves possible questions about other attitudes and training opportunities about LGBQ veterans' sexual health in this country. Third, 65.7% of the participants identify as heterosexual; this demographic variable may have contributed to the data considering that this research has touched upon how sexual minority status can impact an individual. It could have been beneficial to get the perspective of the LGBQ provider that is treating an LGBQ veteran to compare any possible differences. Lastly, 94.3% of participants identified as White. It is possible that other cultures and ethnicities hold different beliefs about talking about sex in general or LGBQ individuals which could have been explored further in a more representative sample. Overall, the sample was limited and by no means can reflect the experience of all VHA providers.

No causal inferences are possible from this study. The chi-squared design is capable of identifying a significant relationship between training and willingness to ask LGBQ veterans about their sexual functioning. It however, is not reasonable to assume that training in this area directly causes providers to ask. There could be other variables that this study did not explore such as the quality, format, depth, etc. of the training. Lastly, a chi-squared analysis cannot determine the direction of the relationship and thus, this study cannot conclude that training causes more providers to ask or if a providers' willingness to ask causes them to seek out training opportunities in the area of SD.

Implications for Future Research

The great need for attention and research in the field of LGBQ veteran issues leaves room for many different directions for future research. One example is to recruit for a larger, more representative sample to increase power of statistical analysis. The majority of participants in this study identified as female, White, heterosexual, and mostly from and trained in the Northeast

region. It was be beneficial to recruit a larger and more diverse population to increase generalizability. On the other hand, future research could go in the opposite direction a recruit a smaller sample utilizing a qualitative approach where this research was mainly focused on quantitative data. This could have research go more in depth with VHA providers and their experience with LGBQ veterans.

Future research could also consider the LGBQ veteran's experience and ask if their VHA provider assesses them for sexual functioning. While current research indicated that LGBQ veterans often mistrust their provider and will not always openly disclose sexuality identity or sexual problems, it may be beneficial to explore any changes that may have occurred through the years. It is also possible that their perspective of when their VHA provider does not ask could be very different then what is actually occurring. For example, results of this study suggest that VHA providers who do not assess for sexual functioning are generally comfortable and are not afraid to offend their client. However, an LGBQ veteran could assume that their providers' silence about the issues is communicating something different.

This research specifically did not include VHA providers' interactions with their transgender veterans in an effort to respect the difference between sexuality and gender identity. Research also indicates that transgender individuals can experience sexual difficulties that are different from LGBQ individuals. Future research may want to explore VHA providers' experience assessing sexual functioning with transgender veterans and explore any unique barriers. This is also important given there are other variables at play with the transgender veteran population that could impact results for example, the political climate and attitudes of transgender individuals in the military. The current debates on banning transgender veterans in the military can possibly add unique aspects not covered in this study.

Lastly, it could be informative to further explore the relationship between training and willingness to assess for sexual functioning. This study concludes that the relationship exists but leaves out the crucial information about causation or other variables of influence. This research also highlights a need for training on sexual disorders in the VA and it would be interesting to examine what form the training could take. For example, most participants in this study who reported training in sexual functioning stated that it was voluntary. It would be beneficial to see if mandatory training at a VA has any relationship to providers' willingness to ask when compared to training that is offered to its employees as optional.

Conclusions

This research set out to explore the general hesitations of VHA providers to ask LGBQ veterans about their sexual functioning given that current research has shown that this is a prominent issue for this population. Historically, research has concentrated on the male, heterosexual experience and providers' interactions with them, and very little research has been focused on the LGBQ veterans. This study examined this gap in literature to highlight the need for more research and hopefully contribute to any changes the VA needs to make in regards to training their staff. These results suggest a significant relationship between VHA providers' willingness to ask and whether they have received training as predicted. The results showed no significant relationship between years of training or status of trainee and willingness to ask suggesting no matter what point an individual is in their career, there is value in being educated and being open to new material. Ultimately, this results of this research hopes to bring awareness to the needs to LGBQ veterans as well as the VHA providers that are caring for this ever growing population.

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Appendix A

Demographic and Experience Questionnaire

1. **Gender Identity**: Man, Nonbinary, Transgender, Woman, Other (open box), Prefer not to answer
2. **Age**: Under 18, 18-24, 25-34. 35-44. 45-54, 55-64, 65+
3. **Ethnicity**: American Indian or Alaska Native, Asian, Black or African American, Latinx, Middle Eastern or North African, Native Hawaiian or other Pacific Islander, White, Other (open box), Prefer not to answer
4. **Sexual Orientation**: Asexual, Bisexual, Gay/Lesbian/Homosexual, Heterosexual/Straight, Queer, Questioning, Other (open box), Prefer not to answer
5. **State in which you were raised**: Pull down menu – List of States
6. **State in which you receive(d) graduate training**: Pull down menu – List of States
7. **State in which you currently work**: Pull down menu – List of States
8. **What is your highest degree**: BA, BS, MA, MS, PhD, PsyD, EdD, MD, other
9. **If you are still in graduate school, how far along are you in your training**? Practicum, Internship, Post-Doctoral, N/A
10. **What license(s) or certification do you hold? Please check all that apply**: LMFT, CMHC, LPC, LCSW, CAC, LDC, APRN, Psychologist, MD, none, other
11. **How many years of experience do you have in the mental health field (specifically, since starting your graduate clinical training)** Pull down menu - Numbers
12. **To the best of your knowledge, what percentage of veterans have you worked with that have self-identified as Lesbian, Gay, Bisexual, or Queer**: Pull Down Menu - Percentages
13. **To the best of your knowledge, what percentage of your caseload identifies as male and what percentage identifies as female?** Open Box
14. **Have you received any training on sexual functioning (e.g., classes, seminars, workshops, etc.):** Yes, No, Not Sure

a. **Approximately how many hours of training have you received? (Please only enter numerical value, e.g., 10)** Open Box

b. **Approximately how many classes about sexual functioning did you take in your graduate training?** Pull down menu – 0, 1, 2, 3, 4, 5, 6, 7+

c. **When was the last workshop you attended that was dedicated to training about sexual functioning?** Pull down menu – Within a year, within 5 years, within 10 years, within 20 years, more than 20 years ago

d. **Was this training mandatory or voluntary?** Mandatory, Voluntary

15. **Do you ask your LGBQ veterans about their regular sexual practices**: Yes, No

a. **If you inquire about your LGBQ veterans sexual functioning, please rate the relevance of each statement from 0 (not at all) to 5 (all the time) to describe what influences you asking these questions**:

"I personally feel comfortable"

"My place of practice requires me to ask"

"I am trained in this area"

"It was relevant to the treatment"

"I am not afraid to offend my client"

"I know where to refer my client for treatment"

"I am not under a time constraint"

"I am the only provider asking these questions"

Open Box

b. **If you do not inquire about your LGBQ veterans sexual functioning, please rate the relevance of each statement from 0 (not at all) to 5 (all the time) to describe what influences you not asking these questions**:

"I personally do not feel comfortable"

"My place of practice does not require me to ask"

"I am not trained in this area"

"It was not relevant to their treatment"

"I am afraid to offend my client"

"I do not know where to refer my client for treatment"

"I am under a time constraint"

"Another provider has already asked these questions"

Open Box

Appendix B

Recruitment Letter

Dear Veterans Affairs (VA) Mental Health Provider,

My name is Melanie Brayman, and I am a Psy.D. student at Antioch University New England, in Keene, New Hampshire. I am conducting research for my dissertation, which is entitled "Sexual Dysfunction in Lesbian, Gay, Bisexual, and Queer Veterans: Understanding the Whole Person." My research focuses on VA mental health providers that inquire (or do not inquire) about their LGBQ veterans sexual functioning. There is currently a great deal of research on this phenomenon in the field with heterosexual veterans, but very little looking at mental health providers interactions with LGBQ veterans. The goal of this study is to examine potential barriers to asking LGBQ veterans about their sexual functioning.

To qualify for the study you must provide direct individual and/or group therapy or psychopharmacology services to the veteran population. Also, the to best of your knowledge, provide services for LGBQ veteran(s). The data collected in the survey will be completely anonymous and your answers will not be able to be linked to your name, nor to the IP number of your computer.

This survey has been estimated to take approximately 10 to 15 minutes to complete.

If you have any questions, please feel free to contact me at [redacted]. If you have any questions about your rights as a research participant, you may contact Kevin Lyness, Chair of the Antioch University New England IRB, at [redacted] and phone [redacted]. You may also contact Barbara Andrews, Ph.D., Interim Provost, at [redacted] or by phone at [redacted].

To continue, please, click on the link below to be directed to the Informed Consent form and participate in the study.

Thank you very much for your help.

Melanie Brayman, M.S.

Appendix C

Informed Consent

Dear Veterans Affairs (VA) Mental Health Provider,

This survey attempts to gather information from VA mental health providers that have provided treatment to Lesbian, Gay, Bisexual, and Queer veteran(s). It seeks to examine your experience inquiring (or not inquiring) about your LGBQ veterans' sexual functioning. This survey is also interested in your clinical training.

Your response will assist in providing information about potential barriers to asking LGBQ veterans about their sexual functioning while adding knowledge to the existing scholarly literature on how VA providers screen for sexual dysfunction.

There are minimal, if any, risks from participating. Your identity will be confidential, you will not be asked for your name, and all demographic information collected will be reported as aggregated information. No personally identifiable information will be associated with your response to any reports of these data. This survey will take approximately 10-15 minutes to complete.

This survey is part of the dissertation research at Antioch University New England in the Psy.D. Clinical Psychology program. The study results may be included in future presentations and publications.

Your participation is voluntary and you may decide to discontinue the survey at any time. If you do fill out the survey, you may leave any questions blank, but I ask that you answer as many questions as you can. If you should have any questions about the survey, please email me at [redacted].

This project has been approved by the Institutional Review Board at Antioch University New England. If you have any questions about your rights as a research participant, please contact Dr. Kevin Lyness at [redacted] or by phone [redacted]. You may also contact AUNE interim provost, Dr. Barbara Andrews by email at [redacted] or by phone at [redacted].

I have read and understood the above information. By clicking "Yes" below, I am indicating that I have read and understood this consent form and agree to participate in this research study.

Please print a copy of this page for your records.

Thank you for your participation!
Melanie Brayman, M.S.

Table 1

Participant Demographics (N=35)

	n	%
Age		
18-24	1	2.9
25-34	17	48.6
35-44	11	31.4
45-54	4	11.4
55-64	1	2.9
65+	1	2.9
Gender		
Female	26	75.3
Male	8	22.9
Non-Binary	1	2.9
Sexual Orientation		
Heterosexual	23	65.7
Bisexual	8	22.9
Queer	3	8.6
Asexual	1	2.9
Ethnicity		
White	33	94.3
Black /African American	2	5.7
State raised in		
Northeast	26	74.3
Midwest	1	2.9
South	6	17.1
West	2	5.7
State trained in		
Northeast	25	75.6
Midwest	0	0
South	7	21.2
West	1	3.0
State currently working in		
Northeast	29	85.3
Midwest	0	0
South	0	0
West	5	14.7
Degree		
BA	1	2.9
MA	1	2.9
MS	7	20.0
PhD	18	51.4

PsyD	5	14.2
Other	3	8.6
Training Status		
Practicum	1	2.9
Internship	5	14.7
Post-Doctoral Fellow	6	17.7
N/A	22	64.7
License		
APRN	2	5.7
LMFT	1	2.9
Psychologist	22	62.9
LICSW	9	25.7
None	1	2.9

Table 2

Participant Experience, Caseload, and Training (N=35)

	n	%	$\bar{x}$	*s*	Range
Years Experience			11.1	7.1	4-32
Percentage LGBQ					
Less than 10%	9	25.7			
10%	11	31.4			
20%	9	25.7			
30%	5	14.3			
40%	1	2.9			
Percentage Male			73.4	17.6	5-100
Percentage Female			26.2	17.4	0-95
Received Training					
Yes	16	45.7			
No	17	48.6			
Not sure	2	5.7			
Hour of Training			58.2	124.6	5-500
Last Workshop					
Within a year	4	25.0			
Last 5 years	12	75.0			
Details of Training					
Mandatory	4	25.0			
Voluntary	12	75.0			
Number of Classes					
0	5	31.3			
1	10	62.5			
3	1	6.3			

Table 3

Participants who Asses for Sexual Functiong Statement Ratings (N=11)

Statements	n	%
I personally feel comfortable		
0	0	0
1	0	0
2	1	9.1
3	2	18.2
4	4	36.4
5	4	36.4
My place of practice requires me to ask		
0	3	27.3
1	2	18.2
2	3	27.3
3	0	0
4	1	9.1
5	2	18.2
I am trained in this area		
0	0	0
1	1	9.1
2	1	9.1
3	4	36.4
4	2	18.2
5	3	27.3
It was relevant to the treatment		
0	0	0
1	0	0
2	1	9.1
3	1	9.1
4	5	45.5
5	4	36.4
I am not afraid to offend my client		
0	0	0
1	0	0
2	3	27.3
3	1	9.1
4	4	36.4
5	3	27.3
I know where to refer my client for treatment		
0	0	0
1	1	9.1
2	5	45.5
3	1	9.1
4	1	9.1
5	3	27.3

I am not under a time constraint		
0	1	9.1
1	4	36.4
2	4	36.4
3	0	0
4	0	0
5	2	18.2
I am the only provider asking these questions		
0	4	36.4
1	3	27.3
2	1	9.1
3	1	9.1
4	1	9.1
5	1	9.1
Other		
0	1	50.0
1	0	0
2	0	0
3	0	0
4	1	50.0
5	0	0

Note. Participants who answered “Other” did not leave an explanation

Table 4

Participants who Don't Asses for Sexual Functiong Statement Ratings (N=24)

Statements	n	%
I personally do not feel comfortable		
0	3	13.6
1	8	36.4
2	7	31.8
3	3	13.6
4	1	2.6
5	0	0
My place of practice does not requires me to ask		
0	4	18.2
1	2	9.1
2	4	18.2
3	8	36.4
4	2	9.1
5	2	9.1
I am not trained in this area		
0	3	13.6
1	0	0
2	2	9.1
3	4	18.2
4	11	50.0
5	2	9.1
It was not relevant to the treatment		
0	2	8.7
1	0	0
2	5	21.7
3	1	4.4
4	10	43.5
5	2	21.7
I am afraid to offend my client		
0	3	13.6
1	12	54.6
2	5	22.7
3	2	9.1
4	0	0
5	0	0
I do not know where to refer my client for treatment		
0	4	18.2
1	3	16.4
2	3	16.4
3	7	31.8
4	5	22.7
5	0	0

I am under a time constraint		
0	3	13.6
1	4	18.2
2	1	4.6
3	3	13.6
4	10	45.5
5	1	4.6
Another provider has already asked these questions		
0	3	13.6
1	4	18.2
2	6	27.3
3	6	27.3
4	3	13.6
5	0	0
Other		
0	3	60.0
1	0	0
2	1	20.0
3	0	0
4	1	20.0
5	0	0

Note. Participants who answered “Other” did not leave an explanation