
Structural Competency and Responsivity in Military Psychology: LGBTQIA+ Equity and Justice

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In this article, we describe actions that military psychologists can take to be structurally responsive, affirming, and inclusive. We employ the concept of “structural competency,” here defined broadly as a movement to improve population health at the level of social structures, institutions and policies (e.g., Hansen & Metzl, 2016). We highlight this particular idea as a response to the many well-intentioned papers and guidelines that focus on cultural competence as individual interactions without attending to dynamic structural causes of illness and distress and providers’ potential roles in those broader structures (Kleinman & Benson, 2006). Whereas providers’ direct interactions with patients can indeed help alleviate harmful structural forces, they need to be understood and practiced in connection with broader structural interventions to impact the health of marginalized communities in a sustained way.

All military psychologists must receive general training in LGBTQIA+ affirming healthcare. We indicate firmly here that LGBTQIA+ affirming interactions is not complicated, nor are LGBTQIA+ individuals inherently wounded and require “specialized” care. Instead, it is incumbent on the military psychologist to obtain (continuing) education to ensure alignment with ethical guidelines and best practices in affirming care; similarly, the psychologist should

seek consultation when indicated. In many ways, there will be overlap amongst the practices listed below, as inclusive healthcare and work environments are integrated, not sectioned into neat categories. As queer, transgender, and allied psychologists and psychologists-in-training, we recognize that the information described below is not exhaustive of all the practices you can take. We encourage you to carefully consider our words and their applications to your training and future practice. We encourage you to consider the ways in which creativity, openness, and critical evaluation can be applied across different scenarios. Creativity and imagination are key themes of structural work and queer communities as we recognize that solutions need collective work and effort and require broad scale change for which we do not have templates. The military holds many opportunities for psychologists to work creatively and structurally as they practice in an occupational medicine capacity and have expanded their roles over time into various consultative and operational spaces.

Figure 1: Structural Scales of Justice provides a visualization of five recommended practices and understanding their rationale from a structural perspective. On one side, we depict five recommended practices as “alleviating forces” and on the other side, we depict the weight of his-

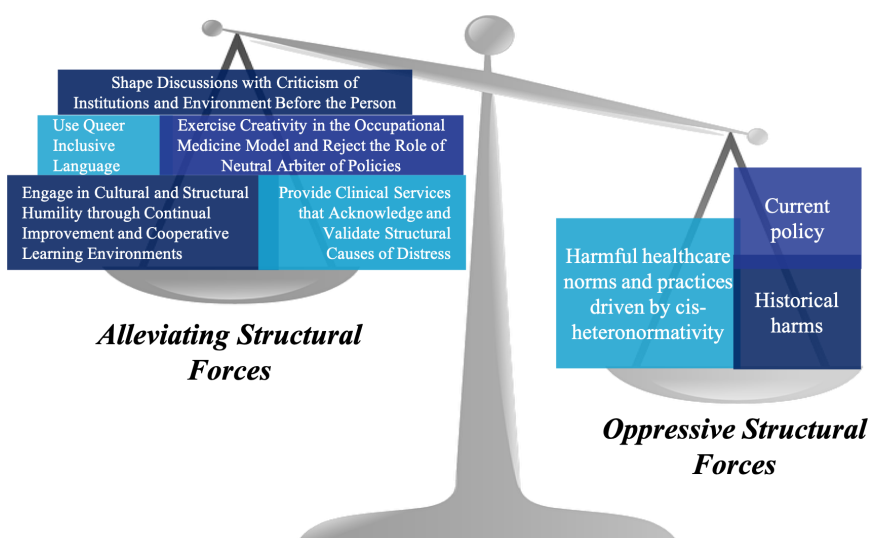


Figure 1: *The Structural Scales of Justice* depicts the alleviating structural factors (left), reflective of the five practices we describe, and the oppressive structures that negatively impact and harm LGBTQIA+ individuals within the Military Health System (right).

torical and current policies and systems as harmful structural forces. We describe these five recommended practices in the narrative below and invite the reader to consider other practices within whatever unique space they exist.

Practice 1: Use LGBTQIA+ Inclusive Language

While gender neutral and inclusive language, facilities, and more continue to increase within the United States, similar actions to cultivate a culture of embracing gender diverse service members and eschewing exclusionary policies and practices is less evidenced in the US military. To be truly inclusive, military readiness should not be gender-dependent. The historical message that effective service members are male, cisgender, and white should be combated. As such, it is incumbent on military psychologists, regardless of their position and authority, to take steps to mitigate exclusionary language whenever possible. A military psychologist may be part of committees that will determine the next step of policies to be released, or be part of working groups that are charged with optimizing healthcare pathways and outcomes. In these and many other roles, military psychologists have the opportunity to correct gender binary language (e.g., “he/she” should be changed to “they”) and ensure person-first language that refers to people (e.g., “homosexuals” should not be used, and instead, phrases like “LGBTQIA+ people” should be used), their bodies (e.g., clients undergoing gender affirming chest reconstruction are not having their “breasts removed,” they are having chest reconstruction), and their care (e.g., “sex change surgery” is not appropriate and should be replaced with “gender affirming surgery”). Language is continually evolving to be more inclusive and client-centered. Military psychologists should keep up-to-date by reviewing nationally-recognized LGBTQIA+ health education leaders, such as the National LGBTQIA+ Health Education Center (<https://www.lgbtqihealtheducation.org/>), for new resources and continuing education opportunities. In lieu of an example, we have elected to include a non-exhaustive list of common phrases that should be not be used, as well as inclusive phrases that should be (Table 1).

Practice 2: Provide Clinical Services that Acknowledge and Validate Structural Causes of Distress

Military psychologists must also be aware of when they are teaching LGBTQIA+ clients to habituate to trauma and the dangers therein, such as teaching coping skills to clients that enable them to become numb to harassment and discrimination, versus addressing the source of the issue with the client’s consent (e.g., consulting with the client’s command). Barriers to inclusive healthcare may stem from providers who engage in heteronormativity and cisnormativity in their conversations with clients, even those who are well-intentioned (Joy et al., 2022; Norris & Borneskog, 2022; Sileo et al., 2022; Waters et al., 2021).

Example: Though a military psychologist considers themselves to be an inclusive provider, they erroneously label a client’s behavior of having sex with multiple people of all

genders as demonstrating ‘impulsive’ behavior, but does not ascribe such a label to clients who are cisgender men who have sex with multiple women. Later, this military psychologist asks a lesbian client who indicates she is getting married: “So which of you is going to wear the tuxedo?” and asks a transgender man if he was having second thoughts about his gender identity because he was wearing nail polish.

Practice 3: Engage in Cultural and Structural Humility through Continual Improvement and Cooperative Learning Environments

Do not position yourself as a “subject matter expert” on LGBTQIA+ people and healthcare. Recognize that there is an inherent and harmful “subject matter expertise culture.” Here, individuals without lived experience, with very little training - if any, who lack genuine longitudinal and cultivated trust with LGBTQIA+ communities outside of a medical model have positioned themselves to be “experts” of LGBTQIA+ identities and healthcare. Non-LGBTQIA+ individuals have largely misemployed themselves as “subject matter experts” instead of elevating the voices, lived experiences, and works of LGBTQIA+ individuals, including their colleagues. A cooperative learning environment is one in which non-LGBTQIA+ individuals, including non-LGBTQIA+ military psychologists, take efforts to withdraw from “subject matter expertise culture” and refer entities, governing bodies, and leaders to LGBTQIA+ stakeholders (Ciszek, 2020). It is important for military psychologists to actively seek publications and additional content written by and with LGBTQIA+ people, while also minimizing the medicalization and pathologization of LGBTQIA+ individuals (Eckhart, 2016; Kronk et al., 2022; Snow, 2022; Wagner et al., 2022).

Example: As a military psychologist, a client was referred to you for depression and sleep problems. In your third session, they disclose to you that they are trans and are considering transitioning while in service. Your graduate training program did not provide adequate or appropriate information on gender identity, gender expression, and sex assigned at birth, nor did you receive training on what transition entails and how it varies vastly by person. Recognizing the limits of your current knowledge, you indicate to the client that you very much appreciate their openness in disclosure and that you are here to support them. You also disclose up front that your knowledge of transitioning, especially while in service, is limited, but you are committed to providing the best care and will take steps to obtain more information and consultation. You indicate that if the client would like to have a different provider at any time, that you will honor their request. After the session is over, you identify recent literature that is well regarded by transgender individuals and researchers as being affirming. You then take additional continuing education courses provided by a nationally recognized LGBTQIA+ healthcare education center and engage in supervision with a psychologist who has significant training and experience in gender-affirming psychological care.

Table 1. Exclusionary terms (left column) and more inclusive terms (middle column) with explanation (right column)

Exclusionary Terms	More Inclusive Terms	Explanation
He/she, him/her, his/hers; ladies and gentlemen	They, Them; Folks, Esteemed Colleagues	Using binary gender terms exclude non-binary people who do not use such pronouns or identify with such terms.
Biological Sex, Natal Sex, Biological Male, Biological Female	Sex Assigned at Birth, Assigned Male at Birth, Assigned Female at Birth	At birth, sex is assigned based almost always on external genitalia. Most states only provide the option of “M” or “F” on birth certificates. Thus, sex is assigned at birth and not reflective of the multitudes of ways in which sex characteristics develop (e.g., hormones, chromosomes, receptor function, internal and external reproductive structures).
Male-to-Female (MTF) and Female-to-Male (FTM), Transsexual, Transvestite, Transgendered, Transmale and Transfemale, Female-Identifying, Male-Identifying	Trans(gender) Man, Trans Woman, Trans Non-Binary Person, Trans Masculine/ Masc Person, Trans Feminine/Femme/ Fem Person	Transgender is an adjective to describe an aspect of one’s gender identity. While some trans people may use these terms to describe themselves, it is important to note that erring to the side of inclusion is likely a good way to go. By indicating someone’s gender was one way before and then they became another gender with healthcare (e.g., “MTF/FTM”) does not resonate with all trans people. Gender-affirming care does not change someone’s gender. Every person is the authority on their own gender. Using terms like “transfemale” (one word) and “male-identifying” caveats identities as being less authentic or as something other than a woman and man, respectively.
Sex/Gender Reassignment Surgery, Sex Change, Gender Confirmation Surgery, Cross-Sex Hormones	Gender Affirming Surgery & Hormone Therapy	Healthcare does not change someone’s gender. Recall above, everyone is the authority on their own gender. “Reassignment” and “confirmation” indicate that care was required to have a different gender than one congruent with sex assigned at birth. Terms like “cross-sex” implies a binary notion of sex and gender - thereby erasing intersex individuals.
Homosexual	Lesbian, Gay, Bisexual, Pansexual, Asexual, Demi-Sexual, Queer People and More	“Homosexuality” and “Homosexuals” were used as both diagnoses per the DSM and as derogatory terms used to marginalize lesbian, gay, bisexual, queer, and other sexual minoritized individuals.
Lifestyle (Choice), Sexual Preferences	Sexual Orientation, Sexual Practices and Partners	It is cisnormative and heteronormative to describe one’s sexual orientation (or gender identity for that matter) as “lifestyle (choice)” and “sexual preferences” - that somehow, LGBTQIA+ people are living “alternative” lifestyles that they choose - and such lifestyles vary in a monolithic way from cisgender straight people. It is also reductionistic to sum up one’s entire life(style) as being contingent on one’s sexual orientation and gender identity. Moreover, consider when these terms are primarily used - to describe LGBTQIA+ people, demonstrating a majority-minoritized conceptualization and utilization pattern.
Preferred/Chosen Pronouns	Pronouns	“Preferred” implies choice in utilization by others. As in - “you can use many pronouns, but these are the ones I like best.”
Ambiguous Genitalia, Hermaphroditic People, Sexual Development Disorders, Abnormal Sex Development	Sex Traits, Intersex People, Differences in Sex Development	Intersex people and their bodies are not disordered, diseased, abnormal, or ambiguous. Intersex traits are also not singular - there are many combinations of hormonal, chromosomal, receptors, etc. that correspond to intersex traits. It’s important to not pathologize intersex people and traits.

Note: Some LGBTQIA+ people may use terms from the left-side column and it is important to respect the language LGBTQIA+ use.

Practice 4: Exercise Creativity in the Occupational Medicine Model and Reject the Role of Neutral Arbiter of Policies

There should be clear boundaries between self and command, especially as it relates to the degree to which one is embedded in the unit. This structure threatens the ethical principle of dual/multiple relationships. Embedded mental health providers must be affirming and responsive when performing command consultations. This work includes being assertive with commanders who may be contributing to harmful environments or experiences (e.g., using a service member's pronouns and refraining from using harmful language), as well as providing basic education regarding gender identity, sex assigned at birth, gender expression, and sexual orientation, as needed. Overall, the military psychologist must hold the needs of the unit, as well as the needs of individual service members, in tandem.

Example: *A psychologist embedded within a unit recognizes that members of the unit repeatedly make fun of a queer service member through derogatory statements disguised as "jokes." The psychologist recognizes this pattern of harassment as being a pervasive issue, which has gone unchecked by unit command. They take steps to consult with unit command as to what is happening, the impact on readiness, and evidence-based practices in reducing harassment, while ensuring that such actions do not make the situation worse for the queer service member. It is important to ensure that the psychologist takes steps to maintain confidentiality; obtaining consent from and providing transparency with the service member is of utmost importance.*

As psychologists and care providers, we are ethically bound and obligated to provide affirming and inclusive care (e.g., Nakamura et al., [2022](#)). Military psychologists are also instructed to be officers first. While military psychologists certainly hold dual roles with obligations to their service, commanding officers, and clients, one should never use their commitment to an institution as a shield to prevent ethical advocacy. The act of advocating for minoritized people and those with marginalized identities is *not* a political one, but one of ethical obligation (Hailes et al., [2021](#); Melton, [2018](#); Singh, [2016](#)). Therefore, providing LGBTQIA+ affirming and inclusive care may mean advocating for inclusive environments and practices through command-directed actions and recognizing the impact of discrimination, harassment, and other forms of oppression in the military.

Example: *A military psychologist providing evaluation services as part of a transgender service member's medical evaluation board recognizes that repeated harassment and discrimination related to the service member's gender identity, and subsequent omnipresent threats of such harassment and discrimination, are directly attributable to posttraumatic stress disorder. The psychologist does not minimize the service member's reports of trauma*

as they related to harassment and discrimination, but instead, believes the service member when they indicate these experiences were traumatic.

The U.S. Military Health System operates under an occupational health model (Collmann, [2009](#)) whereby the primary responsibility of all providers is to continually assess fitness for duty. Therefore, psychologists have the power to render diagnoses that have significant implications to a service member's career longevity, limited duty status, medical separation, and disability compensation upon medical separation. Historically, some military psychologists have separated service members on the basis of gender identity and sexual orientation (Bérubé, [2010](#); Burks, [2011](#); Dietert & Dentice, [2022](#); Scott & Stanley, [1994](#)). More recently, psychologists may serve as gatekeepers for gender-affirming healthcare. Thus, it is incumbent on military psychologists to engage in critical evaluation of their role and exercise creativity to ethically work with clients (Flynn et al., [2021](#)). Military psychologists must work to mitigate documented barriers to obtaining affirming and inclusive care, such as the requirement for a client to receive a diagnosis corresponding to gender dysphoria to receive gender-affirming treatments or having healthcare encounters with harmful providers (Ashley, [2021](#); Crissman et al., [2022](#); Glick et al., [2018](#); Romanelli & Lindsey, [2020](#)). The care requirements in place by the Department of Defense often decrease the accessibility of gender affirming care for gender diverse service members and place burdens on psychologists as gatekeepers of such care. Some psychologists may perceive gender dysphoria as requiring a presentation that is one of significant functional problems - and therefore, any recommendation for gender-affirming healthcare would be *curative*, whereas a creative approach is to recognize that gender-affirming care can be *preventative*.

Example: *A non-binary client presents to care indicating they are trans and are currently seeking gender-affirming chest surgery. To qualify for surgery, they need to have a diagnosis of gender dysphoria. However, they are not depressed and describe feeling pleasure and support in their social activities and relationships and do not desire gender-affirming hormone therapy. They may be wearing makeup and feminine clothing. The responsive psychologist believes the client and recognizes that the client is coming to care with the express goal of qualifying for medically-necessary, gender-affirming chest surgery. The psychologist also recognizes that gender identity and gender expression are separate constructs, and that there are no "rules" about the need for each construct to "match" one another. The psychologist then takes steps to ask the minimal number of questions needed to assess gender dysphoria, recognizing that the client's symptoms would worsen without receipt of gender-affirming chest surgery and that the client is currently engaging in 'compensated coping' - which is effort they could be dedicating to other aspects of their life and occupational functioning.*

Practice 5: Shape Discussions with Criticism of Institutions and Environment before the Person

Despite the noted violence and harms perpetuated by *Don't Ask, Don't Tell* and the trans-ban policies (Bérubé, 2010; Burks, 2011; Dietert & Dentice, 2022; Scott & Stanley, 1994), there has been no restoration or reparation. Many harmful components of such policies continue to exist. Despite an Executive Order ([Office of the President of the United States](#)), there remains an effective ban on asking service members their sexual orientation and gender identity for the purposes of quality improvement and health services research, without significant governance approvals that reach higher echelons of review per other existing policy. There remains a lack of acknowledgement for the existence of non-binary service members, as evidenced by the rigid gender binary options listed in DEERS and fitness and grooming standards. Criteria for service accession by intersex persons, as outlined by the Department of Defense Instruction 6130.03 (Department of Defense, 2022), is fraught with not only harmful language (e.g., “hermaphroditism, pseudohermaphroditism”), but specifically limits the service of some intersex persons as outlined in the sections “*Female Genital System*” and “*Male Genital System*” based on anatomy - not actual functioning - as it relates to readiness. And unlike the Veterans Administration (Department of Veterans Affairs, 2018, 2020), there is no unified means by which LGBTQIA+ individuals can self-identify, if so desired, to contribute to overarching programs of healthcare optimization. Thus, the system structures and policies in place as part of *Don't Ask Don't Tell* and the trans bans are not simply artifacts in the current Military Health System. Being critical is not akin to embodying political dissidence, but is the act of identifying areas of improvement and taking steps to contribute to evolving policies, procedures, and programs that promote equitable work and healthcare environments.

The disempowerment of LGBTQIA+ service members compounds with the continued lack of guidance and policies on gender-affirming healthcare - both for service members, as well as for individuals practicing in states with anti-trans legislation. With such continued delays, military psychologists may continue to field anti-trans and bigoted statements guised as bad-faith “questions” regarding the readiness of LGBTQIA+ service members on the basis of their sexual orientation and gender identity (e.g., “Can trans people even be deployed?”), as well as “whataboutism” (e.g., “what if they just separate anyways”). It is important for military psychologists in all positions of leadership and authority (e.g., policy and program development) to reject questions outright and reframe these statements with clear reminders of the historical oppression and discrimination of LGBTQIA+ individuals, particularly in the military. Military psychologists also need to advocate for LGBTQIA+ individuals to be part of any governing body tasked with shaping policies, programs, and educational efforts within the Military Health System that are relevant to LGBTQIA+ individuals. Psychologists have an ethical obligation to advocate for policy development that is done in partnership

with empowered LGBTQIA+ persons who have the agency to make decisions. This point is especially salient given the historical and ongoing mistreatment of LGBTQIA+ service members and family members (Oblea et al., 2022; Oswald & Sternberg, 2014; Ritchie et al., 2018).

Example. *A military healthcare provider indicates at a team huddle that trans patients require extra care because they are vulnerable. The healthcare provider then states that trans people die by suicide way more often than cisgender people. The military psychologist can respond here by indicating something like: “It is important to remember oppressive and discriminatory structures and systems historically experienced by trans people, which have been linked to psychiatric concerns and diagnoses. Evidence indicates that trans people who experience affirming and equitable living, work, and family environments and gender affirming healthcare are much less likely to experience suicidal ideations and psychological distress.”*

Conclusion

We hope that these practice steps and their descriptions above provide tangible support in conducting affirming care and ethical advocacy in support of LGBTQIA+ people and our communities. It is the ethical responsibility for psychologists to abide by these principles and contribute to the evolving nature of what it means to provide affirming care. It is important to underscore that these are not principles that can be maintained through passivity, and psychologists should strive to take an action-oriented approach to provide responsive, affirming, and inclusive LGBTQIA+ psychological care. Moreover, while we sought to provide comprehensive recommendations, this list is not exhaustive. The responsibility of psychologists to be on the forefront of advocacy and action within the communities of our patients is one that requires continuous attention and dedication.

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