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Pride in all Who Served: Development, Feasibility, and Initial Efficacy of a Health Education Group For LGBT Veterans

Tiffany M. Lange, Psy.D^a, Michelle M. Hilgeman, Ph.D^{b,c,d}, Kaitlin J. Portz, Ph.D^e, Vincent A. Intoccia, Psy.D^b, and Robert J. Cramer, Ph.D^f

^aOffice of the Associate Director, Hampton VA Medical Center, Hampton, VA, USA; ^bResearch and Development Service, Tuscaloosa VA Medical Center, Tuscaloosa, AL, USA; ^cPsychology Department & Alabama Research Institute on Aging, University of Alabama, Tuscaloosa, AL, USA; ^dDepartment of Medicine, University of Alabama at Birmingham (UAB), Birmingham, AL, USA; ^eSiteman Cancer Center, Siteman Psychology Service, Barnes-Jewish Hospital, St. Louis, MO, USA; ^fDepartment of Public Health Sciences, University of North Carolina at Charlotte, Charlotte, NC, USA

ABSTRACT

Many of the more than 1 million military veterans who identify as lesbian, gay, bisexual, and/or transgender (LGBT) have encountered “rejecting experiences in the military” and stigma from prior “Don’t Ask Don’t Tell” policies. Associated minority stress and social isolation have been linked to a disproportionate risk for depression and suicide, as well as a reluctance to seek medical care at Veterans Health Administration (VHA) facilities. This paper describes feasibility and preliminary outcomes of the newly developed, Pride in All Who Served Health Education Group created to meet the unique needs of sexual and gender minority veterans. The 10-week, closed, health education group (e.g., continuums of identity, military culture) enables open dialogue, fosters social connectedness, and empowers veterans to be more effective self-advocates within the healthcare system. Feedback from formative evaluations ($n = 29$ LGBT veterans and $n = 25$ VHA stakeholders) was incorporated before conducting a small scale, non-randomized pilot. Preliminary pre-post surveys ($n = 18$) show promise (i.e., *Cohen’s d* range ± 0.40 to 1.59) on mental health symptoms (depression/anxiety, suicidal ideation), resilience indicators (identity affirmation, community involvement, problem-focused coping), and willingness to access care within the VA system (satisfaction with VA services, perception of staff competence). Results suggest that the 10-week Pride Group may be an effective tool for addressing minority-related stress in LGBT veterans. A full-scale, randomized clinical trial of this intervention is needed to determine short and long-term impacts on clinical and healthcare access-related outcomes.

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CONTACT Michelle M. Hilgeman  Michelle.Hilgeman@va.gov  Clinical Psychologist, Research & Development Service (151), Tuscaloosa VA Medical Center, 3701 Loop Road, Tuscaloosa, AL 35404

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Introduction

Lesbian, gay, bisexual, and transgender (LGBT) veterans represent an often-invisible group of individuals at risk for discrimination, internalized stigma, and health inequities (Livingston et al., 2019). LGBT persons in general face a disproportionate risk for hate crime victimization (Herek et al., 2009), with lifetime prevalence estimates ranging from approximately 15–33% depending on source and measurement approach (e.g., Burks et al., 2018; Cramer et al., 2018; Herek et al., 1999). Additionally, the Institute of Medicine (2011) documented LGBT persons are at risk for a multitude of concerns such as depression, anxiety, and suicide, largely because of discriminatory and victimization experiences. Indeed, suicide rates among sexual minority individuals are 3–4 times higher than their heterosexual counterparts (Hottes et al., 2016). The Minority Stress Model (Meyer, 2003, 2013) explains potential pathways to mental and physical health risk for LGBT persons. Among the pertinent theoretical tenets is that both general and minority-specific experiences (e.g., discrimination, internalization of prejudice or stigma) can impact risk for negative health outcomes, a premise echoed by Herek's (2016) stigma-based understanding of LGBT health. Such pathways may be mitigated or exacerbated by a range of factors such as coping skills, community and social support, and minority identity characteristics (e.g., integration, valence; Meyer, 2013). Importantly, recent literature has extended the Minority Stress Model to transgender and gender non-conforming (TGNC) persons in domains of theory and research (Testa et al., 2015), as well as clinical recommendations for practitioners working with TGNC patients (Hendricks & Testa, 2012).

Experiences with military culture and previous policies compound the risk for LGBT service members and veterans. Many of the more than 1 million veterans who identify as LGBT have encountered social rejection and stigma influenced by US military bans on openly lesbian, gay, bisexual or transgender service members (e.g., "Don't Ask Don't Tell" in place from 1994 to 2011), (Ramirez & Sterzing, 2017; Sherman, Kauth, Ridener et al., 2014). Following such experiences, lesbian and bisexual female veterans – an estimated 10% of women veterans from recent conflicts in Iraq and Afghanistan – are at increased risk for suicide (e.g., Lehavot & Simpson, 2014; Matarazzo et al., 2014), whereas gay male veterans are at increased risk of depression and substance abuse (Cochran et al., 2013). Transgender veterans' risk of suicide is 20 times higher than for general veteran populations – representing one of the greatest demographic-related mortality inequities documented across populations (Blosnich et al., 2013; Curtin et al., 2016). Recent application of the Minority Stress Model to transgender veteran suicide risk (Tucker et al., 2019) validated and implicated transgender-specific external (e.g., rejection, discrimination) and internal (e.g., internalization of stigma) stress processes in recent suicidal ideation. Prejudice and well-being concerns have further downstream impacts on LGBT veterans.

One study highlighted that 24% of LGBT veterans had not disclosed their sexual orientation or gender identity status to any VA provider (Sherman, Kauth, Shipherd et al., 2014), suggesting that the disproportionate prevalence of LGBT health concerns may go undetected by many practitioners.

Ramirez and colleagues published the first intervention work in this space using Queer theory to inform an open-ended, LGBTQ+ veteran support group (Ramirez & Sterzing, 2017). Their rich contextualization (Ramirez & Sterzing, 2017; Ramirez & Bloeser, 2018; Ramirez et al., 2013), a rapidly expanding LGBT veteran literature, and a 3-phase local needs assessment informed the novel clinical health education program described here. For example, providing education on the Minority Stress Model's unique manifestations in the military (e.g., historically intrusive investigations and dismissals of LGBT service members) is a central element in establishing the Veterans Health Administration (VHA) as an affirming environment for health care. Similarly, to begin redress of LGBT veteran health disparities and build LGBT veteran resilience, a Queer Theory perspective suggests infusion of LGBT content in trainings, spaces and resources, as well as creating safe "underground" LGBT veteran networks (e.g., closed groups). Creation of a closed group is further supported by Minority Stress Models (Meyer, 2013; Testa et al., 2015) which hold that fostering LGBT peer and community support can buffer against manifestation of negative health outcomes and promote redefining one's marginal identity as a source of strength (Unger, 2000).

Provider- and patient advocate-focused initiatives continue to expand in an attempt to shift the culture for LGBT veterans (e.g., Cramer et al., 2019; Kauth et al., 2019), with promising impacts such as improvement in LGBT veteran comfort disclosing identity. A critical next step is the development of LGBT veteran-focused health programming. Such approaches may enable more direct impacts on health outcomes such as positive health behavior, increased social connectedness, and building resilience through awareness, community involvement and self-advocacy in healthcare settings. Community involvement and social justice/advocacy are of interest, as they have seen recent attention as a positive manifestation of LGBT identity (Riggle et al., 2014); advocacy and social justice in particular are often associated with positive mental health and well-being for LGBT persons (e.g., Cramer et al., 2017; Riggle et al., 2014; Rostosky et al., 2018).

Development of a new clinical service for LGBT veterans

This paper describes a newly developed, manualized 10-week health education group for LGBT veterans (Lange-Altman, 2018). The group content was developed by the first author (TL) with input from LGBT veterans to respond to critical health-care needs to address isolation, trauma, discrimination, and

poor access to mental health services. The resulting structured group approach facilitates healing from collective trauma (e.g., experienced stigma, discrimination) by providing a corrective emotional experience within the VA healthcare setting. This paper describes the initial feasibility and pilot testing of the group at the development site (Hampton VA) and a new VA facility (Tuscaloosa VA), one predominantly urban and the other more rural. The phased evaluation includes veteran outcome data centered on mental health symptoms (i.e., depression, generalized anxiety, suicide risk), identity (i.e., socio-cultural experiences as a sexual and/or gender minority person), and resilience (i.e., coping self-efficacy, positive identity development).

Though this body of work was developed as an innovative clinical program and not a research study, we evaluated whether the program would result in the following positive impacts for veteran participants:

- (1) Improved mental health (e.g., reduced symptoms of depression, suicidal ideation).
- (2) Decreased self-perceived negative identity-related characteristics (e.g., internalization of heterosexist beliefs, pressure to conceal one's minority identity).
- (3) Enhanced coping self-efficacy (e.g., belief in use of thought stopping or getting social support) and positive identity (e.g., increasing involvement in LGBT community, enhanced self-awareness).

We also tracked feasibility-related indicators of importance to the VA Health Administration that would impact implementation in other facilities within the VA healthcare system:

- (1) Improved perception of the VA as a healthcare provider, VA providers as affirming, and willingness to disclose LGBT identity to VA providers.
- (2) Satisfaction with the group and support for maintaining the group long term.

Health education group

Pride in All Who Served: A Health Education Support Group for LGBT Veterans (called the *Pride Group*, for short; Lange-Altman, 2018) is a manualized program of veteran-focused content, psycho-educational handouts and resources, self-reflection exercises/tools, and guided discussion questions that encourages group-level processing (see Table 1). Weekly topics include (1) continuums of identity, LGBT terminology, and definitions, (2) coming out, emergence, and disclosure, (3) identity models, (4) military culture, (5) VA culture, (6)

Table 1. PRIDE in All Who Served Group Session Content and Delivery Support Tools.

Session	Topics Covered	Example Resources	How Covered
PRIDE Group Manual Topics and Sample Resources			
1	Continuums of Identity; Terminology	The Genderbread Person v2.0 (itspronouncedmetrosexual.com) (IPM, 2018)	Psychoeducation, process, group discussion
2	Coming Out Process	Coming Out Support (HRC, 2020) (thetrevorproject.org/section/YOU , The Trevor Project, 2020; www.hrc.org/explore/topic/coming-out)	Psychoeducation, process, group discussion, role play
3	Identity Models	Including Cass (1979) Homosexual Identity Model; Lev (2004) Transgender Emergence Model	Psychoeducation, process, group discussion
4	Military Culture – Then and Now	Discharge Upgrades (www.vets.gov/discharge-upgrade-instructions); Coming Out in Camouflage (Ramirez & Sterzing, 2017)	Psychoeducation, process, group discussion
5	VA Culture – The Changes Ahead	VHA Directives (www.patientcare.va.gov/LGBT); Healthcare Equality Index (www.hrc.org/hei), (HRC, 2018)	Psychoeducation, process, group discussion
6	Affirmative Care; Whole Health	Whole Health (https://www.va.gov/wholehealth/); Ask Me 3 (www.npsf.org/ask3) (IHI, 2020)	Psychoeducation, process, group discussion, role play; Optional: co-facilitated by Whole Health Coordinator, completion of Advance Directive
7	Sexual Health	HIV Prevention and Treatment (www.hiv.va.gov); Barrier Protections (CDC, 2020; www.cdc.gov/condomeffectiveness/dental-dam-use.html)	Psychoeducation, process, group discussion; Optional: co-facilitated by Infectious Disease provider
8	Healthy Intimate Relationships; Safety in Relationships	Safety Planning and Resources (The National Domestic Violence Hotline: 1–800–799–7233, National Domestic Violence Hotline, 2020; loveisrespect.org , Love is Respect, 2020; www.socialwork.va.gov/IPV)	Psychoeducation, process, group discussion, role play; Optional: co-facilitated by IPV Coordinator
9	LGBT Families	VHA Directives (www.patientcare.va.gov/LGBT); Family Support (PFLAG.org, PFLAG, 2020)	Psychoeducation, process, group discussion; Optional: completion of Advance Directive
10	Community Resources and Engagement	Crisis Resources (Veterans Crisis Line, Trans Lifeline, 2020); Local LGBT Support Services (e.g., housing, legal, occupational)	Psychoeducation, process, group discussion, certificates of completion
PRIDE Group Delivery Support Tools			
Facilitation Need		Example Tools / Resources Provided	
Recruitment and Referrals		Lessons learned, sample flyer and brochure templates, example e-mail notifications, identifying a neutral group room location, consultation	
Creating a Welcoming Environment		Safe Zone images, guidance on increasing visibility, coaching on systemic change efforts	
Documentation Templates		Electronic health record note and consult templates, recommended note titles, electronic clinic set up resources, encounter and billing codes	
Consultation Calls		Weekly problem solving for group facilitators during initial group implementation, resource sharing, networking with other group facilitators	
Launch Site Visit		Meeting with leadership to secure systemic support, prioritizing goals to create a welcoming environment, train-the-trainer for staff education (see below), support completing the facility-level Healthcare Equality Index (HEI) (HRC, 2020)	
Staff Training		Complementary provider- and staff-focused training materials are included in the manual that parallel content in the health education group	

affirmative care and whole health, (7) sexual health, (8) healthy intimate relationships, (9) LGBT families, and (10) community resources and conclusions. The manual also includes delivery support tools for the group facilitator (i.e., clinician or health educator) such as guidance on (1) creating an affirmative environment, (2) setting-up referral and documentation processes, (3) conducting pre-screening procedures, (4) handling difficult group discussion topics and situations, (5) establishing group rules and confidentiality, and (6) self-rated treatment fidelity forms. Sample staff training materials (i.e., a 1-hour version of PowerPoint slides) are also provided to enable complementary training for VA healthcare staff on LGBT health issues that mirrors the content veterans receive (see Table 1). The manual is available on request from the study authors.

The Pride Group content and evaluation are grounded in both the Minority Stress Model (Meyer, 2003, 2013) and Queer Theory on resilience among LGBT military personnel (Ramirez & Sterzing, 2017). Central themes focus on processing experiences and internalization of prejudice, enhancement of coping and social support, and understanding self-identification of minority identity (see Figure 1, adapted from Meyer, 2013 and Testa et al., 2015). Given this focus, the group does not directly address mental health symptoms and is not positioned as a mental health group. However, if improvements in well-being, resilience, social connectedness, and identity affirmation are observed after participating, reduction in sexual and gender minority veteran suicides would be anticipated.

Health education implementation and evaluation

Two VA Medical Centers (the development site and a new pilot site) implemented the closed, 1-hour, 10-week health education group. Program

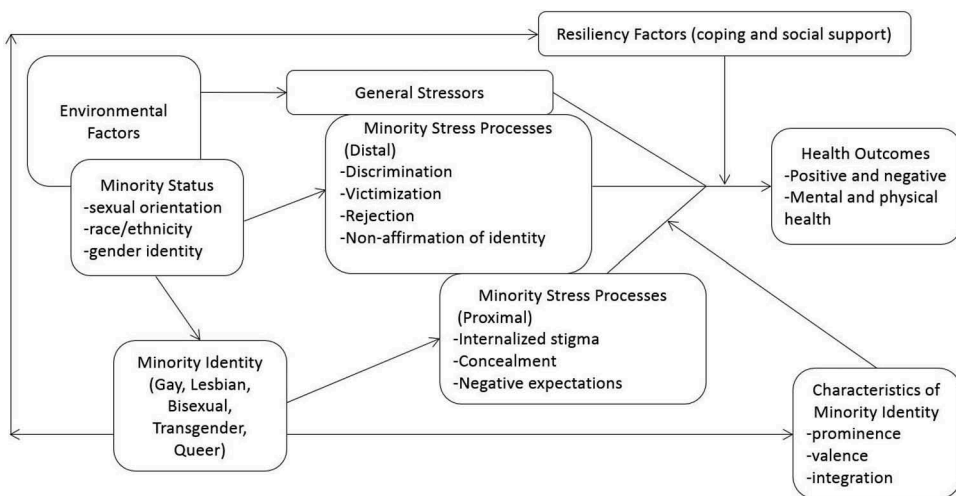


Figure 1. LGBT Minority Stress Model adapted from Meyer (2013) and Testa et al. (2015).

evaluation plans were reviewed by the Tuscaloosa and Hampton VA Medical Centers' and Old Dominion University Human Subjects Review Boards. The evaluation of feasibility and preliminary efficacy testing was conducted across three phases: (1) formative veterans needs assessment, (2) VA stakeholder interviews, and (3) pilot implementation and evaluation of the health education program at two VA facilities. Written instructions described the purpose of collecting outcome measures, that paper surveys should be completed anonymously and were completely voluntary. Additional written informed consent was not obtained.

Formative needs assessment

Phase one consisted of a structured survey of 37 LGBT-identifying veterans who had the opportunity to provide program feedback during a trial phase of the health education program. A total of 29 veterans completed open-ended feedback. Two investigators (RC & MH) reviewed these short responses, coding for themes. Themes emerging from this feedback demonstrated both desire for and benefit from the program, as well as expression of clear need for further development. Responses to open-ended questions concerning program benefits highlighted (frequency of each thematic endorsement in parentheses): a) enhanced social connectedness (e.g., "[The group] gave me a sense of belonging." $n = 15$), b) improved sense of well-being (e.g., "The group helped me to the core" $n = 5$), c) learning about gender identity (e.g., "Talking about gender identity has been a lot of fun for me" $n = 6$), and d) increased comfort with self-identity (e.g., "The group gave me the confidence to come out to my wife and closer friends!" $n = 7$). These themes informed selection of quantitative evaluation assessments for the primary pilot project (see instruments section). Areas of veteran-suggested improvement concerned content revision (e.g., "[I] would like to address some specific topics about transgender [identity]." $n = 6$), and increasing program length and sustainability (e.g., "My concern is directed toward ensuring that this group remains an option for future generations." $n = 8$). These needs were addressed in the design of the manual to include additional system-support related content (Lange-Altman, 2018; see Table 1).

VA stakeholder interviews

Phase two consisted of key VA staff stakeholders participating in a series of meetings and interviews. Stakeholder interviews occurred at both sites, the development site and the new pilot site. Stakeholders ($n = 25$) spanned VA hospital administration, clinical staff (e.g., mental health, endocrinology, etc.), employees that identify as LGBT, police services, diversity committee members, and non-VA community agency partners/advocates. Questions focused on understanding current hospital initiatives serving LGBT veterans,

available resources, organizational culture, and leadership support. Potential barriers and logistical considerations were also discussed (e.g., safety, confidentiality, privacy, discrete documentation practices, organizational alignment). Resulting themes depicted both staff and administration interest and readiness for program implementation, as well as barriers to consider (e.g., widespread lack of resources, staff competency to deliver the program). To address staff competency barriers, education materials that parallel group content were developed for inclusion in the facilitation manual (Lange-Altman, 2018; see Table 1). In addition, group facilitators were trained and weekly telephone consultation was provided by the program developer (TL).

Program implementation and evaluation

Phase three consisted of the following: 1) providers were encouraged to make referrals to the group; 2) flyers with pull-tabs were distributed throughout the facility for self-referral; and 3) information was posted on internal televisions around the facility to enable self-referral. Early recruitment efforts consisted of offering staff trainings, making announcements during staff meetings, and internal e-mail distributions. An approach that incorporated both staff involvement and self-referral promoted a consistent message of diversity inclusion and affirmative care. Interested veterans were screened to ensure that they: (1) identified as a sexual or gender minority (SGM); (2) were questioning sexual orientation or gender identity; (3) felt isolated or disconnected from other veterans related to their sexual orientation or gender identity; (4) served before or during Don't Ask Don't Tell (DADT) or received a discharge related to their sexual orientation or gender identity; (5) experienced harassment or punishment during military as a result of sexual orientation or gender identity; and/or (6) had a desire to learn more about personal identity and relevant healthcare disparities. Exclusion criteria focused on readiness for the program or barriers to meaningful engagement in the group process, such as having active substance use and/or a serious mental illness that interfered with functioning, or promoting unethical practices (e.g., conversion therapy). Priority was given to overall care needs of each referral, with preference for group inclusion over group exclusion. Those participating in the program completed voluntary pre-post assessments using paper and pencil surveys described below. Participants were encouraged to attend all sessions of the 10-week program.

Program evaluation instruments

The following measures were utilized to evaluate preliminary outcomes of the 10-week Pride Group. The surveys were selected for their clinical relevance, fit with current conceptual models of positive identity development and minority stress (e.g., Mohr & Kendra, 2011; Riggle et al., 2014), and brevity to ensure a feasible assessment battery in a clinical setting.

Demographics

A brief demographic questionnaire assessed age, race, ethnicity, sexual orientation, gender identity, sex assigned at birth, medical conditions, veteran status, branch of service, and LGBT community involvement. Extensive lists of sexual and gender identity labels were provided to participants including options to fill in unique/other category and/or to check multiple identities should a participant desire to do so. As such, veterans could report unique self-label(s).

Mental health-related symptoms

Depression, anxiety, and suicide symptoms were assessed via three instruments: Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001), Generalized Anxiety Disorder-7 Scale (GAD-7; Spitzer et al., 2006), and the Suicidal Behaviors Questionnaire-Revised (SBQ-R; Osman et al., 2001). The PHQ-9 is a measure of depressive symptoms each rated on a 0–3 scale. The measure demonstrates good internal consistency ($\alpha = .86-.89$; Kroenke et al., 2001), and values were .90 (pre) and .89 (post) in the present sample. The GAD-7 is an assessment of generalized anxiety symptoms, each rated on a 0–3 scale. The measure demonstrates good internal consistency ($\alpha = .92$; Spitzer et al., 2006), and values were .88 (pre) and .90 (post) in the present sample. The SBQ-R is a 4-item suicide risk screener containing separate items for varying aspects of suicide-related behavior (each rated on varying scales). A total score can be tabulated (α range = .76–.88; Osman et al., 2001); however, as we were interested in pre-post change in well-being, we utilized the last item because it provides a future-oriented assessment of suicide attempt risk.

Identity

Sexual minority identity was assessed with the 27-item Lesbian, Gay, and Bisexual Identity Scale (LGBIS; Mohr & Kendra, 2011). The instructions retained focus on sexual orientation and not gender identity; however, the following was added to clarify intent for participants who did not identify as lesbian, gay, or bisexual (i.e., “For those identifying as heterosexual but as gender diverse, please respond to the items on this page only as you feel comfortable in how they may apply to you”). The LGBIS assesses domains of sexual minority identity: acceptance concerns (i.e., extent of fear of negative judgment or rejection by others; $\alpha = .77-.82$); concealment motivation (i.e., extent to which one feels pressure to hide LGB identity; $\alpha = .72-.78$); identity uncertainty (i.e., degree of vacillation in self-identifying as LGB; $\alpha = .88-.93$); internalized homonegativity (i.e., level of internalization of heterosexist beliefs or sexual stigma; $\alpha = .87-.89$); difficult process (i.e., extent to which accepting one’s own LGB identity has been challenging; $\alpha = .79-.86$); identity superiority (i.e., degree to which one feels LGB identity

makes them unique; $\alpha = .78-.82$); identity affirmation (i.e., extent to which one has resolved coming out/embraced identity; $\alpha = .89-.94$); and identity centrality (i.e., degree to which one's LGB identity is a core feature of identity; $\alpha = .84-.86$). Internal consistency values in the present study ranged from .54-.94.

Resilience

Two measures evaluated veteran resilience: the Coping Self-Efficacy Scale (CSE; Chesney et al., 2006) and the Lesbian, Gay, and Bisexual Positive Identity Measure (LGB-PIM; Riggle et al., 2014). The CSE is a thirteen-item measure (rated on a 0–10 scale) yielding three subscales: problem-focused coping ($\alpha = .91$), stopping unpleasant thoughts and emotions ($\alpha = .91$), and getting social support ($\alpha = .80$). Internal consistencies in the present sample ranged from .87-.97. The LGB-PIM contains 25 items (rated on a 1–7 scale) assessing self-concept and social aspects of sexual and gender minority identity; higher scores reflect more positive identity. Items are phrased so that they also apply to gender minority persons (Riggle et al., 2014). The five dimensions are self-awareness (i.e., extent to which one believes LGBT identity has increased their insight); authenticity (i.e., degree of comfort expressing one's LGBT identity in social situations); community involvement (i.e., extent of perceived involvement in and support from the LGBT community); intimacy (i.e., extent of belief that one's LGBT identity enhances capacity for closeness and sexual freedom); and social justice beliefs (i.e., extent to which one's LGBT identity has influenced focus on activism and social justice to overcome oppression; Riggle et al., 2014). Internal consistency values in the present sample ranged from .75-.93.

Veteran engagement and feedback

A primary feasibility indicator was Veteran perception of the program, which was gathered in two formats. First, participants responded to seven satisfaction and engagement questions (each rated on a 1–7 scale) assessing perception of staff cultural competence, VA health services delivery, overall experience with the program, intent to use program content and resources, intent to recommend the program to other veterans, intent to become further involved in the LGBT community, and intent to use VA healthcare services because of the program. A composite satisfaction score of these items yielded acceptable reliability (.82). Next, two open-ended questions requested suggestions to improve: (a) the VA's response to LGBT veteran needs, and (b) the Pride Group program.

Program evaluation analyses

Multiple imputation was not used to handle missing data because of the small sample size.¹ Person-mean substitution was used where individual measures lacked responses to 25% of items or less.² This imputation approach was only necessary for LGBT veteran responses to 16 total missing items. Paired-samples *t*-tests with Cohen's *d* effect sizes were implemented to evaluate pre-post program changes in LGBT veteran mental health, identity, coping skills, and program/services satisfaction (Cohen et al., 2003). Finally, qualitative summaries of LGBT veteran program and service feedback are provided. Sufficient amounts of data were lacking for formal qualitative or thematic analysis.

Program evaluation results

Participants

A total of 22 LGBT veterans ($M = 46.77$ years old, $SD = 14.47$) took part in the program across sites (5 from one site and 17 from the other). Sexual orientation was reported as gay (22.7%, $n = 5$), pansexual (22.7%, $n = 5$), lesbian (18.2%, $n = 4$), straight (9.1%, $n = 2$), and the following categories of 4.5% ($n = 1$) don't know, queer, bisexual, other (i.e., transgender – this person identified their sexual orientation with this label), and multiple (unique identity pattern not reported to maintain anonymity). Gender identity was reported as female (31.8%, $n = 7$), transgender female/male-to-female (27.3%, $n = 6$), male (22.7%, $n = 5$), transgender male/female-to-male (9.1%, $n = 2$), and the following categories of 4.5% ($n = 1$) – gender queer and multiple (unique identity pattern not reported to maintain anonymity). Sex at birth was reported as male (54.5%, $n = 2$) and female (36.4%, $n = 8$), with 2 veterans electing not to report such information. Race was reported as White (50%, $n = 11$), Black (31.8%, $n = 7$), and Other (18.1%, $n = 4$). The sample was 90.9% ($n = 20$) non-Hispanic. Nineteen (86.4%) were veterans only, with another 3 (13.6%) indicating they were both veterans and familial relation to other service members or veterans. Military branches represented were Army (40.9%, $n = 9$), Navy (40.9%, $n = 9$), Air Force (13.6%, $n = 3$), and Coast Guard (4.5%, $n = 1$).

Pre-post program veteran well-being, identity, and resilience

Table 2 contains summary statistics for pre-post health education program participation impacts on well-being, identity, and resilience.

¹Missing data on scale items ranged from 0% to 40.9%, yielding analyzable data available from 18 to 22 (81.8%) of LGBT veterans.

²This approach to data imputation has documented limitations in the statistical literature.

Table 2. Preliminary Outcomes of the Pride in All Who Served LGBT Veteran Health Education Group (N = 18).

Outcome	Pre-Program M(SD)	Post-Program M(SD)	T(df)	p	Cohen's d	Descriptor of Effect
<i>Mental Health-Related Symptoms</i>						
Depression¹	11.69(7.80)	8.77(6.65)	-2.08(12)	.06	-0.58	Moderate
Anxiety²	9.77(6.58)	7.08(5.28)	-3.06(12)	.01	-0.85	Large
Suicide Attempt Likelihood³	1.94(1.51)	0.83(0.92)	-3.56(17)	.003	-0.84	Large
<i>Identity</i>						
Acceptance Concerns	10.58(5.27)	9.63(4.79)	-1.52(16)	.15	-0.36	Small
Concealment Motivation	9.35(3.39)	9.23(3.86)	-0.23(16)	.82	-0.06	-
Identity Uncertainty	7.96(5.22)	6.47(3.28)	-2.78(16)	.01	-0.67	Moderate-to- Large
Internalized Homonegativity	6.65(4.48)	5.41(3.48)	-1.66(16)	.12	-0.40	Moderate
Difficult Process	10.11(4.99)	9.23(4.44)	-1.28(16)	.22	-0.31	Small
Identity Superiority	4.76(2.08)	4.59(2.03)	-0.50(16)	.63	-0.12	-
Identity Affirmation	13.76(4.11)	15.34(3.14)	2.98(16)	.009	0.73	Large
<i>Resilience</i>						
Identity Centrality⁵	21.59(6.71)	23.76(4.48)	2.34(16)	.03	0.57	Moderate
Self-Awareness⁵	26.89(8.41)	29.00(5.44)	1.88(17)	.08	0.44	Moderate
Authenticity⁵	28.61(7.60)	30.67(5.43)	2.52(17)	.02	0.59	Moderate
Community Involvement⁵	19.44(8.15)	26.00(7.86)	4.83(17)	<.001	1.14	Large
Intimacy⁵	21.72(9.56)	26.67(5.54)	2.39(17)	.03	0.56	Moderate
Social Justice Beliefs ⁵	28.44(5.63)	30.55(4.94)	1.58(17)	.13	0.37	Small
Problem-focused Coping⁶	37.11(15.57)	42.72(15.87)	2.96(17)	.009	0.70	Large
Stopping Unpleasant Thoughts⁶	21.22(10.87)	24.50(11.33)	1.92(17)	.07	0.45	Moderate
Getting Social Support⁶	14.94(9.33)	19.00(8.37)	1.95(17)	.07	0.46	Moderate
<i>Veteran Satisfaction & Feedback</i>						
Staff Cult. Competence⁷	3.80(1.95)	6.00(1.03)	6.73(17)	<.001	1.59	Large
Satisfaction with VA Services⁷	4.86(1.71)	6.11(1.13)	3.74(17)	.002	0.88	Large

Notes: ¹PHQ-9 total, ²GAD-7 total, ³SBQ-R item 4, ⁴LGBIS subscale, ⁵LGB-PIM subscale, ⁶Coping Self-Efficacy subscale, ⁷VAMC derived question; **Bold** denotes potentially meaningful outcomes that warrant further study in a larger trial. df = degrees of freedom; Descriptor of effect = small (± 0.2), moderate (± 0.5), or large (± 0.8); Effect size directions specified so negative values denote pre-post program reductions.

Depression, anxiety, and suicide symptoms

Pre-post program scores showed reductions in symptoms of mental health as follows: a moderate sized reduction in depression, as well as large sized reductions in anxiety and likelihood of enacting a future suicide attempt. Clinical guidelines exist in the literature for symptoms of depression (Kroenke et al., 2001) and anxiety (Spitzer et al., 2006); veterans' pre-post depressive symptom changes in the present study reflect a clinically meaningful change from, on average, moderate to mild depression, reflecting a decreased likelihood of satisfying criteria for a depressive diagnosis

(Kroenke et al., 2001). Veterans' pre-post anxiety symptom changes in the present study, however, reflect a less clinically meaningful shift from the moderate-mild cutoff to mild anxiety (Spitzer et al., 2006).

Identity

Pre-post program scores showed meaningful negative identity improvements as follows: a moderate to large reduction in identity uncertainty, as well as a moderate reduction in internalized homonegativity. However, the following aspects of identity were unaffected by program participation: acceptance concerns, concealment motivation, difficult process, and identity superiority.

Resilience

Pre-post program scores showed meaningful positive identity enhancements as follows: large increases in identity affirmation and community involvement, as well as moderate increases in identity centrality, self-awareness, authenticity, and intimacy. No impact on social justice beliefs was observed. Pre-post program scores showed meaningful coping-related belief enhancements as follows: a large increase in problem-focused coping beliefs, as well as moderate increases in beliefs related to stopping unpleasant thoughts/emotions and getting social support. Finally, pre-post program scores showed meaningful and large improvements in LGBT veteran perceptions of staff cultural competence and overall satisfaction with VA services.

Veteran program satisfaction and feedback

Veteran program satisfaction

Descriptive data suggested high satisfaction with and intent to use health education program content (items rated on a 1 to 7-point scale). LGBT veterans expressed very high satisfaction with the health education program ($M = 6.83$, $SD = 0.38$). LGBT veterans also expressed high to very high intent to use program content across the following domains: intent to use program content and resources ($M = 6.44$, $SD = 0.78$), intent to recommend the program to other veterans ($M = 6.78$, $SD = 0.55$), intent to become further involved in the LGBT community ($M = 5.72$, $SD = 1.18$), and intent to use VA healthcare services because of the program ($M = 6.33$, $SD = 0.91$). Furthermore, a composite total score of intent to use program content was calculated by summing all four intent items. This composite score demonstrated moderate to large positive correlations with the following wider post-program perceptions: staff cultural competence ($r = .68$, $p = .002$), overall satisfaction with VA services

($r = .86$, $p < .001$), and health education program satisfaction ($r = .60$, $p = .009$).

Veteran program feedback

Ten of the veterans provided short program feedback suggestions in response to open-ended prompts. The low-frequency count precluded formal thematic analysis. The brevity of these statements allowed researchers to easily list suggested program enhancements. LGBT veterans provided the following suggestions for overall improvement of VAMC services ($n = 1$ for each suggestion): (1) additional programming similar to the health education program; (2) increased access to primary care services; (3) increased provider openness and acceptance; (4) coverage of medical services related to starting a family; and (5) improved case management services. LGBT veterans provided the following suggestion to enhance the health education program: (1) desire to spread the program to other VAMCs. Finally, LGBT veterans expressed the additional positive impacts of the program: (1) improved ability to communicate with other providers; (2) gratitude and satisfaction that the VA implemented the program in any form; (3) positive experiences with other group members; and (4) organization and structure of the program.

Discussion

This program is the first to manualize and evaluate a structured health education group tailored to the unique needs of LGBT military veterans. The preliminary positive impact observed in the pilot data (e.g., reduced depressive symptoms, suicidal intent, improved social connection, etc.) reflects the iterative, evidence-informed process that was used to shape the group experience, topics, handouts, and procedures that ensure an affirming and supportive environment for participants. Yet several domains assessed were not impacted in this small feasibility trial, including pre-post anxiety symptoms, negative identity indicators, and social justice outcomes. Positive program impacts on identity and resilience support general LGBT health (Herek, 2016; Meyer, 2013) and LGBT Veteran Queer Theory (Ramirez & Sterzing, 2017) perspectives in an LGBT veteran health context. For instance, social support (e.g., community and peers) is an empirically supported protective factor for LGBT mental health (Meyer, 2013; Testa et al., 2015). Early development of this health education program suggests LGBT veterans experience enhanced connectedness with LGBT peers (formative assessment) and display positive gains in beliefs in using social support and a sense of belonging to the LGBT community, thereby building a critical protective factor against negative mental health outcomes. Moreover, the intervention content (e.g., identity, coping, stigma) and positive impact on LGBT veteran

mental health support the notion that Minority Stress Model (Meyer, 2013) and coping self-efficacy (Chesney et al., 2006) based health education program is promising.

Implications for trauma & advocacy

LGBT persons endure hate crimes, discrimination, and a litany of other trauma in general and military contexts (Cramer et al., 2018; Herek et al., 2009). In response, LGBT affirmative therapies (e.g., Austin & Craig, 2015; Moradi & Budge, 2018; Pixton, 2003) have seen greater attention in the literature. For instance, Austin and Craig (2015) articulate how cognitive-behavioral therapy can be adapted to be transgender-affirming to treat issues such as trauma, discrimination, and suicide. Consistent with a recent call for increased examination of LGBT-affirming treatment approaches (Pachankis, 2018), the present health education program continues this trend of research concerning LGBT-affirming approaches to address trauma, discrimination, and well-being by providing both content and a safe setting in which LGBT veterans can learn and begin the process of navigating the impact of previous experiences. Indicators of enhanced resilience (e.g., community involvement, authentic sense of self, getting social support) also highlight a theme of providing possible grounding for advocacy and community education efforts by LGBT veterans. This program can serve as both a place to gain a sense of identity and a sense of purpose, motivating LGBT veterans to become more informed self-advocates. That is, as participant identities, resilience, and community involvement are bolstered, commitment to social justice and indirect fostering of change in military settings and the general community may also be impacted. Finally, contemporary LGBT identity models and measures (e.g., Mohr & Kendra, 2011; Riggle et al., 2014) highlight positive identity facets of LGBT identity. To our knowledge, this program is the first to specifically target such identity aspects and utilize these measures in pre-post evaluation. Given the strong psychometrics of these instruments (Cramer et al., 2017; Mohr & Kendra, 2011; Riggle et al., 2014), we recommend consideration of LGBT identity measures in future evaluation of health education programs, as well as LGBT-affirming psychotherapeutic interventions and social advocacy trainings for LGBT veterans and community members.

Limitations and conclusions

The pilot of this health education program contains methods and sampling limitations that could be addressed through more rigorous testing in a larger clinical trial in the future. For example, we used an established measure of sexual minority identity (i.e., LGBIS), but altered instructions to attempt to allow gender diverse veterans to respond to items as well. This approach

limits conclusions concerning sexual minority identity gains by potentially conflating heterosexual identity and gender diversity. Moving forward, similar to the structure of the LGB-PIM (Riggle et al., 2014), the LGBIS (Mohr & Kendra, 2011) may be adapted and tested for overt inclusion of TGNC identity item content. Alternatively, parallel TGNC-only identity measure development represents a needed area for future research. Utilization of a small sample, single-group design with a threat of self-selection also limits the present pilot study (e.g., limited generalizability to LGBT veterans beyond those self-selecting to participate in the program). Missing data is also a limitation. In total, causality cannot be asserted, nor is this small-scale pilot evaluation evidence of program efficacy or effectiveness. As such, conclusions must be tempered, and the health education program should be exposed to further field testing with larger sample sizes and optimally a comparison or control group.

Implications for LGBT veteran health services

In the future, the Pride Group program could contribute to efforts to fill a lingering gap in patient care services within VA medical centers. In 2012, the Office of Patient Care Services established the LGBT Health Program to develop and refine policy recommendations, provider education programs, and encourage patient-driven healthcare for LGBT veterans (VHA Directive 1340, 2017; VHA Directive 1341, 2018). In 2016, this expanded to establishing a point of contact for LGBT veterans in the form of an LGBT Veteran Care Coordinator (LGBT VCC) at every facility in the country (https://www.patientcare.va.gov/LGBT/VA_LGBT_Policies.asp). Tasked with implementation of national and facility-level LGBT-related policies, among other duties, LGBT VCCs are a ready-resource for future roll out. The Pride in All Who Served LGBT Veteran Health group manual provides a practical tool for LGBT VCCs to systemically address the needs of an underserved population in replicable ways not available to date. Given that earlier studies suggest that “location was not a major factor in explaining health differences among LGBT veterans” and possessing a “strong sense of community” is a more meaningful health indicator (Kauth et al., 2017), we anticipate that the current work could be packaged for scalability to additional VA facilities in the future.

Provider-focused education and inclusive facility policies are beneficial (Kauth et al., 2019), but not sufficient. Beyond inclusive healthcare policies and provider training, direct patient health education is a necessary component for encouraging positive health behavior. The newly developed LGBT health education group described here provides information about unique healthcare needs directly to the veteran population. Consistent with a recent call for LGBT-affirming practice development (Pachankis, 2018), next steps

include further testing (e.g., comparing outcomes to an unstructured LGBT veteran support group), refining program evaluation approaches, identifying potential mechanisms of positive change and when indicated, implementation and spread to additional facilities. Future work examining impacts of the Pride Group on healthcare access and quality indicators is also needed (e.g., referral to appropriate follow-up resources, initiation of pre-exposure prophylaxis or PrEP, etc.).

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Declaration of conflicts

Authors declare no conflicts of interest.

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