Addressing Sexual Dysfunction in DoD and VA: Policies and Procedures

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"Medically Ready Force…Ready Medical Force"

Disclosure

The views expressed in this presentation are those of the presenters and do not reflect the official policy of the Department of Defense (DoD), the Veterans Administration (VA), or the U.S. Government.

The presenters have no relevant financial relationships to disclose.

Overview

- Purpose
- Brief overview of sexual dysfunction
- VA current state and way forward
- DoD current state and way forward
- Future state discussion

U.S. Department of Veterans Affairs

Treatment of Sexual Dysfunction in VA

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OBJECTIVES

- Provide a brief overview of sexual dysfunction
- Describe current VA policies regarding treatment of sexual dysfunction
- Offer key recommendations and action steps for addressing current gaps in care

SEXUAL DYSFUNCTION

- Difficulties engaging in and enjoying sexual relationships (e.g., due to desire, arousal, pain, orgasm)
- Sexual dysfunction disorders[1] in women:
  - Female Sexual Interest/Arousal Disorder*
  - Female Orgasmic Disorder
  - Genito-Pelvic Pain/Penetration Disorder
  - Substance/Medication-Induced Sexual Dysfunction
  - Other Specified/Unspecified Sexual Dysfunction
- Other "sexual disorders"[1]
  - Paraphilia
  - Gender Dysphoria
  - Persistent Genital Arousal
  - Nonparaphilic Hypersexuality Disorder
- Healthy sexual functioning and satisfaction are related to relationship quality, well-being, and overall quality of life[2]

[1]Diagnostic and Statistical Manual Disorders–V (DSM-V; APA); [2]Butzer & Campbell, 2008; Laumann et al., 2006
*controversial

VA POLICIES AND PROCEDURES

- No official VA policy or national program office governing sexual dysfunction specifically
  - International Consultation of Sexual Medicine Committee Report (2017)
  - International Society for the Study of Women's Sexual Health Recommendations (2016)
- Sexual dysfunction is treated in an individualized manner via various modalities
  - Different models for care, local offerings vary
  - Referrals via choice may be an option
- No existing VA database or resource document listing providers/programs with expertise
  - VA providers credentialed in Sex Therapy have specific expertise and privileges

KEY VA RECOMMENDATIONS

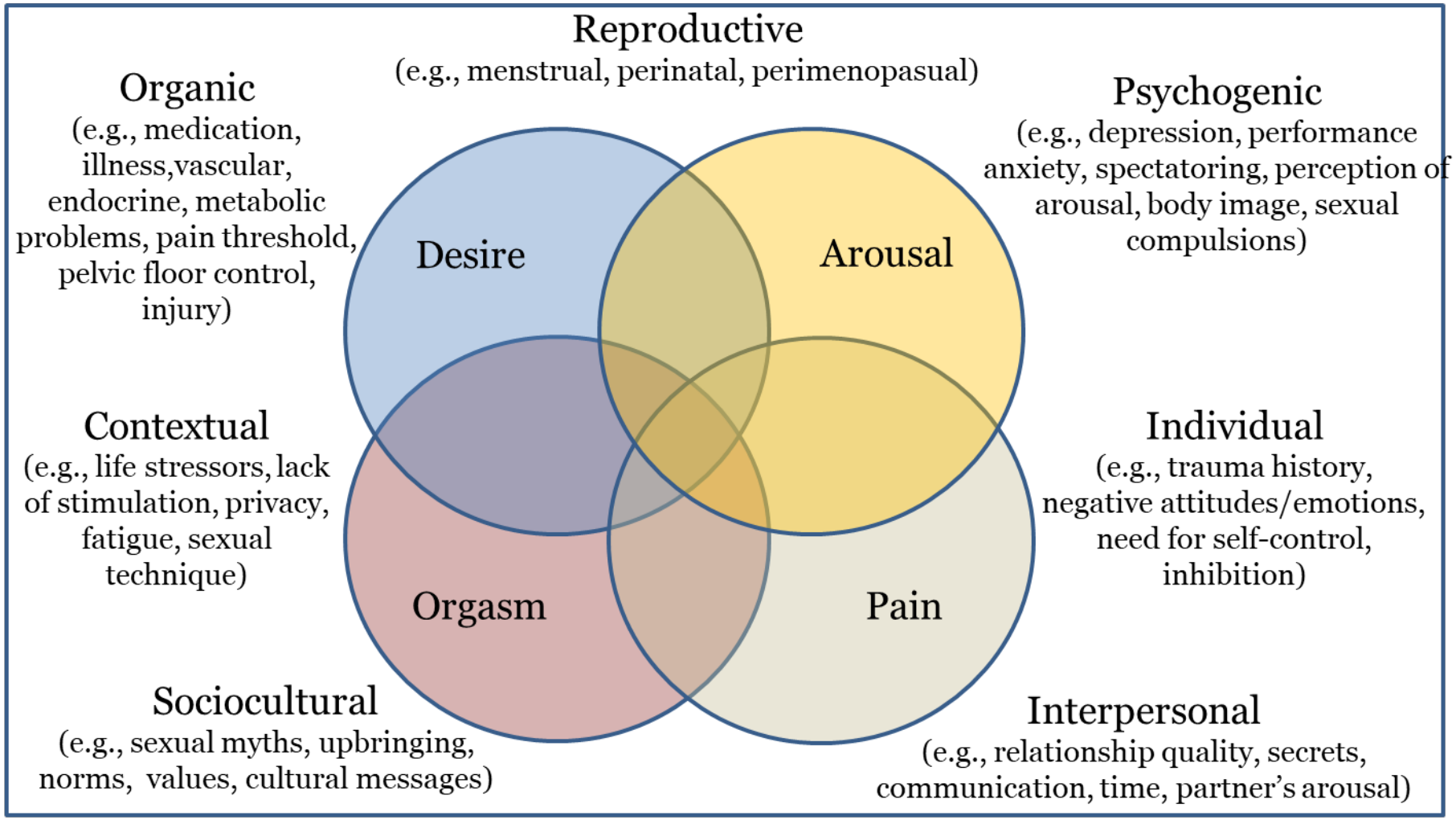
- Assess sexual functioning routinely
- Conduct biopsychosocial assessment and utilize interdisciplinary approaches as needed
- Use a trauma-informed lens for assessment, treatment and conceptualization

WHY IS THERE A NEED FOR ROUTINE SCREENING?

- Prevalence rates in research range from 16 to 50%[1]
  - Estimates derived from VHA medical record data are <1 to 2.4%[2]
- VHA medical record also suggest that providers under-address and under-assess sexual functioning[3]
- Many patients do not initiate discussions due to:
  - Lack of awareness of treatment options[5]
  - Beliefs that issues are not serious enough or appropriate to discuss with providers[6]
- Provider-initiated discussions can help alleviate Veterans' feelings of shame and embarrassment[7] and honor their preferences[4]

[1]Gilhooly et al., 2011; Nunnink et al., 2010; Sadler et al., 2012; [2]Turchik et al., 2012; Cohen et al., 2012; [3]Helmer et al., 2013; Hosain et al., 2012; [4]Nunnick et al., 2012; [5]Moreiera et al., 2008; [6]Marwick, 1999; [7]Nusbaum et al., 2002

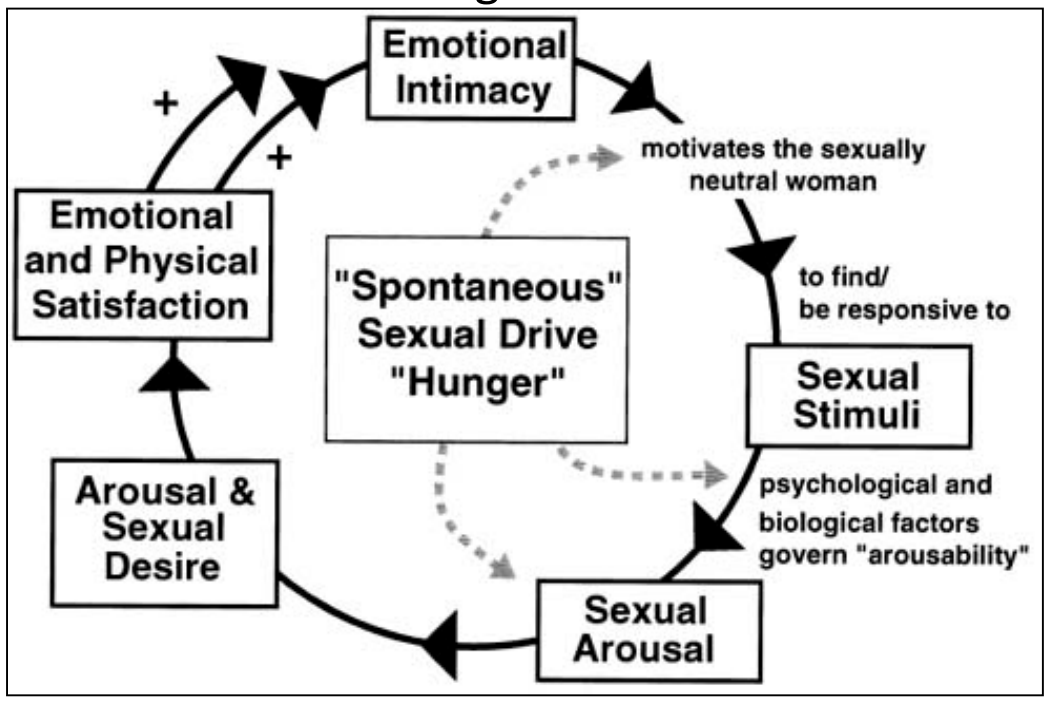
WHY IS THERE A NEED FOR BIOPSYCHOSOCIAL ASSESSMENT AND INTERDISCIPLINARY CARE?



FEMALE SEXUAL RESPONSE CYCLE (BASSON, 2001)

- Arousal in women is a biopsychosocial and non-linear process with both intimacy- and sexual drive-based contributors

Figure 2



Female Sexual Response: The Role of Drugs in the Management of Sexual Dysfunction.
Basson, Rosemary; MB, BS

Obstetrics & Gynecology. 98(2):350-353, August 2001.

Figure 2 . Blended intimacy-based and sexual drive-based cycles. Basson. Drugs for Sexual Dysfunction. Obstet Gynecol 2001.

BIOPSYCHOSOCIAL ASSESSMENT AND INTERDISCIPLINARY CARE

Area of concern	Potential disciplines involved
Medication	Psychiatry, Primary Care
Genital injury	Gynecology
Posttraumatic Stress Disorder, Depression	Mental Health
Smoking or obesity	Behavioral Medicine
Urge/stress incontinence, pelvic floor control/organ prolapse	Urology, Physical Therapy
Pain	Prosthetics, Pain Clinic, Physical Therapy
Testing (e.g., Estrogen, TSH, Prolactin)	Primary care, Endocrinology
Inflammation, anatomical variations, dermatological condition	Primary Care, Mental Health
Other perinatal and perimenopausal influences	Primary Care, Obstetrics and Gynecology, Endocrinology, Mental Health

WHY IS THERE A NEED FOR TRAUMA-INFORMED APPROACHES?

- Women with histories of MST are more likely to
  - report sexual dissatisfaction (39%)[1]
  - be diagnosed with sexually transmitted infections and sexual dysfunction disorders[2]
- Women with a history of a lifetime sexual assault are:
  - more likely to report pain w/intercourse (67% vs. 45%)[3]
  - less likely to report a satisfying relationship with their main sexual partner[3]
- Compared to female veterans without PTSD, those with PTSD are:
  - more likely to have a sexual dysfunction diagnosis (14.9% vs. 9.4%)[4]
  - less likely to be sexually active (58.7% vs.72.1%)[4]
  - less likely to report sex-life satisfaction (23.0% vs. 45.7%)[4]

[1]McCall-Hosenfeld et al., 2009; [2]Turchik et al., 2012; [3]Sadler et al., 2012; [4]Breyer et al., 2016

TRAUMA-INFORMED ASSESSMENT, CONCEPTUALIZATION, TREATMENT

- Sexual symptoms are often trauma reactions[1] that can be conceptualized functionally
- Changing sexual functioning may not be optimal[2,3]
  - High levels of sexual functioning do not necessarily translate into decreased distress in CSA survivors[4]
- Treatment of trauma-related sexual dysfunction requires thoughtful consideration
  - Sequential vs. simultaneous vs. adjunctive
  - PTSD rather than trauma exposure may be the proximal antecedent
  - Negative alterations in cognition and mood, anhedonia, dysphoria may mediate association between MST and sexual dysfunction[4]

[1]Maltz, 2012; [2]Berman et al., 2001; [3]Brotto et al., 2008; [4]Stephenson et al., 2012; [4]Blais et al., 2018

KEY VA RECOMMENDATIONS AND ACTION STEPS

- Assess sexual functioning routinely and comprehensively
  - Enhance your comfort/confidence in asking about sexual dysfunction
  - Consider routine ways to ask – e.g., intake, initial session
  - Familiarize yourself with best practice guidelines and documents
- Conduct biopsychosocial assessment and use interdisciplinary approaches
  - Find out who at your facility has expertise and collaborate
  - Reach out to your privileging department
  - Consult (e.g., with local teams, MST Consultation Program)
- Use a trauma-informed lens
  - Increase your skillset via-self study and/or supervision
  - Share what you learn with colleagues
  - Use this language and framework directly with your clients

MST Consultation Program

Free one-on-one consultation to assist you in your work with Veterans who experienced sexual assault or sexual harassment during military service

Speak directly to experts about:

IMPACT ✦ UNIQUE NEEDS ✦ RECOVERY
TREATMENT ✦ SCREENING ✦ ASSESSMENT
DIAGNOSIS ✦ PROGRAM DEVELOPMENT

Available to *anyone* working in VA

Contact us at MSTConsult@va.gov or (866) 948-7880

Treatment of Sexual Dysfunction in DoD

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National VA/DoD Women's Mental Health Mini-Residency:
Building Clinical Expertise to Meet Women's Unique Treatment Needs
Crystal City, Virginia | August 28-30, 2018

Overview

- Background
- Treatment of sexual dysfunction
- Plan of action

Background

- Psychological Health and Readiness Council
- Sexual Assault Advisory Group
- Male Sexual Assault Prevention and Response
  - Review of current research literature for gaps in funding and in published literature on mental health needs
  - Review of relevant policies for gaps and opportunities for improvement
  - Review of treatment programs and clinical practices for gaps and promising practices
  - Make recommendations to mitigate gaps

Treatment of Sexual Dysfunction

CHAMPUS document dated December 2016 describes basic program benefits:

- (27) **TRICARE will cost share forensic examinations following a sexual assault or domestic violence**. The forensic examination includes a history of the event and a complete physical and collection of forensic evidence, and medical and **psychological follow-up care.** The examination for sexual assault also includes, but is not limited to, a test kit to retrieve forensic evidence, testing for pregnancy, testing for sexually transmitted disease and HIV, and medical services and supplies for prevention of sexually transmitted diseases, HIV, pregnancy, and counseling services.
- **Exclusions and Limitations:** (30) **Therapy or counseling for sexual dysfunctions or sexual inadequacies**. Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sexual deviations (i.e. transvestic fetishism), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

Treatment of Sexual Dysfunction

- Currently psychological health treatment follow-up for sexual assault is an allowed benefit, but psychological treatment for sexual dysfunction is specifically excluded
- For sexual dysfunction from causes other than sexual assault, sexual therapy/counseling is an excluded benefit under TRICARE
- Medical treatment for sexual dysfunction from organic cause is allowed, but psychotherapy treatment for sexual dysfunction is not a covered benefit, even for organically caused sexual dysfunction

Treatment of Sexual Dysfunction

- Tricare spent $84.2 million on medicine to treat male erectile dysfunction (ED) in 2014; ED is known to have multiple potential causes and contributing factors, many of which are non-organic and could benefit from psychological interventions
- DoD does not currently have a large or widespread pool of providers certified to deliver direct care psychological treatment of sexual dysfunction, regardless of sexual dysfunction cause
- Provision of mental health treatment for sexual dysfunction within the MTF appears to be locally determined and governed by the credentialing process
- DoD does not have a comprehensive resource or central database available to guide providers to refer patients to other providers who are certified and qualified to treat sexual dysfunction

Treatment of Sexual Dysfunction

- TRICARE also doesn't cover psychiatric treatment for sexual dysfunction from organic causes
- TRICARE does provide medically appropriate medical care for erectile dysfunction due to organic, vice psychological or psychiatric, causes
- TRICARE covers the following treatments for organic impotency:
  - External vacuum appliance
  - Penile implants and testicular prostheses
  - Hormone injections
  - PDE5 inhibitors (i.e., Cialis, Levitra, Viagra) subject to limitations established by the DoD Pharmacy and Therapeutics Committee

Plan of action

- Work to revise TRICARE law to make exception to allow psychiatric treatment for sexual dysfunction as a result of sexual assault first, then work to expand eligibility for other than organic causes for sexual dysfunction over time; (proposed legislative change submitted, 2017)

- Locate DoD experts who are certified in this specialty area, and initiate discussion about how to address gap in services and expertise

- Develop a registry of DoD providers with this specific expertise

- Develop a plan to address gap; (ie, through pipeline development of skillset, or through external agreements for supervision, etc.)

- Develop plan to ensure providers are aware of need, gap, and proposed solution

- Collaborate with VA to leverage expertise and resources

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Discussion

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