Addressing Sexual Dysfunction in DoD and VA: Research, Policy and Clinical Considerations

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Disclosures

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
- Current research
- Policy and coordinating care
- Future state discussion

Poll Question

Poll Question #1

In your practice, how many women Service members and Veterans have you worked with who have experienced sexual dysfunction? (multiple choice)

1) **I never assess for sexual dysfunction in my patient population**
2) **Less than 10%**
3) **Between 10 and 50%**
4) **More than 50%**
5) **I assess for sexual dysfunction, but have never identified sexual dysfunction in my patient population**

U.S. Department of Veterans Affairs

Addressing Female Sexual Dysfunction in VA and DoD: Research, Policy, and Clinical Considerations

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September 24th, 2020

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SEX-POSITIVITY AS AN OVERARCHING FRAMEWORK

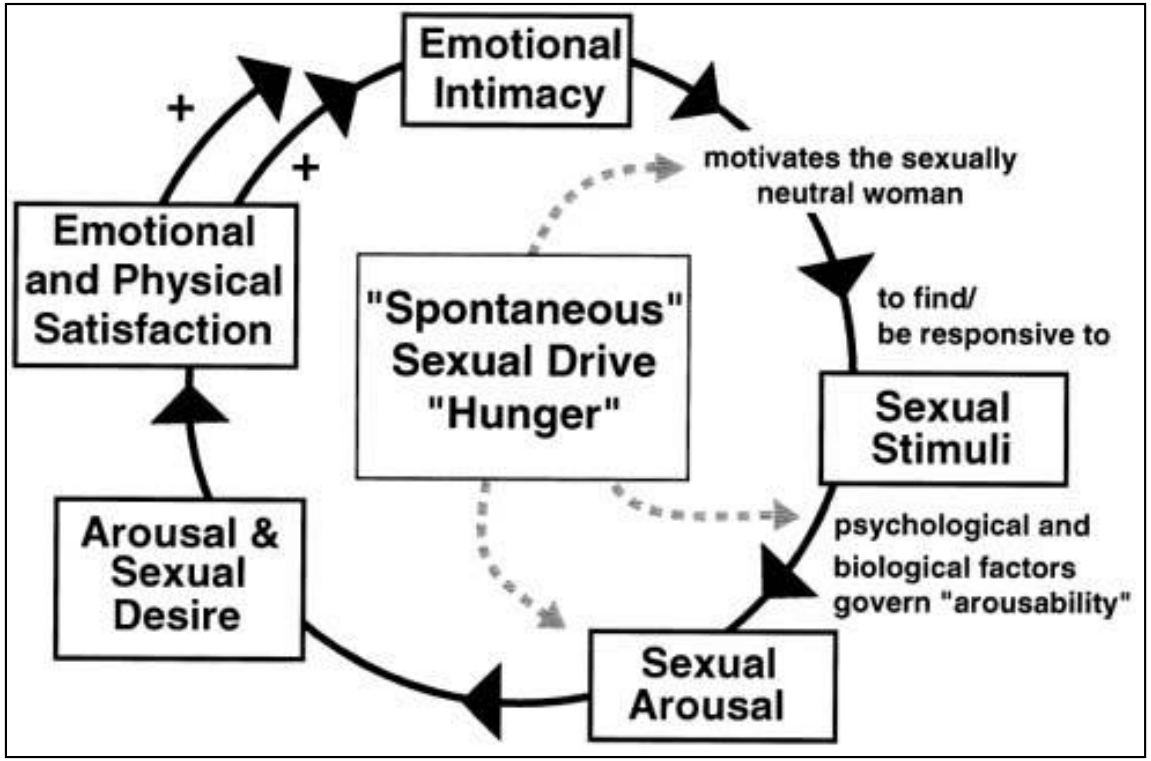
SEXUAL DYSFUNCTION

- Difficulties in one or more domains: desire, arousal, pain, orgasm, satisfaction
- Specific disorders[1] in women include:
  - 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

FEMALE SEXUAL RESPONSE CYCLE (BASSON, 2001)

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



Blended intimacy-based and sexual drive-based cycles

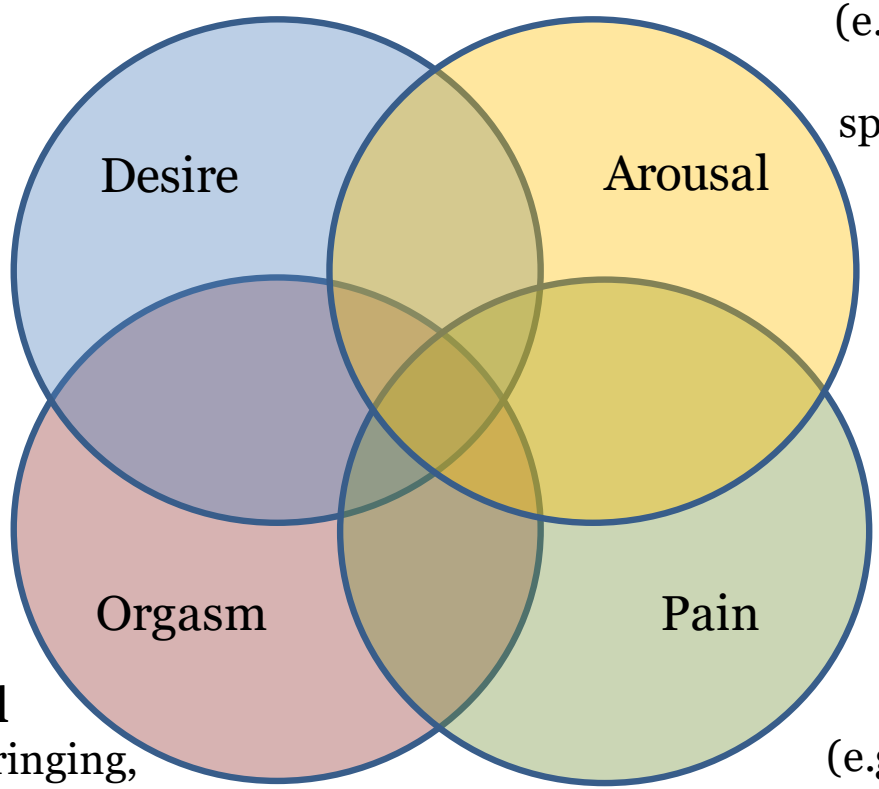
Basson R: Female Sexual Response: The Role of Drugs in the Management of Sexual Dysfunction. Obstet Gynecol 98(2):350-3, 2001.

SEXUAL DYSFUNCTION IN WOMEN

Reproductive
(e.g., menstrual, perinatal, perimenopausal)

Organic
(e.g., medication, illness, hormones, vascular, endocrine, metabolic problems, pain threshold, pelvic floor control, injury)

Psychogenic
(e.g., depression, posttraumatic stress disorder, performance anxiety, spectatoring, subjective arousal, body image, sexual compulsions)



Contextual
(e.g., life stressors, lack of stimulation, privacy, fatigue, sexual technique)

Individual
(e.g., trauma history, negative attitudes/emotions, need for self-control, inhibition)

Sociocultural
(e.g., sexual myths, upbringing, norms, values, cultural messages)

Interpersonal
(e.g., relationship quality, secrets, communication, time, partner's arousal)

MENSTRUAL CYCLE INFLUENCES

- Sexual interest/activity increase in follicular phase, peak at ovulation, and decline in luteal phase[1]
- Findings regarding sexual response across phases is mixed
  - Hormonal influences can be modified by conditioning and learning
  - Psychosocial influences also matter
- Oxytocin significantly lower during the luteal phase[2]

Endogenous/ Exogenous Hormone	Impact on Sexual Function*
Estrogen	Desire (+)
Progestin	Desire (-/0)
Testosterone	Desire (+/0) Arousal (+/0)
Prolactin	Desire (-) Orgasm (+)
Oxytocin	Desire (+) Arousal (+) Orgasm (+)

[1] Stuckey et al., 2008; [2] Salonia et al., 2005

*premenopausal

PERINATAL AND PERIMENOPAUSAL INFLUENCES

Perinatal

- Low body image and urinary problems during pregnancy[1]
- Breastfeeding[2,3]
- Mode of delivery[3]
- Postpartum depression[3] and other mental health issues
- Perinatal trauma (emotional and physical)[2]
- Fatigue[2]
- Other barriers (e.g., fear of pain or hurting baby, family planning)[2]

Perimenopausal[4]

- Estrogen decline (e.g., smooth muscle relaxation, vasocongestion)
- Vulvovaginal atrophy[5]
- Increased vaginal pH
- Reduced lubrication and tissue elasticity
- Shortening/narrowing of the vaginal vault
- Diminished sensory response
- Reduced androgen levels
- Aging of other body systems
- Medication side-effects
- Increased BMI[6]

[1]Pauls et al., 2008; [2]Rowland et al., 2008; [3]Abdool et al., 2009; [4]Goldstein et al., 2005; [5]Levine et al., 2008; [6]Pace et al., 2009

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

TRAUMA-INFORMED ASSESSMENT, CONCEPTUALIZATION, TREATMENT

- Lifetime sexual trauma (including military sexual trauma) and Posttraumatic Stress Disorder are risk factors for sexual dysfunction[1,2,3,4]
- Sexual symptoms are often trauma reactions[5] that can be conceptualized functionally
- Enhancing sexual functioning is not always optimal[6,7]
  - High levels of sexual functioning do not necessarily translate into decreased distress in child sexual abuse survivors[8]
- Treatment of trauma-related sexual dysfunction requires comprehensive assessment and thoughtful consideration given lack of evidence base

[1]McCall-Hosenfeld et al., 2009; [2]Turchik et al., 2012; [3]Sadler et al., 2012; [4]Breyer et al., 2016, [5]Maltz, 2012; [6]Berman et al., 2001; [7]Brotto et al., 2008; [8]Stephenson et al., 2012;

POLL QUESTION

Poll Question #2

What do you see as your most significant challenge in treating sexual dysfunction in female Veterans and/or Service members (choose more than one if needed)?

1) **Lack of comfort in beginning the conversation with patients**
2) **Lack of skill in assessing and/or treating sexual dysfunction**
3) **Lack of sufficient expertise in local community to refer patients to for treatment of sexual dysfunction**
4) **Patient hesitancy to raise or openly discuss matters related to sexual dysfunction**

DISCOMFORT IS COMMON IN ASKING ABOUT SEXUAL HEALTH

“Ironically, it may require greater intimacy to discuss sex than to engage in it.”

“The Hidden Epidemic”

Institute of Medicine, 1997

THE GOOD NEWS

- You do have skillsets that apply in this context. Consider…
- In your work, what other topics are difficult to talk about?
  - Sharing medical or psychiatric diagnoses?
  - Giving interpersonal feedback?
  - Observing limits?
- What other topics feel sensitive or private?
  - Details of trauma history?
  - Topics that might induce shame in patients (e.g., weight, promiscuity, substance use, medication adherence)?
- What was more challenging earlier on in your career that is easier now?

VIGNETTE

Sadie is a 35-year-old, African-American patient who identifies as lesbian. She and her wife have been together for almost 4 years and have been married for 2. This marriage is her 2nd; she was previously married to a man. She has a history of military sexual trauma as well as childhood sexual trauma. She was raised Catholic but is not currently practicing. She reports significant symptoms of posttraumatic stress disorder and depression. During a routine medical encounter, Sadie shared in passing that she is unable to enjoy sex with her wife.

SELF-REFLECTION

- What comes up for you (e.g., thoughts, feelings, physical sensations) as you think about asking Sadie for more details?
- What do you want to know more about?
- What might get in the way of you getting that information?
- In general, what gets in the way of you asking about sexual functioning difficulties in women? What helps?
- Do you tend to ask all of your female patients about sexual functioning routinely and comprehensively? To what do you attribute this approach?

SIX KEY PRINCIPLES OF EFFECTIVE CONVERSATIONS

- Provide a rationale for asking
- Normalize the discussion/difficulties and set expectations
- Acknowledge potential discomfort
- Assess all areas of functioning
- Ask clarifying questions
- Monitor reactions and engage in ongoing self-reflection

SAMPLE OPENING

"I'd like to ask you some questions about your sexual health. Sex is a big part of many people's lives, so this is something I speak to all of my patients about to help ensure that I'm providing you with well-rounded care. We'll spend 5-10 minutes talking about your sexual functioning, whether you've noticed any difficulties, and if you are satisfied with this area of your life. It can feel awkward to many people to talk about these issues, so please let me know if you are feeling uncomfortable and we can discuss that or change our pace."

1. Provide a rationale for asking
2. Normalize the discussion/difficulties and set expectations
3. Acknowledge potential discomfort
4. Assess all areas of functioning
5. Ask clarifying questions
6. Monitor reactions and engage in ongoing self-reflection

4. ASSESS ALL AREAS OF FUNCTIONING

- Ask about presenting concern **and** all other domains (e.g., orgasm, pain, arousal, desire, satisfaction)
- Attend to subtle cues and signs
    - "My relationship isn't what is used to be."
- Ask about trauma
- Assess for potential interconnections between trauma and sexual functioning
- Ask about family planning and other forms of trauma (e.g., intimate partner violence, reproductive coercion, birth trauma, traumatic losses) that also may be relevant to sexual difficulties

SAMPLE PROMPTS

Desire

- How has your sex drive or desire for sexual activity (partnered and solitary) been in the past month?
- Does this represent a change from what your desire level was in the past? If so, when did it begin?
- When do you remember your sexual desire to be at its highest level?
- How sexually attracted have you felt toward your partner (0-10) in past month?

Arousal

- In the past month, what percentage of the time have you felt aroused or “turned on” by sexual activity?
- …how would you rate the usual intensity of your arousal? (0-10)
- …how confident are you in your ability to become aroused? (0-10)
- …how often did you become lubricated or “wet” during sexual activity?
- ..how difficult has it been to become lubricated? To maintain lubrication until completion of activity?

SAMPLE PROMPTS

Orgasm

- How many times have you attempted partnered sexual activity and self-stimulation in the past month?
- On average, in the last month, what percentage of the time were you able to orgasm during manual stimulation, oral stimulation, and intercourse (0-100%)?
- Do you have any habitual patterns of stimulation associated with masturbation that are not easily replicated through intercourse?

Pain

- How often do you experience vaginal pain (e.g., during/following penetration, thrusting, withdrawal, w/ejaculation, urination)?
- Where does it hurt? How would you describe the pain? How intense is it (0-10)? How long does it last?
- Do you feel your body tensing before penetration/during sexual activity (e.g., overall, pelvic floor)?

SAMPLE PROMPTS

Satisfaction

- In the past month, how satisfied have you felt with your relationship with your partner?
- …how satisfied have you felt with emotional closeness during sexual activity?
- …how satisfied have you felt with your overall sex life?
- …do you find yourself avoiding initiating sexual contact with your partner or seeking partners because of a concern about not being able to perform sexually?

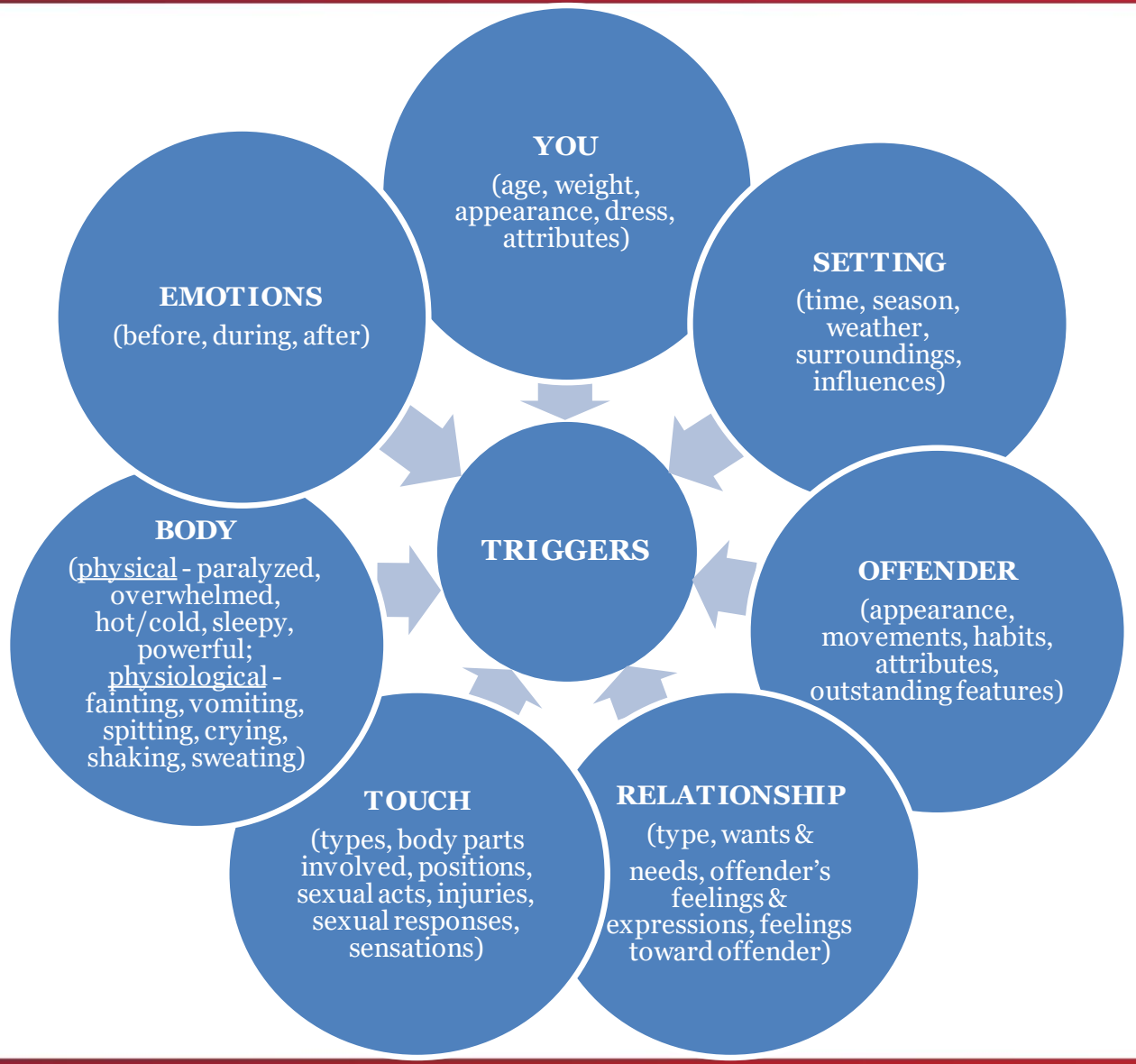
Distress

- How distressing has _____ been for you in the past 6 months? (0-10)
- Has it helped/harmed other areas of your life? How so?
- Is anyone else in your life distressed by these problems?

SAMPLE PROMPTS

- What kinds of trauma-related images and thoughts do you experience before/during/after sexual activity?
  - During what kinds of activities (e.g., partnered/solitary, oral (giving or receiving), vaginal, anal, hugging, holding hands, intimate conversations)?
  - At what point in the process (e.g., during foreplay, before/after orgasm)?
- What kinds of factors make it worse? What makes it better? (e.g., time of day, lighting, fatigue, smells, specific words, specific body parts)
- How do you respond and handle these memories/images/thoughts?
  - Probe for guilt/shame, interpersonal skills, avoidance, stuckpoints, judgments

DISCOVERING TRIGGERS (ADAPTED FROM MALTZ, 2012)



5. ASK CLARIFYING QUESTIONS

- Use anatomically correct words for body parts and specific terms for difficulties
- Clarify vague language and ensure your understanding is accurate
  - "You mentioned you are having 'problems in the bedroom'. That can mean a lot of different things. The best way that I can help you is if I understand exactly what is going on. So let's talk more specifically. Are you having difficulty with desire? Lubrication? Orgasm?"
- Mirror the patient's language but also model direct language
  - "You've used the phrase "private parts" and I just want to make sure I am understanding correctly – do you mean your breasts, your vagina, your buttocks or something else? I ask because I can be more effective in helping if I am clear about what specifically you are experiencing."

6. MONITOR YOUR REACTIONS

- Stay mindful of potential discomfort and avoidance especially as it relates to your nonverbal behavior and word choice
- Be clear with yourself about your rationale for specific questions
- Balance expected discomfort with observation of limits when patients:
  - use language that you find off-putting
  - focus on you as an object of sexual attention
  - ask you personal questions about your sex life
- Maintain ongoing awareness of your values, history, and biases and how those may affect your behavior as a clinician within and across patients
- Recognize what you don't know and make efforts to educate yourself

SEX MATTERS!

- Initiate conversations and ask about sexual functioning in order to:
  - Normalize the difficulties and give patients a vocabulary
  - Legitimize concerns and their importance
  - Empower and encourage patients to address difficulties
  - Reduce anxiety, shame, and hopelessness
- Assess sexual functioning routinely and comprehensively using a trauma-informed and sex-positive framework
  - 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
- More comprehensive assessment and treatment often requires specific expertise
  - Remember to consult and/or refer as needed
  - Identify local staff who may have expertise (e.g., Behavioral Medicine, Gynecology)
  - Reach out to Privileging Department

ADDITIONAL RESOURCES

- Referral sources:
  - Sex Therapy: https://www.aasect.org/referral-directory
  - Women's Health Physical Therapy: http://aptaapps.apta.org/findapt/
- Clinical Publications and Factsheets on Female Sexual Functioning, Screening and Treatment, etc.:
  - https://www.arhp.org/Topics/Sex-and-Sexuality
  - https://www.arhp.org/publications-and-resources/clinical-fact-sheets
  - https://www.arhp.org/Publications-and-Resources/Clinical-Practice-Tools/Handbook-On-Female-Sexual-Health-And-Wellness
  - http://www.issm.info//sexual-health-qa/#female-sexual-health
  - DESIRE Manual and Handouts (Brotto et al., 2018): $40; Contact Faith Jabs at faith.jabs@vch.ca
  - Sexual Inventory Stocklist: https://www.scarleteen.com/sites/files/scarleteen/yesnomaybe.pdf
- Clinical Training
  - http://cir.usc.edu/wp-content/uploads/2015/07/SexMilitaryToolkit_InteractiveVersion-Jul2015_002.pdf

BEST PRACTICE GUIDELINES

- Schultz, W. W. et al. (2005). Women's sexual pain and its management. Journal of Sexual Medicine, 2, 301-316.
- Basson, R. et al. (2010). Summary of the recommendations on sexual dysfunctions in women. Journal of Sexual Medicine, 7, 314-326.
- International Consultation of Sexual Medicine Committee Report (2017)
- International Society for the Study of Women's Sexual Health Recommendations (2016)

RELEVANT ARTICLES

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- Leonard, L. M. & Follette, V. M. (2002). Sexual Functioning in Women Reporting a History of Child Sexual Abuse: Review of the Empirical Literature and Clinical Implications. Annual Review of Sex Research, 14(1), 346-388.
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- Binik, Y. M. & Hall, K. S. (2014). *Principles and Practice of Sex Therapy: Fifth Edition*. New York, NY: The Guilford Press.
- Cass, V. (2007). *The elusive orgasm: A woman's guide to why she can't and how she can orgasm*. Cambridge, MA: Da Capo Press.
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- Heiman, J. R. & Lopiccolo, J. (1988). *Becoming Orgasmic: A Sexual and Personal Growth Program for Women*. New York, NY: Simon & Schuster.
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- Laken, V., & Laken, K. (2002). *Making love again*. Sandwich, MA: Ant Hill Press.
- Maltz, W. (2012). *The Sexual Healing Journey (3rd ed)*. New York: William Morrow.
- Waxman, J. (2007). *Getting off: A woman's guide to masturbation*. Berkeley, CA: Seal Press.

ADDITIONAL RESOURCES CONTINUED

- Sexual history taking
  - LGB SharePoint: https://vaww.infoshare.va.gov/sites/LGBEducation/SitePages/Assessing%20Sexual%20Health.aspx
  - 5 P's: https://www.cdc.gov/std/treatment/SexualHistory.pdf
  - Sample Prompts: https://vaww.infoshare.va.gov/sites/pcsclipro/trer/Shared%20Documents/Assessing%20Sexual%20Health/Trans_LGBT_Overview.pdf
  - Nusbaum, M. R. H. (2002). *Am Fam Physician*, 66(9):1705-1713.
    - https://www.aafp.org/afp/2002/1101/p1705.html)

- Cultural Sensitivity
  - In Principles and Practice of Sex Therapy, 5th Edition:
    - Hall, K. S. K. & Graham, C. A. (2014). Culturally sensitive sex therapy: the need for shared meanings in the treatment of sexual problems.
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Research Related to Sexual Dysfunction in Female Service Members and Veterans

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September 2020

Overview

- Background research

- Future directions

Background Research

Letica- Crepulja, M., et al (2019) Predictors of Sexual Dysfunction in Veterans with Posttraumatic Stress Disorder

Pulverman, C., et al (2019) Military Sexual Trauma and Sexual Health in Women Veterans: A Systematic Review

Blais, R., et al (2018) Sexual Dysfunction is Associated with Suicidal Ideation in Female Service Members and Veterans

Future Directions

- Increase funding to expand the body of knowledge on the impact of sexual dysfunction on the mental health of Service members and Veterans
- Include within existing psychological health research portfolios studies on sexual dysfunction or that include sexual dysfunction as a variable
- Fund new studies with strong methodology and design that use validated measures of sexual function
- Evaluate which types of sexual dysfunction screening and assessment in which type of medical care environment is most effective and helpful to Veterans and Service members

Policies and Procedures for Treatment of Sexual Dysfunction in DoD and VA

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September 2020

All Care for Sexual Dysfunction (SD) Care in the Military Health System *June 1, 2019 – May 31, 2020*

		ANY SD CARE		OUTPATIENT SD CARE				INPATIENT SD CARE			
	Beneficiary Population	Patients		Patients		Encounters		Patients		Admissions	
		n	%	n	%	Total	Per Patient	n	%	Total	Per Patient
All	9,577,114	208,750	2.18%	207,557	2.17%	388,057	1.87	2,224	0.02%	2,278	1.02
Female	4,694,055	33,859	0.72%	33,770	0.72%	110,970	3.29	273	0.01%	274	1.00
Male	4,882,833	174,894	3.58%	173,790	3.56%	277,087	1.59	1,951	0.04%	2,004	1.03
Dependents of AD*	1,963,852	13,939	0.71%	13,903	0.71%	45,638	3.28	135	0.01%	137	1.01
Retirees	2,219,841	134,262	6.05%	133,318	6.01%	212,849	1.60	1,621	0.07%	1,654	1.02
Others	3,801,044	24,609	0.65%	24,478	0.64%	53,382	2.18	247	0.01%	260	1.05
ADSMs**	1,592,378	36,508	2.29%	36,421	2.29%	76,182	2.09	222	0.01%	227	1.02
Female											
Dependents of AD*	1,273,281	11,914	0.94%	11,883	0.93%	42,501	3.58	118	0.01%	118	1.00
Retirees	184,600	1,189	0.64%	1,185	0.64%	3,472	2.93	13	0.01%	13	1.00
Others	2,953,905	15,776	0.53%	15,734	0.53%	39,292	2.50	99	0.00%	99	1.00
ADSMs*	282,269	5,110	1.81%	5,098	1.81%	25,704	5.04	43	0.02%	44	1.02
Male											
Dependents of AD*	690,569	2,026	0.29%	2,021	0.29%	3,137	1.55	17	0.00%	19	1.12
Retirees	2,035,114	133,074	6.54%	132,134	6.49%	209,377	1.58	1,608	0.08%	1,641	1.02
Others	847,092	8,833	1.04%	8,744	1.03%	14,090	1.61	148	0.02%	161	1.09
ADSMs*	1,310,058	31,399	2.40%	31,324	2.39%	50,478	1.61	179	0.01%	183	1.02

* Includes dependents of activated National Guard and Reservists and includes purchased care

** Includes activated National Guard and Reservists

DoD: Background and Update

- 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

DoD: 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.

DoD: 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

DoD: 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 military Medical Treatment Facility (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

DoD: 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 (e.g., Cialis, Levitra, Viagra) subject to limitations established by the DoD Pharmacy and Therapeutics Committee

Addressing DoD Treatment Gap

- Worked to revise TRICARE law to make exception to allow psychiatric treatment for sexual dysfunction as a result of sexual assault first, with intent to expand eligibility for other than organic causes for sexual dysfunction over time; (proposed legislative change submitted through DHA, 2017, but not supported; Congress who proposed legislation, House approved legislation, in conference Senate also concurred, change not included in NDAA20)
- Future action steps:
  - 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 (i.e., 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
- Current DoD process: Active Duty Service members will need to seek individual TRICARE waiver from local military treatment facility to fund treatment for sexual dysfunction treatment provider locally or via telehealth remotely

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
  - Community referrals 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 Overall 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 with local teams and national programs

- Use a trauma-informed lens
  - Increase your skillset via-self study and/or supervision
  - Share what you learn with colleagues
  - Use trauma-informed language and framework directly with your clients

Poll Question

Poll Question #3

What is one key take-away from today that you can implement immediately to help women seeking treatment for sexual dysfunction in your clinical setting? (open-ended)

Discussion

Thank you!

For any questions, feel free to reach Dr. Foynes at melissa.foynes2@va.gov

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Addressing Sexual Dysfunction in DoD and VA: Research, Policy and Clinical Considerations

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