

The Elephant in the Bedroom: Sexual Functioning in Military Populations

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Sexual health refers broadly to sexually related physical, emotional, mental, and social well-being, and also emphasizes absence of both disease and dysfunction.^{1,2} This comprehensive conceptualization emphasizes that sexual health is a vital component of overall quality of life (QOL).^{3,4} However, the comprehensive nature of this conceptualization of sexual health shows the complexity of fully assessing sexual health without breaking it into key components. This brief focuses on the sexual functioning (SF) aspect of sexual health in military populations, including military personnel, veterans, and military spouses.

Military personnel have an increased exposure to risk factors for sexual dysfunction (SD), which equates to a higher likelihood of experiencing SD.⁵ Both the physical and mental health problems that some military personnel report experiencing are significantly associated with sexual functioning problems – directly, as a result of the physical or mental health problem or indirectly, through medication or other mechanisms. Currently, sexual functioning in military personnel is an understudied area and much is unknown. Here we provide a brief overview of the problem, discuss challenges associated with assessment, present available treatment options, and provide recommendations for applying the key findings.

Sexual Functioning in Military Populations

While advanced military technologies, medicine, and equipment have boosted survival rates in the most recent wars, many service members return home injured physically and/or psychologically.⁶⁻¹⁰ Recent research found that approximately 17 to 19 percent of service members return home with at least one physical injury.^{11,12} Military personnel who have experienced a physical injury are three to seven times more likely to report experiencing erectile dysfunction (ED) symptoms than those who have not been physically injured.¹³ Physical injuries, however, are also associated with an increased risk of psychological injury, which can further increase risk for SF problems.

Upward of 30 percent return home experiencing a psychological injury, primarily posttraumatic stress disorder (PTSD) and/or depression.^{8,14,15} Those who experience psychological injuries are

more likely to experience SF problems. PTSD and depression, both of which are independently associated with SF problems, are fairly common in military populations. In civilian literature, it is considered “generally agreed upon” that the relationship between depressive symptoms and SF difficulties is bidirectional and further complicated by the use of antidepressant medication.¹⁶⁻¹⁸ Recent research in civilian populations has found that adults with depression have a 50 to 70 percent increased risk of SF problems compared to those without depression, and those with SF problems have a 130 to 210 percent increased risk of depression compared to those without SF problems.¹⁷ Reduced sexual desire and arousal are the most common SF issues experienced by depressive patients.¹⁸⁻²⁰ The medications used to treat depression, particularly selective serotonin reuptake inhibitors (SSRIs), present a greater risk for SF problems, including orgasmic difficulties, when compared to patients with untreated depression.^{19,21}

PTSD is strongly linked to SF problems in military populations.²²⁻²⁴ SSRIs, which are also commonly prescribed to treat PTSD symptoms, have been associated with delayed ejaculation, ED, reduced sexual desire, and other SF problems in those with PTSD.²⁴ Anti-psychotic medications, which are occasionally used to treat PTSD symptoms, have also been linked to desire, arousal, and orgasmic difficulties.²⁵ PTSD has been independently associated with SF problems;²⁶ over 80 percent of male veterans with PTSD diagnoses also report SF problems, most commonly low desire and ED.^{23,27} Female veterans with PTSD are also 6 to 10 times more likely to be diagnosed with SF problems.²⁸ The association between PTSD and SF problems may be due to negative alterations in cognition and mood, such as detachment from others or restricted range of affect, which can be damaging to SF.²⁹

The rates of SF problems across all age groups in the military have been increasing since 2004,³⁰ mirroring the increase in psychological injuries experienced by service members returning from recent operations. Two recent studies have found that up to a third of young (i.e., 40 years of age or younger) male military personnel experience ED.^{13,30} Other studies have indicated that nearly 25 percent of the recent post-9/11 generation of male and female veterans (i.e., Operation Iraqi Freedom [OIF], Operation Enduring Freedom [OEF]) report experiencing SF problems,

as either self-reported by veterans or as indicated in medical records.^{31,32} Recent research has also found that nearly half (48%) of the military ED cases are considered to be of psychogenic origin (i.e., related to psychological factors, such as PTSD or depression).^{30,33,34} Young male military personnel with a psychological injury may be up to 30 times more likely to report experiencing ED symptoms than those without a psychological injury.^{13,35} It is important to note that since the military is male-dominated, the emphasis of available research is on ED and male-related SF problems. However, SF problems in the military go beyond ED and are also present in female military personnel.

Overall, these findings clearly demonstrate the close link between many of the psychological problems that military populations face, and the increasing presence of SF difficulties. Experiencing SF problems is associated with reduced QOL and happiness. Military personnel without SF problems report 5 to 13 times better QOL and happiness than those with sexual functioning problems.¹³ These findings highlight the important influence that SF and intimacy can have on psychological well-being.

Assessment Challenges

There are many challenges associated with assessing sexual functioning in military populations. First, few behavioral health professionals (BHPs) are trained in SF, thus limiting their knowledge and confidence in assessment.³⁶⁻³⁸ While relationship problems are fairly common concerns presented by military populations to BHPs,³⁹ few receive training in SF and fewer receive training in military culture.^{8,40-43} Second, in addition to SF being a difficult topic for BHPs to address, it is also uncomfortable for patients to discuss. In fact, more than 90 percent of patients expect their physician to initiate conversations about SF problems.⁴⁴⁻⁴⁶ Third, there is a lack of standardized assessments for evaluating SF.^{26,31,32,35,47-49} Within the military system, documentation of sexual problems is often lacking or inconsistent.³² This presents challenges in evaluating the prevalence of SF problems, as some methods use criteria specified in the DSM, while others use International Classification of Diseases (ICD) codes, prescribed medications, patient self-report, or notes in charts by providers.^{26,31,32,35,48,49} Interestingly, and demonstrating the inconsistency in ED assessment by medication usage, research indicates that there are either twice²⁶ or half³⁵ as many prescriptions for ED medication as there are veterans diagnosed with ED. This highlights the lack of standardization of sexual functioning assessment and procedures, and underlines potential underreporting issues that lead to a perceived lack of importance.

Access to Treatment

Despite high rates of sexual functioning problems and the strong association with reduced QOL and happiness, there is a lack of widely available treatment within military health care systems, particularly for SF problems diagnosed as having a psychogenic origin.⁵⁰ In addition to the lack of treatment, SF problems have

not been considered as a national priority for military populations—the 2007 report from the President’s Commission on Care for America’s Returning Wounded Warriors did not address sexual health or functioning.^{51,52}

While TriCare/United HealthCare previously offered some limited coverage for sexual problems specifically related to depression,⁵³ it currently excludes coverage for sexual dysfunction therapy.^{50,53} The 2013 Provider Handbook specifically states, “Any therapy, service, or supply provided in connection with sexual dysfunction or inadequacies is excluded from TriCare coverage” (pp. 75).⁵⁰ However, service members under TriCare may be eligible to receive specific medication (up to six tablets per month) for ED that is considered of organic, mixed organic/psychogenic, or medication-induced origin, but not for ED of psychogenic origin.⁵⁴

The gap in available resources for SF problems is not only unique to military healthcare coverage; it is also mirrored in many civilian healthcare systems. Coverage of SD and SF problems within civilian health insurance plans is often limited and restrictive, and is largely directed at ED. Approximately 60 percent of OIF and OEF veterans access the VA for healthcare; the remaining likely seek treatment in civilian community-based facilities.⁵⁵ Military personnel who receive their treatment outside of the military may face added challenges, including the lack of preparedness of civilian BHPs to treat military populations in a culturally appropriate manner.^{56,57} Overall, adequate and appropriate coverage for SF problems is lacking. The available coverage within the military primarily addresses ED at a pharmacological level and does not comprehensively address SF problems, regardless of origin.

Key Findings and Recommendations

In response to the research findings and treatment gaps, below are key findings with specific recommendations for addressing each. These efforts have the potential to improve well-being and QOL for military populations. Additionally, with the implementation of the Affordable Care Act and the enhanced focus on comprehensive healthcare and wellness,⁵⁸ the United States, as a whole, is presented with a unique opportunity to bring sexual health and functioning into a national focus and to integrate care for SF problems into existing health systems.

Finding 1

At least 30 percent of young military personnel report experiencing sexual functioning problems; sexual functioning problems are as common as mental health disorders.

Recommendation

Incorporate a mechanism that consistently and comprehensively detects and documents SF problems into routine practice.

Discussion

Not only would this increase the diagnosis and treatment of SD for those in need, but it also would create an environment of normalcy in which patients feel encouraged to discuss sexual problems more openly. Nunnink and colleagues³² recently recommended a standardized, system-wide screening policy to address barriers to SD treatment and care. This policy would include the use of screening reminders within the VA computerized record system with prompted questions focused on SF. It would also require a broad training platform for new and existing BHPs, focused on communication skills and promoting a psychosocial approach to enhance BHPs' comfort in and ability to assess SF.⁵⁹ Finally, such a standardized screening procedure must prioritize cultural competency, as perceptions of sexual health, sexual problems, and help-seeking behaviors are highly influenced by cultural context.^{42,46} Adoption of this kind of strategy within the Department of Defense and VA medical systems has the potential to address under-reporting and increase the identification of SD among military members, as well as provide an access point for treatment and care.

Finding 2

Few BHPs are trained to assess and address sexual and relationship functioning problems.

Recommendation

Incorporate SF and intimacy training into the core curriculum and practice for BHPs. Allow trainees to practice assessing SF in their intake and learn ways to treat SF problems. Existing BHPs should be encouraged to complete training in SF and intimacy. Since limited trainings exist, additional post-graduate, continuing education courses need to be developed.

Discussion

Both BHPs and patients are not comfortable addressing SF.⁴⁴⁻⁴⁶ Incorporating SF and intimacy assessment and treatment into standard training and practice will help to enhance BHP knowledge and self-efficacy in assessing SF and relationship problems. Assessing these problems regularly with all patients will help identify those with specific needs, and allow them to receive the appropriate treatment. A critical part of this training is to help BHPs learn when to refer patients to qualified specialists for treatment.

Finding 3

Military personnel do not have adequate coverage for treatment of SF problems, regardless of origin.

Recommendation

Expand coverage (military, TriCare, VA, and civilian) for SF problems regardless of origin.

Discussion

Despite the strong link between common mental health disorders (e.g., PTSD and depression) and SF problems, military personnel do not have adequate benefits for SF problems, particularly those considered to be of psychogenic origin. Even among those with combat- or other military-related behavioral health problems, less than half are receiving treatment and only 5.6 percent are receiving minimally adequate treatment.⁸ Moreover, the shift of focus within the medical community from the psychological to the biological nature of SF occurred without a complete understanding of the causes of SD, and disregards psychological symptoms and comorbidities, which are often present in those experiencing sexual difficulties.^{60,61} The classification system specifying organic or psychogenic often serves as the determinant of SD treatment coverage within healthcare systems, and has led to substantial gaps in treatment and care by focusing on organic causes. Coverage that omits psychogenic SF problems ignores the inherent psychological nature of SF, and leaves many without needed treatment. A comprehensive model of sexual healthcare must address SF from a comprehensive, biopsychosocial perspective,⁵¹ and access to care must be expanded through broader insurance coverage.

Conclusions

While both civilian and military populations experience SF problems, the military presents a unique set of risk factors that can place service members at a greater risk. The rates of SF problems have been increasing in military personnel in recent years and a high rate of young military personnel have reported SF problems.^{13,30} Although the intimate partner (i.e., military spouse/partner) serves as an important source of support for military personnel and veterans,⁶² the physical and psychological injuries experienced during military service can negatively impact the intimate relationship.

The findings of this report indicate that, despite high rates of SF problems, BHPs have not effectively engaged military populations in appropriate treatment and are not adequately prepared to address these problems. It has become increasingly clear that there is a dire need for training BHPs, improving assessment of SF problems, and providing appropriate coverage for those who experience SF problems regardless of origin.

The lack of training is primarily due to a lack of clinical programs that require coursework in sexual dysfunction and intimacy, despite relationship problems being a common concern presented to clinicians.³⁹ Additionally, the lack of engagement from BHPs may be due, in part, to inadequate organizational support. For instance, the lack of adequate benefits for service members suggests that limited treatment options would be available, thus a limited number of adequately trained BHPs needed to address those who are able to get treatment. Unfortunately, this logic limits the capacity of BHPs to adequately

address the needs of their clients.

In addition to needed training and research, policy changes will be key to ensuring that progress can be made in this area. If policy is limiting the needed treatment for military populations, then these individuals are forced to suffer. The consequences of untreated physical or psychological injuries, including SF problems, can have severe public health implications.

Overall, it is clear that this is a huge challenge that impacts us all and is a key area for future research and policy change. SF problems are associated with significantly lower QOL and happiness, and significantly greater physical, psychological, and social difficulties.¹³ More work is needed in this area—researchers, clinicians, educators, military populations, and policymakers need to work together to create and share new best practices in this area so that military populations get needed treatment.

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