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Addressing Sexual Health With Patients

This is the first article of a regular column focused on mental health care and traumatic brain injury, edited and occasionally authored by COL (Ret) Elspeth Cameron Ritchie, MD, MPH. Proposals for articles are encouraged and can be sent to fedprac@frontlinemedcom.com.

Why start this new column on mental health with an article that focuses on sexual health? Surely that is the domain of family practice, urology, gynecology, endocrinology, or some other discipline. While it is true that all these disciplines and many others are central to the diagnosis and treatment of sexual health, mental health providers need to be an integral part of the conversations.

I have a problem with arbitrarily separating mental health and behavioral health from physical health. Mental health is directly affected by physical health and vice versa. If a woman has a urinary tract infection, she is not feeling mentally or sexually healthy. If a man has erectile dysfunction (ED), he seldom is at the top of his game emotionally. For our war-wounded who lack limbs or who have genitourinary injuries, optimal sexual functioning can be a challenge.

I am probably preaching to the choir here, so I will not belabor the point. However, I will develop this point by using lessons learned from combat-injured service members, the psychiatric adverse effects (AEs) of commonly used psychiatric medications, and most important, asking about sexual health as part of taking a mental health history.

THE WAR-WOUNDED

Since 9/11, 2.7 million U.S. service members have served in wars. Much discussion has been focused on posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI), the invisible wounds of war. Probably about 25% of service members who have been deployed have PTSD, and about 300,000 service members have TBI.[1] About 50,000 have other physical injuries. These injuries directly affect intimate relationships.

The signature weapon of the wars in Iraq and Afghanistan was the bomb, or improvised explosive device. Motor vehicle accidents and gunshot wounds also have added to the myriad of injuries. Physical war wounds involve sexual functioning. These include, but are not limited to, lower extremity amputations, genitourinary injuries, and facial disfigurement or burns. All of these may involve multiple surgeries, pain, and disability and can significantly impact self-esteem.

One of the many lessons I have learned in putting together my most recent book, *Intimacy Post Injury: Combat Trauma and Sexual Health,* is that there is a void in the recent general medical and popular literature about optimizing sexual health in those with injuries or diseases.[2] The majority of wounded warriors are men, but injuries happen to women service members as well. Of course, sexual assault causes severe harm to intimate relationships as well.

At this time, most injured personnel are still in the Military Health System (MHS) or have transitioned to the VHA. However, many service members also will be treated in the civilian health system.

PSYCHIATRIC MEDICATIONS AND SEXUAL ADVERSE EFFECTS

The treatment of PTSD, depression, and other psychiatric conditions often involves medications that have sexual AEs. Sexual AEs usually refer to problems with erectile function (impotence), difficulties with ejaculation, lack of orgasm or desire, or lack of lubrication for women. Selective serotonin reuptake inhibitors (SSRIs) have a very high incidence of sexual AEs, ranging from 30% to 70%.[3] When I speak with clinicians about their anecdotal experience, the percentage always is high, usually more than 50%. Other psychiatric medications, such as antipsychotics, older antidepressants, and stimulants also have sexual AEs, and narcotics are notorious for their sexual AEs.

Fortunately, many solutions exist. For SSRIs, the solutions include lowering the dose of the offending agent, switching to another agent, drug holidays, or adding other medications, such

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as bupropion or cyproheptadine. Family practice and other physicians are very familiar with phosphodiesterase inhibitors, such as sildenafil, tadalafil, and vardenafil. Although these medications have AEs and are very expensive, they work well for impotence.

Other solutions are nonpharmacologic: Setting aside time for intimacy can be crucial. Gels and creams can help with lubrication. Communication with providers and between partners and families is the most important ingredient.

ASKING ABOUT SEXUAL HEALTH

I encourage all medical personnel who treat active-duty service members or veterans to (1) discuss sexual health with their patients; (2) learn the basics of how to evaluate, treat, or refer ED, including SSRI AEs; and (3) understand how to discuss the effects of physical injury, pain, and disability on sexual functioning.

The conversation should touch on sexual activity, satisfaction with intimacy, exposure to sexually transmitted diseases, and if appropriate, previous sexual abuse. The appropriate time and place for a conversation about sexual health depends on the setting. In the outpatient setting, I bring up the subject after I ask about sleep and appetite and before I ask about suicidal and homicidal thoughts; others may choose elsewhere in the patient history. However, asking about sexual issues may or may not be appropriate in an emergency department situation.

Providers often are uncomfortable with asking about sexual issues, perhaps more so if they are young and female and the patient is older and male. Therefore, I encourage expanded training in medical school and throughout residency.

SEXUAL DIFFICULTIES AND SUICIDE

In the military, the suicide rate has been rising from about 10 per 100,000 per year in 2004 to about 20 per 20,000 in this decade.[4,5] According to the VA Office of Suicide Prevention, about 20 veterans commit suicide daily.[6] One question that has received little attention is the relationship between sexual difficulties and suicide. Although there has been an important focus on causes of suicide in the military and veterans, little is known about the important issue of how many service members commit suicide because of impotence.

We do know a lot about the big picture as to why service members commit suicide. In about two-thirds of the completed suicides, there were relationship issues. In addition, there are often legal, occupational, and financial difficulties. About two-thirds of service members commit suicide using firearms. Jumping and strangulation are other common methods.[4,5]

But there is much we do not know. What percentage of relationship difficulties are related to sexual dysfunction? Is ED the straw that breaks the camel's back and leads to the shot to the chest? Other subjects outside the scope of this column (but included in *Intimacy Post Injury*) include sexual therapy, fertility, adaptations for those with disabilities, reproductive AEs of toxin exposure, and surgeries that include penile transplantation.

My hypothesis is that sexual problems, specifically ED or impotence, contribute to feelings of failure and inadequacy and thus to suicidal or homicidal thoughts.

CONCLUSION

Health care providers do not always talk to patients about their sexual health and may barely mention the sexual AEs of psychiatric or other medications. In whatever setting you practice, you should not neglect asking questions about sexual health, as it is a critical issue for many of our patients and should be for us. ●

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