Sexual Dysfunction and Preferences for Discussing Sexual Health Concerns Among Veteran Primary Care Patients

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Background: Sexual health is an important, yet often overlooked, aspect of overall health. Veterans may be particularly at risk for sexual dysfunction. The objectives of this study were to assess the prevalence and correlates of sexual dysfunction and examine preferences among veterans for discussing sexual problems.

Methods: In this cross-sectional study, we mailed 1500 surveys to a random sample of primary care patients from 3 Veterans Affairs medical centers; 313 were returned (21% response rate) and 248 had complete data. Veterans (M age = 49.4 years) were mostly White (86.7%), women (60.9%), and married (79.0%). The Arizona Sexual Experience Scale was used to screen for sexual dysfunction.

Results: Half of veterans, 62.3% of women and 32.0% of men, screened positive for sexual dysfunction. More than 60% of veterans agreed that the primary care team should provide information, proactively ask, and inquire on medical history forms about sexual problems; 59.3% were open to meeting with behavioral health providers.

Conclusions: Primary care providers should ask veterans about sexual health, as sexual dysfunction was prevalent, especially among women and among men over age 65. Most veterans were receptive to being asked about sexual problems in primary care and preferred to be asked rather than bring it up. (J Am Board Fam Med 2021;34:357–367.)

Keywords: Cross-Sectional Studies, Military Medicine, New York, Primary Health Care, Sex Disorders, Sexual Health, Surveys and Questionnaires, Veterans Health Administration

Introduction

Sexual dysfunction is common, yet often overlooked, by health care providers despite its association with poor quality of life and emotional distress and its importance to overall health and well-being. Defined as a “disturbance in a person’s ability to respond sexually or to experience sexual pleasure,” sexual dysfunction may be impacted by a variety of psychological (eg, depression), interpersonal (eg, relationship conflict), sociocultural (eg, religious beliefs), and contextual (eg, work schedule) factors in addition to biological factors. The prevalence of self-reported sexual dysfunction among American adults aged 18 to 59 was...
43% in women and 31% in men, with even higher rates among those aged 57 to 85.

Research suggests that military veterans may be at greater risk for sexual dysfunction, although differences in assessment methods and sample demographics hinder direct comparisons of prevalence rates. Veterans experience high rates of mental health disorders associated with sexual dysfunction, including major depressive disorder (MDD) and post-traumatic stress disorder (PTSD), physical health risk factors, such as tobacco use and medications with sexual side effects, and service-related risk factors, such as combat trauma and traumatic brain injury, that may make them particularly susceptible to sexual dysfunction. Two studies found that 22% to 24% of veterans new to Veterans Affairs (VA) health care reported sexual health concerns on a checklist or had documentation of sexual dysfunction in the VA electronic medical record (EMR). Another study using a self-report measure found that 18% of Iraq/Afghanistan veterans screened positive for sexual dysfunction. Notably, these 3 samples comprised 87% to 90% men with average ages of 29 to 31.

Research on sexual health among women veterans is scarce and limited by methodological constraints. A large study using VA EMR data found the prevalence of sexual dysfunction diagnoses among women veterans of all ages to be 0.61%, while VA EMR studies focused on women Iraq/Afghanistan veterans found rates of 0.45%, 2.4%, and 12.7%. However, their reliance on EMR diagnoses likely yields an underestimate due to under-reporting and underdocumentation. In a telephone interview, 28% of women veterans aged 20 to 52 reported pain during intercourse, but other types of sexual dysfunction were not assessed.

Prior research has established the importance of studying sexual dysfunction among veterans, especially given the risks of physical and psychological trauma they often experience. Although there is a growing literature on veterans’ sexual health, extant work has focused on predominately male samples with narrow age ranges, older adults with PTSD, antidepressant side effects among men with PTSD, or the effects of military sexual trauma among women. Sexual health research among women veterans is especially needed, as women veterans may be a vulnerable subgroup given high rates of sexual assault and mental health disorders.

Specific subgroups of veterans may be at elevated risk for sexual dysfunction. In the general population, correlates of sexual dysfunction include depression, anxiety, relationship dissatisfaction, physical health, and demographic factors, including age, race, ethnicity, marital status, sexual orientation, education, and socioeconomic status. Chronic alcohol consumption is believed to be a risk factor, but findings have been equivocal. Among Iraq/Afghanistan veterans, screening positive for MDD or PTSD was associated with sexual dysfunction in addition to demographic factors. Identifying and treating sexual dysfunction is important to enhancing veterans’ overall health and well-being. As the entry point to the health care system, primary care is the ideal setting for identifying sexual health concerns, with primary care providers (PCPs) positioned as the first point of contact. Openings to discuss sexual health abound in primary care, as many prevalent chronic medical conditions and commonly used medications negatively impact sexual functioning. Furthermore, patients prefer this setting for discussing sexual health concerns. Most primary care patients want PCPs to provide information and ask about sexual dysfunction and prefer to seek help from PCPs due to feeling comfortable given their existing relationship.

Despite primary care being an opportune setting to address sexual health, both PCPs and patients are reluctant to discuss it. Only 12% of men and 15% of women aged 40 to 80 reported being asked about sexual difficulties during a routine visit in the past 3 years, and only 18% to 37% of individuals with persistent sexual problems discussed it with a health care professional in the past year. PCPs recognize the importance of sexual health for their patients but do not routinely discuss this topic for many reasons, including limited time, lack of training, and the high complexity and sensitivity of the topic. PCPs find it especially challenging to discuss sexual health with several subgroups of patients, including people of color, gender and sexual minorities, and those who are older or of another sex. Patients are reluctant to bring up sexual problems due to barriers such as shame/embarrassment, the PCP being a different sex or age, and lack of awareness that sexual dysfunction can be treated.

Obtaining greater understanding of primary care patients’ preferences for discussing sexual health concerns can help direct primary care teams to be more patient centered and reduce these barriers. As
primary care is increasingly team based, often including embedded behavioral health providers (BHPs), there are a range of primary care team members, especially in VA settings, who can assist PCPs with assessment and management of sexual dysfunction. BHPs such as psychologists may be particularly well suited to help bridge the communication gap between PCPs and patients to better address sexual health as part of an interdisciplinary, biopsychosocial approach that is recommended for the assessment and treatment of sexual dysfunction.

The objectives of this study were to assess the prevalence of sexual dysfunction, examine correlates of sexual dysfunction, and describe preferences for discussing sexual health concerns in primary care among veterans. This research is important to help better identify the scope and presentation of sexual health concerns in primary care among veterans, a population who may be particularly at risk for sexual dysfunction.

Methods

Procedures

Data were collected as part of a larger study on intimate partner violence (IPV) in veteran primary care patients. This study was approved by the Syracuse VA Medical Center Institutional Review Board. The parent study used a cross-sectional design with a one-time mailed survey. The survey, a letter explaining that the study was examining “common relationship problems,” a study description explaining that completing the survey indicates informed consent, and a postage-paid return envelope were mailed to a random sample of 1500 veterans aged 18 to 85 who used primary care services at any of 3 VA health care systems in Central and Western New York in 2018 and were in a romantic relationship per the VA EMR. Women veterans were oversampled to achieve a 1:1 sex ratio, and veterans aged 18 to 55 were oversampled at a 4:1 ratio based on prior IPV research indicating a reduction in all forms of IPV by age 55. Veterans diagnosed with major neurocognitive disorder, delusional disorder, or severe/profound intellectual disability were not eligible. Participants were compensated $20 for completing the survey.

Measures

Demographic questions included sex, age, race, ethnicity, relationship status, sexual orientation, highest level of education completed, annual household income, and combat exposure. For analyses, race was collapsed to White, Black, or other, and relationship status was collapsed to currently dating or married and living together versus other. To avoid confounding with sex, sexual orientation was recoded to heterosexual versus other.

Validated self-report questionnaires were used to measure sexual dysfunction and mental health correlates. The 5-item Arizona Sexual Experience Scale (ASEX) was used to assess sexual dysfunction (α = 0.89 in this sample). Items were rated on a 6-point Likert scale from 1 (hyperfunction, eg, extremely strong sex drive) to 6 (hypofunction, eg, no sex drive). ASEX scores can be used to screen for sexual dysfunction (total score ≥19, any 1 item ≥5, or any 3 items ≥4), including global dysfunction as well as pronounced difficulties in specific domains. The ASEX has been used in veteran primary care.

MDD was assessed using the Patient Health Questionnaire-9 (PHQ-9; α = 0.91) following established scoring algorithms for probable MDD diagnosis. PTSD was assessed using the PTSD Checklist for DSM-5 (PCL-5; α = 0.97), with a total score ≥33 indicating probable diagnosis. Alcohol use was assessed using the Alcohol Use Disorders Identification Test (AUDIT; α = 0.84), with a total score ≥5 for women and ≥8 for men indicating probable hazardous use. Relationship satisfaction was assessed using the 4-item Couples Satisfaction Index (CSI-4; α = 0.96), with a total score <13.5 indicating relationship dissatisfaction.

Preferences for discussing sexual health were assessed using 6 items adapted from a prior study (we changed “primary care doctors” to “the primary care team”) and 2 items referencing BHPs created for this study. Items were rated on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). A seventh item assessed discussing sexual problems with a BHP given our interest in integrated primary care. These 7 items were examined separately, but Cronbach’s α was high for the 5 proactive items (α = 0.83) and 2 reactive items (α = 0.84). The eighth item assessed preferred format for help with sexual problems.

Analysis Plan

Descriptive statistics were calculated. Chi-square tests (categorical variables) and logistic regressions (interval/continuous variables) were used to examine demographic and mental health correlates of screening.
positive for sexual dysfunction; when these variables differed by sex (see Table 1), we examined correlates separately by sex. Logistic regression was used to calculate odds ratios. Chi-square tests were used to examine differences in preferences (strongly or somewhat disagree and neutral vs strongly or somewhat agree) by sex, age-group, and screening positive for sexual dysfunction. \( \alpha \) for all analyses was set a priori at 0.05.

### Table 1. Descriptive Statistics for Demographic and Mental Health Variables in Veteran Primary Care Patient Sample

| Variable                        | Women (n = 151) | Men (n = 97) | Total Sample (n = 248) | \( P \) Value |
|---------------------------------|-----------------|------------|------------------------|--------------|
| Age-group                       |                 |            |                        | <0.001       |
| 18 to 44 years old              | 65 (43.1)       | 22 (22.7)  | 87 (35.1)              |              |
| 45 to 64 years old              | 73 (48.3)       | 50 (51.6)  | 123 (49.6)             |              |
| 65 years and older              | 13 (8.6)        | 25 (25.8)  | 38 (15.3)              |              |
| Race                            |                 |            |                        | 0.27         |
| White                           | 129 (85.4)      | 86 (88.7)  | 215 (86.7)             |              |
| Black or African American       | 10 (6.6)        | 8 (8.3)    | 18 (7.3)               |              |
| Other                           | 12 (8.0)        | 3 (3.1)    | 15 (6.1)               |              |
| Hispanic or Latino ethnicity*   | 10 (6.6)        | 3 (3.1)    | 13 (5.2)               | 0.25         |
| Relationship status             |                 |            |                        | 0.79         |
| Currently married and living together | 119 (78.8)     | 72 (74.2)  | 191 (77.0)             |              |
| Currently dating and living together | 18 (11.9)      | 15 (15.5)  | 33 (13.3)              |              |
| Other†                          | 14 (9.3)        | 10 (10.3)  | 24 (9.7)               |              |
| Sexual orientation              |                 |            |                        | <0.001       |
| Heterosexual                    | 120 (79.5)      | 94 (96.9)  | 214 (86.3)             |              |
| Other‡                          | 31 (20.5)       | 3 (3.1)    | 34 (13.7)              |              |
| Highest level of education completed |             |            |                        | 0.002        |
| Less than high school           | 0 (0)           | 0 (0)      | 0 (0)                  |              |
| High school or GED              | 10 (6.6)        | 23 (23.7)  | 33 (13.3)              |              |
| Some college                    | 82 (54.3)       | 45 (46.4)  | 127 (51.2)             |              |
| 4-year college degree           | 37 (24.5)       | 20 (20.6)  | 57 (23.0)              |              |
| Master’s degree or higher       | 22 (14.6)       | 9 (9.3)    | 31 (12.5)              |              |
| Annual household income         |                 |            |                        | 0.92         |
| Less than $20,000               | 9 (6.0)         | 8 (8.3)    | 17 (6.9)               |              |
| $20,000 to $39,999              | 24 (15.9)       | 13 (13.4)  | 37 (14.9)              |              |
| $40,000 to $59,999              | 30 (19.9)       | 19 (19.6)  | 49 (19.8)              |              |
| $60,000 to $79,999              | 34 (22.5)       | 26 (26.8)  | 60 (24.2)              |              |
| $80,000 to $99,999              | 23 (15.2)       | 14 (14.4)  | 37 (14.9)              |              |
| More than $100,000              | 31 (20.5)       | 17 (17.5)  | 48 (19.4)              |              |
| Military combat exposure        | 31 (20.5)       | 51 (52.6)  | 82 (33.1)              | <0.001       |
| Probable MDD (PHQ-9)            | 33 (21.9)       | 25 (25.8)  | 58 (23.4)              | 0.48         |
| Probable PTSD (PCL-5)           | 47 (31.1)       | 28 (28.9)  | 75 (30.2)              | 0.71         |
| Hazardous alcohol use (AUDIT)   | 33 (21.9)       | 14 (14.4)  | 47 (19.0)              | 0.15         |
| Relationship dissatisfaction (CSI-4) | 69 (45.7)     | 41 (42.3)  | 110 (44.4)             | 0.60         |

AUDIT, Alcohol Use Disorders Identification Test; CSI-4, Couples Satisfaction Index; GED, general equivalency diploma; MDD, major depressive disorder; PCL-5, PTSD Checklist for DSM-5; PHQ-9, Patient Health Questionnaire-9; PTSD, post-traumatic stress disorder.

Data were collected via a mailed survey in August–September 2019.

*Proportion who reported Hispanic or Latino ethnicity out of full sample; responses were missing for 38 participants.

†Includes participants who were currently married and living apart, currently dating and living separately, currently dating but not in a committed relationship, divorced, widowed, and single, never married and not dating anyone.

‡Includes 2 men and 5 women who identified as sexually attracted equally to males and females, 5 women who identified as sexually attracted only to females, 21 women who identified as sexually attracted primarily to males, and 1 man who identified as sexually attracted only to males.
Results

Of the 316 veterans who returned surveys, 248 had complete data with all variables used in this analysis. Missing data occurred across all variables (eg, demographics, mental health) with only 10 participants excluded due to missing data on the ASEX. There were no significant differences on any variables between the study sample and the 68 veterans excluded for missing data, with 1 exception; the study sample was slightly younger than those excluded (49.4 ± 13.0 vs 53.9 ± 14.3, \( P = .02 \)).

Most participants were female (60.9%) and White (86.7%), with an average age of 49.4 years (13.0), range: 25 to 85. On average, men in the sample were older than women (53.2 ± 13.3 years vs 47.0 ± 12.2, \( P < .001 \)). See Table 1 for descriptive data on demographic and mental health variables. Almost all participants (96.4%) reported having a current dating or marriage partner; among these, the average relationship duration was 17.18 ± 13.24 years.

Half of the sample (50.4%) screened positive for sexual dysfunction on the ASEX; among these, 28.8% met 1 ASEX criteria, 16.8% met 2, and 54.4% met all 3. Table 2 displays the proportion indicating enhanced (scores of 1, 2, or 3), subthreshold (4), and reduced (scores of 5 or 6) sexual functioning on each ASEX item as well as the proportion meeting any criteria for sexual dysfunction. The average ASEX total score was higher for women than men (17.56 ± 5.86 vs 14.57 ± 4.85, \( P < .001 \)). Women were more likely than men to screen positive for sexual dysfunction (odds ratio [OR] = 3.51, 95% confidence interval [CI], 2.05, 6.02, \( P < .001 \)) and to have an ASEX total score ≥19, suggestive of global sexual dysfunction (OR = 4.26, 95% CI, 2.28, 7.96, \( P < .001 \)).
For women (OR = 1.04, 95% CI, 1.01, 1.07, \( P = .005 \)) and men (OR = 1.07, 95% CI, 1.03, 1.11, \( P < .001 \)), the odds of screening positive for sexual dysfunction increased with age. Although age-group was not associated with screening positive for women, it was for men; 60.0% of men aged \( \geq 65 \) screened positive compared with 24.0% of men aged 45 to 64 and 18.2% of men aged 18 to 44 (\( P = .002 \)). Sexual orientation, education, and combat exposure were not associated with screening positive for sexual dysfunction for women or men. No other demographic or mental health variables were associated with screening positive for sexual dysfunction in the total sample.

Overall, most participants (61.7% to 68.2%) agreed that the primary care team should provide information, proactively ask patients, and inquire on medical history forms about sexual problems (see Table 3). Most (59.3%) reported they would meet with a BHP if recommended. Participants had mixed opinions regarding the team waiting until the patient brought up sexual health, but most indicated they preferred to be asked about sexual problems. One third of participants preferred a face-to-face discussion with their PCP to discuss sexual problems; a face-to-face discussion with a BHP and printed information to read at home were the next most preferred formats (see Table 3).

There were no differences in preferences for discussing sexual problems in primary care by sex and only 1 for age-group. Veterans aged 45 to 64 were more likely than those aged 18 to 44 or \( \geq 65 \) to agree that the primary care team should only talk about sexual problems after patients bring them up (48.0% vs 31.0% and 31.6%, \( P = .026 \)). Differences in preferences by screening status are displayed in Table 4. Veterans who screened positive for sexual dysfunction were more likely to prefer being asked about sexual problems than initiating the discussion themselves.

Table 3. Preferences regarding Sexual Health Discussions Among Veteran Primary Care Patients (n = 248)

| Preference Item                                                                 | Strongly or Somewhat Disagree n (%) | Neutral n (%) | Strongly or Somewhat Agree n (%) |
|---------------------------------------------------------------------------------|--------------------------------------|---------------|----------------------------------|
| The primary care team should give all patients information about sexual problems| 26 (10.5)                            | 69 (27.8)     | 153 (61.7)                       |
| The primary care team should ask all patients if they are having sexual problems| 24 (9.7)                             | 69 (27.8)     | 155 (62.5)                       |
| The primary care team should only talk about sexual problems after patients bring them up | 94 (37.9)                            | 56 (22.6)     | 98 (39.5)                        |
| The primary care team should include a question about sexual problems on the medical history form | 20 (8.1)                              | 59 (23.8)     | 169 (68.2)                       |
| If I were having sexual problems, I would like my primary care team to ask me about them | 24 (9.7)                              | 61 (24.6)     | 163 (65.7)                       |
| If I were having sexual problems, I would like my primary care team to wait until I bring them up | 101 (40.7)                            | 66 (26.6)     | 81 (32.7)                        |
| If I were having sexual problems, I would meet with a behavioral health provider in primary care if my primary care team recommended it | 33 (13.3)                             | 68 (27.4)     | 147 (59.3)                       |
| Preferred format for help with sexual problems                                  |                                      |               |                                  |
| Face-to-face discussion with my primary care provider                            | 81 (32.7)                            |               |                                  |
| Face-to-face discussion with behavioral health provider                          | 41 (16.5)                            |               |                                  |
| Printed information to read at home on my own                                   | 40 (16.1)                            |               |                                  |
| Website with information                                                        | 36 (14.5)                            |               |                                  |
| No preference                                                                   | 34 (13.7)                            |               |                                  |
| Mobile app with information                                                     | 7 (2.8)                              |               |                                  |
| Telephone call with behavioral health provider                                   | 5 (2.0)                              |               |                                  |
| Telephone call with my primary care provider                                     | 4 (1.6)                              |               |                                  |
Half of the veterans in this primary care sample—62% of women and 32% of men—screened positive for sexual dysfunction on a validated self-report measure, suggesting it is a significant concern among veteran primary care patients. Women were 3.5 times more likely than men to screen positive for sexual dysfunction, highlighting the importance of addressing this concern for women veterans seen in primary care. Women veterans may be particularly at risk for sexual dysfunction due to an array of inter-related vulnerabilities, including childhood sexual abuse, IPV, physical hazards of combat, higher rates of PTSD and MDD, and lack of access to gynecological care while deployed. Women veterans are also much more likely than men to experience military sexual trauma, which is associated with increased risk of sexual dysfunction.

Sexual dysfunction was also more likely among older veterans. Advancing age may bring about physiologic (eg, declining physical health) and psychosocial (eg, increased stress) changes that interfere with sexual functioning. There were no other correlates of sexual dysfunction in this sample, but the null findings may be related to a lack of statistical power given our sample size. Future research should continue to explore correlates of sexual dysfunction in veterans using larger samples, including those who do and do not use VA health care.

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**Table 4. Preferences for Discussing Sexual Health Among Veteran Primary Care Patients by Sexual Dysfunction Screen Status (n = 248)**

| Preference Item and Sexual Dysfunction Screen Status* | Strongly or Somewhat Disagree or Neutral n (%) | Strongly or Somewhat Agree n (%) | P Value |
|------------------------------------------------------|------------------------------------------------|-------------------------------|---------|
| The primary care team should give all patients information about sexual problems | 55 (44.7) | 68 (55.3) | 0.039 |
| Negative screen | 40 (32.0) | 85 (68.0) |         |
| Positive screen |             |                     |         |
| The primary care team should ask all patients if they are having sexual problems | 53 (43.1) | 70 (56.9) | 0.07 |
| Negative screen | 40 (32.0) | 85 (68.0) |         |
| Positive screen |             |                     |         |
| The primary care team should only talk about sexual problems after patients bring them up | 62 (50.4) | 61 (49.6) | 0.001 |
| Negative screen | 88 (70.4) | 37 (29.6) |         |
| Positive screen |             |                     |         |
| The primary care team should include a question about sexual problems on the medical history form | 45 (36.6) | 78 (63.4) | 0.11 |
| Negative screen | 34 (27.2) | 91 (72.8) |         |
| Positive screen |             |                     |         |
| If I were having sexual problems, I would like my primary care team to ask me about them | 50 (40.7) | 73 (59.4) | 0.036 |
| Negative screen | 35 (28.0) | 90 (72.0) |         |
| Positive screen |             |                     |         |
| If I were having sexual problems, I would like my primary care team to wait until I bring them up | 72 (58.5) | 51 (41.5) | 0.003 |
| Negative screen | 95 (76.0) | 30 (24.0) |         |
| Positive screen |             |                     |         |
| If I were having sexual problems, I would meet with a BHP in PC if my primary care team recommended it | 51 (41.5) | 72 (58.5) | 0.81 |
| Negative screen | 50 (40.0) | 75 (60.0) |         |
| Positive screen |             |                     |         |

BHP, behavioral health provider; PC, primary care.
*A positive screen for sexual dysfunction on the Arizona Sexual Experience Scale is indicated by a total score ≥ 19, any 1 item ≥ 5, or any 3 items ≥ 4.*

**Discussion**

Half of the veterans in this primary care sample—62% of women and 32% of men—screened positive for sexual dysfunction on a validated self-report measure, suggesting it is a significant concern among veteran primary care patients. Women were 3.5 times more likely than men to screen positive for sexual dysfunction, highlighting the importance of addressing this concern for women veterans seen in primary care. Women veterans may be particularly at risk for sexual dysfunction due to an array of inter-related vulnerabilities, including childhood sexual abuse, IPV, physical hazards of combat, higher rates of PTSD and MDD, and lack of access to gynecological care while deployed. Women veterans are also much more likely than men to experience military sexual trauma, which is associated with increased risk of sexual dysfunction.

Sexual dysfunction was also more likely among older veterans. Advancing age may bring about physiologic (eg, declining physical health) and psychosocial (eg, increased stress) changes that interfere with sexual functioning. There were no other correlates of sexual dysfunction in this sample, but the null findings may be related to a lack of statistical power given our sample size. Future research should continue to explore correlates of sexual dysfunction in veterans using larger samples, including those who do and do not use VA health care.
One commonality between men and women in this veteran sample was sex drive being the most prevalent sexual problem. One in 5 men indicated hypofunction in sex drive, followed by 1 in 8 with erectile dysfunction. Among women, 2 in 5 indicated hypofunction in sex drive, followed by 1 in 4 with sexual arousal and reaching orgasm. Thus, PCPs working with veterans should be cognizant of the potential for difficulties across the full sexual response cycle.

Consistent with prior research, veterans indicated receptivity to discussing sexual health in primary care. Approximately two thirds agreed that the primary care team should provide all patients with information about sexual problems, ask all patients about it, and include a question about it on the medical history form. Taken together, high prevalence rates and patient preferences suggest shifting current clinical practices in primary care toward more proactive screening approaches—especially among women veterans and older adults—initiated by the primary care team rather than patients. Patients may be reluctant to bring up sexual problems due to embarrassment, shame, concerns about making providers uncomfortable, or beliefs that sexual dysfunction is normal with aging, is not a medical problem, or cannot be treated.

Regarding their preferred format for help for sexual problems, veterans were most likely to prefer a face-to-face discussion with their PCP. However, the next most preferred option was a face-to-face discussion with a BHP, and 59% of veterans indicated willingness to meet with a BHP if their primary care team recommended it. Incorporating BHPs may have advantages for PCPs and patients, as BHPs are highly trained in discussing sensitive topics, likely have more time to spend with patients than PCPs, and, most importantly, can provide biopsychosocial assessments and behavioral interventions to address sexual dysfunction.

As for format, veterans seemed to strongly prefer face-to-face discussions rather than telephone calls or a mobile app, which may reflect privacy concerns or the sensitive nature of this topic.

Generally, veterans screening positive for sexual dysfunction were more likely to want to receive information and be asked about sexual problems by the primary care team rather than bring it up themselves. It can be so uncomfortable to raise sexual health concerns that many patients deal with sexual dysfunction for years before discussing with a health care professional. PCPs thus have an opportunity to offer patient-centered care for veterans by proactively inquiring about possible sexual dysfunction to open the door for this discussion.

**Methodological Strengths and Limitations**

Strengths of this study include our focus on an understudied topic within veteran health care and using validated measures to screen for sexual dysfunction and mental health. The ASEX is well suited for primary care because it is brief, easy to understand, and minimally intrusive. Our sample had higher proportions of women, veterans ≥45 years old, and individuals with diverse sexual orientations than prior work, which likely contributes to the prevalence rate of sexual dysfunction being higher than in prior studies. Our prevalence rate among men aged 18 to 44 is equivalent to past research using the ASEX with a similar-aged predominantly male veteran sample. The prevalence of sexual dysfunction among women veterans in our sample is much higher than prior studies, but the ASEX directly assesses a range of sexual health difficulties compared with previous research that relied on EMR diagnoses or assessments of 1 symptom. However, it is consistent with higher rates found in nationally representative studies using self-reports of sexual dysfunction.

Although this supports the generalizability of the results, future research should replicate this study in a national sample with more diversity in race/ethnicity. Given concerns about the medicalization of sexual dysfunction, it is imperative to supplement self-report data with clinical interviews to elucidate the prevalence of sexual dysfunction symptoms versus clinically significant distress and impairment. Further assessment is particularly prudent given that the most common problem endorsed at a level indicating a positive ASEX screen (item score ≥5) was diminished sex drive, which may be impacted by a variety of biopsychosocial factors.

Methodological limitations should be considered when interpreting our results. As with any survey study, the potential exists for social desirability bias. Our response rate of 21% raises the potential of response bias but is comparable to those obtained in other recent mailed health surveys of veterans (21%, 25%, 26%). The sample was limited to veterans using VA health care in 1 state. Like most
self-report measures of sexual dysfunction, the ASEX focuses on the individual’s bodily responses rather than the broader intrapersonal and interpersonal context of sexuality. We did not collect data on physical health conditions or medications relevant to sexual functioning or assess whether participants had been diagnosed with or discussed sexual problems with their primary care team. Due to the cross-sectional study design, no attributions of causality can be made.

Clinical and Research Implications
Results from our study indicate that primary care teams should increase their attention to sexual health among veteran patients, especially for women of all ages and men aged 65 and older. Sexual health is often neglected in the American health care system despite its importance to overall well-being and quality of life.2,3

Based on veteran preferences for proactive screening, PCPs should incorporate a question about sexual problems into their standard medical history and ask about it regularly (eg, annually). Questionnaires can serve as conversational aides to help providers and patients broach the topic of sexual dysfunction. A brief validated measure, such as the 5-item ASEX,36 the 5-item International Index of Erectile Function for men,56 or even a single-item screener57 could significantly increase discussions regarding sexual health in primary care settings.

PCPs are encouraged to consult published guidance on assessing sexual health, which not only provides examples of what domains to cover and how to word sensitive questions but also illustrates the process of nonjudgmental, patient-centered assessment using a biopsychosocial approach.58-61 The Extended PLISSIT model62,64 offers providers a structure for how to talk with patients about sexual health, and the 5 Ps model65 offers a structure for what to assess. For those seeking in-depth resources, the Kinsey Institute Library provides online access to a textbook entitled Sexual Medicine in Primary Care.65

Future research should expand on this work. Recognizing that sexual dysfunction is only one aspect of sexual health, research needs to explore how to shift clinical practices toward acknowledging the importance of sexuality across the lifespan and normalizing discussions of this topic in primary care. In addition, future work should explore veterans’ preferences for and effectiveness of BHP and/or PCP interventions for sexual dysfunction in primary care.

To see this article online, please go to: http://jabfm.org/content/34/2/357.full.

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