

**SEX** &  
the **military**  
The Other Invisible Wounds



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# Welcome!

## Dear Behavioral Health Provider:

The Center for Innovation and Research on Veterans & Military Families (CIR) of the University of Southern California School of Social Work is dedicated to strengthening the transition of veterans and their families into the community. An important facet of this transition involves the intimate relationship and the integration of the service member back into family life. CIR developed this toolkit to help behavioral health practitioners address some of the sexual and intimate relationship challenges that injured service members, veterans, and their spouse/partner may experience.

**Target.** The toolkit materials were designed for social workers, but are applicable to other behavioral health practitioners, such as nurses and psychologists, who work with or plan to work with military populations and/or those who are at risk for sexual functioning problems. Students in an undergraduate or graduate social work or other behavioral health degree program are a secondary audience. These materials are designed to be readily used by faculty in such academic programs, and integrated with other educational materials.

**Focus.** While sexual functioning problems can occur in both military and civilian populations, this toolkit focuses on the unique features within the military that can impact sexual functioning. Service members are exposed to physical and psychological challenges that can lead to or exacerbate sexual functioning and intimacy problems. While this toolkit does not provide comprehensive training related to sexual functioning and military populations, it aims to increase your awareness and knowledge of these issues so that you will be better prepared to address them in a clinical setting.

**How the Toolkit Helps You (Learning Objectives).** Using this toolkit, you should be able to:

- Recognize salient issues related to intimacy and sexual functioning in military personnel, veterans, and their intimate partner.
- Identify communication strategies for talking with patients about sexual functioning.
- Recognize intervention strategies for patients with sexual functioning issues, and when to refer to other clinical personnel.
- Recognize the need for policy change in the area of sexual functioning and the military, and identify strategies to champion this change.

**Components.** This toolkit includes the following main components.

- **Research Overview.** A brief research-based background of the issues presented.
- **Video Vignettes Activity.** Three video vignettes of a client/patient interaction with supporting materials for background and discussion, as well as communication and intervention strategies.
- **CIR Policy Briefs.** CIR's recommendations for policy change related to sexual functioning issues in the military, and what can be done to help effect change.
- **Resources and References.** Additional resources for working with clients with sexual functioning issues, references used to compile the toolkit, and suggestions for further reading.

Thank you for your commitment to service members, veterans, and military families! For additional information about this project, please visit:

<http://cir.usc.edu/research/research-projects/sexual-functioning>.

Sincerely,

**Sherrie L. Wilcox, PhD, CHES**

Research Assistant Professor

Principal Investigator, *The Other Invisible Wounds: Sex & the Military*

# Research Overview

## Importance of Sexual Functioning

Sexuality and sexual functioning have been described as an “integral part of human life” (Satcher, 2001). An individual’s sexual health encompasses not only the absence of disease and dysfunction, but also physical, emotional, mental, and social well-being (World Health Organization, 2014). In military populations, sexual functioning has been highlighted as an important issue due to the increased exposure to risk factors and the high likelihood of experiencing sexual functioning problems (Mulligan & Moss, 1991; Wilcox, Redmond, & Hassan, 2014).

## Combat and Physical Injuries

Advanced technology, medicine, and equipment have boosted military survival rates. Despite a lower death rate, many service members return home both physically and psychologically injured (Gawande, 2004; Goldberg, 2010; Tanielian & Jaycox, 2008; U.S. Department of Defense, 2014; Warden, 2006).

Recent research indicates that approximately 17-19% of service members return home from combat with at least one physical injury (Afari et al., 2009; Baker et al., 2009). The unique nature of the most recent conflicts in Iraq and Afghanistan, including the heavier reliance on dismounted patrol and the overwhelming presence of improvised explosive devices (IEDs), has given rise to a substantial increase in the presence of urotrauma (Ficke et al., 2012; Han, Edney, & Gonzalez, 2013; Sharma, Webster, Kirkman-Brown, Mossadegh, & Whitbread, 2013; Woodward & Eggertson, 2010).

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**Approximately 17-19% of service members return home from combat with at least one physical injury**

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## Urotrauma

Urotrauma involves injury to the genitourinary (GU) system, which includes the genitals, bladder, urinary tract, and kidneys, and results primarily from IEDs. It is believed that approximately 12% of war injuries sustained during recent operations involved GU injury (Woodward & Eggertson, 2010). Data from the Joint Theater Trauma Registry has indicated that approximately 5% of battle trauma injuries involve GU injury (Serkin et al., 2010; Waxman, Beekley, Morey, & Soderdahl, 2009). Among men fighting in Iraq and Afghanistan, loss of genital or penile tissue is of great concern and has been rated by service members as more important than other lower limb extremity injuries (Lucas, Page, Phillip, & Bennett, 2014; D. Rosen, 2013; Wood, 2012). Although the American Urologic Association (AUA) has recently

developed detailed guidelines for the medical treatment of these injuries (Morey et al., 2014), the long-term impact remains understudied, despite the potential effects on the service member's psychological, sexual, and reproductive functioning. Recent research indicates that male military personnel with a genital injury are 9-32 times more likely to have sexual functioning problems than those without a genital injury (Wilcox et al., 2014).

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## Psychological Injuries and Sexual Functioning

In addition to the physical wounds of war, service members are at risk for psychological injuries. Upwards of

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**Approximately 80% of those with PTSD also suffer from sexual functioning problems**

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30% of service members return home suffering from a mental health disorder, primarily posttraumatic stress disorder (PTSD) or depression (Hoge et al., 2004; Tanielian & Jaycox, 2008). Although there is a dearth of research on sexual functioning in military populations, available research indicates

that approximately 80% of those with PTSD also suffer from sexual functioning problems (Cosgrove et al., 2002; Letourneau, Schewe, & Frueh, 1997). The rates are likely elevated in those who take certain medications for depression and PTSD, due to the side effects of reduced sexual desire and arousal difficulties (R. C. Rosen, Lane, & Menza, 1999). Recent research indicates that over 30% of male military personnel report symptoms of erectile dysfunction and 8.45% report symptoms of sexual dysfunction (Wilcox et al., 2014). Additionally, male military personnel with mental health problems, including PTSD, depression, and anxiety, are 5-30 times more likely to have problems with sexual functioning than those without mental health problems (Wilcox et al., 2014).

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**30% of male military personnel report symptoms of erectile dysfunction and 8.45% report symptoms of sexual dysfunction**

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## Lack of Treatment

Similar to the lack of widely available resources for genitourinary injuries, sexual functioning problems as a result of psychological injuries among military personnel also lack adequate and widely available treatment. Currently, treatment strategies within the military and Department of Veterans Affairs (VA) health care systems are largely focused on pharmacological and medical treatments for erectile

dysfunction, despite the presence of a variety of sexual functioning issues among men and women, and the availability of various forms of treatment. Military personnel with sexual functioning problems are more likely to have lower quality of life and lower happiness than those without sexual functioning problems (Wilcox et al., 2014).

## Behavioral Health Providers' Preparation to Address Sexual Issues

Despite a high rate of sexual functioning problems, their strong association with common physical and psychological injuries, and their impact on quality of life and happiness, few behavioral health providers are prepared to address these problems. Many behavioral health providers receive limited training on sexual functioning and intimacy, which limits their knowledge and confidence in assessment and treatment of these problems (Hough & Squires, 2012; Miller & Byers, 2009; Wiederman & Sansone, 1999). There is a clear need to train behavioral health providers to address these problems in military populations in order to effectively support service members, veterans, and military families. These injuries can have lifelong psychological and interpersonal implications, and efforts to improve the outcomes of such injuries have the potential to also improve quality of life for military populations.

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**There is a clear need to train behavioral health providers to address these problems in military populations**

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## How This Toolkit Can Help

To address this need, this educational toolkit focuses on the physical and psychological injuries that are associated with sexual functioning problems in both male and female service members, veterans, and their intimate partners. Three video vignettes depict three different types of sexual functioning problems along with associated physical and/or psychological issues. While this toolkit is not a comprehensive sexual functioning course, it provides suggested strategies for addressing these problems in military populations. **This toolkit aims to increase knowledge and awareness of sexual functioning problems in military populations so that you will be better prepared to address them in a clinical setting.** With the implementation of the Affordable Care Act and the enhanced focus on comprehensive health care and wellness, the United States as a whole is presented with a unique opportunity to bring sexual health and functioning into a national focus (National Defense Authorization Act for Fiscal Year 2014, 2013). The integration of care for sexual functioning problems into existing health systems would reflect its intricate involvement in many aspects of health and well-being.



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# Video Vignettes Activity

## Introduction

### Overview

This activity comprises viewing three short video vignettes (each approximately 10 minutes) which depict examples of sexual functioning issues for three different military clients of varying age, gender, sexual orientation, relationship status, and ethnicity: Jake, Grace, and Manny. Each main character is seen in a social worker's office as a client, with background information describing the problems interspersed with the clinician/patient interactions. After viewing each video, thought questions are presented for reflection and discussion, and suggested answers are provided as feedback. In addition, an introduction to communication and intervention strategies for such issues is presented, providing additional resources to help you work with individuals faced with sexual functioning problems.

### Learning Objectives

These videos are intended to:

- Raise awareness of issues in sexual functioning that may occur in military populations.
- Indicate how military service may impact sexual functioning.
- Compare and contrast differences between military and civilian cultures as well as the influence of ethnicity, gender, and sexual orientation relevant to sexual issues.

### How to Complete the Activity

This activity is designed to be completed by either an individual working in a self-study mode, or as an instructor-led activity within a learning environment. There are various components of this activity which are intended to be navigated as follows.

1. Read this [Introduction](#) completely.
2. Read [Video Vignettes Activity - Overall Dynamics](#) to learn the aspects common to all three vignettes relevant to working with military-affiliated individuals.
3. Read [Overview of Relevant Mental and Sexual Disorders](#).

4. Then for each video vignette:

- ✓ Read the one paragraph film background.
- ✓ Watch the video vignette.
- ✓ Read the dynamics specific to the vignette to gain additional knowledge about the client and his/her issue now that the video has provided you the basics of the problems faced.
- ✓ Reflect on the thought questions and answer each. Refer to the *Communications Strategies* and *Intervention Strategies* provided as you prepare your answers.
- ✓ Review answers to the questions using the suggested answers/feedback provided.
- ✓ For additional research information, read *Research Behind the Vignette*.

## Overall Dynamics

The three video vignettes have several commonalities, as well as specific dynamics particular to each. The common themes are integral to military culture and provide the backdrop for all post-viewing review and discussion.

### Military Culture

Across all three vignettes, you will see the following manifestations of military culture in the lead characters, which affect the dynamics of their relationships and their behaviors.

- **Warrior Mentality or Ethos.** Each film's main character (Jake, Grace, Manny) has been steeped in the "warrior" tradition, a worldview that informs their actions and a lens through which their own behavior is evaluated. This warrior ethos implies strength, invulnerability, and being combat-ready (i.e., being adaptable and letting their training kick in automatically without thinking). This mentality is so integrated into the psyche of military personnel that it becomes part of their DNA, so to speak, and the warrior struggles to put it aside when s/he returns home.
- **Stoicism.** The warrior mentality also requires stoicism. Feelings are expected to be internalized rather than expressed. A person is expected to be autonomous and not need anyone (although perhaps paradoxically s/he is expected to rely on and respect authority). While these behaviors are likely essential during military service, they can wreak havoc on civilian relationships. Expressing both positive and negative feelings to people one cares about requires an emotional vulnerability that would be dangerous during combat, and thus has been covered over with protective armor. All of the protagonists in our films suffer from this conditioning.
- **Lock and Load Mentality.** Additionally, and very relevant to the sexual life of our characters, is what has been referred to as a "lock and load" mentality. This philosophy demands that a man be tough, ready at all times, and perform well. While this philosophy infuses American life in general, it is accentuated in the military environment, which is first and foremost a masculine entity. Thus, our female character is not immune to these messages either.

### Invisible Wounds

The consequence of not living up to the ideals of military culture is the negative impact on one's self-esteem, how one evaluates one's own worth in the world. A sense of shame often results, propelling the person to withdraw or hide. Sexual functioning in relation to oneself and one's partner is a significant component of self-esteem (even the word "performance," which is often used in connection with sex, implies evaluation by oneself and one's partner). When sexual functioning is impaired, the wound to the Self is great. The physical wounds to the body may pale in comparison to these psychological wounds.

## **How Trauma Alters One's Worldview**

Another important point to consider is how trauma in general can alter one's worldview, both civilian and military. From seeing the world as a relatively just, benevolent, and predictable place, one's worldview may shift to seeing the world as unjust, with no predictability, where people cannot be assumed to be basically good. This shift in perception may seriously affect how one views people who were formerly trusted and cherished – a wariness or guardedness may overlay the relationship.

## **Considering These Variables**

As you view the films and think about/discuss the dynamics of each, be sure to consider how the variables mentioned above impact these clients. Being a culturally sensitive clinician, how might you address these issues?

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## Overview of Relevant Mental & Sexual Disorders

A full discussion of mental and sexual disorders is beyond the scope of this toolkit. However, following are the major characteristics of several relevant disorders, as listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) (American Psychiatric Association, 2013). Behavioral health practitioners should keep in mind that while not everyone meets full criteria for a mental disorder, many have some characteristics that cause difficulty in their daily lives.

### **Posttraumatic Stress Disorder (PTSD)**

- Exposure to actual or threatened death, serious injury, or sexual violence
- Intrusive symptoms
- Avoidance of reminders of the event
- Arousal and reactivity
- Negative alterations in cognitions and mood
- Disturbance that causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- Disturbance is not attributable to the physiological effects of a substance or another medical condition

### **Major Depressive Disorder (MDD)**

A diagnosis requires five or more of the following symptoms present during the same two-week period and representing a change from previous functioning. At least one must be either depressed mood or loss of interest or pleasure.

- Depressed mood most of the day, nearly every day
- Markedly diminished interest in all or almost all activities most of the day, nearly every day
- Significant weight loss when not dieting, or weight gain, or decrease or increase in appetite nearly every day
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt

## DSM-V Sexual Dysfunctions Diagnostic Criteria

**Note:** For all male and female sexual dysfunctions, the following additional diagnostic criteria must be met: symptoms must cause clinically significant distress, and the dysfunction must not be better explained by a non-sexual mental disorder or attributable to the effects of a substance/medication or other medical condition.

*Table: DSM-V Sexual Dysfunctions (Source: American Psychiatric Association, 2013)*

<b>Sexual Dysfunction</b>	<b>Diagnostic Criteria</b>
<b>Male</b>	
Delayed Ejaculation	Marked delay in ejaculation, and/or marked infrequency or absence of ejaculation, for at least 6 months
Erectile Disorder/Dysfunction	Marked difficulty in obtaining or maintaining an erection during sexual activity, and/or marked decrease in erectile rigidity, for at least 6 months
Male Hypoactive Sexual Desire Disorder	Persistently deficient or absent sexual thoughts, fantasies, and desire for sexual activity, as judged by a clinician, for at least 6 months
Premature (Early) Ejaculation	Persistent or recurrent pattern of ejaculation during partnered sexual activity within 1 minute following vaginal penetration, and before the individual wishes it, for at least 6 months and during the majority of sexual intercourse occasions

Table: DSM-V Sexual Dysfunctions (Source: American Psychiatric Association, 2013)

<b>Sexual Dysfunction</b>	<b>Diagnostic Criteria</b>
<b>Female</b>	
Female Orgasmic Disorder	Marked delay in, infrequency in, or absence of orgasm, and/or reduced intensity of orgasmic sensations, for at least 6 months
Female Sexual Interest/Arousal Disorder	At least 3 of the following symptoms, resulting in a lack or significantly reduced sexual interest/arousal, for at least 6 months <ul style="list-style-type: none"> <li>• Absent/reduced interest in sexual activity</li> <li>• Absent/reduced sexual thoughts or fantasies</li> <li>• No/reduced initiation of or reception to sexual activity</li> <li>• Absent/reduced pleasure during sexual activity</li> <li>• Absent/reduced sexual arousal in response to external sexual cues</li> <li>• Absent/reduced genital or non-genital sensations during sexual activity</li> </ul>
Genito-Pelvic Pain/Penetration Disorder	Persistent or recurring difficulties, for at least 6 months, with at least one of the following: <ul style="list-style-type: none"> <li>• Vaginal penetration during intercourse</li> <li>• Pain during intercourse</li> <li>• Fear or anxiety about sexual pain</li> <li>• Tensing or tightening of the pelvic floor muscles during attempted penetration</li> </ul>

*Table: DSM-V Sexual Dysfunctions (Source: American Psychiatric Association, 2013)*

<b>Sexual Dysfunction</b>	<b>Diagnostic Criteria</b>
<b>Non-Gender Specific</b>	
Substance/Medication-Induced Sexual Dysfunction	<ul style="list-style-type: none"> <li>• A clinically significant disturbance of sexual function</li> <li>• Symptoms developed during or soon after substance intoxication or withdrawal, or after exposure to a medication</li> <li>• The involved substance/medication is capable of producing the symptoms of sexual dysfunction</li> <li>• The dysfunction is not better explained by a sexual dysfunction that is not substance/medication-induced</li> <li>• Symptoms cause clinically significant distress</li> </ul>
Other Specified/Unspecified Sexual Dysfunction	Symptoms characteristic of a sexual dysfunction that cause clinically significant distress predominate, but do not meet full criteria for any sexual dysfunction.

## Video Vignette: Jake



### Film Background

In this film, Jake Roberts (22) has been seeing a clinician (social worker) once every three months through the VA (US Department of Veterans Affairs). He served 4 years in the US Marine Corps and recently separated from service as an E-3 (Lance Corporal). He did two tours of active duty, one in Iraq and one in Afghanistan. He has no physical injuries, but he suffers from severe PTSD. He is on anti-depressants, [i.e., selective serotonin reuptake inhibitors (SSRIs)] and other medications (e.g., Prazosin) prescribed by his doctor.

### Watch

<http://vimeo.com/user12512400/sexandthemilitary-jake>

## Jake: Specific Dynamics

**Now that you have watched the video, read the following for more information about Jake.**

Jake, a 22 year old veteran, is suffering from Posttraumatic Stress Disorder (PTSD). He is caught in the usual catch-22, where psychotropic medications are concerned. When he takes the medications, his nightmares remain under control but his sexual functioning becomes negatively affected. If he doesn't take the medication, he can function well sexually but the nightmares and other symptoms of PTSD interfere with his emotional relationships. Specifically, the medications are causing symptoms of erectile dysfunction (ED) and Jake's sense of masculinity is being challenged. He feels ashamed of his impaired sexual capacity, even denying something is wrong. As a Marine, and as a man, his masculine self-image is very important to him.

While sexual side effects of medications are well-documented in the literature, there are probably psychosocial factors contributing to Jake's diminished sexual abilities as well. We might even interpret the ED as a metaphor, reflecting Jake's impotence outside the bedroom as well as inside. We are made poignantly aware in this vignette of the difficulty Jake is having adjusting to civilian life. Unemployed and feeling overwhelmed, he is experiencing many transition challenges, despite the story he tells his clinician. The state of his life contributes to feelings of shame as evidenced by the fact that he isn't completely truthful with his therapist.

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**As a Marine, and as a man, his masculine self-image is very important to him.**

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A hallmark of PTSD is isolation. We don't know what terrible things Jake experienced in the war but it is likely that he lost friends, witnessed atrocities, and sustained moral injuries. Thus, he is reluctant to form new relationships out of fear of losing these as well. We notice Jake's "short fuse," another characteristic of PTSD, where Jake is unable to regulate his affect, going from calm to rage in an instant.

**Proceed now to the thought questions for this vignette, beginning on the next page.**

## Jake: Thought Questions

**For individuals:** Reflect on the questions below and jot down your answers in the space provided.

**For instructors:** Instructors can pose the questions and discuss with their students as a group. A suggested follow-up activity is to work in pairs/small groups, assigning the roles of client(s) and clinician to role play the next scene. **What would happen next in the client/patient interaction at the point the video vignette ends?**

1. Thinking of your scope of practice, how would you address the medication issue?

2. How can you understand Jake's anger and his reaction to his injuries beyond what is shown in the film, given his military experiences?

3. What characteristics of combat-related PTSD do you see in the film?

4. What interventions would you consider in treating Jake? (The *Intervention Strategies* information included in this toolkit can assist you in your answer.)

5. What are some of the challenges Jake faces as he moves forward with his life after military service?

6. Would Jake qualify for a diagnosis of *Erectile Dysfunction* and why or why not?



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## Jake: Answers for Thought Questions

Following are answers, feedback, and suggestions for the thought questions relevant to Jake.

1. *Thinking of your scope of practice, how would you address the medication issue?*

Your discipline will determine how you would address this issue. Only MDs and prescribing PhDs will be able to give advice on types of medication, dosages, and other specifics. The role of the non-prescribing clinician is to provide the empathy and support the client needs as he/she adjusts to the medication and deals with the various side effects, often suggesting non-medical coping strategies. Support during this time of adjustment is essential as the compliance rate goes down when people get frustrated with the side effects (as we saw with Jake). Because it is often the clinician rather than the prescribing physician who sees the client more frequently, he/she is often the first person to become aware of these negative side effects; this information should be conveyed to the physician immediately. Sometimes a medication with toxic side effects can be changed to one that is more benign. Certain clients might feel a sense of empowerment if they are encouraged to educate themselves and self-advocate, so this could be another potential approach as a non-prescribing clinician.

2. *How can you understand Jake's anger and his reaction to his injuries beyond what is shown in the film, given his military experiences?*

Jake's anger is multi-determined. He is understandably angry at having to sacrifice good sexual functioning for better mental health. Additionally, he may be angry about events in the military, or in his previous life, experiences that may be compounding his PTSD. There is any number of other possibilities which would need to be explored, such as whether or not he feels he is being treated fairly by the VA or whether he lost a partner while he was deployed. His statement, "This is not what I signed up for," could also be a reflection of anger he may have towards himself. The clinician should remember that anger is often a cover up for more vulnerable feelings, in this case embarrassment, shame, dependency, longing, powerlessness, and anxiety. Getting to these feelings, under the defense of anger, would help to heal Jake's invisible wounds. It would also be important to look at Jake's level of understanding of his PTSD, and consider that he may be feeling angry because he doesn't understand it as well as he could. Specific to his sexuality, he is likely feeling as though he has lost his manhood because he can't "control" himself and/or be sexual while he is on this particular cocktail of medications. At this developmental stage, it is often a time when young men may be experimenting with different women and/or having a variety of sexual partners, and Jake may feel angry because it is much more complicated for him.

3. *What characteristics of combat-related PTSD do you see in the film?*

In the film, Jake shows the following criteria for PTSD:

- Intrusive symptoms (e.g., Jake's nightmares) which are related to his experiences in combat
- Arousal and reactivity (e.g., Jake's aggression, irritability)

4. *What interventions would you consider in treating Jake? (The Intervention Strategies information, included in this toolkit, can assist you in your answer.)*

Interventions to consider in treating Jake would need to include physical as well as psychosocial components, as PTSD is first and foremost a body reaction. There is a high sympathetic response and probably a high parasympathetic response, resulting in some of the above-mentioned symptoms and lack of ability to regulate his affect. Therefore, interventions that address physical reactions are indicated, such as anxiolytics to reduce anxiety.

Jake can utilize anything that helps with affect regulation, such as meditation, relaxation exercises, listening to music, dancing, or prayer. He can be taught to take breaks when he feels his adrenaline rising by walking away or counting to ten. These are delay tactics that have been found to help contain a highly reactive stress response.

It should also be noted that the sexual side effects of medications can often be minimized with: (a) a sensitive partner; (b) anxiety-reducing interventions, since the more worried the person is about failure in a sexual encounter, the more likely it is to happen; (c) taking more time for sexual stimulation and arousal, rather than rushing into intercourse; (d) patience for adjusting to side effects sexually; and (e) client education.

There are also specific evidence-based practices (EBPs) addressing PTSD such as Acceptance and Commitment Therapy (ACT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), as well as Cognitive Processing Therapy (CPT) and Prolonged Exposure, which have been effective in reducing PTSD symptoms in military populations.

Continued monitoring by an M.D. or prescribing Ph.D. is of course essential.

Other interventions can be chosen from the Intervention Strategies document included in this toolkit.

5. *What are some of the challenges Jake faces as he moves forward with his life after military service?*

Jake will need to work through the trauma that precipitated his PTSD and learn to manage the symptoms in order to move forward and have a satisfying life. Specifically, at the moment he will

need to find a way to balance his need for medications, which are managing his nightmares and intrusive thoughts, with his ability to function sexually. Jake will also have to work at further integrating into civilian life as he appears to be prone to isolation. Additionally, it will be important for Jake to continue to discuss his feelings, thoughts, and experiences with his therapist (and ideally with other people in his support system), so that he has less of a tendency to build up frustration and anger, or to displace anger onto others. Because he feels he “can’t get close to people,” he may be inclined to shield himself from others and any emotional attachments.

6. *Would Jake qualify for a diagnosis of Erectile Dysfunction and why or why not?*

No, Jake would not qualify for a diagnosis of Erectile Dysfunction. Criteria D of DSM-V states “The sexual dysfunction is not ... attributable to the effects of a substance/medication or another medical condition” (APA, 2013, pp. 426). We can assume that Jake’s erectile difficulties are secondary to his medication. Aside from PTSD, the most appropriate diagnosis would probably be Substance/Medication-Induced Sexual Dysfunction (APA, 2013, pp. 446).v

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## Jake: Research Behind the Vignette

- Approximately 80% of veterans with PTSD also suffer from sexual functioning problems (Cosgrove et al., 2002; Letourneau et al., 1997).
- PTSD can significantly increase the risk of sexual functioning problems by up to 30 times (Wilcox et al., 2014).
- The medication used to treat PTSD and depression, particularly selective serotonin reuptake inhibitors (SSRIs), presents a greater risk for sexual functioning problems compared to patients who are untreated, specifically by contributing to erectile dysfunction, lower sexual desire, and orgasmic difficulties (Bonierbale & Tignol, 2003; Rosen et al., 1999).
- The only two medications that are approved by the Food and Drug Administration for PTSD are SSRIs – sertraline (Zoloft) and paroxetine (Paxil) (Brady et al., 2000; Marshall, Beebe, Oldham, & Zaninelli, 2001).
- Research indicates that 52-65% of adult men with erectile dysfunction reported that their erectile dysfunction prevented them from forming new relationships (Guest & Gupta, 2002).
- For young men who attach their personal identity and sexuality to sexual potency and performance, sexual functioning difficulties can negatively impact feelings of masculinity, self-esteem, and self-confidence. This may be especially true for younger men (Althof, 2002; De Silva, 2001; Guest & Gupta, 2002).

## Video Vignette: Grace



### Film Background

In this film, Grace Taylor (31) has been home from deployment for 3 weeks. She is still active duty, but has been on block leave. Grace is an Air Force officer serving as an Arabic linguist. Last year during a deployment, she was en route to a village on foot when her translator stepped on an Improvised Explosive Device (IED). She was several dozen yards behind and slightly uphill, but the blast still hit her hard. She has been with her partner, Claire (31), since they met in college nine years ago. Grace and Claire had seen a couples' therapist (social worker) prior to Grace's deployment, and this is the first session since Grace returned home.

### Watch

<https://vimeo.com/user12512400/sexandthemilitary-grace>

## Grace: Specific Dynamics

**Now that you have watched the video, read the following for more information about Grace.**

This case revolves around body image issues, although they cannot be completely separated from the effects of trauma. Grace, a 31 year old Air Force officer, has sustained scars as the result of an IED blast. Her partner of nine years, Claire, is thrilled to have her home but Grace is having a hard time with the reunification. Not only have Grace's legs been scarred, but her psyche has as well. As Freud

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**Not having been able to live up to her own ideals she feels a sense of shame, resulting in her desire to withdraw and hide.**

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(1923/1960) said, "The ego is first and foremost a body ego." Thus, the visible scars are also the external manifestation of internal wounds. Grace's self-image as a strong, invulnerable woman has been shattered as she came face-to-face with her mortality. Grace projects onto Claire (and the world in general) the disgust she feels about her vulnerability in

the form of the scars that are visible. She shies away from the physical intimacy she used to enjoy as she feels undesirable, like "damaged goods." This narcissistic injury is also resulting in narcissistic rage which Grace seems to be turning on herself, punishing herself by denying herself pleasure. She appears to be having orgasmic difficulties at this point as she is "in her head," pre-occupied with negative thoughts and feelings, unable to relax and enjoy being pleased.

We also want to remember that Grace has been inculcated with the military "warrior" ethos. The physical injuries she sustained pierce the facade of invulnerability. Not having been able to live up to her own ideals she feels a sense of shame, resulting in her desire to withdraw and hide. Additionally, she exhibits characteristics reminiscent of those who have experienced trauma (e.g., irritability). Whether or not she meets full criteria for Posttraumatic Stress Disorder (PTSD) is not apparent from the film.

**Proceed now to the thought questions for this vignette, beginning on the next page.**

## Grace: Thought Questions

**For individuals:** Reflect on the questions below and jot down your answers in the space provided.

**For instructors:** Instructors can pose the questions and discuss with their students as a group. A suggested follow-up activity is to work in pairs/small groups, assigning the roles of client(s) and clinician to role play the next scene. **What would happen next in the client/patient interaction at the point the video vignette ends?**

1. What clinical issues depicted in the video should be a focus of treatment and how do these relate to her military service?

2. What do you think of Claire's reaction to Grace's injuries and reluctance to wear a bikini? Include evidence for your answer.

3. What strengths and limitations can you see in this couple's relationship?

4. What interventions would you consider in helping this couple as they deal with the challenges associated with a combat-related injury? (The *Intervention Strategies* information included in this toolkit can assist you in your answer.)

5. What are some of the challenges this couple might face going forward given Grace's military experiences?

6. What are some factors unique to this couple that might be different from other couples with the same clinical issues? And, how would you address those factors?

7. Would Grace qualify for Female *Sexual Interest/Arousal Disorder* or *Female Orgasmic Disorder*? Please provide your rationale.



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## Grace: Answers for Thought Questions

Following are answers, feedback, and suggestions for the thought questions relevant to Grace.

1. *What clinical issues depicted in the video should be a focus of treatment and how do these relate to her military service?*

Grace's body image issues take center stage in this vignette and are a direct result of her combat experiences while in service in the military. She is clearly depressed and possibly suffering from PTSD. Her sadness reflects her grief and sense of loss. She is mourning the loss of the body she once knew, a body to be envied according to Claire. The sight of her scars might act as a trigger for Grace, stimulating memories of the traumatic events she experienced in combat.

2. *What do you think of Claire's reaction to Grace's injuries and reluctance to wear a bikini? Include evidence for your answer.*

Claire does not appear to be sensitive to Grace or realistic about her situation. Her comment that "she's been home for three weeks" indicates an unrealistic timeframe for adjusting to civilian life. Her statement that Grace "should be happy she's home" also indicates an insensitivity to what Grace went through and the damage to her body and spirit. Her comment, "This isn't how we handle things," also shows a resistance or lack of awareness as to the drastic change she/they have experienced since Grace's injury. Claire is also oblivious to Grace's embarrassment about her legs; rather than being empathic and understanding the depth of Grace's grief, she pressures Grace into exposing her wounds. Claire might also be avoiding the reality that her partner's body looks different, and could be having a number of her own feelings (e.g., she might find her less attractive, be feeling guilty or angry, or even have some relief that her partner isn't "perfect" anymore). It appears that Claire continues to deflect and to function from a place of avoidance and denial throughout the clip. It is evident that Grace, as a result, doesn't feel safe and understood by Claire.

3. *What strengths and limitations can you see in this couple's relationship?*

It appears that this was a loving couple and that the relationship was basically good since it has lasted nine years. They appear to have had good communication skills up to this point, as Claire states that talking to each other is how they've solved their problems in the past. Claire does appear as if she is trying to connect, to "stay positive," and to help Grace "snap out of it" or see the light at the end of the tunnel. They were able to plan a get-away together — this can be seen as a first step, even though they didn't follow through. Grace does show signs, periodically, of opening up to Claire and not shutting her down.

Military deployments are difficult for military couples and military families. Often, it can be difficult for the non-deployed spouse or partner to fully understand the challenges that the deployed service member experiences. This is particularly evident when Claire feels that Grace should be fully recovered after a few weeks. It will be important for you, as the clinician, to help Claire understand Grace's deployment experiences and how to best help and support Grace as she recovers.

Claire's current insensitivity to Grace's depression and feelings of loss make us wonder how empathically attuned she has been throughout their relationship. The fact that they had seen a therapist prior to this session hints at previous tensions that preceded Grace's deployment. This present crisis may be bringing into sharper focus issues previously gone unnoticed. They may also have had different needs within the relationship prior to Grace's deployment, and those needs may have shifted for both of them. Claire may not be able to accommodate those changes or needs of Grace. For example, if Grace has the need to move at a slower pace (emotionally or sexually, for example), this may be very difficult for Claire as this could be a drastic shift in their dynamic. It's possible that Grace was more of the communicator or the asserter in the relationship before and if this were the case, it would be important to explore the shifts for both of them as it relates to their needs on a variety of levels.

4. *What interventions would you consider in helping this couple as they deal with the challenges associated with a combat-related injury? (The Intervention Strategies information, included in this toolkit, can assist you in your answer.)*

Communication would be especially important for this couple. The therapist can assist each partner to express their needs to the other, building empathic bridges. This would involve Grace sharing more of her thoughts and feelings and progression with respect to her healing. For Claire, it would involve talking about her potential confusion about the changes in roles and their dynamic, and being honest about her level of patience through this process.

Claire could benefit from some psycho-education around the symptoms of depression. This knowledge would help her understand that Grace's irritability and emotional withdrawal are the concomitants of trauma, rather than personally addressed to her. Such awareness would allow Claire to give Grace the room she needs to grieve and heal. It would also be important to be attuned to the challenges each of them might have in tolerating this process and rebuilding a connection.

It would also be important for Grace to have some individual sessions so she can process the traumatic events that resulted in her wounds. Feelings of guilt, shame, and anger often accompany traumatic experiences. She might also benefit from Eye Movement Desensitization and Reprocessing (EMDR) therapy, somatic sensory, and/or mindfulness techniques. Self-soothing techniques for Grace

would be important, so that she is less likely to be reactive, and to avoid and deflect. A support group for military women with combat-related injuries (especially those with damage to their bodies) would be a strong consideration. Other techniques are presented in the *Intervention Strategies* section.

An exploration of what Grace most connects to spiritually, if anything, would also be prudent. If Grace were connected to a faith or spiritual path prior to her injuries, it might be helpful to work with her to reconnect with that, if she hasn't already. Also, for some, once a serious life-altering event happens, spiritually-based approaches can be helpful for the healing process.

The sexual relationship Grace and Claire had previously will be an important matter to address, when the timing is right. Before working towards interventions, it will be important to assess what their sexual relationship was prior to the deployment, and to do a complete sexual history. Questions that will need to be addressed include, but are not limited to:

- Did they feel equal as sexual partners?
- Did either of them have any desires or needs not being met within their relationship?
- Were there any issues related to either of their sexual pasts that were negatively impacting their relationship with one another?
- Did they have an ongoing open dialogue related to their sexual relationship?

It will be hard for Grace to engage in any pleasurable activities (e.g., sex) if she is burdened with survivor guilt, intrusive thoughts, or shame about her body. Some desensitization techniques, such as those inherent in Sensate Focus exercises, might also be important, particularly with regard to having her legs touched. It would also be helpful for Grace to see how she feels about self-stimulation and/or exercises (both sexual and non-sexual) that she could do with herself. It will be important to know to what degree she would have been open to this prior to her injuries, as this will influence how receptive she is to these kinds of exercises now. An example would be looking in the mirror when she is alone and reconnecting with her body, getting to know and accept it.

The relationship each partner has with her own and her partner's body will be important to discuss in the sessions, in an effort to work toward an appropriate intervention. How open were they before? How open were/are either of them to different exercises? How open is either of them to spending time on their own if it helps them reconnect sexually? Claire may feel sexual frustration and have unrealistic expectations of Grace, and might therefore need support and encouragement with ways in which she can self-satisfy (if she is open to it).

Additionally, working on an agreement/arrangement with the couple to have ground rules for the focus on their sexual relationship is vital. If Grace feels Claire is being “pushy,” she might retreat; if Claire feels Grace is being too avoidant, then she may get resentful. Defining how often they can discuss their sexual feelings and relationship and what feels safe to Grace is essential. Other interventions can be chosen from the *Intervention Strategies* section.

5. *What are some of the challenges this couple might face going forward given Grace’s military experiences?*

Both Grace and Claire will need to adjust to the “new Grace.” Trauma and bodily disfigurement change a person. They will need to understand and be sensitive to each other’s needs if they are to continue as a couple. Sleep, sexuality, types of needs, temperament, motivation, self-awareness, and personal growth are only some of the areas in which it will be important to identify challenges and differences.

Grace may also ultimately experience challenges as she transitions out of the military and into the civilian world. The transition may be difficult for this couple and may lead to new intimacy challenges, and should be discussed in advance of the transition.

6. *What are some factors unique to this couple that might be different from other couples with the same clinical issues? And, how would you address those factors?*

This is a same-sex and biracial couple, which adds other layers of complexity to the situation. For example, although we don’t see any internalized homophobia, the clinician should be attuned to it. Some other issues to consider would be:

- Are they both “out” or is there any secrecy surrounding their relationship?
- Has Grace been harassed in the military because of her sexual orientation?
- Has Grace been exposed to any military sexual trauma (MST)? Has either partner previously experienced any sexual or physical trauma?
- Are their families accepting/aware of their relationship, or is there any tension coming from outside the system?
- Do they live in a supportive geographical location that generally accepts same-sex couples? Biracial couples?
- Does their support system include same-sex, biracial, and/or military couples?
- What are their long-term relationship plans? Do they plan to marry or have children? (The purpose of this question (and of course feel free to omit) is that, as with any couple, there are

more layers of commitment, responsibility, financial stress, familial pressures, etc. if a couple is planning on marrying or conceiving. If this is the case, this could add to their complexity as a couple, and potentially as a same-sex couple depending on above).

Asking these questions requires a high level of sensitivity and clinical skill. Most importantly, the provider needs to be aware of his/her own biases with regard to same-sex and biracial relationships so that countertransference feelings do not contaminate the therapy.

7. *Would Grace qualify for Female Sexual Interest/Arousal Disorder or Female Orgasmic Disorder? Please provide your rationale.*

At this time, Grace would probably not qualify for either disorder. She has only been home for 3 weeks and the criterion requires 6 months duration. Also, like Jake, the dysfunction is better explained by other factors, in this case major stressors (APA, 2013, pp. 433). *Adjustment Disorder* might also be appropriate here. If her symptoms persisted, however, the sexual dysfunction diagnoses might be considered as well as *Other Specified Sexual Dysfunction*.

## Grace: Research Behind the Vignette

- Body image dissatisfaction following injury can interfere with adjustment (Fauerbach et al., 2000).
- Permanent physical changes to one's appearance can be predictive of poor sexual satisfaction and negative self-esteem (Tudahl, Blades, & Munster, 1987).
- Injury victims who use mental disengagement or emotional venting as a coping mechanism have reported greater body image dissatisfaction and poor social adjustment (Fauerbach et al., 2002).
- Female veterans with PTSD are 6-10 times more likely to be diagnosed with sexual dysfunction (Cosgrove et al., 2002).
- PTSD symptom severity has been linked to greater difficulties with sexual desire, orgasm, and satisfaction (Cohen et al., 2012; Johnson, Makinen, & Millikin, 2001).
- Symptoms of PTSD, especially related to emotional numbing, may cause an individual to become emotionally restricted or withdrawn, which can hinder the level of engagement and communication with a partner, and impact intimacy (Cohen et al., 2012; Nunnink, Goldwaser, Afari, Nievergelt, & Baker, 2010).
- Depressive symptoms can negatively impact sexual desire and arousal, as well as contribute to orgasmic difficulties (De Silva, 2001; Derogatis, Meyer, & King, 1981; Meis, Erbes, Polusny, & Compton, 2010; Williams & Reynolds, 2006).
- Adults with depression are at a 50-70% increased risk of sexual dysfunction, and adults with sexual dysfunction are at a 130-210% increased risk of depression (De Silva, 2001; Hartmann, 2007).
- Veterans who have experienced trauma during deployment and report initial depressive symptoms fueled by guilt and self-blame also report reduced sexual desire (Kennedy, Dickens, Eisfeld, & Bagby, 1999).
- Deployments can damage levels of attachment and support between partners, and emotional and sexual reconnection can be challenging (Baptist et al., 2011; Hurley, Field, & Bendell-Estoff, 2012).
- Partners of service members returning from deployment may experience "rejection sensitivity," when they don't receive desired or clear communication from their partner and develop psychological distress related to concerns about infidelity or abandonment (Calhoun, Beckham, & Bosworth, 2002).
- Partners of individuals with symptoms of depression, PTSD, or other psychological difficulties may also experience feelings of hostility, anger, sadness, and anxiety. Both partners may feel less sexual and relationship satisfaction when one partner is depressed (Kahn, Coyne, & Margolin, 1985; Merikangas, Prusoff, Kupfer, & Frank, 1985).

## Video Vignette: Manny



### Film Background

In this film, Manny Calzada (36) is a former Staff Sergeant in the Army. He is married to the love of his life, Angela (35), and has a daughter Crystal (6). Manny and Angela have been married for eight years during which Manny has been deployed four times. In his last deployment, Manny sustained injuries from an improvised explosive device (IED) blast. One of his testicles had to be removed; he is eight months post-surgery. The couple is seeing a therapist whom they've seen a few times prior to Manny's last deployment. This is the 2nd session since his return home.

### Watch

<http://vimeo.com/user12512400/sexandthemilitary-manny>

## Manny: Specific Dynamics

**Now that you have watched the video, read the following for more information about Manny.**

It appears that Angela and Manny have been a loving couple throughout their marriage, although the therapist might want to get more information about their pre-injury relationship. As a military wife, Angela has been supportive of her husband, standing by him and maintaining family life throughout his four deployments. It probably has not been easy for the family to continually contract and expand their boundaries over the last eight years; routines have been disrupted, roles have had to be re-negotiated, connections have been broken and then re-established.

Couples often use sex as one means of repairing emotional and physical disruptions in their relationships. Usually this is a powerful and effective method of bridging the emotional distance created by the separation. In this case, however, sex is causing more friction than helping to repair, pushing the couple further apart. Manny's injuries have left him with sensitivity and pain during intercourse. Thus, he is conflicted, wanting to share physical intimacy with his wife but needing to avoid pain. He goes through the motions of having sex with Angela with little enjoyment and uses pornography to satisfy his sexual needs more completely. Understandably, Angela takes this personally, believing Manny does not find her attractive anymore as she is older than the women in the pornography that she sees on his computer. His rejection confirms her own insecurities as she sees herself aging and feels less attractive. She feels betrayed and unloved, covering up these more tender feelings with anger.

As a longtime soldier, Manny has a "warrior mentality." He expects himself to always be in control and in charge. Not being able to control the pain during sex makes him feel weak and vulnerable, feelings that challenge his warrior self-image. He feels "attacked" by his own body and, unlike in the field where he would be able to attack back, he can only withdraw. To Manny, this feels like surrendering, something his training has taught him is unacceptable. Additionally, having lost one testicle due to an Improvised Explosive Device (IED) blast, "one of his man parts," he literally feels "less of a man." He may be projecting these feelings onto Angela, believing she is no longer attracted to him, just going through the motions and pretending. He expresses that, during sex with Angela, the pressure of "taking care" of both himself and his wife sexually is too much, which heightens his sexual anxiety.

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**Not being able to control the pain during sex makes him feel weak and vulnerable, feelings that challenge his warrior self-image.**

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Compounding these specific sexual issues is the fact that he may also have some features of Posttraumatic Stress Disorder (PTSD), namely avoiding interpersonal contact in general and survivor guilt. Regarding

the latter, Manny may feel that he doesn't deserve to be happy because many of his buddies have died; thus, feeling any pleasure at all might reactivate this guilt. Additionally, nudity can trigger intrusive memories of pain and death since he saw many of his friends wounded and dying on the battlefield, clothes torn off and sometimes mutilated.

In therapy, as Manny begins to lower his defenses and reveal the real reasons for avoiding intimacy with Angela, Angela's anger begins to melt into compassion. She begins to recognize that Manny's inhibited sexuality is in the service of avoiding an attack on his own self-esteem rather than a personal rejection of her. Sharing her own insecurities in future sessions will help Manny recognize the effect his actions have on his wife. As the couple builds these empathic bridges to a greater understanding, the marriage will be strengthened.

**Proceed now to the thought questions for this vignette, beginning on the next page.**



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## Manny: Thought Questions

**For individuals:** Reflect on the questions below and jot down your answers in the space provided.

**For instructors:** Instructors can pose the questions and discuss with their students as a group. A suggested follow-up activity is to work in pairs/small groups, assigning the roles of client(s) and clinician to role play the next scene. **What would happen next in the client/patient interaction at the point the video vignette ends?**

1. What factors other than his injury should be considered to more fully understand Manny's reluctance to engage in sexual activity with Angela?

2. What do you think their relationship was like prior to the injury? Why might knowing this be important?

3. Considering his military background, how can you understand Manny's initial statement to the therapist that "everything is fine"?

4. What interventions would you consider in helping Manny and Angela given their military experiences? (The *Intervention Strategies* information included in this toolkit can assist you in your answer.)

5. What are some of the challenges this couple might face going forward with life after military service (also taking military culture into consideration)?

6. What are some possible sexual dysfunction diagnoses for Manny?



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## Manny: Answers for Thought Questions

Following are answers, feedback, and suggestions for the thought questions relevant to Manny.

1. *What factors other than his injury should be considered to more fully understand Manny's reluctance to engage in sexual activity with Angela?*

There may be other bio-psycho-social factors contributing to the problems that would be important to consider in order to get a full clinical picture of this couple. Social and psychological factors would include the quality of the relationship, previous tensions, and how successfully the couple re-negotiates roles. For example, during Manny's deployment Angela would have had to take on many of Manny's responsibilities (e.g., disciplining children, making household repairs). Boundaries had to contract to accommodate his absence. With his return home, these boundaries need to expand to include him once again.

Cultural factors might also play a part. Consider how traditional values of different ethnic groups might play into and/or change this scenario. For example, if this is a Latino couple they might adhere to traditional sex roles. It is difficult to tell from the film whether this is true of Angela and Manny, but if so, it must have been difficult for Angela to be as assertive as she is in the therapy session. A Muslim couple might not discuss their problems at all. Men of an older generation might refuse to come to therapy, associating it with "being crazy." These are clearly generalizations and somewhat stereotypical; nevertheless they should be considered.

2. *What do you think their relationship was like prior to the injury? Why might knowing this be important?*

The couple's relationship, and particularly their physical relationship, prior to Manny's injury is important to evaluate in order to recognize and build on the strengths already existing in the couple system. These strengths can then be utilized to optimize the outcome. It appears from the introduction to the film that Manny and Angela have been a loving couple in the past although there may have been ups and downs, as in any marriage. It would be important to know if there were any sexual challenges prior to Manny's injury, as these will most likely be exacerbated. How well have they communicated in the past? Have they ever discussed their sex life with one another? This "crisis" is also an opportunity – to learn better communication skills for more enhanced emotional intimacy and a better sexual life.

3. *Considering his military background, how can you understand Manny's initial statement to the therapist that "everything is fine?"*

Manny's initial denial of his sexual difficulties is congruent with his self-image. Being able to function

adequately and satisfy his wife sexually are important aspects of his masculine role identity. As a “warrior,” he is supposed to be invulnerable. Thus, at first he minimizes the effects of his injuries and surgery and manages them the best he can, using pornography in a defensive manner. It isn’t that he is in denial, but he is not comfortable admitting his vulnerabilities even to himself, let alone to anyone else.

4. *What interventions would you consider in helping Manny and Angela, given their military experiences? (The Intervention Strategies information, included in this toolkit, can assist you in your answer.)*

Both psychosocial and behavioral interventions would be indicated for this couple, as they would for most couples entering treatment. In therapy, as Manny would begin to talk about the reasons for avoiding intimacy, and to understand the narcissistic wounding of his sense of self, his façade of invulnerability would begin to crumble. In the empathic environment of therapy, these invisible wounds of war may be healed. With this deeper level of understanding, Angela’s anger would begin to melt into compassion. We see the beginnings of this occur in the video as Manny discloses his pain and the real reasons for using pornography. Angela begins to realize that Manny’s inhibited sexuality is in the service of avoiding an attack on his own self-esteem rather than a personal rejection of her. Sharing her own insecurities will help Manny recognize how his actions affect his wife. As the couple is able to listen to, and empathize with, each other’s feelings, they will reach a deeper level of intimacy than ever before.

The couple will also need to re-negotiate their sexual repertoire to accommodate Manny’s sensitivity and pain threshold. Sexual practices they may have relied upon in the past may not work now. The therapist can remind them that all couples have to modify their sexual behavior as they go through life and being able to make these changes, to flexibly adapt to what life throws their way, is a hallmark of mental health.

Behavioral interventions would include, but are not limited to:

- Having a date night
- Focusing on the non-sexual parts of their relationship
- Sensate focus exercises
- Sensual touching that does not lead to intercourse
- Guided touch with a focus on Manny’s needs; this would include him communicating with Angela what is pleasurable, what is painful, and how much pressure/stimulation he needs and where.
- Experimentation and exploration of the use of oils, lubricants, vibrators, and other sexual toys to see what works for Manny in terms of his special needs, but also for Angela to enhance her pleasure.

It is important to remember that cultural practices and conventions need to be considered when offering sexual suggestions (military culture, as well). Some cultures prohibit oral sex or masturbation, and/or have conventions around kissing and other signs of affection. (Please see a more detailed discussion of culture as a variable in sex therapy in the *Communication Strategies* section.)

5. *What are some of the challenges this couple might face moving forward with life after military service (also taking military culture into consideration)?*

Manny's need to be seen as invulnerable and his tendency not to express his feelings may be obstacles for this couple. His definition of what it means to be a man is being challenged and needs to be modified. Any PTSD symptoms will also need to be addressed. Some individual sessions for Manny with another therapist would allow him the private space to work through his trauma. Whether he would accept such a referral however is questionable. What do you think?

6. *What are some possible sexual dysfunction diagnoses for Manny?*

The most obvious diagnosis is *Genito-Pelvic Pain/Penetration Disorder*. However, again, Criterion D might make this diagnosis inappropriate. Probably the most accurate diagnosis would be *Other Specified Sexual Dysfunction (Genito-Pelvic Pain/Penetration Dysfunction)* since his symptoms do not meet the full criteria but cause significant distress.

As for other diagnoses outside of sexual dysfunction, also consider PTSD and Depression. The vignette does not give us enough information to make a definitive diagnosis. However, Manny would probably qualify for a diagnosis of Adjustment Disorder.

## Manny: Research Behind the Vignette

- Genital injuries are common in the recent generation of combat veterans, due largely to the increase of dismounted patrols, where service members patrol an area on foot (Sharma et al., 2013; Woodward & Eggertson, 2010).
- Approximately 5-12% of battle injuries during Operation Iraqi Freedom and Operation Enduring Freedom have involved genitourinary injury (Waxman et al., 2009; Woodward & Eggertson, 2010).
- Genitourinary trauma can result in pain during intercourse (Morey, Metro, Carney, Miller, & McAninch, 2004; Wesselmann, Burnett, & Heinberg, 1997) as well as impact fertility, sexual functioning, and psychological functioning, among others (Han et al., 2013).
- In addition to the resulting pain, loss of genitalia can lead to feelings of emasculation and may lead to difficulties with intimacy (Frappell-Cooke, Wink, & Wood, 2013).
- Male sexual pain (male dyspareunia) occurs in approximately 3% of men (Laumann, Paik, & Rosen, 1999).
- Urogenital and pelvic pain among men has previously been associated with sexual dysfunction, including erectile dysfunction and reduced sexual desire (Lutz et al., 2005; Mehik, Hellström, Lukkarinen, Sarpola, & Järvelin, 2000).
- Pain during sex can contribute to decreased sexual satisfaction, as well as avoidance of intimacy and sexual activity (Corden, 2013).
- Pain during sex can also negatively affect quality of life and emotional well-being, and contribute to psychological effects such as anxiety and depression (Corden, 2013).
- While access to pornography is becoming easier (Paul & Shim, 2008), the use of pornography in this vignette was due to fear of pain when having sexual intercourse, but still wanting to satisfy his sexual needs.
- Women with partners who use pornography have described feelings of betrayal, negative self-esteem, and sexual dissatisfaction (Stewart & Szymanski, 2012; Zitzman, 2007).
- Use of pornography by one's spouse may result in loss of trust and confidence, as well as damage to the relationship (Manning, 2006).
- The rapid cycles of deployment and re-deployment can lead to "attachment injuries" among military couples, as their systems of attachment become strained and partners become less capable of offering support and comfort to each other – this can enhance reintegration difficulties and hinder sexual reconnection (Baptist et al., 2011; Basham, 2008; Johnson et al., 2001; Jordan, 2011).
- Sexual and emotional re-integration with partners after deployment may be even more challenging for service members who sustain physical or psychological injury, as relationship and family roles are renegotiated (Satcher, Tepper, Thrasher, & Rachel, 2012).

# Communication Strategies for Sexual Issues

This provides suggestions for communicating with clients when dealing with sexual issues.

## General Comments

As all clinicians know, conducting a clinical interview involving discussion of sexual issues is a delicate matter though often very important. The clinician is entering into the most intimate realm of the client's life. Thus, such a discussion must be done sensitively; otherwise it can feel intrusive and even violating. The skill for such discussion rests largely on the therapeutic relationship, the therapist's degree of experience and knowledge, and his/her own comfort level in discussing sexual matters. Other variables of course come into play – the comfort level of the client, his/her cultural values, and whether he/she sees this as a priority in the relationship or something he/she is willing to work on.

## Considering Culture

Cultural factors always need to be part of the equation when working with clients. The following are a few questions that can help guide the clinician. (This is by no means a comprehensive list.)

- Does the culture permit discussion of sex between people of different genders?
- Does the culture allow discussing sexuality with a stranger (i.e., the therapist)?
- What is the culture's view on same-sex relationships?
- What are the culture's views on interracial relationships?
- What is the culture's view on premarital sex?
- Are there conventions around male-female relationships?

If the therapist plans to suggest specific practices, s/he should know what the culture allows and prohibits. If the therapist doesn't know, it would be important for him/her to ask the client(s). For example, although Directed Masturbation is an intervention commonly prescribed for anorgasmia, several cultural groups prohibit this practice. Since the clinician is not expected to know the values and practices of every culture, and there is great heterogeneity even within each culture, s/he can ask: "Are there any sexual practices that your culture does not allow?"

Follow up question(s) could include:

- How do you feel about these restrictions?
- Have you adhered to these restrictions?

If the client has not adhered to the cultural/religious restrictions the clinician would want to know how they feel about the discrepancy – for example, guilty, ashamed, secretive, relieved, and/or reconciled.

## Introducing the Topic of Sex

The therapist should begin by asking for permission to discuss the sexual life of the client(s). This not only shows respect, but helps the client get emotionally prepared for the subject. Some suggestions:

- *Now, I'd like to spend a little time talking with you about your physical relationship with your partner. Would that be okay with you? OR Can we talk about your physical relationship with your partner? Your sex life?*
- *It sounds like there are some concerns related to your physical/sexual relationship. Since this is one part of a relationship, it could be helpful to talk about some of these things to see if I can help you. Would that be okay with you?*
- *(If it appears that the client might be feeling uncomfortable or awkward): I would like to open up a conversation about sex, which I know can be uncomfortable for people sometimes, but this is one of those conversations that once you begin, it can often get a little easier. Would you like to give it a try?*
- *As a therapist, I've had the opportunity to work with people who are struggling with sexuality in some way. So you can look at me as someone who has talked with people who have had scenarios even more challenging or awkward. Maybe that can be helpful to start the conversation?*

It is also recommended that at least one session be conducted individually with each partner in a couple. This allows each person the privacy of disclosing very personal information without worrying about how their disclosures will be received by the partner. Additionally, the clinician will be able to note any discrepancies in perceptions regarding sexual satisfaction and difficulties. This format needs to be done very carefully by the clinician and with the understanding from each partner that there may be issues brought up in the individual session that haven't been brought up in the couple's sessions. The therapist should set clear guidelines, with the agreement of the couple, regarding how such discrepancies and disclosures will be handled. In other words, will they be kept confidential or will they be shared in the couple's session? (Note: While there are advantages and disadvantages either way, a full discussion is beyond the scope of this toolkit. The essential point is that all parties should know ahead of time what the ground rules are as part of "informed consent.")

## General Questions

- How are you feeling about the sex you're having with \_\_\_\_?
- How satisfied are you with your sex life?

### If satisfied,

- What do you like about it?

### If not satisfied,

- What would you like to be different?
- Is something missing?
- Have you enjoyed sex in the past with your partner?
- Have you enjoyed sex in the past with other partner(s)?
  - » Has that changed?
  - » If so, when did it change? To what do you attribute the change?
- Have you had sex for pleasure and/or conceiving?
- Do you wish to conceive (again) with your partner?
  - » If so, have you discussed this with one another?

(A therapist might want to explore the motivations for a person to engage in sexual activities but by specifically asking about "conception," unless the therapist knew this issue was on the table, it might not be appropriate.)

Motivations for sexual contact may be part of a couple's problem. For example, in a Desire Discrepant couple, as may be the case with Angela and Manny, the motivations might be a factor. One person might be more goal-directed (having the most intense orgasm) while the partner might be more concerned with the process (enjoying all aspects of the sexual encounter and making an emotional connection). Of course, people have sex for different reasons at different times. In the Angela/Manny video, we might assume that the two have different reasons for engaging in sex at this particular time. To explore motivations, the therapist can say something like the following:

- "People have sex for many different reasons and they are different at different times. Some of those reasons are to have fun, for pleasure, to feel loved and express their love to the partner, or just because it feels good. What are some of your reasons?"

Questions specific to physical injuries and/or surgeries can include:

- Has your sexual enjoyment changed since your injury? (If so, how?)
- Has the injury affected your sex life? (If so, how?)
- What did you like about your sex life before the injury/surgery?
- How long have the difficulties been going on?
- What do you think has caused them?
- How have you handled them?
- What have you done to cope with these issues?
- Do you have hope for change?

Couples need to be helped to vary their sexual repertoire to accommodate body changes, so assessing their flexibility in this regard would be important.

- Is the couple adventurous?
- Are they willing to try new things that might help manage their disabilities or challenges?

## **A Word about Pornography**

The subject of pornography often provokes an emotional response. At the very least, its use is controversial, with many experts believing it is an obstacle to intimacy and others denying any negative consequences. Be very careful to not pathologize the use of pornography and, at the same time, to not minimize the relationship the person may have with pornography. This topic should be approached openly, but with caution, so as to create a comfortable environment for the client to discuss pornography freely. For example, we see that use of pornography has both benefits and disadvantages.

Level of pornography use can be assessed by asking directly. It is important to keep in mind that, as with masturbation, sometimes people will under-report. The clinician should try to explore what the person gets from it and if they feel they cannot get the same benefits with their partner. It is often the case that people feel embarrassed about certain sexual proclivities and feel too vulnerable to ask for them. Internet porn is anonymous and easily accessible and the viewer does not have to worry about being rejected or shamed. The therapist can provide the acceptance the client needs to bravely discuss the practice with the partner. (Note: Any sexual practice that does not hurt the person or the partner would be deemed "acceptable." If religious or cultural values prohibit it, these injunctions need to be taken into account.)

Pornography can be a method of escape and/or numbing and/or detaching from a partner, which can warrant concern and potentially lead to conflicts within the relationship. However, if the person using

the pornography and his/her partner are comfortable with it and it is not negatively impacting the relationship, then it can be okay. The most important thing to address is whether the use of pornography is creating problems within the relationship.

There may also be conflicting feelings on the part of the client or partner as to whether or not masturbation is “okay” or healthy. There are a few short tests that one can take online to work towards assessment of sex addiction:

- The Men’s Sexual Screening Addiction Test (G-SAST-R)
- Women’s Sexual Addiction Screening Test (W-SAST)

There are also organizations that have a wealth of information regarding sexuality and sexual health. Some organizations focus on sexuality, using a non-recovery model, and look to avoid pathologizing [e.g., American Association of Sexuality Educators, Counselors and Therapists (AASECT)], while others look at addiction to porn as pathological, from a disease model perspective [e.g., Society for the Advancement of Sexual Health (SASH)]. Both organizations are well versed in sexuality and are extraordinary resources, but often have different perspectives.



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# Intervention Strategies for Sexual Issues

## Introduction

There are probably hundreds of strategies individuals and couples can engage in to enhance their sex lives and improve their physical intimacy. For people with injuries, many of the suggestions offered here can help to circumvent their sexual challenges. Clients should be reminded that the most important sexual organ is between their ears, that is, the brain. Their thoughts, fantasies, and feelings are just as important, if not more so, to a good sexual response as other sexual organs. It will also be helpful and very important to rule out any medical issues by referring to a urologist or gynecologist, for example.

Additionally, one of the most important characteristics of a good sex life is the willingness of the individual to be emotionally flexible. When there is an injury, indeed whenever the body changes whether in civilian or military life, couples have to make adjustments to their usual sexual repertoire in order to accommodate these changes. If they insist on adhering to “tried and true” practices that may no longer work, they will continue to be disappointed and frustrated. This is where it can be extremely helpful to have a therapist with whom the client(s) can talk, or a referral to a therapist specializing in sexual challenges.

Many people, due to the nature of sex and sexuality, may not only be uncomfortable talking about sex or trying new practices, but they may have a very limited self-awareness about their own sexuality. If this is the case, it could take more time to work through challenges, changes, and education than if the client(s) are more experienced with discussing the subject matter and are more self-aware.

The following strategies are offered to assist with these challenges and enhance sexual functioning. Some can be encouraged and gently supported by the therapist (non-sex therapist), and some might be addressed with a sex therapist, if the client(s) is inclined to go that route. It is always important to keep in mind that one should stay sex-positive, non-judgmental, and focus on education.

## Non-Sexual Intervention Strategies for Greater Intimacy

- Focus on the non-sexual parts of the relationship
- Have a date night
- Act out a fantasy, such as picking one another up at a bar
- Wear sexy lingerie
- Go to a sex shop or lingerie store together
- Take a bath or shower together
- Read romantic novels or watch romantic movies together

- Breathing together while eye gazing and other tantric practices
- Communication exercises
- Sentence completion (examples follow)
  - » “What I like about your body is...”
  - » “What I like about our sex life is...”
  - » “A fantasy I’ve often thought about is....”
  - » “A sexual activity I’d like to try is....”
  - » “My injury has resulted in my inability to....”
  - » “Turn-ons for me are....”

(Couples can make up their own sentences. As the therapist gets to know the couple and their issues s/he can also create some sentences to facilitate communication.)
- Heighten senses
  - » Taste – chocolate, wine
  - » Sound – music
  - » Smell – scented candles
  - » Sight – eye gaze
  - » Touch – massage

## **Sexual and Quasi-sexual Intervention Strategies for Greater Intimacy**

- Non-erotic massage
- Sensual touching that does not lead to intercourse
- Erotic massage (this can be a helpful way to remedy symptoms and can be empowering)
- Sensate Focus exercises
- Guided touch
- Watch erotic or sexy films together
- Read erotic stories together
- Directed masturbation
- Experimentation with oils, lubricants, vibrators, other sexual toys
- Exploration of different practices, positions, activities that take into account the injury or surgery
- Sexual Tantric techniques

## Adjunctive Sex Therapy: Psychosocial Intervention Strategies

Explore psychosocial factors such as:

- What it means to be a man/woman.
- What is being stirred up/triggered with sexual touch. These might include memories the person is trying to avoid (as in PTSD), survivor guilt, vulnerability, potential past experiences with previous partner(s), and/or various thoughts/feelings/experiences in his/her history.

Teach couples to be process-oriented in their lovemaking vs. goal-oriented: to enjoy all sensual and sexual activities rather than being focused on achieving orgasm.

### Psychoeducation

This is an opportunity to give clients information about sexuality and physical/psychological changes so that they can experience some sense of normalcy. When normalization is used in working with people therapeutically, they are often more receptive to interventions and ideas that they might not have otherwise. Topics can include how anatomy works, and differences between male and female bodies and responses. The use of books (biblio-therapy) or online articles might be helpful, and writing can also be a healing agent.

Another possible intervention (which was popularized in the recent movie *Sessions*) is the use of a sexual surrogate. Surrogates have been used in cases of high anxiety and fear around sex, and in situations of major physical challenges. There is a specific protocol when this option is chosen, in which the surrogate has regular verbal contact with the referring therapist who helps the client work through the emotions that are aroused by the sexual contact. Because of its non-traditional and controversial nature, a therapist considering this option should consult with another experienced therapist before making such a referral.

It can be helpful to look at a number of aspects/elements of the person's overall existence by considering: intra-psychic factors, interpersonal factors, economic factors, political factors, and sociocultural factors, when conducting a thorough assessment. Essentially, there can also be underlying causes to the sexual challenges that are being masked by an actual "identified problem."

It is important to work with clients from the perspective that there can be opportunities for/through change, as this can help them in their progress. Due to the nature of the many feelings that can come up (e.g., grief, loss, rage, longing), approaching these as an opportunity for healing is also useful. For some people, there might be shifts and changes in what they view as appealing and/or "turn-ons," and it's possible that an entirely new sexual world may emerge for them.

## Intervention Strategies for Specific Challenges

In addition to the general suggestions above, the following are specific dysfunctions or challenges, and some biological and sexual interventions. However, the therapist should keep in mind that these do not work in a vacuum. The sociocultural and psychological context must always be taken into account.

### Trauma

If there has been any military sexual trauma (MST), this will need to be addressed in individual sessions. The partner can be brought in when appropriate to gain a better understanding of the survivor's ambivalence around sex. Bearing witness to the traumatic narrative will likely increase his/her empathy, reduce pressure on the survivor, and make for a better prognosis. Time and patience are essential. Another aspect to note is that with MST there might be a sexually transmitted infection (STI) with which the veteran is contending. If this is the case, there could be any number of concerns, ranging from physical pain/challenges during sex to shame, guilt, and disgust with contracting a STI. There is also the issue of transmission and the importance of addressing this if there is any concern (dependent on if there has been treatment or intervention).

Wendy Maltz, a sex therapist, educator, and social worker, has developed some specific interventions for trauma-related sexual difficulties. These include exercises for re-learning that touch can be positive rather than traumatic. The reader is referred to the following resource: *The Sexual Healing Journey: A Guide for Survivors of Sexual Abuse* (2012), 3rd ed., William Morrow Paperbacks.

### Desire Discrepancy

Desire discrepancy refers to the relative desire levels within couples; individuals may perceive that their desire is too high or too low based on their perceptions of their partners' desire levels.

- Is the low frequency partner enjoying the sex s/he is having?
- If not, why would s/he want to have more of it?
- Has the person conveyed his/her preferences to the partner or remained silent?
- What is keeping the person from disclosing? (The answer to this is usually that the person feels embarrassed about what they like; they are afraid of being laughed at or shamed in some way.)

### Delayed Ejaculation

The therapist can use similar questions to those questions addressing Desire Discrepancy, and also assess medication use and any underlying causes that might be contributing to this particular challenge. Military populations may be particularly prone to withholding something that is unresolved and/or may be having a control issue.

### **Premature (Early or Rapid) Ejaculation**

- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Start/Stop techniques
- Squeeze Technique
- Promescent Topical Medication
- Condoms (with or without benzocaine)
- Kegel exercises
- Tantric techniques or deep breathing
- Penile rings

### **Erectile Dysfunction**

- Phosphodiesterase Type 5 Inhibitors (PDE5i's) (e.g., Viagra, Cialis, Levitra)
- Pumps
- Implants
- Testosterone replacements
- Injections (e.g., Papaverine)
- Suppositories

### **Anorgasmia**

- Sexual education
- Directed Masturbation (DM)
- Kegel exercises
- Systematic de-sensitization
- Expression and resolution of emotional contribution or underlying causes
- Education about anatomy
- Altering sexual positions
- Estrogen therapy
- Testosterone therapy
- Use of toys during intercourse or as part of sexual play

## **Genitopelvic Pain/Penetration Disorder (involuntary spasm or tightness preventing vaginal penetration) and Dyspareunia (pain with intercourse)**

- Sexual education
- Pelvic floor exercises/Kegel exercises
- Insertion or dilation training
- Pain elimination techniques
- Transition steps and exercises
- Expression and resolution of emotional contribution or underlying causes (e.g., anxiety most commonly linked)
- Detailed sexual history
- Education about anatomy
- Sensate focus and techniques
- Altering sexual positions
- Building of sexual trust and intimacy

## **Spinal Cord Injuries (SCI)**

- See videos by Mitchell Tepper on YouTube, available at: <http://www.youtube.com/user/SexualHealthdotcom>.

**Note:** It is important for the partner of the veteran to have support to talk through feelings about loss, and what they may need to grieve with respect to the sexual relationship. It will also be important to really gauge (over time) how safe each partner feels with trying different positions and/or techniques. There will be a drastic shift in the sexual relationship/dynamic and sexual identity for each person. Both parties will need a space in which they can discuss their potential sexual disinterest and what this means for them.

## **Culture and Interventions**

If the therapist is going to suggest specific practices, s/he should know what the culture allows and what it prohibits. For example, although Directed Masturbation is an intervention commonly prescribed for anorgasmia, several cultural groups prohibit this practice. Since the clinician is not expected to know the values and practices of every culture, and there is great heterogeneity even within each culture, an exploration of cultural practices and prohibitions would be pertinent (please see *Communication Strategies* section for specific suggestions on how to guide this discussion).

# CIR Policy Briefs

## Overview

In response to the gaps in service need, treatment quality and availability, and health insurance coverage options regarding sexual functioning in military populations, CIR has two policy briefs.

- *The Elephant in the Bedroom: Sexual Functioning in Military Populations*, focuses on the high prevalence of sexual functioning problems in military populations, the lack of adequate training for behavioral health providers, and the absence of adequate health care coverage for sexual dysfunction.
- *Genitourinary (GU) Trauma in the Military: Impact, Prevention, and Recommendations*, addresses the rising presence of urotrauma in the most recent wars and its prevention; the lack of knowledge regarding long-term implications; and the gaps in the resources available to injured service members, veterans, and their families.

Both briefs highlight the current areas of greatest need, and include recommendations for policy and practice. It is clear that sexual dysfunction and genitourotrauma in military populations are highly salient issues with far-reaching implications. We need to work together to create and share innovative best practices and policies. These policy briefs, along with this toolkit, provide a starting point for change.

## How to Use for Behavioral Health Providers

You are encouraged to review the policy briefs and to present them to your organization to internally support some of the needed changes.

## Link to CIR Policy Briefs

The CIR Policy Briefs and other CIR publications can be accessed at [cir.usc.edu/publications](http://cir.usc.edu/publications).



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# Resources and References

This section of the toolkit provides information on additional resources, as well as references used in developing the toolkit, and suggestions for further reading.

## Resources

This section provides resources for working with sexual dysfunction issues, including information about sex therapists, sex shops, videos, journals, and a list of assessment tools.

### Locating a Certified Sex Therapist

The American Association of Sexuality Educators, Counselors and Therapists ([www.aasect.org](http://www.aasect.org)) has a list of providers.

### Sex Shops (online)

- Good Vibrations ([www.goodvibes.com](http://www.goodvibes.com))
- Freddy and Eddy ([www.freddyandeddy.com](http://www.freddyandeddy.com))
- Come as You Are Co-Operative (includes toys, etc. for people with disabilities) ([www.comeasyouare.com](http://www.comeasyouare.com))
- Sexual Intimacy.com ([www.sexualintimacy.com](http://www.sexualintimacy.com))
- The Alexander Institute ([www.lovingsex.com](http://www.lovingsex.com))
- The Pleasure Chest ([www.thepleasurechest.com](http://www.thepleasurechest.com)) — also in store on Santa Monica Blvd.

### Informational and Instructional Videos

- Sexuality and Disability: Dr. Mitchell Tepper ([www.youtube.com/user/SexualHealthdotcom/feed](http://www.youtube.com/user/SexualHealthdotcom/feed))
- Relearning Touch – Healing Techniques for Couples: Wendy Maltz (<http://healthysex.intervisionmedia.com/>)
- SexSmart Films – Promoting Sexual Literacy ([www.sexsmartfilms.com](http://www.sexsmartfilms.com))

## Organizations and Journals for Information and Continuing Education

- American Association of Sexuality Educators, Counselors and Therapists (AASECT) ([www.aasect.org](http://www.aasect.org))
- American Board of Sexology ([www.americanboardofsexology.com/](http://www.americanboardofsexology.com/))
- The Kinsey Institute ([www.kinseyinstitute.org/index.html](http://www.kinseyinstitute.org/index.html))
- National Coalition for Sex Freedom (NCSF) ([www.ncsfreedom.org/](http://www.ncsfreedom.org/))
- New View Campaign ([www.newviewcampaign.org](http://www.newviewcampaign.org))
- Resolve: The National Infertility Association ([www.resolve.org](http://www.resolve.org))
- Society for Advancement of Sexual Health (SASH) ([www.sash.net](http://www.sash.net))
- Society for the Scientific Study of Sexuality (SSSS) ([www.sexscience.org](http://www.sexscience.org))
- Society for Sex Therapy and Research (SSTR) ([www.sstarnet.org](http://www.sstarnet.org))
- World Association for Sexual Health (WAS) ([www.worldsexology.org](http://www.worldsexology.org))
- World Professional Association. for Transgender Health (WPATH) (<http://www.wpath.org>)

## Sex Addiction Resources/Materials

- Sexual Recovery Institute ([www.sexualrecovery.com](http://www.sexualrecovery.com))

## Peer-reviewed Journals

- American Journal of Sexuality Education (<http://www.tandfonline.com/loi/wajs20#.VVzTdvIVhBc>)
- Journal of Sex and Marital Therapy ([www.tandfonline.com/toc/usmt20/current](http://www.tandfonline.com/toc/usmt20/current))
- Journal of Sexual Medicine ([onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1743-6109](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1743-6109))
- Journal of Humanistic Psychology ([jhp.sagepub.com/](http://jhp.sagepub.com/))
- Journal of Psychology and Human Sexuality ([www.tandfonline.com/toc/wzph20/current](http://www.tandfonline.com/toc/wzph20/current))
- Journal of Sex Research ([www.sexscience.org/journal\\_of\\_sex\\_research/](http://www.sexscience.org/journal_of_sex_research/))

## Suggested assessments of sexual functioning

### Arizona Sexual Experience Scale (ASEX)

A 5-item rating scale that assesses core elements of sexual function – sexual drive, arousal, penile erection/vaginal lubrication, ability to reach orgasm, and satisfaction with orgasm. Items are measured using a 6-point Likert scale, ranging from hyper-function (1) to hypo-function (6).

Citation: McGahuey, C. A., Gelenberg, A. J., Laukes, C. A., Moreno, F. A., Delgado, P. L., McKnight, K. M., & Manber, R. (2000). The Arizona Sexual Experience Scale (ASEX): Reliability and validity. *Journal of Sex & Marital Therapy, 26*, 25–40. doi:10.1080/009262300278623

### Female Sexual Function Index (FSFI)

A brief, multidimensional self-report measure for assessing key dimensions of sexual functioning in women. The scale includes 19 items that assess sexual function over the previous 4 weeks, in six domains: sexual desire, sexual arousal, lubrication, orgasm, satisfaction, and pain.

Citation: Rosen, R., Brown, C., Heiman, J., Leiblum, S., Meston, C., Shabsigh, R., ... D'Agostino, R. (2000). The Female Sexual Function Index (FSFI): A multidimensional self-report instrument for the assessment of female sexual function. *Journal of Sex & Marital Therapy, 26*, 191–208. doi:10.1080/009262300278597

### International Index of Erectile Function (IIEF-5)

A multidimensional self-report measure for the evaluation of male sexual function. The measure consists of 5 items, covering 5 domains: erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction. Each item rated on a 5-point scale, and scores are classified as severe, moderate, mild-moderate, mild, and no erectile dysfunction.

Citation: Rosen, R. C., Cappelleri, J. c., Smith, M. D., Lipsky, J., & Peña, B. M. (1999). Development and evaluation of an abridged, 5-item version of the International Index of Erectile Function (IIEF-5) as a diagnostic tool for erectile dysfunction. *International Journal of Impotence Research, 11*, 319–326. doi:10.1038/sj.ijir.3900472

### Quality of Sexual Function Scale (QSF)

A self-administered assessment which measures and compares quality of sexual function for men and women. The scale consists of 32 items, across 4 dimensions: 1) psycho-somatic quality of life, 2) sexual activity, 3) sexual (dys)function – self-reflection, and 4) sexual (dys)function – partner's view. Items are rated based on in degree of intensity or severity, on a 5-point scale.

Citation: Heinemann, L. A. J., Pothoff, P., Heinemann, K., Pauls, A., Ahlers, C. J., & Saad, F. (2005). Scale for Quality of Sexual Function (QSF) as an outcome measure for both genders? *Journal of Sexual Medicine*, 2, 82–95. doi:10.1111/j.1743-6109.2005.20108.x

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## Funder

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