

Chapter 5

SEXUALITY AND INTIMACY

OVERVIEW

Perhaps no other aspect of spinal cord injury is as defined, discussed, and misconceived as is the area of sexuality. Sexuality refers to a deep and encompassing aspect of a person's existence, a significant portion of one's personality, which includes physical, intellectual, emotional and social dimensions of life. It is the way we think and feel about ourselves and relate to others—men and women, adults and children.

Spinal cord injury (SCI) can potentially impact any of these aspects of our being. As persons with SCI adjust to a new physical reality, it may be difficult to change self-perceptions to accommodate the injury in a positive way. Newly injured persons may wonder whether they can still have children, whether their sexual partners will stay with them, whether anyone will find them sexually desirable, or whether they will ever enjoy sex again. They may assume sexual pleasure is no longer possible because of loss of sensation in their genitals.

As a result, some may decide to ignore issues regarding sexuality, while others will seek out any opportunity to restore sexual-esteem. It is important to keep in mind that questions, fears, and feelings of anger about one's sexuality are natural after SCI, and all of these concerns are legitimate. People often find resource books and videos regarding sexuality, in conjunction with candid conversations regarding sex, self-image and their body, to be helpful as they search for different ways to express sexual feelings. Discussions with other persons with a disability and/or counseling with a professional trained in this area may also be helpful (see resource listing).

Although a spinal cord injury may alter sexual function and response, it need not alter a full range of satisfying sexual options. Sometimes physical adaptations are necessary, and yet physical closeness and sexual activity are still attainable. Despite physical limitations, sex can be a means by which two people's lives are merged emotionally and spiritually as well as physically. If a couple has a

relationship based on mutual respect, and the partners are able to communicate openly about sexual concerns, their sexual relationship will fall into place.

It's helpful to know....if you want to have sexual intercourse (vaginal, anal or oral), you still can and that sexual pleasure is still possible, no matter what the level or completeness of injury. If you are a woman and want to have a baby, you still may be able to. If you are a man and want to father a child, you may still be able to. If you want to find a sexual partner, it's still possible. If you are already in a committed relationship, it is possible to maintain that relationship.

Issues relating to sexuality are not exclusive to the heterosexual population. People with SCI who are homosexual or bisexual experience the same feelings of separation from their peers as their heterosexual counterparts. Changing perceptions of one's body coupled with a lack of opportunities to meet others in similar situations can be devastating. The burden of experience of being a member of a discriminated group may often increase. Information is available through organizations including the SCIA Resource Center (see resource listing).

Read on for more information on: effects of SCI on male and female sexual functioning, reproductive function, pregnancy, contraception, safe sex, sexual aids, sexual education counseling, and resource listings. Also included are personal reflections of women and men regarding sexuality after SCI.

HOW IS SEXUAL FUNCTIONING AFFECTED BY SCI?

Sexual function in humans is controlled by parts of the central nervous system, particularly the brain and spinal cord. Interruption to the central nervous system through injury to the spinal cord will therefore have some effect on sexual function. The extent to which it is affected depends on a variety of factors including: level of injury, severity of damage to the spinal cord, and gender. There are also varying individual reactions to the injury, which must be taken into account such as previous adjustment, experience, current knowledge, attitudes and feelings, as well as availability of a partner.

Psychosocial/Emotional Issues and Physical/Practical Considerations

- Completeness/Incompleteness of injury

- Continued risk of STD's—SCI does not protect you from sexually transmitted infections or HIV/AIDS. The use of condoms for all types of intercourse is highly recommended to substantially reduce the risk of transmitting infections
- Decreased sexual desire
- Altered body image
- Difficulty or inability to achieve orgasm—achieving orgasm may take longer than before the injury and require more intense stimulation. Some people have the experience of arousal and or orgasm in extra genital or psychological forms. Use of fantasy, memories and multiple sensory inputs may be valuable.
- Fertility and Birth Control— Women are able to become pregnant and may do so without orgasm. Some men are able to ejaculate and there other fertility options for men who want to have children.
- Adoption, as with people without SCI, may be an option to consider.
- Changes in erectile function including reflex erections
- Changes in ejaculation function
- Changes or lack of sensation in specific areas, notably the genitals— Pleasure from touching, kissing and intimate stroking may be an important part of your experience. This can give you information about how you can achieve erotic pleasure. Touching in areas where you do not have sensation or where you did not have arousing feelings before may be pleasurable such as the head, face, hair, ears, neck, chest, abdomen, under arms, finger, feet and toes. Use of vibrators, lubricants and pulsating shower heads may add additional pleasure. Masturbation, when appropriate, can be enjoyable and help you learn more about your own body. Using all your senses such as visual cues, music, smells, taste, touch and imagination may be helpful to have an enjoyable experience even without orgasm. You may get great satisfaction from encouraging your partner to have orgasm even if you may not be able to.
- “The transition zone”—After SCI, there is usually an area where the sensation goes from normal to “different.” This area, known as “the transition zone,” often has altered sensation and can be perceived as a source of erotic pleasure. Stimulation of this area can be arousing for both partners. Exploring the transition zone can help to determine how best to receive sexual pleasure using stimulation to this area.

- Possible use of adaptive equipment or sexual aids
- Skin care
- Mobility impairment—exploring optimal positioning
- Spasticity
- Safety issues such as the possibility of falling
- Weakness and fatigue
- Changes in bowel and bladder function
- Possible onset of autonomic dysreflexia and what to do about it
- Pain
- Decreased lubrication or dyspareunia (painful intercourse)
- Privacy restrictions due to living conditions
- Wounds/Ostomies/Catheters
- Medical issues

EDUCATION AND COMMUNICATION

Assuming that sexual function has been altered and the injured person and partner intend to engage in sexual activities, communication between them is extremely important. An understanding of some anatomy and physiology (functioning) and the human sexual response cycle is helpful, as well as the possible effects of SCI and medication on sexual functioning. Openness to trying new techniques may also be part of the process. Use of the unaffected areas of sensation and the reflexes still available is particularly important in experiencing pleasure and mutual satisfaction. All of these factors may be helpful in learning to adapt successfully to changes resulting from SCI.

Overcoming these challenges requires assuming responsibility for developing coping strategies, just as in other aspects of living. Services of a qualified counselor or sexual therapist may or may not be required. While open communication between partners can often resolve many sexual issues, a therapist can sometimes assist in the transition issues following SCI. The American Association of Sex Educators, Counselors, and Therapists (AASECT) have a list of qualified and certified professionals (see resource listing).

Understanding one's sexuality is a key to the process of re-adaptation to the community, and avoiding premature retirement from sexual life. As with individuals without SCI, people with spinal cord injuries need to consider birth

control, safe sex, and other issues related to prevention of health problems. See your physician for assistance or more information.

THE FOLLOWING IS GENDER SPECIFIC INFORMATION

FEMALE SEXUAL FUNCTION

Considerations for SCI women include: pleasuring one's partner (see suggested resources below), alternative positioning, bowel and bladder management, (including catheters and ostomies), management of pain and spasticity, working around ventilators, etc. Lack of sensation and/or mobility restrictions may require special consideration in the choice of contraception and gynecological/obstetric care.

A woman is often able to have intercourse as easily after SCI as before, although additional lubrication may be needed to avoid chafing and to make the act of intercourse easier to initiate. If there is inadequate lubrication intercourse, a water-based lubricant such as KY jelly or Surgi-Lube should be used. Vaseline or other petroleum based products increase the chances of infection and will reduce the effectiveness of condoms. The use of lubrications applies whether inserting a penis, vibrator, or any other object into the vagina or rectum.

CONTRACEPTION

Birth control may be an issue of interest for many women, with or without SCI. A woman with a spinal cord injury has additional reasons for concern.

The male partner's use of condoms, in conjunction with a spermicidal foam or cream, is the easiest and most recommended method, provided neither partner has sensitivity to latex. Using the sponge or diaphragm require hand dexterity and may be difficult for a woman with tetraplegia.

Surgical sterilization is the second most common form of birth control for women after spinal cord injury, followed by the use of oral contraceptives. Both SCI and the pill are known to cause vascular complications in certain individuals. The pill may be contraindicated for some women with SCI.

The use of intrauterine devices is associated with a higher risk of pelvic inflammatory disease and is generally avoided.

FERTILITY/REPRODUCTIVE FUNCTION/PREGNANCY

While certain aspects of female sexual functioning may be changed after SCI, the ability to conceive, carry and give birth is usually not affected. Women usually do not get their menstrual periods for a few to several months immediately following injury. However, during this time ovulation can continue and it is possible to become pregnant. Women who do not wish to become pregnant must consider contraceptive methods. Menstrual periods typically return within the first year, usually with the same flow and cycle pattern as before injury.

Pregnancy can develop normally in a woman with SCI. There is, however, a slight increased risk of: phlebitis, urinary problems, anemia, and difficulty maintaining balance, transferring, and skin integrity. There is also a potential for autonomic dysreflexia during labor and delivery with injuries at or above T6. It may also be necessary to reassess medications (e.g., spasticity drugs) due to potential effect on the fetus.

Delivery method may not be affected (vaginal delivery is usually possible). As with all pregnant women, good nutrition is very important. With proper monitoring, many women with SCI's have experienced normal pregnancies, uncomplicated deliveries, and the usual joys and anxieties of raising children today.

It is important to choose a competent gynecologist/obstetrician who is either familiar with spinal cord injury or willing to learn. It is also important to check out the accessibility of the doctor's office (including the examination table) and the availability of assistance with dressing/undressing if needed.

MALE SEXUAL FUNCTION

Significant areas of concern for males with SCI include the ability to pleasure one's partner (see suggested resources below), birth control (see above), to achieve or maintain erections and the ability to ejaculate.

CHANGES IN ERECTILE FUNCTION

Some men are able to achieve erections quite easily after SCI. Others can achieve erections occasionally, and some are unable to achieve erections at all. Factors that influence ability to have an erection, as previously mentioned, include: level of injury, severity of injury, time since injury; medical complications, medications, surgical procedures, and type of injury (upper or lower motor neuron type of injury).

There are two basic types of erections: psychogenic erections (the kind that occur as a result of having thoughts about sex, or by looking at erotic pictures); and reflexogenic erections (the kind that occur as a result of direct physical stimulation of the penis or surrounding area). Erections require increased blood flow to the penis and restricted blood flow out of the penis. Options for males experiencing difficulty achieving or maintaining erections include:

“Stuffing” technique — an option for men at any level. For men who experience reflex erections from direct or indirect stimulation of the penis, stuffing the penis into the vagina or anus while your partner uses his/her muscles to stimulate the penis may cause an erection and help maintain it.

Constriction device — a rubber or silicone ring or adjustable leather strap; an option for men who are able to achieve an erection but have difficulty maintaining it. Biggest concerns are skin integrity and adequate blood flow. It is important to use liberal amount of water-based lubricant to avoid skin breakdown when applying and removing any device that you slide over your erect penis. Proper fit is also important. You should be able to get a prescription for a custom fitted device from your urologist. The device should not be left on for more than 30 minutes to avoid permanent damage to penis.

Vacuum-induced erections — a plastic cylinder with a vacuum pump is placed over the penis and activated, pulling air out of cylinder and causing blood to inflate the penis; a constriction device is placed around the base of the penis to maintain an erection. Again, it is important to use a liberal amount of water-based lubricant to avoid skin breakdown. This is successful with men who have difficulty attaining an erection. Furthermore, this is recommended by many

urologists as a first step and least invasive of available procedures and is covered by Medicare and may be covered by other insurance providers.

Injected vasoactive drug — Different formulations of Alprostadil can be injected into the base of the penis, causing little or no discomfort. The drug causes blood vessels in penis to enlarge, allowing an erection to occur within 5 to 10 minutes that lasts for about one hour. The medication needs to be adjusted according to each individual. The drug is effective with men who have difficulty attaining an erection. Potential side effects include bruising, scarring at the injection site, and priapism (an erection that lasts for more than four hours). This drug is only available through a prescription from a doctor or urologist. The same drug, Alprostadil, also comes in a urethral suppository but this is considered less effective than injected Alprostadil in men with SCI.

Oral medications — Viagra (Sildenafil), Levitra (Vardenafil HCl) and Cialis (Tadalafil) are oral medications of phosphodiesterase inhibitors used to treat erectile dysfunction in SCI patients. It is recommended that males wishing to use these medications should take them approximately 1½ hours before sexual activity and physical stimulation is still a necessary factor in achieving an erection while taking these medications. Both Viagra and Levitra will allow a 3-4 hour window to achieve sexual intercourse. Cialis has up to a 36 hour window to achieve sexual intercourse. These medications are available in different doses through prescription only and do not protect against any sexually transmitted diseases. These medications may also increase the chances of ejaculating.

Penile implants or penile prostheses — Surgical procedures are typically reserved for men for whom all the above techniques are ineffective. Options include semi-rigid or malleable rods, fully inflatable devices, and self-contained unit implants. Inflatable implants have several chambers that are filled with fluid to achieve an erection. The chambers are emptied by a release valve after intercourse. The pump, chambers to be filled with fluid, and connecting tubes are all implanted. Semi-rigid implants consist of two implants made of a flexible material that causes a permanent rigid state. The penis can be bent against the pelvis when not engaged in intercourse. Surgical implants carry higher risks than other methods.

A CONSULTATION WITH AN UROLOGIST WHO IS FAMILIAR WITH ALL OF THE ABOVE IS STRONGLY RECOMMENDED IN EXPLORING OPTIONS

CHANGES IN EJACULATORY FUNCTION

Ejaculation is the part of the sexual response in which the semen is rhythmically propelled through the penis to the exterior. It involves coordination of contractions causing: *emission* (propelling of semen into the urethra), *bladder neck closure* (which prevents semen from moving backward into the bladder), and *antegrade ejaculation* (propelling of semen forward through the urethra and out of the penis).

Ejaculation ability is often affected by SCI because of a lack of coordination of these contractions resulting from impaired messages between the brain and sacral segments S2-4. Lack of coordination may result in retrograde ejaculation, in which the semen/sperm move backward into the bladder (if the bladder neck does not close). Although this is neither dangerous nor harmful, it does impair the function of fertility. It is important to know that ejaculation is a fertility function and it is possible that it may occur with or without an erection and may or may not be accompanied by the feeling of orgasm.

The current options for ejaculation impairment involve two major strategies: penile vibratory stimulation (PVS) and electroejaculation stimulation (EES).

Penile vibratory stimulation – involves placing a powerful vibrating unit on the undersurface of the head of the penis, the site of greatest sensation. The sensory nerves are stimulated and transmit this information back to the sacral spinal cord and up to the ejaculatory reflex center. If the stimulus is enough, the ejaculatory center will be triggered to activate the sequence of ejaculation and semen is delivered through the penis in the “usual” manner. Not all males with SCI will respond to PVS, depending on the amount of nerve damage at T11-L2 and S2-S5. There is risk of autonomic dysreflexia with injuries at T6 and above. PVS should always be attempted first in a monitored office setting. If PVS works, the individual and his partner are taught how to do it and how to collect the semen. PVS has been shown to be up to 75% effective in achieving ejaculation for men with injuries of T10 or above. Once the couple is proficient in capturing the semen, a host of therapies can be tried, depending on the count and motility of the male’s sperm.

Electro ejaculation stimulation (EES) – involves inserting a probe (with electrodes along the length of the probe) into the rectum. The electrodes deliver an electric current to the nerves next to the prostate gland. These nerves control the process of ejaculation. Possible problems with EES include autonomic dysreflexia in injuries at T6 and above, damage to the rectal area if the probe becomes too hot or perforates the tissue, and pain in incomplete injuries. It is performed in a physician's office or hospital and has a lower quality of semen when compared to penile vibratory stimulation.

If the male is unable to engage in sexual intercourse to allow for fertilization, other options such as artificial insemination are possible. A man with SCI who is interested in fathering a child should first consult an urologist knowledgeable in SCI to obtain a complete urological exam. Once factors such as erectile and ejaculatory function, and sperm viability, have been determined, the individual and his urologist should determine the appropriate method of proceeding to improve fertility. It is recommended that the urologist with whom you are working have a solid background in sexual and reproductive function of individuals with SCI and that he/she be familiar with possible complications associated with the different methods available to achieve ejaculation.

INDIVIDUAL PERSPECTIVES ON SCI AND SEXUALITY

Following are personal reflections of individuals who were willing to share their experiences.

Let's face it—when you become spinal cord injured, things ain't going to be the same—including sex. However, if you and your partner have good sexual communications, verbal and non-verbal, you can expect to have an equally satisfying and rewarding sex life.

On the verbal level, you as a woman may have to take a more assertive role than you are accustomed to. It will be up to you to tell your partner what feels good and what doesn't.

At first you may have to coach your partner by telling him which position is comfortable for your legs. Often times it is possible to balance on your knees and elbows or forearms, thereby making the top position a more comfortable and free

one to take. Your partner can guide your hips, keeping you from toppling to either side or on your head!

Sexual creativity can be really fun if two people care for each other and respect each other's needs. Alternative methods of sexual satisfaction other than straight intercourse are to be encouraged if each partner is willing and feels comfortable with this. Oral sex is one alternative as is the use of devices such as vibrators. Anything that is agreeable to both partners is all right. Just remember to communicate.

On the non-verbal level, touching is a very important means of communicating love and affection. Our bodies have many erogenous zones, and places such as the neck and ears can become very sensitive stimulus points, substituting for loss of sensation elsewhere. It's important to remember that an orgasm is much more psychological than physical, so if your head is in the right place, your sex life will fall into the right place also.

Daphne Sprague

I am a C5-6 quad. I knew I wasn't going to walk again, but what about sex? That was something I had always enjoyed and wasn't going to give up. There was hardly any information at all for women...lots for men (and just because we're "innies" and they're "outies"). So we're left to wonder and work it out for ourselves. That is basically what you have to do anyway. If you enjoyed it before, you'll enjoy it again, just in a different way.

Learn how your body works now. Don't be afraid to work with your partner to see what you enjoy. If you can't feel in certain areas, it doesn't mean it can't be a part of it. Use all your senses...sight, smell, hearing, taste...and imagination. They are all just as important as feeling.

Try different positions. Experimentation is the key! Just watch out for accidents, and be honest and open with your partner about how that works. This way, there are no surprises. Take your time. Self-worth is very important.

Anonymous

A few years ago a dear friend asked me if sex was still fun and enjoyable. If I recall correctly, my response to him was, "You bet. It's what you make of it that counts!"

Shortly after my injury I began to think about how my disability would affect me and alter this important activity of my life. However, at the time other concerns seemed more important; and due to my own fears, I neglected to ask for or seek professional advice. Needless to say, I left the hospital with many unresolved problems.

My concerns, I guess, were no different from those any twenty-one year old newly cord injured male would experience. Could I achieve an erection? Could I father a child? How would my incontinence compound what already seemed like an overwhelming problem to overcome? How would the opposite sex perceive me? Would not my use of a wheelchair reflect sexual inability, if not total lifelessness?

Although some of these answers were provided as I became more familiar with my condition, most of my sexual education was a result of my own post injury experiences. Subjectively, some of these could be judged successful, others not; however, regardless of the results, something was gained from each. What has become evident to me is that communication between partners must exist for a successful relationship to happen. Talking and learning about one another's needs and desires is vital. Personally, I am very fond of ascertaining what makes my partner "tick" and if I am unable to accommodate her in a particular manner, I can still be imaginative and try something else. Of equal importance is providing her with knowledge about my condition which helps to reduce her anxieties, and she will have many, especially if it is her first experience with someone who is visually "different." Understanding and assuming this responsibility will assist in alleviating apprehension and make the relationship more natural and less tense.

I realize that every spinal cord injured person is different and that no two have the same physical capabilities. What may work for one, may not work for another. It seems to me that what it boils down to is recognizing your abilities and making whatever adjustments are appropriate. Realizing this and acting accordingly should assist you in overcoming most of the problems you are confronted with. Let's face it, not every encounter between the able-bodied is a success either. I have learned that very little is easy for cord injured people, and certainly sexual fulfillment is no exception; however, sexual satisfaction can be obtainable if you want it badly enough.

Stephen Tremblay

My injury happened 17 years ago, diving, I was 15. I remember it being about a week or two after my accident, I guess the shock was dissipating, I realized I hadn't had the urge to go to the bathroom. I asked my nurse about it and she told me about cathing, but that was it, she was quite vague. I was there alone—still in bed—in traction, I started touching myself and this was the first time I realized the concept of “no sensation below level of lesion.” My penis was in my hand, but all I could feel was my penis in my hand, not my hand on my penis. I got an erection right away and attempted to masturbate, but all I achieved was a tired arm. At some point, I asked my doctor, “what about sex?” He gave me a couple of books and nothing more was said.

I'm 32 now and the previous seems like a lifetime ago, almost as though it never happened, and—yes—I'm sexually active. Not too long ago, a guy who was newly injured asked me, “what about—you know—sex?” In general, my response was, “you need to figure it out for yourself,” which disappointed me because that's what I was told, but not in so many words. I guess he wanted what I had wanted—someone to tell me exactly what to expect. As with anyone, disabled or not, it's completely dependent on the individual, you know—“different strokes for different folks” or “whatever floats your boat.” Of course, a partner who is willing to work with you is helpful. I guess some pointers would help too, something to work with.

As far as intercourse is concerned, although it's still great, it's more for my partner's satisfaction than my own. It's no longer a case of “getting my rocks off.” With the help of modern medicine and the fact that I can't orgasm physically, my partner's physical pleasure is virtually guaranteed and their satisfaction becomes my own. I know it sounds weird, but if you've ever been there, I can guarantee you know what I mean and if you haven't, you will.

As people mature, they (hopefully) learn that, indeed, intercourse is sex, but sex isn't necessarily limited to intercourse. Over the past 17 years, I've come to understand the sensual part of sexuality as an intimate appreciation of all of the senses, not just the one between my legs. I achieve sexual satisfaction through sensuality. An appreciation of the sight, sound, smell, touch, and—yes—taste of another person from a sexual perspective can be very fulfilling.

In reference to my physical pleasure, what feels best is usually considered foreplay. All of the physical (touch) sensation that I have left intact is extremely sensitive and becomes intensified during sex. It might seem outrageous to you because it still does to me but manipulation and concentration of my ears, neck, shoulders, and me sometimes, and parts of my arms (I've heard this is common) can be unbelievably pleasurable and can result in what might be considered a psychological orgasm. It's amazing!! As you may know or will soon learn, much of the experience of being a person with a spinal cord injury involves a lot of trial and error, figuring out what works best for you, including sex. Only you can figure out what's best for you. I don't think anyone can tell you exactly what to do or expect. That's up to you and a willingness to experiment helps. If you can see the whole thing life from a different perspective instead of a tragedy, you might develop a greater appreciation for the whole thing.

Anonymous

Following are excerpts from an article, "Finding the Right Mate," written by Mitch and Cheryl Tepper for the Connecticut *Conn-Cord* Newsletter (Vol. 2, 1966) on their tenth wedding anniversary (note that on April 2016, Mitch and Cheryl celebrated their 30th wedding anniversary).

Happiness does not merely come from finding the right mate; it comes from being the right mate.

This is the beginning of a psalm that was read on our wedding day. We believe in this whole heartily. If we want to have a life partner, we have to find that mate. No doubt, this is made more difficult for someone with a disability. It is, however, possible and likely. Contrary to popular belief, there are people in this world who care for more than physical qualities when they are looking for an intimate connection. There are people who are attracted to a myriad of other qualities or virtues that have nothing to do with physical appearance or physical ability. These qualities include but are not limited to intelligence, personality, humor, deep reflective thought, creativity, kindness, goodness, integrity, and spirit.

I (Mitch) think one of the keys to finding a mate is that we must be open to love before we can identify these potential partners. We must also be open to looking beyond the narrowly defined imagination of the perfect partner we all conjure up. There are literally millions of single, able-bodied men and women who want a

partner but have been unsuccessful in meeting that right person. Finding the right mate is not only a problem for people with disabilities.

Mitch and Cheryl's relationship began in college after Mitch's spinal cord injury. In dealing with the newness of his injury, Mitch was floundering, looking for an intimate relationship and was beginning to feel isolated. Cheryl was looking for a way out of a relationship she was in with someone at the time she met Mitch. She welcomed the honest and open communication they shared. Mitch was impressed with Cheryl's confidence and intelligence. They soon found that they shared many common interests and a mutual attraction. Their relationship developed quickly, and they admittedly fell in love. After five months, Mitch proposed, Cheryl accepted, and twenty months later they got married.

There were initially concerns from both Mitch and Cheryl's parents because of Mitch's disability, but they (Mitch and Cheryl) didn't share those concerns. Cheryl says, *"It was easy for me to look past his disability. I saw Mitch as just another person and liked being around him."*

So far, in their ten years of happily married life, Mitch and Cheryl have shared a rich and beautiful relationship with the "right mate." Both have lovingly supported one another's career and personal goals. Amidst their busy career schedules, they are now also experiencing the joys and excitement of parenthood with the birth of their son, Jeremy Joseph.

The moral of the story.....

Mitch: Real relationships don't come in perfect packages. I used a wheelchair and had occasional problems controlling my bowels. Cheryl dressed differently from my image of a sexy woman and was more introverted than other girls I had dated. But by getting to know her, I found a best friend and lover.

Cheryl: I met Mitch when I least expected it. I saw him as just another person, not as a potential partner, and I was able to be myself around him. We got to know each other and our relationship developed. Mitch stood out because he used a scooter, but it was easy for me to look past his disability since I never really noticed it. I value the honest and open communication between us and the intimacy we share.

Sex and sexuality are important aspects of life. Developing or continuing a close relationship that includes sex can be extremely rewarding. A disability need not prevent you from achieving this. The best way to find out your own likes, dislikes and needs is to explore them openly with a willing and loving partner. Whatever works best for you is right. If you can feel comfortable with your body and yourself, maintain an open mind, good communication with your partner, and are willing to try new approaches, sexual fulfillment can be an integral part of your life and that of the person you love.

RESOURCES

Resource materials about sexuality and persons who have disabilities have become more numerous and readily available in recent years. A selection of these materials is listed below, as well as a listing of organizations, workshops, and professionals qualified to provide sexual education counseling.

SEXUAL EDUCATION AND COUNSELING

As a result of specialized training and experience, some professionals are qualified to provide sexual education counseling to spinal cord injured persons. Frequently, problems arising within a person or between people can be resolved with the expertise and knowledge that such a professional can provide, leading to a more satisfying sex life between those involved. Peer support may also be a vital link in recognizing your own sexuality. Some individuals available in Connecticut with considerable experience in providing sexual counseling to SCI persons are:

Harris E. Foster, Jr., M.D.
**Yale University School of Medicine, Section
of Urology**
Box 208041
New Haven, CT 06520-8041
203-785-2815
Fax 203-785-4043

Mitchell Tepper, PhD, MPH
Sexologist
**AASECT Certified Sexuality Educator and
Counselor**
mitchelltepper.com
404-478-7840

Joseph E. Struckus, Ph.D.
Health Psychology Associates Northwest
409 Bantam Road, Suite A-1
Litchfield, CT 06759
860-567-0096

Lindsay Harvey, Ph.D.
769 Newfield Street
Middletown, CT 06457
860-632-2052

Other Resources for Obtaining Assistance Include:

Spinal Cord Injury Association, Connecticut Chapter

Peer Assistance Program

c/o Gaylord Hospital
P.O. Box 400
Wallingford, CT 06492
Phone 203-284-1045

American Association of Sex Educators, Counselors and Therapists (AASECT)

1444 I Street NW, Suite 700
Washington, DC 20005
202-449-1099
<http://www.aasect.org>

The Sex Information & Educational

SIECUS NY Office

90 John Street, Suite 402
New York, NY 10038
Phone: 212-819-9770
<http://www.siecus.org>

**Planned Parenthood of Connecticut
Education Department**

129 Whitney Avenue
New Haven, CT 06510
203-865-5158

SEXUAL ATTITUDE REASSESSMENT (SAR)

Several universities, rehabilitation centers and other organizations periodically sponsor workshops designed to raise the awareness of an individual's attitudes and feelings about his/her sexuality and the sexuality of others, with special emphasis on physical disability. The workshop includes large group presentations and small group discussions with trained group facilitators. Participants are encouraged to bring with them a significant other person: a spouse, sexual partner, or a close friend of the same or opposite sex. It is not necessary that a sexual relationship exist between the participant and the significant other. These workshops are open to any interested person for a fee. Further information can be obtained from:

American Association of Sex Educators, Counselors and Therapists (AASECT)

1444 I Street NW, Suite 700

Washington, DC 20005
202-449-1099
www.aasect.org

Planned Parenthood of Connecticut, Education Department
129 Whitney Avenue
New Haven, CT 06510
203-865-5158

SEXUAL AIDS

Numerous devices designed to enhance sexual experiences are available from a variety of sources, including Internet sites, drug stores, mail order catalogues, “sex shops,” and adult bookstores. These devices can often be effective tools in exploration and assist in achieving maximum sexual satisfaction. The key to the purchase and use of any type of sexual toy or device is acceptance of varied sexual desires and frequent and honest self-exploration or communication between sexual partners. Websites available include:

MyPleasure.com <http://www.mypleasure.com/education/sexed/disabilitylist.asp>
Good Vibrations <http://www.goodvibes.com/main.jhtml>
Sinclair Institute <http://www.sinclairinstitute.com/index.php/> or Liberator.com
Sportsheets.com

AUDIOVISUALS

Numerous films and videos have been produced about the issue of sexuality and how it relates to persons with disabilities. Many of these are available for rent or purchase from universities or rehabilitation centers.
Sexsmartfilms.com

“**Sexuality Reborn**,” produced by Craig Alexander, Ph.D. and Marca Sipski, M.D, is a sexually explicit video. Four couples discuss the physical and emotional effects of SCI. It is available from Kessler Institute for Rehabilitation, West Orange, N.J., 1-800-435-8866.

BOOKS AND REPORTS

“*pleasureABLE: Sexual device manual for persons with disabilities*” **by A. Kassioukov, E. MacHattie, K. Naphtali, W. C. Miller and S. Elliott.** Funded Project: Disabilities Health Research Network, 2009, Manual Located at www.scisexualhealth.com (Free Download).

The Ultimate Guide to Sex and Disability: For All of Us Who Live with Disabilities, Chronic Pain, and Illness, <http://www.amazon.com/The-Ultimate-Guide-Sex-Disability/dp/1573441767>.

“The Guide to Getting It On,” http://www.amazon.com/The-Guide-Getting-It-On/dp/1885535333/ref=sr_1_1?ie=UTF8&qid=1338750827&sr=8-1.

“Sexuality and Reproductive Health in Adults with Spinal Cord Injury Clinical Practice Guideline,” <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2941243/>.

“Sexuality and Reproductive Health for Adults with Spinal Cord Injury: What You Should Know”

<http://www.pva.org/site/apps/ka/ec/product.asp?c=ajIRK9NJLcJ2E&b=6423003&en=ghKIJSMBLfIKITOGKcKHIWMIIQLXOALfIRL8NQKvG&ProductID=954656>.

Enabling Romance: A Guide to Love, Sex, and Relationships for the Disabled (And People Who Care About Them) by Ken Kroll & Erica Levy Klein. Explores sexual variations and alternatives for romantic and sexual relationships. The book provides specific information on the sexual abilities and limitations of those with spinal cord injuries, and other disabilities. 1992 (ISBN#517-57532-9, to order 1-800-733-3000). Harmony Books/Crown Publishers, Inc., 201 East 50th St., New York, NY 10022; 212-572-6179. https://www.newmobility.com/bookstore-romance.cfm?type=REG&order_id=new.

Spinal Network is a total resource for the wheelchair community and is an award-winning informational tool. https://www.newmobility.com/bookstore-spinalnet.cfm?type=REG&order_id=new.

Sexuality after Spinal Cord Injury by Stanley H. Ducharme and Kathleen M. Gill, Paul H. Brookes Publishing Co., P.O. Box 10624, Baltimore, MD 21285-0624; 1997.

Journals, Newsletters, Periodicals:

“Disability, Pregnancy & Parenthood International,” <http://www.dppi.org.uk/>.

“New Mobility,” <http://www.newmobility.com>.

ORGANIZATIONS

Through the Looking Glass: Parenting with a Disability. An organization staffed primarily by people with personal disability experience involved in providing services, research, training, information and assistance in parenting with a disability <http://www.lookingglass.org/>

Spinal Cord Injury Association Resource Center (NSCIRC). Provides information and referral on any subject related to spinal cord injury at 1-800-962-9629.