

LIVING *your* LIFE: SEXUALITY FOLLOWING SPINAL CORD INJURY

MITCHELL S. TEPPER, PhD, MPH

About the Author



Mitchell Tepper, PhD, MPH, author of *Regain That Feeling: Secrets to Sexual Self-Discovery*, brings a lifetime of first-hand experience with chronic conditions and disability to his work as an American Association of Sexuality Educators, Counselors and Therapists (AASECT) Certified Sexuality Educator, AASECT Certified Sexuality Counselor, sex coach, writer, researcher, public speaker, licensed PAIRS Instructor, and self-proclaimed Prophet of Pleasure. After breaking his neck in 1982 and a short career in business and finance, Dr. Tepper realigned his life with his mission to end the silence around sexuality and disability. Since then he has be-

come an internationally recognized expert in the field and leading advocate for the provision of comprehensive sexual health care in rehabilitation programs, including rehab programs for wounded warriors and their partners. His academic credentials include a Master of Public Health from Yale University, and a PhD in Human Sexuality Education from the University of Pennsylvania where his research focused on pleasure and orgasm in people with spinal cord injury (SCI).

Many in the SCI community know Dr. Tepper from his past column, Love Bites, which he wrote for New Mobility magazine for 10 years. Dr. Tepper is also a long-time friend of United Spinal Association, having served in various board positions, including president, for NSCIA CT Chapter from 1985-1991 and as First Vice President of NSCIA from 1991-1993. He lives in Atlanta with his wife Cheryl and they have a 19-year-old son, Jeremy.

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**Anyone seeking specific medical advice or highly technical questions should
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Spinal cord injury (SCI) can potentially impact any aspect of our sexuality. We may wonder whether we can still have children, whether our sexual partners will stay with us, whether anyone will find us sexually desirable, or whether we will ever enjoy sex again. Many of us come to believe common myths such as “I have no feeling; therefore, my sex life is over!” and “I’m not experiencing pleasure or orgasm anymore so sex is pointless! Why bother?”

Our sexual-esteem, the positive regard for and confidence in our capability to experience our sexuality in a satisfying and enjoyable way, may be shattered. This often leads us to believe another myth; “No one will want a person with a disability as a lover.” As a result, some may decide to ignore issues regarding sexuality because we believe they no longer apply to us; others will seek out any opportunity to restore sexual-esteem.

Questions, concerns, and feelings of anger about our sexuality are natural after SCI. Concluding that our sex life is over makes sense based on messages about sexuality and disability we have learned from television and movies, and what we have not been taught in school. People with SCI are often portrayed in movies as sexually frustrated men and women who either have to rely on buying sex from a sex worker or have to go without. At the same time, schools often focus on only the dangers of sex and fail to educate us about our sexual potential as humans for sexual pleasure and connection.

Even much of the medical profession is misinformed about the sexual potential of people with SCIs. Many medical professionals still believe orgasm is not possible for people with complete SCI, that men with SCI cannot have children, and that women with SCI should not have children. This booklet is meant to dispel these myths and provide accurate information about sexuality and SCI.

If you continue to read, you will find out that if you want to have sexual intercourse (vaginal, anal, or oral) you still can and that sexual pleasure, even orgasm, 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 can. If you are a man and want to have a baby, 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 still maintain that relationship.

If you want to be a parent, you can.

An understanding of models of human sexual response cycles from a physiological, psychological, and social perspective, in addition to an understanding of the possible effects of SCI on sexual response and expression are helpful in learning to adapt successfully to changes resulting from SCI.

Human Sexual Response Cycles

Masters and Johnson's Model of The Human Sexual Response Cycle

Masters and Johnson were sex researchers who described sexual response as the result of two principal physiological changes -- increase in blood flow to various parts of the body (vasocongestion) and increase in muscle tension (myotonia). Masters and Johnson chose to use the words “excitement,” “plateau,” “orgasm,” and “resolution” to specify phases of the human sexual response cycle. According to Masters and Johnson, these phases correspond to the level of sexual arousal and describe typical responses.

Immediate signs of sexual excitement we are most familiar with are erections of the penis or clitoris and lubrication. Masters and Johnson also described other physiological effects of sexual stimulation on both men and women. As we get excited, an increase in heart rate and blood pressure, and often a noticeable “sex flush” in the chest, neck, face and ears is associated with increased blood flow and vasocongestion. In addition, there is nipple erection and an increase in muscle tension throughout the body. As excitement moves to plateau there are significant increases in heart rate, blood pressure sex flush, breast size, respiration rate (heavy breathing), and muscular tension. All physiological responses peak during orgasm accompanied by a rapid release of neuromuscular tension. Resolution sees a return to pre-excitement levels for heart rate, blood pressure, and respiration.

After experiencing changes in sexual responses that often accompany SCI (see discussion below), we may or may not experience erection or lubrication when we feel sexually excited. Men may not experience emission or ejaculation usually associated with orgasm or may experience retrograde ejaculation (the semen is forced

into the bladder instead of out of the penis). Women may or may not experience contractions in the uterus and around the vagina (pubococcygeous or PC muscle). Women, who experienced ejaculation before injury, may or may not continue to experience ejaculation.

However, if we pay attention, we will notice that we are experiencing all of the other responses described. Sex flush may be exaggerated, and increase and rapid release of muscle tension may be experienced as spasms, depending on the injury. Increase in blood pressure during sexual response may result in automatic dysreflexia (AD), dangerously high blood pressure that may cause severe headache, irregular heart-beat, and can lead to convulsions and/or stroke if not treated immediately.

Nancy Brackett, PhD, a research professor in male fertility with the Miami Project, recommends taking 20-40 mg of the calcium channel antagonist, nifedipine, by mouth 45-60 minutes prior to ejaculation, but only in those whose level of injury is T6 or above. Otherwise, it can be administered under the tongue, 15 minutes prior to ejaculation, but this route of administration requires some skill — make sure you fully understand your doctor's instructions.

Regarding other ways to prevent dysreflexia, Brackett says, "We have not used nitro-paste. We have used nitroglycerin tablets only in people with very labile blood pressures [may fluctuate abruptly] who require extra management in addition to nifedipine. Nitroglycerin tablets should not be administered routinely or casually, but only when indicated," she cautions. Ask your doctor before pursuing any kind of mechanical or electrical stimulation of your penis if you are prone to AD. Besides being very painful and taking away from your ejaculatory experience, it could leave you more disabled or dead.

With that warning firmly in mind, it is safest to try your first vibrostimulation at a center or clinic where your blood pressure can be monitored. While this is ideal, it's not practical for most. I encourage you to at least get a home blood pressure cuff to monitor yourself. AD is sometimes "silent" — as there are often no noticeable symptoms until it's too late.

It is important to recognize all these as sexual responses, especially with impaired sensation in the genitals. We can learn to focus in on non-genital bodily changes, use stimulation to areas where we may have heightened sensation above the level of injury, and learn to use breathing and imagery to enhance our sexual response and pleasure.

Kaplan's Triphasic Model of Sexual Response

Masters and Johnson's model of the human sexual response cycle focused mainly on the body's physiological changes. However, a sex therapist named Helen Singer-Kaplan pointed out that without the desire to be sexually active, we are not going to get excited or have orgasms. The inclusion of desire as part of the human sexual response cycle leads to consideration of psychological and physical factors that many inhibit sexual desire. Factors that might block sexual desire include stress, fatigue, depression, pain, fear, some prescribed medication and recreational drugs, negative past sexual experiences, power and control issues in a relationship, loss of interest in a partner, low self-image, and hormonal influences. Many of these factors are associated with early stages of SCI. As rehabilitation progresses and we learn to manage these non-sexual aspects of our lives, we are likely to experience an improvement in sexual response over time.

David Reed's Erotic Stimulus Pathway

Sex therapist David Reed proposed another model of sexual response that focuses more on the psychosocial aspects of human sexual response. Reed's four stages are "seduction," "sensation," "surrender," and "reflection."

Seduction includes all those things we might do to entice someone into sexual activity -- wearing cologne and perfumes, using makeup, dressing sexy, making eye contact, sexting, buying flowers, arranging time, sharing feelings, and asking for sex.

In the next stage, sensation, we are open to sexual stimulation from all of our senses. Sight, sound, taste, smell, touch, imagination and fantasy all have potential to arouse. This potential is dependent on how we interpret sensations, which is often influenced by our prior learning about what is sexually stimulating. Fortunately we are able to learn new ways to experience sexual pleasure from all our remaining senses.

During the stage of surrender we can experience orgasm. According to Reed, orgasm requires momentarily surrendering and giving up control. It requires us to take our mind off our performance or to stop “spectatoring.” After injury it requires us to stop comparing our present experiences to the past. To experience orgasm also requires us to stop worrying about how we look or smell, or about making too much noise, or about whether we are going to have a bowel or bladder accident. It also requires trust of ourselves and of our partners.

The last stage of reflection is a very important stage for us after a new experience, especially after experiencing sex for the first time after acquiring a SCI. In this stage, we look back over our sexual experience and examine how we felt about it. If it was a positive experience then we would most likely look forward to the next cycle beginning with seduction. However, if it was a negative experience we may tend to avoid future sexual encounters. That is why it is important to understand and be prepared for the possible changes in sexual function and response and to communicate possible changes with sexual partners.

A new sexual experience is something that needs to be worked on like everything else in the rehabilitation process. It may not be perfect the first time but there are ways to adapt and there is hope for a fulfilling sexual life.

Non-linear Model of Female Sexual Response

Rosemarie Basson's formation of the sexual response cycle was drawn from her experience working with women but is relevant to men too. Basson's model recognizes that spontaneous or “innate” desire does not always come first. We all have various reasons and incentives for initiating or agreeing to sex. Sometimes these motivations lead to a willingness to engage in sexual activity even when we may not be feeling in the mood. Sexual stimulation in the appropriate context can then lead to arousal and responsive sexual desire and the benefits of emotional intimacy and well-being. Avoiding sex in an otherwise loving and committed relationship can have detrimental effects to the relationship, assuming sex was important in the relationship before injury.

Possible Effects of SCI On Sexual Function and Response

As I am sure you have already figured out from experience, SCI impairs messages from the brain to other parts of the body. Every SCI is unique depending on level and completeness of injury. Accompanying other functional changes resulting from SCI may be changes in sexual function and response. Some type of change in sexual function and response is experienced by roughly 80-90% of people with SCI.

Likely changes in genital function have been associated with various levels and completeness of SCI. Changes in erectile function in men or changes in lubrication in women often result from SCI.

For men with cervical SCI (broken necks) and other thoracic injuries above T10, erections are likely to result from direct stimulation to the penis or scrotum, and indirect stimulation to the penis from a full bladder, for example, or from stimulation to the anus or rectum. These are often referred to as “reflex” erections and are not always associated with sexual activity. reflex erections are common during catheterization, bowel routines, and range of motion exercises of the legs and are beyond our control. Erections that result from messages sent from the brain are not likely in men with complete injuries above T10.

In women with cervical SCI or complete SCI above T10, erection of the clitoris and lubrication of the vagina is likely to result from direct or indirect stimulation to the vulva (pubic area, clitoris, outer and inner lips, entrance to the vagina) but is not likely from messages sent from the brain.

For both men and women with injuries between L2 and S2, it is believed that sexual responses resulting from messages sent from the brain (psychogenic) and sexual responses resulting from direct or indirect stimulation to the genital area (reflexogenic) are likely, however they are not likely to be coordinated.

In men with lesions below L2, seminal emission (the stage prior to ejaculation

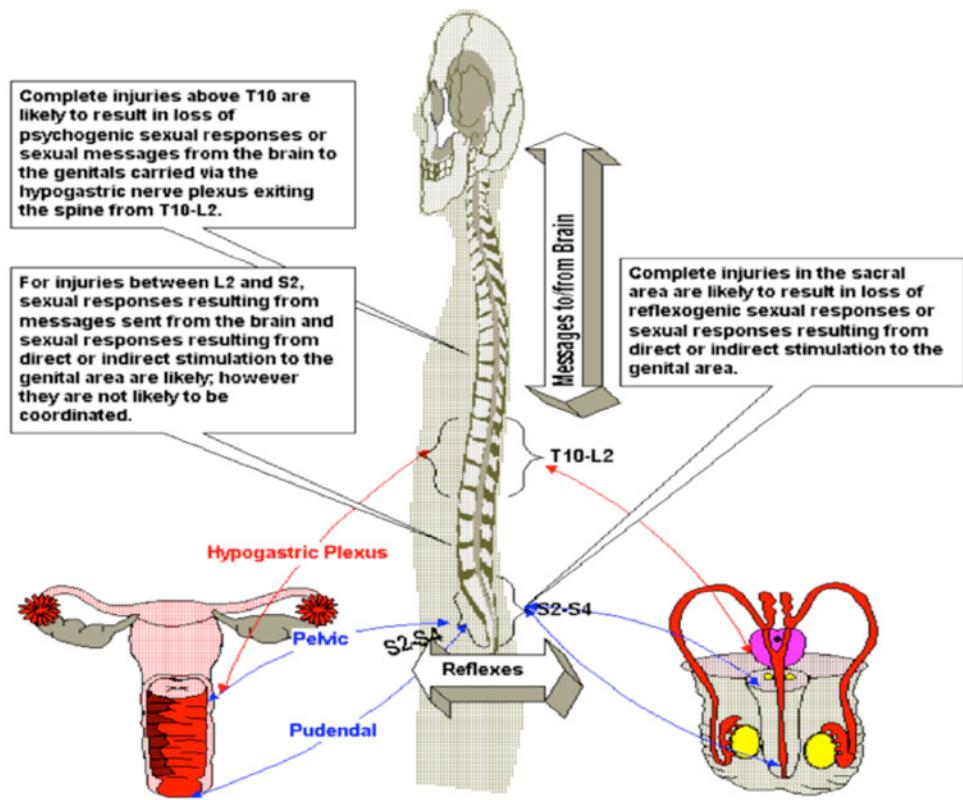
where sperm and seminal fluid is forced into the urethra) may accompany intense arousal. More information about ejaculation and fertility in men is included later.

We cannot make valid generalizations about changes of sexual function and response when injury is between T10 and L2 or when injury is incomplete. In all cases, we need to rely on our own observations of our sexual function and response and assess our own ability. It is also helpful to learn how to talk about our sexual function and response with appropriate health professionals and our current and future sexual partners.

While there are expected changes in sexual function based on the level of SCI, the ability to experience sexual satisfaction and orgasm after SCI has not been significantly related to level of injury. Factors associated with positive sexual adjustment include the level of sexual knowledge, openness and communication with partner, and time since injury. Time since injury is associated with a general increase in self-esteem and an increase in sexual-esteem. There is not room in this booklet to discuss the following information in great detail, however being familiar with our options will help in guiding further exploration of sexual issues with various members of the rehabilitation team or other specialists as needed, and through the resources included at the end.



Innervation of the Sexual System



Adapted from Providing Comprehensive Sexual Health Care in Spinal Cord Injury Rehabilitation: Continuing Education and Training for Health Professionals (Tepper, 1994)

If you want to find a partner, you can...

Having an SCI doesn't mean that no one will ever be interested in us as a sexual partner again. Beauty is truly in the eye of the beholder. Some people will admire and be attracted to someone who deals with adversity well, who is confident in themselves, who has a sense of humor, or who listens and pays attention to them. Of course there are added challenges. We need to come to terms with changes in our body image and function, and there will be people that we like who will not be able to see past our disability. It's important to keep rejection in perspective. Everyone gets rejected at some point in the dating process. Trust that it is possible to find someone, whatever the nature of our SCI. Remember the Internet can be a valuable tool in helping to meet and screen potential partners.

If you are already in a relationship it's possible for that relationship to survive and even thrive...

Open communication with your partner is a must. Share this booklet with them as a starter. It is important to be honest about your fears and concerns, as well as truthful about your hopes, wishes, and dreams. It is also important to negotiate boundaries between the caregiving and the sexual relationships so that the dynamics of the relationship do not change from equal partners to caregiver-patient.

If you want to have sexual intercourse you can...

There are at least a half-a-dozen options for men who have erectile dysfunction (ED) or difficulty attaining or maintaining an erection. Erection requires increased blood flow to the penis and restricted blood flow out of the penis. Options are roughly listed from the least invasive/lowest relative risk to the most invasive/highest relative risk:

- 1.** The “stuffing” technique is an option for men at any level. For men who experience reflex erection from direct or indirect stimulation of the penis, stuffing the penis into the vagina or anus while your partner uses their muscles to stimulate the penis may cause erection and help maintain it. Often both partners are satisfied with this sexual activity whether an erection is attained or maintained or not.
- 2.** For men who have no problem attaining an erection but have difficulty maintaining it, the use of a constriction device (rubber or silicone ring or adjustable strap) can help. It is safest to get a prescription for a custom fitted device from your urologists so they can thoroughly review the proper use of the product, however these devices are available “over the counter” online, in drug stores, and in sex shops and marketed as “cock rings.” The two biggest concerns are skin integrity and adequate blood flow. The use of plenty of water-based lubricant such as KY jelly or one of the many lubricants made specifically for sexual activity is necessary to avoid skin breakdown when applying and removing the device. A proper fit that allows some blood flow is important to avoid bruising the penis and damaging erectile tissue inside the penis. Even with a good fit the device should not be left on more than 30 minutes or permanent damage to the penis may occur. This means set the alarm before having intercourse or make sure you do not fall asleep with the device on!

- 3.** Vacuum erection devices have been successful with men who have difficulty attaining an erection. A cylinder is placed over the penis and a mechanical or electrical pump is used to create a vacuum and draw blood into the penis. Then a constriction device as described in #2 is used to trap the blood in the penis.
- 4.** Oral medications like Viagra, Cialis, and Levitra, listed here as the fourth option, are often the first option tried in men who have at least some erectile response and when there are no contraindications. Contraindications include being on nitrates or other medications (certain alpha blockers) that when combined with one of these oral medications for ED can lead to dangerously low blood pressure, or the presence of retinitis pigmentosa. They all work similarly and are well tolerated by men with SCI. If you have an option, it is best to get samples of each and see which brand works best for you with the fewest side effects. These oral medications are only available through a prescription from your doctor or urologists.
- 5.** Intracavernosal injections, delivering medication directly into the shaft of the penis using a small syringe, has also been effective with men who have difficulty attaining an erection. The quality of erection attained using this method is sometimes preferred to erections maintained with a constriction device, however some men are initially uncomfortable with the thought of injecting medication or anything else into their penis. Risks of this method include bruising, scarring at the injection site, and priapism (an erection that lasts for more than four hours). This method, sometimes referred to as Pharmacological Erection Program (PEP), is only available through a prescription from your doctor or urologists.
- 6.** Surgical implants permanently alter the erectile tissue in the penis and carry higher risks than other methods mentioned. Therefore surgical implants are considered the option of last resort, even though some men may opt for this before trying other solutions. Implants involve surgically inserting semi-rigid rods or inflatable tubes in the shaft of the penis. This procedure involves all the risks of surgery plus the added risk of long term infection, erosion of the device through the skin, and malfunction and replacement of the device. This device is only available through your urologists.

In addition to treating ED with one of the above listed options, men with SCI who are experiencing a decrease in sexual desire or difficulty with erections should also have their testosterone levels checked. Research indicates that men with SCI are more likely than matched able-bodied peers to have lower levels of testosterone (hypogonadism).

For women, the main consideration for intercourse is proper lubrication. If there is lack of sensation and/or inadequate lubrication in the vagina, and in all cases of anal intercourse, a water-based lubricant such as KY jelly or one of the many lubricants made specifically for sexual activity should be used. Vaseline or other petroleum-based products increase the chance of infection and will deteriorate and reduce the effectiveness of condoms. Use of lubrication applies whether inserting a penis, a vibrator, or any other object into the vagina or rectum.

Physical management for sexual activity might be needed for both men and women. Proper bowel and bladder management including management of catheters and ostomies, management of pain and spasticity, help with positioning, and working around ventilators are possible considerations. Avoiding intense genital or anal stimulation when you have a full bowel will help avoid an unscheduled bowel movement during sexual activity. Empty your bladder before sexual activity will help avoid voiding during sex. It is a good idea to keep some protective sheets (blue pads or chucks), a towel, and a urinal nearby if you are concerned about your bowel or bladder. Both men and women with indwelling catheters can leave the catheter in during intercourse. The catheter can be folded along the penis and held in place with a condom or tape. For women, the condom can be taped to the lower abdomen. Plenty of water based lubricant should be used when having intercourse and leaving the catheter in place. Pillows, foam wedges and supports, Velcro restraints, vibrators, and other devices are available to assist with sexual positioning and stimulation.

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.

If you want to have a baby...

SCI does not physiologically interfere with a woman's ability to conceive. Although

menstruation (periods) may stop for six to eight months after SCI, it is still possible to get pregnant. Regular menstrual cycles will come back in time. Carrying a baby to term involves similar risks to any pregnancy, however there is increased risk of bladder infection, pressure sores, hypertension, and, for women with injuries at or above T6, automatic dysreflexia. All these risks are manageable with a knowledgeable physician. Balancing and transferring can also present an increased challenge. With regard to delivery, women can deliver vaginally despite lack of voluntary muscle control. Breast-feeding is still a viable option although adaptive equipment such as a sling or harness to help hold the baby may be necessary.

Difficulty ejaculating and poor sperm quality are two problems men with SCI face. For men who have difficulty with ejaculation, the two most commonly used procedures for retrieving sperm for use in insemination procedures are vibratory stimulation and electroejaculation stimulation (EES). Direct aspiration of the sperm from the vas deferens and other high-tech procedures are also available. Little can be done to improve sperm quality at this time, however there are advanced procedures to deliver sperm directly into the ovum (egg). An evaluation of your sperm quality is the best way to determine the possibility of having a baby. Ask your doctor for a referral to a fertility clinic that specializes in SCI if you are interested in having a baby. For both men and women, adoption is a viable option for becoming a parent.

If you want to be an active parent...

Regardless of how you get a baby, if you want to be an active parent, you can. An occupational therapist can help you choose the adaptive equipment (accessible cribs, changing tables, carrying slings, etc.) you may need. If you are already a parent of a child who can manage their own personal care, you can still play an active role in parenting your child giving love, support, and direction and finding mutual ways to have fun together.

If you do not want to have a baby...

All options are available to couples interested in contraception, however a few carry increased risks or may present some physical difficulty using. The intrauterine device or IUD presents increased risk of urinary tract infections and there is decreased ability to self-monitor for perforated uterus or infection for women with loss of sensation. Diaphragms may present a problem with insertion and atrophy in the muscles surrounding the vagina may create a problem with fit and decrease the

efficacy of this method. A partner can assist in inserting the diaphragm if you are both comfortable with the situation.

The male condom is still the most popular form of birth control for women with SCI; it is one of the easiest and safest methods of contraception and it helps prevent the transmission of infections. The second most popular form of birth control for women with SCI is a permanent surgical procedure like tubal ligation. Oral contraceptives (hormonal methods such as the pill) were once believed to present increased risk of deep vein thrombosis (blood clots) for women with SCI. However, this is questionable with newer oral contraceptives. Oral contraceptives are the third most popular form of birth control for women with SCI. You should consult a health professional familiar with SCI to help you choose the best method for your personal considerations.

Note that men with limited hand function may have difficulty putting on a condom. Once again, a partner can help if they have adequate hand function and are comfortable.

We cannot restore sensation....

Unfortunately, we cannot restore sensation to parts of the body affected by SCI. However, systematic exploration with a partner can help increase awareness to areas of our body where sensation is still intact and where we may be open to sexual stimulation, while also increasing sexual communication and sexual pleasure. Have your partner take time to explore all parts of your body including your head, hair, face, ears and neck; your chest, breasts, nipples, abdomen; your back, buttocks, anus, arms, underarms, hands, fingers, legs, feet, and toes. Exploration can include using different kinds of touch with the hands like stroking, rubbing, squeezing; different kinds of touch with the mouth like kissing, sucking, nipping; incorporating lotions, oils, and powders, feathers, silk, or even a vibrator. Experiment and see if stroking the same area up is different than down or side-to-side. Create a simple communication feedback system for what feels good, neutral or irritating; neutral can be the number 0, irritating to painful can go from -1 to -3, ok to good to great can go from 1 to 3. It is best to set time aside to explore a certain portion of your body, say from the shoulders up. During that time just focus on stimulation to the chosen area without any plans of moving to any other areas or of having sexual intercourse. Only explore an area of about the size of your hand at a time as sensa-

tions can differ in a matter of inches. This exercise places the emphasis on intimacy and pleasure versus the goal of performance and orgasm and is not specific to people with SCI. Everybody has the potential for sexual growth through these fun activities. Sexual pleasure adds to quality of life for everybody, including people with SCI.

Sexual pleasure is still possible...

It is of importance to note the self-reported incidence of orgasm in people with SCI is consistently around 50% and laboratory studies, at least in women, lend support to that number. As mentioned earlier, reports of orgasm have not been strongly associated with level or completeness of the SCI. Many people report an area of hyper-sensitivity above the level of injury that when stimulated results in sexual arousal and sometimes orgasm; other people report having orgasm as the result of stimulation of the ears, neck, breasts, or through fantasy. Orgasm in people with SCI usually requires a much longer period of stimulation than before injury. It is also important to note that the majority of people with SCI report sexual satisfaction even if they do not experience orgasm.

Sexuality spans the biological, psychological, social, emotional, and spiritual dimensions of our lives. Sexuality begins with us and our relationship with ourselves, and extends to our relationships with others. Our relationship with ourselves includes how we feel about ourselves as a person, as sexual beings, as men and women, and how we feel about our body and how we feel about sexual activities and behaviors. Our relationships with others may include friendship, emotional intimacy, love, and/or sexual activities. We are all sexual people regardless of SCI and we have a right to live a fully sexual and satisfying life.



Suggested Resources

DrMitchellTepper.com

<http://drmitchelltepper.com>

Male Fertility Following Spinal Cord Injury: A Guide For Patients. Second Edition

By Nancy L. Brackett, PhD, HCLD Emad Ibrahim, M.D. Charles M. Lynne, M.D. 2011

<http://www.themiamiproject.org/wp-content/uploads/2015/07/male-fertility-booklet-2010-lowres.pdf>

PleasureABLE Sexual Device Manual for People With Disabilities

Kate Naphtali and Edith MacHattie, MOT Disabilities Health Research Network 2009

<http://sci-bc-database.ca/wp-content/uploads/PleasureABLE-Sexual-Device-Manual-for-PWD.pdf>

Pregnancy and Women with Spinal Cord Injury

Amie McLain, MD, Taylor Massengill, BA, and Phil Klebine, MA SCI MSKTC 2015.

<http://www.msktc.org/sci/factsheets/Pregnancy>

Regain That Feeling: Secrets to Sexual Self-Discovery: People Living With Spinal Cord Injuries Share Profound Insights Into Sex, Pleasure, Relationships, Orgasm, and the Importance of Connectedness

Paperback; January 13, 2015 by Mitchell S. Tepper, PhD, MPH, 2015.

<http://www.amazon.com/Regain-That-Feeling-Self-Discovery-Relationships/dp/1505444993>

Sex and Paralysis Video Series.

Mitchell S. Tepper, PhD, MPH. 2013. Sex and Paralysis Video Series

http://www.drmitchelltepper.com/sex_and_paralysis_video_series

Sexuality and Reproductive Health in Adults with Spinal Cord Injury: What You Should Know, A Guide for People with Spinal Cord Injury

Consortium for Spinal Cord Medicine and Paralyzed Veterans of America. 2011.

<http://www.pva.org/atf/cf/%7BCA2A0FFB-6859-4BC1-BC96-6B57F57F0391%7D/WHAT%20YOU%20SHOULD%20KNOW.PDF>

The Ultimate Guide to Sex and Disability: For All of Us Who Live with Disabilities, Chronic Pain, and Illness

Paperback use preformatted date that complies with legal requirement from media matrix – November 28, 2007 by Miriam Kaufman (Author), Cory Silverberg (Author), Fran Odette (Author).
<http://www.amazon.com/The-Ultimate-Guide-Sex-Disability/dp/1573443042>

Thomas Jefferson University Hospital and Magee Rehabilitation, "Sexuality-Spinal Cord Injury Manual" (2009)

Spinal Cord Injury Manual (English). Manual 17.

http://jdc.jefferson.edu/spinalcordmanual_eng/17

Through the Looking Glass National Center for Parents with Disabilities and their Families

<http://www.lookingglass.org>

United Spinal Association Spinal Cord Resource Center

<https://www.unitedspinal.org/ask-us/>

United Spinal Association

Mission Statement

United Spinal Association is dedicated to enhancing the quality of life of all people living with spinal cord injuries and disorders, including veterans, and providing support and information to loved ones, care providers and professionals.

United Spinal Association

120-34 Queens Boulevard #320, Kew Gardens, NY, 11415
718-803-3782 www.unitedspinal.org

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Life-Enhancing Programs & Services



Spinal Cord
Resource Center

Spinal Cord Resource Center

When someone is spinal cord injured or diagnosed with a spinal cord disorder, there can be a great deal of uncertainty and an overwhelming amount of questions. Our Spinal Cord Central Resource Center connects people living with SCI/D with information, resources, and access to our "Ask Us" help desk. www.unitedspinal.org



VetsFirst

VetsFirst works to ensure veterans, their spouses, dependent family members and survivors receive healthcare, compensation, rehabilitation, and other benefits offered by the U.S. Department of Veterans Affairs. This program's call center and online help desk, connects with over 2,000 veterans and their caregivers annually, offering assistance with questions on military separation, claims appeals, and state benefits. www.vetsfirst.org



New Beginning Backpack

Our New Beginning Backpack program provides information and resources as a person transitions into a "new beginning" after SCI/D. The backpack is distributed through our national network of rehab hospital partners, member chapters, and peer support groups.
www.spinalcord.org/backpack



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Service Providers

Affiliate Service Providers

United Spinal's Affiliate Service Providers provide the full spectrum of clinical care, products and services, with an emphasis on spinal cord injury and disease (SCI/D). Search our valuable directory to discover service providers near you that specialize in optimizing the health, independence and quality of life of people with SCI/D.

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United Spinal Association knows that disability is a shared experience that affects you, your family, friends and communities. Fortunately, we are stronger together, and United Spinal brings decades of expertise to help: information, peer mentoring, advocacy and much more. Become a member today and **Share the Journey.**

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