
ORIGINAL RESEARCH—MEN'S SEXUAL HEALTH

Perspectives on Sexual Health and Function of Recent Male Combat Veterans of Iraq and Afghanistan

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ABSTRACT

Background. U.S. veterans of recent wars in Iraq and Afghanistan may be at greater risk for sexual dysfunction due to injuries, mental health conditions, medications used to treat those conditions, and psychosocial factors.

Objective. To explore the perceptions of recent Veterans about sexual health and dysfunction, contributing factors, its impact and solutions.

Design. Qualitative study.

Participants. Eight men who screened positive for sexual dysfunction at initial presentation to a postdeployment clinic at a Veterans Affairs medical center

Approach. Patients who screened positive for sexual dysfunction and indicated an interest in participating were contacted and scheduled for an in-person private interview with a researcher. Interviews were semistructured, utilizing open-ended and follow-up probe questions to elicit the individual's perspective about sexual dysfunction and its cause, impact and solutions. Interviews were recorded, transcribed and analyzed for themes.

Key Results. These heterosexual men discussed a range of sexual dysfunction in their activities including lack of desire, erectile dysfunction, delayed orgasm, premature ejaculation, and distraction. They also discussed the importance of setting or context and changes over time to their sexual health and function. The men shared their ideas about contributory factors, including normal aging, medication side effects, injury and a possible role for combat deployment more generally. Reported solutions for sexual dysfunction included medications, herbal remedies, and new positions and approaches to sexual activity. Participants reported discussing sexual dysfunction with their health-care providers and what was helpful. Finally, the men expressed in their own words the significant impact of sexual dysfunction on their self-perception, their partners, and their relationships.

Conclusions. Sexual dysfunction in recent combat veterans can have important negative effects on their health and relationships. Our findings elucidate perceived contributory factors and preferred solutions, which can be applied by health-care providers to improve the management of sexual dysfunction in these patients. **Helmer DA, Beaulieu G, Powers C, Houlette C, Latini D, and Kauth M. Perspectives on sexual health and function of recent male combat veterans of Iraq and Afghanistan. Sex Med 2015;3:137–146.**

Key Words. Veteran; Sexual Health; Qualitative Research

Introduction

Sexual activity is an important aspect of human life, central to reproduction and creating and maintaining intimate relationships. Sexual health, i.e., the physical, mental, and social capability to engage in activities related to establishing intimate relationships and procreation, is significantly associated with satisfaction with life and health in general [1–3].

Many factors may contribute to sexual dysfunction, or diminished potential for pleasure experienced during any stage of intimate physical activity, including desire, arousal, and orgasm. These include structural damage, disease processes, depression and other mental health conditions [4], and medications, such as selective serotonin reuptake inhibitors (SSRIs) [5].

Sexual dysfunction is not routinely assessed in routine primary care or mental health encounters [6]. Only a minority (<30%) of individuals endorsing sexual health concerns reported discussing these issues with a health-care provider attributed to concerns that they would not be perceived as serious by the providers and a lack of awareness of medically mediated treatments [7–10]. Patients indicate that they do not expect physicians to assist with sexual dysfunction [11] and providers rarely initiate the discussion [12,13].

Recent Veterans of conflicts in Iraq and Afghanistan are perhaps at increased risk for sexual dysfunction, but little is known about their sexual health or function [14,15]. The majority (70%) are younger than 40 years old and there is a high prevalence of mental health conditions, such as PTSD and depression [16]. Trauma, including sexual trauma, is more prevalent in the Veteran population than in the general U.S. population [17,18]. To treat these mental health conditions, Veterans are often prescribed medications, such as SSRIs, that may exacerbate sexual difficulties [19]. Finally, reintegration into civilian society after combat can be challenging and stressful and sexual dysfunction may further strain partner relationships [20–24].

To better understand their perspectives on sexual health and the role of health-care providers in addressing sexual dysfunction, we interviewed recent combat Veterans who screened positive for sexual health concerns. We report insights into the scope, relevance, impact, and help-seeking behaviors of recent combat Veterans with sexual health concerns.

Methods

Population

Veterans of Operation Enduring Freedom (Afghanistan), Operation Iraqi Freedom and Operation New Dawn (both Iraq) presenting to a VHA post deployment clinic for the first time.

Sample

Between January, 2011, and December, 2012, 276 Veterans presenting to the post-deployment clinic at a large Veterans Affairs Medical Center completed the Arizona Sexual Experience Scale (ASEX) as part of the routine psychosocial intake screening by a social worker or other clinician. The ASEX is a five-item instrument designed to screen for sexual dysfunction in a clinical or research setting [25]. Item responses are ordinal (1–6) and summed to achieve a total score ranging from 5 (little sexual dysfunction) to 30 (marked sexual dysfunction). Each item corresponds to a phase of the sexual response cycle; items are appropriate for male or female respondents. Sexual dysfunction can be derived from the ASEX by several methods: total score >19, 3 or more items with a score of 3 or more, and any single item score of 5 or more. For this study, we contacted patients who met criteria on the ASEX using any of these scoring methods and who also indicated interest in further participation in the study on an informational sheet.

Procedures

The interviewer (C.H., G.B., or C.P.) scheduled and arranged an in-person one-on-one interview with the patient and completed written informed consent. After introductions and explaining the purpose of the research project, the interviewer followed a semi-structured interview script starting with broad, open ended questions and proceeding to more focused inquiries. More probing questions were asked to follow up on incomplete thoughts and encourage the participant to elaborate in his own words. The interviews were audio recorded and transcribed and all personal identifying information was removed.

Chart abstraction data used in this analysis included the 4 item Prime Posttraumatic Stress Disorder Screen [26], Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) [27], and Patient Health Questionnaire-2 [28]. Age was recorded in years; race as Black, White, or Other; and ethnicity as Hispanic or non-Hispanic. Military history included rank, branch, compo-

nent, and time from separation from military to interview. Participants were not reimbursed. The protocol was approved by the institutional review board and VA Research committee.

Analysis

Three research team members (G.B., C.P., D.A.H.) independently developed a coding scheme from the interview script and the first interview transcript. All three coders applied the coding scheme to the second transcript and reviewed their codes for agreement which was reached by consensus. The perfected coding scheme was shared with a fourth research team member (M.K.) who reviewed the second transcript using the coding scheme which was then finalized. Two of the three coders independently coded each transcript and rectified coding for each transcript with his/her coding partner. Discrepancies were resolved by consensus, appealing to the third coder. All coded text for each transcript was reviewed and merged into a single document.

Three authors (G.B., D.A.H., M.K.) reviewed the final coded transcripts and identified examples of text from each code to illustrate the coding scheme domain and the variations within each domain. The demographics, health information, and ASEX results for participant interviewees are summarized using descriptive statistics and linked to the interview transcripts (e.g., participant 1).

Results

Of 22 patients determined to be eligible and interested, 21 were contacted, 14 confirmed interest and were scheduled, and eight completed the interviews. All participants were male from 24 to 46 years old; five were married and two separated or divorced. Time since separation from the military ranged from 1 to 57 months; two were still in the National Guard. Five screened positive for PTSD, two screened positive for depression, and one screened positive for problem alcohol use. Only two reported active cigarette use. Their total ASEX scores ranged from 15–25; six screened positive for sexual dysfunction with a total score >18 and two with >3 items scored as 3 or higher. The most troublesome domain of sexual function for this group as denoted on the ASEX was ease of erection (Table 1).

Eight broad themes emerged from the interviews. These are summarized in Table 2. The following sections present each theme with sample quotes (see Appendix A for additional quotes).

Table 1 Individual participant characteristics and ASEX responses

Variable	Participant number							
	1	2	3	4	5	6	7	8
Age (years)	29	29	46	29	27	24	31	29
Race	White	Black	Black	White	Unknown	White	Black	Black
Ethnicity	Non-Hispanic	Non-Hispanic	Non-Hispanic	Non-Hispanic	Hispanic	Non-Hispanic	Non-Hispanic	Non-Hispanic
Relationship	Married	Separated	Married	Divorced	Married	Married	Single	Married
Medications	Yes	No	Yes	Yes	No	No	Yes	Yes
SSRI/SNRI	Yes	No	Yes	No	No	No	Yes	Yes
PTSD screen (0–4)	4	4	4	0	4	1	4	0
Depression screen (0–6)	6	2	2	2	0	0	6	0
AUDIT-C (0–16)	2	5	0	11	2	1	2	2
Cigarette use	Active	Negative	Negative	Active	Negative	Negative	Negative	Negative
Time since military service (months)	55	21 (still in National Guard)	5	10	1	5	57	4 (still in National Guard)
Rank	Enlisted	Enlisted	Enlisted	Enlisted	Enlisted	Enlisted	Officer	Enlisted
Branch	Navy	Marines	Army	Air Force	Army	Army	Army	Army
ASEX Item 1	5	5	5	4	3	2	5	4
Strength of Sex Drive								
ASEX Item 2	5	5	5	4	4	3	4	5
Ease of Arousal								
ASEX Item 3	5	5	5	4	4	4	4	5
Ease of vaginal lubrication or penile erection								
ASEX Item 4	5	4	4	2	5	3	5	4
Ease of orgasm								
ASEX Item 5	5	3	4	4	5	3	5	5
Orgasm satisfaction								
ASEX Total	25	22	23	18	21	15	23	23

Table 2 Summary of interview themes

Theme	Description
Sexual dysfunction	Pathophysiological and psychological problems interfering with the body's ability to engage and participate in sexual activity
Activity	Issues related to sexual activity, including the frequency, type, and pattern of activity.
Setting	Talk about the importance of the setting or context of sexual activity to sexual health and function.
Temporal shift	Changes in sexual health, function and activity over time.
Cause	Causal attribution of sexual health concerns, including dysfunction
Solutions	Treatments or management strategies for sexual dysfunction, including health-care and medical options
Impact	Psychosocial impact of sexual dysfunction including impact on the participant's perception of self- cognitive, emotional, and behavioral; the partner; and relationships
Overall wellness	Relationship between overall health and wellness and their sexual health

Sexual Dysfunction

We identified a range of sexual dysfunction from the participants including lack of desire, an inability to focus during sexual activity with a partner, erectile dysfunction (difficulty with arousal and maintenance of erection), and early and delayed ejaculation.

Just my erections; that's it. . . . Sometimes I don't get them and then sometimes I get it, but then I—then it goes away. (Participant 2)

It's . . . just different you know. Seems like everything is over a lot quicker. (Participant 8)

If I feel like it's mechanical, or whatever, it's not going to—it'll take a while. She'll enjoy it because it's going to take a while, but I was, like, you know what, let's think about something else and see if I can just hurry up and get this over with. In some instances I've had to fake an orgasm. (Participant 7)

Three different participants volunteered issues with distraction that they associated with sexual dysfunction. One of those participants theorized that sexual activity had lost its novelty and was not as “pleasurable.”

I don't know; I'm just not into it. You know, like it's—my mind just kind of wanders, or I always seem like I'm just more alert to other things than what I should be as far as, you know, whatever we're doing. I'm just worried about other stuff or distracted I guess. (Participant 1)

Activity

All participants reported sexual relationships exclusively with women. All reported sexual encounters in the past 1–2 years, although all reported a recent frequency of sexual activity they perceived as lower than sometime earlier in their lives. One participant explicitly volunteered use of pornography. No participants reported use of prostitutes, group sexual activity, or hypersexual

activity or specific practices that interfered with daily functioning or risked legal complications.

After deployments I was kind of the complete opposite. I was like a . . . raging hormone walking down the street It's like (now) I'm the complete opposite. I wish there was like a middle road; I'll be completely happy with that. (Participant 7)

Well, before the head injury, I was having sex roughly three to four times a week. . . . After I was actually able to have sex again, it went from four times a week to maybe once every week just because I didn't have the drive for it. (Participant 6)

Setting

A number of participants talked about the importance of the setting or context to sexual function. In general, participants had an easier time achieving sexual satisfaction through masturbation. At least one participant noted that he had less difficulty with sexual function when he was with a new partner.

I know what I like; I know how to do it. I consider masturbation like maintenance. (Participant 7)

I think it's usually after the first time I've been with someone that it turns into a chore. (Participant 7)

Temporal Shifts

As expected with the age range represented, a number of men discussed changes in their sexual function and activity over time. Often, a particular milestone, such as return from deployment, injury, or change in relationship status marked a change in sexual activity or sexual function. However, participants did not always view these milestones as causally linked to the change.

When I came home from Iraq. . . . Then after me and my wife split up. I—I just—I didn't want it anymore. (Participant 5)

It's just—I've been dealing with it [sexual dysfunction] since I got hurt, and this is just how it is now. (Participant 6)

Cause of Sexual Health Concerns

Many participants proposed a specific cause for their sexual dysfunction. Three participants attributed their sexual dysfunction to their deployment in general or specific deployment-related events.

I—I don't know what it was. A lot of my—my buddies because I know—I know like a couple that have the same problem [sexual dysfunction]. . . . And they said it was from the—injuring their backs and I injured my back when I was there a few times . . . and they said it has something to do with your back among other things. From seeing a lot of, uh, you know, stuff over there. (Participant 5)

On the other hand, when asked, several participants denied or downplayed a role for their military or deployment experiences in contributing to their sexual dysfunction.

I never really thought about it—if the military contributed to it or not. I more or less contributed it to the medication I was on, but I was on the medication when I was there and still didn't have that problem. (Participant 4)

Other possible causes mentioned included specific injuries, medications, stress, alcohol use, and normal aging. Some participants noted more than one contributing factor.

Um, probably the stress levels. . . . I know when I was drinking that probably played a big part in it—the chemical balance or something. (Participant 4)

I just thought a lot of it [reduced libido and pleasure] came with just getting older. I was like, alright, whatever. . . . I was like, maybe, I—am I normal? I think so; maybe I'm not. (Participant 7)

Solutions for Sexual Dysfunction

Most participants reported trying a number of solutions to address their sexual dysfunction including medications, pornography, vitamins, herbal remedies, and sex toys. Many of these measures were reported not very effective. Only one participant appeared unsure about what he could do to address his sexual dysfunction.

I've tried to watch porn. . . . And that gets boring. It's like, just like . . . I've seen the same thing before. I've tried—what's that thing called? Smiling Bob, the Smiling Bob commercial. . . . I tried that [Extenze]; didn't really see a difference. . . . I've tried taking testosterone pills. . . . I just wanted to go work out more. (Participant 7)

I need that pill [ildenafil]. . . . And sometimes it don't damn work. (Participant 3)

Use toys for her, just different positions; going at it twice a day if we have to; stuff like that. . . . She doesn't like those things. She likes my dick. (Participant 6)

One participant noted with disappointment that he was limited to four doses of a phosphodiesterase-5 inhibitor (PDE5i; e.g., sildenafil) per month. On the other hand, at least one participant was concerned about adding another medication to his regimen, as well as the potential side effect of priapism from a PDE5i.

Yeah, I've mentioned it to the physicians, and they've put me on pills for it. . . . I just didn't see any need for it [the pills], and I don't want to have that—I don't want to be that guy that walks into the ER with a full flag showing. (Participant 6)

I'm already taking enough medication as it is. I don't want to take one more just so I can, you know, have sex. (Participant 6)

Participants reported a number of sources for assistance with sexual dysfunction, including health-care providers at the VA, military medics, friends, and family members. Most participants who commented on discussing sexual health issues with health-care providers were enthusiastic about obtaining information and assistance in the context of health care; only one participant expressed some reservations about this.

I: "How often have you been asked about your sexual health by medical professionals?" P: "Pretty much every time I come in. It doesn't bother me any. They do a good job at asking if somebody's not willing to tell them about it." (Participant 6)

A couple of participants indicated a desire for a more in depth conversation with the provider about sexual health.

Um, mentioned it briefly in OEF/OIF [post-deployment clinic] when I first got here. And they thought maybe prescribing Viagra, but we never pursued anything like that. Um, it [the conversation] was brief. I kind of wish they would've went more into depth about it. . . . This may be something we need to look at on another appointment or something. Instead of, oh, it's just the medication, let's just wing it out and see how it goes. (Participant 4)

Impact

Participants expressed the impact of sexual dysfunction on their perception of self in cognitive, emotional, and behavioral domains. They also

described how they see their sexual dysfunction affecting their partners and their intimate relationships.

Impact on Self

It just kind of, like, takes something from you. You know, it's, um, what word am I looking for? Degrading, that's a good word right there. (Participant 3)

I: "Do you ever have the feeling that you might have an orgasm but you don't reach that point?" P: "Yes." I: "What happens after that?" P: "I go quiet. I go—I go dark. I lose it [his erection], and I just go dark. I shut myself out, like, I don't—I don't want to be touched. I don't want to—I, uh, like, I'd rather be in a different world." (Participant 5)

Well, like I said, I try not to think of it [sexual problems] but it does—does bother me quite a bit because I wasn't like this before. I used to like, you know, having sex. (Participant 5)

Impact on Partner

I think it's more frustrating, maybe, to my wife that I don't . . . get her all the time to where she wants to be during intercourse. Because sometimes I see it in her face. You know, I can see it in her face, in that expression, and just like, you know, she's almost there but then it's, like, I'm done [achieved orgasm] so I can't perform anymore. She really don't—she really don't complain but you can see the frustration that she's not able to get where she wants to be. (Participant 8)

Well, this one girl, she was pretty pissed. I just told her, "I'm sorry." I made up an excuse that it was—it was too dark in the room and that I couldn't do it. (Participant 5)

Impact on Relationship with Partner

Compared to what it was before, I—you know, after I got back from Iraq and everything, it definitely—definitely sucks. Not having sex as much, not making my wife happy and stuff like that. It just makes it harder for me to—takes me longer to get up to the point where she's at, and I can't satisfy her in enough time or I can't satisfy her at all because my drive is just gone. We have a very open relationship with each other. If something's bothering us we tell each other. You know, it sucks hearing it from your wife that you've been married to for seven years that you're not satisfying her. (Participant 6)

I just don't have the desire to and it's—and it's affecting my relationship, you know. (Participant 1)

A few participants also noted that sexual dysfunction was not the most important aspect of their lives.

I have other things that are more important [than sexual activity] like goals and objectives and some other stuff

I'm trying to get done. I really don't put—I don't place a value on it. (Participant 7)

I think sex is—it's not, uh, the main focal point of a marriage, but it—it's a big focal point of it. I mean, it's—it's between that and, you know, all the other, you know, issues and stuff that's just taking its toll on the marriage. (Participant 1)

Guess you kind of get used to it, but it still bothers me that—the whole situation bothers me that I can't—that I'm not the same person I used to be. It's not even so much just the sex part of it. It's just all, uh, in general. It's just fucked up, I guess. (Participant 1)

Of note, there were no spontaneous mentions of concerns about sexual function negatively impacting fertility or family size. Seven participants had one or more child; we did not query explicitly about desired family size.

Discussion

From the interviews we identified eight domains of sexual health similar to concerns of men in other populations. We heard, in their own words, about their experiences with assessment and management of sexual dysfunction. These findings can be applied by health-care providers to other recent combat Veterans, as well as other men and partners.

First, our participants discussed many of the types of sexual dysfunction common in men, particularly diminished desire, erectile dysfunction (obtaining and maintaining an erection), and delayed or premature ejaculation [29]. There was no mention of painful sexual activity, the other main category of sexual dysfunction. We also gained a better understanding about their perceptions of the impact of sexual dysfunction on their self-image, partners, and relationships. Universally, the men acknowledged the negative impact of sexual dysfunction in these areas. In particular, there was sense of loss—of masculinity, role, or identity. Several men talked about their sexual dysfunction affecting their duty to perform and satisfy their partners and experiencing a nagging doubt about their worth given this deficiency that destroys their confidence. These sentiments were clearly expressed, although they were counterbalanced by indications that sexual dysfunction was perhaps not the highest priority concern, sometimes overshadowed by other issues.

These findings echo the importance of sexual health and function reported in men with erectile dysfunction [30] and in prostate and bladder cancer survivors. For example, men with erectile

difficulties after prostate cancer treatment indicated changes in their sense of self and in disruptions in their sense of intimacy with their spouse or partner [31]. Men treated for prostate cancer also report a variety of interventions for erectile difficulties [32].

We also gained a better understanding of perceived causal factors from the participants. Many plausible causes were mentioned, including medications, alcohol use, physical injuries, age, and psychosocial stressors. Of note, only one participant spontaneously identified a military experience (traumatic brain injury) as the main cause of his sexual problems, however several participants endorsed the experience of deployment as a potential contributing factor upon questioning. This included one participant who reported a period of increased sexual interest and activity immediately after returning from combat which then turned into "the complete opposite."

PTSD is known to be associated with sexual dysfunction, although the exact mechanism is not well established [19]. Several participants screened positive for PTSD and also discussed how they felt "distracted" during sexual activity. Symptoms of PTSD may disrupt psychosocial function and attention and interfere with sexual behavior [33,34] or an underlying biochemical pathophysiology may diminish sexual function independent of comorbid depression, and medication side effects [35]. Additional research into the possible mechanisms by which PTSD contributes to sexual dysfunction and in the qualitative changes in the sexual experience would substantially enhance understanding.

Finally, we learned much about "solutions" to sexual dysfunction and preferences for the involvement of health-care professionals, many consistent with other reports [36]. We heard about trusted sources of information, including peers, military health-care paraprofessionals, family members, and primary care professionals. At least a few participants mentioned discussing sexual function explicitly with their partners with implied conjoint problem solving (e.g., use of sexual toys, novel positions). However, for other participants, communication was less direct (e.g., a look on their partner's face) or more perfunctory (e.g., do you want to try a toy?). Veterans like the ones in our study may benefit from interventions that encourage communication with a partner and provide skills in broaching difficult subjects like sexual dysfunction. Better communication has been shown to be associated with improved quality of life

among couples with cancer dealing with sexual dysfunction [37,38].

Most participants appeared to try solutions available to them (e.g., herbal remedies, sex toys) and the majority had interacted with one or more health-care professionals about sexual dysfunction. The participants appeared split when discussing the use of PDE5i's for erectile dysfunction; some greatly appreciated it, while others shunned it for possible side effects or a perceived stigma of relying on a medication "this early" in their lives.

It is clear that these participants did not want sexual dysfunction simply attributed to medication side effects and then dismissed by their providers. They also did not want providers to reflexively prescribe a PDE5i. These participants wanted a more biopsychosocial and individualized approach to the issue, as recommended by experts [39–42]. Of note, only one participant voiced concern about providers raising the "personal issue" of sexual function and his concern was actually a call for a patient-centered approach to conversations about sexual health. It appears that the primary care providers of these participants addressed their sexual health concerns. This may be partially an artifact of the authors' involvement in the clinic and the use of the ASEX sexual dysfunction screening tool in the clinic.

Despite six of our participants screening positive for one or more mental health conditions and five reporting psychiatric medication use, none of the participants proactively mentioned an experience of discussing sexual health with a mental health provider or a desire to do so. Other studies have highlighted the importance of mental health providers in addressing the psychological burden that may accompany sexual dysfunction [43–45].

Some medications are known to have a high rate of adverse effects on sexual function, e.g., SSRIs [46]. The lack of explicit mention of management strategies related to medication effects [47] is notable given the high rate of medication use in this group (5 of 8 on SSRI/SNRI) and the frequent mention of their possible contribution to sexual dysfunction.

The sexual health issues discussed in these interviews represent the most likely issues heterosexual male Veterans might bring to a health-care provider. Given the homogeneity of the participants, these findings provide no insight into the less common issues (e.g., paraphilias, compulsive sexual behaviors, illegal sexual behaviors), which would likely benefit from the involvement of specialized services. The perspectives of women and

lesbian, gay and bisexual (LGB) and transgender Veterans about sexual dysfunction and its management in the health-care setting might be quite different from the perspectives of heterosexual male Veterans summarized in this report [48].

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Appendix A: Additional Quotes by Theme

Sexual Dysfunction

"It's not pleasurable anymore. I think that's what it is." (P#7, p. 6, l. 251–266)

Setting

"Get in and get out, man. That's when it [masturbation] happened in Iraq. When it's a hundred and fifty degrees inside of the porta-shitter . . . you've got to be quick or you die." (P#6, p. 17, l. 740–758)

Temporal Shifts

"I guess to me when I went on deployment . . . I haven't been able to perform as well as I used to with my wife." (P#8, p. 5–6, l. 225–239)

"You know, it was after deployment; that's when it really just kind of went full effect." (P#1, p. 7, l. 282–288)

Cause

"I don't know. I just—like I said it's just based on the experiences that you know happened on deployment." (P#1, p. 7, l. 303–309)

"It was just that deployment that got me, I guess. Um, it changed me." (Participant 5)

"I don't know if the military has anything to do with it. I mean, it might but, you know, I'm—who knows. I—I couldn't—I couldn't say if it was, or if it wasn't." (P#2, p. 11, l. 494–495)

"I can't really say; I'm not a doctor. So I would just say it's old age, but I don't know—I don't know what it is really." (P#3, p. 11, l. 503–504)

"After my head injury, I've noticed a decent—decent decrease in overall drive, stamina; basically everything." (Participant 6)

"Most of that's due to the medications I'm on. Takes longer for me to get an erection—just for the blood pressure issues and stuff for my migraines." (Participant 6)

Solutions

"I've tried, you know, taking vitamins, herbal-like vitamins . . . I've taken them and now and then it seems like it's still the same, so . . ." (P#8, p. 15, l. 621–630)

"I guess the concern is the lack of medication that they've given me. Because, I mean, that's only good for four days, you know?" (P#2, p. 20, l. 914–919)

"I mean, I'm 29. I didn't think I would have to resort to that [PDE5 inhibitor] yet." (P#1, p. 12, l. 516, 530)

"Oh yes, I feel comfortable [discussing sexual dysfunction with a health-care provider]. . . . I had to bring it up." (P#2, p. 22–23, l. 996–1018)

"Yes, actually this last time I talked to the doc about it, and he actually prescribed me some pills. And they actually—actually, it improved a whole lot. When I spoke to him, he actually kind of—he kind of had already—it registered with him pretty quick because he said other soldiers have been telling him about the same situation, you know. He said a lot of soldiers been coming from deployment, and it's been more and more lately so he kind of understood it. He already knew so he prescribed me something. It was great because I kind of felt not, say, embarrassed, but I kind of felt like I didn't know how he would look at it—if he wanted to go further into it or what. But he kind of understood it, and he told me to try some things out, and it actually helped." (P#8, p. 14–15, l. 634–662)

"I think they're doing a great job because, like me . . . that's a sensitive subject to some people. . . . So most people are going to bring it up if . . . it's becoming a problem more and more to them . . . They let you bring it to them . . . being a personal issue; most people would bring it to their attention." (P#8, p. 18, l. 786–801)

Impact on Self

"I could probably be happier if I were, you know, engaging in intimate—in anything intimate." (P#5, p. 22, l. 976–987)

"It's where I don't—I don't feel like I'm doing a good job. You know, it's my job to make sure my wife is happy, and I can't even make her happy." (P#6, p. 12, l. 529–533)

"Yeah, it gets frustrating sometimes. But, um, for me, it's—I get pleasure out of pleasing the woman. And so, I mean, it—it gets frustrating on my end, but, you know, if she's satisfied then, you know." (P#2, p. 15, l. 680–689)

Impact on Partner

"I don't—you know, I—I don't know what she thinks. We don't really talk about it. She just kind of knows, you know. It's not—it's just not something openly discussed, I guess." (P#1, p. 12–13, l. 546–558)

Impact on Relationship with Partner

"I just think once it comes time to do it [have intercourse], I'm, like, my drive is not there anymore. It's frustrated a couple of people besides myself." (P#7, p. 6, l. 240–242)

"Well, I worry that my wife's happy, you know. Then, you know, I—like I said, I try to please her and stuff. I know or—I know she would never run around." (P#1, p. 13, l. 562–567)

"I guess, you know, my wife gets frustrated or, you know, I get frustrated, or whatever the case is. So it's just, you know, not even worth it." (Participant 1)

Overall Impact

"It's not to the point of where I'm going to sit in my corner and pout afterwards." (P#6, p. 18, l. 810–820)

"I still try to be a husband. And a dad, you know, and I try to be normal so, you know, even if the desire is not there; I still try to do what I can do." (P#1, p. 10, l. 418–432)