VETERAN HUB

RESEX

CHANGES IN SEXUALITY

Among Veterans with Sensory Impairments

Study

2026

Abstract

We, the team of the Veteran Hub Think Tank, continue to study the diverse experiences of veterans returning from service and the impact of combat experience on various areas of their well-being.

Sexuality is an important part of life and romantic relationships. However, this topic remains underexplored in the context of recovery after injury. This analytical report builds on Veteran Hub's previous work and focuses on the experiences of veterans with impairments affecting the sensory organs, or with loss of sensation in the body or its parts, resulting from injury or treatment.

The findings of the study contribute to a better understanding of the possible journey of recovery of sexuality after injury or trauma and outline approaches to sexual rehabilitation that may support veterans, their partners, and assisting professionals.

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Kostenko, A., Kudelia, M., Stratiienko, I. (2026). *Changes in Sexuality Among Veterans with Sensory Impairments: Study Report.* Veteran Hub.

The study was conducted between October 2025 and February 2026. The main body of the study uses a 14-point Inter font to ensure accessibility for people with varying vision capabilities.

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About the organisation

Veteran Hub is a sustainable support network for veterans and families of warriors. Established in 2018, the organisation provides legal advice, psychological support, career counselling and personalised case management. The network comprises physical spaces in Kyiv and Vinnytsia, as well as Mobile Offices that provide home service delivery in Kyiv and Vinnytsia Oblasts, along with a national Trust Line available by phone at 067 348 28 68.

Drawing on its daily experience of working with veterans and their families, the organisation conducts expert research, advocates for improving their well-being, develops information and media projects, and helps various stakeholders in the field better support service members and their loved ones.

Website: veteranhub.com.ua
Facebook: fb.com/VeteranHubUa
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Acknowledgements

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We also extend our gratitude to organisations and media figures who shared information about the study and helped increase its visibility among potential respondents, thereby enabling us to engage a wider range of participants. In particular, we thank the following initiatives and communities: Invictus Games, CBA Initiatives Centre, the Patronage Service of the 3rd Separate Assault Brigade ‘Angels’, Vilnyi Vybir, Vilni Voiny, U+, Dialog Hub, Kharakter.Media, VETERANKA, Ebaut, Mitsni 300, as well as Vlad ‘Samurai’ Yeshchenko, Oleksii Prytula, and Olena Ryzh.

Opening remarks

In Ukrainian society, sexuality is often perceived as too private and intimate for open and detailed discussion. Based on everyday observations, the sexuality and sexual health of veterans are more often considered in the context of reproductive health or in connection with discussions of sex work and everyday life in frontline areas.

However, sexuality is one of the key components of a person's well-being, particularly in the areas of health, relationships, and self-perception, for everyone. When combined with combat experience, time spent in life-threatening situations, and separation from loved ones, sexuality, its expressions, the changes it undergoes, and the impact of combat experience or injury on it become even more important.

Injury can indeed change the body, sensitivity, and the way intimacy is experienced, but it does not cancel a person's right to sexuality, desire, and an intimate life. That is precisely why sexuality is not a secondary issue, but an important part of recovery.

At the time of injury and throughout treatment, a person undergoes a life-altering experience that can affect their self-perception and body image, their functioning and sensation, and their understanding of sex and its importance. Despite the evident relevance of sexuality, particularly during treatment, it is often overlooked and is not given sufficient consideration by either professionals or society. Such silence around the topic may also prevent veterans from seeking support themselves.

Through this study, we seek to show the multiplicity of experiences that veterans go through in the process of sexual recovery and sensory changes. There is no single or correct journey. It is a non-linear, complex and difficult process. It is important for us that this experience be seen and heard, and that veterans be able to access products and support that ease their journeys.

We encourage all readers of this report to remain open and not be afraid to speak about their own sexuality, as it is an inseparable part of human experience. We hope this analysis will inspire people to explore their own sexuality, approach sensory changes openly, experiment with their partners, seek and find pleasure. We also express our gratitude to all respondents who shared their stories and experiences with us. We would also like to thank you for your contribution to the defence of Ukraine.

We hope that this report will also be useful to healthcare professionals, psychologists, psychotherapists, rehabilitation professionals, social workers and all professionals who stand alongside veterans during recovery after injury. Sexuality often remains outside professional conversations because of the lack of time, training, or a sense of the topic's sensitivity. We hope that the experience presented in this study will serve as a basis for more sensitive, open and interdisciplinary support.

We also address this report to representatives of state institutions, particularly in the fields of healthcare, veterans' affairs and social protection. Recovery after injury is not limited to physical rehabilitation, and sexual health is an important part of return and must be taken into account in support programmes, standards and policies.

Ultimately, this text may be part of an important dialogue within society. To speak about the sexuality of veterans means to see them not only through the prism of war, but as people with a multiplicity of experiences and needs. This is also an important part of the broader conversation about sexuality, as it is an inseparable part of human life, dignity and well-being. So let us speak without stigma, shame or silence.

Anna Kostenko and Mariia Kudelia,
senior analysts of the study

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List of abbreviations

ATO — Anti-Terrorist Operation

ED — erectile dysfunction

ICD-10 — International Classification of Diseases, Tenth Revision

JFO — Joint Forces Operation

LGBTQIA+ — an acronym encompassing lesbian, gay, bisexual and transgender people, queer people, intersex and asexual people, as well as others who belong to the queer community

MMC — Military medical commission

MoD — Ministry of Defence

MoH — Ministry of Health

PRM — physical and rehabilitation medicine

PTSD — post-traumatic stress disorder

TBI — traumatic brain injury

WHO — World Health Organization

Glossary

Acceptance of physical injury — the process of psychological and social adaptation to changes in the body after injury, involving the gradual recognition and integration of this experience into one's identity. In this study, the concept is used primarily to describe the social and psychological levels of acceptance, including overcoming shame and the need to conceal the injury[1].

Ejaculation — a reflex physiological process of the release (expulsion) of semen through the urethra, usually accompanied by orgasm in men[2].

Embodiment — the way a person experiences and understands their own body as part of their identity, lived experience and interaction with the world. In the context of this study, embodiment encompasses bodily sensations, sensitivity, mobility, appearance, physical limitations and a person's emotional attitude towards their own body after injury.

Erectile dysfunction (ED) — a persistent inability to achieve and maintain an erection sufficient for satisfactory sexual intercourse[3].

Femininity — a set of socially constructed norms, perceptions and practices that define the expected 'female' behaviour within a particular culture[4].

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[1] Lee, H., Pyo, J., Ock, M., & Kim, H. J. (2024). Qualitative case study on the disability acceptance experiences of soldiers with disabilities. International Journal of Qualitative Studies on Health and Well-being, 19(1), 2350081. doi.org/10.1080/17482631.2024.2350081

[2] World Health Organization (2021). WHO laboratory manual for the examination and processing of human semen (6th ed.). who.int/publications/i/item/9789240030787

[3] Ministry of Health of Ukraine. Guideline No. 3362. guidelines.moz.gov.ua/documents/3362

[4] Connell, R. W. (1987). Gender and power: Society, the person and sexual politics. Stanford University Press.

ICD-10 (International Classification of Diseases, Tenth Revision) — an international standard developed by the World Health Organization (WHO) for coding diseases, causes of death and health-related issues.

Intimate relationships — relationships involving physical or emotional closeness[5]. Intimate relationships may include not only sexual relationships but also other forms of closeness with family members, friends, or acquaintances[6]. In this study, we consider intimate relationships in the context of relationships with romantic partners.

Libido — a person's sexual drive or desire to engage in sexual relationships with other people[7]. The concept originates from Sigmund Freud's psychoanalytic theory. The intensity of libido is associated with biological, hormonal and psycho-emotional factors[8].

Masculinity — a set of socially constructed norms, perceptions and practices that are associated with 'male' behaviour and roles in a given society[9]. In this text, we address masculinity in the context of a set of practices or perceptions that are expected to characterise male sexuality.

Sensation — a person's ability to perceive bodily stimuli through the sensory organs (touch, smell, taste, sight and hearing), which may affect sexual arousal and the experience of intimacy[10].

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[5] Wong, D. W., Hall, K. R., Justice, C. A., & Hernandez, L. W. (2014). Counseling individuals through the lifespan. SAGE Publications. p. 326. books.google.co.uk/books?id=dnYcBgAAQBAJ&pg=PA326&redir_esc=y#v=onepage&q&f=false

[6] McCarthy, J. R., Doolittle, M., & Sclater, S. D. (2012). Understanding family meanings: A reflective text. Bristol University Press. doi.org/10.2307/j.ctt1t89hkr

[7] Shamdasani, S. Libido. The Lancet, 365(9454), 115. doi.org/10.1016/s0140-6736(05)17687-9

[8] Berga, S. L., & Smith, Y. R. (2012). Handbook of neuroendocrinology. Elsevier. sciencedirect.com/topics/agricultural-and-biological-sciences/libido

[9] Connell, R. W. (1987). Gender and power: Society, the person and sexual politics. Stanford University Press.

[10] Cross, C. L., & Weeks G. R. (2007). Sex, sexuality, and sensuality. In Low-cost approaches to promote physical and mental health (pp. 386). Springer. doi.org/10.1007/0-387-36899-X_19

Sensory changes or impairments — changes in a person's ability to perceive bodily sensations through the sensory organs or the nervous system, which may manifest as reduced, lost, heightened or distorted sensation in particular parts of the body or in the sensory organs.

Service member — a person serving in the Armed Forces or other military formations established under the applicable laws of Ukraine[11].

Sexual dysfunction — in this study, we follow the WHO definition set out in ICD-10: "the inability of a person to participate in a sexual relationship as he or she would wish"[12]. In this context, we will consider disorders of sexual desire, arousal disorders, orgasmic disorders and pain disorders among female and male service members and veterans (codes N48.4 and F52, respectively)[13].

Sexual intercourse — a bodily form of intimate interaction between people, encompassing both physical contact and the subjective sensations, experiences and social perceptions associated with sexuality.

Sexual health — we use the WHO definition in this study: "it is not merely the absence of disease, dysfunction or infirmity, but a state of physical, emotional, mental and social well-being in relation to sexuality. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence"[14].

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[11] Verkhovna Rada of Ukraine (1992). On General Military Duty and Military Service (Law of Ukraine No. 2232-XII of 25 March 1992). zakon.rada.gov.ua/laws/show/2232-12.

[12] World Health Organization. (2016). International statistical classification of diseases and related health problems (10th revision). icd.who.int/browse10/content/statichtml/icd10volume2_en_2016.pdf

[13] Hatzimouratidis, K., & Hatzichristou, D. (2007). Sexual dysfunctions: Classifications and definitions. The Journal of Sexual Medicine, 4(1), 241–250. doi.org/10.1111/j.1743-6109.2007.00409.x

[14] World Health Organization. Sexual health. who.int/health-topics/sexual-health

Sexual recovery — an individual and non-linear process of rethinking and adapting a person's sexuality after changes in the body, health or life experience. It may involve changes in sexual practices, ways of experiencing intimacy, perceptions of attractiveness, sexual desire and interaction with a partner or with one's own body.

Sexual rehabilitation — a set of interdisciplinary medical, psychological, rehabilitative and educational interventions aimed at restoring or adapting a person's sexual health, intimacy and sexual functioning after trauma, injury, illness or treatment. It may include healthcare, psychotherapeutic support, work with bodily sensations, partner interaction and sex education.

Sexuality — we use the WHO definition in this study: "a central aspect of being human throughout life, which encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors"[15].

The Journeys of Veterans — a concept and study of the experiences and needs of ATO/JFO veterans from the moment of enlisting until the end of life, developed by Veteran Hub[16].

Trajectory of the journey — an individual sequence of passing through the stages of the Journeys of Veterans, reflecting an individual's personal experience, the pace of transition between stages, and possible returns, pauses or parallel processes in their

[15] World Health Organization. Defining sexual health. who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/sexual-health/defining-sexual-health

[16] Veteran Hub. Exploring the Journeys of Veterans. veteranhub.com.ua/analytics/doslidzhenya-shlyahu-veteraniv-i-veteranok

life after service. We distinguish a positive trajectory, in which a person gradually integrates and improves their quality of life despite challenges, and a negative trajectory, characterised by the accumulation of barriers and risks that worsen well-being[17].

Trauma — in this study, we consider physical injuries and wounds sustained by service members as a result of combat during the Russo-Ukrainian war.

Veteran — a person who participated in combat operations to defend the Homeland or took part in combat operations on the territory of other states if such participation was part of Ukraine's international commitments[18].

Warrior — a service member who, during service, carries out or has carried out combat tasks.

Well-being — categorisation of various human needs, necessary for a comprehensive analysis of the person's condition, functionality and level of satisfaction with various aspects of their life[19].

[17] Veteran Hub (2023). Journeys of Veterans: Research on War Experience and Return to Civilian Life. veteranhub.com.ua/wp-content/uploads/2024/10/doslidzhennia-shliakh-veteraniv-ta-veteranok.pdf

[18] Veteran Hub, Pryncyp, Space of Opportunities, Legal Hundred (2025). Updated Concept of Veteran Policy. veteranspolicy.org.ua

[19] Veteran Hub. Well-being. veteranhub.com.ua/dobrobut

Introduction

Sexuality is one of the important components of a person's physical and mental health and an important part of intimate and romantic relationships. According to the WHO, sexuality is a central aspect of being human throughout life. It encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction[20]. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, values, attitudes, roles and practices.

Sexual health and sexuality are also important components of a person's well-being — a combination of diverse factors and needs that affect the level of their life satisfaction.

Military service and combat experiences, including difficult living conditions, an unbalanced diet, prolonged stress and threat to life, can alter the sexuality of veterans at the physical, psychological and social levels. In cases of injury or trauma, captivity, physical and psychological violence, this impact becomes significantly stronger.

The contemporary Russo-Ukrainian war is characterised by high-intensity of combat, an uncertain service duration and the specific nature of modern weaponry, including the use of drones and ballistic missiles. In such conditions, the risk of a wide range of injuries and trauma increases — from traumatic brain injuries and musculoskeletal injuries to pelvic injuries, spinal cord injuries, extensive scarring, chronic pain and mental health disorders, including post-traumatic stress disorder (PTSD).

[20] World Health Organization. (2026, February 4). Defining sexual health. who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/sexual-health/defining-sexual-health

These injuries may affect sexuality physically by altering sensation and the nervous system, hormonal balance, and by causing chronic or phantom pain and fatigue. Psychologically — by increasing anxiety, creating a sense of alienation from or rejection of one's own body, complicating arousal and sexual desire, and giving rise to fears and avoidance of intimacy. Socially — by affecting self-perception among others and interaction with social understandings of embodiment and sexuality.

The sexuality of service members and veterans with injuries or trauma remains underexplored worldwide. American studies show that, after trauma and injury, sexuality remains an important part of service members' lives and has a significant effect on their self-esteem and sense of life satisfaction[21,22]. Since sexual health is part of overall physical and mental health, medical professionals play a key role in providing support during treatment and rehabilitation.

Ukrainian researchers rely on the U. S. experience due to limited access to national data and anumber of domestic studies. However, this does not reflect the specific features of the Ukrainian context — a prolonged war, the types of injuries sustained and the conditions for recovery. As a result, most existing works are review-based or theoretical and focus on how war changes the mental state of service members and how these changes are reflected in their sexuality[23, 24].

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[21] Ellis, K. M., Nordstrom, M. J., Bach, K. E., et al. (2021). Sexuality and intimacy rehabilitation for the military population: Case series. Sexuality and Disability, 39, 231–243. doi.org/10.1007/s11195-021-09680-5

[22] Brundage, J. A., Williams, R. D., Powell, K., Raab, J., Engler, C., Rosin, N., & Sepahpanah, F. (2020). An interdisciplinary sexual health rehabilitation program for veterans with spinal cord injury: Case reports. Sexuality and Disability, 38, 343–353. doi.org/10.1007/s11195-020-09629-0

[23] Fedorets, S. (2023). Psycho-Sexual Fundamentals of Sexual Rehabilitation of Military, Veterans and Civilians with Disabilities. Scientific Notes of 'KROK' University, 3(71), 199–207. doi.org/10.31732/2663-2209-2022-71-199-207

[24] Volosheniuk, T. V. (2024). A post-traumatic stress disorder in military servicemen and war veterans. News of Pharmacy, 107(1), 131–135. doi.org/10.24959/nphj.24.134

To collect our own empirical data, we conducted the first study on the experiences of veterans returning to sexual life after injury in the Ukrainian context as part of the Resex project in 2023[25]. We focused on the overall impact of injury on sexuality, the challenges faced by warriors and their partners, the restoration of sexual relationships within a couple and barriers to accessing healthcare and support. In this second iteration of the project, we examine how changes in physical sensation resulting from different types of injuries affect sexuality.

We are focusing on the personal experiences of veterans: from their first thoughts and doubts to their actions — courtship, dating, touching their own body and sexual contact with another person or with themselves. In this study, we define veterans as persons with combat experience in the Russo-Ukrainian war, regardless of their current service status: they may either have completed military service or continue to serve, including after injury.

Since sexuality is not limited to interpersonal interaction and is closely linked to individual sensitivity, the functioning of the sensory organs and bodily sensations, damage to the sensory organs or the emergence of insensitive areas in the body as a result of trauma or injury may substantially alter the experience of sexuality, affecting imagination, erogenous zones, bodily sensations and sexual desire.

This study is an important step towards understanding the experience of recovery among veterans after injury or trauma. The knowledge gained may serve as a foundation for professionals in medicine, rehabilitation, and psychosocial support in developing more sensitive and effective approaches to restoring the sexual health and well-being of veterans after injury. For the academic community, and particularly for researchers, it offers new knowledge about sexuality among warriors after injury in the context of the full-scale invasion.

[25] Veteran Hub (2023). Sexual Life of Warriors after Injuries: A Study of the Sexual and Intimate Experiences Among Service Members/Veterans with Injuries and Their Partners. resex.veteranhub.com.ua

Methodology

Goal

To identify changes in the sexuality of veterans with injuries to the sense organs or insensate areas of the body resulting from combat wounds

Objectives

1. To determine how aspects of the perception of their own sexuality change among veterans after injury and sensory organ impairment during the stages of injury and treatment
2. To identify how sexuality is transformed in later life after treatment in the bodies of veterans with altered sensation
3. To develop practical recommendations based on the findings of the study

Methods

The topic of sexuality and a person's intimate life is sensitive and requires particular care in the selection of methods and ethical approaches. Since the goal of the study is to identify changes in the sexuality of veterans, we chose a qualitative method for the research, specifically in-depth interviews, as this enables participants to speak at length about their own experiences, including traumatic ones[26].

[26] Liamputtong, P. (2007). Traditional interviewing research methods appropriate for researching vulnerable people. In Researching the vulnerable: A guide to sensitive research methods (pp. 95–117). SAGE Publications. doi.org/10.4135/9781849209861.n5

We also used the method of expert interviews to understand the context of treatment and rehabilitation.

We used a semi-structured guide in all interviews. In conversations with veterans, this enabled us to remain flexible, build trusting relationships, and create a comfortable environment for discussion. The interview guide covered topics related to the moment of injury, treatment, ideas about sexuality, post-injury experience, bodily sensation, relationships, and the perception of one's own body. During in-depth interviews, the conversation was structured retrospectively: together with veterans, we traced their journeys of recovery — from the events of injury and treatment to the gradual changes in the experience of the body, intimacy and sexuality after combat trauma.

The semi-structured interview format helped create a safe space in which respondents could speak openly about their experiences. The research team also made it clear in advance that respondents could answer questions with whatever degree of detail they felt comfortable with. Interviewers deliberately did not probe into highly sensitive aspects of sexual experience if participants were not ready to discuss them.

During the exploratory phase of the study, we conducted expert interviews with rehabilitation professionals, sexologists and occupational therapists. The aim was to gain a holistic understanding of practices and challenges in the field of rehabilitation in general, and sexual rehabilitation in particular. The semi-structured interview method used in conversations with experts enabled us to remain flexible and explore more deeply the topics with which they work in practice[27].

[27] Bogner, A., Littig, B., & Menz, W. (2009). Introduction: Expert interviews – An introduction to a new methodological debate. In A. Bogner, B. Littig, & W. Menz (Eds.), *Interviewing experts*. p.2. Palgrave Macmillan. doi.org/10.1057/9780230244276_1

Sample

In qualitative research, non-probability sampling is used to select participants for the study. In such sampling, units are selected deliberately to reflect particular characteristics or groups within the population under study[28]. We used a combined non-probability sampling approach in this study, specifically a convenience sample combined with a maximum variation sample.

The sample included service members and veterans of the Russo-Ukrainian war who had sustained physical injuries during combat and were at different stages of their Journeys of Veterans[29], including those who continue their military journey and those who have been discharged from military service and are living in the civilian environment. Some of them were injured at the very beginning
of the Russo-Ukrainian war in 2014, while others sustained injuries after the full-scale invasion. The timing of injuries covered the period from 2014 to 2025, which enabled us to trace the long-term dynamics of the transformation of sexuality — from the early stages of recovery to the experience of living with the consequences of injury for more than ten years.

Ukraine does not currently have any open data or analytics on the number and types of injuries sustained by service members during combat. Owing to the constantly changing nature of the war, the intensity of combat and the complexity of evacuation, warriors may sustain injuries of varying types and levels of severity. Therefore, the sample includes respondents with various types of injuries that caused sensory changes in the body. For some respondents, this took the form of loss of sensation in particular parts of the body due to scarring or burns. Others experienced more extensive changes — loss of sensation in whole parts of the body, loss of particular

[28] Ritchie, J., & Lewis, J. (Eds.). (2003). Qualitative research practice: A guide for social science students and researchers. SAGE Publications. 77-78

[29] Veteran Hub (2023). Map of the Journeys of Veterans. veteranhub.com.ua/veteran-way

sensory organs or changes in the perception of sensation resulting from traumatic brain injury (TBI).

A total of 27 veterans with various injuries took part in the study. Among them were people with:

- Neurological injuries (traumatic brain injury, spinal cord injury (paresis, paralysis, loss of sensation), spinal injuries, acoustic barotrauma)
- Limb and musculoskeletal injuries (upper limb injuries, shoulder joint injuries, lower limb amputation)
- Injuries to the sensory organs (vision, hearing)
- Facial and soft tissue injuries (maxillofacial area, burns, shrapnel injuries)
- Injuries to internal organs and to the thoracic and abdominal cavities, removal of part of the intestine, and haemothorax
- Blast injuries[30]

Respondents were selected in two stages. First, inclusion criteria were applied to determine a person's eligibility to participate in the study. Subsequently, we included additional participant characteristics in constructing the sample to ensure the greatest possible diversity of experiences within the defined target groups.

Additional inclusion criteria:

1. Age (18–25, 26–45, 46–60, 61+)
2. Gender
3. Education
4. Place of residence (urban/rural)
5. Long-term relationship

When constructing the sample, we took into account a number of additional criteria that could affect the experience of sexuality and sexual recovery after injury.

[30] A more detailed breakdown of respondents by type of injury is provided in the Annex

We included respondents from different age groups, as age may influence a person's physical health and social perceptions of sexuality, expectations regarding intimate life and willingness to speak about these topics. Gender was a separate criterion: it was important for us to include both male and female veterans, as experiences of men and women in the context of sexuality and gender perceptions may differ substantially.

Age distribution of respondents in the study

Number of respondents	Age group
1	18–25
17	26–35
4	36–45
4	45–60
1	over 60

Education was an additional criterion, as it shapes the person's cultural perceptions, which may influence how they view sexuality, their level of sex education and the way they make sense of their own experience. Another criterion was the type of settlement, as it may affect access to support and willingness to seek help or discuss intimate matters openly. In particular, issues related to sexuality may remain more strongly taboo in smaller or rural communities, which are often more closed. The presence or absence of a long-term relationship was also important to us, as it may play a significant role in recovery and in supporting sexual health after injury.

We also took into account that sexuality may be affected by the use of pain medication, psychoactive substances or antidepressants. Information about this was collected during the interviews, but was not included in the recruitment questionnaire because these questions are sensitive.

Gender distribution of respondents

Number of respondents	Gender
25	male
2	female

We recruited respondents through Veteran Hub's social media channels and those of partner organisations, including the Invictus Games, which shared the call to participate in the study within their own communities. For recruitment purposes, the project team also visited the TYTANOVI REHAB and Lisova Poliana rehabilitation centres.

Due to the sensitivity of the topic of sexuality and the taboo surrounding it in Ukrainian society, the recruitment process was challenging and took longer than had been anticipated at the planning stage. Overall, the research team had four months to recruit and interview participants. The interviews were conducted between October and December 2025.

We also conducted expert interviews with rehabilitation professionals, psychologists and sexologists. We involved professionals with practical experience in the physical and psychological recovery and rehabilitation of veterans after injury, including in the area of sexuality and sexual health. Experts gave consent to be mentioned in the report.

Experts participating in the study

Expert's name	Specialisation
Olena Lysenko	psychotherapist, sexologist
Olena Hrytsenko	psychotherapist, sexologist, sexual rehabilitation specialist, EMDR therapist
Oleksandr Arkhypchuk	rehabilitation professional, Head of the Department of Physical and Rehabilitation Medicine, State Institution "Main Medical Clinical Centre of the Ministry of Internal Affairs of Ukraine"
Liubov Holivets	hospital occupational therapist
Yehor Iordek	psychologist specialising in pain management
Anonymous	psychologist, psychotherapist, family mediator

Analysis of empirical data

We analysed the qualitative data collected during the in-depth interviews using thematic coding. Within this approach, we applied an empirically inductive coding method, which involved the step-by-step data coding, classification, clustering and the development of analytical generalisations.

We used MAXQDA software during the analysis. Before coding, we developed a code tree, which we refined after several coding stages. The coding was carried out by several analysts in order to strengthen analytical validity.

Methodological features

For the purposes of the study, we involved a veteran interviewer without prior sociological experience, who underwent special training in conducting interviews. As the topic of the study concerns sexuality and intimate life, discussion of which may be sensitive and not always comfortable because of cultural and social stereotypes, particularly when speaking with a person of a different gender and background (civilian/military), we offered respondents the opportunity to choose their interviewer themselves. In this way, they could take part in the conversation with a veteran interviewer without military experience, depending on what felt more comfortable for them.

At the same time, this option was not available to all respondents from the very beginning of the interview process in the study, owing to time constraints and the interviewer's availability. However, when it was clear that the possibility of choice could reduce tension and help create safer conditions for an open conversation, the research team always informed respondents of this option.

It was important for some respondents that we sought to make interview conditions more comfortable and safer, including by offering a choice. At the same time, we did not observe respondents placing frequent emphasis on the interviewer's gender or asking about it, nor did they ask about the interviewer's combat experience. Even when we mentioned the option to choose between a woman and a man, they made no requests for a specific choice.

Ethical principles

- All interviewers signed a non-disclosure agreement.
- All cited quotations are anonymised to make it difficult to identify the respondent.
- All interviewers underwent prior training on the mechanics and ethical principles of in-depth interviews, providing psychological first aid, storing personal data, and the principles of Veteran Hub's code of ethics.
- Interviews took place only after respondents had signed informed consent to participate in the study and to the processing of their personal data. Study participants signed the consent form either in person or online via the Vchasno service.
- All respondents were informed of the study's aim, how their personal data would be protected, and that they could choose not to answer any questions or withdraw from the study at any time.
- Where needed, respondents could receive an initial crisis consultation from a trained interviewer and seek free support using the contacts provided in the information sheet.
- In-depth interviews were conducted in Veteran Hub spaces in compliance with safety protocols or online in accordance with safety instructions.
- Respondents could stop the interview at any point and withdraw from the study.

Limitations

- The study is not representative and does not generalise the experiences of individual participants to all service members and veterans.
- As we are interested in a period of respondents' lives that may span more than ten years, some of the accounts are retrospective. This may affect the accuracy and objectivity of the information.
- The study was conducted during the full-scale war and active hostilities. Exposure to shelling, news, possible losses and the overall security situation may have affected the emotional state of respondents who remain in Ukraine, as well as that of the research team.
- Only two female veterans were included in the sample, so women's experience is represented only to a limited extent in the study.
- The study does not examine the sexual health experiences of veterans without injuries, although we assume that combat service affects a person's sexuality and sensation.
- The sample does not include all possible types of injuries, including the loss of genitalia, although it does include respondents with a complete loss of sensation in those areas.
- We do not treat LGBTQIA+ respondents as a separate group, as this is not the focus of this study.
- The respondents include high-profile veterans who share their stories on social media. The repeated public retelling of their stories may have altered those stories and influenced how they were narrated during the interviews.

Conceptual framework of the study

In this subsection, we describe the conceptual framework of the study on which we drew in developing the methodology and analysing the empirical data, as well as key concepts related to sexuality we used in our analysis. In the analysis, we examine how a person's journey of recovery unfolds after injury and what happens to different aspects of sexuality at different stages. In particular, we distinguish two stages: treatment and life after treatment.

Sexuality

There is no single precise definition of sexuality in scholarship, as different disciplines construct concepts of sexuality based on their own key concepts. Each discipline explains sexuality through its own lens, concepts and methods. At the same time, none of these definitions is universal or final. In general, sexuality is understood as a multidimensional phenomenon that combines physical, psychological, sociocultural, economic and political components[31]. In this text, we place less emphasis on the political and economic components of sexuality and instead focus on its social, psychological and physical manifestations.

The physical component is fundamental to the experience of sexual arousal and pleasure, since these experiences occur directly through stimulation of the body. For example, orgasm and pleasure depend on muscular tension and the release of neuromuscular

[31] Plummer, K. (2008). Studying sexualities for a better world? Ten years of sexualities. Sexualities, 11(1–2), 7. doi.org/10.1177/1363460707085448

energy[32]. Therefore, this study focuses first and foremost on physical changes in the body after injury, as described by respondents.

At the same time, physiological changes are inseparable from psychological ones: how the body is accepted, ideas about one's own attractiveness and contact with the body. They are also inseparable from the social aspect: social norms and perceptions regarding the body and attractiveness, how men and women are perceived socially and how interaction and contact with others are formed at the level of relationships and flirtation.

A person's sexuality may change in its different manifestations: physical, psychological and social. Accordingly, this study considers each of these aspects of change.

In particular, among the components of sexuality, we identify: libido, acceptance of one's own body, perceptions of masculinity and femininity, sexual intercourse, relationships and sensation. We identified these components when analysing the in-depth interviews.

Libido is a term that originates in the work of Sigmund Freud and refers to sexual desire and sexual drive, that is, a person's desire to have sexual relationships with other people[33]. The brain regulates libido, which depends on biological and physiological factors, such as the levels of certain hormones, as well as on a person's psycho-emotional state[34].

Acceptance of one's own body and physical injury is a concept that refers to the recognition of one's injury through psychological and social adaptation and gradual adjustment to it. This study focuses primarily on the social and psychological levels of acceptance,

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[32] Goettsch, S. L. (1989). Clarifying basic concepts: Conceptualizing sexuality. The Journal of Sex Research, 26, 250. doi.org/10.1080/00224498909551509

[33] Shamdasani, S. Libido. The Lancet, 365(9454), 115. doi.org/10.1016/s0140-6736(05)17687-9

[34] Berga, S. L., & Smith, Y. R. (2012). Handbook of neuroendocrinology. Elsevier. sciencedirect.com/topics/agricultural-and-biological-sciences/libido

which may involve overcoming shame and the desire to conceal one's injury[35].

Sexual intercourse is not only a physical interaction, but also an embodied experience in which individual sensations intersect with the physical. It is a process through which social ideas, symbols and fantasies are transformed into a physical state (pleasure)[36].

Sensation involves the engagement of sensory organs (touch, smell, taste, sight and hearing), which influence arousal and sexuality[37].

Two other important concepts we use in this text are masculinity and femininity.

Masculinity is the adherence to prescribed standards associated with men that help reinforce male dominance over women[38].
In this text, we address masculinity in the context of a set of practices or perceptions that are expected to characterise male sexuality. Although there is no single understanding of traditional masculinity, it is associated with achievement, endurance, toughness, emotional control and antipathy towards anything perceived as 'feminine' in many Western cultures.

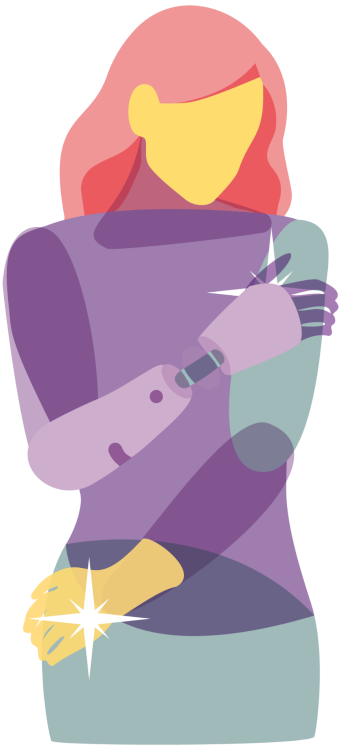
[35] Lee, H., Pyo, J., Ock, M., & Kim, H. J. (2024). Qualitative case study on the disability acceptance experiences of soldiers with disabilities. International Journal of Qualitative Studies on Health and Well-being, 19(1), p.2 2350081. doi.org/10.1080/17482631.2024.2350081

[36] Godelier, M. (2003). What is a sexual act? Anthropological Theory, 3(2), 179–198. doi.org/10.1177/1463499603003002004

[37] Cross, C. L., & Weeks, G. R. (2007). Sex, sexuality, and sensuality. In Low-cost approaches to promote physical and mental health. Pp. 386. Springer. doi.org/10.1007/0-387-36899-x_19

[38] Connell, R. W. (1987). Gender and power: Society, the person and sexual politics. Stanford University Press.

Femininity is likewise a set of norms, practices and perceptions that, in turn, regulate women's behaviour so that they conform to culturally acceptable ways of being 'feminine' within a particular community. Femininity and masculinity are shaped in tandem, often in opposition to each other. In most contemporary societies, femininity is associated with expectations that a woman should be caring, modest and attractive, and should also be expected to submit to a man and take care of their home, family and relationship[39].



All these gendered perceptions may affect how veterans respond to their experiences. For example, combat injury may give rise to men's feelings of powerlessness and hopelessness, which do not align with the social expectation that they should remain in control at all times[40].

[39] Connell, R. W. (1987). Gender and power: Society, the person and sexual politics. Stanford University Press.

[40] Neilson, E. C., Singh, R. S., Harper, K. L., & Teng, E. J. (2020, January 27). Traditional masculinity ideology, posttraumatic stress disorder (PTSD) symptom severity, and treatment in service members and veterans: A systematic review. Psychology of Men & Masculinities. Advance online publication. P. 44-45. dx.doi.org/10.1037/men0000257

01

Changes in sexuality after injury

Sexuality at the time of injury

Changes in a person's body begin at the moment an injury is sustained. Respondents usually describe this as a moment in which all other dimensions of life disappear, giving way to a single task: survival.
At the same time, the experiences of respondents in this study show that, for some injured people, awareness of the trauma is accompanied not only by questions of physical survival, but also by thoughts about bodily integrity, sexuality and even future reproductive function.

"Overall, I was very lucky to stay alive, because the explosion went off literally two metres from me. And why did I lose my sight? Because the blast wave and the fire gases [damaged it — ed.]. The right eye was burned straight away, and the left one was blown out completely... Plus, I had a closed traumatic brain injury. I also had problems with my hearing immediately, because my eardrums had burst. My right arm was almost severed; it was hanging on by the tendons. And my legs were badly torn up: both legs were severely mangled right up to the pelvis. There's even a chunk of flesh missing on the right one."

Veteran, 26–35 years old, with a closed traumatic brain injury and burn injuries; injuries to the organs of vision/hearing, the pelvis/genitalia, and multiple shrapnel wounds

Within this study, we asked respondents whether they were concerned about their sexual health or the condition of their genitalia in the first moments after injury. The answers varied and did not always depend on the severity of the injury or on overall health status, but rather on how important sexual life was to the person.

Some respondents asked medical staff about the condition of their reproductive organs and wanted to know whether their penis was still there, which resembled a brief check-in[41].

> *"Of course, I didn't give a damn about my arm or my leg — I felt to make sure my penis was still there. The first thing I did was reach down and check with my hand that it was still there."*
>
> *Veteran, 26–35 years old, with traumatic brain injury and burn injuries; amputated parts of lower limbs; injuries to the pelvis, organs of vision, face and abdomen; spinal and lung injuries; damage to internal organs*

> *"When I was already at the stabilisation point, I simply asked the physician whether everything down there had not been damaged. To put it simply: 'Is everything okay down there? — Okay.'"*
>
> *Veteran, 26–35 years old, with an amputated part of the upper limb*

Some respondents were able to assess their own condition, including the possible impact of their injuries on future sexual health, because they were combat medics or had medical experience.

> *"I'm a medical professional myself. I could fully assess my own condition, as far as that was possible."*
>
> *Veteran, 26–35 years old, with traumatic brain injury and acoustic barotrauma, burn injuries and shrapnel wounds, and injuries to the limbs, face, and organs of vision and hearing*

[41] Check-in means verification here.

Some respondents also said that medical staff at the stabilisation point helped them check whether their genitalia were intact, as they understood how important this issue was for an injured warrior.

“I was trying to check whether I still had a penis with my right hand, which was the one that was still intact. Even under narcotics [strong pain-relieving medication — ed.]. They had given me such a strong shot that I couldn’t feel anything at all. I tried to feel for my penis with my right hand and couldn’t feel anything. Not my right hand, not my penis, nothing. I was terrified that it had been blown off. And there was a male nurse there, and he saw that I was trying to check whether I still had my genitalia, and he said, ‘Do you want me to help you?’ I said, ‘Yes.’ And he put his hand inside my underwear, squeezed, and then I felt it, and he said that everything was fine, no need to worry.”

Veteran, 26–35 years old, with traumatic brain injury; injuries to the pelvis/genitalia and both lower limbs, with loss of part of the muscle tissue and shrapnel wounds

This was also confirmed by a respondent who had worked as a medical professional at a stabilisation point. According to him, some severely injured warriors tried to check their genitalia immediately after being wounded.

“When I was working at the stabilisation point, they were bringing in seriously injured lads from Bakhmut. They were mangled, torn apart, pumped full of heavy painkillers, and with pain relief like that, opiates and all that stuff, you lose sensation. As soon as they started coming round, the first thing they did was look for it, but their hand couldn’t feel. I pulled up so many penises — I was wearing gloves, obviously — just so the owner could see it was still there.”

Veteran, 36–45 years old, with traumatic brain injury and acoustic barotrauma; minor shrapnel wounds and an injury to the lower limb

At the same time, some respondents noted that, at the moment of injury and during evacuation, they did not think about their sexuality.

Some of them were unconscious for most of the time, and therefore remember that period only in fragments. As a result, their memories of these events are often shaped by what they were told by their brothers- or sisters-in-arms and by eyewitnesses.

> *"At that moment, your brain switches off, and you act on instinct. What difference does it make what's happened to your small willy?"*
>
> *Veteran, 18–25 years old, with an upper limb injury*

In contrast to some of the male experiences, the experiences of female respondents showed a different focus of attention at the moment of sustaining an injury. One female veteran who sustained a blast injury noted that during this period, she did not think about her sexuality or health.

> *"I don't know about men, but I wasn't thinking about that at all. First of all, my husband was in captivity. While he wasn't with me, nothing like that matters."*
>
> *Female veteran, 26–35 years old, with traumatic brain injury and blast injury; injuries to the organs of vision/hearing and shrapnel wounds*

Questions about the functioning of the genitalia, already at the time of sustaining an injury or evacuation, may be understood as a practical manifestation of the theory of masculinity, particularly for warriors. Theoretical work on this subject notes that, for men, the penis and erection are important parts of identity. The theory of hegemonic masculinity explains that men may, to some extent, equate themselves with the penis, perceiving themselves through the functioning of the sexual organ and the capacity for erection.

The penis may also be endowed with distinct human qualities, a mind, or even consciousness. It is regarded as an important symbol of male power in theories of masculinity[42].

In addition to sexual function, some male respondents were concerned about their reproductive health and their future chance of having a child at the evacuation stage. Such thoughts arose particularly among those who did not yet have children.

> *"That was one of the first questions [about future reproductive health — ed.]. I didn't have any children at that point. And it really bothered me a bit during the war"*
>
> *Veteran, 26–35 years old, with an amputated part of the lower limb*

[42] Potts, Annie. (2000). 'The essence of the hard on': Hegemonic masculinity and the cultural construction of 'erectile dysfunction'. Men and Masculinities, 3 (1),p. 85–86. doi.org/10.1177/1097184X00003001004

Sexuality at the treatment stage

After evacuation, veterans enter the treatment stage, which may last from several months to more than a year, and for some, may develop into an ongoing need to undergo periodic health examinations and treatment. During treatment, veterans who took part in this study were mostly concerned with the physical aspect of sexuality, in particular, the possibility of having sex. At the psychological level, they may be concerned with how others perceive their body and with their own self-esteem.

Although this study focuses only on the sexual health of veterans, we also identified various challenges and problems within the medical system faced by warriors. These include, inter alia, the quality of healthcare, sanitary conditions in the hospital, and staff qualifications. At the same time, the provision of health services to veterans with complex injuries requires a separate study, which would require access to and analysis of the healthcare system and health data related to service members, as well as a different research methodology.

After injury and before treatment, the processes are more or less the same: evacuation to the nearest stabilisation point, where the injured person is stabilised and provided with the first necessary and available care, and then transported to a larger hospital in the nearest city. After that, depending on the severity of the injury and the hospital's capacity, the injured person may

either be admitted there or further stabilised and transported to a larger city with more capable hospitals or specialised facilities focused on that particular type of injury.

At the treatment stage, the needs of injured people vary: some of our respondents required one or several surgeries, some were placed in a medically induced coma to maintain a more stable condition, and some had relatively short treatment before moving on to the rehabilitation stage. The process and duration of treatment depended largely on the injuries sustained, their specific nature and severity. For some, treatment lasted around two months, while others underwent active treatment for almost two years.

> *"The one thing I was badly mistaken about was that I thought another month or two and I'd be on prostheses. In reality, it took more than six months before I got onto them."*
>
> *Veteran, 36–45 years old, with amputated parts of the lower limbs*

Relationships with the body, adjustment to the consequences of injury, sexual desire and the state of libido at the treatment stage also vary. In this context, respondents generally did not single out sexual health as a separate sphere, but rather spoke about a general lack of information about their condition and the next steps. This is linked, inter alia, to the absence of systemic approaches in this area.

At present, Ukraine has no developed and approved protocol for sexual rehabilitation or for providing information on sexual health. As a rule, discussion of sexuality, libido and intimate needs is not part of treatment and arises only on the initiative of healthcare professionals or the individual — when a specialist decides to mention or ask about it, or when a patient dares to raise the question.

Hospitals do not always have specialists who can provide professional advice on sexual health. For some healthcare professionals, the topic may be taboo and uncomfortable

to discuss. According to an American study on sexuality following injury[43], the absence of information from physicians and rehabilitation professionals about possible changes in sexuality following injury may negatively affect a person's further recovery. In such cases, people are often left alone with these changes, begin to perceive uncertainty in themselves as normal, may become afraid of transformations in their sexuality and avoid talking about these experiences.

Some respondents in our study said that they had not been informed about possible changes in sexual health. In some hospitals, psychologists were available, but their consultations focused only on mental state and self-acceptance after injury. In most cases, the experience of engaging with these professionals was negative because of a lack of expertise, experience, understanding and empathy — both regarding sexuality and in general.

> *"Psychologists did, of course, come over in different centres, but a psychologist is not a sexologist. They spoke in general terms about life and stuff like that."*
>
> *Veteran, 26–35 years old, with an amputated part of the lower limb; acoustic barotrauma and injury to the hearing organs*

Respondents also noted that they independently searched for information on sexual health in open sources, including information on changes in fertility after injury. One respondent said that he was concerned about whether acoustic barotrauma could affect his reproductive function, and therefore searched for academic studies on the subject by himself.

The need for information was discussed, especially by veterans with spinal cord injury. One respondent recalled that crucial support was provided by a female physician who explained in detail the possible options for sexual rehabilitation. In particular, she spoke

[43] Connell, K. M., Coates, R., Wood, F. M. Sexuality following trauma injury: A literature review. Burn Trauma. (2014, April). P. 61–70. doi.org/10.4103/2321-3868.130189

about ways of improving erection and the possibilities of achieving ejaculation given his condition. Another respondent with a spinal cord injury said that it had been useful for him to learn about the sexual experiences of other people with a similar injury.

> *"But later a woman appeared at the hospital.... She had previously worked in a sanatorium [in the region] and already knew about the particular features of sexual life with a spinal cord injury. She gave a fairly comprehensive, short briefing. And after that, we talked among ourselves, with the lads. [...] [The physician provided — ed.] advice on how to prolong erection and induce ejaculation."*
>
> *Veteran, 26–35 years old, with a spinal cord injury, an upper limb injury, and a lung injury*

Some respondents mentioned that they had received advice on sexual health from occupational therapists or rehabilitation professionals. However, such consultations were the initiative of the individual specialist rather than part of their official duties.

In an expert interview conducted for this study, a rehabilitation professional who is himself a veteran and works with veterans following injury noted that he provided advice on and studied sexual rehabilitation on his own initiative. In his view, sexual rehabilitation is an important component that affects a person's quality of recovery. He even helps patients find the courage to begin dating or relationships in his consultations.

> *"I show them [dating — ed.] apps. [...] Say a warrior has lost his right lower limb. And he feels awful. He doesn't want to get onto a training prosthesis and has even started going to the shop for alcohol and drinking. I say, 'What are you doing?' [...] Well, I asked whether he had a partner or not. He said, 'No.' [...] So we installed the app for him, filled it in nicely, and made him a good profile. And that was it. Then he started getting his first matches. I suggested the first words he should say. [...]*

That he needed to explain to his partner that he liked her so much, wanted her so much, that the sun didn't shine for him, that he wanted to make love to her so badly. That was it, the man got onto the training prosthesis because he had to travel to the left bank to see his lover. That is real motivation, and it works."

Oleksandr Arkhypchuk, rehabilitation professional, Head of the Department of Physical and Rehabilitation Medicine, State Institution "Main Medical Clinical Centre of the Ministry of Internal Affairs of Ukraine"

At present, information or counselling about sexual life depends not on the person's needs, but on the initiative of a particular physician.

Some of our respondents also noted that they were not interested in this issue, as they did not need consultations on sexuality or sexual health. They also did not ask the medical staff anything or look for supporting information.

Acceptance of one's body at the treatment stage

For some of our respondents, awareness of the new self in a changed body came when they could touch or see themselves.

"When I began to regain consciousness after the anaesthetic, following the surgery, I was in the ambulance on the way to intensive care. I placed my hand there and realised that this was where it ended. I immediately thought to myself: 'Okay, these are my boundaries, this is my body, this is the new me now.' And that was it. At that moment, I came to accept my body as it was: damaged, but still mine."

Veteran, 26–35 years old, with an amputated part of the upper limb

One of the psychological challenges for veterans during treatment is the lack of understanding of their own condition, the seriousness of the injury, the diagnosis, further treatment or rehabilitation, recovery prospects and the body's new capacities. A lack of information about their health also prevents them from fully grasping the situation and moving towards acceptance of their body. In the first days, respondents could also perceive themselves and their physical condition rather fatalistically. One respondent said that he had even urged his wife to leave him. However, her support later helped him accept his body[44].

> *"I was really spiralling at first. In the first few days, when I first came round, and they moved me to a ward, I was telling my wife, basically, to leave me, that it was fine, that I'd accept it all. That lasted one day, one time I was given a proper telling-off, and that was it."*
>
> *Veteran, 26–35 years old, with traumatic brain injury and burn injuries; amputated parts of the lower limbs; injuries to the pelvis, organs of vision, face and abdomen; spinal and lung injuries; damage to internal organs*

Libido during treatment

One of the physical manifestations of sexuality that respondents emphasised at the treatment stage was libido. According to the respondents' accounts, after their condition had stabilised and they began to feel better, they experienced an increased desire for sexual contact, heightened libido and the return of erections. This physical response of the body was characteristic of most respondents with different types of injuries. Some respondents recalled experiencing erections even while in intensive care.

[44] A more detailed discussion of acceptance of the body following injury is provided in Section 2.

“Just between us, I’ll say that everything was working so well that I was already having erections even in intensive care, in that condition.”

Veteran, 26–35 years old, with traumatic brain injury and acoustic barotrauma, burn injuries and shrapnel wounds, and injuries to the limbs, face, and vision and hearing organs

Some veterans recalled that, even after a slight improvement in their condition while still in hospital, they began having erections in the morning.

“If it works, it works. The lads in the ward pretended they didn’t see anything. That’s just a standard thing.”

Veteran, 26–35 years old, with traumatic brain injury and burn injuries; amputated parts of the lower limbs; injuries to the pelvis, organs of vision, face and abdomen; spinal and lung injuries; damage to internal organs

Respondents also linked heightened libido at the treatment stage to the desire and curiosity to test how the body functioned now.

“You start having these thoughts, you want to watch something already. Like, to test your body a bit, to see how it functions now.”

Veteran, 26–35 years old, with an amputated part of the upper limb

*“It wasn’t even about the idea that it might be nice to f*** [have sex — ed.], but about the fact that, basically, it wasn’t a lost possibility after all.”*

Veteran, 36–45 years old, with amputated parts of the lower limbs

At the same time, such observations appeared only in interviews with male veterans. Female veterans did not mention that. This may be explained by a range of factors, including the more limited representation of women’s experiences in the study, cultural

and social differences in expectations regarding male and female bodies, as well as physiological and hormonal differences between female and male bodies.

The first sexual practices following injury

Since, immediately after their condition had stabilised, some respondents experienced an improved libido and an intense desire for physical intimacy, they began looking for ways to satisfy this need. Respondents also said that one of their motivations for trying was the desire to 'test' their body. One such option was masturbation. It was mentioned by both respondents who were in relationships and those who were not.

> *"Masturbation was a way to test your body, and it started to hurt less over time. And then, accordingly, you wanted to try how this could be realised in a sexual intercourse. Because by then, the leg had sort of healed."*
>
> *Veteran, 26–35 years old, with an amputated part of a limb*

Veterans also linked the intense desire for sex to the stress they had experienced because of injury and to their prior combat experience. One respondent described this state not as erotic arousal, but as a constant bodily tension that required release.

> *"It had stopped being about pleasure, or about the kind of curiosity it used to involve before — trying different positions, experimenting with different things. It had now turned into something more like relieving a need, meeting a necessity."*
>
> *Veteran, 26–35 years old, with traumatic brain injury and acoustic barotrauma, burn injuries and shrapnel wounds, and injuries to the limbs, face, and vision and hearing organs*

In an expert interview, a sexologist noted that such a response may be typical of service members who have spent a long time under conditions of chronic stress. According to her, sexual activity becomes one of the ways of coping with tension for some veterans, whereas the opposite response develops in others — a sharp decrease in, or complete absence of, sexual desire.

For some veterans, the return to sexual life began already at the treatment stage — long before physical recovery had been completed. Some respondents said that they had sex while still in hospital, when they found an opportunity to be alone. One respondent recalled that he first had sex with his wife on a train while being transferred from one hospital to another.

For many respondents, the first sexual intercourse after injury was primarily a way of making sure that the body still 'worked' and that they could still have sex. In this experience, what proved decisive was not so much the process of intimacy itself as the fact of ejaculation as the completion of the sexual intercourse and confirmation of physical capacity.

> *"But in fact, I had that first sexual intercourse in a hospital. And it went quite normally — I confirmed to myself that everything was fine. So after that, I could gradually get used to it, try different things, this and that, but sexual intercourse happened, ejaculation happened."*
>
> *Veteran, 26–35 years old, with an amputated part of the upper limb*

For some respondents, the first sexual experience after injury was accompanied by pain, in particular because of wounds that had not yet healed. One respondent with a spinal cord injury and no sensation in the genitalia said that, during the first attempt at sex, he felt severe pain in the abdominal area, which forced him to interrupt the sexual intercourse. Another respondent recalled that he felt pain in the stump of his leg[45] during arousal.

[45] Stump (residual limb) — the part of a limb that remains after amputation or injury.

“The first time, it was really unusual. It is because you’re already without a leg. So it’s a completely different story. Plus, when you tense up, and arousal happens, there’s such blood flow in that leg, it feels as if someone is working on it with a blowtorch. And it’s very uncomfortable — you want to concentrate on this, but it keeps distracting you.”

Veteran, 26–35 years old, with an amputated part of the upper limb

“If you observe men or women with a spinal cord injury, sometimes their legs move involuntarily, or they start having these spasms. It’s not a cramp; it’s not related to the brain, but it looks similar to cramping. And these spasms will be very strong and very pronounced during the first ejaculation. You need to be prepared for that. That’s also why blood pressure can rise, and it can drop equally. So, there may be blood pressure problems. But as a rule, that only happens the first time.”

Veteran, 26–35 years old, with a spinal cord injury, an upper limb injury, and a lung injury

Respondents who were in long-term relationships also noted that the support of a wife helped them take the step towards first sex after injury.

“We talked about sex before the moment when we first had it. I said that I did not fully understand how I was supposed to do it, because it was difficult for me to put any weight on my left leg due to the shrapnel in my knee and hip joint.

I said that I did not really understand how to do it or which positions to use. But I simply have the best wife in the world. Her attitude was that this was not a problem at all, that people in far worse health still had sex without any issues, that it is not a problem, and that there is always a way to work it out.

And that if we wanted to, we would always be able to find a way for both of us to feel good.

She supported me enormously in that respect. She reassured me that it was nothing to be afraid of, that it was okay, that it was only natural — this is war, people are maimed, but life does not stop there. Everything is possible if you have desire and imagination."

Veteran, 26–35 years old, with traumatic brain injury; injuries to the pelvis/genitalia and both lower limbs, with loss of part of the muscle tissue and shrapnel wounds

Some respondents who did not have a long-term partner at the time of injury said that they did not want to build a long-term romantic relationship during the treatment period, but rather wanted to satisfy their physical needs. For example, one respondent who did not have a long-term partner at the time of injury said that he managed to form a relationship and have sex while still in the hospital during treatment.

"My libido had not gone anywhere. The issue was that I was some sort of cross between a mole and a rabbit — I couldn't see anything. I returned to sexual life in [hospital]. I started a relationship with one of the volunteers, which then developed further. My libido found an outlet."

Veteran, 26–35 years old, with traumatic brain injury and blast injury; injuries to the organs of vision/hearing and multiple shrapnel wounds

Conclusions

- Veterans may be concerned about sexual and reproductive health as early as the stage of injury, evacuation, or stabilisation in the hospital. In particular, we identified such a concern among men at this stage.

- Immediately after injury and during treatment, sexual interest and sexuality are expressed primarily in physical terms. In other words, the precondition for sexual desire becomes either a physical need or the wish to make sure that the genitalia are intact.

- During treatment, veterans begin to adjust to their changed bodies and to understand their capabilities more broadly. Those who have a long-term partner are already trying to have sex at the treatment stage in most cases. However, this is not usually to experience pleasure, but to confirm that it is physically possible and that this aspect of a person's physical well-being remains accessible.

- At present, there are no early awareness-raising programs in Ukraine about sexual life at the time of injury: this is done only by some physicians on their own initiative.

02

Sexual life following injury

Over time, the stages of treatment and rehabilitation transition to life with injury. Depending on the type and severity of injuries sustained, service members follow one of two scenarios within the Journeys of Veterans[46]: they either continue their service or begin the process of discharge and settling back into civilian life.

Some service members fully complete their medical treatment and gradually return to their usual way of life. Others, by contrast, integrate long-term rehabilitation, periodic treatment, and new rules of self-care into their lives. Despite differences in these trajectories, veterans face a number of similar challenges affecting different areas of their lives, which may indirectly shape their journeys towards the recovery of their sexuality.

One of the main challenges is everyday life and routine. Ordinary activities, such as getting dressed, caring for yourself, and moving around, may require more time and effort, or the assistance of others. This can lead to a temporary or complete loss of autonomy and a sense of dependence on others, which may be painful and complicate acceptance of their own body.

> *"Without this [other people's help], I can't manage completely, but, for instance, I can stay at home on my own for a few days. If some food is cooked in advance, then I basically don't have any problems. I look after myself on my own. Getting dressed, hygiene, even warming something up to eat — I do all of that myself. The only thing is that I'm not going outside at the moment, but I'll do it later. [...] I also still have problems with the prostheses. I think that once they make these prostheses — or rather the orthosis — maybe I'll be able to cook something simple for myself."*
>
> *Veteran, 36–45 years old, with injuries to the organs of vision, hearing, and the lower limb; multiple shrapnel wounds; blast injury and amputated upper limbs*

[46] Veteran Hub, Pryncyp, Space of Opportunities, Legal Hundred (2025). Updated Concept of Veteran Policy. veteranspolicy.org.ua

Even after the completion of the main course of treatment following trauma or injury, some health consequences of military service may remain or emerge over time. Veterans may therefore require additional health care: returning for treatment of chronic conditions, consulting physicians who were not included during the main course of treatment or the MMC (Medical Military Commission), or addressing their mental health with a psychologist.
The realisation that health problems may be long-term requires separate emotional effort.

> *"The first thing you need to do when you come back from service is go to a urologist, because that can also drag on. That was the very first thing I went to address. Blood pressure, surgery and any other problems as well."*
>
> *Veteran, 45–60 years old, with injuries to the organs of hearing and the shoulder joint*

After injury and the loss of sensation or a sensory organ, veterans' sexuality may change, along with their perception of sex and its significance. For some, emotional closeness becomes more valuable, others feel nostalgic for their previous experience, while for some people, sex loses its importance and is accompanied by a sense of apathy.

> *"I definitely started approaching intimacy more cautiously. You already understand how fragile your body and soul are — they're like a vase that can shatter at the slightest wrong remark or reaction. It can simply knock out absolutely any desire for even the slightest contact."*
>
> *Veteran, 26–35 years old, with traumatic brain injury and blast injury; injuries to the organs of vision/hearing and the face; shrapnel wounds and an inguinal hernia*

However, the experience of injury does not necessarily change a person's understanding of sexuality. Some respondents noted that their perception of sex had not changed.

*“Sex is sex. Nothing more and nothing less. It hasn’t changed for me. It is closeness, physical and emotional pleasure. In a certain way, it is also self-affirmation, a sense of personal attractiveness. How do you feel attractive? Because someone is f***ing you [having sex with you — ed.]! In other words, it is a basic element of normal life.”*

Veteran, 26–35 years old, with traumatic brain injury and blast injury; injuries to the organs of vision/hearing and multiple shrapnel wounds

At first, discomfort with a changed body may give rise to complete apathy and alienation from one’s own body.

“Well, of course, when I was having suicidal thoughts, I had no desire at all. My body was so numb and frozen that it did not respond to anything. Obviously, at that time, I was simply dead inside.”

Female veteran, 45–60 years old, with traumatic brain injury, acoustic barotrauma and injuries to hearing organs

Acceptance

Acceptance is an important aspect of rehabilitation for people with physical injuries and may influence sexuality, sexual desire and self-confidence. These changes may continue throughout life and are initially expressed emotionally and behaviourally. A person rethinks their attitude towards their changed body, integrates this experience into everyday life, and gradually changes their behavioural strategies[47].

That is why the journey towards self-acceptance is always individual. It is shaped by a range of factors: from the type of trauma or injury and related complications during treatment to the person's psychological state and general living conditions.

> *"Of course, there was a moment when I was used to seeing myself one way, and now I'm like this. I'm just a perfectionist by nature. I was unhappy with all of it."*
>
> *Veteran, 26–35 years old, with traumatic brain injury and acoustic barotrauma, burn injuries and shrapnel wounds, and injuries to the limbs, face, and vision and hearing organs*

Below, we examine how acceptance unfolds across three dimensions: physical, psychological and social.

Physical aspects

Physical recovery and positive changes in appearance helped our respondents accept their experiences more easily. In particular, some of them noted that, once catheters, bandages and other

[47] Lee, H., Pyo, J., Ock, M., & Kim, H. J. (2024). Qualitative case study on the disability acceptance experiences of soldiers with disabilities. International Journal of Qualitative Studies on Health and Well-Being, 19(1), p. 2. 2350081. doi.org/10.1080/17482631.2024.2350081

things that might restrict them were removed, they began to feel better.

In addition, when veterans were able to improve their appearance or restore bodily functioning through plastic surgery and prostheses, this gave them more confidence and improved their self-esteem.

> *"They put in a plate, and the next day, a blood vessel burst in my head. Because of that, the muscle here shifted slightly downwards. And so I ended up with a hollow. [...] I texted a friend of mine, and she said it could be fixed easily. She's also a physician, though she works as a cosmetologist in [city]. She wrote to me, 'If you want, I can fix this problem.' But it's the kind of thing, you know, like having an injection in your lips. You have to keep doing it. She said, 'You'd need to buy the material, which costs 4,000 hryvnias. The procedure itself would be free on my part.' And I still haven't made it to [city], but I want to fix this small defect."*
>
> *Veteran, 26–35 years old, with traumatic brain injury*

At the same time, some respondents felt discomfort because their trauma or injury was 'invisible'. Since the injury caused physical discomfort in movement but was not visually apparent, people around them did not always respond to their experience with understanding.

> *"To be honest, I also see myself as an able-bodied person, simply because everything is in its place. Although my physical condition does not allow me to be fully able-bodied. And then there's the way people look at it and say, 'Well, everything seems to be in place, so what the f*** are you making a fuss about?', and that's how it is."*
>
> *Veteran, 26–35 years old, with traumatic brain injury; injuries to the pelvis/genitalia and both lower limbs, with loss of part of the muscle tissue and shrapnel wounds*

A wheelchair could be a source of discomfort for warriors with amputated lower limbs. In particular, veterans noted that it made them feel ashamed and helpless. However, they perceived crutches as an intermediate stage that provided greater mobility and independence from others, thereby improving their well-being. Meanwhile, a prosthesis ultimately restored the body to an upright position and gave them greater confidence.

> *"I went out among people for the first time, and I felt this sense of self-pity. There were lads with prostheses, lads with injured arms, but they were on their feet. A lot of people were walking on their own legs. And there I was, in a wheelchair, without a leg and with an injured arm. Well, there was a bit of self-pity. Then, after sitting there for a while, I looked around and thought, 'It's all right, my arm will recover, I'll get the leg sorted, and I'll walk, nothing terrible will happen.' Once I got onto crutches, I said, 'The wheelchair isn't for me, it's uncomfortable.' I'm more mobile on crutches and can get around anywhere. It's awkward to go up the stairs in a wheelchair. Since May, once I got onto crutches, I've wanted nothing to do with wheelchairs. [...] It's been five months without a wheelchair, and now I feel really good with the prosthesis."*
>
> *Veteran, 36–45 years old, with an amputated part of the lower limb; an abdominal injury; damage to internal organs and an upper limb injury*

In contemporary disability studies, some researchers view prosthetics as a tool that blurs the boundary between a 'healthy' person and a person with a disability. Others see it as a form of mimicry of 'normality' — an adaptation of the body to widespread social ideas about what a 'complete' body should be like: autonomous, upright and with two legs[48].

[48] Sun, H. (2018). Prosthetic configurations and imagination: Dis/ability, body, and technology. Concentric: Literary and Cultural Studies, 44(1), p. 24. doi.org/10.6240/concentric.lit.201803_44(1).0002

Our respondents tended towards the first interpretation and said that, after prosthetic fitting, they felt as though nothing had changed. At the same time, they also spoke about the difficulties: pain, fatigue and the need to rest after prolonged walking. This experience confirms that, although prostheses visually resemble legs, they do not replace them and may introduce new challenges. That is why it is important to study not only the symbolic significance of prosthetics but also the lived experience of daily life with them.

Spinal cord injury led to dysfunction below the level of injury, including in both lower limbs (paraplegia), among the service members we spoke to. For them, the very fact of the loss of sensation in a substantial part of the body became a difficult psychological experience, provoking anger and shame and making self-acceptance more difficult.

Psychological aspects

Based on the interviews, we identified four strategies for accepting the experience of injury. Some of these strategies are well established in sociology and psychology, while others we conceptualised based on our own analysis. At the same time, there may be more of them, and the strategies themselves may overlap and shift at different stages of recovery. These ways help warriors adapt psychologically to changes in their bodies.

The first strategy is the warriors' subjective ranking of trauma or injuries according to the extent to which this experience affects their future life. For example, veterans may compare their injuries with those of others whose wounds may require more complex or longer treatment or recovery, or may have a greater impact on their ability to live familiarly. From time to time, they recall those service members and veterans who sustained more severe trauma or injuries, or those killed. This comparison enables them to reduce the intensity of their distress, preserve a sense of perspective and support while adapting to new living conditions.

> *"I always looked at other lads around me who had sustained what, in my subjective view, were much worse injuries. I'm a gamer; everything I do depends on my hands. I read a lot, so I really need my eyes. And it would have been much harder for me psychologically to come to terms with an injury like that. But I saw guys who, f***, had more severe injuries than mine and still carried themselves with the utmost dignity. They were always an example to me."*
>
> *Veteran, 36–45 years old, with amputated parts of the lower limbs*

In the interviews conducted for this study, only veterans with spinal cord injury did not resort to ranking different types of combat injuries. Instead, they focused on their own injuries and their degrees of severity, and if they compared their experiences with those of others, they did so only with people who also had a spinal cord injury.

The second strategy used by our respondents was narrativization — shifting attention away from bodily damage and onto the story behind it.

"The most important thing I realised is this: scars do not make a man more attractive, whatever anyone may say. There is nothing beautiful about scars, but there is something beautiful in the story behind them. [...] I was carrying out a mission to defend my Homeland. And that really is a worthy reason. So yes, that side of the issue let go of me, and I accepted it. At some point, I even began to feel proud of those scars. [...] Above all, what became important to me was that it is the personality that should draw attention, and of course, the journey an individual has been through. Only after that, somewhere further down the line, comes the body."

Veteran, 26–35 years old, with traumatic brain injury and acoustic barotrauma, burn injuries and shrapnel wounds, and injuries to the limbs, face, and vision and hearing organs

These ways of interpreting one's experience are described as part of a 'heroic narrative' in the academic literature[49]. This is a framework within which trauma or injuries and changes in appearance after participation in combat are recognised by society as worthy, right and heroic. The thought "I defended my country" becomes a protective mechanism that helps veterans feel the importance of their service and take pride in it. This, in turn, helps them accept their new body.

The third strategy is rationalisation. Veterans distance themselves from emotional feelings and reactions related to trauma or injury and move immediately to practical questions: how to live now as a 'changed' person. This restores their sense of control over the body and shifts their thoughts into the sphere of everyday life, communication with different people and other areas of life.

[49] Keeling, M., Harcourt, D., White, P., Evans, S., Williams, V. S., Kiff, J., et al. (2025). Body image and appearance distress among military veterans and civilians with an injury-related visible difference: A comparison study. PLoS ONE, 20(2) p.20. doi.org/10.1371/journal.pone.0305022

“And plus my attitude towards my injury. I accepted it almost immediately. Not from the point of view of, oh, that’s it, I have no eye — I’m ugly. Okay, yes, I’m ugly. I can cry about it, but it won’t change anything. The eye won’t grow back, and beauty won’t come back either. So I approached it from the perspective that this is a new reality. I accept it. I may not like it, it may annoy me, but there is no point in dwelling on it. [...] I kept saying, ‘Okay, and what then, if I refuse to accept myself? A noose round the neck and that’s it?’ It would be such a damn shame to go through all that, survive something like that, and then end it all in such a stupid way.”

Veteran, 36–45 years old, with amputated parts of the lower limbs

The fourth strategy we identified was visual confrontation. Often, the first reaction to a changed body is the wish to look away from it. To overcome this barrier, service members deliberately made themselves look at their new bodies in the mirror. This helped them reduce their sensitivity to the trauma and, ultimately, integrate the new image into their sense of self.

“I was in the hospital in [city in Ukraine] after the surgery, and for the first time, I really saw myself properly, almost full-length, without shorts, just in my underwear. And it was like, ‘Damn, what am I going to do now without a leg?’ It wasn’t even irony — it was self-pity, this feeling that I was somehow incomplete. I still hadn’t accepted myself. When I came back to [city in Ukraine] for the second time, I just waited until my roommate was out, took a shower, stood in front of the mirror and looked at myself, so that I could accept myself as I now was. Apart from the missing leg, nothing had changed. It became a bit easier.”

Veteran, 36–45 years old, with an amputated part of the lower limb; an abdominal injury; damage to internal organs and an upper limb injury

Strategies that helped respondents on their journeys towards accepting their bodies after trauma and injury

Strategy	Manifestations
Subjective ranking of trauma/injuries	Service members compare themselves with brothers- or sisters-in-arms, or other service members who sustained more severe injuries or were killed. This helps them avoid focusing excessively on themselves
Narrativization	Service members perceive trauma or injuries as stories of defence and dignity. This allows them to shift the focus away from the body and onto the journeys they have been through
Rationalisation	Service members distance themselves from their emotions and move into the sphere of practical life in order to regain a sense of agency
Visual confrontation	Service members deliberately look at their reflection in the mirror for a period of time in order to get used to and normalise their changed body

Alongside these strategies, warriors also mentioned new hobbies and various activities, adaptive sport and psychotherapy as additional tools in the process of accepting themselves. Each of these, in its own way, helped them shift their focus away from the trauma, rethink or work through it indirectly, and find new meanings or answers to their questions.

"I started working with a psychologist because I realised that I simply could not accept myself on my own..."

Female veteran, 26–35 years old, with traumatic brain injury and blast injury; injuries to the organs of vision/hearing and shrapnel wounds

“It’s very important not to sit at home, not to stare at your phone all the time, but to keep yourself occupied. […] It’s important to keep yourself constantly engaged: sport, studying, work, and attending events. Two months ago, I was more in [country] — I was travelling, after all. When your life is constantly like that, when you’re always sorting something out, you keep layering yourself with emotions, understanding and sensations. And somehow I got through it normally. I just don’t really have time for PTSD. It’s tough for some people. For me, it went pretty smoothly.”

Veteran, 26–35 years old, with an amputated part of the lower limb; acoustic barotrauma and injury to the hearing organs

In the course of the analysis, we determined that acceptance is, above all, a process rather than an outcome. It may be prolonged, non-linear and difficult. It is problematic to identify its ‘completion’, as respondents themselves often doubted during the interviews whether they had fully accepted their trauma or injuries.

“Talking to you now, I’m beginning to realise that I probably still haven’t fully accepted my physical condition as it is now, even though quite a lot of time has passed. And I suppose it’s uncomfortable for me even to begin this conversation, because it means admitting that there is something different about me. […] I still haven’t really come to terms with the idea that my body is not the same as it was before. I probably haven’t fully realised it. I don’t want to realise it.”

Veteran, 26–35 years old, with traumatic brain injury; injuries to the pelvis/genitalia and both lower limbs, with loss of part of the muscle tissue and shrapnel wounds

Ultimately, veterans themselves regard the successful state as one in which physical differences become less significant, while greater importance is given to everyday routine, new interests and plans for the future. Even with occasional setbacks or moments of self-doubt, this state remains stable and safe for them.

"If we're talking specifically about appearance, I still sometimes think about my appearance. What I think about myself is not always positive, but you get used to it over time. Eventually, you stop caring so much."

Veteran, 26–35 years old, with burn injuries and closed traumatic brain injury; injuries to the organs of vision/hearing, the pelvis/genitalia, and multiple shrapnel wounds

However, some of our respondents with injuries sustained between 2022 and 2024 still do not accept their injuries and bodily changes. They continue to feel ashamed of themselves, to feel nostalgic for life before injury and to face difficulties when meeting or communicating with others. For warriors who have not accepted themselves and have not found a partner, the issue of relationships remains one of the most anxiety-provoking and painful.

Social aspects

One study of the experiences of British veterans with injuries shows that changes in appearance are often accompanied not only by physical and psychological challenges, but also by social ones. In particular, respondents spoke about fear of judgement from others and an intensified sense of self-disgust — an inward shame

directed at oneself, similar to self-stigmatisation, which arises when a person feels that their appearance violates social norms[50].

Some respondents in our study also shared that they focused on their 'difference' for a long time. They compared their bodies, appearances and physical capacities with an imagined social norm, thereby stigmatising themselves. In particular, this was reflected in the words they used to describe themselves in their changed body: disabled, cripple, ugly.

> *"I have two legs, but one of them is badly torn up. If I talk about myself, without comparing myself with anyone else, I look at my legs and see that I'm a cripple. And in fact I am, because I can't run. And then it gets into your head that there's something wrong with you, that you're not fully able-bodied, all that s*** [nonsense — ed.], that it shouldn't be like this. And that really held me back, because it all somehow... I was very fixated on my disability."*
>
> *Veteran, 26–35 years old, with traumatic brain injury; injuries to the pelvis/genitalia and both lower limbs, with loss of part of the muscle tissue and shrapnel wounds*

As a result, respondents began to doubt whether others would be able to accept them. These thoughts were especially troubling for veterans who were not in a long-term relationship at the time they sustained the trauma or injury.

> *"And I was such a cutie then: burnt, arm broken, tooth knocked out, eye gone. Who would want me like that?"*
>
> *Veteran, 26–35 years old, with traumatic brain injury and acoustic barotrauma, burn injuries and shrapnel wounds, and injuries to the limbs, face, and organs of vision and hearing*

[50] Keeling, M., Harcourt, D., White, P., Evans, S., Williams, V. S., Kiff, J., et al. (2025). Body image and appearance distress among military veterans and civilians with an injury-related visible difference: A comparison study. PLoS ONE, 20(2) p.16. doi.org/10.1371/journal.pone.0305022

After injury, warriors also encountered social ideas about the ‘sick body’. In theoretical literature, trauma and injuries are conventionally divided into ‘visible’ and ‘invisible’[51]. The former are visually apparent in a person’s appearance (amputated limbs, scars, burns), while the latter are not visible (traumatic brain injuries, damage to internal organs). This does not determine the significance of particular trauma or injuries. However, it often affects the extent to which a person’s experience can be seen by society. As a result, trauma is perceived differently both by the surrounding people and by veterans themselves.

For some, the visibility of their injuries became a marker of being different. This provoked feelings of discomfort, anger or shame, especially when respondents noticed ambiguous looks directed at them or heard similar comments about their appearance.

> *“The most common thing I hear when I’m walking around the city, especially in [district], when it’s warm, and people start coming out to have some alcohol, is the phrase, ‘Oh, f***ing hell [well, well — ed.], a pirate.’ It’s just one of those lines that has really got on my nerves. I’ve been hearing it for 10 years of my life.”*
>
> *Veteran, 26–35 years old, with traumatic brain injury and blast injury; injuries to the organs of vision/hearing and multiple shrapnel wounds*

Some men said that they did not know how they would have coped without their girlfriend or wife. They described having a long-term female partner as the greatest source of support in their recovery.

[51] Javaid, S. F., & Yusuf, R. (2024). Invisible disabilities. In G. Bennett & E. Goodall (Eds.), The Palgrave Encyclopedia of Disability. Palgrave Macmillan. P. 2. doi.org/10.1007/978-3-031-40858-8_299-1

“I do not worry about my attractiveness, because I know that I am the most handsome to the person I love. And she accepts me as I am. So I do not worry now about attractiveness or think about whether I am attractive. But in my own view, I am less attractive than I used to be.”

Veteran, 26–35 years old, with traumatic brain injury; injuries to the pelvis/genitalia and both lower limbs, with loss of part of the muscle tissue and shrapnel wounds

At the same time, for respondents who managed to build close relationships after injury, this experience had a particularly positive, even therapeutic effect. It is because their new partners not only supported them emotionally, but also confirmed that trauma or injury does not negate a person’s worth, attractiveness or sexuality. These relationships also motivated them not to give up and to keep moving forward.

“But I did not expect [girlfriend’s name] to take such a step. We were strangers, per se, but she made that decision. Yes, a gesture like that meant a great deal to me. It gave me a kind of stimulus — to make sure that she would feel good with me, that she would not grow tired of me.”

Veteran, 36–45 years old, with injuries to the lower limb and the organs of vision and hearing; multiple shrapnel wounds; blast injury, and amputation of both upper limbs

A female veteran who took part in the study told us about a different experience. Her concerns were more focused on her appearance and on how her loved one perceived her after the injury. In her account, she concentrated extensively on how her injuries had changed her body, how others reacted to this and how the process of accepting her new self unfolded. Although support from her loved one helped, it could not always compensate for her own perception of her body.

"I even tell him, if he's taking photos of me from behind, from the right side, then no. I can see it, I can see those scars, even with long hair. He says, 'I don't see them.' But I do. I look at the photo, and I can already see them. You may not see them, but I know they are there... For example, I don't like when he touches my head."

Female veteran, 26–35 years old, with traumatic brain injury and blast injury; injuries to the organs of vision/hearing and shrapnel wounds

This perception may partly be linked to female gender socialisation, according to which women experience greater pressure to conform to standards of beauty and attractiveness[52]. In this context, any bodily changes following trauma or injury may negatively affect their self-esteem and their sense of themselves as attractive, sexual and desirable.

[52] Wolf, N. (2002). The beauty myth: How images of beauty are used against women. HarperPerennial.

Libido

The veterans with whom we spoke had different experiences of libido changes as they were rebuilding their lives after injury or trauma. The level of sexual desire could either decrease or increase. Respondents who did not experience a decrease in libido linked this to their young age.

> *"Arousal is easy to achieve. There are no particular problems with that. We're still young."*
>
> *Veteran, 26–35 years old, with traumatic brain injury and burn injuries; amputated parts of the lower limbs; injuries to the pelvis, organs of vision, face and abdomen; spinal and lung injuries; damage to internal organs*

One veteran who reported an increased libido following injury compared with the period before the trauma suggested that this might be related to his psycho-emotional state.

> *"I even came across articles by psychologists and therapists myself. Many of them write that a lot of men, after injury, after PTSD, and all these related issues, have two possibilities: either a decrease in sexual desire or, on the contrary, an increase. In my case, I think it may be the second one. Because I can feel it myself — maybe I even want it more than is really necessary."*
>
> *Veteran, 26–35 years old, with burn injuries and closed traumatic brain injury; injuries to the organs of vision/hearing, the pelvis/genitalia, and multiple shrapnel wounds*

At the same time, there are cases in which low sexual desire is not a consequence of injury and is not perceived by veterans as a change. One respondent noted that, after injury, his sexual desire had not changed and had remained low. In his opinion, this was more related to his psychological state (in his case, attention deficit hyperactivity disorder), and generally did not have a negative impact on his quality of life.

> *"It [the injury — ed.] did not affect sexual desire at all. Yes, I did have that phase of accepting and not accepting it, but here it is important to note that I'm one of those with ADHD [a person with attention deficit hyperactivity disorder — ed.]. I have this fear of rejection; it's basically been with me my whole life. But, so to speak, there is no connection between my injury and my libido. So the problem here is not with my sexual life, at least not for me. The problem is for my partner."*
>
> *Veteran, 26–35 years old, with traumatic brain injury and blast injury; injuries to the organs of vision/hearing and multiple shrapnel wounds*

At the same time, most of the veterans with whom we spoke either had experienced or were experiencing a decrease in libido at the stage of returning to civilian or military life (approximately one and a half to two years after injury). They believe several factors influenced this.

The first is the direct consequence of trauma or injury, including the direct loss of a sensory organ. Thus, one veteran who had completely lost his sight noted that, after injury, it had become more difficult for him to experience sexual arousal, as he had lost one of the ways he used to perceive the surrounding world.





“Well, it’s there, but not as often as before. And I also have issues with sight. Damn, I don’t really know. It’s hard with hearing; it’s easier with sight. But with sight, of course, it’s a bit harder. I mean without sight. Even in that respect. Because when you can see, you get aroused more quickly [than] when you can’t.”

Veteran, 26–35 years old, with injuries to the organs of vision and hearing; amputated parts of the lower and upper limbs; fracture of the lower limb

The second factor may be the absence of a loved one nearby. In this study, we interviewed only a small number of women, so we cannot fully trace possible differences between women’s and men’s experiences of changes in libido following injury. At the same time, one female veteran noted that she had not felt sexual desire during the period of her injury and treatment because her husband was in Russian captivity back then. She recalled that her sexual desire began to reappear only after they were together again. At the same time, in this case, it is difficult to determine unequivocally what exactly influenced the absence of desire — separation from her partner or the consequences of the injury.

“There was definitely nothing in the autumn. Then, probably sometime in winter, something started, and these very painful episodes began. And it hurt me so much. I didn’t understand what was happening with my body. I went to the physician — everything was fine. At that time, I was still in the hospital, in a sanatorium. They just gave me pain relief, and that was it. I realised that maybe everything there was fine. But I still wasn’t thinking about it until my husband was brought back. That whole aspect was completely closed off for me then, closed off to everything, to men. I spoke to them. There were lots of men there. But it was like speaking to a comrade, to a veteran,

the same as to a wounded comrade, so to speak, in that sense, but I didn't have that kind of feeling."

Female veteran, 26–35 years old, with traumatic brain injury and blast injury; injuries to the organs of vision/hearing and shrapnel wounds

This respondent was living through a dual experience: her own treatment and recovery, and at the same time, the experience of being the wife of a prisoner of war. Later, her libido was also affected by her husband's prolonged absence after he returned to military service. Since her partner continues to serve, the time they spend together varies — from a few days to a two-week leave. According to the veteran, sexual desire feels less intense during longer periods of leave, because there is a sense of time 'ahead'. By contrast, desire becomes stronger during short meetings because of the limited time they have together.

"When, you know, it's a day or two, everything is just heightened. The less time you have together, the more you understand that there may not be another chance. So you take that moment now. But when you have, say, a week, you think, 'No, tomorrow. Not today'."

Female veteran, 26–35 years old, with traumatic brain injury and blast injury; injuries to the organs of vision/hearing and shrapnel wounds

According to the respondents' accounts, a third important factor affecting libido is psycho-emotional state. One respondent noted that physical consequences of injury did not affect his sexual desire, as he could adapt to almost any physical condition, for example, by changing position or shortening the duration of sex. Rather, desire depended more on the relationship with a partner, the emotional state at a given moment, and news from brothers- or sisters-in-arms. For respondents in long-term relationships that had begun before injury, a decrease in libido could become a challenge not only at the individual level but also affect the overall dynamics of the relationship. One veteran noted that the decline

in his sexual desire affected the way his partner assessed the quality of their sexual life and the relationship as a whole. In particular, she perceived it as a possible sign of a deterioration in the relationship or even infidelity.

> *"That was exactly the problem: it was not something particularly significant for me. She may have associated it with my losing interest in her. She was already a very jealous person, even without that. And then, of course, she immediately started asking whether I might be dealing with these needs somewhere else, with someone else. I told her that we were trying to have a child. She said that was all well and good, but I should not forget other aspects either."*
>
> *Veteran, 26–35 years old, with traumatic brain injury and acoustic barotrauma, burn injuries and shrapnel wounds, and injuries to the limbs, face, and organs of vision and hearing*

It is also important to highlight the experience of one of the female respondents, who did not face difficulties specifically with arousal or sexual desire, but did experience difficulties with acting on that desire after her combat experience. She experienced a panic reaction and physical discomfort during attempts at physical sexual contact with men. The respondent could not clearly explain the nature of this reaction and did not seek professional support to address it.

Most respondents whose sexual desire remained reduced even after treatment and rehabilitation had ended expressed a wish to restore their libido. At the same time, attempts to return to a previous level of sexual desire may be accompanied by certain barriers, including heightened expectations of the situation and of oneself. After a long separation, when an opportunity to spend time together or to be alone at home finally arises, sex is often perceived as an inseparable part of the couple's reunion. This, in turn, may create additional psychological pressure. At the same

time, the process of recovery is individual, and sexual desire may not yet have recovered after injury and the stress experienced.

> *"I had the desire, but not the opportunity. But now, when I think back and really dig into it, I'm not sure it was actually desire. To some extent, it may have been more like: Here is my wife; here is someone dear to me. I see her once every six months, so logically, you are at home; here is the bed. And then suddenly something just... didn't work."*
>
> *Veteran, 36–45 years old, with traumatic brain injury and acoustic barotrauma; minor shrapnel wounds and an injury to the lower limb*

Despite the presence of barriers and gradual recovery, one veteran noted that his libido began to recover together with his acceptance of the changes and his understanding of how to live with them.

> *"Until I understood that the only change that had happened to me was that I had no leg, and that the world did not end there, I did not even feel like watching orange YouTube [porn site — ed.], as it is sometimes called. The thought of it did not even cross my mind."*
>
> *Veteran, 36–45 years old, with an amputated part of the lower limb, an abdominal injury, damage to internal organs, and an upper limb injury*

When speaking about their state of libido after injury, veterans often referred to their previous sexual experience with a sense of nostalgia.

> *"Before, let's put it this way, I was vulgar, dirty-minded. I was very passionate, and that applied to intimacy too. And then all of that suddenly disappeared. It was as though it had become less important. Maybe it is temporary, maybe all this crap will end, and we will return to our old life, and maybe things will*

become much better. Maybe this is just how chronic stress affects all of us. Some more, some less. I don't know."

Veteran, 26–35 years old, with traumatic brain injury and acoustic barotrauma, burn injuries and shrapnel wounds, and injuries to the limbs, face, and organs of vision and hearing

However, not everyone has a desire to return to their previous life, including their previous sexual life. In response to the question of whether they felt nostalgic for their sexual life before injury, some respondents answered in the negative.

This may be related, among other things, to the proportion between the length of life with injury and the period of active sexual life before it.

"I was 23 before I was injured. My sexual life was not all that active even then. I have already spent most of my sexual life with the injury. So there was nothing to feel nostalgic about."

Veteran, 26–35 years old, with a spinal cord injury, an upper limb injury, and a lung injury

At the same time, nostalgia was connected not only with sexual life before injury, but also with other important stages in a couple's life that had shaped their intimacy. For example, one veteran felt nostalgic for the sexual life he and his wife had before the birth of their child and before her pregnancy.

Changes in sexual intercourse

Nostalgia for sexual life before injury among veterans was related to different aspects, from the level of sexual desire to particular sexual practices that became unavailable after injury. Thus, respondents with amputated lower limbs repeatedly mentioned that they could no longer practise certain sexual positions because they lacked points of support — for example, when a man needs to brace himself on his knees or to be on top of his partner.

> *"I have fewer possibilities now because of the limitations caused by the amputation. In sexual terms, I can no longer use every position, because there is no point on which I can brace myself additionally."*
>
> *Veteran, 36–45 years old, with an amputated part of the lower limb; an abdominal injury; damage to internal organs and an upper limb injury*

> *"There is a constant sense of something missing where that part of the limb used to be, and I do feel that loss. But somehow we manage, and I wouldn't say that it [sex — ed.] has become all that constrained. It feels as though it may not be quite as good as it was before, not quite as varied, but now, I relate to it in a way that makes it feel sufficient. I wouldn't say it is terrible. But the fact that I can't kneel on both knees — that is something I do miss."*
>
> *Veteran, 26–35 years old, with an amputated part of the lower limb*

Because of the cultural norms that shape male sexuality, the inability to have sex in the same way as before, or in the way imagined in fantasy, may lead to a sense of loss of one's masculine dignity. Theorists of masculinity draw attention to the widespread

idea that a ‘real man’ should always be ‘on top’, although this can be interpreted not only in the context of sexuality[53]. One of our respondents with a spinal cord injury did indeed note that he felt more confident when he could be in the top position during the sexual intercourse.

> *“And what really matters is these attempts to be on top. I don’t know how it works. No matter how much I understand that it all looks awkward, like complete crap, and I can’t feel anything. Damn, you still feel different. I don’t know how or why, but somehow a bit different, a bit more vivid.”*
>
> *Veteran, 26–35 years old, with a spinal cord injury*

In addition to physical limitations affecting particular sexual positions, some veterans were forced to limit the variety of their sexual life as a whole following injury. This concerned not only positions, but also the conditions under which sex was possible, e.g., only in a lying position. This, in turn, narrowed the range of places where sex could take place, both within the home and beyond.

> *“I used to love having sex on a train, in a compartment. There’s Gorky Park in Kharkiv. When I used to go there with my girlfriend, there was a cable car there — we had sex in one of those cabins. There’s also the Ferris wheel in Gorky Park. A girl once gave me oral sex there — another girl, an even earlier ex. That’s how much I loved experimenting. I used to love having sex in the park. In other words, I had a desire, a kind of thrill. And all of that disappeared after my injury.”*
>
> *Veteran, 26–35 years old, with a severe traumatic brain injury that resulted in loss of mobility in part of the body*

For some respondents, physical consequences of injury and trauma meant less spontaneity in their sexual life. For example, they may

[53] Kon, I. (2003). Men Who Change in a Changing World. Independent Cultural Studies Journal ‘I’, (27), 7–48. ji.lviv.ua/n27texts/kon.htm

need time to remove a prosthesis or, in the case of short-term relationships, to discuss how sexual contact will take place and which kinds of touch may cause discomfort in advance with a partner.

> *"For example, physically, I can, of course, still do key things and essential elements of sex. Nothing has changed in that sense. But the variety will, of course, be completely different now. If I used to be able to walk into the kitchen, push my wife down on the floor, and we'd have sex, that's obviously not going to happen now. Because doing that in prostheses is actually extremely difficult. In my particular case, it is only possible when standing, because stability suffers greatly. It's the same in bed. It's hard for me to use my legs."*
>
> *Veteran, 36–45 years old, with an amputated part of the lower limb*

However, these forced changes prompted others to experiment with sex and to look for alternative positions and ways of experiencing pleasure with their partners.

> *"Obviously, you compare things. Because even during sex, when you can lift your partner[54] in your arms, that's one kind of experience, and even pinning them against the wall — that all brings one kind of emotion, one kind of sensation. But then you can't do that, because physically you just can't. That does get in the way a bit, but again — experimentation. You can use some things differently. You can add something. Even a partner, say, if you have some sort of pull-up bar at home, can hold on to that while you do all these things. And it becomes interesting. And once again, it comes back to experimenting. You have to keep adding that spark through your experiments."*
>
> *Veteran, 26–35 years old, with an amputated part of the upper limb*

[54] The quote retains the respondent's original wording. The word partner is used here as a gender-neutral term without specifying gender, although it refers to a female partner in this context.

Sensory changes

Sensation is one of the important components of sexuality, grounded in sensory perception through sight, hearing, smell, taste and touch[55]. In this study, we focus on sensory changes following injury, which may manifest across different dimensions of sexuality, namely physical, psychological, and in interaction with a partner. Since sensation is an individual bodily experience, this text does not cover all possible changes that may occur in the body as a result of injury.

Physical aspects

Respondents with complete or partial loss of sight noted that, whereas visual perception of a partner had previously been central for them, touch became a more important way of experiencing intimacy after injury. Some respondents also noted that they had begun to perceive scents more intensely, and as a result, smells had become a more important element of their sexual experience.

[55] Cross, C. L., & Weeks, G. R. (2007). Sex, sexuality, and sensuality. In Low-cost approaches to promote physical and mental health p. 385. Springer. doi.org/10.1007/0-387-36899-x_19

“I think that, on the contrary, it completely turned my sex life upside down. Before the injury, you simply saw with your eyes and took pleasure in your partner[56]. But in my case, when you cannot see, you experience everything through touch — you run your hands over them, stroke the body — and these are different emotions, different sensations, tactile ones. It is all heightened tactility, plus heightened awareness of scents — you notice every scent. And that’s quite a drastic change from how things were before the injury.”

Veteran, 26–35 years old, with burn injuries and closed traumatic brain injury; injuries to the organs of vision/hearing, the pelvis/genitalia, and multiple shrapnel wounds

“I learned to see with my hands at some point. I’m not saying that I can read Braille now, but because I could no longer properly perceive my partner visually, I, so to speak, perceived her through touch.”

Veteran, 26–35 years old, with traumatic brain injury and blast injury; injuries to the organs of vision/hearing and multiple shrapnel wounds

One of the sensory changes experienced by veterans with amputated limbs is heightened sensitivity in the stump. In an expert interview for this study, a psychologist who works with phantom pain and phantom sensations after amputation noted that this sensitivity may manifest differently in different people: for some, it involves pain, while for others, it may even be pleasurable.

“One thing that does sometimes happen, though not often, is that men experience orgasm simultaneously in the penis and in the phantom limb.”

Yehor Iordek, psychologist specialising in pain management

[56] The quote retains the respondent’s original wording. The word partner is used here as a gender-neutral term without specifying gender, although it refers to a female partner in this context.

Because of physiological characteristics, men may also experience similar sensations in the stump[57] of an amputated lower limb during orgasm. At the same time, intimate closeness may be accompanied by phantom pain or phantom sensations for some people.

> *"My leg became sensitive in its own way, too, because the tissues are different here, the blood vessels are different. And it has developed its own kind of erogenous zone as well. So certain kinds of touch became interesting."*
>
> *Veteran, 26–35 years old, with an amputated part of the upper limb*

Sensation may also change in scars left after injury. Some respondents noted that they felt pain in these areas, and therefore warned their partners in advance which parts of the body should not be touched during intimacy.

> *"My head, for example. Well, anything connected with my injury. Do not touch my head. These little scars still ache a bit. But my back has basically healed already. So everything that heals is more or less fine. You can't touch my elbows, there is still shrapnel there, and sometimes it hurts badly when touched."*
>
> *Female veteran, 26–35 years old, with traumatic brain injury and blast injury; injuries to the organs of vision/hearing and shrapnel wounds*

We also recorded experiences of sensory changes in respondents with traumatic brain injury. One veteran noted that sensation in his penis had changed after the injury: during oral sex, pain appeared on the left side, and he experienced uncontrollable laughter during orgasm.

[57] A stump is the part of a limb that remains after amputation.

“I developed very strong sensitivity. There are two options. The first is that, when I climax in my wife’s mouth, I can climax and laugh at the same time. I don’t know why that happens. I just laugh. And I also developed some sort of hypersensitivity. When she starts giving me oral sex, it is very painful, really painful. The left side hurts. Half of the penis is painful. But the pain goes away after a while. And when I climax in her mouth, my hand bends really sharply. It kind of jerks. Not upwards, but downwards. So those are some rather interesting changes I’ve noticed in myself.”

Veteran, 26–35 years old, with traumatic brain injury

For some respondents, however, their injuries and scars that had lost sensation did not become a barrier to being touched by other people. One respondent noted that the injury had not changed his love of touch or his need for it.

“I’m one big erogenous zone. You can touch me anywhere, and I enjoy it.”

Veteran, 45–60 years old, with traumatic brain injury, burn injury and acoustic barotrauma; multiple shrapnel wounds; injuries to the organs of hearing, the pelvis and the lower limb

Psychological aspects

Fantasies may become a more important part of sexual arousal for warriors with complete or partial loss of sight after injury. One respondent told us that after losing his sight, a new practice for their couple became using his partner's lingerie, which he could explore through touch and imagination.

> *"Especially since I'd more or less come across that kind of outfit before, even seen it in movies, so I know what it looks like on a person and what it is. If I'd been blind from birth, that would be different. Then I probably wouldn't even think about it at all, or what it was for. But when you know what it is and what it's for, then yes, it adds a bit more spark."*
>
> *Veteran, 26–35 years old, with burn injuries and closed traumatic brain injury; injuries to the organs of vision/hearing, the pelvis/genitalia, and multiple shrapnel wounds*

Altered sensation in scars may also be unpleasant not only physically, but psychologically as well, because of memories associated with combat, the moment of injury or the death of brothers- or sisters-in-arms.

> *"My former classmate was killed in the same place. We carried out many of the lads, because a guided aerial bomb was dropped directly on the warehouse there. We had 52 killed in action. And when we were carrying the lads out, they were dying in our arms. I remember that lake of blood. I remember holding one of them and not being able to understand why his leg was here, his arm was there, and his head was somewhere down by his stomach. And there was this human being twisted up like a knot, and I couldn't make sense of it, and he was gasping in convulsions and dying."*
>
> *Veteran, 45–60 years old, with traumatic brain injury, burn injury and acoustic barotrauma; multiple shrapnel wounds; injuries to the organs of hearing, the pelvis and the lower limb*

Social aspects

Loss of sensation in particular parts of the body may affect interaction within a couple. One respondent, who had multiple scars on his face and had lost sensation in the area of his lips, noted that he was concerned less about his own loss of feeling than about how his partner perceived it — in particular, whether she felt comfortable kissing lips that had lost sensation.

> *"No, in fact, it did get in the way. I couldn't understand whether my partner[58] liked kissing these lips. It's basically a piece of cheek pulled tight. I don't have the kind of sensation in my lips that I used to have. Only this tiny part remained without sensation, while the rest is just stretched scar tissue. My whole face is scarred. You can't tell whether your partner likes it. And you can't see the reaction in her eyes."*
>
> *Veteran, 26–35 years old, with traumatic brain injury and burn injuries; amputated parts of the lower limbs; injuries to the pelvis, organs of vision, face and abdomen; spinal and lung injuries; damage to internal organs*

Respondents also noted that whether touch is experienced as pleasant or unpleasant may vary depending on mood or circumstances. For example, kissing scars may feel pleasant at times, while in other situations they may be irritating.

> *"It's an area that is, so to speak, on the boundary between sensation and loss of sensation. Overall, it's a very unpleasant area to touch. And sometimes kisses feel pleasant, while at other times they are more irritating."*
>
> *Veteran, 26–35 years old, with a spinal cord injury, an upper limb injury, and a lung injury*

[58] The quote retains the respondent's original wording. The word partner is used here as a gender-neutral term without specifying gender, although it refers to a female partner in this context.

Conclusions

In this section, we examined how sexuality is transformed after injury. In particular, we looked at acceptance of one's body, the state of libido, sensory changes, and changes in sexual positions from three perspectives: psychological, physical, and social.

Transformation of sexuality

The experiences of veterans show that sexuality following injury is transformed not only at the level of physical capacity, but primarily in the meaning a person attaches to sex and intimacy. For some people, emotional closeness and safety become more valuable; others feel nostalgic for their previous experience, while for some, sexuality temporarily loses its importance and is accompanied by apathy.

Acceptance

Veterans go through the process of accepting their new bodies in different ways, depending on their individual characteristics and life circumstances.

- Acceptance begins with adaptation to the changed body: scars, amputations, loss or distortion of sensation and functional limitations. Respondents gradually rethink their embodiment and learn new ways of moving, touching and experiencing pleasure. Adaptive devices and additional mobility aids, such as wheelchairs, crutches and prostheses, also play an important role in physical acceptance.

- Above all, acceptance is a process rather than a result. It may be prolonged, non-linear and difficult. At the psychological level, it is associated with a reduction in shame, fear of rejection and the feeling of being 'different'. In this study, we identify four strategies of accepting bodily changes among veterans: subjective ranking, heroisation, rationalisation and visual confrontation.
- Social acceptance is shaped through the reactions of partners, loved ones and the wider environment. Supportive relationships significantly ease the integration of bodily changes into everyday life, whereas stigmatisation or avoidance of the topic of sexuality may slow down the adaptation process.

Libido

Changes in libido following injury are individual and cannot be reduced to physiological factors alone. Most respondents in this study had a decrease in sexual desire during the treatment stage, associated with pain, medication, exhaustion, or psycho-emotional state. Changes in veterans' psychological state may lead to a decrease in libido among veterans and to nostalgia for their previous sexual life.

Changes in sexual life

Sexual practices undergo adaptation after injury. Respondents described the need to experiment with new positions, pace and duration, as well as the need to prepare physically for sex. For some respondents, this process proved difficult and was accompanied by discomfort, uncertainty and pain, whereas others found in it a space for new forms of sexual interaction.

Sensory changes

- The physical manifestations of sensory changes after injury also alter how intimacy is experienced: other sensory perceptions, such as touch or smell, become more important; new erogenous zones may emerge; and some areas may remain painful.
  As a result, veterans relearn their own bodies and adapt sexual interaction to these new sensations.
- Sensory changes following injury also affect the psychological experience of intimacy: sexual arousal may rely more heavily on fantasy, imagination and previous bodily experience.
  At the same time, certain parts of the body or scars may trigger traumatic memories, apathy or alienation from one's own body.
- Sensory changes and the corresponding changes in sexuality and its manifestations may also have social implications through their impact on interactions within a couple. In particular, following their injuries, veterans experience a re-evaluation of their sexuality — specifically, sex and changes in the perception of their own bodies. The social dimension of sensory changes is also reflected in the need to explain new bodily boundaries and needs to a partner.

03

Conclusions of the study and recommendations

Conclusions of the study

1 Veterans may have concerns about their sexual health as early as the stage of injury and treatment

Veterans may be concerned about sexual and reproductive health as early as the stage of injury, evacuation or stabilisation. In particular, we recorded interest among men in the presence and functioning of the genitalia. During treatment, veterans begin to adjust to their changed bodies and to understand their capabilities more broadly. Accordingly, the desire for sex emerges, at least in part, from the wish to make sure that sex is physically possible, rather than from a desire to experience pleasure.

2 The study identified changes in sexuality after treatment among veterans in terms of libido, bodily sensation, acceptance of their own bodies and sexual intercourse

After treatment, veterans with sensory changes in the body or in its particular parts may experience changes in sexuality at the physical, psychological and social levels. In particular, this is reflected in changes in libido, in the process of accepting their own bodies, and in adaptation to changes in sexual intercourse itself.

3 Acceptance of bodily changes following injury or trauma is a non-linear process for veterans

Although veterans may be aware of bodily changes immediately, acceptance of trauma or injury requires considerably more time, effort and support, and involves different levels of acceptance. Physical acceptance of one's body is achieved with the help of adaptive tools. At the psychological level, veterans may use different strategies of acceptance and seek support from professionals. The social aspect of accepting bodily changes develops directly through interaction with romantic partners.

4 Sensory changes in the body and its particular parts affect the physical, psychological and social aspects of sexuality

Sensory changes in the body may affect the importance of different sensory organs in the process of arousal and in sex itself. In addition, veterans may develop areas where touch becomes unpleasant and painful, or, conversely, pleasant. Because of the loss of sensory organs, veteran's fantasies and the psycho-emotional state may play a more important role in sex. In the social dimension of sexuality, sensory changes and the rethinking of sex and its role may affect relationships within a couple.

5 The impact of physical and psychological aspects of sensory changes in the body, together with the experience of trauma, may give rise to nostalgia for previous sexual life

The impact of sensory changes in the body, broader changes in sexuality, the state of libido and the ability to engage in particular sexual positions may lead veterans to feel nostalgic for their previous sexual life. This nostalgia may relate to the inability to have sex in a particular position because of physical limitations, the need to plan sex more carefully, and, accordingly, the loss of spontaneity and variety in sexual life.

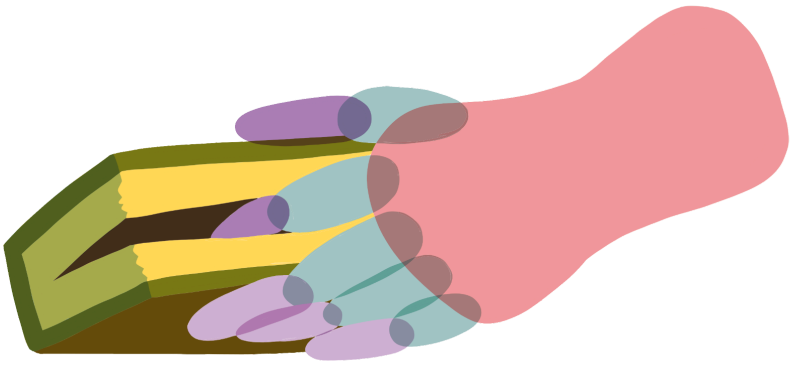
At the same time, changes in the ability to engage in previous sexual practices may also lead to experimentation and the search for something new in sex.

Recommendations

In the course of this study, we identified several challenges that veterans face in their sexual recovery following injury. In our view, addressing these challenges requires the involvement of professionals from different fields and at different levels of support. In this section, we offer recommendations aimed at improving the conditions for veterans' return to an active sexual life.

We first briefly outline the key challenges identified through the analysis of experiences shared by study participants, and then present possible solutions relevant to different professional fields and levels of responsibility. Even targeted changes — at the level of individual service providers or the media environment — can become meaningful support for those in need. At the same time, systemic solutions can influence rehabilitation policies, standards, and practices.

The recommendations are addressed to both professionals working directly with veterans and to the institutions shaping the environment for change, in particular service providers, media, the Ministry of Health of Ukraine, the Ministry of Defence of Ukraine, the Ministry of Veterans Affairs of Ukraine and other stakeholders involved in the field of sexual health and rehabilitation.



Identified challenge No. 1

Issues related to sexual health and rehabilitation are not discussed with veterans in treatment and rehabilitation facilities

Healthcare facilities where the participants in this study received treatment had no sexologists or other professionals with appropriate sexual health competencies. As a result, sexuality-related issues were not treated, on the one hand, as a specialised area of support and, on the other, were not integrated into the overall treatment and rehabilitation plan for veterans.

Formally, these functions were assigned to staff psychologists, yet veterans emphasised the low level of trust in such professionals, both in general and in the context of discussing intimacy and sexuality. At the same time, other medical staff acted within clearly defined professional responsibilities, focusing primarily on treating physical injuries or on rehabilitation.

The absence of specialised professionals indicates that issues related to sexual health, intimate relationships and changes associated with them following trauma or injury remain systemically overlooked by professionals and are not treated as a component of comprehensive rehabilitation. This, in turn, leads to veterans' needs remaining unmet or being left to their individual initiative.

Identified challenge No. 2

Sexual rehabilitation for warriors following trauma or injury is currently not available at the state level as a separate area of health care

Due to the absence of regulatory provision within Ukraine's healthcare system, the delivery of services in the field of sexual rehabilitation remains non-systematic and fragmented.

This creates gaps in the treatment and recovery of veterans with trauma or injury: relevant services are either not provided at all or, according to one of the study's experts, are delivered on the initiative and at the discretion of individual healthcare professionals, without defined standards or protocols.

Proposed solutions for service providers

1. At the stage of initial treatment, it is important that treating physicians themselves initiate a conversation about possible changes in sexual health as part of a standard consultation and create space for this conversation with veterans. As part of the initial consultation and ongoing medical support, it is important to provide veterans with basic information about possible changes in the functioning of genitalia, sexual life and reproductive health following trauma or injury, surgical interventions and the use of medication already at the treatment stage. This will help veterans develop realistic expectations regarding potential changes in their sexual life and health.

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2. At the rehabilitation stage, it is advisable for professionals involved in working with veterans to provide basic information about possible changes in sexual and reproductive health within their professional competence. Such information helps develop realistic expectations regarding changes in sexual health and prepare better for them.

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3. During physical rehabilitation, occupational therapists and rehabilitation professionals may provide information about functional changes in the body that may potentially affect veterans' intimacy and sexual activity.

4. It is important that occupational therapists and rehabilitation professionals increase their own awareness of the importance of sexual rehabilitation and the impact that the physical consequences of trauma and injury may have on a person's sexual capacities. Within physical rehabilitation, they may teach veterans safe ways of restoring intimacy with due regard to pain and limited mobility. In particular, they may provide information about adaptive sexual aids and the possibilities for their use.

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5. It is important that psychologists and psychotherapists who work with veterans after injury make clear that sexual life, sexual health and recovery can be discussed within therapeutic sessions. This may reduce stigma and embarrassment when voicing concerns related to the acceptance of one's own body, changes in one's sexuality or sexual life.

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6. Professionals who work with veterans at different stages of recovery should have an up-to-date list of narrowly specialised professionals in the field of sexual health and sexual rehabilitation to whom they can refer people. The existence and regular updating of such a list may make it easier for veterans to access specialised support when needed.

Proposed solutions for the media

1. When covering the experiences of veterans after injury or trauma, the media should also pay attention to sexual rehabilitation. Normalising changes that may occur in a person's body is an important part of self-acceptance and recovery of sexual life after injury.

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2. Since veterans do not always have access to information about narrowly specialised professionals in sexual rehabilitation during treatment and rehabilitation, it would be worthwhile to gather and cover information about the work of these professionals. This includes, inter alia, the specific nature of their work and their contact details. This could make it much easier for veterans to find relevant and necessary information when they wish to seek specialised support.

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3. It may also be useful to share information about adaptive sexual aids and tools that may be relevant for veterans with different types of injuries, trauma and impairment. Finding and discovering such aids may become an important step for them in returning to an active sexual life and familiar or new sexual positions.

Proposed solutions for the MoH/MoD/Ministry of Veterans Affairs of Ukraine regarding systemic changes in the field of sexual rehabilitation

1. Institutionalise the field of sexual health and sexual rehabilitation for service members within healthcare facilities, namely by:
   - introducing dedicated positions for sexual health professionals (sexologists, psychologists or other specially trained professionals);
   - engaging private professionals in sexuality and intimacy to work in healthcare facilities as external consultants;
   - integrating issues related to the functioning of genitalia, the impact of medication, and the restoration of sexual life following trauma or injury into the health treatment and rehabilitation plans for veterans;
   - improving the qualifications of existing medical staff in the field of sexual health and professional communication with patients on this topic.

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2. Support the further work of the working group established pursuant to the Order of the Ministry of Health of Ukraine No. 1546 of 9 October 2025[59] on drafting a law on the creation of a separate field of sexual rehabilitation.

[59] Ministry of Health of Ukraine. (2025) On Establishing a Working Group to Develop the Procedure for the Provision of Rehabilitation Care in Conditions Accompanied by Sexual Dysfunction (MoH Order No. 1546 of 9 October 2025). moz.gov.ua/uk/decrees/nakaz-moz-ukrayini-vid-09-10-2025-1546-pro-utvorennya-robochoyi-grupi-z-rozrobki-poryadku-nadannya-reabilitacijnoyi-dopomogi-pri-stanah-yaki-suprovodzhuyutsya-statevoyu-disfunkciyeyu

3. Ensure the formal incorporation of sexual rehabilitation into the general system of medical rehabilitation in Ukraine, including through the approval of standards, protocols, duties and professional competencies.

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4. Include urologists in the list of mandatory physicians involved in the medical examination of persons liable for military service and veterans prior to the MMC, and ensure the mandatory and systemic consideration of their findings when decisions are made regarding a person's degree of fitness for different types of military service.

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5. Develop clear protocols to examine and document the health status of the genitourinary system, in particular the male genitourinary system, including recommendations for examinations and treatment, so that all data are available during repeated MMC procedures.

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6. Develop a clear sexual rehabilitation pathway, including a list of relevant specialists.

04

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Annex

Information about the participants in the in-depth interviews

#	Type of injury	Age	Gender
1	Traumatic brain injury; burn injuries; upper limb injury; shrapnel wounds; facial injuries (maxillofacial area, soft tissue injury); injury to the organs of vision; acoustic barotrauma; injury to the hearing organs	26–35	male
2	Traumatic brain injury; injuries to the pelvis/genitalia; injuries to both lower limbs with loss of part of the muscle tissue; shrapnel wounds	26–35	male
3	Traumatic brain injury	26–35	male
4	Amputation of lower limbs	36–45	male
5	Traumatic brain injury; injuries to the organs of vision/hearing; blast injury; shrapnel wounds; facial injuries (soft tissue damage); inguinal hernia	26–35	male
6	Abdominal injury, damage to internal organs; removal of part of the intestine	26–35	male
7	Amputation of the lower limb	26–35	male
8	Traumatic brain injury; injuries to the organs of hearing; acoustic barotrauma	45–60	female
9	Amputation of the upper limb(s)	26–35	male
10	Spinal cord injury (paresis, paralysis, loss of sensation)	26–35	male
11	Amputation of the lower limb(s); acoustic barotrauma; injury to the hearing organs	26–35	male
12	Injury sustained in the course of military service: spinal injury	45–60	male
13	Amputation of the lower limb; abdominal injury, damage to internal organs; upper limb injury	36–45	male
14	Traumatic brain injury; amputation of both lower limbs; pelvic injuries; injuries to the organs of vision; haemothorax (lung injury); burn injuries; facial injuries (maxillofacial area); abdominal injury, damage to internal organs; spinal injury	26–35	male

#	Type of injury	Age	Gender
15	Traumatic brain injury; lower limb injury; minor shrapnel wounds; acoustic barotrauma	36–45	male
16	Spinal cord injury (paresis, paralysis, loss of sensation); haemothorax; upper limb injury	26–35	male
17	Traumatic brain injury, paralysis of the upper/lower limbs	26–35	male
18	Traumatic brain injury; multiple shrapnel wounds; burn injuries; injuries to the organs of hearing; lower limb injury; acoustic barotrauma; pelvic injuries	45–60	male
19	Traumatic brain injury; acoustic barotrauma; blast injury; lower limb injury	26–35	male
20	Traumatic brain injury; injuries to the organs of vision/hearing; blast injury; shrapnel wounds	26–35	female
21	Injuries to the organs of vision; injuries to the organs of hearing; multiple shrapnel wounds; blast injury; lower limb injury; amputation of both upper limbs	36–45	male
22	Injuries to the organs of vision; injuries to the organs of hearing; amputation of the upper limb/limbs; amputation of the lower limb/limbs; lower limb fracture	26–35	male
23	Closed traumatic brain injury; injuries to the organs of vision/hearing; burn injuries; multiple shrapnel wounds; injuries to the pelvis/genitalia	26–35	male
24	Upper limb injury	18–25	male
25	Injuries to the organs of hearing; shoulder joint injury	45–60	male
26	Traumatic brain injury, injuries to the organs of vision/hearing, blast injury; multiple shrapnel wounds	26–35	male
27	Acoustic barotrauma; PTSD	> 60	male