

QUALITY OF SEXUAL LIFE IN MEXICAN MEN AFTER SPINAL CORD INJURY

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Objective: To evaluate the quality of sexual life in men with spinal cord injury.

Design: Cross-sectional analytical study.

Patients: Males with a history of spinal cord injury who attended an outpatient rehabilitation service.

Methods: An analytical study examined adult male patients with complete spinal cord injury in rehabilitation. A modified Sexual Life Quality Questionnaire (SLQQ) examined quality of sexual life, with scores below 50 suggesting significant sexual dysfunction and dissatisfaction. The assessment evaluated age, occupation, marital status, comorbidities, and treatment methods.

Results: A total of 80 patients were included; 33 (41%) had a thoracic spinal cord injury, and 47 (59%) had a lumbar spinal cord injury. Thirty-seven patients (46%) were dissatisfied with the quality of their sexual life; 29 patients (88%) with thoracic spinal cord injury and 8 patients (17%) with lumbar spinal cord injury were dissatisfied with the quality of their sexual life ($p = 0.001$). Patients with higher education level experienced less sexual dissatisfaction ($p = 0.03$).

Conclusion: Human sexuality involves numerous interconnected elements that impact on general health. Sexual pleasure, self-esteem, and personal relationships are crucial for patients with spinal cord injury to identify rehabilitation needs. These results indicate the importance of supporting sexual well-being in recovery. Further studies of sexual enjoyment and quality of life for patients with spinal cord injury are needed, using larger and more diverse populations.

Key words: sexual dysfunction; spinal cord injury; psychosocial support; sexual health; neurological rehabilitation; self-esteem; masculinity; biopsychosocial sphere.

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LAY ABSTRACT

Spinal cord injury can adversely affect the quality of sexual life in men. However, support and early application of strategies for sex practices are often overlooked during spinal cord injury rehabilitation for men. The aim of this study was to gain insight into the factors associated with dissatisfaction and sexual quality of life in men with spinal cord injury. The study found that dissatisfaction depends on the anatomical region of the spinal injury and education level. Multidisciplinary teams that specialize in spinal cord injury can provide earlier strategies to help men adopt new methods to improve their sexual lives.

Spinal cord injury (SCI) is a pathological process with numerous possible aetiologies that affect the spinal cord and can alter motor, sensory, or autonomous function below the level of SCI lesion (1). SCI poses a significant threat to the quality of life of affected patients. The working population faces an increasing risk of occupational and vehicular accidents in our globalized world (2). Non-traumatic events, such as tumours, cancer, and infections, can also lead to spinal cord injuries (3). These injuries have long-term consequences, often lasting several decades. As a result, individuals with SCI experience significant changes in their lives, including work, personal relationships, family dynamics, and romantic partnerships (4).

Worldwide, SCI is a pathology that represents a challenge for healthcare workers because of its effects on various organs and systems and, therefore, the biopsychosocial sphere (5). However, one crucial aspect of a patient's quality of life, sexuality, is often overlooked and disregarded. Sexuality, is a vital and significant factor in patients' self-esteem and personal satisfaction. Sexuality is an integral part of adult life for all individuals and profoundly impacts their relationships with their partners. It can also contribute to, or exacerbate, personal issues that affect patients' self-esteem and perception of personal fulfilment (6).

Many men with SCI will experience erectile dysfunction, significantly affecting their quality of life (7). Men with SCI may view erectile dysfunction as a potential threat to their sense of masculinity and personal identity. Self-esteem and life satisfaction are crucial components of quality of life that are often overlooked but have significant impacts (8). A survey revealed that sexual function was the highest priority for improving quality of life among paraplegic patients with SCI (9). The permanent consequences of an injury of this nature require many adaptive changes in daily life, affecting self-esteem, interpersonal relationships, and quality of life (10). The function and quality of sexual life is an aspect that is often ignored or not addressed because of the patient's fears, lack of an optimal doctor–patient

relationship, or the doctor's unfamiliarity with the strategies needed (11).

Rehabilitation specialists promote health, prevent and diagnose diseases, and evaluate patients' conditions. The primary aim is to attain functional objectives, enhance ergonomics, facilitate occupational reintegration, and restore human sexuality (11). Human sexuality includes sex, gender, eroticism, emotional bonding, and love. Reproduction is influenced by multiple factors, such as biological, psychological, socioeconomic, cultural, ethical, and religious-spiritual aspects (12). Sexuality is a crucial element of human nature that should not be disregarded when evaluating an individual's well-being. Evaluating the sexual satisfaction, self-esteem, and personal relationships of

Table 1. Sexual Life Quality Questionnaire (SLQQ) (Spanish version translated to english; 15)

"The following questions ask you to compare your sexual life and lovemaking (both foreplay and intercourse) *during the past 8 weeks* to the period of time *after the development of impotence*. Please circle the number (–4 to +4) on each scale that the best reflects your rating."

1. How would you rate your satisfaction with the <i>frequency (how often)</i> of lovemaking during the past 8 weeks compared to the period of time prior to the development of impotence?											
-4	-3	-2	-1	0	+1	+2	+3	+4			
?				?				?			
Much more dissatisfied with frequency of foreplay/intercourse than before impotence				Same	Much more satisfied with frequency of foreplay/intercourse than before impotence						
2. How would you rate your satisfaction with the <i>duration (how long)</i> of lovemaking during the past 8 weeks compared with the period of time after the development of impotence?											
-4	-3	-2	-1	0	+1	+2	+3	+4			
?				?				?			
Much more dissatisfied with duration of foreplay/intercourse than before impotence				Same	Much more satisfied with duration of foreplay/intercourse than before impotence						
3. How would you rate the difficulty of <i>inserting the penis into the vagina</i> during the past 8 weeks compared with the period of time after the development of impotence?											
-4	-3	-2	-1	0	+1	+2	+3	+4			
?				?				?			
Much more difficult to insert the penis than before impotence				Same	Much easier to insert the penis than before impotence						
4. How would you rate the difficulty of <i>achieving orgasm (climax)</i> during the past 8 weeks compared with the period of time after the development of impotence?											
-4	-3	-2	-1	0	+1	+2	+3	+4			
?				?				?			
Much more difficult to achieve orgasm than before impotence				Same	Much easier to achieve orgasm than before impotence						
5. How would you rate your <i>anxiety about sexual performance</i> during the past 8 weeks compared with the period of time after the development of impotence?											
-4	-3	-2	-1	0	+1	+2	+3	+4			
?				?				?			
Much more anxious about performance than before impotence				Same	Much less anxious about performance than before impotence						
6. How would you rate your <i>anticipation of lovemaking</i> during the past 8 weeks compared with the period of time after the development of impotence?											
-4	-3	-2	-1	0	+1	+2	+3	+4			
?				?				?			
Anticipation of foreplay/intercourse not at all as pleasurable as than before impotence				Same	Anticipation of foreplay/intercourse much more pleasurable than before impotence						
7. How would you rate your <i>feelings during lovemaking</i> during the past 8 weeks compared with the period of time after the development of impotence?											
-4	-3	-2	-1	0	+1	+2	+3	+4			
?				?				?			
Much less carefree during foreplay/intercourse than before impotence				Same	Much more carefree during foreplay/intercourse than before impotence						
8. How would you rate the <i>orgasm (climax)</i> you experience during lovemaking during the past 8 weeks compared with the period of time after the development of impotence?											
-4	-3	-2	-1	0	+1	+2	+3	+4			
?				?				?			
Orgasm not at all as pleasurable as before impotence				Same	Orgasm much more pleasurable than before impotence						
9. How would you rate <i>your overall pleasure</i> from lovemaking during the past 8 weeks compared with the period of time after the development of impotence?											
-4	-3	-2	-1	0	+1	+2	+3	+4			
?				?				?			
Overall, foreplay/intercourse not nearly as pleasurable as before impotence				Same	Overall, foreplay/intercourse much more pleasurable than before impotence						
10. How would you rate <i>your partner's overall pleasure</i> from lovemaking during the past 8 weeks compared with the period of time after the development of impotence?											
-4	-3	-2	-1	0	+1	+2	+3	+4			
?				?				?			
Overall, foreplay/intercourse not nearly as pleasurable as before impotence				Same	Overall, foreplay/intercourse much more pleasurable than before impotence						

individuals with SCI is vital for identifying areas for rehabilitation interventions (12).

This study aims to evaluate the quality of sexual life among male patients with SCI who are undergoing treatment at the Department of Physical Rehabilitation of the Specialties Hospital, National Medical Center of the West, Mexican Institute of Social Security, Guadalajara, Jalisco, México. The decision to prioritize this particular population was based on the observation that male patients constitute the majority of individuals seeking treatment in our institutions. To assess the quality of their sexual lives, this study used the Sexual Life Quality Questionnaire (SLQQ). This questionnaire has been designed explicitly for the purpose of evaluating the sexual experiences of individuals who are affected by erectile dysfunction as a consequence of SCI (8-12). Furthermore, the objective of this study is to set out a thorough depiction of the sociodemographic and clinical attributes of the individuals comprising the study sample, focusing on men, since in this environment they are the most affected.

In addition, a scoping review published in 2022 indicated that recent research related to sexuality has tended to focus on the experiences of women with SCI (13).

MATERIALS AND METHODS

An analytical cross-sectional study was conducted on adult male patients diagnosed with complete SCI who were undergoing rehabilitation at Specialties Hospital of the National Medical Center of the West in Guadalajara, Jalisco, Mexico, from March 2021 to March 2022.

Male patients were invited to participate in the study and were provided an informed consent for participation, which detailed the study information. Eligible volunteers who returned the informed consent for participation then completed the SLQQ with a practitioner researcher during an external appointment at the Rehabilitation Medicine Department.

The inclusion criteria were: male patients older than 18 years of age; having a prior diagnosis of a complete SCI or grade A on the ASIA impairment scale for a minimum duration of 1 year. Exclusion criteria encompassed patients who underwent a period of spinal shock within the initial 6 months following the accident, individuals who were unable to complete the survey due to cognitive impairment, those who submitted incomplete or incorrectly completed surveys, and patients who were lost to follow-up.

Spanish-translated version of the Sexual Life Quality Questionnaire

In this study, a Spanish-translated version of the SLQQ, a reliable questionnaire commonly employed

in research on the efficacy of treatments for erectile dysfunction, was utilized (8). The authors made modifications to the wording of the questions in order to tailor them to the context of SCI, similar to previous studies conducted on this topic (9). The survey comprises a set of 10 questions designed in a Likert scale format to evaluate different aspects pertaining to the quality of sexual life among individuals with SCI. The evaluation of each item is conducted using a scoring range from -4, indicating complete disagreement, to +4, indicating complete agreement, with zero representing no change (Table I) (9).

The scores for the responses to the SLQQ were evaluated using a numerical scale ranging from 0 to 100, as indicated in Table II (10). The patients were stratified into 4 groups according to their sexual life quality scores. The participants were categorized into 2 cohorts for examination: individuals with scores ranging from 0 to 50 points, and those with scores ranging from 50 to 100 points. In contrast to a score exceeding 50 points, which indicates a satisfactory sexual life, a score equal to or less than 50 points indicates notable sexual dysfunction and dissatisfaction with the quality of one's sexual life. It is possible to make a comparison of the quality of life after the occurrence of a SCI, since the questionnaire assesses rehabilitation progress and treatment responses (10). Which was originally proposed and validated by Woodward et al. (17).

The study encompassed various additional variables, such as age, occupation, marital status, comorbid conditions, duration since injury, mechanism of injury, pre-existing history of erectile dysfunction, treatment approaches for post-injury erectile dysfunction, psychological interventions for erectile dysfunction (including pharmacological and interventional methods), completed family size, and post-spinal cord injury psychotherapy. These variables were considered alongside the assessment of quality of sexual life.

Statistical analysis

The data were stored in an Excel program. IBM SPSS Statistics for Windows (version 20; IBM Corp., Ar-

Table II. Description of scores in the Sexual Life Quality Questionnaire (SLQQ) on quality of sexual life (16)

Score	Description
0-25	I feel dissatisfied with my quality of sexual life, I do not have sexual contact with a partner, and when I try to masturbate, I rarely feel sexual pleasure.
26-50	I feel dissatisfied most of the time with my quality of sexual life, I have occasional sexual contact that involves sexual play, with occasional penetration, without completing the sexual intercourse.
51-75	I feel satisfied most of the time with my quality of sexual life, I have occasional sexual contact that involves sexual play, with penetration on most occasions, culminating in the sexual act on some occasions.
76-100	I feel satisfied with my quality of sexual life, I have satisfactory sexual contact, with penetration most of the time, with the culmination of the sexual act most of the time.

monk, NY, USA) was used for the statistical analysis. Qualitative variables are presented as raw numbers and percentages, and quantitative variables as means and standard deviations (SDs). Statistical inference tests were performed using the χ^2 or Fisher's exact test, and the likelihood ratios or odds ratios (ORs) with their 95% confidence intervals (95% CIs) were calculated. A value of $p < 0.05$ was significant. For the measurement of association and risk, 95% CIs above or below a value of 1 were considered to indicate consistency of the OR.

Ethical considerations

In accordance with Article 17 of the *General Health Law of the United Mexican States*, this study falls under category II of the investigation procedures, which indicates a "minimal risk" investigation because the clinical records were evaluated using a patient-completed survey. All participants consented to participation. Since the data are presented in aggregate form without personal information, there is no cause for concern regarding confidentiality. The protocol was approved by the Local Health Research and Ethics Committee (registration number 2021-1301-135) located at the Specialties Hospital, National Medical Center of the West, Guadalajara, Jalisco, Mexico.

RESULTS

A total of 80 patients who completed the SLQQ were included. Their mean (SD) age was 35.59 (9.73) years, and the age range was 20–60 years. The general characteristics of the patients, such as marital status, comorbid conditions, trauma mechanism, time since injury, sexual dysfunction before the trauma, treatment before and after the trauma, and satisfaction with paternity, are described in Table III.

The patients were classified according to the site of SCI: thoracic SCI in 29 patients (36%) and lumbar SCI in 51 patients (63%). The precise levels of trauma are reported in Table IV. In all patients, the injury caused a complete lesion of the intraspinal structures.

The study found no significant differences according to the level of SCI in the basal variables, education level, occupation, marital status, and others described in Table V. Six patients exhibited comorbid conditions such as diabetes mellitus with or without arterial hypertension. Sixty percent of the patients had fewer than 6 years since the injury. Pretrauma erectile dysfunction was reported by 11 patients (14%), and 48 received post-trauma treatment with phosphodiesterase 5 blockers and psychological support. Twenty-three patients reported incompleting family size.

A score of less than 50 points on the SLQQ indicates significant sexual dysfunction and dissatisfaction of

Table III. General characteristics of patients with spinal cord injury (SCI)

Characteristics	
Age, years, mean (SD)	35.59 (9.73)
Education level, <i>n</i> (%)	
Primary and middle school	33 (41.25)
High-school and college	47 (58.75)
Occupation, <i>n</i> (%)	
With remuneration	38 (47.5)
Without remuneration	42 (52.5)
Marital status, <i>n</i> (%)	
Single	15 (18.8)
Married	65 (81.2)
Comorbid conditions, <i>n</i> (%)	
Yes	6 (7.5)
No	72 (92.5)
Time since injury, <i>n</i> (%)	
< 72 months	48 (60)
> 72 months	32 (40)
Mechanism of injury, <i>n</i> (%)	
Home/work accident	51 (63.7)
Road accident	29 (36.3)
Erectile dysfunction before injury, <i>n</i> (%)	
Yes	11 (13.75)
No	69 (86.25)
Post-injury erectile dysfunction treatment, <i>n</i> (%)	
Yes	24 (13.75)
No	56 (86.25)
Psychotherapy after injury, <i>n</i> (%)	
Yes	20 (25.0)
No	60 (75.0)
Completed family size, <i>n</i> (%)	
Satisfied	57 (71.25)
Not satisfied	23 (28.75)

SD: standard deviation.

quality of sexual life. The mean (SD) score was 27.3 (18.8) in patients with thoracic SCI and 63.4 (15.5) in those with lumbar SCI ($p < 0.01$). Eighty-eight percent of patients with thoracic SCI ($n = 29$) and 17% ($n = 8$) of patients with lumbar SCI self-defined themselves as sexually dissatisfied ($p < 0.001$). The risk of developing sexual dissatisfaction was 8 times higher in patients with thoracic SCI than in those with lumbar SCI ($p < 0.001$, OR 8.4, 95% CI 3.2–21.7). Patients with a higher level of education (high school or university) reported less sexual dissatisfaction than those with a lower level of schooling ($p = 0.03$; OR 1.78, 95% CI 1.04–3.07). As shown in Table VI, other variables were not significantly associated with the risk of sexual dissatisfaction.

Table IV. Lesions by anatomical region

Level of injury		N (%)
T10 and lower	T4	4 (5)
	T5	4 (5)
	T6	4 (5)
	T7	4 (5)
	T8	2 (2.5)
	T9	6 (7.5)
	T10	5 (6.3)
	T11	2 (2.5)
	T12	2 (2.5)
T10 and below	L1	6 (7.5)
	L2	13 (16.3)
	L3	8 (10)
	L4	10 (12.5)
	L5	10 (12.5)

Table V. Univariate analysis between variables and the level of injury

Variables	Thoracic injury <i>n</i> = 33	Lumbar injury <i>n</i> = 47	<i>p</i> - value
Age, years, mean (SD)	35.0 (10.4)	36.0 (9.3)	0.62
Education level, <i>n</i>			
Elementary or middle school	13	20	0.79
High-school or university	20	27	
Occupation, <i>n</i>			
With salary	16	17	0.88
Without salary	17	25	
Marital status, <i>n</i>			
Single	5	10	0.70
Married	28	37	
Comorbidities, <i>n</i>			
Yes	1	5	0.39
No	32	42	
Time since injury, <i>n</i>			
< 72 months	20	28	0.93
> 72 months	13	19	
Mechanism of injury, <i>n</i>			
Home/work trauma	22	29	0.81
Road trauma	15	18	
Erectile dysfunction before injury, <i>n</i>			
Yes	5	6	0.75
No	28	41	
Dysfunction treatment after injury, <i>n</i>			
Yes	10	14	0.96
No	23	33	
Psychotherapy after injury, <i>n</i>			
Yes	7	13	0.60
No	26	34	
Completed family size, <i>n</i>			
Satisfied	23	34	0.81
Dissatisfied	10	13	

SD: standard deviation.

DISCUSSION

Many studies have shown that traumatic SCI disrupts motor, sensory, and autonomic pathways, resulting in sexual dysfunctions, such as decreased libido, erectile or ejaculatory dysfunction, semen abnormalities, and anorgasmia (18, 19), significantly diminishing men's general and sexual quality of life (20). A cross-sectional observational study in Germany revealed that the level and integrity of the lesion in patients with SCI are unrelated to their quality of life or sexual life (21). However, Guerrero et al.'s cross-sectional descriptive observational study in Cuba in 2019, found alterations in sexual function, including erectile, ejaculatory, and orgasmic dysfunctions, regardless of injury severity in male patients with SCI. The level and completeness of SCI are the major determinants of sexual functioning (22).

Research has provided evidence indicating that individuals with lesions in the lumbosacral region experience a decreased sexual quality of life, exemplified by a study conducted on patients diagnosed with SCI, which aimed to examine sexual satisfaction levels beyond 1 year post-diagnosis. According to the research findings, individuals with lower motor neurone lesions, who identify as male, exhibited diminished levels of sexual satisfaction (23). The review article

Table VI. Quality of sexual life satisfaction according to different variables

Variables	Satisfied <i>n</i> = 43	Dissatisfied <i>n</i> = 37	<i>p</i> - value	OR (95% CI)
Level of injury				
Thoracic spine	4	29	<0.001	8.4 (3.2–21.7)
Lumbar spine	39	8		
Marital status				
Single	9	6	0.60	1.06 (0.86–1.3)
Married	34	31		
Education level				
Primary or secondary school	13	20	0.03	1.78 (1.04–3.07)
High-school or university	30	17		
Occupation				
With salary	25	17	0.27	1.3 (0.81–2.1)
Without salary	18	20		
Comorbidities				
Yes	4	2	0.68	1.04 (0.92–1.18)
No	39	35		
Time since injury				
<72 months	24	24	0.41	1.16 (0.81–1.66)
>72 months	19	13		
Mechanism of injury				
Home/work trauma	26	25	0.51	1.12 (0.80–1.55)
Road trauma	17	12		
Erectile dysfunction before injury				
Yes	5	6	0.74	1.40 (0.46–4.20)
No	38	31		
Erectile dysfunction treatment after injury				
Yes	12	12	0.66	1.16 (0.59–2.27)
No	31	25		
Psychotherapy after injury				
Yes	12	8	0.51	1.08 (0.84–1.4)
No	31	29		
Family size				
Complete	29	14	0.41	1.12 (0.85–1.48)
Incomplete	28	9		

by Hou et al. (24) mentioned the correlation between thoracic lesions and enhanced erectile potential after reflexological and ejaculatory stimulation. Patients experience persistent genital arousal due to the activation of parasympathetic preganglionic neurons located in the sacral segments, which play a role in facilitating erection (25). In addition, a separate study in Canada in 2017 yielded comparable results, suggesting that individuals with a complete lower motor neurone injury specifically impacting the sacral cord exhibited a notably diminished probability of experiencing orgasm compared with individuals with varying levels and grades of SCI. However, it is crucial to acknowledge that individuals with sacral cord injury can undergo orgasmic experiences by encouraging them to explore non-genital sexual options (26).

A cross-sectional study conducted in 2015 in Jamaica, which involved males with traumatic SCI, assessed overall sexual satisfaction using The International Index of Erectile Function (IIEF) Index Score. The results revealed that a considerable percentage of patients (62.8%) had a severe diagnosis of ED. Furthermore, it was observed that the thoracic region was the most affected area among the patients (16). Krassioukov et al. (26) performed a study in Canada, which found that

individuals with thoracic lesions above the T10 level did not preserve psychogenic arousal. This lack of preservation is due to the interruption of neural pathways connecting the brain to the T10–L2 spinal segment, which is crucial in facilitating psychogenic arousal. In their 2012 study in the USA, Hess et al. (27) observed that males with a thoracic SCI exhibited psychogenic erectile dysfunction. The current study revealed that individuals with thoracic SCI exhibited a significantly higher dissatisfaction with their sexual quality of life (88%, $n=29$ out of 33) than individuals with lumbar SCI, where only 17% reported dissatisfaction.

The results of the current study indicate a notable correlation between lower levels of education and increased levels of sexual dissatisfaction ($p=0.03$). This finding aligns with an earlier study carried out by Choi et al. (28) in South Korea in 2015, a cross-sectional study that discovered a significant association between lower levels of education and sexual dissatisfaction among individuals with SCI. The limited knowledge, challenges in communication, cultural norms, and constrained availability of resources and services may impact the correlation between lower education levels and sexual dissatisfaction (29). These findings may reflect the observation that a higher education level can act as a protective factor against sexual dysfunction because people with a high education level may adhere more to medical treatment (29). In contrast, the quantitative study conducted by Hidalgo et al. (30) revealed no significant correlation between education level and sexual function or satisfaction among men in a broader context. Another cross-sectional study involving the Hispanic population in 2006 yielded similar findings, indicating that a higher level of education did not demonstrate a significant correlation with increased sexual satisfaction among men without SCI (30).

Empirical studies have examined the complex connection between sexual satisfaction, marital quality, and marital instability. Previous research consistently shows a significant link between increased sexual satisfaction and decreased marital instability (32, 33). Therefore, this research indicates that one should be aware of all the effects sexual dysfunction can have, such as on one's relationships. Sexual satisfaction is crucial for relationship dynamics, as it contributes significantly to developing intimacy, trust, and emotional connection between partners (33, 34). A fulfilling sexual life can improve both sexes' well-being, self-esteem, and relationship satisfaction (35). Effective communication and mutual satisfaction in the intimate dimension of a relationship can enhance the strength and longevity of the bond between partners. The high prevalence of erectile dysfunction has significant implications for the sexual quality of life of both males and females (36). This condition significantly impacts their psychologi-

cal well-being and emotional state (37, 38). Research consistently demonstrates that erectile dysfunction can result in reduced self-esteem among males, as it may make individuals feel inadequate or less masculine due to their sexual performance difficulties (39). The decline in self-esteem can have broad implications, impacting personal relationships, marriage, and mental well-being (40).

In conclusion, the field of human sexuality encompasses various interconnected elements that play a vital role in an individual's holistic well-being. Addressing sexual satisfaction, self-esteem, and personal relationships is paramount, particularly among individuals with SCI, to identify areas requiring attention and intervention during rehabilitation. This study shed light on the significant disparity in sexual dissatisfaction between individuals with thoracic and lumbar SCI, with patients with thoracic SCI reporting notably higher levels of dissatisfaction. Moreover, this study found a compelling correlation between lower education levels and increased sexual dissatisfaction among patients with SCI, emphasizing the need to prioritize sexual well-being in rehabilitation. While this research adds valuable insights, we recognize the limitations stemming from the sample size, lack of partner assessments, and pre-SCI dissatisfaction data. To advance knowledge in this area, future studies should consider larger and more diverse sample sizes, facilitating a more comprehensive understanding of sexual satisfaction and quality of life for individuals living with SCI.

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