

Men's Experiences with Sexual Dysfunction Following Traumatic Pelvic Fracture: A

Qualitative Study

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Abstract

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Introduction: Sexual dysfunction in men following traumatic pelvic fracture is common. However, little is known of how men experience changes in their sexual health after injury and how they interact with the healthcare system to address these issues.

Aim: To explore in-depth the personal and interpersonal impacts of sexual dysfunction in men after pelvic injury, and to understand how interactions with the healthcare system can be optimized to improve patient-centered survivorship care.

Methods: Fifteen semi-structured interviews were conducted with men who had a history of traumatic pelvic fracture and self-reported sexual dysfunction. Interviews were audio recorded, transcribed, and uploaded to a web-based qualitative analysis platform. A

codebook was developed and intercoder reliability verified. Inductive thematic analysis was performed to identify notable themes related to patient post-injury sexual health experiences.

Outcomes: Identification of themes related to the impact of post-injury sexual dysfunction and the provision of care.

Results: Median age of interviewees was 46 years (IQR 44, 54), with a median time since injury of 41 months (IQR 22, 55). Five primary themes were identified from the analysis: effects on self-image and romantic relationships; unknown care pathways and lack of communication; inconsistencies with healthcare provider priorities; provision of sexual health information and resources; and the importance of setting expectations. Men struggled with the impact that new sexual dysfunction had on both them individually and on their relationships. They reported a decreased sense of confidence and virility. Men felt alone and uninformed, and that there were no available outlets to seek information or treatment. Furthermore, they often felt that sexual health concerns were delegitimized by providers. Interviewees suggested that improved communication, provision of information related to possible side-effects of their injuries, and expectation setting would improve experiences.

Clinical Implications: Sexual dysfunction after traumatic pelvic fractures can have significant effects on both individuals and their relationships, but these effects can be modified by improvements in communication and resource provision after injury.

Strengths & Limitations: Strengths include a rigorous qualitative methodology that provided in-depth descriptions of personal experiences and healthcare interactions. Limitations include single-center experience and limited heterogeneity in terms of race and sexual orientation.

Conclusion: Men's experiences with sexual dysfunction after pelvic trauma can be heavily influenced by their interactions with healthcare providers and the value that is placed on sexual health as a component of survivorship. Incorporating these findings into a patient-centered trauma survivorship program may improve patient experiences.

Introduction:

The association between traumatic pelvic fractures and sexual dysfunction (SD) in men is well-established, with prior studies estimating the prevalence of SD between 14% to 72% of injured men.¹⁻⁶ However, how these men navigate and cope with changes in their sexual function after injury remains unclear.² A number of previous studies have used qualitative methodologies to explore how men experience SD associated with various other medical ailments, such as colorectal cancer, stroke, and prostate cancer given the relatively high rates of sexual health impairment attributed to those conditions.⁷⁻¹¹ However, to date no studies have explored in-depth men's experiences with SD after pelvic fracture. Furthermore, outcomes related to sexual health impairment are especially important in this population as the majority of traumatic pelvic fractures occur in young men who are otherwise healthy and have excellent long-term survival prognoses.^{2,12,13} As such, this population is especially susceptible to the psychological, social and emotional impacts of an abrupt change in sexual health and potentially could be those who most benefit from interventions to improve their sexual health-related quality of life.

In order to develop appropriate survivorship and post-injury care pathways for men after pelvic trauma, it is imperative to understand how they experience the changes in their sexual health and functioning after injury, what sort of value they put on sexual health, and how they feel healthcare providers can most optimally provide care. With this framework in mind, this study was designed to explore in-depth the personal and interpersonal impacts of SD in men after pelvic injury. Furthermore, we sought to better

understand patient interactions with the healthcare system in this setting in order to inform future patient-centered survivorship care.

Methods:

Participants and Sampling

This study reports results from the qualitative interviews completed as part of a larger study examining barriers to care of sexual health problems following traumatic pelvic fracture in men. Details of the sample were described previously.² Briefly, a retrospective cross-sectional survey addressing sexual health after pelvic trauma was administered and respondents were given the opportunity to volunteer to participate in an in-depth telephone interview to discuss their experiences related to sexual health after injury. Of the 28 survey respondents who volunteered, 15 men reported post-injury SD and they were purposively selected for interviews.⁸ Sexual dysfunction was defined as any patient-perceived difficulty with erection, orgasm, ejaculation, sexual desire, sexual enjoyment, genital pain, or genital numbness.² These men had variable ages, relationship statuses, educational backgrounds, locations of residence, injury patterns, and comorbidities, which provided a diversity of experiences and insight. Severity of injury was quantified and expressed using the Injury Severity Score (ISS), a comprehensive injury grading system that allows comparison of multiply-injured patients with varying injury patterns.¹⁴ Pre-injury sexual function was based on subject recall and quantified using the International Index of Erectile Function (IIEF).¹⁵ Post-injury sexual function was

similarly assessed. Participants were provided with a \$25 gift card for completion of the telephone interview.

Interview Process

A semi-structured interview guide was designed to assess the sexual health experience in this group (Table 1). Specifically, the aim was to explore the impact of SD on the individual's recuperation both personally and interpersonally, as well as to determine how care and management of sexual health was experienced following injury. The interview guide was jointly designed through multiple iterations by a fellowship-trained urologist with expertise in genitourinary trauma and men's sexual health (NVJ) and an experienced qualitative researcher (MM).

Interviews began with general questions about how the subject had been feeling since injury, what types of new struggles he has had to face both physically and emotionally, and how the injury overall has impacted his life. After this, participants were asked specifically about how the injury has affected his sex life, his relationships, and his perceptions of himself. Probes explored coping and management strategies related to new sexual health issues and the role that healthcare providers had played in addressing, managing and helping post-injury sexual health. Subjects were asked about barriers to discussing or obtaining care for sexual health concerns after injury. Furthermore, they were asked how these barriers both affected their experience and how they could be modified to improve the experiences of others in the future.

All interviews were conducted between April 26, 2019 and May 15, 2019 via telephone by a single male interviewer (NVJ). The interviews generally lasted 25 to 30 minutes depending on subject narrative, with a range of 14 to 31 minutes. When no new concepts or themes were observed, the team agreed thematic saturation was achieved and no more interviews were conducted.¹⁶ No study team member had a prior or ongoing clinical relationship with any subject who participated in the study. Each interview was recorded on a digital recording device and then transcribed verbatim by professional transcriptionists. These interview transcripts were then uploaded to Dedoose® Version 7.0.23, a web-based application for managing, coding and analyzing qualitative and mixed-methods data (SocioCultural Research Consultants LLC, Los Angeles, CA).

Data Analysis

An inductive, thematic analysis approach was undertaken to identify notable themes related to patient post-injury experiences as related to sexual health. All transcripts were read multiple times by three authors (NVJ, EC and TJ) to identify key meanings and interpretations of the data. NVJ, as previously discussed, is a fellowship-trained urologist with specialization in genitourinary trauma and men's health. EC and TJ are both experienced qualitative researchers with backgrounds in social work. These three authors met regularly to review developed codes, to critically evaluate suitability of application of these codes, and to reconcile discrepancies. Initially, each author open-coded the same three transcripts before meeting together to review similarities and discrepancies in

themes, chosen codes, and applications of these codes. An initial codebook was created based on these selected transcripts. This codebook included definitions of each category, guidelines of code applications, and excerpts of the data exemplifying each code. The unified codebook was then applied subsequently to an additional three transcripts. Codes were again updated and edited based on consensus among the three coders. Ultimately, an agreed upon final codebook was created to capture the primary thematic elements of the data after multiple iterations.

A collection of excerpts chosen to best exemplify the chosen codes was then selected by the first author (NVJ) and coded using the final codebook. This excerpt group was used as a testing set to verify inter-rater reliability among the three coders using the built-in Cohen's kappa statistic testing program within Dedoose®. This test showed good to very good agreement for all major codes (kappa = 0.71 – 0.95). Two authors (EC and TJ) subsequently applied the finalized codebook to all 15 transcripts, with each coder coding half of the transcripts. The third coder (NVJ) then reviewed all 15 transcripts and code-applications to ensure consistency and accuracy of the chosen codes and classification schemes. Discrepancies were resolved via open dialogue and consensus. Reporting of the data followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines for reporting qualitative research.¹⁷

Results:

Sociodemographic factors and post-injury sexual function are shown in Table 2. All

patients sustained traumatic pelvic fractures and developed new post-injury SD following these injuries. Median time from injury to survey response was 41 months (IQR 22, 55 months), with all patients having at least 14 months from injury to time of survey. Two participants reported resolution of SD without treatment, two were currently receiving treatment at the time of the interview, while the remainder (11) continued to have sexual health concerns that had yet to be addressed. The most common types of SD experienced by this group of respondents was erectile dysfunction (13/15, 87%), difficulty with orgasm and ejaculation (12/15, 80%), low sexual desire (10/15, 67%), genital pain (5/15, 33%), and genital numbness (5/15, 33%).

A number of similar experiences, beliefs and opinions were expressed that described the common experience of these men in navigating the post-injury period as it related to sexual health. Five primary themes emerged from the analysis: effects on self-image and romantic relationships; unknown care pathways and lack of communication; inconsistencies with healthcare provider priorities; provision of sexual health information and resources; and the importance of setting expectations.

Effects on self-image and romantic relationships

Men with SD after pelvic trauma struggled with the impact that their new sexual health difficulties had on how they viewed themselves and how they interacted with those with whom they had romantic relationships. They described feelings of embarrassment, anxiety, shame and depression as a result of SD. Furthermore, there was a feeling of

hopelessness as sexual health issues persisted despite recovery from their other injuries.

“I’m not the same, you know, big man, that I used to be.”

“I need to depreciate my image.”

“You know, males usually define themselves by how virile they are.”

This alteration in their sense of manhood had further deleterious effects on their relationships. Diminishing self-confidence was found to lead to more pronounced feelings of discouragement, inadequacy, and hesitancy to be intimate with sexual partners. Fear of pain with intercourse, as well as fear of being unable to perform sexually, drove men to avoid intimacy with their partners all together. Furthermore, many avoided having discussions about these issues with their partners due to embarrassment, feeling “silly”, or harboring feelings of “defeat.” While some acknowledged that their shame and sense of inadequacy was self-imposed, others felt that their partners made them feel this way. Many men stated their partners no longer viewed them as capable of intimacy or of the ability to express desire or affection, with partners wondering “what’s wrong with him,” which further fostered the growth of shame and self-doubt.

“Because there’s no physical attention. I don’t give her any anymore because I can’t do anything about it. Like, you know, why bother starting it if I can’t finish it?”

“She finally just reached her limit, you know, where she’s, you know, just doesn’t think I care about her anymore.”

But not all men had significantly negative relationship changes from their injury and resultant SD. Men in longstanding relationships tended to have these negative impacts muted, which appeared to positively impact self-image and confidence.

“Since I’m with somebody who loves me and doesn’t care about, you know, that part of it, it makes me feel better about things.”

“It wasn’t about performance. It was about connection.”

“It wasn’t a big deal because I’ve been married so long and married people just don’t have as much sex as they did when they were younger.”

Unknown care pathways and lack of communication

As men began to recover from their bony pelvic injuries, they soon realized that they had sexual health issues that had not been addressed in their healthcare interactions and that they did not know where to turn for care. Men reported that despite being acutely treated by numerous different healthcare professionals, no one specifically addressed sexual health and no guidance on how to obtain care for sexual health issues was provided.

“I had all these different doctors and no one that I could talk to, you know what I mean?”

“I feel like I wasn’t answering the questions right in order to get more help.”

“I mean, to me, it’s I felt like I needed to talk to somebody about it and really try

to work through it, but there's – I mean that's a sensitive subject, right? So I really feel like I should have been helped towards some counseling, if you, you know, and so that was never, never mentioned once by anybody.”

Men felt that there was a significant lack of communication not just in the responsibility to care for sexual health issues, but of these issues themselves. Men reported that discussions of sexual health “just didn't come up” and that providers did not suggest that having SD may be a part of the post-injury recovery period. This lack of communication and unknown care pathway led to significant anxiety and a perception of loneliness among men experiencing SD, with one man stating, “it would have been good to know that I could, you know, ask somebody.” And for those who did broach the subject, the answers they received did nothing to calm their anxiety and concerns.

“I realized I had been asking the right questions. It just didn't seem like there was right answers.”

“I asked him hey, this is what's happening, you know, is it permanent? And of course, you know, he couldn't tell me.”

“Nobody ever had any solution or suggestion.”

Others acknowledged that the follow-up care for their sexual health likely falls in the realm of their primary care doctors. However, they felt that these physicians were likely not well suited to address this either, and that this perception often prevented them from discussing their sexual health with these providers as well.

“It didn’t even occur to me to ask him because it’s like he would say, go talk to your surgeon or something like that.”

“Seeing my primary care doctor once a year doesn’t really handle it, you know.”

Inconsistent healthcare provider priorities

For men who did bring up their concerns about their SD with providers after injury, they reported significant difficulty in obtaining any appropriate information or guidance. Men felt healthcare provider priorities were not necessarily in line with their own quality of life goals and priorities regarding their survivorship care. Men felt that providers were only concerned about the more immediate issues related to their physical injuries and not those of their long-term health. Discrediting of their sexual health concerns further emphasized feelings of hopelessness and discouragement.

“So the surgeon looked at my ankle, said looks good. The incision was good and looked at all the other incisions and said all right, you look great, and then I brought it up. I said, you know, I can’t get an erection and he goes, do you know that’s the number one... and then he just, he just fired off, you know, that’s the number one concern most men have when they have pelvic trauma. He goes, I mean geeze, all these other things just happened to you, like let’s just, like why do people worry about that.”

“When I mentioned that, she goes that’s interesting... you know most men are

like focused on loss of their sexual ability when they have this massive injury that they should really be worried about. And I was like hey, come on, don't tell me what I should worry about."

Many felt that their physicians simply did not want to address their sexual health.

Although concerns were raised, men felt these were passed over and ignored. As a result, men reported feeling that their concerns were delegitimized, inconsequential, or an unmodifiable part of how their lives would be moving forward.

"I told everyone about it, you know, when they asked how are you doing with your thing. Oh, this is still a problem? And then they just wrote it in their chart and we moved on... they didn't do anything with that information."

"They're more concerned about well, do you walk with a limp now, or you know, the physical, not the mental or sexual things."

Provision of sexual health information and resources

Men stated that the information and resources that they received around the time of the injury about their sexual health and risks of SD were tremendously lacking. They felt that not understanding that their injuries could result in sexual health issues made them less likely to discuss these topics with healthcare providers and further drove them into isolation on the topic. Two men, in particular, stated that despite the fact that they had been dealing with SD for years since their injuries, the first time they had even associated

the injury with their SD came when they received the initial survey for this study in their email.

“What the survey did was more about patient information than I’ve gotten at all.”

“That [the survey] was all I was looking for in the beginning.”

Men longed for information just to put their experiences in context and to know if trouble with sexual health after pelvic injuries was common. Men reported significant distress, feelings of isolation, and defeat as they dealt with their new SD as they felt that their experiences were unique and unsolvable. They craved any sort of information that would have helped them understand that what they were experiencing was not uncommon after their injuries and that there are options for treatment. Furthermore, they felt that this type of information provision should be standard at the time of discharge from their acute hospitalization, similar to information provided about physical therapy and mental health.

“When I was discharged, they gave me information on depression, you know, like meetings and other people I should talk to, and they gave me other information for mental health and that kind of thing. But, again, nothing as far as [sexual health]. I think it’s germane to the injury you know, put it for everybody.... I think they should automatically throw them in.”

“Any kind of information, I think, would have been acceptable.”

“Maybe if I got something after surgery that said, you know, this is, this might be something normal that happens and, you know, we recommend maybe seeking

treatment somehow from the urologist or something because they have ways to fix things like that. I just don't know enough of it.”

Importance of setting expectations

Coupled with the lack of information that men received about their condition was a lack of counseling regarding expectations of recovery of sexual function. Men struggled with balancing the hope of functional recovery and the acceptance that this may be a permanent state. This uncertainty resulted in men often attributing their sexual health difficulties to a multitude of non-injury related factors despite otherwise good health and excellent pre-injury sexual function. But a lack of expectation setting and counseling that these injuries are often related to SD left some men paralyzed from action and avoidant of addressing the issue with healthcare providers.

“I was just like well, this sucks. I'm really kind of hoping it would come back and I wouldn't have to deal with it, which is kind of sad.”

“If [patients] had just some, you know, expectations where they might be, then maybe if it wasn't progressing to that point, maybe then they would feel more comfortable about asking questions.”

The concept of having a timeline was repeatedly raised, such that men could have a standard with which to compare their progress or lack of progress in terms of sexual function recovery. They felt having some understanding of “normal” would ease anxieties, open them up to raising the topic with providers, and help them understand

what the possible outcomes were. Primarily, again, men wanted to understand why they were having problems, that they were not alone in these problems, and that there were people who could help them should they not progress to where they wanted to be.

“For them to be like okay, let’s say that you have an 80% chance of regaining 100% of your sexual ability. That is enough numbers for me to give me a little reassurance in myself, which is only going to help my mental, you know what I mean?”

“Like I would have appreciated just even, even just like a general idea of what to expect maybe, you know, would have been like a lot of relief in my mind and shit.”

“You’re not being weird. You’re you know, we see that it happens to a lot of people who have had this kind of trauma, and therefore, don’t be too worried about it. You know, here’s the kinds of things that can maybe mitigate some of the affects, you know. I think that kind of conversation is helpful.”

Discussion:

Given the paucity of research on survivorship care following traumatic pelvic fractures, the purpose of this exploratory qualitative study was to better understand and describe the experience that men who develop SD after pelvic fracture have in navigating the healthcare system, and to identify potential leverage points in this experience to create novel post-injury care pathways to improve the quality of care provided to this patient

population. Taken together, the results of the present study highlight the value that men place on sexual function in determining health-related quality of life and that the long-term impact of pelvic trauma extends well beyond the orthopedic recovery. Furthermore, this study illuminates consistent deficiencies in addressing sexual health as part of routine initial and follow-up care.

A predominant theme from the present study is that men with SD have a number of unmet needs as it relates to sexual health in the post-injury period. These unmet needs include the desire for information and resources related to the impact of their injuries on sexual function, the setting of appropriate expectations regarding timelines for potential sexual recovery, and guidance as to when to seek treatment and with whom. This concept of unmet sexual health needs has been extensively addressed for many medical conditions including prostate cancer and stroke, but has not previously been evaluated in pelvic trauma patients.^{9,18-20} What these prior studies have shown, however, is that many of these unmet needs stem from the lack of clearly defined care pathways that incorporate sexual health evaluation and that a failure to address unvoiced sexual health agendas often leads to significant patient dissatisfaction.²¹

One notable area of unmet needs is that due to insufficient or inaccurate expectations as it relates to sexual health. Unlike planned procedures for the treatment of conditions such as prostate cancer and colorectal cancer, traumas are by definition unplanned. Patients preparing for prostatectomy have the opportunity to extensively explore the potential adverse side-effects of treatment and to make treatment decisions based on informed

expectations. Pelvic trauma patients, however, experience a sudden, unintended injury and are then left to deal with the unexpected. As a result, men lack prior knowledge and, without suitable guidance from healthcare providers after injury, have no means by which to establish appropriate expectations. Failure of the health team to communicate about these potential adverse effects after injury then often leaves patients ignorant of how to view SD in light of their injuries and how to manage it.

The lack of expectation setting is compounded by the rarity with which sexual health is discussed following injury. In a prior study, we found that only 20% of men after pelvic trauma recalled having discussions about sexual health with providers and that of these conversations, 71% were patient-initiated.² The present study goes further to illuminate the reasons that men are often unlikely to discuss their sexual health. Feelings of shame and embarrassment, that their concerns were illegitimate, and that there was no possible avenue for treatment often drove them to avoid seeking care. There is also widespread evidence that men as a whole utilize health services less frequently than women and are, furthermore, less likely to discuss topics that can be considered to be associated with weakness or vulnerability.^{22,23} As such, it becomes the responsibility of the healthcare system to seek out these issues in a systematic manner to provide guidance and reasonable expectations for these patients.

While there are inherent difficulties in establishing a dedicated pelvic trauma survivorship program, there is ample opportunity to make systematic changes to the care of these patients after their injuries. The present study showed that, more than anything,

patients crave information about potential sexual health impacts of injury and resources to help them navigate the healthcare system to address their concerns. Inclusion of information about the potential for SD after injury into the discharge paperwork after injury was suggested by a number of participants as a simple way to raise awareness and to show them that they are not alone. Prior work in trauma populations has shown that for this to be effective, patients often need targeted and iterative communication strategies at the time of discharge that include patient-centered care summaries.²⁴⁻²⁶ Incorporation of the IIEF questionnaire into routine follow-up care would similarly help to identify patients at risk for SD and also provide an avenue to stimulate conversation around sexual health. Previous work in prostate cancer has shown the importance of healthcare providers in framing and normalizing help-seeking behaviors for sexual health, so incorporating this into routine care may help address this barrier.²⁷ Lastly, establishing close working relationships between men's health provider teams and the orthopedic trauma teams has the potential to stimulate innovative and collaborative efforts to improve the survivorship care of these patients.

There are a number of limitations to this study. As is common in qualitative studies, our sample is not intended to be representative of all subjects, but rather to be an in-depth descriptive analysis that provides a deeper understanding of the phenomenon of interest. The timing of our interviews in relation to injury likely influenced subject responses. It is possible that interests and needs change over time after injury and that what subjects report to be important at the present may have been less so in the past. The cohort for this study included only those with SD after injury and, while their experiences are

undoubtedly different than those without SD, the value of sexual health education and resources for them is likely different from those without SD. Similarly, men with SD who did not volunteer to participate in the in-depth interviews may have had different experiences than those who did. All included subjects were from a single institution, so those managed at other facilities may have had different experiences with addressing sexual health. While there was heterogeneity for our sample in terms of age, relationship status, education and urban/rural residency, there was significant homogeneity in terms of race and sexual orientation. Thus, the experiences of individuals with differing racial and sexual orientation demographics may differ. Lastly, the experiences of women were not addressed and deserve future in-depth evaluation.

Conclusions:

Sexual dysfunction following traumatic pelvic fracture is common and can have a significant impact on afflicted men, who are often young and otherwise healthy. Men's experiences with changes in sexual function after injury can be heavily influenced by their interactions with the healthcare team. Both patients and providers are reluctant to discuss sexual health issues after major trauma, despite the significant impact that this can have on overall recovery. Improvements in the provision of sexual health resources and the setting of realistic expectations for functional recovery are vital components of a needed patient-centered trauma survivorship program.

Table 1. Semi-structured interview guide

Warm-up questions	<ul style="list-style-type: none">▪ Tell me about how you have been feeling since your injury.▪ What sort of new issues have you had to face?
Impact of injury on everyday life	<ul style="list-style-type: none">▪ What impact has your injury had on your day-to-day life?▪ How has this impacted you personally?
Impact of injury on sexual life	<ul style="list-style-type: none">▪ How has your injury affected your sexual life?▪ How has it impacted your relationships?▪ How has it affected how you feel about yourself?▪ How have you coped with these new issues?
Experiences and satisfaction with management of sexual health issues	<ul style="list-style-type: none">▪ Have you discussed your sexual health with anyone, healthcare providers in particular, since your injury?▪ If so, how helpful have these discussions been for you?▪ If not, what information would have been helpful to you?▪ How do you think information about sexual health after injury should be provided?▪ What were barriers to you addressing your sexual health after injury with healthcare providers?
Final comments	<ul style="list-style-type: none">▪ What do you feel would be important for individuals with pelvic injuries to know about sexual health?▪ Do you have any final comments for healthcare providers seeing patients like you?

Table 2. Sociodemographic and sexual function of interview participants (n = 15)

Age at survey, y (median, IQR)		46 (44, 54)
Race (n, %)		
	White	14 (93)
	Asian	1 (7)
Time since injury, mo (median, IQR)		41 (22, 55)
ISS (median, IQR)		29 (17, 34)
Primary insurance (n, %)		
	Commercial	10 (67)
	Medicare	1 (7)
	Medicaid	4 (26)
LGBTQ (n, %)		1 (7)
Relationship Status (n, %)		
	Married/Partnership	9 (60)
	Single	6 (40)
Rural/Urban (n, %)		
	Rural	8 (53)
	Urban	7 (47)
Educational Attainment (n, %)		
	High School	2 (13)
	Some College	4 (27)
	Four Year College	6 (40)
	Master/Higher	2 (13)
	Other	1 (7)
Subjective Pre-Injury Sexual Dysfunction (n, %)		0
	Pre-Injury IIEF (median, IQR)	67 (65, 72)
Subjective Post-Injury Sexual Dysfunction (n, %)		15 (100)
	Post-Injury IIEF (median, IQR)	41 (31, 59)

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