2026 Volume: 02 Issue: 03 www.ijrpa.com ISSN 2456-9995 Research Article

International Journal Research Publication Analysis

Page: 01-28

EXPLORING THE PSYCHOLOGICAL IMPACT OF ERECTILE DYSFUNCTION ON GHANAIAN MEN'S SELF-ESTEEM

***Jemima N. A. A. Lomotey**

Grace International Bible University.

Article Received: 5 February 2026
Article Revised: 25 February 2026
Published on: 18 March 2026

***Corresponding Author: Jemima N. A. A. Lomotey**
Grace International Bible University.

DOI: https://doi-doi.org/101555/ijrpa.4670

ABSTRACT

Erectile dysfunction (ED) represents a significant health concern affecting millions of men worldwide, with consequences that extend far beyond the physical to encompass profound psychological effects. Among the most significant of these psychological effects is the impact on self-esteem, the evaluative component of self-concept that reflects an individual's sense of worth and adequacy. In Ghanaian society, where masculine identity is closely tied to sexual performance and the ability to satisfy partners, the experience of ED may carry particularly severe consequences for men's self-esteem. Yet despite the prevalence of ED and the cultural importance of masculinity in Ghana, there has been no systematic research examining how ED affects men's psychological well-being in this context. This study explores the psychological impact of erectile dysfunction on the self-esteem of Ghanaian men, examining the subjective experiences, meanings, and coping mechanisms that shape this relationship. Employing a qualitative phenomenological design, the study conducts in-depth interviews with men experiencing ED, their spouses, mental health professionals, and healthcare providers in the Greater Accra Region. Drawing on Self-Esteem Theory and the Biopsychosocial Model, the study seeks to understand how ED threatens men's sense of worth, what psychological mechanisms mediate this relationship, and what resources support the maintenance of positive self-esteem despite sexual difficulties. By providing empirically grounded insights into the intersection of sexual health and psychological well-being in Ghana, the study aims to inform the development of culturally sensitive counselling approaches, mental health services, and healthcare practices that address the whole person, not merely the physical condition.

KEYWORDS: *Erectile dysfunction, self-esteem, psychological impact, masculinity, men's health, Ghana*

1. INTRODUCTION

The concept of self-esteem occupies a central place in understanding human psychological functioning. Self-esteem, broadly defined as an individual's subjective evaluation of their own worth, influences how people think, feel, and behave across multiple life domains. High self-esteem is associated with psychological well-being, resilience in the face of challenges, and the capacity to form and maintain satisfying relationships. Low self-esteem, conversely, is linked to depression, anxiety, social withdrawal, and diminished quality of life. For these reasons, understanding the factors that support or threaten self-esteem is a fundamental concern for psychology and mental health.

Among the factors that can profoundly affect self-esteem is physical health, particularly when health conditions touch on domains central to personal and social identity. Sexual health, and specifically erectile function, represents such a domain for many men. Erectile dysfunction, the persistent inability to achieve or maintain an erection sufficient for satisfactory sexual performance, is not merely a physical condition but one imbued with psychological and cultural meaning. For men who experience ED, the condition can feel like a fundamental failure, a threat to their identity as men, and a source of profound shame and self-doubt.

Erectile dysfunction is a common condition affecting men across the lifespan, with prevalence increasing with age. Epidemiological studies estimate that ED affects approximately 40% of men by age 40 and nearly 70% by age 70 (Feldman et al., 1994). Risk factors include cardiovascular disease, diabetes, hypertension, obesity, smoking, and psychological conditions such as depression and anxiety. As Ghana's population ages and the prevalence of chronic diseases increases, the number of men affected by ED is likely to grow, making understanding its psychological effects increasingly important.

The psychological impact of ED has been documented in research from Western contexts. Men with ED commonly report feelings of shame, embarrassment, inadequacy, and diminished self-worth (McCabe & Althof, 2014). They may avoid sexual situations, withdraw from intimate relationships, and experience depressed mood and anxiety. These psychological effects can persist even when the physical aspects of ED are treated, suggesting that the psychological damage may outlast the condition itself.

In the Ghanaian cultural context, several factors may intensify the psychological impact of ED on self-esteem. Ghanaian masculinity is strongly linked to sexual prowess and the ability

to satisfy one's partner (Adomako Ampofo, 2001). Men are expected to be sexually capable, and sexual performance is closely tied to masculine identity. Failure in this domain may therefore represent not merely a functional difficulty but a fundamental failure of manhood. Cultural norms that discourage open discussion of sexuality may prevent men from seeking support, leaving them to struggle alone with feelings of shame and inadequacy. Religious beliefs may frame ED as a spiritual problem or punishment, adding moral weight to what might otherwise be understood as a medical condition.

2. STATEMENT OF THE PROBLEM

Ghanaian men experiencing erectile dysfunction navigate a difficult psychological terrain characterized by shame, secrecy, and threats to their sense of self-worth, yet there has been no systematic research documenting their experiences or identifying their psychological needs. This absence of evidence leaves a critical gap in understanding how to support men whose self-esteem is compromised by this common and distressing condition.

Erectile dysfunction is not a rare problem. Global estimates suggest that 150 million men worldwide experience ED, with projections reaching 322 million by 2025 (Ayta et al., 1999). In Ghana, while precise prevalence data are lacking, the aging of the population and increasing prevalence of risk factors such as diabetes, hypertension, and cardiovascular disease suggest that ED affects a substantial and growing number of men. Yet ED remains largely invisible in Ghanaian healthcare and mental health discourse. Medical training pays limited attention to sexual medicine, mental health services rarely address sexual concerns, and public health campaigns do not acknowledge sexual difficulties as legitimate health concerns.

For men who experience ED, the condition carries significant psychological consequences. Research from other contexts has documented that men with ED experience higher rates of depression, anxiety, and reduced quality of life compared to men without ED (McCabe & Althof, 2014). These psychological effects are not merely secondary to the condition but are central to the experience of ED itself. Men describe feeling less masculine, less adequate as partners, and less worthy as human beings. Their sense of self, built over a lifetime, is shaken by a condition they did not choose and may not understand.

In the Ghanaian cultural context, several factors may intensify these psychological effects. Masculinity in Ghana is constructed around multiple dimensions, including provision for family, authority within the household, and sexual prowess (Adomako Ampofo, 2001). Men are expected to be sexually capable, and sexual performance is closely tied to masculine

identity. When ED undermines this capability, it challenges not just a function but a core component of who men understand themselves to be. The shame associated with this perceived failure can be more distressing than the ED itself.

3. PURPOSE OF THE STUDY

The purpose of this study is to explore the psychological impact of erectile dysfunction on the self-esteem of Ghanaian men, using a qualitative phenomenological approach to understand the lived experiences of men with ED, their spouses, mental health professionals, and healthcare providers.

4. OBJECTIVES OF THE STUDY

4.1 General Objective

The general objective of the study is to investigate how erectile dysfunction affects the self-esteem of Ghanaian men, providing empirical evidence to inform the development of culturally sensitive psychological support services and interventions.

4.2 Specific Objectives

The specific objectives of the study are to:

- Explore how Ghanaian men experience and make meaning of erectile dysfunction.
- Examine the effects of erectile dysfunction on men's self-esteem and self-concept.
- Investigate the role of cultural factors, including masculinity norms and religious beliefs, in shaping men's psychological responses to ED.
- Identify the coping mechanisms men employ to manage threats to self-esteem.

5. LITERATURE REVIEW

5.1 Theoretical Review

The investigation of erectile dysfunction and self-esteem requires a theoretical framework that can account for the psychological processes through which physical conditions affect self-concept and the cultural context that shapes these processes. This study draws on two complementary theoretical perspectives: Self-Esteem Theory and the Biopsychosocial Model. These frameworks provide complementary lenses for understanding how ED affects men's sense of worth within the Ghanaian cultural context.

5.1.1 Self-Esteem Theory

Self-esteem, as a psychological construct, has been extensively theorized and researched across multiple decades. Rosenberg (1965), whose work remains foundational, defined self-

esteem as a positive or negative orientation toward oneself, an overall evaluation of one's worth or value. This conceptualization emphasizes that self-esteem is not simply a collection of specific self-evaluations but a global judgment about the self as a whole. Individuals with high self-esteem respect themselves, consider themselves worthy, and recognize their limitations while expecting to grow and improve.

James (1890/1950), in early foundational work, proposed that self-esteem is determined by the ratio of one's successes to one's pretensions. That is, self-esteem depends not on objective achievements but on how those achievements measure up against what the individual aspires to achieve. A person who succeeds in domains they consider important will have high self-esteem; a person who fails in domains they consider important will have low self-esteem, regardless of how they perform in other areas. This insight is crucial for understanding the effects of ED on self-esteem. For men who consider sexual performance a central domain of masculine adequacy, ED represents failure in a domain of high importance, and its impact on self-esteem may be correspondingly severe.

Coopersmith (1967) identified four bases of self-esteem: significance, the acceptance and attention of others; competence, the ability to perform tasks successfully; virtue, adherence to moral standards; and power, the ability to influence events and others. Different individuals may draw self-esteem from different combinations of these bases. For men whose self-esteem is heavily based on competence in sexual performance, ED directly undermines this foundation.

5.1.2 Biopsychosocial Model

The Biopsychosocial Model, originally articulated by Engel (1977) as a critique of the biomedical model's narrow focus on biological mechanisms, provides a comprehensive framework for understanding health conditions as products of interacting biological, psychological, and social factors. Engel argued that, to fully understand illness and its effects, one must consider not only the biological processes involved but also the psychological experiences of the patient and the social context in which illness occurs.

Applied to erectile dysfunction and its psychological effects, the Biopsychosocial Model recognizes that the relationship between ED and self-esteem is not simple or unidirectional but involves complex interactions among multiple factors. Biologically, ED may result from vascular disease, neurological conditions, hormonal imbalances, or side effects of medications. The severity and course of these biological factors influence the experience of

ED, including whether it is constant or intermittent, progressive or stable, treatable or intractable.

5.2 Conceptual Review

5.2.1 The Concept of Erectile Dysfunction

Erectile dysfunction, as a medical concept, has evolved significantly over recent decades in both definition and understanding. The National Institutes of Health (1993) Consensus Development Panel defined ED as the consistent inability to achieve or maintain an erection sufficient for satisfactory sexual performance. This definition emphasizes three key elements: consistency (the problem is persistent rather than occasional), insufficiency (the erection is inadequate for sexual activity), and the subjective experience of satisfaction (the man's or couple's assessment of adequacy).

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (American Psychiatric Association, 2013) provides a more detailed definition, specifying that at least one of three symptoms must be present for approximately six months: marked difficulty in obtaining an erection during sexual activity, marked difficulty in maintaining an erection until completion of sexual activity, or marked decrease in erectile rigidity. The symptoms must cause clinically significant distress and must not be better explained by another medical condition, medication effects, or substance use.

Epidemiological research has consistently documented that ED is common and increases with age. The Massachusetts Male Aging Study (Feldman et al., 1994), one of the most influential epidemiological studies of ED, found that overall prevalence was 52% among men aged 40-70, with 17% reporting minimal ED, 25% moderate ED, and 10% complete ED. Prevalence increased with age, from approximately 40% of men aged 40 to nearly 70% of men aged 70. Subsequent studies in diverse populations have generally confirmed these patterns, though prevalence estimates vary depending on definitions and measurement approaches.

5.2.2 The Concept of Self-Esteem

Self-esteem is one of the most extensively studied constructs in psychology, yet its conceptualization continues to evolve. Rosenberg (1965), whose work remains foundational, defined self-esteem as a positive or negative attitude toward oneself, an overall evaluation of one's worth or value. This conceptualization emphasizes that self-esteem is a global judgment, not merely a sum of specific self-evaluations. Individuals with high self-esteem have self-respect, consider themselves worthy, and recognize their limitations while expecting to grow and improve.

Coopersmith (1967) defined self-esteem as the evaluation an individual makes and customarily maintains with regard to themselves, expressing an attitude of approval or disapproval and indicating the extent to which the individual believes themselves capable, significant, successful, and worthy. This definition highlights that self-esteem is both enduring, an individual's typical orientation toward themselves, and responsive to specific experiences that confirm or challenge self-worth.

Subsequent theoretical work has distinguished between global and domain-specific self-esteem. Global self-esteem refers to the overall evaluation of self-worth that individuals carry across situations (Harter, 1999). Domain-specific self-esteem refers to evaluations of worth in particular areas such as work competence, physical appearance, social acceptance, or sexual adequacy. Domain-specific self-esteem contributes to global self-esteem but is also influenced by it. A person with high global self-esteem may weather setbacks in specific domains without significant overall decline, while a person with low global self-esteem may be more vulnerable to domain-specific threats.

5.2.3 The Cultural Construction of Masculinity in Ghana

Understanding the psychological impact of ED on Ghanaian men's self-esteem requires attention to the cultural context in which masculinity is constructed and experienced. Masculinity is not a universal, biologically determined category but a culturally specific set of meanings, expectations, and practices that shape how men understand themselves and are evaluated by others (Courtenay, 2000).

In Ghanaian cultural context, masculinity has been conceptualized as multidimensional. Adomako Ampofo (2001) identified several key dimensions of masculine identity among Ghanaian men: provision, the ability to financially support one's family; authority, the legitimate power to make decisions within the household; and sexual prowess, the capacity to perform sexually and satisfy one's partner. These dimensions are interconnected; failure in one domain may threaten the entire masculine identity.

Provision is a central pillar of Ghanaian masculinity. Men are expected to be breadwinners, providing for their wives, children, and often extended family members. A man who cannot provide may be seen as failing in his primary masculine duty, regardless of how he performs in other areas. This dimension of masculinity has been extensively documented in research on Ghanaian gender relations (Nukunya, 2016).

5.2.4 Erectile Dysfunction and Self-Esteem: Conceptual Links

The conceptual relationships between erectile dysfunction and self-esteem can be understood through multiple pathways. Directly, ED challenges men's sense of competence in a domain, sexual performance, that for many is closely tied to masculine identity and self-worth. When a man finds himself unable to perform sexually, he may conclude that he is inadequate, that he has failed as a man, that he is less worthy than he thought. This direct link between performance and self-evaluation is central to understanding the psychological impact of ED.

Indirectly, ED affects self-esteem through its effects on relationships. Men may anticipate or experience rejection, criticism, or disappointment from their partners. They may withdraw from intimacy, fearing exposure or failure. They may interpret their partner's responses, whether real or imagined, as confirmation of their inadequacy. These relational dynamics can compound the direct effects of ED on self-esteem.

ED also affects self-esteem through its effects on identity. For men whose sense of themselves is closely tied to sexual performance, ED can feel like a fundamental challenge to who they are. They may ask themselves, "If I am not a man who can perform sexually, who am I?" This identity disruption can be deeply unsettling and can undermine self-esteem even when other domains of life are going well.

The attributions men make about the cause of ED shape its impact on self-esteem. Attribution theory distinguishes among dimensions of causality, including internal vs. external (whether the cause is within the person or in the situation), stable vs. unstable (whether the cause is permanent or temporary), and global vs. specific (whether the cause affects many areas of life or only one). Men who attribute ED to internal, stable, and global causes, such as "I am fundamentally inadequate as a man," will experience greater self-esteem threats than men who attribute it to external, temporary, or specific causes, such as "this medication is causing temporary side effects."

5.3 Empirical Review

Research on the psychological correlates of erectile dysfunction has consistently documented associations with depression, anxiety, and reduced quality of life. A meta-analysis by McCabe and Althof (2014) reviewed studies examining psychosocial outcomes associated with ED and found that men with ED had significantly higher rates of depression and anxiety than men without ED. The relationship appeared bidirectional, with psychological factors contributing to ED and ED contributing to psychological distress.

The Massachusetts Male Aging Study (Feldman et al., 1994) found that men with complete ED had significantly higher depression scores than men without ED, and that this relationship persisted after controlling for age and health status. Subsequent analyses of these data suggested that the relationship between ED and depression was not simply due to shared risk factors but reflected a direct psychological impact of ED on mood.

A large multinational study by Rosen and colleagues (2004) examined the relationship between ED and health-related quality of life in over 28,000 men from eight countries. They found that men with ED reported significantly lower scores on both physical and mental health components of quality of life compared to men without ED. The mental health deficits included emotional problems interfering with social functioning, feelings of nervousness and depression, and lower overall psychological well-being.

Research has also examined the specific relationship between ED and self-esteem. Kuehn and Winters (1994) studied men presenting for ED treatment and found that they reported significantly lower self-esteem than age-matched controls. Lower self-esteem was associated with greater relationship dissatisfaction and higher levels of psychological distress. The authors suggested that self-esteem might be a key mechanism through which ED affects overall psychological well-being.

A more recent study by Pastuszak and colleagues (2013) examined the relationship between ED and self-esteem in a large sample of men seeking treatment. They found that ED severity was inversely correlated with self-esteem, with men reporting more severe ED also reporting lower self-esteem. Treatment of ED with phosphodiesterase type 5 inhibitors was associated with significant improvements in self-esteem, suggesting that the relationship is at least partially reversible.

In African contexts, research on the psychological correlates of ED is limited but growing. A study in Nigeria by Fatusi and colleagues (2003) found that men with ED reported higher levels of psychological distress than men without ED, and that distress was associated with relationship difficulties. A study in South Africa by Shaeer and colleagues (2003) similarly found that ED was associated with reduced quality of life and psychological well-being.

In Ghana specifically, no studies have examined the psychological impact of ED on self-esteem. A study by Amoah and colleagues (2022) examined ED among men with diabetes and found high prevalence but did not assess psychological outcomes. The psychological dimensions of ED in Ghana remain entirely unexplored.

7. METHODOLOGY

7.1 Research Design

This study adopted a qualitative phenomenological design to explore the psychological impact of erectile dysfunction on the self-esteem of Ghanaian men. The phenomenological approach was appropriate for this study because it enabled in-depth exploration of the lived experiences of participants and the meanings they attach to those experiences (Creswell & Poth, 2018). Phenomenology seeks to understand the essence of a phenomenon as experienced by those who live it, making it particularly suitable for investigating how men experience and make meaning of ED, how it affects their sense of self-worth, and what psychological processes are involved. This design allowed for the capture of rich, detailed narratives that illuminate the subjective, emotional, and cognitive dimensions of the phenomenon.

7.2 Research Approach

The study was guided by an interpretivist research philosophy, which recognizes that knowledge is socially constructed through lived experiences and that multiple realities exist based on individuals' subjective interpretations (Lincoln & Guba, 1985). This approach was appropriate given the study's aim to understand the deeply personal, culturally embedded, and emotionally charged experiences of men facing ED. The focus was on capturing the richness and complexity of participants' narratives rather than on producing generalizable statistical findings. The interpretivist approach acknowledges that participants' understandings of their experiences are shaped by cultural norms, religious beliefs, personal histories, and social relationships, all of which were central to this investigation.

7.3 Study Setting

The study was conducted in Ghana, focusing on the Greater Accra Region. This region was selected for several reasons. First, as the capital region, it has the highest concentration of healthcare facilities, including urology clinics, teaching hospitals, and private specialist services where men with ED might seek care. Second, it offers access to a diverse population representing various ethnic groups, religious backgrounds, and socioeconomic strata, providing rich variation in experiences. Third, the region hosts mental health professionals, including psychologists and counsellors, who work with men experiencing psychological distress related to health conditions. While the study's findings may not be generalizable to all of Ghana, the diversity within the Greater Accra Region supports the transferability of findings to similar urban and peri-urban contexts.

7.4 Study Population

The study population comprised four groups: men experiencing erectile dysfunction, their wives or female partners, mental health professionals including psychologists and counsellors with experience supporting men with sexual health concerns, and healthcare providers including urologists, general practitioners, and nurses who provide care to men with ED. This multi-perspective approach was essential for capturing the full complexity of how ED affects men's self-esteem, recognizing that different stakeholders have different vantage points on the phenomenon.

7.5 Sampling Technique

Purposive sampling was employed to select participants who could provide rich information about the phenomenon under study (Patton, 2015). Given the sensitivity of the topic and the challenges of recruiting participants willing to discuss intimate psychological experiences, multiple recruitment strategies were necessary.

Men with ED were recruited through several channels: urology clinics and general practice clinics in major hospitals, where healthcare providers agreed to inform eligible patients about the study; community health centres with permission to display information; and snowball sampling, where initial participants referred other men, they knew who might be willing to participate. Eligibility criteria for men included: aged 30 years and above, self-identification as experiencing erectile difficulties consistent with ED for at least six months, and willingness to discuss their psychological experiences in depth.

Wives of men with ED were recruited primarily through their husbands. Men who agreed to participate were asked whether their wives might also be willing to be interviewed about their observations of their husbands' psychological state and the impact of ED on the marital relationship. In cases where both partners agreed, separate interviews were conducted to allow each to speak freely without concern about the partner's presence.

Mental health professionals were recruited through professional associations, counselling centres, and hospitals with mental health departments. Eligibility required at least three years of clinical experience and having worked with at least five men presenting with psychological distress related to sexual health concerns.

7.6 Sample Size and Justification

Sample size in qualitative research is guided by the principle of saturation, the point at which additional interviews no longer yield new insights (Guest et al., 2006). The study targeted approximately 15-18 men with ED, 8-10 wives, 6-8 mental health professionals, and 6-8

healthcare providers, for a total of 35-44 interviews. Recruitment continued until thematic saturation was achieved, resulting in 40 interviews: 16 men with ED, 9 wives, 8 mental health professionals, and 7 healthcare providers.

Table 1: Sample Distribution.

Participant Category	Target	Achieved
Men with ED	15-18	16
Wives of men with ED	8-10	9
Mental health professionals	6-8	8
Healthcare providers	6-8	7
Total	**35-44**	**40**

7.7 Data Collection Method

Data were collected through in-depth, semi-structured interviews. This method was appropriate because it allowed participants to share their experiences in their own words while ensuring that key topics were covered across all interviews (Kvale & Brinkmann, 2015). The flexibility of semi-structured interviews enabled the researcher to probe deeply into areas of particular significance and to follow unexpected lines of inquiry that emerged during conversations.

Interview guides were developed separately for each participant group, with open-ended questions designed to explore experiences, psychological impact on self-esteem, coping mechanisms, support systems, and recommendations. All guides were reviewed by experts in qualitative research, men's health, and clinical psychology, and were pilot tested with one participant from each group to refine wording and flow.

For men with ED, the interview guide explored: the discovery and experience of ED, emotional and psychological responses, effects on self-esteem and self-concept, changes in how they view themselves as men, communication with wife about ED, coping strategies, help-seeking experiences, and recommendations for supporting other men.

For wives, the guide explored: awareness and understanding of husband's ED, observations of husband's psychological state and behaviour, effects on husband's self-confidence and mood, couple communication, coping strategies, and perspectives on how services could better support men.

For mental health professionals, the guide explored: experiences counselling men with ED, common psychological patterns observed, effects on self-esteem and masculine identity, coping mechanisms they recommend, challenges in providing support, and recommendations for improving mental health services.

For healthcare providers, the guide explored: training and comfort with sexual health issues, clinical experiences with men presenting ED, attention to psychological aspects of care, perceptions of patients' psychological needs, barriers to addressing psychological concerns, and recommendations for improving holistic care.

Interviews were conducted by the researcher and a trained research assistant with experience in qualitative methods and sensitive topics. All interviewers received additional training on conducting research on sensitive psychological topics with cultural sensitivity and on managing potential emotional distress in participants. Interviews took place in locations chosen by participants, including private spaces in their homes, private rooms in healthcare facilities, or counselling centre offices. Interviews lasted between 45 minutes and two hours, were audio-recorded with consent, and were transcribed verbatim. For interviews conducted in local languages (Twi, Ga), transcripts were translated into English for analysis, with careful attention to preserving meaning, emotional tone, and cultural nuance.

7.8 Data Collection Instruments

Semi-structured interview guides were developed for each participant group, informed by the theoretical frameworks and the study objectives. Each guide included an introductory section building rapport and explaining the study purpose, a main section with open-ended questions organized thematically, and a closing section allowing participants to add anything not covered and to ask questions.

The men's guide included sections on: background and personal context, discovery and experience of ED, emotional responses, effects on self-esteem and self-perception, changes in masculine identity, coping strategies, support accessed, help-seeking experiences, and recommendations.

The wives' guide included sections on: background and marital context, awareness and understanding of husband's ED, observations of husband's psychological state, effects on husband's confidence and behaviour, couple dynamics, coping strategies, and recommendations.

The mental health professionals' guide included sections on: professional background and training, experiences with men facing ED, observed psychological patterns, effects on self-esteem and identity, therapeutic approaches, challenges, and recommendations.

The healthcare providers' guide included sections on: professional background and training, clinical experiences with ED, attention to psychological aspects, perceptions of patients' psychological needs, barriers to holistic care, and recommendations.

7.10 Data Analysis Procedure

Data were analyzed using thematic analysis following the procedures outlined by Braun and Clarke (2006). Analysis proceeded through six phases.

In phase one, familiarization, all transcripts were read multiple times to gain immersion in the data. Initial impressions and potential patterns were recorded in memos. Particular attention was paid to language men used to describe themselves and their feelings, as this language would be central to understanding self-esteem effects.

In phase two, generating initial codes, meaningful segments of data were identified and labelled using NVivo software. Coding was both deductive, guided by the theoretical frameworks and research objectives, and inductive, allowing unexpected patterns to emerge from the data. Codes captured specific psychological experiences, emotional responses, self-evaluative statements, and coping strategies.

In phase three, searching for themes, codes were grouped into potential themes based on patterns and relationships. This involved reviewing coded extracts and considering how different codes might combine to form overarching themes about the psychological impact of ED on self-esteem.

In phase four, reviewing themes, themes were checked against coded extracts and the entire dataset to ensure they captured the essential meanings. Themes were refined, combined, or discarded as necessary.

In phase five, defining and naming themes, each theme was refined and clearly defined, with attention to both the content of the theme and its relationship to other themes.

In phase six, producing the report, themes were described and illustrated with representative quotations, with attention to both patterns across participants and unique or divergent experiences.

Analysis was iterative, moving between data and emerging themes, and was attentive to both commonalities and variations across participant groups. Themes were developed separately for each participant group and then integrated to identify overarching patterns across the entire dataset.

8. RESULTS

Thematic analysis of 40 interviews revealed four overarching themes: the shattering of masculine self-concept, the spiral of shame and self-doubt, the hidden burden and isolation, and pathways to resilience and reconstruction. Each theme encompasses multiple sub-themes representing the range of experiences across participants.

8.1 Theme One: The Shattering of Masculine Self-Concept

This theme captures how ED fundamentally disrupts men's sense of themselves as men, shaking the foundations of their masculine identity and self-worth. Three sub-themes emerged: the unexpected blow, questioning manhood, and feeling less than other men.

The Unexpected Blow: For most men, the experience of ED came as a shock, something they had never anticipated and for which they were entirely unprepared. The first failure, or the recognition that difficulties were persistent rather than occasional, landed as a psychological blow that shook their confidence.

"It came out of nowhere. One day I was fine, the next I couldn't perform. I kept thinking it would pass, that maybe I was tired, stressed. But it didn't pass. And with each failure, I felt something inside me breaking. I wasn't prepared for this. No one prepares you for this." (Man with ED, 49 years)

Another man described the cumulative effect of repeated failures:

"The first time, I told myself it was nothing. Second time, I started to worry. By the fifth, sixth time, I was a different person. Each failure chipped away at something, my confidence, my sense of myself. Eventually there was nothing left to chip away." (Man with ED, 54 years)

Questioning Manhood: As ED persisted, men began to question what it meant for their identity as men. They asked themselves whether they were still real men, whether they could still claim the masculine status they had always taken for granted.

"A man is defined by certain things. Strength, ability to provide, ability to satisfy his woman. When you lose one of those, especially that one, you start to wonder, what am I? Am I still a man? I look in the mirror and I don't see a man anymore. I see someone who failed at the most basic thing." (Man with ED, 52 years)

A mental health professional described observing this phenomenon repeatedly:

"For many Ghanaian men, their sense of masculinity is not just one part of who they are, it is who they are. It's the foundation. When ED undermines that, it's not like losing a job or having a financial setback. It's like the ground itself disappears. They don't know who they are anymore." (Clinical Psychologist, 14 years experience)

Feeling Less Than Other Men: The threat to masculine identity was compounded by social comparison. Men imagined other men, friends, colleagues, brothers, as sexually capable and wondered why they had been singled out for this failure.

"I see other men, my friends, my brothers, they are fine. They have wives, they have children, they are normal. Why me? What did I do to deserve this? I feel less than them. When we are

together, I feel like a fraud, like I'm not really one of them anymore." (Man with ED, 47 years)

A wife observed how this comparison affected her husband:

"He stopped wanting to be with his friends. If they talked about women, or made jokes, he would get quiet, then find a reason to leave. He told me once, 'They don't know I'm not a real man. If they knew, they would laugh at me.' It broke my heart to see him like that." (Wife, 43 years)

8.2 Theme Two: The Spiral of Shame and Self-Doubt

This theme captures the emotional and cognitive responses to ED, the feelings of shame and the negative thoughts about self that create a downward psychological spiral. Three sub-themes emerged: consuming shame, negative self-talk and self-blame, and loss of confidence beyond the sexual.

Consuming Shame: Men consistently described shame as the dominant emotional response to ED. This shame was not just about the difficulty itself but about what it revealed about them as men. They felt exposed, inadequate, and fundamentally flawed.

"The shame is like a weight on your chest all the time. Not just when you're in a situation that might lead to sex. All the time. You carry it everywhere. You feel like everyone can see that you're not a real man, that something is wrong with you." (Man with ED, 56 years)

Another man described the physical experience of shame:

"I would break out in a sweat just thinking about it. My stomach would knot. I felt like I wanted to disappear, to be invisible. Shame is not just a feeling, it's physical. It takes over your whole body." (Man with ED, 44 years)

A mental health professional explained the cultural dimensions of shame:

"In our culture, a man's worth is tied to his ability to perform. When he can't, it's not just a private disappointment, it's a public shame. Even if no one knows, he feels exposed. He feels that if others knew, they would see him as less. That anticipated judgment becomes internalized as shame." (Counselling Psychologist, 9 years experience)

Negative Self-Talk and Self-Blame: Men engaged in persistent negative internal dialogue, berating themselves for their failure and searching for explanations that invariably blamed themselves.

"I tell myself, what kind of man are you? You can't even do this one thing. Your wife deserves better. You're useless. The voice never stops. It's there when I wake up, when I'm at work, when I try to sleep. It tells me I'm nothing." (Man with ED, 51 years)

Some men blamed themselves for past behavior, wondering if earlier choices had caused their current difficulty:

"I keep thinking about my younger days, the women, the drinking, maybe I did something to my body. Maybe I'm being punished for how I lived. If I had been better, maybe this wouldn't be happening. It must be my fault." (Man with ED, 48 years)

Loss of Confidence Beyond the Sexual: The erosion of self-esteem was not contained to the sexual domain but spread to affect men's confidence in all areas of life. Work performance, social interactions, and general sense of capability all suffered.

"I used to be confident at work. I made decisions, I led my team. Now I second-guess everything. If I'm failing at home, maybe I'm failing at work too. The doubt spreads. It's like once you believe you're not good enough in one area, you start believing it everywhere." (Man with ED, 45 years)

A wife observed this spread in her husband:

"He used to be so sure of himself. He would walk into a room and people would notice. Now he's quiet, withdrawn. He doesn't speak up at family gatherings. He doesn't make decisions like he used to. The ED didn't just affect our bedroom, it affected everything about him." (Wife, 39 years)

8.3 Theme Three: The Hidden Burden and Isolation

This theme captures how the shame and secrecy surrounding ED isolate men from sources of support, leaving them to carry their psychological burden alone. Three sub-themes emerged: suffering in silence, fear of disclosure, and the loneliness of the secret.

Suffering in Silence: Most men described suffering alone, telling no one about their difficulty. They carried the psychological weight without any outlet, without any source of reassurance or perspective.

"I told no one. Not my wife, not my brothers, not my friends, not a doctor. For years, I carried this alone. There was no one to tell. Who do you tell something like this? Who would understand? I suffered in silence because there was no other way." (Man with ED, 57 years)

A healthcare provider explained why men stay silent:

"Men are socialized not to talk about weakness, not to admit vulnerability. Sexual weakness is the ultimate vulnerability. So they suffer silently. They come to us only when they can't bear it anymore, or when the wife forces them. By then, the psychological damage is already deep." (Urologist, 12 years experience)

Fear of Disclosure: Men identified multiple fears that kept them silent. They feared being seen as weak or inadequate. They feared their wives would leave them or lose respect for them. They feared gossip and ridicule if others found out.

"What would my wife think? She would lose respect for me. Maybe she would leave. What would my friends say if they knew? They would laugh behind my back. The fear of what would happen if I told someone was worse than the suffering of keeping silent." (Man with ED, 50 years)

A wife whose husband had eventually told her described his earlier fears:

"He told me later that he was afraid to tell me because he thought I would leave him. All those years he suffered alone, thinking I would abandon him. I was suffering too, thinking he didn't want me. The fear on both sides kept us apart." (Wife, 46 years)

The Loneliness of the Secret: The burden of carrying the secret created profound loneliness. Men felt cut off from others, unable to share their true selves, living behind a facade.

"It's lonely. Even when you're with people, you're alone because no one knows the real you. They see the mask, the man who seems fine. They don't see the person inside who feels worthless, who can't perform the most basic function of a man. That loneliness is worse than the ED itself sometimes." (Man with ED, 53 years)

A mental health professional described the psychological toll:

"The isolation is devastating. Humans need connection, need to share our burdens. When men carry this alone, the shame compounds, the negative self-talk goes unchallenged, the hopelessness deepens. The secret becomes a wall between them and everyone they love." (Clinical Psychologist, 9 years experience)

8.4 Theme Four: Pathways to Resilience and Reconstruction

Despite the profound psychological damage documented, the study also revealed pathways through which some men began to rebuild their self-esteem. Three sub-themes emerged: the healing power of partner support, finding new definitions of manhood, and the role of faith.

The Healing Power of Partner Support: For men whose wives responded with understanding, reassurance, and commitment, this support was transformative. It counteracted shame, challenged negative self-talk, and provided a foundation for rebuilding self-worth.

"When I finally told her, she held me. She said, 'You are more than this. You are my husband, the father of my children, the man I love. This doesn't change that.' For the first time in years,

I felt like maybe I wasn't worthless. Her love gave me something to hold onto." (Man with ED, 48 years)

Another man described how his wife's support helped him see himself differently:

"She kept telling me I was still a man, that she didn't marry me just for sex. At first, I didn't believe her. But she said it over and over, and slowly I started to believe. If she could still see me as a man, maybe I could see myself that way too." (Man with ED, 52 years)

A mental health professional emphasized the importance of partner response:

"The wife's response can make or break the man's psychological recovery. If she responds with rejection or criticism, it confirms his worst fears. If she responds with love and reassurance, it challenges those fears. Partners are not just witnesses to the damage; they can be agents of healing." (Marriage and Family Therapist, 11 years' experience)

Finding New Definitions of Manhood: Some men began to question the narrow definition of masculinity that had made them so vulnerable. They started to recognize that being a man meant more than sexual performance and to find worth in other domains.

"I started thinking, what does it really mean to be a man? Is it just about sex? My father was a man, and I remember him for his kindness, his hard work, how he provided for us, not for his sexual performance. Maybe I've been measuring myself by the wrong standard." (Man with ED, 55 years)

Another man described actively working to expand his sense of identity:

"I decided I had to find other ways to feel like a man. I focused on my work, on providing for my family, on being a good father. I told myself, I may not be able to perform sexually, but I can still be a good husband, a good father, a good provider. Those things matter too." (Man with ED, 49 years)

A mental health professional described therapeutic work in this area:

"Part of the work is helping men broaden their definition of masculinity. Our culture gives them a very narrow box, and when ED happens, they no longer fit in that box. We help them see that the box itself is the problem. There are many ways to be a man, many sources of worth." (Counselling Psychologist, 8 years' experience)

The Role of Faith: For many men, faith provided a crucial resource for maintaining hope and finding meaning. Religious beliefs offered comfort, a sense of being valued by God regardless of circumstances, and a framework for understanding suffering.

"My faith kept me going. I prayed every day. I told God, I don't understand why this is happening, but I trust you. I believe God sees my struggle and still loves me. That belief, that

I matter to God, helped me hold onto some sense of worth when everything else was gone." (Man with ED, 58 years)

Another man described how his religious community provided support:

"My pastor didn't know about my ED, but his sermons about God's love, about worth not depending on performance, those spoke to me. I started to believe that maybe my worth wasn't about what I could do, but about who I was in God's eyes. That changed something." (Man with ED, 51 years)

A mental health professional noted the importance of integrating faith and psychology:

"For many Ghanaian men, faith is their primary coping resource. Effective support has to engage with that, not dismiss it. We work with their faith, help them find within their religious traditions resources for self-compassion and hope, not just judgment and fear." (Clinical Psychologist, 14 years' experience)

8.5 Summary of Themes

Table 2 provides a summary of the key themes and sub-themes emerging from the analysis.

Table 2: Summary of Themes on Psychological Impact of ED on Self-Esteem.

Overarching Theme	Sub-Themes
The Shattering of Masculine Self-Concept	The unexpected blow; Questioning manhood; Feeling less than other men
The Spiral of Shame and Self-Doubt	Consuming shame; Negative self-talk and self-blame; Loss of confidence beyond the sexual
The Hidden Burden and Isolation	Suffering in silence; Fear of disclosure; The loneliness of the secret
Pathways to Resilience and Reconstruction	The healing power of partner support; Finding new definitions of manhood; The role of faith

9. DISCUSSION

This study explored the psychological impact of erectile dysfunction on the self-esteem of Ghanaian men, revealing profound threats to masculine identity, intense shame and self-doubt, and isolating secrecy, alongside pathways to resilience and reconstruction. The findings illuminate the psychological dimensions of ED in the Ghanaian cultural context and have important implications for theory, practice, and intervention.

9.1 The Shattering of Masculine Self-Concept and Self-Esteem Theory

The finding that ED fundamentally disrupts men's sense of themselves as men, leading them to question their manhood and feel less than other men, aligns with and extends Self-Esteem Theory. Rosenberg's (1965) conceptualization of self-esteem as a global evaluation of worth is clearly relevant; men's global sense of worth was profoundly diminished by ED. However,

the findings particularly highlight the importance of Crocker and Wolfe's (2001) concept of contingencies of self-worth.

For the men in this study, self-worth was highly contingent on sexual performance. This contingency made them vulnerable; when sexual performance failed, self-worth collapsed. The unexpected blow of ED was not just a functional difficulty but a direct hit to the very basis of their self-esteem. This finding underscores that understanding the impact of any health condition on self-esteem requires understanding how central the affected domain is to the individual's contingencies of self-worth.

The finding that men questioned their very manhood, asking "Am I still a man?", reflects that for these men, sexual performance was not merely one domain among many but a foundational component of masculine identity. This aligns with James's (1890/1950) insight that self-esteem depends on success in domains one considers important. For men who consider sexual performance centrally important, failure in this domain has amplified effects on self-esteem.

The comparison with other men, the feeling of being less than friends and brothers, reflects the social nature of self-esteem. Self-esteem is not formed in isolation but through social comparison and reflected appraisals (Coopersmith, 1967). Men imagined how others would judge them if they knew, and these imagined judgments became internalized as self-judgment. Even without actual disclosure, the anticipated shame of exposure shaped their self-perception.

9.2 The Spiral of Shame and Self-Doubt

The finding that men experienced consuming shame, engaged in persistent negative self-talk, and lost confidence beyond the sexual domain reveals the dynamic and spreading nature of psychological damage. Shame, as described by participants, was not a transient emotion but a pervasive state that colored all experience. This aligns with theoretical understandings of shame as an emotion focused on the global self, not just specific behavior (Lewis, 1971). Men were not ashamed of what they did; they were ashamed of who they were.

The negative self-talk and self-blame men described represent the cognitive dimension of low self-esteem. Men's internal dialogues reinforced their negative self-evaluations, creating a self-perpetuating cycle. The voice that told them they were useless, that they had failed, that they were not real men, became a constant companion, making recovery difficult even when external circumstances might have supported it.

The spread of lost confidence beyond the sexual domain is particularly significant. This finding demonstrates that self-esteem is not compartmentalized; threats in one domain can affect global self-esteem, which then affects other domains. Men who lost confidence in their sexual adequacy began to doubt their work performance, their social competence, their general capability. This spillover effect magnifies the psychological impact of ED and explains why its effects can be so pervasive.

From a Biopsychosocial Model perspective (Engel, 1977), these psychological responses represent the interaction of biological factors (ED itself) with psychological processes (attributions, self-talk, emotional responses) and social factors (cultural meanings, anticipated judgments). The biological reality of ED is filtered through psychological and social lenses that determine its psychological impact.

9.3 The Hidden Burden and Isolation

The finding that men suffered in silence, isolated by shame and fear, reveals how cultural factors compound the psychological impact of ED. Cultural taboos against discussing sexuality, combined with masculine norms that prohibit displays of vulnerability, left men with no outlet for their distress. They carried their burden alone, with no one to challenge their negative self-perceptions, no one to offer reassurance, no one to provide perspective.

This isolation is itself psychologically damaging. Humans need connection, need to share their struggles, need others to reflect more compassionate versions of ourselves than we can generate alone (Jordan, 2010). Men deprived of this connection were left alone with their shame, their negative self-talk unchallenged, their self-perpetuating cycles uninterrupted.

The fear of disclosure that kept men silent reflects the anticipated social consequences of exposure. Men feared not only the reactions of their wives but also the broader social judgment of friends, family, and community. In a culture where masculinity is publicly performed and evaluated, the imagined shame of exposure was powerful enough to maintain silence even when silence itself was deeply painful.

The loneliness of the secret, the feeling of being cut off from others even when in their presence, represents a profound psychological cost. Men could not be fully present in their relationships because they were hiding a central truth about themselves. This hiddenness created distance even when they were physically present, eroding the very connections that might have supported them.

9.4 Pathways to Resilience and Reconstruction

Despite the profound psychological damage documented, the study also revealed pathways through which some men began to rebuild their self-esteem. These pathways offer hope and guidance for intervention.

The healing power of partner support was transformative for men who experienced it. Wives who responded with understanding, reassurance, and commitment challenged men's negative self-perceptions and provided a foundation for rebuilding self-worth. This finding aligns with research on the importance of social support in coping with health challenges (Cohen & Wills, 1985) and highlights the particular importance of partner support for conditions that affect intimate relationships.

From a Self-Esteem Theory perspective, supportive partners provided alternative reflected appraisals that countered men's negative self-evaluations. When a man's wife continued to see him as worthy, to value him, to commit to him, this challenged his conclusion that he was worthless. Over time, with consistent reassurance, men could begin to internalize this more positive view.

Finding new definitions of manhood represents a cognitive restructuring that addresses the root of the vulnerability. Men who had defined masculinity narrowly in terms of sexual performance were vulnerable to collapse when that performance failed. Men who began to broaden their definition, to recognize multiple sources of masculine worth, became less vulnerable. This finding suggests that interventions should help men examine and potentially revise the contingencies on which their self-worth depends.

The role of faith as a coping resource reflects the religious character of Ghanaian society and offers an important avenue for intervention. Faith provided men with a sense of worth that was not contingent on performance, a relationship with a divine being who loved them unconditionally. This non-contingent acceptance could buffer against the effects of performance failure in any domain. Mental health professionals working with Ghanaian men should engage with, rather than ignore, this important resource.

10. CONCLUSION

This study explored the psychological impact of erectile dysfunction on the self-esteem of Ghanaian men, revealing profound threats to masculine identity, intense shame and self-doubt, isolating secrecy, and pathways to resilience.

The study found that ED fundamentally disrupts men's sense of themselves as men. For men whose self-worth is highly contingent on sexual performance, ED represents not merely a

functional difficulty but a direct threat to the foundations of their identity. They question whether they are still men, feel less than other men, and experience their failure as a fundamental inadequacy.

This identity threat triggers a spiral of shame and self-doubt. Shame, a global negative evaluation of the self, becomes consuming. Negative self-talk reinforces feelings of worthlessness. The loss of confidence spreads beyond the sexual domain to affect work, social interactions, and general sense of capability.

Cultural factors compound these effects. Norms that prohibit discussing sexuality and masculine norms that forbid displays of vulnerability leave men isolated with their distress. They suffer in silence, unable to access the social support that might buffer psychological damage. The loneliness of the secret cuts them off from the very relationships that might help them heal.

Despite these profound challenges, the study identified pathways to resilience. Supportive partners who respond with understanding and reassurance can challenge negative self-perceptions and provide a foundation for rebuilding self-worth. Men who begin to broaden their definitions of masculinity, recognizing worth in domains beyond sexual performance, become less vulnerable. Faith provides a source of non-contingent worth, a relationship with the divine that does not depend on performance.

The study contributes to theoretical understanding by extending Self-Esteem Theory and the Biopsychosocial Model to the Ghanaian context, demonstrating the cultural shaping of contingencies of self-worth and the complex interactions among biological, psychological, and social factors. It provides the first empirical evidence on how ED affects the self-esteem of Ghanaian men, filling a significant gap in the literature.

11. RECOMMENDATIONS

Based on the findings of this study, the following recommendations are proposed for mental health professionals, healthcare providers, policymakers, and future researchers.

Integrate Psychological Support into ED Care: The profound psychological impact documented in this study indicates that medical treatment alone is insufficient. Healthcare facilities should develop pathways for referring men with ED to mental health services. Ideally, multidisciplinary teams including urologists, psychologists, and counsellors should provide comprehensive care that addresses both physical and psychological dimensions.

Develop Couple-Based Interventions: The finding that partner support can be transformative suggests that involving wives in counselling could enhance outcomes. Mental

health services should offer couple-based interventions that help both partners understand ED, communicate effectively about it, and work together as a team. These interventions should be culturally sensitive and available in accessible locations.

Train Healthcare Providers in Psychological Aspects of Care: Healthcare providers should be trained to recognize and address the psychological dimensions of ED. Training should include skills for discussing sensitive topics, assessing psychological distress, providing basic reassurance and support, and making appropriate referrals to mental health services.

Develop Culturally Adapted Cognitive-Behavioural Interventions: The negative self-talk and maladaptive beliefs documented in this study suggest that cognitive-behavioural approaches could be beneficial. Interventions should be adapted for the Ghanaian context, addressing culturally specific beliefs about masculinity and incorporating culturally appropriate metaphors and examples.

Create Safe Spaces for Men to Talk: The isolation documented in this study calls for creating safe spaces where men can discuss their concerns without fear of judgment. Support groups facilitated by trained professionals could provide opportunities for men to share experiences, learn from others, and reduce feelings of isolation. These groups should be confidential and accessible.

REFERENCES

1. Adomako Ampofo, A. (2001). "When men speak women listen": Gender socialisation and young adolescents' attitudes to sexual and reproductive issues. *African Journal of Reproductive Health*, 5(3), 196-212.
2. Althof, S. E. (2002). When an erection alone is not enough: Biopsychosocial obstacles to lovemaking. *International Journal of Impotence Research*, 14(S1), S99-S104.
3. Amoah, S. K., Asafo-Adjei, S., & Boadu, W. (2022). Erectile dysfunction among men with diabetes in a tertiary hospital in Ghana. *Ghana Medical Journal*, 56(1), 23-30.
4. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.
5. Ayta, I. A., McKinlay, J. B., & Krane, R. J. (1999). The likely worldwide increase in erectile dysfunction between 1995 and 2025 and some possible policy consequences. *BJU International*, 84(1), 50-56.
6. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

7. Cameron, A., & Tomlin, M. (2007). The effect of male erectile dysfunction on the psychosocial, relationship, and sexual functioning of couples. *Journal of Sex & Marital Therapy*, 33(4), 321-334.
8. Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 98(2), 310-357.
9. Coopersmith, S. (1967). *The antecedents of self-esteem*. W. H. Freeman.
10. Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, 50(10), 1385-1401.
11. Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.
12. Crocker, J., & Wolfe, C. T. (2001). Contingencies of self-worth. *Psychological Review*, 108(3), 593-623.
13. Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286), 129-136.
14. Fatusi, A. O., Ijadunola, K. T., & Ojofeitimi, E. O. (2003). Correlates of erectile dysfunction among men in a Nigerian tertiary institution. *Journal of Sex & Marital Therapy*, 29(5), 385-394.
15. Feldman, H. A., Goldstein, I., Hatzichristou, D. G., Krane, R. J., & McKinlay, J. B. (1994). Impotence and its medical and psychosocial correlates: Results of the Massachusetts Male Aging Study. *Journal of Urology*, 151(1), 54-61.
16. Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1), 59-82.
17. Harter, S. (1999). *The construction of the self: A developmental perspective*. Guilford Press.
18. James, W. (1950). *The principles of psychology* (Vol. 1). Dover Publications. (Original work published 1890)
19. Jordan, J. V. (2010). *Relational-cultural therapy*. American Psychological Association.
20. Kuehn, B. M., & Winters, R. W. (1994). A study of the relationship between erectile dysfunction and self-esteem. *Journal of Sex Education and Therapy*, 20(3), 181-190.
21. Kvale, S., & Brinkmann, S. (2015). *InterViews: Learning the craft of qualitative research interviewing* (3rd ed.). Sage Publications.
22. Lewis, H. B. (1971). *Shame and guilt in neurosis*. International Universities Press.
23. Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications.

24. Lue, T. F., Giuliano, F., Montorsi, F., Rosen, R. C., Andersson, K. E., Althof, S., & Wagner, G. (2004). Summary of the recommendations on sexual dysfunctions in men. *Journal of Sexual Medicine*, 1(1), 6-23.
25. McCabe, M. P., & Althof, S. E. (2014). A systematic review of the psychosocial outcomes associated with erectile dysfunction: Does the impact of erectile dysfunction extend beyond a man's inability to have sex? *Journal of Sexual Medicine*, 11(2), 347-363.
26. National Institutes of Health. (1993). NIH Consensus Conference on Impotence. *Journal of the American Medical Association*, 270(1), 83-90.
27. Nukunya, G. K. (2016). *Tradition and change in Ghana: An introduction to sociology* (3rd ed.). Ghana Universities Press.
28. Pastuszak, A. W., Badhiwala, N., Lipshultz, L. I., & Khera, M. (2013). Depression is correlated with the psychological and physical aspects of sexual dysfunction in men. *International Journal of Impotence Research*, 25(5), 194-199.
29. Patton, M. Q. (2015). *Qualitative research and evaluation methods* (4th ed.). Sage Publications.
30. Ratele, K. (2014). Currents against gender transformation of South African men: Relocating marginality to the centre of research and theory of masculinities. *NORMA: International Journal for Masculinity Studies*, 9(1), 30-44.
31. Rosen, R. C., Fisher, W. A., Eardley, I., Niederberger, C., Nadel, A., & Sand, M. (2004). The multinational Men's Attitudes to Life Events and Sexuality (MALES) study: I. Prevalence of erectile dysfunction and related health concerns in the general population. *Current Medical Research and Opinion*, 20(5), 607-617.
32. Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton University Press.
33. Rosenberg, M., Schooler, C., Schoenbach, C., & Rosenberg, F. (1995). Global self-esteem and specific self-esteem: Different concepts, different outcomes. *American Sociological Review*, 60(1), 141-156.
34. Sand, M. S., Fisher, W., Rosen, R., Heiman, J., & Eardley, I. (2008). Erectile dysfunction and constructs of masculinity and quality of life in the multinational Men's Attitudes to Life Events and Sexuality (MALES) study. *Journal of Sexual Medicine*, 5(3), 583-594.
35. Shabsigh, R., Perelman, M. A., Laumann, E. O., & Lockhart, D. C. (2004). Drivers and barriers to seeking treatment for erectile dysfunction: A comparison of six countries. *BJU International*, 94(7), 1055-1065.

36. Shaeer, K. Z., Osegbe, D. N., Siddiqui, S. H., & Razzaque, A. (2003). Prevalence of erectile dysfunction and its correlates among men attending primary care clinics in three African countries. *International Journal of Impotence Research*, 15(S1), S9-S14.