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THE EFFECTS OF ERECTILE DYSFUNCTION ON MARITAL SATISFACTION AMONG GHANAIAN MEN

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ABSTRACT

Erectile dysfunction (ED) represents a significant health concern affecting millions of men worldwide, with implications extending far beyond the physiological to encompass psychological well-being, relationship quality, and overall quality of life. In Ghanaian society, where marriage is highly valued and masculine identity is closely tied to sexual performance, the experience of ED may carry particularly profound consequences for marital satisfaction. Yet despite the prevalence of ED and the cultural importance of marriage in Ghana, there has been no systematic research examining how ED affects marital relationships in this context. This study investigates the effects of erectile dysfunction on marital satisfaction among Ghanaian men, exploring the psychological, relational, and cultural dimensions of this experience. Employing a qualitative phenomenological design, the study conducts in-depth interviews with men experiencing ED, their spouses, marriage counsellors, and healthcare providers in the Greater Accra Region. Drawing on the Biopsychosocial Model and Social Exchange Theory, the study seeks to understand how ED influences marital dynamics, what coping mechanisms couples employ, and how cultural factors shape these experiences. By providing empirically grounded insights into the intersection of sexual health and marital quality in Ghana, the study aims to inform the development of culturally sensitive interventions, counselling approaches, and healthcare services that support couples affected by ED.

KEYWORDS: *Erectile dysfunction, marital satisfaction, sexual health, masculinity, couples, Ghana.*

1. INTRODUCTION

Marriage occupies a central place in Ghanaian social life, representing not merely a union between two individuals but a fundamental building block of family, community, and social identity. Across Ghana's diverse ethnic groups, marriage is celebrated through elaborate ceremonies, blessed by religious institutions, and supported by extended family networks. It is within marriage that adults are expected to find companionship, raise children, and achieve full social standing. The success of a marriage, therefore, carries profound personal and social significance.

Central to marital success in most unions is the quality of the sexual relationship between spouses. Sexual intimacy serves multiple functions within marriage: it expresses love and affection, reinforces emotional bonds, provides physical pleasure, and, for many couples, fulfills procreative purposes. When the sexual relationship is satisfying, it can strengthen the overall marital bond and contribute to feelings of connection and commitment. When sexual difficulties arise, they can reverberate throughout the relationship, affecting communication, emotional intimacy, and overall marital satisfaction.

Erectile dysfunction, defined as the persistent inability to achieve or maintain an erection sufficient for satisfactory sexual performance, is one of the most common sexual difficulties affecting men. Epidemiological studies estimate that ED affects approximately 40% of men by age 40 and nearly 70% by age 70 (Feldman et al., 1994), though prevalence varies across populations and measurement approaches. While ED is often discussed in medical terms as a vascular or neurological condition, its effects extend far beyond the physiological. Men experiencing ED commonly report feelings of inadequacy, shame, anxiety, and depression (McCabe & Althof, 2014). They may withdraw from sexual situations, avoid intimacy, and experience diminished self-esteem.

For married men, these individual psychological effects intersect with relational dynamics. Sexual difficulties do not occur in isolation but within the context of an ongoing relationship with a partner who has her own needs, expectations, and responses. Spouses of men with ED may interpret the condition as a loss of attraction, infidelity, or personal failure. They may experience frustration, rejection, and decreased sexual satisfaction themselves. Communication about the difficulty may be hampered by embarrassment, cultural taboos, or fear of hurting the partner's feelings. Over time, these dynamics can erode the marital bond and diminish satisfaction with the relationship.

In the Ghanaian cultural context, several factors may intensify these effects. Ghanaian masculinity is strongly linked to sexual prowess and the ability to satisfy one's wife (Adomako Ampofo, 2001). Men who cannot perform sexually may feel that they have failed not only themselves but also their wives and their masculine identity. The cultural expectation that sexual matters should remain private may prevent couples from seeking help or discussing the difficulty openly. Religious teachings that emphasize the importance of marital sexuality may add moral weight to the difficulty, with some couples interpreting ED as a spiritual problem or punishment. Extended family involvement in marriage may create additional pressure, as wives may confide in relatives and concerns about the marriage may spread beyond the couple.

Despite the prevalence of ED and its potential significance for marital satisfaction in Ghana, there has been no systematic research examining this phenomenon. The limited available literature on sexual health in Ghana has focused primarily on HIV prevention, adolescent sexuality, and reproductive health, with little attention to the sexual difficulties that affect established couples. Studies from Western contexts have documented negative associations between ED and relationship satisfaction (Cameron & Tomlin, 2007; Fisher et al., 2005), but the applicability of these findings to Ghana cannot be assumed given cultural differences in marriage, gender roles, and attitudes toward sexuality.

This study seeks to address this gap by providing the first comprehensive examination of the effects of erectile dysfunction on marital satisfaction among Ghanaian men. Using a qualitative phenomenological approach, the study explored the lived experiences of men with ED, their wives, and the professionals who counsel and treat them. The findings will illuminate how ED affects marital dynamics in the Ghanaian context, what coping mechanisms couples employ, and what forms of support are most needed. Ultimately, this research aims to inform the development of culturally sensitive interventions that can help couples navigate the challenges of ED and protect the quality of their marital relationships.

2. STATEMENT OF THE PROBLEM

Ghanaian couples facing erectile dysfunction navigate a difficult terrain with virtually no support from healthcare systems, mental health services, or community resources, yet there has been no systematic research documenting their experiences or identifying their needs. This absence of evidence leaves a critical gap in understanding how to help couples maintain marital satisfaction when faced with 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 discourse. Medical training pays limited attention to sexual medicine, public health campaigns do not address sexual difficulties, and few healthcare providers feel comfortable or competent to discuss sexual concerns with patients.

For men who experience ED, the condition carries significant psychological consequences. Research from other contexts has documented high rates of depression, anxiety, and reduced quality of life among men with ED (McCabe & Althof, 2014). Men may experience their difficulty as a threat to their masculine identity, leading to shame, withdrawal, and avoidance of intimacy. In Ghana, where masculine identity is closely tied to the ability to provide for and satisfy one's wife (Adomako Ampofo, 2001), these psychological effects may be particularly severe.

For wives of men with ED, the experience is equally challenging. Wives may interpret their husband's difficulty as a loss of desire for them, leading to feelings of rejection, diminished self-esteem, and concerns about their own attractiveness. They may experience sexual frustration and decreased sexual satisfaction. They may worry about the future of their marriage or about whether their husband is being unfaithful. Yet they may feel unable to discuss these concerns with their husband, fearing that doing so would add to his distress or be culturally inappropriate.

The marital relationship itself is affected. Couples may experience decreased communication about sexual matters, withdrawal from physical intimacy, and diminished emotional connection. Sexual difficulties can become a source of tension, blame, and conflict. Over time, these dynamics can erode the overall quality of the marriage, leading to decreased marital satisfaction and, in some cases, marital dissolution.

In the Ghanaian cultural context, additional factors compound these challenges. The expectation that sexual matters should remain private may prevent couples from seeking help from healthcare providers, counsellors, or religious leaders. The involvement of extended family in marriage may create pressure, as wives may feel they cannot disclose the difficulty even to close relatives, yet the absence of children (if ED prevents conception) may become a

matter of family concern. Religious interpretations may frame ED as a spiritual problem requiring prayer or spiritual intervention, which may delay or prevent access to medical care.

The healthcare system offers little support. Most Ghanaian healthcare facilities lack the resources, trained personnel, or protocols for addressing sexual health concerns beyond reproductive health and STI management. Men seeking help for ED may encounter providers who are uncomfortable discussing sexual matters, who lack knowledge about treatment options, or who dismiss their concerns as unimportant. Mental health services that could address the psychological dimensions of ED are scarce and concentrated in urban areas. Support groups or counselling services specifically for couples facing sexual difficulties are virtually nonexistent.

The absence of research on this topic means that interventions, when they exist, are developed without evidence about what Ghanaian couples actually need or what approaches would be culturally appropriate. Counselling approaches imported from Western contexts may not resonate with Ghanaian couples' values, communication styles, or expectations about marriage. Healthcare providers lack guidance on how to address ED in culturally sensitive ways. Religious and community leaders who might otherwise support couples lack information about the condition and its effects.

This study seeks to address these gaps by documenting the experiences of Ghanaian men with ED and their wives, examining how ED affects their marital satisfaction, and identifying the resources and coping mechanisms that support couples in navigating this challenge. By providing empirically grounded insights into these experiences and needs, the study aims to inform the development of culturally appropriate interventions, counselling approaches, and healthcare services that can help couples maintain satisfying marriages despite the challenges of ED.

3. PURPOSE OF THE STUDY

The purpose of this study is to examine the effects of erectile dysfunction on marital satisfaction among Ghanaian men, using a qualitative phenomenological approach to understand the lived experiences of men with ED, their wives, marriage counsellors, 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 marital satisfaction among Ghanaian couples, providing empirical evidence to inform the development of culturally sensitive support services and interventions.

4.2 Specific Objectives

The specific objectives of the study are to:

- Explore the psychological experiences of Ghanaian men living with erectile dysfunction.
- Examine how erectile dysfunction affects communication and emotional intimacy within marriage.
- Investigate the effects of erectile dysfunction on wives' marital satisfaction.
- Identify the coping mechanisms employed by couples facing erectile dysfunction.

5. LITERATURE REVIEW

5.1 Theoretical Review

The investigation of erectile dysfunction and marital satisfaction requires a theoretical framework that can account for the complex interplay of biological, psychological, and social factors that shape this experience. This study draws on two complementary theoretical perspectives: the Biopsychosocial Model and Social Exchange Theory. These frameworks provide complementary lenses for understanding how ED affects individuals and relationships within the Ghanaian cultural context.

5.1.1 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, the Biopsychosocial Model recognizes that ED is rarely purely biological or purely psychological but typically involves complex interactions among multiple factors. Biologically, ED may result from vascular disease, neurological conditions, hormonal imbalances, or side effects of medications. Common risk factors such as diabetes, hypertension, and cardiovascular disease have clear biological pathways affecting erectile

function. Age-related changes in physiology also contribute to increased ED prevalence among older men.

Psychologically, ED is both caused by and causes psychological distress. Performance anxiety, depression, and stress can contribute to the development or maintenance of ED, creating a cycle where fear of failure produces failure, which then reinforces fear. Once ED develops, it commonly triggers psychological responses including shame, embarrassment, reduced self-esteem, and avoidance of sexual situations. These psychological responses can become additional barriers to recovery, even when biological causes are addressed.

Socially, ED is embedded in cultural meanings, relationship dynamics, and social expectations. How men and their partners understand ED, what meanings they attach to it, and how they communicate about it are shaped by cultural norms about masculinity, sexuality, and marriage. The quality of the couple's relationship before ED develops influences how they navigate the difficulty together. Social support, or its absence, affects coping. Access to healthcare and the quality of interactions with providers are shaped by social factors including education, economic resources, and the organization of health services.

The Biopsychosocial Model is particularly relevant to this study because it directs attention to all three domains. Understanding the effects of ED on marital satisfaction requires examining not only the biological reality of erectile difficulties but also how men experience these difficulties psychologically and how couples navigate them socially within the specific cultural context of Ghana. The model also highlights that interventions may need to address multiple domains simultaneously, combining medical treatment with psychological support and relationship counselling.

5.1.2 Social Exchange Theory

Social Exchange Theory, rooted in the work of Thibaut and Kelley (1959) and subsequently developed by Rusbult and colleagues (Rusbult et al., 1998), provides a framework for understanding relationship satisfaction and commitment as products of the rewards and costs partners experience within the relationship. The theory posits that individuals evaluate their relationships based on comparison levels, the outcomes they expect based on past experiences and knowledge of others' relationships, and comparison levels for alternatives, the outcomes they believe they could obtain outside the current relationship.

According to Social Exchange Theory, satisfaction with a relationship is determined by the degree to which the rewards of the relationship exceed the costs, relative to the individual's

expectations. Rewards can include companionship, emotional support, sexual satisfaction, shared activities, and social status. Costs can include conflict, emotional demands, financial burdens, and sexual dissatisfaction. When rewards consistently exceed costs and meet or exceed expectations, satisfaction is high. When costs mount or rewards diminish, satisfaction declines.

Commitment to the relationship, distinct from satisfaction, is influenced by satisfaction level, quality of alternatives, and investment size (Rusbult et al., 1998). Investments are resources tied to the relationship that would be lost if the relationship ended, including shared memories, joint possessions, emotional energy, and social connections with extended family. High investment and poor alternatives can sustain commitment even when satisfaction declines.

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.

5.2.2 The Concept of Marital Satisfaction

Marital satisfaction is one of the most extensively studied constructs in relationship research, yet its conceptualization continues to evolve. At its most basic level, marital satisfaction refers to an individual's subjective evaluation of the quality of their marriage (Spanier, 1976). It encompasses cognitive judgments about how well the marriage meets expectations and affective experiences of happiness, contentment, and fulfillment within the relationship.

Bradbury, Fincham, and Beach (2000) conceptualized marital satisfaction as a global evaluation of the marriage that reflects the balance of positive and negative experiences, the degree to which needs are met, and the overall sense of well-being derived from the relationship. This conceptualization recognizes that satisfaction is not simply the absence of problems but the presence of positive connection, shared meaning, and mutual fulfillment.

Research has identified multiple dimensions that contribute to marital satisfaction. Emotional intimacy, the feeling of being close, connected, and understood by one's spouse, is consistently associated with satisfaction (Reis & Shaver, 1988). Effective communication, including the ability to express feelings, resolve conflicts, and share experiences, supports satisfaction (Gottman, 1994). Shared values and goals provide a sense of partnership and direction. Sexual satisfaction, while not the only determinant, contributes significantly to overall marital satisfaction for most couples (Yeh et al., 2006).

5.2.3 Erectile Dysfunction and Marital Satisfaction: Conceptual Links

The conceptual relationships between erectile dysfunction and marital satisfaction can be understood through multiple pathways. Directly, ED affects the sexual relationship, which for many couples is an important source of pleasure, connection, and affirmation. When sexual activity becomes difficult, impossible, or fraught with anxiety, this direct source of marital reward diminishes. Both partners may experience sexual frustration and loss of a valued form of intimacy.

Indirectly, ED affects marital satisfaction through its psychological consequences for both partners. Men experiencing ED may struggle with feelings of inadequacy, shame, and diminished self-esteem (McCabe & Althof, 2014). These feelings may affect how they interact with their wives, leading to withdrawal, irritability, or avoidance. Wives may interpret ED as loss of desire, leading to feelings of rejection, concerns about their own attractiveness, and worry about the marriage. These psychological responses can create emotional distance even when the couple otherwise gets along well.

ED may also affect communication within the marriage. Couples who previously communicated openly about sexual matters may find themselves avoiding the topic, uncertain how to discuss something so personal and potentially embarrassing. This communication avoidance may spread to other topics, reducing overall openness and connection. When couples do attempt to discuss ED, they may struggle to find words, may misunderstand each other's feelings, or may become defensive or blaming.

The effects of ED on marital satisfaction are likely moderated by several factors. The quality of the relationship before ED developed matters; couples with strong foundations of trust, communication, and commitment may navigate the difficulty better than those with pre-existing vulnerabilities. The attributions couples make about the cause of ED matter; if both partners understand it as a medical condition rather than a personal failing or loss of desire, they may be more likely to approach it as a shared problem to be solved together. The coping strategies couples employ matter; those who seek help together, maintain non-sexual intimacy, and communicate openly may protect their satisfaction better than those who avoid or ignore the difficulty.

5.3 Empirical Review

Research on the prevalence and correlates of erectile dysfunction has been conducted primarily in Western populations, though studies from other regions are increasingly available. The Massachusetts Male Aging Study (Feldman et al., 1994) established a foundation, documenting that ED was common, age-related, and associated with multiple health conditions. Subsequent research has confirmed these findings and extended them to diverse populations.

In African contexts, research on ED is limited but growing. A study in Nigeria by Fatusi et al. (2003) found that among men aged 30-70 attending a general outpatient clinic, 43.8% reported some degree of ED, with prevalence increasing with age and associated with diabetes, hypertension, and lower educational attainment. Similarly, a study in South Africa by Shaeer et al. (2003) found high rates of ED among men with chronic diseases and among those reporting psychological distress.

In Ghana specifically, epidemiological data on ED are extremely limited. A study by Amoah et al. (2022) examining men with diabetes in a tertiary hospital in Accra found that 64% reported some degree of ED, with severity associated with duration of diabetes, poor glycemic control, and presence of other diabetic complications. This study suggests that ED is common among Ghanaian men with chronic disease, but it does not provide population-based estimates or examine ED in the general population.

Research has consistently documented that ED is associated with psychological distress. A meta-analysis by McCabe and Althof (2014) found that men with ED had significantly higher rates of depression and anxiety than men without ED, and that psychological distress often persisted even when ED was treated. The relationship appears bidirectional, with psychological factors contributing to ED and ED contributing to psychological distress.

Research examining the effects of ED on intimate relationships has documented consistent negative associations. Cameron and Tomlin (2007) studied couples seeking treatment for ED and found that both partners reported lower relationship satisfaction compared to couples without sexual difficulties. Men with ED reported feeling less masculine and less adequate as partners, while their female partners reported feeling less desired and less satisfied with their relationships.

Fisher and colleagues (2005) conducted a large multinational study examining the effects of ED on women partners. They found that women whose partners had ED reported significantly lower sexual satisfaction, lower relationship satisfaction, and lower overall quality of life compared to women whose partners did not have ED. Many women reported that ED had negative effects on their emotional connection with their partner and on their ability to communicate about intimate matters.

McCabe and Matic (2008) examined the impact of ED on both partners in a relationship, finding that the effects extended beyond the sexual domain to affect overall relationship quality. Couples reported decreased emotional intimacy, increased conflict, and concerns about the future of their relationship. The study also found that the quality of communication about ED was an important moderator; couples who could discuss the difficulty openly reported better relationship outcomes than those who avoided the topic.

7. METHODOLOGY

7.1 Research Design

This study adopted a qualitative phenomenological design to examine the effects of erectile dysfunction on marital satisfaction among 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 couples navigate the sensitive and deeply personal experience of ED within the Ghanaian cultural context. This design allowed for the capture of rich, detailed narratives that illuminate both the individual and relational 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 couples 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, and relationship histories, 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 marriage counsellors, religious leaders, and other professionals who work with couples experiencing marital difficulties, providing access to additional perspectives. 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, marriage counsellors and therapists with experience counselling couples with sexual difficulties, 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 marital satisfaction, 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 sexual matters, 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; advertisements placed in community health centres with permission; 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, currently in a marital relationship of at least two years' duration, self-identification as experiencing erectile difficulties consistent with ED, and willingness to discuss their experiences.

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. In cases where both partners agreed, separate interviews were conducted to allow each to speak freely without concern about the partner's presence. In some cases, only the husband participated, with reasons including the wife's reluctance, the couple's separation, or the husband's preference that his wife not be involved.

Marriage counsellors and therapists were recruited through professional associations, counselling centres, and religious organizations that provide marriage counselling services. Eligibility required at least three years of counselling experience and having worked with at least five couples where ED was identified as a concern.

Healthcare providers were recruited from major hospitals in the region, including urologists, general practitioners with interest in men's health, and nurses working in relevant departments. Eligibility required at least two years of experience and having provided care to at least ten men presenting with ED.

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 12-15 men with ED, 8-12 wives, 6-8 marriage counsellors, and 6-8 healthcare providers, for a total of 32-43 interviews. Recruitment continued until thematic saturation was achieved, resulting in 38 interviews: 14 men with ED, 10 wives, 7 marriage counsellors, and 7 healthcare providers.

Table 1: Sample Distribution.

Participant Category	Target	Achieved
Men with ED	12-15	14
Wives of men with ED	8-12	10
Marriage counsellors/therapists	6-8	7
Healthcare providers	6-8	7
Total	**32-43**	**38**

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, effects on marital satisfaction, coping mechanisms, support systems, and recommendations. All guides were reviewed by experts in qualitative research, sexual health, and marriage counselling, 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-concept and masculinity, communication with wife about ED, effects on marital intimacy and satisfaction, coping strategies, help-seeking experiences, and recommendations for supporting other couples.

For wives, the guide explored: discovery and awareness of husband's difficulty, emotional responses, communication with husband, effects on sexual satisfaction and marital intimacy, coping strategies, support accessed, and perspectives on how services could better help couples.

For marriage counsellors, the guide explored: experiences counselling couples with ED, common patterns observed, effects on marital dynamics, coping strategies they recommend, challenges in providing support, and recommendations for improving services.

For healthcare providers, the guide explored: training and comfort with sexual health issues, clinical experiences with men presenting ED, approaches to involving partners, perceptions of patients' needs, barriers to effective care, and recommendations for improving services.

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 sexuality 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 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 marital context, discovery and experience of ED, psychological responses, marital communication, effects on intimacy and satisfaction, coping and support, help-seeking experiences, and recommendations.

The wives' guide included sections on: background and marital context, awareness and understanding of husband's ED, emotional responses, marital communication, effects on intimacy and satisfaction, coping and support, and recommendations.

The counsellors' guide included sections on: professional background and training, experiences with couples facing ED, observed patterns and effects, approaches to counselling, challenges, and recommendations.

The healthcare providers' guide included sections on: professional background and training, clinical experiences with ED, approaches to patient communication, partner involvement, perceptions of patient needs, barriers to care, and recommendations.

7.9 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.

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.

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.

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 38 interviews revealed four overarching themes: the burden of secrecy and silence, the erosion of intimacy and connection, threats to masculine identity, and sources of coping and support. Each theme encompasses multiple sub-themes representing the range of experiences across participants.

8.1 Theme One: The Burden of Secrecy and Silence

This theme captures participants' experiences of living with ED in a context where sexual matters are culturally taboo and open communication is difficult. Three sub-themes emerged: the initial silence, fear of disclosure, and the weight of secrecy.

The Initial Silence: Most men described an initial period, often lasting months or years, during which they did not discuss their difficulty with anyone, including their wives. They suffered in silence, uncertain what was happening, ashamed to speak, and hoping the problem would resolve on its own.

"For almost two years, I said nothing. Not to my wife, not to my friends, not to anyone. I kept hoping it would pass, that maybe it was stress from work, that next time would be different. But next time was the same. I carried this thing alone, and it was heavy." (Man with ED, 47 years)

Wives confirmed this silence, describing awareness that something was wrong but uncertainty about what. Some wondered if they were the cause, if their husbands had lost interest in them, or if there was another woman.

"I knew something had changed. He stopped touching me, stopped initiating. When I tried to initiate, he would make excuses, tired, headache, busy tomorrow. I thought maybe he didn't want me anymore, maybe I had gained weight, maybe he was seeing someone else. I didn't know it was a medical problem because he never told me." (Wife, 42 years)

Fear of Disclosure: When asked why they did not speak, men described multiple fears. They feared hurting their wives, who might interpret ED as loss of desire. They feared being seen as less than a man. They feared that speaking would make the problem real and permanent rather than temporary. They feared their wives might leave them.

"How do you tell your wife that you cannot perform? That you are not a real man? I was afraid she would look at me differently, that she would lose respect for me. In our culture, the man is supposed to be strong, to satisfy his wife. To admit failure in that area is to admit failure as a man." (Man with ED, 53 years)

The Weight of Secrecy: The burden of maintaining secrecy took psychological tolls. Men described constant anxiety, preoccupation with their next sexual encounter, and avoidance of situations that might lead to sex. Some withdrew from physical affection entirely to avoid the risk of situations escalating.

"I stopped holding her hand, stopped hugging her, stopped any touch that might lead somewhere. I became cold, distant. She didn't understand why. I couldn't explain. The secret was eating me alive, but I couldn't let it out." (Man with ED, 49 years)

A marriage counsellor described observing this pattern repeatedly:

"The secrecy is often more damaging than the ED itself. The wife doesn't know what's wrong, so she makes up stories, usually stories that blame herself. The husband is suffering alone. The distance grows. By the time they come for counselling, there's so much hurt on both sides." (Marriage Counsellor, 12 years experience)

8.2 Theme Two: The Erosion of Intimacy and Connection

This theme captures how ED, and the silence surrounding it, gradually erodes the emotional and physical intimacy that sustains marriages. Three sub-themes emerged: the loss of physical intimacy, the breakdown of communication, and growing emotional distance.

The Loss of Physical Intimacy: For most couples, ED led to a complete cessation of sexual activity. Men avoided initiating, and wives, after repeated rejections or failed attempts, stopped initiating as well. The loss extended beyond intercourse to include all forms of physical affection.

"We don't touch anymore. Not sex, not even cuddling, not even a goodnight kiss. It's like we are roommates living in the same house, not husband and wife. I miss being held. I miss feeling close to him. But I don't know how to get that back without sex, and sex is not possible." (Wife, 38 years)

A healthcare provider noted that couples often do not know how to maintain intimacy without intercourse:

"Sex is more than intercourse, but many couples don't know that. They think if they can't have intercourse, there's nothing. They stop all physical connection. No one tells them there are other ways to be intimate, other ways to give and receive pleasure. So, they lose everything." (Urologist, 8 years' experience)

The Breakdown of Communication: The silence about ED often spread to other topics. Couples who once talked freely became guarded, avoiding not only discussions of sex but also other areas of potential conflict or vulnerability. Communication became functional, limited to household logistics and children.

"We used to talk about everything. Now we talk about who will pick up the children, what to buy from the market, when the school fees are due. Nothing real. Nothing about us. The elephant in the room has made everything else impossible to discuss too." (Man with ED, 44 years)

Growing Emotional Distance: Over time, the loss of physical intimacy and breakdown of communication created emotional distance that affected how couples felt about each other. The warmth, affection, and sense of partnership that once characterized their relationships diminished.

"I love my husband. I do. But I don't feel in love with him anymore. We are like two people sharing a house, sharing children, but not sharing a life. Something essential has died between us, and I don't know if it can come back." (Wife, 45 years)

A counsellor described this progression:

"What starts as a sexual problem becomes a relationship problem. The couple stops being lovers, then stops being friends, then becomes strangers living together. By the time they seek help, the ED is almost secondary. The real problem is the damage done to the relationship over years of silence and distance." (Marriage Counsellor, 15 years' experience)

8.3 Theme Three: Threats to Masculine Identity

This theme captures how ED threatens men's sense of themselves as men, husbands, and adequate partners, with profound psychological consequences. Three sub-themes emerged: shame and diminished self-worth, feeling like a failure as a husband, and the search for explanations.

Shame and Diminished Self-Worth: Men consistently described feelings of shame and reduced self-worth. ED was not merely a functional difficulty but a fundamental threat to

who they were. They felt less than other men, less than they used to be, less than their wives deserved.

"A man is supposed to be able to perform. When you can't, what are you? I look at myself in the mirror and I don't recognize the person I've become. I feel small. I feel worthless. I feel like I'm not a real man anymore." (Man with ED, 56 years)

Feeling Like a Failure as a Husband: The shame extended beyond personal identity to their role as husbands. Men felt they were failing their wives, not meeting their needs, not fulfilling their marital duties. This sense of failure was particularly acute when wives expressed, directly or indirectly, their own frustration and disappointment.

"My wife never said it directly, but I could see it in her eyes. Disappointment. Frustration. She married a man, and I couldn't be a man for her. I failed her. No matter what else I do for her, provide for her, care for her, I'm failing in the most basic husband duty." (Man with ED, 51 years)

The Search for Explanations: Men struggled to make sense of why this was happening to them. Some blamed themselves, wondering if past sexual behavior or moral failings had caused their difficulty. Some blamed their wives, wondering if they were no longer attracted to them. Some sought explanations in spiritual causes, wondering if they were cursed or being punished.

"I asked myself over and over, why me? What did I do wrong? I went to my pastor, and he said maybe there was a spiritual problem, maybe someone had cursed me. That made sense in a way, because the medical explanations didn't satisfy. It had to be something." (Man with ED, 48 years)

A healthcare provider noted the prevalence of spiritual interpretations:

"Many men come to us after they've already tried spiritual solutions. They've been to pastors, prophets, prayer camps. They've spent money on anointing oils and deliverance services. When they finally come to the hospital, it's often because the spiritual route didn't work. But by then, they've lost years, and the relationship damage is deeper." (General Practitioner, 10 years' experience)

8.4 Theme Four: Sources of Coping and Support

Despite the profound challenges documented, the study also revealed resources that helped some couples cope. Three sub-themes emerged: the power of open communication, supportive partner responses, and the role of faith.

The Power of Open Communication: Couples who managed to break the silence and discuss ED openly reported better outcomes. Open communication allowed them to understand that ED was a medical condition, not a personal rejection or failure. It allowed them to problem-solve together, to express their feelings, and to maintain connection.

"The day I finally told her, it was the hardest conversation of my life. But she surprised me. She said she thought it was her, that she wasn't attractive to me anymore. We both cried. We held each other. From that day, we started talking about it, not hiding. It's still hard, but we're in it together now." (Man with ED, 45 years)

A wife whose husband had eventually told her described the difference:

"Before he told me, I was angry, hurt, confused. After he told me, I was sad, but I wasn't angry anymore. It wasn't about me. It was a problem we had together. We started reading about it online. We started looking for help together. We're not fixed, but we're together." (Wife, 41 years)

Supportive Partner Responses: Wives' responses to disclosure profoundly influenced how couples navigated ED. Wives who responded with understanding, reassurance, and commitment to work together helped protect their marriages. Wives who responded with blame, criticism, or withdrawal compounded the damage.

"She said to me, 'You are more than your erection. I married you, not your penis. We will figure this out together.' Do you know what that meant to me? She gave me back my dignity. She made me feel like a man again, even when my body wasn't working." (Man with ED, 52 years)

Conversely, unsupportive responses deepened men's distress:

"She laughed. She actually laughed. She said, 'So what kind of man are you?' I wanted to die. I wanted to walk out and never come back. I stayed for the children, but something in me died that day." (Man with ED, 49 years)

The Role of Faith: For many couples, faith provided a framework for understanding and coping with ED. Religious beliefs offered comfort, hope, and a sense that they were not alone in their struggle. Prayer provided a way of actively engaging with the problem, even when medical solutions were unavailable or ineffective.

"We pray together every night. We ask God to heal, but also to give us strength to bear it if healing doesn't come. Our faith has held us together when nothing else could. We believe God sees our struggle and will not abandon us." (Wife, 50 years)

A counsellor noted that faith could be either supportive or problematic:

"Faith can be a tremendous resource. It gives couples hope, meaning, a way to bear suffering. But it can also be problematic when couples rely only on prayer and reject medical help, or when they interpret ED as punishment and live with guilt instead of seeking solutions." (Marriage Counsellor, 8 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 Effects of Erectile Dysfunction on Marital Satisfaction.

Overarching Theme	Sub-Themes
The Burden of Secrecy and Silence	The initial silence; Fear of disclosure; The weight of secrecy
The Erosion of Intimacy and Connection	The loss of physical intimacy; The breakdown of communication; Growing emotional distance
Threats to Masculine Identity	Shame and diminished self-worth; Feeling like a failure as a husband; The search for explanations
Sources of Coping and Support	The power of open communication; Supportive partner responses; The role of faith

9. DISCUSSION

This study examined the effects of erectile dysfunction on marital satisfaction among Ghanaian men, revealing profound challenges across multiple dimensions of marital life alongside resources that support coping. The findings illuminate the experiences of couples navigating a deeply personal difficulty within a cultural context that shapes how they understand, respond to, and manage ED.

9.1 The Centrality of Silence and Secrecy

The finding that silence and secrecy are central to the experience of ED in Ghanaian marriages aligns with research from other contexts documenting men's reluctance to disclose sexual difficulties (Shabsigh et al., 2004). However, the Ghanaian cultural context intensifies this silence. Cultural taboos against discussing sexuality, combined with expectations of masculine stoicism and sexual prowess, create powerful barriers to open communication. Men suffer alone, not only from ED itself but from the psychological burden of carrying a secret they dare not share.

From a Biopsychosocial Model perspective (Engel, 1977), this silence represents a social factor that transforms a biological difficulty into a source of profound psychological distress and relational damage. The biological reality of ED, whatever its cause, becomes embedded in a social context that forbids speaking of it, leaving men isolated with their suffering. The

psychological consequences, shame, anxiety, and diminished self-worth, are not inevitable results of ED but products of the meaning attached to it and the isolation imposed by silence.

For wives, the silence creates its own form of suffering. Without information about what is happening, wives construct explanations that often blame themselves or the marriage. They wonder if they are no longer attractive, if their husbands are unfaithful, if the marriage is failing. These misinterpretations create hurt and distance that compound whatever effects ED itself would have had.

Social Exchange Theory (Thibaut & Kelley, 1959) illuminates how silence increases the costs of ED while reducing potential rewards. The secrecy itself is costly, requiring constant vigilance and producing anxiety. The misinterpretations wives develop add emotional costs. Meanwhile, the potential rewards that might come from open communication, shared problem-solving, mutual support, are foreclosed. The exchange balance becomes increasingly negative, eroding marital satisfaction.

9.2 The Progressive Erosion of Marital Quality

The finding that ED leads to progressive erosion of intimacy, communication, and emotional connection reveals the dynamic nature of its effects on marriage. What begins as a sexual difficulty, if unaddressed, spreads to affect multiple dimensions of the relationship. Physical intimacy diminishes, then all physical affection ceases. Communication narrows to functional topics, then becomes guarded and superficial. Emotional warmth fades, replaced by distance and, in some cases, resentment.

This progression aligns with research documenting the spillover effects of sexual difficulties on overall relationship quality (McCabe & Matic, 2008). Sexual intimacy is not isolated from other aspects of marriage but connected to them in complex ways. When sexual intimacy becomes problematic, couples lose not only that specific source of connection but also the emotional closeness that sexual intimacy supports and the communication patterns that surround it.

From a Social Exchange Theory perspective, this erosion represents a cascading increase in relationship costs. Each dimension that deteriorates adds new costs: loneliness, frustration, confusion, and hurt. Meanwhile, rewards diminish: companionship, emotional support, physical affection, shared pleasure. The cumulative effect can transform a once-satisfying marriage into a source of primarily negative experiences.

The Biopsychosocial Model helps explain why some couples experience more severe erosion than others. The biological severity of ED matters, but so do psychological factors, such as

how men interpret their difficulty and whether they become depressed or anxious, and social factors, such as the quality of communication and the responses of wives. Couples with strong pre-existing relationships, good communication skills, and supportive partner responses may experience less erosion than those with vulnerabilities in these areas.

9.3 Masculine Identity and Its Discontents

The finding that ED profoundly threatens men's sense of masculine identity, leading to shame, diminished self-worth, and feelings of failure, highlights the cultural embeddedness of this experience. In the Ghanaian context, as in many cultures, masculinity is closely tied to sexual performance (Adomako Ampofo, 2001). Men are expected to be sexually capable and to satisfy their wives. When ED undermines this capability, it challenges not just a function but an identity.

This identity threat helps explain the intensity of men's psychological distress and their reluctance to disclose. Admitting ED is not simply admitting a medical problem; it is admitting a failure of manhood. The shame associated with this perceived failure can be more distressing than the ED itself. Men may avoid healthcare, avoid disclosure to wives, and avoid any situation that might expose their inadequacy.

The search for explanations documented in this study reflects men's attempts to make sense of a threat to their core identity. Explanations that locate the cause externally, such as spiritual attack or curse, may be psychologically protective because they preserve some sense of personal adequacy. Explanations that locate the cause internally, such as personal failure or punishment for past sins, compound the psychological damage.

From a Biopsychosocial perspective, these identity dynamics represent the psychological and social dimensions of ED that interact with its biological reality. Effective intervention must address not only the biological aspects of ED but also these psychological and cultural meanings. Men need not only treatment for their difficulty but also support in reconstructing a sense of masculine adequacy that is not solely dependent on erectile function.

9.4 Resources for Resilience

Despite the profound challenges documented, the study also revealed resources that support coping. Open communication, supportive partner responses, and faith emerged as important sources of resilience, offering clues about how couples can be helped.

The finding that open communication, when it occurs, is powerfully protective aligns with research on the importance of couple communication in managing sexual difficulties (Althof, 2002). Communication allows couples to understand ED as a shared problem rather than

individual failure, to coordinate their responses, to maintain emotional connection, and to seek help together. The difficulty is that cultural barriers to open communication are precisely what must be overcome.

Supportive partner responses, wives who respond with understanding, reassurance, and commitment to work together, can buffer men against the psychological damage of ED and protect the marriage. These responses communicate that the man's worth is not dependent on his erectile function, that the wife's commitment extends beyond sexual performance, and that they will face the difficulty as a team. Training wives to respond supportively and helping couples have the conversations that enable such responses could be valuable interventions.

The role of faith as a coping resource reflects the religious character of Ghanaian society. For many couples, faith provides meaning, hope, and a framework for bearing suffering. Prayer offers an active way of engaging with the problem even when medical solutions are unavailable. Religious communities can provide support, though they can also compound problems when they interpret ED as spiritual failure. Engaging religious leaders as allies in supporting couples could extend the reach of interventions.

9.5 Implications for Intervention

The findings suggest multiple levels at which intervention is needed. At the couple level, interventions should focus on breaking the silence, facilitating open communication, and helping couples maintain intimacy through non-sexual means. Couples need permission to discuss ED, language for doing so, and guidance on how to have these difficult conversations.

At the individual level, men need support in managing the psychological impact of ED, including shame, diminished self-worth, and threats to masculine identity. Counselling that helps men separate their sense of worth from erectile function, that validates their value as husbands and fathers beyond sexual performance, could be valuable.

At the healthcare system level, providers need training to discuss sexual health comfortably and competently, to include partners in care when appropriate, and to provide comprehensive care addressing not only biological aspects but also psychological and relational dimensions. Protocols for sexual health assessment and referral pathways to counselling services should be developed.

At the community level, efforts to reduce stigma and open space for discussion of sexual health could help normalize ED as a medical condition rather than a personal failing.

Engaging religious leaders, who are trusted sources of guidance for many couples, could extend the reach of interventions.

10. CONCLUSION

This study examined the effects of erectile dysfunction on marital satisfaction among Ghanaian men, revealing profound challenges across multiple dimensions of marital life alongside resources that support coping.

The study found that silence and secrecy are central to the experience of ED in Ghanaian marriages. Cultural taboos against discussing sexuality and expectations of masculine sexual prowess create powerful barriers to open communication. Men suffer alone, carrying the burden of a secret they dare not share. Wives, left without information, construct explanations that often blame themselves, creating additional hurt and distance.

ED progressively erodes multiple dimensions of marital quality. Physical intimacy diminishes and often ceases entirely. Communication narrows to functional topics, losing its depth and openness. Emotional warmth fades, replaced by distance and sometimes resentment. What begins as a sexual difficulty, if unaddressed, spreads to affect the entire relationship.

For men, ED represents a profound threat to masculine identity. The shame and diminished self-worth they experience reflect not only the functional difficulty but the cultural meaning attached to it. Men feel they have failed as husbands, failed as men, and struggle to make sense of why this is happening to them.

Despite these challenges, the study identified resources that support coping. Open communication, when it occurs, allows couples to face ED as a shared problem rather than individual failure. Supportive partner responses can buffer men against psychological damage and protect the marriage. Faith provides meaning, hope, and a framework for bearing suffering.

The study contributes to theoretical understanding by applying the Biopsychosocial Model and Social Exchange Theory to the Ghanaian context, demonstrating their relevance while revealing culturally specific dynamics, particularly the role of masculine identity, extended family expectations, and religious beliefs. It provides the first empirical evidence on how ED affects marital satisfaction in Ghana, filling a significant gap in the literature. The integration of multiple perspectives, men, wives, counsellors, and healthcare providers, provides a comprehensive picture of both the challenges couples face and the resources they draw upon.

For practice, the findings suggest that interventions must address multiple levels: helping couples break the silence and communicate openly; supporting men in managing threats to masculine identity; training healthcare providers to address sexual health competently and sensitively; and engaging religious and community leaders in reducing stigma. By addressing ED not merely as a medical condition but as a biopsychosocial phenomenon with profound relational effects, interventions can better support couples in maintaining satisfying marriages despite this challenge.

11. RECOMMENDATIONS

Based on the findings of this study, the following recommendations are proposed for healthcare providers, counsellors, religious leaders, policymakers, and future researchers.

Develop Couple-Focused Education and Counselling Services: The profound silence and secrecy documented in this study call for the development of accessible, couple-focused education and counselling services. The Ministry of Health and civil society organizations should establish services that provide accurate information about ED, facilitate open communication between spouses, and offer guidance on maintaining intimacy through non-sexual means. These services should be available at primary healthcare facilities, making them accessible beyond urban centres.

Train Healthcare Providers in Sexual Health Communication: The finding that men delay seeking help and encounter providers who are uncomfortable discussing sexual matters requires investment in training. Medical and nursing schools should incorporate sexual health communication into curricula, emphasizing comfort with discussing sensitive topics, knowledge of ED and its treatments, and skills for involving partners appropriately. Continuing professional development programs should offer similar training for practicing providers.

Integrate Mental Health and Relationship Support into ED Care: The psychological and relational effects of ED documented in this study indicate that medical treatment alone is insufficient. Healthcare facilities should develop pathways for referring men and couples to counselling services that can address shame, communication difficulties, and threats to identity. Ideally, multidisciplinary teams including urologists, psychologists, and counsellors should provide comprehensive care.

Engage Religious Leaders as Partners in Support: The finding that faith is an important coping resource, and that many couples seek spiritual solutions before medical care, suggests that religious leaders could be valuable partners. Health authorities should develop programs

to educate religious leaders about ED as a medical condition, equip them to provide supportive counselling, and create referral pathways between religious institutions and healthcare facilities.

Develop Public Education Campaigns to Reduce Stigma: The shame and secrecy surrounding ED reflect broader cultural taboos and stigma. The National Commission for Civic Education, in collaboration with health authorities, should develop public education campaigns that normalize ED as a common medical condition, encourage men to seek help, and promote open communication within marriages. Campaigns should be culturally sensitive and delivered through multiple channels including radio, community gatherings, and religious institutions.

Create Peer Support Opportunities: The isolation experienced by men with ED and their wives suggests that peer support could be valuable. Healthcare facilities or community organizations could facilitate support groups where men can share experiences, learn from others, and reduce feelings of isolation. Similar groups for wives could provide validation and coping strategies. In a context where discussing sexual matters is difficult, structured group settings with professional facilitation may provide safe spaces for sharing.

Include ED in Chronic Disease Management Programs: Given the association between ED and chronic conditions such as diabetes and hypertension documented in the literature, and the aging of Ghana's population, ED should be addressed within chronic disease management. Diabetes and hypertension clinics should routinely assess sexual function, provide information, and offer referrals. This integration would normalize ED as part of chronic disease care and reach men already engaged with healthcare services.

Conduct Further Research on Prevalence and Help-Seeking: This qualitative study provides rich understanding of experiences but does not provide population-based prevalence data. Future research should conduct quantitative surveys to estimate ED prevalence in Ghana, identify risk factors, and examine patterns of help-seeking. Such research would inform service planning and resource allocation.

Evaluate Intervention Effectiveness: As services are developed, rigorous evaluation is needed to determine what works. Future research should evaluate the effectiveness of different counselling approaches, public education campaigns, and healthcare provider training programs. Experimental and quasi-experimental designs can identify effective strategies for supporting couples.

Explore the Experiences of Diverse Populations: This study focused on heterosexual married couples in urban and peri-urban settings. Future research should explore experiences in rural areas, where access to healthcare is more limited and cultural norms may differ. Research should also examine experiences of unmarried men, men in non-marital relationships, and, with cultural sensitivity, sexual and gender minority populations whose experiences may differ.

REFERENCES

1. Adjei, E., Amoah, R., & Osei, K. (2019). Sexual health services in Ghana: Provider perspectives on barriers to care. *Ghana Medical Journal*, 53(2), 112-120.
2. 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.
3. Althof, S. E. (2002). When an erection alone is not enough: Biopsychosocial obstacles to lovemaking. *International Journal of Impotence Research*, 14(S1), S99-S104.
4. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.
5. 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.
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. 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.
9. Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.
10. Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286), 129-136.
11. 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.

12. Fisher, W. A., Rosen, R. C., Eardley, I., Niederberger, C., Nadel, A., Kaufman, J., & Sand, M. (2005). The Multinational Men's Attitudes to Life Events and Sexuality (MALES) Study Phase II: Understanding PDE5 inhibitor treatment seeking patterns, among men with erectile dysfunction. *Journal of Sexual Medicine*, 2(5), 709-718.
13. Gottman, J. M. (1994). *What predicts divorce? The relationship between marital processes and marital outcomes*. Lawrence Erlbaum Associates.
14. 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.
15. Kvale, S., & Brinkmann, S. (2015). *InterViews: Learning the craft of qualitative research interviewing* (3rd ed.). Sage Publications.
16. Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications.
17. 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.
18. 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.
19. McCabe, M. P., & Matic, H. (2008). Erectile dysfunction and relationships: Views of men with erectile dysfunction and their partners. *Sexual and Relationship Therapy*, 23(1), 51-60.
20. National Institutes of Health. (1993). NIH Consensus Conference on Impotence. *Journal of the American Medical Association*, 270(1), 83-90.
21. Nukunya, G. K. (2016). *Tradition and change in Ghana: An introduction to sociology* (3rd ed.). Ghana Universities Press.
22. Osafo, J., Asampong, E., & Langmagne, S. (2020). Religion and sexuality: Mapping the contours of the debate in Ghana. *Ghana Studies*, 23(1), 78-95.
23. Patton, M. Q. (2015). *Qualitative research and evaluation methods* (4th ed.). Sage Publications.
24. Reis, H. T., & Shaver, P. (1988). Intimacy as an interpersonal process. In S. Duck (Ed.), *Handbook of personal relationships* (pp. 367-389). John Wiley & Sons.
25. Rusbult, C. E., Martz, J. M., & Agnew, C. R. (1998). The Investment Model Scale: Measuring commitment level, satisfaction level, quality of alternatives, and investment size. *Personal Relationships*, 5(4), 357-387.

26. 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.
27. Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family*, 38(1), 15-28.
28. Thibaut, J. W., & Kelley, H. H. (1959). *The social psychology of groups*. John Wiley & Sons.