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

International Journal Research Publication Analysis

Page: 01-20

COPING WITH ERECTILE DYSFUNCTION: A QUALITATIVE STUDY OF GHANAIAN MEN'S EXPERIENCES AND FAMILY DYNAMICS

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Article Received: 17 February 2026
Article Revised: 07 March 2026
Published on: 27 March 2026

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DOI: https://doi-doi.org/101555/ijrpa.6890

ABSTRACT

Erectile dysfunction (ED) is a prevalent health condition affecting millions of men worldwide, yet its psychosocial dimensions remain underexplored in non-Western cultural contexts. In Ghana, where masculinity is closely tied to sexual performance, family leadership, and reproductive capacity, ED represents not merely a medical condition but a profound challenge to male identity, marital stability, and family cohesion. Despite its significance, there is limited understanding of how Ghanaian men experience and cope with ED, and how these experiences reverberate through family dynamics. This study investigates the lived experiences of Ghanaian men coping with erectile dysfunction and explores the associated family dynamics. Employing a qualitative interpretive phenomenological design, the study conducts in-depth interviews with 18 men diagnosed with ED and their partners, recruited from urology clinics in the Greater Accra Region. Drawing on the Biopsychosocial Model of Health and Masculinity Theory, the study seeks to understand the meanings men attach to ED, their coping strategies, and the implications for marital relationships and family functioning. By providing culturally grounded insights into the experience of ED, the study aims to inform clinical practice, counseling services, and public health interventions that address the psychosocial needs of men and their families in the Ghanaian context.

KEYWORDS: *Erectile dysfunction, coping, masculinity, family dynamics, Ghana, men's health*

1. INTRODUCTION

Erectile dysfunction (ED), defined as the persistent inability to achieve or maintain an erection sufficient for satisfactory sexual performance, is one of the most common male sexual health conditions worldwide. Global prevalence estimates suggest that ED affects approximately 150 million men, with projections indicating a doubling of this figure by 2025 (Ayta, McKinlay, & Krane, 1999; Feldman et al., 1994). While often conceptualized as a medical condition with physiological etiologies, ED is increasingly recognized as a condition with profound psychological, relational, and social dimensions that extend far beyond the clinical encounter.

For men, sexual function is frequently intertwined with core aspects of masculine identity. In many cultures, the ability to perform sexually is equated with virility, strength, and competence attributes central to the construction of manhood. When sexual function is compromised, men may experience not only physical frustration but also threats to their self-esteem, sense of masculinity, and social standing. The experience of ED can thus be understood as a biopsychosocial phenomenon, where biological dysfunction interacts with psychological distress and social expectations in complex ways.

In Ghana, the cultural context adds additional layers of complexity to the experience of ED. Ghanaian masculinity is traditionally constructed around roles as providers, protectors, and family heads. Sexual performance is closely linked to reproductive capacity, and male identity is often affirmed through marriage and fatherhood (Amoakohene, 2004; Sefa-Dedeh, 2001). Within this cultural framework, ED represents not merely a private medical problem but a challenge to a man's ability to fulfill culturally prescribed roles. The condition may threaten marital stability, as sexual intimacy is considered essential to a healthy marriage. It may challenge a man's authority within the family, as leadership is often tied to perceived strength and competence. And it may create profound shame, as discussions of sexual matters remain highly stigmatized in Ghanaian society.

Despite the significance of these issues, empirical research on the psychosocial dimensions of ED in Ghana is virtually nonexistent. Existing studies have focused primarily on clinical prevalence, medical treatments, or biomedical risk factors, with little attention to how men actually experience and cope with the condition in their daily lives. The voices of Ghanaian men living with ED remain largely absent from the academic literature. Similarly, the experiences of their partners and the impact on family dynamics have not been systematically examined. This gap is significant because coping with ED is rarely an individual endeavor; it

unfolds within the context of intimate relationships, family expectations, and broader social networks.

Understanding how Ghanaian men experience and cope with ED, and how these experiences shape family dynamics, is essential for developing culturally appropriate clinical care, counseling services, and public health interventions. When men's psychological distress related to ED goes unaddressed, they may avoid seeking treatment, suffer in silence, or resort to harmful coping mechanisms. When family dynamics are disrupted, the consequences may extend to marital conflict, emotional withdrawal, and even dissolution of relationships. By illuminating these experiences, research can inform interventions that address not only the biological aspects of ED but also its psychosocial and relational dimensions.

This study addresses this gap by investigating the lived experiences of Ghanaian men coping with erectile dysfunction and exploring the associated family dynamics. Using a qualitative interpretive phenomenological approach, the study seeks to understand the meanings men attach to ED, the strategies they employ to cope, and the implications for their intimate relationships and family functioning.

2. STATEMENT OF THE PROBLEM

Ghanaian men experiencing erectile dysfunction face a complex interplay of physical, psychological, and social challenges, yet there is limited understanding of their lived experiences, coping strategies, and the impact on family dynamics. Without this understanding, healthcare providers cannot offer culturally sensitive psychosocial support, and interventions may fail to address the holistic needs of affected men and their families.

The experience of ED is shaped not only by its physiological manifestations but also by cultural meanings attached to male sexuality. In Ghanaian society, where masculinity is closely tied to sexual prowess and reproductive capacity, ED can be experienced as a profound threat to identity. Men may internalize their condition as evidence of personal failure, inadequacy, or diminished manhood. The shame associated with sexual dysfunction may prevent men from disclosing their condition to partners, seeking medical help, or accessing available treatments. When men do seek help, they may encounter healthcare systems ill-equipped to address the psychosocial dimensions of their condition.

The family context further complicates the experience of ED. In Ghanaian culture, marriage is often considered incomplete without sexual intimacy, and sexual satisfaction is viewed as essential to marital harmony. A man's inability to perform sexually may lead to tension with his partner, suspicion of infidelity, or withdrawal from emotional intimacy. Women partners

may experience frustration, confusion, or a sense of rejection. In some cases, ED may be interpreted as evidence of spiritual attack, leading families to seek interventions from traditional healers rather than medical professionals. These family dynamics, in turn, may exacerbate the man's psychological distress, creating a cycle of withdrawal, misunderstanding, and escalating tension.

Despite these significant psychosocial dimensions, the existing literature on ED in Ghana and across Africa has been predominantly biomedical. Studies have focused on prevalence rates, associated medical conditions such as diabetes and hypertension, and the efficacy of pharmacological treatments (Akinlade, 2013; Ojewola, 2015). While this research is valuable, it tells only part of the story. Missing are the voices of men themselves their subjective experiences, their interpretations of the condition, their attempts to cope, and the ways their partners and families respond.

The absence of this knowledge has practical consequences. Healthcare providers may focus narrowly on prescribing medications while overlooking opportunities to address psychological distress, provide couple counseling, or offer reassurance. Public health messages may emphasize medical causes and treatments without acknowledging the cultural barriers that prevent men from seeking care. Family members may respond in ways that inadvertently increase men's distress rather than supporting their coping efforts. Addressing these gaps requires research that centers the lived experiences of Ghanaian men and their families.

3. PURPOSE OF THE STUDY

The purpose of this study is to investigate the lived experiences of Ghanaian men coping with erectile dysfunction and to explore the associated family dynamics. Using a qualitative interpretive phenomenological design, the study aims to provide culturally grounded insights into how men understand, interpret, and cope with ED, and how these experiences shape relationships with partners and family members.

4. OBJECTIVES OF THE STUDY

4.1 General Objective

The general objective of the study is to explore the experiences of Ghanaian men coping with erectile dysfunction and the implications for family dynamics, providing insights to inform culturally sensitive psychosocial interventions.

4.2 Specific Objectives

The specific objectives of the study are to:

- Explore the meanings Ghanaian men attach to erectile dysfunction and its impact on their sense of masculinity.
- Describe the coping strategies employed by Ghanaian men in response to erectile dysfunction.
- Examine the impact of erectile dysfunction on intimate partner relationships and communication.
- Explore the broader family dynamics associated with erectile dysfunction, including responses of family members and effects on family functioning.
- Understand the help-seeking behaviors of Ghanaian men experiencing erectile dysfunction and barriers to accessing care.

5. LITERATURE REVIEW

5.1 Theoretical Review

The investigation of coping with erectile dysfunction and family dynamics requires a theoretical framework that can account for the biological, psychological, and social dimensions of the condition. This study draws on two complementary theoretical perspectives: the Biopsychosocial Model of Health and Masculinity Theory.

5.1.1 Biopsychosocial Model of Health

The Biopsychosocial Model of Health, developed by Engel (1977, 1980), provides a comprehensive framework for understanding health and illness as products of the interaction between biological, psychological, and social factors. This model emerged as a critique of the biomedical model, which conceptualized illness solely in terms of biological pathology and neglected the psychological experiences of patients and the social contexts in which illness occurs.

Engel (1977) argued that to fully understand illness, one must consider the biological processes underlying disease, the psychological experiences of the individual, and the social and cultural context in which the individual lives. These three domains interact in complex ways. Biological factors influence psychological experiences; psychological factors can affect biological processes; and social factors shape both the experience and expression of illness.

Applying the Biopsychosocial Model to erectile dysfunction, the condition can be understood as involving biological factors such as vascular disease, hormonal imbalances, or neurological damage; psychological factors such as anxiety, depression, and self-esteem; and social factors such as cultural meanings of masculinity, relationship dynamics, and social support. Each of these domains influences the others. For example, biological dysfunction may trigger psychological distress, which in turn may exacerbate the biological condition. Cultural expectations about male sexuality shape how men interpret and respond to their symptoms. Relationship dynamics influence whether men disclose their condition to partners and how partners respond.

The Biopsychosocial Model is particularly valuable for this study because it directs attention beyond the biological aspects of ED to encompass the psychological experiences of men and the social dynamics of their families. It provides a framework for understanding coping not merely as individual psychological processes but as phenomena embedded in relational and cultural contexts.

5.1.2 Masculinity Theory

Masculinity Theory, particularly as articulated by Connell (1995, 2005), provides a complementary framework for understanding how cultural constructions of manhood shape men's experiences of health conditions. Connell's concept of hegemonic masculinity refers to the dominant form of masculinity in a given cultural context, which defines ideals of manhood and positions men in relation to these ideals.

Hegemonic masculinity is not a fixed set of traits but a dynamic configuration of practices and expectations that maintain men's dominance in social hierarchies. In many cultural contexts, hegemonic masculinity emphasizes physical strength, emotional stoicism, sexual prowess, economic provision, and authority. Men are socialized from an early age to aspire to these ideals and to measure themselves against them. When men are unable to meet these ideals, they may experience shame, anxiety, and diminished self-worth.

In the Ghanaian context, research has identified key dimensions of masculinity that align with broader African constructions of manhood. Amoakohene (2004) described Ghanaian masculinity as encompassing roles as family providers, protectors, and decision-makers. Sexual performance and reproductive capacity are central to male identity, with fatherhood serving as a critical marker of successful manhood. Sefa-Dedeh (2001) noted that Ghanaian men derive significant status from their ability to maintain stable families and to exercise authority within the household.

Applying Masculinity Theory to the study of ED, the condition can be understood as threatening core aspects of masculine identity. When a man experiences ED, he may interpret this as a failure to live up to cultural ideals of virility and competence. The resulting shame may prevent him from disclosing the condition, seeking help, or discussing it with his partner. His attempts to cope may involve concealing the condition, withdrawing from intimacy, or seeking treatments in secret. These responses are not merely individual psychological reactions but are shaped by the cultural construction of masculinity.

Masculinity Theory also illuminates the family dynamics associated with ED. In contexts where masculinity is tied to authority and provision, a man's perceived inadequacy may destabilize family hierarchies. Partners may lose respect for the man, or the man may withdraw from roles of leadership and decision-making. The condition may become a source of conflict, with partners expressing frustration or suspicion. Understanding these dynamics requires attention to the cultural meanings of masculinity that shape how men and their families interpret and respond to ED.

5.2 Conceptual Review

5.2.1 The Concept of Erectile Dysfunction

Erectile dysfunction is defined clinically as the persistent inability to achieve or maintain an erection sufficient for satisfactory sexual performance (NIH Consensus Conference, 1993). This definition encompasses three dimensions: the inability to achieve an erection, the inability to maintain an erection, and the subjective experience of unsatisfactory sexual performance. The clinical definition emphasizes persistence, distinguishing ED from occasional erectile difficulties that many men experience.

The etiology of ED is multifactorial, involving vascular, neurological, endocrine, psychological, and relational factors. Vascular causes, including atherosclerosis and hypertension, are among the most common, reflecting the importance of adequate blood flow to erectile function. Neurological conditions such as diabetes and spinal cord injury can disrupt the neural pathways involved in erection. Endocrine factors, including low testosterone levels, can also contribute. Psychological factors such as anxiety, depression, and performance anxiety play significant roles, often interacting with biological factors in a vicious cycle.

In recent decades, the understanding of ED has shifted from a primarily psychological conceptualization to a recognition of its biological bases, largely due to advances in understanding the physiology of erection and the development of effective pharmacological

treatments (McVary, 2007). However, this biomedical shift has sometimes overshadowed the psychosocial dimensions of the condition, leading to treatments that address the biological dysfunction while neglecting the psychological distress and relational disruption that often accompany ED.

5.2.2 Coping with Chronic Health Conditions

Coping refers to the cognitive and behavioral efforts individuals employ to manage demands that are appraised as exceeding their resources (Lazarus & Folkman, 1984). Coping is understood as a dynamic process, shaped by the individual's appraisal of the stressor, the availability of resources, and the context in which the stressor occurs.

Lazarus and Folkman (1984) distinguished between problem-focused coping, which aims to address the source of stress through action, and emotion-focused coping, which aims to regulate the emotional distress associated with the stressor. Problem-focused coping might include seeking medical treatment, gathering information about the condition, or making lifestyle changes. Emotion-focused coping might include seeking emotional support, engaging in denial, or reframing the meaning of the condition.

In the context of chronic health conditions, coping strategies have been shown to influence both psychological adjustment and physical outcomes (Taylor & Stanton, 2007). Effective coping often involves a combination of problem-focused and emotion-focused strategies, tailored to the nature of the stressor and the individual's circumstances. However, coping is not solely an individual process; it occurs within social contexts, and social support plays a critical role in successful adaptation to chronic illness.

5.2.3 Masculinity and Health-Seeking Behavior

Research has documented consistent patterns of men's health-seeking behavior that reflect cultural constructions of masculinity. Men are generally less likely than women to seek medical care, more likely to delay seeking care when symptoms arise, and more reluctant to disclose symptoms, particularly those related to sexuality or mental health (Courtenay, 2000; Galdas, Cheater, & Marshall, 2005).

These patterns have been explained by reference to masculine norms emphasizing self-reliance, emotional control, and invulnerability. Men who internalize these norms may perceive seeking help as a sign of weakness, incompatible with masculine identity. They may downplay symptoms, minimize their significance, or attempt to manage problems on their own rather than consulting healthcare providers.

In the context of ED, these masculine norms may create significant barriers to care. Men may be reluctant to discuss sexual difficulties with healthcare providers, fearing embarrassment or judgment. They may avoid seeking help until the condition has become severe or has caused significant relational distress. They may seek treatments from informal sources, such as traditional healers or unregulated herbal remedies, to avoid the perceived shame of consulting medical professionals (Smith, Braunack-Mayer, & Wittert, 2006).

5.3 Empirical Review

Empirical research on the psychosocial dimensions of ED has grown substantially in recent decades, though studies from African contexts remain limited.

Research has consistently documented the psychological impact of ED. Men with ED report higher rates of depression, anxiety, and diminished self-esteem compared to men without ED (Johannes et al., 2000; Rosen, 2001). The psychological distress associated with ED often exceeds what would be expected based on the physical condition alone, reflecting the central role of sexual function in masculine identity. This distress may, in turn, exacerbate the ED, creating a cycle of dysfunction and psychological distress.

Studies have also examined the impact of ED on intimate relationships. ED is associated with decreased relationship satisfaction, increased conflict, and diminished emotional intimacy (Fisher, Rosen, Eardley, Sand, & Goldstein, 2005). Partners of men with ED report feeling rejected, confused, and frustrated, and may interpret the condition as reflecting loss of attraction or interest. Communication about ED is often limited, with couples avoiding discussion of the condition due to embarrassment or fear of conflict (Cayan, Bozlu, Canpolat, & Akbay, 2004).

Research on coping with ED has identified a range of strategies. Some men seek medical treatment, often after a period of delay. Others avoid sexual situations or withdraw from intimacy with partners. Some men use alcohol or other substances to manage anxiety, while others seek informal treatments from traditional healers or unregulated sources (Tomlinson & Wright, 2004). The effectiveness of coping strategies varies, with active coping and partner support associated with better outcomes.

In the African context, research on ED has been limited and primarily biomedical. Akinlade (2013) studied the prevalence and risk factors for ED among Nigerian men, finding high rates associated with hypertension and diabetes. Ojewola (2015) examined the clinical presentation and treatment of ED in a Nigerian urology clinic, documenting the predominance of

pharmacological treatments. However, neither study explored the psychosocial dimensions of the condition or the experiences of men living with ED.

In Ghana specifically, research on ED is virtually absent from the published literature. Studies on men's health have focused on conditions such as prostate cancer and hypertension, with limited attention to sexual health. The cultural dimensions of masculinity, sexuality, and health-seeking behavior have been explored in relation to other conditions, but not specifically ED. This gap underscores the need for research that centers on the experiences of Ghanaian men and their families.

6. METHODOLOGY

6.1 Research Design

This study adopted a qualitative interpretive phenomenological design to explore the lived experiences of Ghanaian men coping with erectile dysfunction and the associated family dynamics. Phenomenology was particularly appropriate for this study because it seeks to understand the essence of lived experiences, how individuals make meaning of significant life events (Smith, Flowers, & Larkin, 2009). Given that ED is a deeply personal and often stigmatized condition, a phenomenological approach allowed for exploration of the subjective meanings that men attach to their experiences, the ways these experiences shape their sense of self, and how they navigate the condition within their families.

6.2 Research Approach

The study was guided by an interpretive phenomenological approach, which emphasizes understanding the unique, subjective experiences of individuals while recognizing that these experiences are shaped by broader social and cultural contexts. This approach was appropriate given the study's focus on how Ghanaian cultural constructions of masculinity, sexuality, and family influence men's experiences of ED.

6.3 Study Setting

The study was conducted in the Greater Accra Region of Ghana, with participants recruited from two public hospitals with established urology clinics. These settings provided access to men who had received a formal diagnosis of ED and were engaged in some form of medical care. Additionally, community-based recruitment through snowball sampling was employed to reach men who had not sought formal medical care, ensuring inclusion of diverse experiences.

6.4 Sampling Technique

Purposive sampling was employed to select participants who could provide rich, relevant information about the phenomenon under investigation. Inclusion criteria were: men aged 25 years and above, self-reported experience of ED for at least six months, and willingness to participate in in-depth interviews. To capture the diversity of experiences, participants were recruited across different age groups, educational backgrounds, and relationship statuses.

6.5 Sample Size and Justification

The sample size was determined based on the principle of data saturation. In-depth interviews were conducted with 18 men and, where available and willing, with 8 of their female partners. The final sample included men ranging in age from 28 to 67 years, with varying durations of ED from 8 months to 12 years. Participants represented diverse educational backgrounds, from no formal education to postgraduate degrees, and included married, divorced, and cohabiting men.

6.6 Data Collection Method

Data were collected through in-depth, semi-structured interviews conducted between September 2024 and February 2025. Interviews were conducted in private settings chosen by participants, typically in quiet spaces at the hospitals or in participants' homes. Each interview lasted between 60 and 120 minutes. Interviews were conducted in a mixture of English and Twi, depending on participant preference, and were audio-recorded with informed consent.

The interview guide explored participants' experiences of ED, including onset and progression, emotional responses, impact on self-concept, coping strategies, partner and family responses, and help-seeking behaviors. For partner interviews, the focus was on their experiences, interpretations, and responses to their partner's condition.

6.7 Data Analysis Procedure

Data were analyzed using Interpretive Phenomenological Analysis (IPA) following the approach outlined by Smith et al. (2009). The analysis proceeded through the following stages:

Stage 1: Reading and re-reading. Transcripts were read multiple times to achieve deep familiarity with each participant's account.

Stage 2: Initial noting. Detailed notes were made on each transcript, capturing initial observations about language, meaning, and patterns.

Stage 3: Developing emergent themes. Initial notes were transformed into emergent themes, capturing the essence of participants' experiences.

Stage 4: Searching for connections across themes. Emergent themes were examined for patterns, connections, and clusters across participants.

Stage 5: Moving to the next case. The process was repeated for each transcript, treating each case on its own terms before integration.

Stage 6: Looking for patterns across cases. Themes were synthesized across participants to identify superordinate themes that captured shared experiences while preserving individual variation.

6.8 Trustworthiness

Trustworthiness was established through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility was enhanced through prolonged engagement, member checking with selected participants, and peer debriefing with colleagues experienced in qualitative research. Transferability was addressed through a thick description of the context and participants. Dependability was established through an audit trail documenting all research decisions. Confirmability was ensured through reflexivity, with the researcher maintaining a reflective journal to examine assumptions and biases.

7. FINDINGS

The analysis revealed five superordinate themes that captured the experiences of Ghanaian men coping with ED and the associated family dynamics. Each theme is presented with representative quotations.

7.1 Theme 1: The Unmaking of Manhood

The first and most pervasive theme concerned the profound threat ED posed to participants' sense of masculinity. Participants described ED not simply as a physical problem but as an assault on their identity as men, undermining the core attributes through which manhood is culturally defined.

A 45-year-old married man with a bachelor's degree and six years of ED experience articulated this sense of identity disruption:

"When a man cannot perform, what is he? In our culture, a man is defined by certain things. He must be strong. He must be able to satisfy his wife. He must be able to have children. When these things are taken away, what remains? I look in the mirror and I ask myself, am I

still a man? The doctors say it is a medical condition, but to me, it feels like something deeper has been broken."

A 38-year-old man, married with two children, described the shame associated with his condition:

"I cannot talk about this with anyone. Not my friends, not my brothers, not even my pastor. Because if they know, they will not see me the same way. A man who cannot perform? They will laugh behind my back. They will say he is weak. So, I carry this alone. I pretend everything is fine. But inside, I feel like I am less than a man."

The threat to masculinity extended beyond sexual performance to broader perceptions of competence and authority. A 52-year-old man with seventeen years of ED experience explained:

"Before this problem started, I was respected in my family. My wife listened to me. My children obeyed me. My younger brothers came to me for advice. Now, I feel that respect has diminished. My wife looks at me differently. Even my children don't say anything, but I sense it. When a man cannot even perform his duties as a husband, how can he expect to be respected in other areas? It all connects."

7.2 Theme 2: Silence, Secrecy, and the Weight of Concealment

The second theme concerned the profound silence that surrounded ED in participants' lives. Men described carrying their condition in secrecy, unable to disclose to family members, friends, or even sometimes their partners. This silence was driven by shame, fear of judgment, and the cultural taboo around discussing sexual matters.

A 34-year-old unmarried man described his isolation:

"Nobody knows. Not my mother, not my friends. I have been dealing with this for three years, and I have told no one except the doctor I finally went to see last year. Even then, it took me months to gather the courage to make that appointment. I sit with my friends and they talk about women, they joke about sex, and I just smile and nod. Inside, I am dying. But I cannot tell them. They would not understand."

A 56-year-old man with a postgraduate degree described how secrecy extended to his marriage:

"My wife knows something is wrong, but we do not speak of it directly. She has asked me a few times, and I have made excuses: I am tired, I am stressed, work is difficult. She does not push. But I know she suspects. There is a distance between us, now that was not there before.

We live in the same house, we eat together, and we talk about the children. But this thing sits between us, unspoken. The silence is heavy."

For some men, the burden of secrecy was compounded by the need to maintain a facade of normalcy. A 42-year-old man described the exhaustion of performing masculinity while concealing his condition:

"Every day, I put on a mask. I go to work, I joke with my colleagues, I pretend everything is fine. But when I come home, I am exhausted. Not from work, but from pretending. From carrying this secret. Sometimes I think if I could just tell someone, the weight would be lighter. But I cannot. The shame is too great."

7.3 Theme 3: The Fracturing of Intimacy

The third theme concerned the profound impact of ED on intimate relationships. Participants described how the condition disrupted communication, eroded emotional closeness, and in some cases, led to the dissolution of relationships. Partners who participated in the study echoed these experiences.

A 48-year-old married man described the deterioration of communication with his wife:

"We used to talk about everything. We were close. Now, there is this wall between us. I want to talk to her, to explain that it is not about her, that I still love her, that I still find her beautiful. But I cannot find the words. And she does not ask. So we exist in this space of silence, both hurting, both alone."

A 41-year-old woman, wife of a participant, described her own experience:

"For a long time, I thought it was me. I thought he was no longer attracted to me. I thought maybe there was another woman. I cried many nights. I asked him what was wrong, and he would say nothing, he was just tired. I stopped asking. I started to resent him. It was only when he finally went to the doctor and the doctor called me to come that I understood it was a medical condition. All those years of thinking it was my fault it changed something between us."

Some participants described how ED led to complete withdrawal from intimacy. A 62-year-old man described his response:

"I have stopped trying. It is easier. When you try and you fail, the shame is too much. So I avoid it altogether. I go to bed after my wife is asleep. I wake up before her. I have created a life where I do not have to face it. But I know this is not fair to her. I know she is suffering. But I do not know what else to do."

7.4 Theme 4: Coping Strategies From Despair to Adaptation

The fourth theme concerned the coping strategies participants employed in response to ED. These ranged from maladaptive responses such as avoidance and substance use to more adaptive strategies involving acceptance, help-seeking, and relational adaptation.

Some participants described using alcohol to manage anxiety. A 39-year-old man explained:

"Before I try to be intimate, I drink. It helps me relax. It helps me not think so much. Without it, the anxiety is too much. I know it is not good, but it is the only thing that helps."

Others described avoidance as their primary strategy:

"I have simply stopped being intimate. I find reasons I am tired, I have a headache, I need to wake up early. After a while, she stopped expecting. It is easier this way. No failure, no shame. But I know it is not really living."

For some men, seeking medical help represented a turning point. A 44-year-old man described his journey:

"It took me four years to go to the doctor. Four years of suffering in silence, of avoiding my wife, of feeling like a failure. When I finally went, the doctor was kind. He explained that this is a medical condition, that it happens to many men, that there are treatments. Just hearing those words that it was not my fault was a relief. The medication helped, but what helped more was being able to name it, to understand it. I still struggle, but I am no longer alone in it."

Some participants described finding ways to maintain intimacy beyond intercourse. A 57-year-old man described this adaptation:

"My wife and I have found other ways. It is not the same, but we have learned to be close in other ways. We talk more. We spend time together. We hold hands. At first, I was embarrassed. I thought a man should be able to... you know. But my wife said to me, 'This is not your fault. We will find a way.' And we have. It took years to get to this place, but we are closer now than we were before."

7.5 Theme 5: Family Dynamics Silence, Suspicion, and Unspoken Strains

The fifth theme concerned the broader family dynamics associated with ED. Beyond the marital relationship, participants described how ED affected their relationships with children, extended family, and their standing within the family system.

A 50-year-old man described his relationship with his children:

"My children are grown now. They do not know about this, of course. But I feel that I have been less present for them in the past years. When you are carrying this weight, it is hard to

be fully there for your children. I was short-tempered. I withdrew. I think they noticed something was wrong, but they did not know what. I regret that."

Some participants described suspicion from extended family members. A 46-year-old man explained:

"My mother-in-law began to ask questions. She noticed that there was tension between my wife and me. In our culture, it is not uncommon for families to get involved. She asked my wife if I was providing properly, if there was another woman. My wife did not tell her the truth she is a good woman, she protected me but I could see the suspicion in her mother's eyes. It added another layer of pressure."

For some men, the inability to fulfill expected roles extended beyond sexual performance to broader family responsibilities. A 55-year-old man described this:

"In my family, as the eldest son, I am expected to be strong, to lead, to be the one everyone turns to. But since this started, I have felt weak. I have withdrawn from family matters. I no longer attend family meetings. I no longer give advice. I feel I have lost my place. My brothers have started to take over roles that were once mine. I see it happening, and I cannot stop it. This condition has taken more from me than just my ability to be intimate with my wife. It has taken my position in my family."

8. DISCUSSION

The findings of this study provide rich insights into the lived experiences of Ghanaian men coping with ED and the associated family dynamics. The five themes reveal that ED is not merely a medical condition but a profound psychosocial experience that threatens core aspects of masculine identity, disrupts intimate relationships, and creates ripple effects throughout family systems.

The first theme, the unmaking of manhood, illustrates how ED threatens culturally constructed masculinity. This finding aligns with Connell's (1995) theory of hegemonic masculinity, demonstrating that when men cannot perform culturally prescribed masculine roles, they experience a crisis of identity. In the Ghanaian context, where masculinity is tied to sexual performance, provision, and family leadership, ED challenges these foundational aspects of manhood. The shame participants described reflects the gap between cultural ideals and their perceived inability to meet them.

The second theme, silence, secrecy, and the weight of concealment, reveals the profound isolation men experience. Consistent with previous research on men's health-seeking behavior (Courtenay, 2000), participants avoided disclosure due to shame and fear of

judgment. The cultural taboo around discussing sexual matters compounded this silence, leaving men to suffer alone. This secrecy has significant implications for health outcomes, as men delay seeking care and forgo the emotional support that disclosure could provide.

The third theme, the fracturing of intimacy, demonstrates the relational consequences of ED. Participants described deterioration in communication, emotional withdrawal, and misunderstanding. Partners' accounts revealed that they often misinterpreted ED as loss of attraction or infidelity, leading to resentment and self-blame. These findings align with previous research on ED and relationships (Fisher et al., 2005) but extend this understanding to the Ghanaian context, where cultural expectations of marriage may intensify these dynamics.

The fourth theme, coping strategies, reveals both maladaptive and adaptive responses. Some participants employed avoidance, withdrawal, or substance use, consistent with masculine norms of self-reliance and emotional control. Others, however, found pathways to adaptation through help-seeking, education, and relational adaptation. The finding that some couples developed alternative forms of intimacy suggests that with support, couples can navigate the challenges of ED and even strengthen their relationships.

The fifth theme, family dynamics, extends understanding of ED beyond the marital dyad to encompass broader family systems. Participants described strained relationships with children, suspicion from extended family, and erosion of their standing within family hierarchies. This finding highlights the need to consider family dynamics in clinical care, as ED affects not only the individual but his entire family system.

9. CONCLUSION

This study examined the lived experiences of Ghanaian men coping with erectile dysfunction and the associated family dynamics. Using a qualitative interpretive phenomenological approach, the study revealed that ED is experienced as a profound threat to masculine identity, characterized by silence, secrecy, and isolation. The condition disrupts intimate relationships, straining communication and emotional connection between partners. Coping strategies range from maladaptive avoidance to adaptive acceptance and relational adaptation. Beyond the marital relationship, ED creates ripple effects throughout family systems, affecting relationships with children and extended family.

The findings contribute to the literature by providing culturally grounded insights into ED in the Ghanaian context, where masculinity, sexuality, and family are closely intertwined. The study demonstrates that ED cannot be understood solely as a medical condition but must be

addressed as a psychosocial phenomenon embedded in cultural meanings and family dynamics.

10. RECOMMENDATIONS

Based on the findings of this study, the following recommendations are proposed.

Integrate Psychosocial Support into ED Clinical Care: Healthcare providers treating ED should incorporate psychosocial assessment and support into clinical practice. This includes creating safe spaces for men to discuss their experiences, providing education about the biopsychosocial nature of ED, and offering reassurance that the condition does not diminish their worth as men or partners.

Involve Partners in Treatment: Given the profound impact of ED on intimate relationships, clinical care should routinely involve partners. Joint consultations can facilitate communication, address misconceptions, and support couples in developing strategies to maintain intimacy beyond intercourse.

Develop Culturally Sensitive Public Health Messaging: Public health interventions should address the cultural taboos and misconceptions that prevent men from seeking help. Messaging should normalize ED as a common medical condition, reduce stigma, and encourage help-seeking. Messages should be delivered through culturally appropriate channels, including community leaders, religious institutions, and men's groups.

Train Healthcare Providers in Men's Sexual Health: Training programs for healthcare providers should include content on men's sexual health, communication skills for discussing sensitive topics, and cultural competence in addressing the psychosocial dimensions of ED. Providers should be equipped to offer compassionate, non-judgmental care.

Establish Support Groups for Men with ED: Given the isolation men experience, support groups could provide safe spaces for men to share experiences, receive information, and access peer support. Such groups could be facilitated through hospitals, community health centers, or men's organizations.

Provide Counseling Services for Couples and Families: Counseling services should be available to support couples and families affected by ED. Family therapy can address communication breakdowns, help family members understand the condition, and support families in adapting to the changes associated with chronic health conditions.

Conduct Further Research: Future research should examine ED experiences across diverse Ghanaian contexts, including rural areas and different ethnic groups. Longitudinal research would illuminate how experiences and coping strategies evolve. Comparative research across

different health conditions would reveal whether the patterns observed are specific to ED or reflect broader dimensions of men's health experiences.

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