



Spousal Support and Health Locus of Control as Predictors of Hospital Utilisation among Men Diagnosed With Erectile Dysfunction

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ABSTRACT

The psychological impact of erectile dysfunction can be seen in their current marital relationship, the willingness to discuss the illness, the feeling of guilt and denial, depression, anger, decrease in self-confidence and self-esteem, as well as the feeling of failure as a man. However, this study examined how spousal support and health locus of control significantly predict hospital utilisation among men diagnosed with erectile dysfunction in Ibadan, Oyo State. This study adopted an Ex-post facto design involving a purposively sampled 124 participants from Adeoyo Hospital with ages ranging between 37 and 74 and a mean age of 49.87 ± 10.79 years respectively. A 54-item self-report questionnaire comprising socio-demographics, spousal support ($\alpha=.89$), health locus of control ($\alpha=.75$), and hospital utilisation ($\alpha=.86$) was administered. Data collected were analysed using descriptive statistics, Pearson Moment Correlation, Hierarchical Multiple Regression and Analysis of Variance (ANOVA) at 0.05 level of significance. In all, two hypotheses were tested. After statistically controlling for age and duration of illness. It was discovered that spousal support and health locus of control jointly predicted hospital utilisation ($F_{(9,113)} = 72.86$, $R=.92$, $R^2=.85$, $p<.001$). However Information support ($\beta= .55$, $t= 8.63$; $p<.001$), physical comfort ($\beta= .18$, $t= 2.29$; $p<.05$), internal control ($\beta= .16$, $t= 2.56$; $p<.05$) and powerful other ($\beta= .19$, $t= 3.47$; $p<.01$) significantly independently predict patients hospital utilisation. Furthermore, results discovered that educational qualification [$F(5, 113) = 1.465$; $P>.05$] has no significant prediction on hospital utilisation. Finally, knowing how spousal support and health locus of control affect hospital utilisation. Healthcare providers should involve spouses in treatment plans to leverage emotional and informational support, which has been shown to encourage hospital utilisation.

Keywords: *Health Locus of Control, Hospital Utilisation, Spousal Support.*

Introduction

Sexuality is a vital aspect of human life throughout the lifespan, encompassing sex, gender identities and roles, eroticism, satisfaction, sexual preference, closeness, and childbearing (Beredugo et al., 2023). One of the significant sexual illnesses affecting sexuality is erectile dysfunction (ED). Erectile dysfunction is defined as the inability to achieve and/or maintain a satisfactory erection for sexual performance for at least six months and is one of the most common illnesses in men (Amadi et al., 2023; Gbiri & Akumabor, 2023). It disrupts good sexual function, which is a high priority for men and their partners throughout their lives. The loss of sexual harmony significantly reduces the sexual satisfaction and quality of life for both men and their partners. However, erectile dysfunction affects millions of men worldwide, particularly those over the age of 40. Furthermore, men with ED are more likely to experience psychological distress. This condition not only causes sexual decline but also leads to emotional anguish, which can manifest in various ways, including issues in marriage life, reluctance to discuss ED, feelings of guilt and rejection, depressed mood, frustration, reduced self-confidence and self-esteem, and a sense of failing as men (Mesfin et al., 2023; Sayilan, 2024).

Projections indicate that by 2025, the situation will worsen, with an estimated 322 million men globally affected by ED. Despite the prevalence of ED in the male population exceeding 20%, fewer than 30% of affected individuals seek therapy (Muhammad et al., 2023). The prevalence of ED increases with age, reaching its peak among men aged 60-79 (Abu, et al., 2019). Therefore, utilising hospital services is crucial for improving health and well-being. Early diagnosis enhances psychological well-being and reduces mortality rates (Ogunfowokan et al., 2022). However, hospital utilisation encompasses the consumption of healthcare services, including inpatient and outpatient services. This term broadly covers patient interactions with hospital facilities for medical needs, from emergency room visits to planned surgeries, diagnostic tests, and rehabilitation services.

Additionally, comorbidities play a significant role in hospital utilisation among men with ED (Ogunfowokan et al., 2022; Nkafu et al., 2023). Conditions such as cardiovascular diseases, diabetes, hypertension, and obesity are commonly associated

with ED and necessitate ongoing medical management (Abeway et al., 2020; Okey-Ewurum et al., 2020; Shiferaw et al., 2020; Muhammad et al., 2023). Men grappling with erectile dysfunction (ED) often experience feelings of shame, embarrassment, and anxiety, which deter them from seeking medical attention. This avoidance can lead to relationship problems and a decreased quality of life, further complicating their clinical picture. In Nigeria, sociocultural constructs of masculinity, which emphasise virility and sexual prowess, exacerbate this reluctance by creating a stigma around discussing sexual health issues openly. Some men experiencing this issue often hesitate to seek help due to loss of self-esteem associated with the condition, leading to delayed presentation and treatment.

However, some men prefer to seek remedies from African traditional herbal practitioners instead. Consequently, men diagnosed with ED might avoid hospital utilisation, resulting in untreated underlying medical conditions and hindered emotional well-being (Alrumaihi et al., 2024). Hospital utilisation among men with ED necessitates a holistic understanding of factors influencing their decision-making. Factors such as age, relationship status, cultural background, and access to healthcare resources impact how men approach their condition and their willingness to seek professional help (Khatri, & Assefa, 2022; Mursa, et al., 2022; Schaller, et al., 2020). However, this project aims to delve into the factors of hospital utilisation among men diagnosed with erectile dysfunction by analysing spouse support, health locus of control, and demographic characteristics.

Health locus of control is a psychological concept that examines an individual's perception of their influence over health-related circumstances and outcomes. It categorises health experiences into internal and external factors. Individuals with a strong internal health locus of control believe their health journey is primarily influenced by their personal choices, actions, and capabilities. They embrace responsibility for their health, actively set health-related goals, and believe their decisions can significantly impact their well-being (Adegbayi et al., 2023; Aguru, 2022). Men with an internal health locus of control might view ED as a challenge within their sphere of influence, leading them to seek medical assistance, explore treatment options, and

adopt lifestyle modifications to manage their condition. Conversely, men with an external health locus of control may attribute their condition to factors beyond their control, such as genetic predisposition or ageing, resulting in reduced motivation to seek medical interventions (Fatunbi, Obosi, & Asagba, 2022). This perspective may foster feelings of helplessness and limited influence over health outcomes.

However, Spousal support extends beyond financial contributions to include emotional and psychological encouragement, which can play an important role in empowering individuals to seek necessary medical attention (Brown, 2024). A supportive spouse significantly impacts an individual's health and well-being, particularly when addressing sensitive health issues like erectile dysfunction (ED). Understanding, empathy, and the willingness of a supportive spouse to engage in open conversations can create a safe space for discussing concerns. They act as a bridge between personal and medical aspects of health, fostering trust and understanding, and playing an active role in medical intervention decisions (Lawn et al., 2022; Jo, 2020). This supportive environment normalizes the act of seeking medical attention, leading to earlier intervention and improved health outcomes. Improved communication and shared decision-making between partners create a positive feedback loop, where seeking help is seen as a shared responsibility (Onwujekwe, et al., 2020).

Understanding the factors behind hospital underutilisation among men is of significant concern due to its implications for individual health outcomes and the broader healthcare system. In Nigeria, the prevalence of ED is estimated to be around 66.4% among men aged 18 years and above. Awareness of treatment for ED is relatively low, with only 39.4% of subjects aware of treatment options (Abu et al., 2019). Additionally, only about a quarter (26.5%) of men with ED in Nigeria have discussed their sexual challenges with a doctor (Abu et al., 2019). Given these statistics, men's health has long been a topic of interest, given the distinct challenges they face and their generally shorter life expectancy compared to women. Studies have examined different psychological factors such as health locus of control, self-efficacy, perceived stigma depression and anxiety significantly influence hospital utilisation among men with erectile dysfunction (Jombo, et al.,

2020; Muhammad, et al., 2023; Saito, et al., 2023; Takure, & Adewumi, 2023; Umannah et al., 2021).

However, studies have provided valuable insights into the various insight into various factors predicting hospital utilisation among erectile dysfunction men, there remains a gap in understanding the contribution of their spouse. Furthermore, there is a need to explore the specifics of Ibadan, Nigeria. Therefore, this current study aims to address this gap by examining the independent and joint influence of spousal support and health locus of control on hospital utilisation among men diagnosed with erectile dysfunction in Ibadan. By shedding light on the patterns and trends of hospital utilisation among men, we can contribute to a more comprehensive understanding of men's health needs and pave the way for targeted interventions that address their unique concerns.

The following hypotheses, however, were investigated in this research:

1. Spousal support and health locus of control will significantly independently and jointly predict hospital utilisation among men diagnosed with erectile dysfunction in Ibadan, Oyo State
2. There will be a significant difference in educational qualification on hospital utilisation among men diagnosed with erectile dysfunction

Theoretical Review

Andersen Healthcare Utilisation Model

The Andersen Healthcare Utilisation Model, developed by Ronald Andersen in the late 1960s, is a comprehensive framework for understanding the factors influencing the use of healthcare services. Initially introduced in 1968 and subsequently revised over the years, this model has become a cornerstone in health services research. It proposes that health service utilisation is determined by three primary factors: predisposing characteristics, enabling resources, and need factors (Andersen, 1968; Andersen & Newman, 1973).

Predisposing characteristics refer to the socio-demographic factors that influence an individual's propensity to use healthcare services. These include age, gender, education, social status, and beliefs about health and healthcare. For men with erectile dysfunction (ED), these predisposing factors can significantly impact their willingness to seek

treatment. For instance, older men or those with higher educational attainment may be more aware of ED treatments and thus more likely to utilise hospital services (Andersen, 1995). In the present study, the age of the participants is examined as a predisposing factor. Age is particularly relevant in the context of ED, as the prevalence of this condition increases with advancing age (Abu et al., 2019). Older men may be more likely to experience ED and thus may have a greater need for healthcare services. However, cultural beliefs and misconceptions about ageing and sexuality may also affect their willingness to seek treatment, making age a critical factor in understanding hospital utilisation for ED.

Enabling resources are the logistical aspects that facilitate or hinder healthcare utilisation. These include personal/family resources such as income and health insurance, as well as community resources like the availability of healthcare services and transportation. Men with ED might face barriers such as a lack of insurance coverage for ED treatments or limited access to specialized healthcare providers, which can prevent them from seeking necessary medical attention (Andersen & Newman, 1973). In the context of this study, enabling factors include spousal support, income, employment status, communication, and the type of reproductive health facility. Spousal support is particularly significant, as emotional and psychological encouragement from a partner can empower men to seek necessary medical attention for ED (Brown, 2024). Higher-income and stable employment can reduce financial barriers to accessing care, while effective communication with healthcare providers and the availability of specialized reproductive health facilities can enhance the likelihood of seeking and receiving appropriate treatment for ED.

Need factors are the most immediate causes of healthcare utilisation and can be divided into perceived need and evaluated need. Perceived need refers to how individuals view their health and their need for medical care, while the evaluated need is determined by healthcare professionals through clinical assessments. Men with ED often perceive a strong need for medical intervention due to the significant impact of ED on their quality of life, self-esteem, and relationships. In this study, need factors are represented by the length of diagnosis and health locus of control. The duration of time since an ED

diagnosis can influence the urgency with which men seek treatment; those with a longer diagnosis period may have more entrenched symptoms and a greater recognition of the need for medical intervention. Health locus of control, which refers to an individual's belief about the extent to which they can control their health outcomes, also plays a crucial role. Men with an internal health locus of control, who believe they can influence their health through their actions, are more likely to seek medical help for ED. Conversely, those with an external health locus of control may feel helpless and less inclined to utilise healthcare services (Adegbayi et al., 2023; Aguru, 2022).

The Andersen Healthcare Utilisation Model offers a comprehensive framework for understanding hospital utilisation among men with ED. It emphasizes the importance of considering demographic, economic, social, and psychological factors influencing healthcare-seeking behaviour. Older men may face barriers to seeking care due to cultural beliefs and stigma, requiring targeted interventions. Enabling factors like spousal support and financial resources can improve access to care. Healthcare providers and policymakers can enhance communication and support systems within families and communities to encourage men to seek treatment. Addressing financial barriers through policies that improve insurance coverage and reduce out-of-pocket costs can facilitate greater utilisation of hospital services for ED. Educational campaigns that increase awareness about ED, its treatability, and early intervention can empower men to take proactive steps towards managing their condition.

Materials and Methods

Design and Sampling

This study adopted an ex-post facto design also known as “After the fact design”, this is because variables of interest such as; spousal support, health locus of control and hospital utilisation would have occurred before the commencement of the study and the participants are compared on certain qualities that already exist in nature. This study employed a purposive sampling technique. The reason for the choice of this type of sampling technique is that the research has a focus group of interest which is males diagnosed with erectile dysfunction.

Setting

The study was conducted among registered male patients diagnosed with erectile dysfunction at Adeoyo Hospital in Ibadan. These setting was chosen because they accommodated a larger population of participants for the study; also, these settings make accessibility of the participants easy to reach. Hence these study sites were ideal for the study.

Sample size determinant

Sample Size Determination Sampling size was determined using the sample size calculation method developed by Yamane (1967) formula $n = \frac{N}{1+N(e)^2}$.

Where; n =required sample size

N = is the population size with $\pm 5\%$ precision.

$N = 170$, $e = 0.05$

$n = 124$ participants.

Participants

Participants consist of registered male patients diagnosed with erectile dysfunction in Ibadan. One hundred twenty-four (124) patients were for the study in Ibadan (See table 1). The participants must be 18 years and above, currently a patient that attends the hospital for treatment on an appointment basis and indicate willingness to participate in the study. Those who fell short of the inclusion criteria were excluded from the study.

Instrument

Hospital Utilisation Questionnaire (HUQ)

The Hospital Utilisation and Access to Care Questionnaire (HUQ) was developed by The Centre for Disease Control for the National Health and Nutrition Examination Survey, (2017). It is administered to persons 16 years of age and older. It contains 8 items. The scale has a Cronbach alpha of 0f .84. This study reported a Cronbach alpha of. 86

Support in Intimate Relationships Scale-Revised

The SIRRS-R is an adapted version of the SIRRS (Dehle, Larsen, & Landers, 2001) and measures perceptions of support gotten from a spouse over a period of time. The scale measures a wide range of support behaviours; It focuses on support gotten from spouses in an intimate relationship; captures the the adequacy of the relationship; and supportive behaviours. Participants are also asked to report the extent of support gotten from a partner for a period of time (never, rarely, sometimes, often, almost always)

and indicate a preferred frequency for each behaviour (more, less, or the same). To obtain scores of *received support*, responses to estimated frequencies of support behaviours (0=never, 1=rarely, 2=sometimes, 3=often, 4=almost always) are summed. Michalina and Hanna, (2020) reported a Cronbach's α of .94. The scale has four dimensions (informational, physical comfort, emotional/esteem, and tangible). Scores of received support were also calculated for each type of support: informational (items 1 - 8; possible range: 0–32; $\alpha = .87$), physical comfort (items 9 - 12; possible range: 0–16; $\alpha = .92$), emotional/esteem (items 13 - 20; possible range: 0–32; $\alpha = .88$), instrumental/tangible (items 21 - 25; possible range: 0–20; $\alpha = .85$). This study reported a Cronbach alpha of. 89. However Informational support = $\alpha .80$, Physical comfort $\alpha = .90$, Emotional/esteem $\alpha = .98$, Instrumental/tangible $\alpha = .75$.

Multidimensional Health Locus of Control (Wallston, et al., 1978)

This scale was developed by Wallston, et al., in 1978. The scale measures the locus of control related to health and well-being. It contains 18 items. The scale has three subscales which are Internality, powerful others and chance. Each of the dimensions is been measured with 6 items, having a total of 18 items (Internal, Powerful Others; and Chance). All items are scored using a 6-point Likert-type scale ranging from 1: Strongly disagree and 6: Strongly agree, and therefore scores can range from 0 to 36 on each six-item subscale. Items are keyed such that higher scores on internality subscale items (e.g., "I am in control of my health) reflect an Internal health locus of control, whereas lower scores (e.g., "If I take the right actions, I can stay healthy") indicate external health locus of control. High scores on the Powerful Others subscale (e.g., "Regarding my health, I can only do what my doctors tell me"—6: Strongly agree) indicate strong beliefs in external control by Powerful Others, while high scores on the Chance subscale (e.g., "My good health is largely a matter of good fortune) indicate beliefs that health is largely determined by luck, fate, or other chance factors beyond the person's control. Ross et al (2015) reported a coefficient alpha of.66 (Internality), .72 (Powerful Others), and .69 (Chance) for Form B of the MHLC. This study reported a Cronbach alpha of .69, with a coefficient alpha of Internal, (item 1-6

$\alpha = .62$), Powerful Others (item 7-12 $\alpha = .78$), and Chance (item 13-18 $\alpha = .68$).

Procedure

Ethical approval for the study was obtained from the Adeoyo Hospital Ethical Committee. A letter of introduction was obtained from the Department of Psychology, University of Ibadan. The researcher will also seek approval from the appropriate authorities of the hospitals. An appointment date was fixed for the researcher to come and collect data. On that day, the researcher visited the wards where the patients were and informed the participants of the purposes, objectives and importance of the study. During the interaction, the researcher assured the entire participant that their responses would be confidential and be used only for the study. The questionnaire was shared among the patients and directions on how to complete the questionnaire were explained by the researcher. On no account did the researcher force the participant to fill out the questionnaire and no form of incentive was given. After the collection of the questionnaire, the researcher appreciated the management and participants for their utmost cooperation throughout the process.

Statistical Method

The accuracy of the collected data was verified, and the results were examined with SPSS version 26.

Data were analysed using descriptive statistics. Hypothesis one was analysed using hierarchical multiple regression and hypothesis two was analysed using Analysis of Variance (ANOVA).

Ethical Consideration

The Department of Psychology provided an introductory letter to facilitate the researcher's introduction to the Adeoyo Hospital Research Committee, Ring Road, Ibadan, Oyo State. This step ensured that the research adhered to the necessary ethical standards and due processes. Ethical considerations were paramount in this study to protect the rights and well-being of participants. Informed consent was obtained from all participants, ensuring they were fully aware of the study's purpose, procedures, and their right to withdraw at any time without any repercussions. Confidentiality and anonymity were strictly maintained to protect participants' personal information. The study was conducted following the ethical guidelines outlined by the Adeoyo Hospital Research Committee, ensuring that all research activities met the highest ethical standards and minimized any potential risks to participants.

Results

Table 1: Summary showing the distribution of the participants' characteristics across specified demographic variables.

Variables	Category	n(124)	n%
Age	37-74 Mean =49.87, SD = 10.79	124	100.0
Ethnicity	Yoruba	51	41.1
	Igbo	13	10.5
	Hausa	5	4.0
	Others	55	44.4
Religion	Christianity	101	81.5
	Islam	19	15.3
	Others	4	3.2
Educational Quali.	SSCE	52	41.9
	NCE/OND	37	29.8
	HND/BSC	27	21.8
	M.sc/Ph.D	6	4.8
Monthly Income	Below 100,000	55	44.4
	100,000 and above	38	30.0
Duration of diagnosis	Below a year	16	12.9
	More than a year	108	87.1

Table 2: Inter-correlation showing the relationship among spousal support, health locus of control correlate and hospital utilisation among men diagnosed with erectile dysfunction in Ibadan, Oyo State.

Variables	X	SD	1	2	3	4	5	6	7	8	9	10
Hospital utilisation	56.43	8.02	--									
Spousal support	86.24	21.57	.79**									
Information support	28.62	9.48	.75**	.26**	--							
Physical comfort	10.84	2.42	.55**	.62**	.26**	--						
Emotional/ esteem comfort	28.86	6.12	.77**	.89**	.67**	.81**	--					
Instrumental/tangible comfort	17.99	8.87	.44**	.77**	.37**	.40**	.52**	--				
Health locus of control	66.25	7.70	.40**	.09	.04	.13	.09	.06	--			
Internal	18.98	4.46	.38**	.12	.04	.17	.15	.10	.49**	--		
Powerful other	31.96	4.36	.47**	.15	.07	.16	.18*	.11	.80**	.60**	--	
Chance	19.53	7.70	-.09	-.09	-.04	-.08	-.12	-.09	.26**	.58**	.20**	--

****.** Correlation is significant at the 0.01 level (2-tailed).

***.** Correlation is significant at the 0.05 level (2-tailed).

Table 2 Result revealed a significant positive relationship between spousal support and hospital utilisation ($r=.79$, $p<.01$). This implies that patient who receives more encouragement and care from their spouse is more likely to make use of hospital resources. Additionally, further analysis investigated the relationship between the components of spousal support and hospital utilisation revealed that Information support ($r=.75$, $p<.01$), Physical comfort ($r=.55$, $p<.01$), Emotional/ esteem comfort ($r=.77$, $p<.01$), and Instrumental/tangible comfort ($r=.44$, $p<.01$), had a significant positive relationship with hospital utilisation. This implies that patients who were provided with adequate information and advice, who receive physical comfort, who have been showing love, friendship and devotion, and who receive direct or indirect help in dealing with stressful situations like financial and physical assistance are more likely to utilise hospital resources.

However, the result revealed a significant positive relationship between health locus of control and hospital utilisation ($r=.40$, $p<.01$). This implies that

patient who believes that their health is been controlled by their own behaviour or external forces are more likely to make use of the hospital resources. Similarly, further analysis investigated the relationship between the components of health locus of control and hospital utilisation and revealed that internal ($r=.38$, $p<.01$), and powerful other ($r=.47$, $p<.01$), had a significant positive relationship on hospital utilisation. This implies that patient who believes that they are in control of their health and those who also believe that powerful others like doctors and nurses have control over their health are more likely to make use of the hospital. However, no significant relationship was found between change and hospital utilisation ($r= -.09$, $p>.05$).

Hypothesis One

Hypothesis one states that spousal support, health locus of control will significantly independently and jointly predict hospital utilisation among men diagnosed with erectile dysfunction was tested using hierarchical multiple regression and the result is presented in Table 4.2.

Table 3:Summary of Hierarchical Multiple Regression showing the independent and joint prediction of spousal support and health locus of control on hospital utilisation

	Predictors	β	t	Sig	R	R ²	R ² Change	F	p
Model 1	Age	-.08	-.87	>.05	.11	.01	.01	.82	>.05
	Duration of Illness	-.09	-.99	>.05					
Model 2	Age	-.06	-1.30	>.05					
	Duration of Illness	-.01	-.22	>.05					
	Information support	.52	5.85	<.001	.84	.71	.70	46.90	<.001
	Physical comfort	.20	1.77	>.05					
	Emotion/esteem support	.25	1.67	>.05					
	Instrumental or tangible support	.04	.75	>.05					
Model 3	Age	-.05	-1.24	>.05					
	Duration of Illness	.06	1.53	>.05					
	Information support	.55	8.63	<.001	.92	.85	.15	72.86	<.001
	Physical comfort	.18	2.29	<.05					
	Emotion/esteem support	.18	1.65	>.05					
	Instrumental or tangible support	.03	.65	>.05					
	Internal HLOC	.18	3.25	<.01					
	Powerful other HLOC	.28	5.88	<.001					
	Chance HLOC	.07	1.47	>.05					

Results in Table 3 show that, in the first model, the covariate demographic factors of age and duration of

illness showed no significant joint and independent prediction on hospital utilisation. In the second model

where components of spousal support were added to the analysis, the result revealed a significant joint predictor of the variables on hospital utilisation ($F_{(6,116)} = 46.90$, $R = .84$, $R^2 = .71$, $p < .001$), thereby accounting for 71% variation observed on the dependent variable. Additionally, the R^2 Change value of (.70) associated with this model suggests that the addition of spousal support components to the first model accounted for 70% of the variations in hospital utilisation.

However, Information support ($\beta = .52$, $t = 55.85$, $p < .001$) significantly had independent prediction on hospital utilisation, accounting for 52% variance observed in the dependent variable. In the third model, the Health locus of control components was added to the analysis, the result showed a significant joint and independent prediction of these variables on hospital utilisation ($F_{(9,113)} = 72.86$, $R = .92$, $R^2 = .85$, $p < .001$), meaning the variables jointly contributed

85% variance observed in the dependent variable. Additionally, the R^2 Change value of (.15) associated with this model suggests that the addition of health locus of control components to the second model accounted for .15% of the variations in hospital utilisation. Independently, Information support ($\beta = .55$, $t = 8.63$; $p < .001$), physical comfort ($\beta = .18$, $t = 2.29$; $p < .05$), internal control ($\beta = .16$, $t = 2.56$; $p < .05$) and powerful other ($\beta = .19$, $t = 3.47$; $p < .01$) significantly accounted for 77%, 16% and 19% variation in hospital utilisation. Based on the result, the stated hypothesis was partly supported.

Hypothesis Two

The second hypothesis states that there will be a significant difference in educational qualification in hospital utilisation. This was tested using a one-way Analysis of Variance (ANOVA) and the result is presented in Table 4

Table 4: One-Way ANOVA Summary Table Showing the differences in educational qualifications on hospital utilisation

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	462.819	5	92.564	1.465	.207
Within Groups	7393.344	117	63.191		
Total	7856.163	122			

Table 4 presents the significant difference in educational qualification on hospital utilisation among men diagnosed with erectile dysfunction. Results revealed that there was no significant difference in educational qualification on hospital utilisation [$F(5, 113) = 1.465$; $P > .05$]. Based on the result, the stated hypothesis is rejected.

Discussion

The study examined the predictive role of spousal support and health locus of control on hospital utilisation among men diagnosed with erectile dysfunction (ED) in Ibadan, Oyo State. The first hypothesis states that spousal support and health locus of control will significantly independently and jointly predict hospital utilisation among men diagnosed with erectile dysfunction. The results revealed that after statistically controlling for covariates (age and duration of illness), there was a significant joint prediction of spousal support and

health locus of control on hospital utilisation. Furthermore, information support, physical comfort, internal control and powerful others independently predicted hospital utilisation among men diagnosed with erectile dysfunction.

This implies that patients who get physically encouraged and receive more information and advice from their spouse, patients who believe that their health status is a result of their behaviour and patients who believe that external forces have control over their health like doctors are more likely to make use of hospital resources. This outcome was supported

by Ștefănuț, et al., (2021) and Collaço, et al., (2021), who discovered that communication is a vital component of the three principles of caregiver-patient support. Good communication among couples would most likely have a beneficial impact on dynamic interaction and caregiver-patient congruence, which would, in turn, have a favourable effect on the couple's closeness and capacity to cope and enhance caring results. It was revealed that patients who receive greater assistance from their spouses visit the hospital more frequently. However, Adegbayi, et al., (2023) and Cunningham, et al., (2022) discovered that when volunteers from the general community were used, health locus of control was a greater predictor of choices for information exchange and hospital usage than demographic characteristics such as age, gender, and educational attainment.

The second hypothesis states that there will be a significant difference in educational qualification in hospital utilisation. Results revealed that there was no significant difference in educational qualification on hospital utilisation. This result finds empirical backing from the study results of Rusiecki, et al. (2019) who discovered that socioeconomic status did not significantly influence the presence and degree of erectile dysfunction among men attending a primary care clinic.

Conclusions

This study established the prediction role of spousal support and health locus of control on hospital utilisation. The result revealed that age and duration of illness were not a predicting factor on hospital utilisation among men diagnosed with erectile dysfunction. However, spousal support and health locus of control significantly independently and jointly predicted Hospital utilisation. Specifically, the study identified that different dimensions of spousal support, including information support and emotional comfort, are crucial in encouraging men with ED to seek medical help. Patients who receive advice and feel emotionally and physically supported by their spouses are more likely to utilise hospital resources. This finding emphasises the need for healthcare providers to involve spouses in the treatment process, ensuring that patients receive the necessary support and encouragement to seek and adhere to medical treatment. Moreover, the results indicate that health locus of control significantly predicts hospital utilisation. Men who believe that their health outcomes are a result of their behaviours (internal

control) are more proactive in seeking medical care. Additionally, those who perceive that powerful others, such as doctors, have control over their health (external control) also show a higher propensity to utilise hospital resources. These insights suggest that enhancing patients' understanding of the role of personal behaviour and professional medical care in managing ED could improve their health-seeking behaviours. Interestingly, the study found that educational qualification does not significantly predict hospital utilisation among men with ED. However, irrespective of educational background, spousal support and health locus of control play a more crucial role in influencing the decision to seek medical care.

Recommendation

The study suggests several recommendations to improve hospital utilisation among men diagnosed with erectile dysfunction (ED) in Ibadan, Oyo State. Clinical / Health psychologists and other health professionals should emphasise the importance of spousal involvement in the treatment process. Interventions should be designed to educate and engage spouses, highlighting their critical role in providing emotional support and practical advice. Programs such as couples counselling and support groups can be implemented to foster open communication and mutual understanding. This approach can help alleviate the stigma and embarrassment associated with ED, encouraging men to seek timely medical intervention. Psychologists should work closely with healthcare providers to ensure that spousal support is integrated into the overall treatment plan. This can be achieved through personalized health education sessions, workshops, and support groups. Furthermore, psychologists and health professionals should focus on strategies to enhance patients' internal health locus of control. Cognitive-behavioural interventions and Motivational Interviewing can be employed to empower men with ED, reinforcing the belief that their health outcomes are largely influenced by their actions. By fostering a sense of control over their condition, psychologists and health workers can motivate patients to actively seek and adhere to medical treatment.

Furthermore, Health psychologists should also address the perception that healthcare professionals play a crucial role in managing ED. Additionally, healthcare providers should work on building trust

and reinforcing the belief that medical professionals (powerful others) have a significant role in managing ED. This might involve more personalized patient care, clear communication about treatment plans, and ensuring that patients feel heard and understood during medical consultations, thereby increasing their willingness to utilise hospital resources. It is also important for clinical and health psychologists and other health professionals to develop tailored interventions that account for the diverse backgrounds of patients. While the study found that educational qualification does not significantly predict hospital utilisation, interventions should still be accessible and relevant to men of varying educational backgrounds. This ensures that all patients, regardless of their level of education, have the information they need to make informed decisions about their health.

Limitations

Despite the valuable insights gained from this study, several limitations should be acknowledged. First, the study relied on self-reported data, which may be subject to biases such as social desirability and recall bias. Participants might have underreported or overreported their levels of spousal support, health locus of control, and hospital utilisation. Second, the cross-sectional design of the study limits the ability to infer causality between the predictors (spousal support and health locus of control) and hospital utilisation. Longitudinal studies are needed to establish temporal relationships and causal links. Third, the sample was limited to men diagnosed with erectile dysfunction in Ibadan, Oyo State, which may not be representative of other regions or populations. Cultural, social, and economic factors unique to this area may influence the generalizability of the findings. Lastly, the study did not account for other potential variables that could influence hospital utilisation, such as psychological distress, financial constraints, and availability of healthcare services.

Suggestions for Further Studies

Building on the findings of this study, several avenues for further research could be pursued to deepen our understanding of the factors influencing hospital utilisation among men diagnosed with erectile dysfunction (ED) in Ibadan, Oyo State, and potentially other regions. Longitudinal studies are recommended to track changes in spousal support, health locus of control, and hospital utilisation over

time. This approach would help in establishing causal relationships and understanding the long-term effects of these variables on health-seeking behaviour. Additionally, future studies should consider using mixed-method approaches, combining quantitative surveys with qualitative interviews. This would provide a deeper insight into the personal experiences and contextual factors influencing men's decisions to seek medical care. Expanding the geographic scope of the study to include diverse populations from different regions and cultural backgrounds would enhance the generalizability of the findings. Comparative studies across different cultural settings could reveal how cultural norms and values shape hospital utilisation in various contexts. Moreover, future research should investigate the role of additional factors such as psychological distress, economic status, healthcare accessibility and Health-seeking behaviour of Men diagnosed with erectile dysfunction. Finally, intervention studies could be conducted to test the effectiveness of psychotherapy aimed at enhancing hospital utilisation. By pursuing these research directions, future studies can build on the current findings to develop more targeted, effective interventions and policies that enhance hospital utilisation and overall health outcomes for men diagnosed with erectile dysfunction.

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