

Erectile dysfunction prevalence in the United States: report from the 2021 National Survey of Sexual Wellbeing

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Abstract

Background: There has been a great deal of public speculation regarding a surge in erectile dysfunction (ED) in younger men despite data consistently indicating that the ED prevalence rates increase with age.

Aim: In this study we sought to assess the prevalence and risk of experiencing ED in a nationally representative sample of men in the United States across various social groups, describe comorbidities, and examine barriers to treatment.

Methods: Data from the 2021 National Survey of Sexual Wellbeing were analyzed by utilizing the Ipsos KnowledgePanel®, a probability-based online panel, for the purpose of obtaining US nationally representative data of adults aged 18 years and older. The analytic sample consisted of 1822 cisgender men ranging in age from 18 to 87 years, with a mean age of 47.5 years.

Outcomes: Study outcomes were ED as measured by the 5-item version of the International Index of Erectile Function (IIEF-5), as well as self-reported diagnosis by a medical professional, comorbidities with other health issues, medications taken for ED, and barriers to treatment.

Results: The ED prevalence rate based on IIEF-5 scores was 24.2%. Prevalence increased with age: 52.2% of the 75+ age group, and 48.0% of the 65–74 age group meeting diagnostic criteria for ED. Diagnostic criteria were met for more participants in the 18–24 age group (17.9%) than the 25–34 (13.3%) or 35–44 (12.7%) age groups, but less than the 45–54 (25.3%) or 55–64 (33.9%) age groups. Only 7.7% (n = 141) of the sample reported having been diagnosed by a provider (n = 4 in 25–34, n = 6 in 35–44, n = 13 in 45–54, n = 39 in 55–64, n = 44 in 65–74, and n = 34 in ≥75-year olds), indicating a gap in access to treatment. The most common reason selected for not accessing care for ED concerns was a lack of need to see a provider in the past year.

Clinical Implications: The discrepancy between ED self-report and medical diagnosis is critical, given that ED can be an indication of underlying health risks.

Strengths and Limitations: This study is the first nationally representative update to information regarding the prevalence of ED in almost 2 decades. Standard administration of the IIEF-5 is limited to participants who have had sex in the last 6 months, so these rates do not include those men with ED who have been avoiding penetrative sex for a significant time.

Conclusion: The results indicate that ED prevalence and severity remain highest in older age groups and that most individuals who meet criteria for ED have not sought medical care related to this concern.

Keywords: erectile dysfunction; sexual health; healthcare; barriers to healthcare.

Introduction

Erectile dysfunction (ED) refers to consistent difficulty in obtaining or maintaining an erection, a condition for which the frequency can be assessed in patients who complete the 5-item version of the International Index of Erectile Function (IIEF-5).¹ One of the most common definitions of ED is the World Health Organization classification, which characterizes ED as “the inability or marked reduction in the ability in men to attain or sustain a penile erection of sufficient duration or rigidity to allow for sexual activity. The pattern of erectile difficulty occurs despite the desire for sexual activity and adequate sexual stimulation, has occurred episodically or persistently over a period at least several months, and is associated with clinically significant distress.”²

Epidemiological studies have consistently revealed that prevalence rates of ED increase with age³ and that ED

is correlated with underlying medical conditions such as diabetes, hypertension, dyslipidemia, obesity, depression, and smoking.⁴ Prevalence rates vary widely based on the ED definitions used by investigators and the methods of conducting these population-based studies. Due to the subjective nature of existing definitions of erectile function, it can be challenging to understand which men meet diagnostic criteria, what percentage of men seek medical help, and what percentage of men experiencing ED are distressed by it.⁵ For instance, in the United States, the most recent prevalence study explored ED rates based on race/ethnicity, as well as age, and found an overall prevalence of ED of 22%, with Black men experiencing significantly higher rates of ED.⁶ However, these researchers estimated ED with a single item: evaluating the ability of participants to keep an erection adequate for intercourse. In a review, Kessler et al.⁵ found a wide range

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of ED prevalence rates (13.1% to 71.2%) underscoring the variability in methods and definitions around ED. Average prevalence rates in North America were 20.7%, and across countries, there were consistent trends of an increase in prevalence with age and health comorbidities.

One theme that has emerged in public discourse, with only minimal empirical support, is the apparent increase of ED in younger men. Park et al.'s review of the literature demonstrated an increase in self-reported ED between a 2001 study and a 2011 study using the same ED question; in the 2011 study, 14%-28% of men under 40 indicated self-reported ED⁵⁻⁸; however, studies that focus on younger men (under 40) tend to have prevalence rates that vary significantly based on geographic location and how erectile function is assessed. A recent US-based study found that among sexually active men 18 to 31 years, 11.3% reported symptoms of ED.⁹ These trends have been speculated to be due to the increase in the use of pornography and recreational and prescribed medications that are known to have sexual side effects, including antidepressants and hair growth medications such as finasteride.¹⁰ Not surprisingly, Calzo and colleagues⁹ found strong associations between antidepressant use and moderate to severe ED.

Despite the public concern surrounding the perceived increase in ED, there has been relatively little research that has examined the prevalence of ED in more recent population samples using validated measurements with clear diagnostic criteria. Many studies utilize a single self-report item to assess ED, in which erection difficulty is rated on an ordinal scale. One such study utilizing this method was conducted by Goldstein and colleagues,¹¹ who found that self-reported ED prevalence is higher (40.5%) than previous estimates across 8 countries, including the United States. This was a step forward in understanding more recent ED rates, but there is a need to use more diagnostically oriented tools in estimating prevalence rates.

Furthermore, even validated measures of ED data do not always fully capture the number of men who are distressed enough by erectile difficulties to seek medical help. A recent study by Mulhall and colleagues¹² examined ED prevalence rates in men aged 18 and over by assessing the prevalence of PDE-5 prescriptions or an ED diagnosis documented through utilization of health insurance. They found that ED prevalence measured this way was generally low and increased with age (until older age); only 0.4% of those ages 18-29 years met the documented PDE-5 prescription or insurance use criteria for ED, while those aged between 60 and 69 years had a prevalence rate of 11.5%. This method provides clinically relevant information beyond what self-report measures can examine, given the focus on those who are experiencing distress. However, this method alone cannot account for those who do not have access to medical care to address concerns, or those who do not feel comfortable bringing up ED concerns to their provider. There is a need for research that seeks to understand the prevalence rate of meeting diagnostic criteria for ED and the barriers and access to treatment. This gap in the literature is a critical one, given that a diagnosis of ED is a known indicator of cardiovascular disease, in addition to other health risks. For example, in a study by Mulhall and colleagues,¹² men with ED had significantly higher rates of comorbid conditions (63%), including hypertension, diabetes mellitus, depression, and benign prostatic hyperplasia compared to men without ED.

Additionally, many of the studies that have examined rates of ED have not done so in a nationally representative study, which is critical to high quality prevalence statistics. Gaining insight into the prevalence of ED using diagnostic measurement tools and understanding barriers to accessing care for ED is long overdue.

Aims

In the current study we aimed to establish, in a nationally representative sample in the United States, the current prevalence of ED, access to care, co-morbidities, medications, and the barriers of access to care for men with ED.

Methods

This study utilized data from the 2021 National Survey of Sexual Wellbeing (NSSW), a nationally representative, cross-sectional survey of US adults ages 18 and over. The NSSW recruited participants using the Ipsos KnowledgePanel®, a probability-based online panel that has been used for a variety of US nationally representative surveys, including those related to sexuality and health.¹³⁻¹⁶

KnowledgePanel® members were initially recruited through mailings randomly selected using the US Postal Service's Delivery Sequence File and follow-up phone calls. Invited individuals who did not have internet connectivity were offered connectivity to facilitate their joining the panel. KnowledgePanel® members earn points for survey participation, which they can exchange for cash or merchandise. Ipsos created statistical weights using the March 2020 supplement of the Current Population Survey to correct for under/overcoverage or nonresponse of specific variables; these variables are sex, age, race/ethnicity, education, household income, and US Census region. These weighted data were utilized in the study analyses. Institutional review board approval was obtained through Indiana University for data collection and the University of Minnesota for de-identified data analysis.

Recruitment for the NSSW occurred in May and June of 2021. Ipsos identified a sampling frame of 7138 KnowledgePanel® members ages ≥18 years and sent recruitment emails to these individuals. Of these individuals, 4375 members provided consent and partially completed the survey. A total of 3878 participants proceeded to the end of the survey. This survey was confidential and completed online, with a median completion time of 16.1 minutes; the data were de-identified prior to Ipsos sharing it with the research team.

Of the 3875 participants, 1843 participants indicated that they were assigned male at birth on their original birth certificate. Of those, 1822 (98.9%) indicated that they would like to be analyzed in the gender/sex category of "men," 7 (0.4%) selected "women," 4 (0.2%) selected "gender nonbinary," 4 (0.2%) selected "transgender women or transfeminine," and 2 (0.1%) selected "transgender men or transmasculine". Given the small numbers in these categories, and to be respectful of participant self-identification, the analytic sample included the 1822 participants who were both assigned male at birth and requested we analyze their data as "men".

Of these 1822 participants, the racial/ethnic composition of the sample included 63.9% white/non-Hispanic, 16.9% Hispanic, 10.8% Black/non-Hispanic, 6.7% other/non-Hispanic, and 1.8% mixed race/non-Hispanic; 70.6% (n = 1287) were

Table 1. Demographic characteristics of the sample.^a

Variable	No. (%)
Gender identity	
Man	1822 (100%)
Race/ethnicity	
White, non-Hispanic	1165 (63.9%)
Black, non-Hispanic	197 (10.8%)
Other, non-Hispanic	122 (6.7%)
Hispanic	307 (16.9%)
2+ races, non-Hispanic	32 (1.8%)
Sexual identity	
Bisexual	50 (2.8%)
Gay	60 (3.3%)
Heterosexual	1657 (90.9%)
Pansexual	10 (.6%)
Asexual	16 (.9%)
Other	22 (1.2%)
Age, y	
18-24	169 (9.3%)
25-34	331 (18.2%)
35-44	343 (18.8%)
45-54	259 (14.2%)
55-64	342 (18.8%)
65-74	252 (13.8%)
75+	126 (6.9%)
Relationship status	
Single and not dating	445 (24.4%)
Single and dating or hooking up, but not in a romantic relationship	61 (3.4%)
In one romantic relationship	1287 (70.6%)
In more than one romantic relationship	18 (1.0%)
Children <18 y old	
Yes, ≥1 living at home	411 (22.6%)
Yes, but they are not living at home	49 (2.7%)
No	1361 (74.7%)
Education	
No high-school diploma or GED	212 (11.6%)
High school graduate (high-school diploma or GED)	519 (28.5%)
Some college or Associate's degree	528 (29.0%)
Bachelor's degree	305 (16.7%)
Master's degree or higher	258 (14.1%)
Household Income	
>\$10 000	32 (1.7%)
\$10 000-\$24 999	153 (8.4%)
\$25 000-\$49 000	301 (16.5%)
\$50 000-\$74 999	325 (17.8%)
\$75 000-\$99 999	260 (14.3%)
\$100 000-\$149 999	361 (19.8%)
≥\$150 000	390 (21.4%)

^aNot all categories add up to 1822 due to missing-at-random data on some demographic variables.

in a romantic relationship; 24.4% (n = 445) were single and not dating; 3.4% (n = 61) were single and dating or hooking up, but not in a romantic relationship; and 1% (n = 18) were in more than one romantic relationship at the time of data collection. Complete sociodemographic characteristics of the sample are provided in Table 1.

Measures

The sociodemographic characteristics, presence of ED based on the clinical cutoff for IIEF-5 scores (described below), severity of ED based on the IIEF-5, perceived erectile confidence and hardness, self-report of being told by a provider that you have ED, other health conditions diagnosed by a provider, prescription and nonprescription medications taken

for ED, and barriers to seeking care for erectile function issues were the measures of interest in the current analysis. Table S1 contains a full list of the specific questions related to ED that were asked of participants.

Erectile function was assessed using the IIEF-5,¹ with IIEF-5 scores ranging from 5 to 25, and ED was classified into 5 categories based on the scores: severe (5-7), moderate (8-11), mild to moderate (12-16), mild (17-21), and no ED (22-25).

Statistical procedure

We used weighted descriptive statistics to analyze the prevalence, severity, and diagnosis of ED in the United States in addition to barriers experienced by participants in seeking treatment for ED. We excluded from analysis any individuals who did not respond to an item. SPSS (version 27.0) was used for analyses.

Results

The prevalence of diagnosed ED was 24.2%. Within the diagnosable categories of ED, 1.3% were categorized as severe, 2.5% as moderate, 5.1% as mild-moderate, and 15.3% as mild. Generally, erectile function declined with age, although more individuals in the 18-24-year age category reported mild and moderate difficulty with erectile function than in the 25-34- and 35-44-year age categories. In the 18-24-year age category, 17.9% of the sample met diagnostic criteria for ED based on the IIEF-5 compared to 13.3% of the 25-34-year age category, 12.7% of the 35-44-year age category, 25.3% of the 45-54-year age category, 33.9% of the 55-64-year age category, 48.0% of the 65-74-year age category, and 52.2% of the ≥75-year category. The severity of ED by age is depicted in Figure 1. There were no significant differences in IIEF-5 diagnostic cutoffs between any race categories, $\chi^2(4) = 0.55$, $P = .97$.

With regard to self-reported confidence to get and keep an erection, 16.5% of participants had low or very low confidence that they could get and keep an erection over the past 6 months. Additionally, 13.6% of participants indicated that over the past 6 months their erections were not hard enough for penetration at least half of the time. Despite these concerns and an ED prevalence rate of 24.2%, only 16.7% of participants had talked with their provider about their erectile difficulties and only 7.7% had been diagnosed by their provider (Figure 2). Diagnosis by a provider for other health concerns were also provided and Table 2 presents these comorbidities by ED diagnostic criteria; heart attack or myocardial infarction and congestive heart failure were the two other conditions that were significantly more likely to be reported by men who met the diagnostic criteria for ED. Asthma, diabetes, hypertension or high blood pressure, high cholesterol, depression, or anxiety disorder were significantly more likely to be reported by men who did not meet the diagnostic criteria for ED.

Participants reported some prescription and nonprescription medications taken for ED. Specifically, Viagra (sildenafil) was the most common with 248 (13.6%), followed by 164 (9.0%) who reported Cialis (tadalafil), 35 (1.9%) reported Levitra (vardenafil), 16 (.9%) reported penile injections, and 4 (.2%) who reported Stendra (avanafil). Some nonprescription medications were also reported by participants, such as herbal

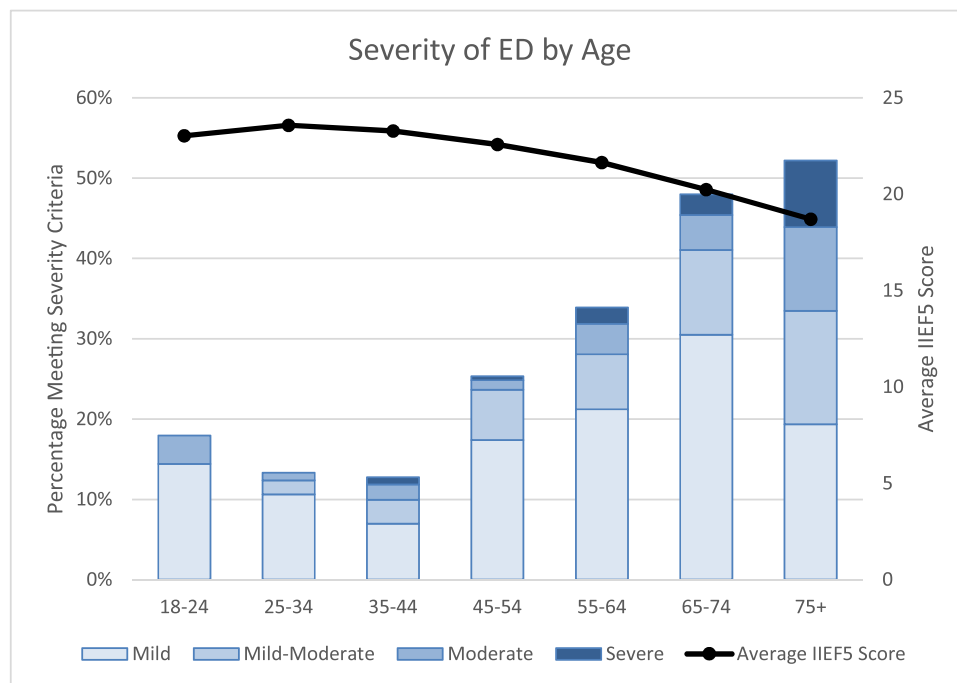


Figure 1. Severity of ED by age.

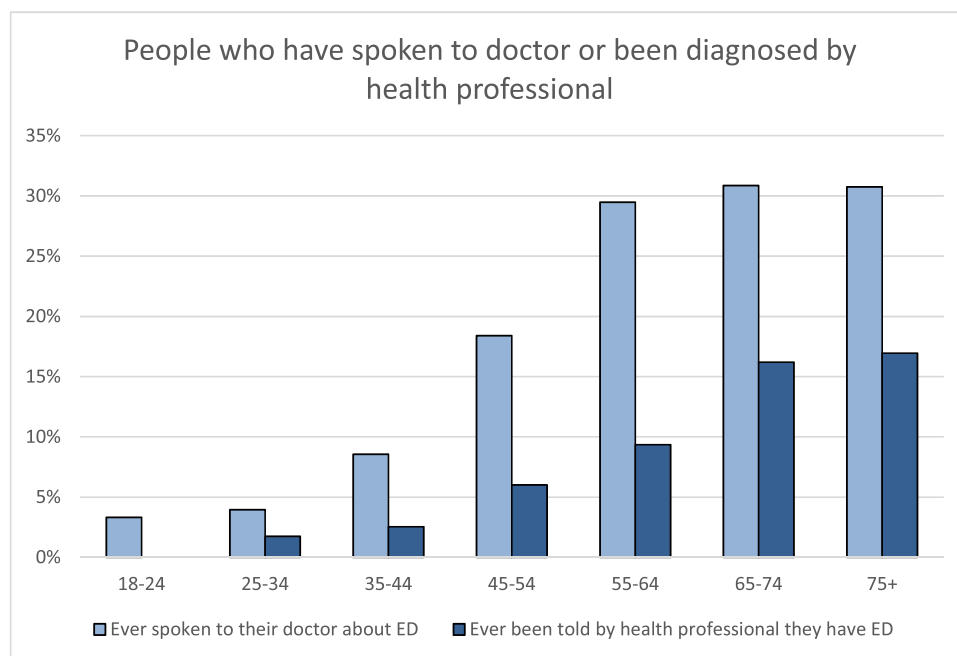


Figure 2. People who have spoken to their doctor and were diagnosed with ED.

pills ($n = 62$; 3.4%), vitamins ($n = 60$; 3.3%), and creams applied to the penis ($n = 16$; 0.9%).

Participants provided several reasons for not accessing care. The most common overall was that they simply did not need to see a provider in the past year, reported by 70% of the sample. The reason of “something else” was the second most selected reason to not access care, endorsed by 11.3% of the full sample (endorsed by 13.0% of those who met diagnostic criteria and 10.4% of those who did not meet diagnostic criteria). Of the 13.0% of respondents diagnosed with ED who selected “something else” as a barrier to care, nearly half (46%) clarified in their text response that they had no need for

this type of care. Of the 10.4% of respondents not diagnosed with ED who selected “something else”, nearly three-quarters (73%) stated they had no need for this type of care. The full list of reasons for not accessing care is provided in Table 3.

Discussion

In the current study the use of diagnostic measurement tools in a nationally representative sample provided insight into the prevalence of ED and clarification regarding the barriers men face when accessing care for ED. Specifically, in this nationally representative sample the ED prevalence rate was

Table 2. Comorbidities by IIEF-5 diagnostic criteria for ED.^a

Diagnosis	Meets diagnostic criteria for ED, No. (%)	Doesn't meet diagnostic criteria for ED, No. (%)
Asthma	31 (29.0%)	76 (71.0%)
Diabetes***	42 (41.2%)	60 (58.8%)
Hypertension or high blood pressure***	124 (39.9%)	187 (60.1%)
High cholesterol***	111 (36.5%)	193 (63.5%)
Heart attack or myocardial infarction***	17 (65.4%)	9 (34.6%)
Congestive heart failure***	11 (64.7%)	6 (35.3%)
Emphysema or COPD	10 (50%)	10 (50%)
Weak or failing kidneys**	12 (63.2%)	7 (36.8%)
Cancer or a malignancy of any kind	20 (48.8%)	21 (51.2%)
Depression or anxiety disorder	39 (33.6%)	77 (66.4%)
HIV/AIDS	3 (42.9%)	4 (57.1%)
Genital herpes	7 (33.3%)	14 (66.7%)
Some other STI	8 (32.0%)	17 (68.0%)
Low testosterone	30 (51.7%)	28 (48.3%)
Enlarged prostate gland	29 (49.2%)	30 (50.8%)
Premature ejaculation	8 (80.0%)	2 (20.0%)

^a χ^2 analyses significance between diagnostic category * $P < .05$; ** $P < .01$; *** $P < .001$.

Table 3. Reasons for not accessing care by IIEF-5 diagnostic criteria for ED.^a

Reason	Meets diagnostic criteria for ED	Doesn't meet diagnostic criteria for ED	Total
I did not need to see a doctor in the last year	52.1%	76.2%	70.0%
Something else	13.0%	10.4%	11.3%
Concerns about getting COVID if I went into clinic	9.9%	6.4%	7.4%
Lack of time	8.3%	4.6%	5.5%
Embarrassment in getting certain kinds of medical care	13.3%	2.4%	5.2%
Lack of health insurance	4.3%	2.0%	2.4%
I had privacy/confidentiality concerns	7.6%	0.9%	2.3%
I did not know where to go for care	5.2%	1.4%	2.2%
I could not take time off from work	3.0%	2.1%	2.2%
I was afraid to hear bad news	6.6%	0.7%	2.0%
I could not afford to pay for a visit	4.3%	0.9%	1.7%
Lack of reliable transportation	0.3%	0.3%	0.3%

^aThis question was asked only of those who had said previously that they did not receive any sexual or reproductive healthcare in the past 12 months. Of those who stated that they did not receive this type of care, 95.6% responded to the questions about why they did not receive care. The percentages in this table are computed as a fraction of those who responded to the questions about why they did not receive care.

24.2%. This prevalence rate is similar to rates based on prior research and reviews estimating prevalence rates in the United States. This finding provides a much-needed update, especially given public concern surrounding the perceived increase in ED. Additionally, we found that the most prevalent reason for not seeking medical care for ED was that men felt that they did not need to see a provider. This finding indicates that the need for medical care for ED is being addressed by a professional only when something else comes up, perhaps reflecting embarrassment, stigma, lack of perceived importance, or a combination of those.

While ED increasingly affects men as they age, there is a concerning trend of a higher rate among the youngest age group, which one might not expect since ED is associated with many medical conditions more often associated with age. However, the youngest age groups in this study (ages 18–24 and 25–34 years) did show slightly higher rates of ED (17.9% in ages 18–24 years; 13.3% in ages 25–34 years) than previous prevalence data that showed ranges between 3.5% to 11.3% in men under 35 years of age.^{9,17} This finding may point to some of the sexual function side effects of antidepressant medications and hair-loss drugs, which have increased in both access and usage in recent years, as well as some of the sociocultural impacts for younger men (e.g.,

performance anxiety, alcohol use, and higher rates of condom use, each of which can affect erections), although we did not directly assess those constructs and additional research is warranted. Additionally, the presence of ED is still far lower in younger age groups and ED is more prevalent among older age groups. Some researchers have found significant correlations between problematic pornography consumption and ED.¹⁸ A possible explanation for this finding is that pornography use may lead to tolerance for the visual overstimulation provided by pornography.^{18,19} However, in a 2021 study of men ages 18–44 years, no significant correlation was found between ED and internet pornography frequency or duration of use; however, the perception of compulsive use, distress around use, and interference with life was associated with a decrease in both erectile and ejaculatory function.²⁰ It appears that distress around pornography use is far more important than pornography use for adverse effects on erectile function.

In addition to prevalence, the severity of ED also increased with age, with more men reporting severe and moderate ED in the older age categories. In comparison, no men from the 18–24- and the 25–34-year age groups reported scores in the severe range, and very few (3.2% and 0.9%) reported scores in the moderate severity range.

Prevalence of ED did not differ in any other sociodemographic category other than age. Previous research is mixed regarding ED rates among racial and ethnic groups,^{6,21} and these differences were not found in the current sample. Notably, recent research suggests a possible correlation between COVID-19 infection and ED.²² Given disparities across racial and socioeconomic groups regarding exposure to COVID-19 and access to adequate medical care for COVID-19, vigilance is needed in future research to identify for potential disparities that may emerge in ED rates related to the pandemic.

The results of this study indicated a clear disparity between self-reported prevalence of ED (24.2%) and diagnosis of ED by a provider (6.2%). This finding is consistent with research suggesting a range of barriers in help-seeking behavior regarding sexual dysfunction, including patient embarrassment and healthcare provider levels of training surrounding sexual health issues.²³ Barriers endorsed in this study included embarrassment, COVID-19 concerns, lack of time, privacy and confidentiality concerns, not knowing where to get care, financial concerns, lack of health insurance, inability to take time off from work, fear of receiving bad news, and lack of transportation.

The most prevalent reason for not seeking medical care was that men did not need to see a provider. It is possible that, for some men, this reflects low health literacy, such as a lack of understanding around ED causes or ED medication. For example, research has shown that awareness of phosphodiesterase-5 inhibitors enhances the speed at which men may seek treatment for ED.²⁴ The low rate of help-seeking may also point to a perception that sexual health concerns alone are not important or substantial enough to seek medical care but are seen as an “add on” topic to bring up in the context of other care. This trend could also be an indicator that providers are failing to ask about sexual concerns within the context of a general visit, and research has indicated that patients prefer for providers to be the ones to bring up sexual health concerns.²⁵

This disparity in health-seeking behavior may also be explained by a lack of distress related to ED. It is presumed that those seeking help for ED would be distressed about this issue enough to seek help; however, the IIEF does not specifically address the issue of distress related to erectile function. Most men indicated not seeking help because they did not need to see a provider in the past year, again suggesting that if ED was an issue, perhaps it was not enough of an issue to be the primary concern of a visit to a healthcare provider. This may also explain why only 16.7% of men discussed ED with their provider, but only 6.2% were diagnosed by a provider; perhaps the distress was not high enough to warrant diagnosis. Additionally, literature supports the tendency for men as they age to experience less distress related to sexual dysfunction,²⁶ which may explain why the oldest men in this sample who reported severe ED may not have accessed care or have been diagnosed by a provider. During routine visits, or visits for other primary concerns, erectile function should be asked about, and therefore addressed as a secondary issue. This practice could have far-reaching benefits, given research showing that access to ED medication may increase users' general healthcare utilization and aid in early detection of underlying comorbidities.²⁷ Additionally, healthy sexual functioning and sexual well-being are interconnected with overall functioning and well-being.²⁸

Strengths and limitations

A major strength of this study is the measurement of ED using a validated measurement tool with a diagnostic cutoff in conjunction with reported diagnosis by a provider in a nationally representative dataset. Many studies examining prevalence rates of ED rely solely on self-report using a single-item question; our method provides a more comprehensive understanding of who meets criteria for ED, severity of ED, treatment access, and barriers to care. These data are incredibly important for gaining insight into the current prevalence rates and mitigating the long-term impact of ED by understanding barriers to medical treatment. Additionally, collecting data about sexual health can be sensitive, and research has shown that online data collection facilitates more accurate reporting of sensitive information.

The study is not without limitations. Consistent with prior research, the IIEF-5 was administered to participants who had sex in the last 6 months. Although this criterion is standard practice, it is possible that these resulting rates do not include those men with ED who have been avoiding penetrative sex for a significant time and are therefore potentially not represented in the prevalence data. Additionally, self-reports of ED may be impacted by the expectations men hold around erectile performance, many of which could be unrealistic. As medical information and treatment options become increasingly available through online platforms, it is unclear if participants consider these methods to be “accessing care,” as reported in this study. Additionally, the rates of ED reported to have been diagnosed by a provider are self-reported and may not truly represent the accurate number of men who have a formal ED diagnosis, as it is common for people to underreport their diagnoses. Finally, although we did assess participant engagement with providers, we did not directly assess distress. It may be that low engagement in seeking medical care for ED is due to low distress about the experience of ED, but we were unable to directly assess that link in the current study.

A strength of this study is that we calculated prevalence statistics through a nationally representative survey that utilized the Ipsos KnowledgePanel®, a probability-based online panel. With that, we did not oversample sexual and gender minority participants, so our rates of non-cisgender participants reflect those of the national population and do not allow for prevalence of ED in subpopulations of sexual and gender minority individuals. We do not anticipate that rates would necessarily be different, especially since the only statistically significant sociodemographic variable was age, though there may be different barriers to care and those would be important to examine in future research.

Data collection took place during the COVID-19 pandemic. It is possible that the various psychosocial and physical effects of the pandemic impacted these findings. This may also be a strength of this study. Particularly, as research points to the possibility that COVID-19 may be associated with ED due to possible biological factors, mental health effects, and access barriers, there is a need to accurately assess ED prevalence rates within and throughout the pandemic.

Conclusion

Findings from this study suggest that ED prevalence is highest in older age groups, and that severity of ED increases with age. Young men appear to have slightly higher prevalence rates of ED than previous studies suggest, though severe

and diagnosable rates of ED remain stable. This study also highlights a disparity between ED and accessing medical care related to ED, with an overall prevalence rate of 24.2% but a provider diagnosis rate of 6.3%. Erectile difficulties must be asked about during routine medical visits to account for this disparity.

CRedit Taxonomy

K.M. Conceptualization-Equal, Formal analysis-Lead, Visualization-Lead, Writing – original draft-Lead, Writing – review & editing-Lead. K.A. Writing – original draft-Equal, Writing – review & editing-Equal. A.G. Writing – original draft-Equal, Writing – review & editing-Equal. D.H. Conceptualization-Equal, Data curation-Equal, Funding acquisition-Equal, Methodology-Equal, Project administration-Lead, Writing – review & editing-Equal. T.-C.J.F. Methodology-Equal, Writing – review & editing-Supporting. Eli Coleman Conceptualization-Equal, Funding acquisition-Supporting, Methodology-Supporting, Supervision-Equal, Writing – original draft-Supporting, Writing – review & editing-Equal.

Supplementary material

Supplementary material is available at *The Journal of Sexual Medicine* online.

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Conflict of interest

None declared.

Data availability

The data underlying this article are available in [repository name, eg, the GenBank Nucleotide Database] at [URL], and can be accessed with [unique identifier, eg, accession number, deposition number].

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