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Propping up pharma's (natural) neoliberal phallic man: pharmaceutical representations of the ideal sexuopharmaceutical user

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ABSTRACT

Contemporary social theorists emphasise the cultural quest for authenticity under conditions of increasing artificiality. Within this context, the body is commonly treated as an 'unfinished' surface requiring ongoing transformation to fulfil identity obligations. In this paper, we examine one such identity authentication project in the form of marketing of men's sexuopharmaceuticals. We use online pharmaceutical advertising for four approved sexuopharmaceuticals (Viagra, Cialis, STAXYN and Stendra) to describe the ideal neoliberal consumer. These campaigns underscore the robust role of pharmaceuticals in sexual authentication projects undergirded by neoliberal consumerist and aspirationalist ideals. Penile dependability as a luxury consumerist project reinvigorates traditional sexual (masculine) authentication as yoked to phallic control, by repackaging sexual enhancement medication use as a neoliberal beacon of aspirational achievements. The ideal targeted user is increasingly younger, and consumption of sexuopharmaceuticals is represented as achieving elite status and exclusive pleasures; masculine authenticity and choice; progressive relationships and a contemporary urban, fast-paced life; and a prepared yet spontaneous romantic sexuality. Women are also increasingly used in promotional materials directed at men; their responsibility centres on coaching and coaxing potential users.

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Introduction

Contemporary social theorists emphasise the cultural quest for authenticity under conditions of increasing artificiality (Potter 2010). This staged authenticity conjoins 'desire for the real, fetishisation of the real, [and] resignation' to its elusiveness (Barcan 2004, 255). In this paper, we examine one such 'identity authentication' project in the form of sexuopharmaceutical marketing and its reliance on the rhetoric of choice, consumerism and authenticity (Featherstone 2007). Our term identity authentication here refers to a neoliberal recoding of liberty and autonomy as privatisation, deregulation and cosmopolitanism, with health responsibilisation key to the project of producing a 'true' self (Harvey 2005). While identity authentication promotes individuality, consumerism dictates the judicious stylisation of

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personhood by targeted product adoption (Featherstone 2007), with the body commonly treated as an 'unfinished' surface requiring ongoing transformation (Turner 2008). Sexuality is a suitable target for aspirational identity projects, as reflected in 'sexual entrepreneurship' discourses (Harvey and Gill 2011a, 2011b) that advocate ceaseless pursuit of sexual improvement. Adopting Jackson and Scott's (1997) genealogy of human sexuality discourses as both 'obeying predictable natural laws and as being amenable to incorporation into a rational, reflexive project of the self' (569), 'sexual entrepreneurship' is similarly a 'technology of sexual subjectification' (i.e., sexuality as central to conception of the self) (Harvey and Gill 2011b, 495). While sexuality retains its status as an instinctual drive, it is becoming a key vehicle for self-transformation through rational commodification of sexual pleasures (Jackson and Scott 2010).

Pharmaceuticalisation, medicalisation and commercialisation of sexuality

Sexuopharmaceutical self-reinvention represents the broader move towards increasingly routinised pharmaceutical consumption – the 'pharmaceuticalisation of daily life' (Fox and Ward 2008, 856) – or the 'transformation of human conditions, capabilities and capacities into opportunities for pharmaceutical interventions' (Williams, Martin, and Gabe 2011, 711). As pharmaceuticals are increasingly produced not for ill health but for managing (dis)satisfaction with everyday living, the demarcation between medical and social conditions becomes blurred (Flower 2004). Distressing psychological and physical states become understood primarily through the prism of organic bodily or brain disruption, with chemical alterations extending beyond treatment to enhancement. Advocates on either side of the human enhancement debate converge in their joint emphasis on the 'moral ideal of authenticity' (Parens 2005, 34). Critics assert that authenticity can only be achieved by retaining bodily and psychological capacities as they 'naturally' present. Proponents argue for biotechnology's creative potential to level out uneven attributes (Parens 2005). This complex bioethical debate – hinging on often murky distinctions between treatment and enhancement, public health costs and health policy obligations – is beyond this paper's scope. We acknowledge that questions concerning sexuopharmaceutical identity authentication are part of this broader conversation.

The turn to pharma for sustaining personhood – creating 'neurochemical selves' (Rose 2006) – has been linked to the recent but increasingly unquestioned conception of ourselves as fundamentally sick and requiring continuous treatment (Dumit 2012; Williams, Martin, and Gabe 2011). A shift from early preventive public health initiatives such as vaccinations to 'medicine by statistics' (Dumit 2012, 4) was propelled by mass statistical gathering that converged with clinical trials targeting 'at risk' populations. Once 'drugs could be paired with risk factors' (Dumit 2012, 5), the door opened for marketing drugs for chronic treatment rather than cure. Personalsing risk, promoting physician consultation about related drugs and developing lasting relationships with the public are chief pharmaceutical promotion strategies (Dumit 2012).

Central to sustaining ongoing drug use for chronic (versus acute) conditions is lowering thresholds for what counts as disease – incrementally smaller health 'deficits' can signal the need for pharmaceutical treatments (Dumit 2012). Symptom transience or non-medical responses become under-emphasised (Moynihan and Mintzes 2010). This 'continuing commercial, clinical and geographical expansion' of pharmaceutical reach (Williams, Martin, and

Gabe 2011, 711) rests on redefining what counts as disease; reducing regulatory thresholds; increasing links between industry and medicine (e.g., industry-funded medical education conferences); global market expansion of pharmaceutical companies; multi-modal media message transmission (e.g., public 'awareness' campaigns through television and home computers); and consumer mobilisation.

Sexuality is a key target for pharmaceutical intervention, particularly as a route to improving men's sexual performance (Berry 2013). [1]The medicalisation of sexuality, like other psychosocial experiences redubbed as medical, is propelled by such forces as media's promotion of magic bullet solutions and consumers with limited sexual knowledge coupled with distress (Tiefer 2002). It is also maintained by the rise of two related new medical specialties: the male sexual dysfunction arena, representing a 15-year development by the surgical subspecialty of urology, and the female sexual dysfunction domain, an outgrowth of the male counterpart (Tiefer 2002). Expanding sexual dysfunction definitions (Tiefer 2002) and increasing alliances between industry and researchers – the subject of vigorous debate (Lo 2010) – play a key role.

Sexual enhancement medication sales are steadily increasing since Viagra's 1998 launch. Just seven years later, the drug was prescribed by 750,000 physicians to 23 million men (Jackson, Gillies, and Osterloh 2005); by 2014, the global sexual enhancement medication market was worth over US$4.39 billion , with Viagra holding over 47% of that revenue (Globe Newswire 2015). Expiring patents and cheap counterfeit options may reduce the valuation of branded sexuopharmaceuticals (Globe Newswire 2015); such intrusion of alternatives only intensifies the need for brand loyalty and consumer trust (Globe Newswire 2015).

Sexual authentication projects: inviolable virility and the modern masculinity icon

Viagra's commercial success and capacity for capturing the popular imagination positions it as a key sexual technology and cultural intervention (Berry 2013; Loe 2004). Sexual technologies do not merely increase 'access to existing sexual practices and relations, but are also about creating sexual imaginaries and trajectories that actually constitute new sexual subjectivities' (Dowsett 2015, 531). Viagra's therapeutic promise extends beyond claims about rectifying failing erections, to assertions about fixing floundering relationships and reinstating fragile masculinities (Tiefer 2007; Vares and Braun 2006). Sexual enhancement medication marketing underscores the robust role of pharmaceuticals in sexual authentication projects that reflect rebooted idealised masculinity discourses (Gurevich et al. 2014 , 2016). A new masculinity icon – the 'new man' – (Alexander 2003; Rogers 2005) is emerging in key men's media outlets. This masculinity icon is an integrated position aimed at resolving dilemmas posed by shifting cultural dictates about male domination and female empowerment (Gill 2009). Characterised by his connection to product consumption rather than previous preoccupations with creating through labour, the new man is coded as a 'natural' man (Cortese and Ling 2011), defined by his 'ontological stability' (Crawshaw 2007). His natural status as properly male is affirmed by associations with muscularity, ruggedly tailored (but seemingly effortless) appearance and adventurous forays into sex and other leisurely pursuits (McKay, Mikosza, and Hutchins 2005). This resurgent form of biological essentialism, with its reassertion of male authority, relies on re-establishing male sexuality as straightforward, efficient and assured (Rogers 2005) – masculine power through 'turbo charged' sexual mastery (Tyler 2004).

Viagra promotion, as the archetypal site of sexual authentication for men (Loe 2004; Tiefer 2007), is characterised by two key narratives: the anti-decline narrative and the revised progress narrative (Potts et al. 2006).[2] The anti-decline narrative represents resistance to the common decline narrative of diminished sexual capacity at older age; it upends the inevitability of sexual diminution with age, including defying changes in erectile capacity. The revised progress narrative emphasises older men's ability to perform comparably to, or better than, younger versions of themselves. Viagra (and its analogues) holds out the promise of regaining youthful erections. Both narratives rest on the 'recent cultural-scientific conviction that lifelong sexual function' is core to successful ageing (Katz and Marshall 2003, 8), and sexual changes (at any age) can be remediated with sexual enhancement medication (Marshall 2006). This inviolable virility – coded as agentic and responsible – is in keeping with the technologised sexuality promoted by the sexuopharmaceutical 'consumerist erectile economy' (Marshall and Katz 2002, 45).

Following Viagra's appearance, several scholars documented Pfizer's 'strategic use of selected science and statistics and a masterful use of imagery' (Tiefer 2007, 549) to expand both the definition of erectile dysfunction (ED) and its target consumer. Key examples are: the move from manufacturing Viagra for dysfunction to marketing it for sexual revitalisation; targeting increasingly younger users; and emphasising athleticism and masculine control (Baglia 2005). Vares and Braun (2006) identified three central cultural Viagra discourses: Viagra as Joke, Legitimate Viagra and Party Pill Viagra. Viagra as Joke referred to comedic depictions that ridiculed both unsuccessful (i.e., requiring assistance) and 'out of control' erections (i.e., those that would not subside). In response, Pfizer began to promote a Legitimate Viagra discourse, declaring erectile dysfunction a serious medical condition warranting treatment. This included a 'couples campaign' – Viagra to improve diminished relationship vitality and closeness (Fishman and Mamo 2002). The Party Pill Viagra stressed Viagra's capacity to make sex more exciting and vigorous, even for men without erectile dysfunction.[3]

Current study focus and method

The impact of this new sexual capital on men's sexuality prompted a surge of critical scholarship in the first decade following Viagra's appearance (e.g., Baglia 2005; Tiefer 2007; Vares and Braun 2006). The last near-decade has notably lagged in the analysis of the pharmaceutical industry's updated approaches to sexual enhancement medication promotion, despite increasing documentation of its use recreationally by men with no erectile dysfunction diagnosis (Gurevich et al. 2014, 2016; see Berry 2013 for exception). We present a discourse analysis of current online advertising by four pharmaceutical companies in order to describe changes and constants in the ideal targeted consumer.[4] Our work diverges from earlier scholarship in its specific interest in the way neoliberal consumerist and aspirationalist ideals (Harvey 2005) converge with 'sexual entrepreneurship' discourses of sexual retooling (Harvey and Gill 2011a, 2011b).

Five types of sexuopharmaceuticals are currently available: Viagra, Cialis, Levitra, Staxyn and Stendra (Huang and Lie 2013). Official websites of four major manufacturers were reviewed (May to October 2015) by two co-authors (MG, UL): Pfizer USA (https://www.viagra.com/); Pfizer Canada (http://www.viagra.ca); Bayer Healthcare/GlaxoSmithKline (http://www.staxyn.com/index.html); Eli Lilly USA (www.cialis.com); and VIVUS Inc. (https://www.stendra.

com/).[5] Online analyses are increasingly used to track popular representations and their circulation in the social imaginary (Ross 2005).

Theoretical and analytic framework

This work adopts a social constructionist framework, positing that knowledge, theories and empirical findings have histories intimately connected to their inception, dissemination and (dis)favour (Burr 2003). We use discourse analysis to interpret the online material, acknowledging that language – and discourse more broadly – is constitutive rather than reflective (Parker 2002). Discourses are more than words; they appear in myriad forms – as text, images, law and interactions between people and institutions (Foucault 1972). A core component of discourse analysis involves mapping out threads of institutional and social power, meaning and knowledge (Burr 2003) by analysing the differential positioning (and validity) of discourses within texts. Discourse analysis seeks to identify: what is being *done* through and by discourses; which subject positions are made possible or inaccessible; and what interests are served (Gavey 1989).

Discursive analyses of masculinity, specifically, have a long tradition (Wetherell and Edley 2014), with gender viewed as a 'practical accomplishment' achieved in various ways, such as body regulation and modification practices aimed at adhering to masculinity ideals. Our analysis centred on the following questions: What meanings and models of sexuality and masculinity are circulated by sexual enhancement medication pharmaceutical companies? Who is the ideal consumer targeted by sexual enhancement medication marketing? What gendered subjectivities are represented in promotional materials? and How are sexual experts and source credibility represented? As analysis proceeded, we tracked the following key domains: age of intended users; class, race and sexual orientation of target users; gender of promotional protagonists; authority status accorded to sexual experts and credibility claims; and definitions of and assertions about erectile dysfunction. Iterative analysis and consensus focused on contextualising sexual enhancement medication in relation to neoliberal sexual norms.

Findings

Analysis of online pharmaceutical sites suggests that erectile difficulty is positioned as a highly prevalent medical disorder easily rectified by pharmaceutical intervention (Gurevich et al. 2014, 2016). Key discursive strategies include: exaggerated and/or misrepresented epidemic rates of erectile dysfunction; male users and female sexual partners depicted as younger (in their 30s–50s) than original target consumers; erectile variability is linked primarily to biological causes; sexual enhancement medication use is framed as guided by patient choice and as providing psychological relief. With the exception of STAXYN, women are used in all pharmaceutical promotions – as either potential sexual partners or sexual coaches. The rhetoric of competent male sexual performance (Rogers 2005; Tyler 2004) is paired with the language of exclusive pleasures, romantic encounters and spontaneous sexual excitement (Harvey and Gill 2011a, 2011b). This new 'natural man' narrative relies on a progressive masculine subject (Cortese and Ling 2011) – simultaneously in control and concerned with his female partner's pleasure (Gurevich et al. 2014, 2016). While earlier sexual enhancement medication promotion stressed average consumers (albeit sometimes aspiring

to fame and athleticism) and established relationships with older women (Vares and Braun 2006), current marketing targets aspirational neoliberal subjects (Harvey 2005); they engage in sexual reinvigoration through consumption choices and individual competence through self-management.

Pzifer USA – the (youthful) gentleman of leisure

The Pfizer US site, the most elaborate of the five, promotes exclusive pleasures as aspirational possibilities. Socioeconomic privilege is signalled by pristine, sprawling homes and luxurious vacation settings; referenced print materials target an affluent and educated reader (e.g. *Popular Science* and *Golf Digest*). The Viagra consumer – and his partner – are people who can afford to apply an equally entrepreneurial approach to building their financial stability and sexuo-relational health (Harvey and Gill 2011a,b) – 'work hard, play hard, get hard, stay hard' is the implied ethos. The male consumer is inculcated into constant self-surveillance and self-management (Foucault 1988), monitoring his body for signs that require Viagra's remediation to accomplish his 'innate' masculinity: 'You only take it when you need it.' Occasional use options provide reassurance of natural phallic (masculine) constancy.

This campaign relies prominently on (reassuring) female protagonists, while the medical (authoritative) advice regarding usage instructions and side-effects is male. An attractive woman (cerebral intimations signalled by books and glasses) amid a summer backdrop in each scene echoes the call of the siren, beckoning men to explore what Viagra can offer for their sexuality and masculinity. Hailing the male consumer with the genteel address – 'GENTLEMEN' – positions the male consumer in direct communication with a presumed confident female sexual partner who knows what she wants – a fulfilling sexual experience with a partner who can perform proficient masculinity through perfect penetrative control: 'If erectile dysfunction is stopping *what you started* … Viagra helps guys with erectile dysfunction get and *keep* an erection.' An atmosphere of maximum discretion prevails; a private exchange between the distinguished consumer and a generic sexually desirous and desirable woman; dressed (lounge uniform cum nightgown), manicured and coiffed in nearly identical ways, the women's seductively attentive, yet slightly detached poses allude to another VIP 'gentlemen's club'. Viagra promises to both achieve and retain sexual capacity, with the target goal at the centre: the ability to have sex with this kind of woman. Whereas earlier Viagra campaigns depicted older men and married couples (Fishman and Mamo 2002), this updated version focuses on the allure of (potential) younger female partners (in their mid-30s to mid-late-40s), rather than actual older female partners, and their role as sexual coaches and coaxers.

The women are allocated the emotional labour of sex (Cacchione 2015), alternately cast as confidant/coach and seductress/sexual partner: relaxing, reassuring and enticing. Mobilising pharmaceutical consumer awareness through physician consultation (Dumit 2012; Williams, Martin, and Gabe 2011), the male physician (stethoscope and medical journals at hand) – a third actor in every implied intimate relationship – is accorded the authoritative status of health information provision: 'Talk to a doctor today'; 'Stay in the know'. Confessional consultation with experts – as part of the 'healthicisation' of sex – promises sexual competence through sexual surveillance (Gupta and Cacchione 2013). Paralleling promotional materials for Staxyn and Strendra, ease of acquisition, portability and spontaneity – neoliberal consumer entitlements – are also signalled by online prescriptions 'delivered straight to your door' and 'NEW VIAGRA single packs'.

Simultaneously reassuring and alarmist statistics are presented: 'About half of men over 40 have some degree of erectile dysfunction.' The rest of the messaging logic pivots on this central claim – if erectile dysfunction is a common (medical) problem, then Viagra is a concrete (medical) solution. Erectile dysfunction is underscored throughout as being 'often caused by something physical, such as a disease, injury, or side effects from other drugs', and defined as occurring 'when not enough blood flows to the penis'. Erectile difficulty is allocated an organic origin, while at the same time men are consoled that for some, 'ED symptoms can happen just once in a while'. Erectile variability, however infrequent or transient, is designated as a common disorder. The cited research is the Massachusetts Male Aging Study (MMAS) (Feldman et al. 1994), based on men aged 40–70 years (in 1987–1989). Results of these impotence severity self-reports (mild, moderate, complete) were collapsed during the Viagra clinical trials, leading to the claim that of 1290 respondents, 52% had some degree of erectile dysfunction (Lexchin 2006).

These conclusions require greater scrutiny. First, the umbrella term of 'degree' conveniently covers over large data variability (partial, temporary or occasional erectile difficulty). Second, the study comprised two different groups of men (Lexchin 2006). The larger proportion of the sample responded to nine sexual activity questions; the smaller sub-sample additionally indicated levels of impotence (none, minimal, moderate, complete). The impotence categories cited by Pfizer are based on this one question for the small group of men, estimated for the first larger group. Potential group differences were also not addressed, although the larger first group was recruited from the Boston Standard Metropolitan Statistical Area; the smaller second group came from a university urology clinic (Lexchin 2006). Third, the 52% projection does not address age-related erectile dysfunction rates. Among 40-year-old men, 39% reported some level of impotence (17% with only minimal levels); for the 70-year-old men, that number was 67%.

Pfizer Canada – the authentic and agentic man

The Canadian Pfizer site emphasises authenticity, agency and self-actualisation through the vehicle of maximal sexual activation (Rogers 2005): 'BE WHO YOU WANT TO BE: You're a man who won't settle for anything but the real deal. Viagra.ca will give you everything you need to be ready – on your own terms.' Key values of self-knowledge and self-governance are intended to strike a chord with this 'new man' (Cortese and Ling 2011), who is self-assured, controlled and aspirational. He is urged to achieve his authentic (albeit 'staged') identity (Barcan 2004) through the consumption of a genuine article – the original sexuopharmaceutical: 'If it doesn't say Pfizer, it's not Viagra.' References to the alleged sexuopharmaceutical gold standard are propped up in several ways. Using a unique ID code, visitors are prompted to 'UNLOCK YOUR VIAGRA ANSWERS/Only VIAGRA customers get access to VIAGRA resources'. Viagra's original, superior status is also underscored by instructions for obtaining Viagra only by medical prescription, verifying authenticity of packaging and pills to ensure safety, and warnings about generic options and Internet offers. Consumers are exhorted to select Viagra over other competing variants with the quintessential neoliberal slogan: 'Exercise your right to choose'. The responsible 'sexual entrepreneur' (Harvey and Gill 2011a,b) – invested in sexual skill-building and improving performance – consults medical experts, while exercising choice (Dumit 2012). Echoing Pfizer's US campaign, the exclusivity of the Viagra 'club' is signalled by: ruggedly attractive (youthful) men immersed in private conversation; golf and

tennis clubs; and invitations to 'take your best shot' in a hockey arena adorned with Viagra logos. The masculine code of keeping score, amassing trophies and extreme exertion is activated (Baglia 2005).

STAXYN – the modern (younger) man on the move

STAXYN's promotional campaign is austere and modest compared to the grandeur of Viagra – a simple layout with striking symbols of contemporary urban, fast-paced life. The prominent tagline, nonetheless, hits its target-user mark efficiently and explicitly: 'STAXYN. Check out the pack. Check out the price'. In three brief phrase segments, the product is broadcast, phallic pride is proclaimed and cost considerations are addressed. The common usage of 'pack' (as container and as vernacular for male genitalia) is strategically invoked.

A sleek and discreet package, resembling a gum dispenser or a credit card, sits amid everyday items – a man's wallet, loose change and car keys. The signifiers reference an urbane, busy 'new man' (Tyler 2004) with no time to waste and easy integration of sexuopharmaceuticals into his efficiently exciting lifestyle. Hovering the mouse over the container elevates it with the inscription 'demo the pack'; with a click, a 3-D demo of the case triples its length (erectile rise anyone?), displaying individually encased STAXYN pills. STAXYN's target user is decidedly younger than those of its current competitors, as indicated in the news release by Bayer Inc:

> STAXYN® – New Innovation in Erectile Dysfunction Helps Younger Men Rise to the Occasion …. Now, for the first time in nearly a decade, younger Canadian men with erectile dysfunction have a new and effective treatment option that rapidly dissolves on the tongue, is roughly half the cost of most erectile dysfunction medications and fits their lifestyle needs.

The five-page report cites men as young as 30 as exhibiting erectile difficulties with no known organic causes, but nonetheless diagnosed as having erectile dysfunction. Appeals to a younger target consumer include: ease of administration; 8-hour duration of effect; efficacy unaffected by alcohol consumption; concordance with an active, spontaneous lifestyle; and lower cost:

> Research shows that 43 per cent of erectile dysfunction medication users split their pills to save money; however, splitting pills can effect [*sic*] efficacy … 'splitting pills is a common practice among erectile dysfunction patients and is generally done to combat the lack of affordability of other erectile dysfunction treatments,' said Dr. Francois Bénard, Associate Professor and Director of Urology, St-Luc Hospital, Montreal, Quebec. 'Now with STAXYN, my younger patients can have a treatment that works and meets their needs, without splitting pills'.

Expert evidence and empirical support explicitly reference younger users requiring less expensive options, citing presentation slides from a market research firm (Research Strategy Group Inc., STAXYN Patient Research):

> 'Physicians are increasingly seeing men in their 30s, 40s and early 50s with erectile dysfunction who have no obvious physical cause, such as diabetes, high cholesterol or hypertension, and it's actually stress acting as a trigger,' said Dr. Gerald Brock, Professor in the Department of Surgery, Division of Urology, at St. Joseph's Health Centre …. Research shows that younger erectile dysfunction patients (aged 35–55 years) attribute stress (59 per cent) as one of the main causes of their erectile dysfunction. These younger men who perceive their erectile dysfunction as temporary are proactive in seeking suitable treatment options for their condition.

Organic erectile dysfunction etiology is not cited as plausible for younger men; a more global psychological explanation suffices – stress (its sources undefined). Potential transience is de-emphasised and labelled as erectile dysfunction: patients' beliefs are downplayed in favour of medical expertise and treatment.

Framing pharmaceutical intervention as pre-emptive also constructs a responsible, 'at-risk' consumer (Dumit 2012; Williams, Martin, and Gabe 2011) – a self-regulating, performance-enhancing 'sexual entrepreneur' (Harvey and Gill 2011a,b) – who achieves the correct solution. Cited erectile dysfunction prevalence rates point to an epidemic: 'three-to-four million Canadian men suffer from erectile dysfunction. The number of men with erectile dysfunction is expected to more than double to 322 million worldwide by 2025'. Echoing the Viagra campaign, the first statistic is taken from a 25-year population projection estimate based on the MMAS (Aytac, Mckinlay, and Krane 1999). The second estimate is taken from the Cross-National Survey on Male Health Issues (Shabsigh et al. 2004), and based on one self-report item referring to 'difficulty getting or keeping an erection'; responses included: 'before, but not now', 'sometimes' and 'always'. Any 'yes' response, past or present, was categorised as erectile dysfunction.

Cialis – the progressive equal partner

Cialis targets mature, informed heterosexual couples, highlighting seamless integration into 'natural,' 'normal' daily routines of spontaneous sexual activity. In contrast to the slick, sexy marketing of Viagra, STAXYN and Stendra, Cialis focuses on dense textual presentation of pseudo-technical medical information, with erectile dysfunction as a partner problem. Cialis has distinguished itself from Viagra by leveraging its long-lasting, once-per-day dosing against Viagra's 'use-as-needed' regimen (Vares and Braun 2006). The drug is further differentiated in the current campaign using its October 2011 FDA approval for treatment of benign prostatic hyperplasia (BPH), or enlarged prostate, (leading to mild-to-severe lower urinary tract symptoms). Though the medical website (www.cialismd.com) acknowledges that the drug's action mechanism 'has not been established', the two conditions are linked – 'ED+BPH – Could you have both?', 'About half of all men with erectile dysfunction may also have BPH symptoms' – underscoring biological etiology and Cialis as widely applicable and scientifically grounded.

A dynamic clip reveals a maturely-attractive, heterosexual, Caucasian couple happily sharing the duty of hanging all-white laundry on an idyllic sunny afternoon. He is an archetypical contemporary 'regular guy': (ruggedly handsome) finding pleasure in the 'calm reassurance of' (albeit glossy) 'ordinariness' (Mark and Pearson 2001,165, 167). He is 'progressively' participative in household responsibilities; she, likewise, is a 'regular gal' (Mark and Pearson 2001, 165): younger than her partner, attractive but modestly attired – a far cry from the beckoning sirens of Viagra's US campaign. Wholesome, heteronormative domestic bliss – attainable and desirable stability – threatened by the spectre of sexual and urological dysfunction. Coming together to fold a towel, the video slows down to interrupt their impending kiss: 'WHY PAUSE? You shouldn't have to pause the moment to take a pill or find a bathroom/ Try CIALIS for daily use.' Pharmacological intervention is characterised as simultaneously undesirable and essential, with pill-fuelled preparedness as key to spontaneity.

Progressive, couple-centric branding sits alongside reinforcement of gendered mono-heteronormativity. Contemporary coupledom discourses highlight communication as a relationship imperative (Harvey and Gill 2011a,b), used as a core marketing strategy here. Men are instructed to 'be open and honest, as well as sensitive, about [their] partner's needs and questions … reassure [their] partner that erectile dysfunction is not her fault, but likely a medical issue'. Cast as nurturing coaches, women are assigned familiar sexuo-emotional work (Cacchione 2015):

> You may be thinking, 'It's me'. But you should know that erectile dysfunction is a real, treatable medical condition often caused by another health problem …. Learn everything you can

> about erectile dysfunction and available treatment options, and share that information with your partner. Once you both have all the facts, your partner can work with his doctor to make a better informed decision about what to do next. Talk with your partner about what's going on and encourage him to visit his doctor to see if he has erectile dysfunction. Offer to make an appointment for him or go to the doctor with him.

Relieved of threats to his essential masculinity, his authority and virility stabilised by informed and responsible management of her fears and his 'medical problem'. She is tasked with supportive education provision – her sexual viability and femininity (re)confirmed – but decision-making is ultimately deferred to her partner and medical experts.

A football field signals Cialis as a lever for the ultimate touchdown – achieving penetrative goals. The Cialis man is a sensitive – but no less powerful – 'new man': progressively egalitarian and 'in touch with his emotions without losing his masculinity' (Cortese and Ling 2011, 7), both 'natural' and connected to product consumption (Alexander 2003). At the goal line, prevalence statistics cast a wide diagnostic net:

> ED … affects approximately 18 million men in the United States, but is treatable in most cases. erectile dysfunction is more common in older men, but can happen at almost any age.

Without shying away from invoking 'older' age, erectile dysfunction is highlighted as an 'everyman' epidemic. Any degree of erectile erraticism ('can't get an erection at all', 'it's not hard enough for penetration', 'can't maintain it') is deemed dysfunctional; although other related health problems, lifestyle factors and 'emotional or personal issues' are recognised, the phrase 'treatable in most cases' links directly to 'Make [Cialis] part of your routine'. The 18-million prevalence refers to 2001–2002 census data (National Health and Nutrition Examination Survey), with 18.4% of men over 20 years of age self-reporting as being 'sometimes unable' or 'never able' to 'get and keep an erection' (Selvin, Burnett, and Platz 2007, 152). Varying frequencies are conflated: 5.1% of those aged 20–39 and 14.8% of those aged 40–59 experienced erectile dysfunction, and 88.1% of men with erectile dysfunction 'had at least one major cardiovascular disease risk factor'. Statistics in estimate-based millions, and targeting men over 20 by disregarding etiology, emphasises erectile dysfunction as a widespread problem.

Stendra – the prepared (voracious) partner

The Stendra campaign combines the rhetoric of perpetual sexual preparedness and proficiency directed at men (Rogers 2005; Tyler 2004) with the aspirational language of romantic encounters and re-kindled coupled sexual excitement (Harvey and Gill 2011a,b). Stendra's promotion, like Viagra's, employs attractive female protagonists, though here the women are depicted as obligingly responsive to the pharmaceutically-(re)enabled sexual readiness of their take-charge partners (Potts 2002). In contrast to Cialis' progressive partnership, Stendra reinvigorates compulsory, gendered sexuo-relational management where intimacy is '"spiced up" through tireless work and [differential skill] acquisition in order to avoid slipping into' sexual stagnancy (Harvey and Gill 2011a, 61). He is tasked with erectile efficiency as a sign of sexual control; she is marked by her willingness to meet her partner's needs. Self-surveillance, practiced spontaneity and a leisure lifestyle are further underscored by Stendra's last-minute dosing and non-interaction with moderate alcohol use.

Both an anti-decline narrative and a revised progress narrative (Potts et al. 2006) are evident – the threat of time on bodily and relational health forestalled by responsible sexual

agency and routinised romance (Harvey and Gill 2011a). His voracious desire – coded by inviolable erections – recalls unbridled youthful lust. Juxtaposing mature coupledom and irrepressible (spontaneous) desire foregrounds sexuopharmaceuticals as *the* means of recapturing natural (obligatory) sexual and relational health (Marshall and Katz 2002).

The website's homepage displays an attractive, middle-aged man in the driver's seat of a car, pulling in a glamorously-styled woman: 'THIS TIME HE WAS READY before date night started'. A series of revolving pictures (and video clip), each accompanied by the same caption, invoke the promotional theme: the legs of a couple under the table at a restaurant – his hand brushing her bare, high-heeled limb – where his drive kicks in 'before dessert'; an upscale kitchen where she happily fields his renewed interest from atop a granite island 'before the table [is] cleared'. Couples are engaged in various relationship-enhancing activities – nights in hotel rooms, games of pool – while his urge strikes 'before room service [arrives]' or 'before the game [is] over'. The imagery signals long-term coupledom and consumerist aspirations and amenities, while recapitulating familiar sexual expert advice about maximising sexual potential (Gupta and Cacchione 2013). Preparedness, proactivity and medical expertise is stressed: 'WHAT ARE YOU WAITING FOR? Ask your doctor if Stendra is right for you'. Erectile dysfunction is both normalised and pathologised; combining occasional and permanent frequency (Selvin, Burnett, and Platz 2007), its epidemic, ordinary nature highlighted by misleading prevalence rates: '18 MILLION MEN IN THE US 20 years of age or older were estimated to have been affected by erectile dysfunction'.

Discussion

Sexual technologies are prominent contemporary staples, from sexual expertise (Gupta and Cacchione 2013) to sexuopharmaceutical interventions (Berry 2013). Our analysis highlights sexual enhancement medication online pharmaceutical promotions as retrofitted docking stations for commoditised sexual aspirationalism. The neoliberal trifecta of choice, consumerism and authenticity (Harvey 2005) operates through 'technologies of the self' (i.e., corporeal and psychological self-transformation projects) (Foucault 1988) to hone bodies, selves and sexualities. Sexual enhancement medication advertising supports neoliberal self-transformation and proficiency/efficiency imperatives for contemporary sexual subjects, who strive for mastery through self-surveillance (Harvey and Gill 2011a).

Consistent with earlier scholarship, sexuopharmaceutical promotion points to increasing targeting of younger users and retrenched idealised masculinity (Gurevich et al. 2014, 2016). Prominent changes include the role of sexual enhancement medication in achieving elite status and exclusive pleasures; masculine authenticity and choice; progressive relationships and fast-paced lives; and prepared and (spontaneous) romantic sexuality. Earlier advertising highlighted increased sexual functionality, relationship stability and masculine control (sometimes through allusions to athleticism). The updated focus is on consumer luxuries that afford recreational opportunities (exclusive properties, pastimes and name-brand supported erections); modern, urban and spontaneous lifestyles (precluding waiting for erections); and natural phallic constancy (exercising choice through occasional use). Sexual enhancement medication is simultaneously a luxury item joining other leisurely activities and a staple in the sexual toolkit of responsible neoliberal subjects.

The new 'natural man' narrative (Cortese and Ling 2011) combines biologically-rooted stability of gender differences – male bodies coded as hard and efficient, while female bodies

are soft and yielding – with a progressive masculinity that is simultaneously in control and concerned with female partners' pleasure (Gurevich et al. 2014, 2016). This natural status of virile masculine sexuality is invoked in sexual enhancement medication promotion by emphasising dependable erections as easily achievable via sexual enhancement medication assistance; men's competence and control in contrast to women's emotional coaching and sexual compliance; men's (natural) primacy in sexual initiation; and irrepressible sexual desires requiring immediate satiation.

An additional notable change is that women have become indispensable staples in the marketing of such drugs; their responsibility centres on coaching and coaxing potential users. The rapid rise of sexuopharmaceuticals during periods of equally dynamic shifts in gender parity and politics is unsurprising; a central marker of hegemonic masculine embodiment is (presumed) penile dependability (Potts 2002). A key correlate of phallic power is the synecdochic relationship of men to penises, wherein the penis stands in for the man and masculinity, in turn, becomes the principal locus of social power (Potts 2002). While there is no natural linkage between the anatomical appendage (penis) and the cultural code of advantage (masculinity), cultural dictates dilute messier material manifestations of power into deceptively simple discourses of biological differences (Rose 1982). The inviolability of male sexuality – marked by permanent penetrative capacity – becomes critical to supporting masculine authority.

Positioning 'Big Pharma [as inventing] medical conditions and manipulat[ing] individuals into identifying with them' (Rose 2006, 480) ignores the inevitably recursive relationship between biomedicine, technoscience and consumer demands (Clarke et al. 2010). Biomedicalisation constitutes an increasingly 'intensifying focus on health … on enhancement by technoscientific means, and on the elaboration of risk and surveillance at individual, niche group, and population levels' (Clarke et al. 2010, 2). Nonetheless, sexual stories 'narrated by the pharmaceutical imagination' Marshall (2010, 220) are significant nodes of 'articulation between cultural ideals and bodily capacities' (216): 'Assumptions about "naturally" (hetero) sexual bodies whose essential properties can be known and then restored obscure the hegemonic conceptions of gender and sexuality upon which they rest' (216).

In contrast to pharma's crude model of masculine control through genital reliability, the few studies on sexual enhancement medication experiences with treating erectile dysfunction (e.g., Potts et al. 2004, 2006) point to a more intricate picture of both possibilities and constraints. For example, Potts (2004) adopts a Deleuzian conception of bodies as *becoming* 'temporary assemblages that may involve connections between the organic and inorganic' (19) (versus static *doing* organisms) to describe women's and men's experiences with Viagra. While most participants – echoing medical sexuality discourses – extolled Viagra's virtues in restoring 'youthful' and reliable erections, some men described Viagra as leading to numbed erections; delayed or suppressed orgasms; or failing to rectify erections. While frustrating for many men, for other men and women, Viagra limits facilitated welcomed prolonged intercourse or more diverse sexual activities. From a Deleuzian perspective, 'Viagra-machine' hybrids have the potential to displace normative conceptions of healthy bodies and sexualities as yoked to erectile stability (Potts 2004).

Such post-humanist figurations of (hetero)sexuality could offer new sexual possibilities. Interrogating 'differential categories of "human" and "nonhuman", examining the practices through which these differential boundaries are stabilized and destabilized' (Barad 2003, 808), such thinking points to variegated biology-culture-technology interfaces, with

biological variation valorised over homogeneity (Hird 2004). Despite the potential of sexual enhancement medication to reconfigure what counts as natural, current representations anchor masculine authenticity to 'artificial authenticity of the phallic penis' (Potts 2002, 118). Real penises are markedly malleable; pharmaceutically reinforced erections, as currently represented, sustain the fallacy of phallic uniformity. This pharmaceutical sexual capital – the augmented 'biopenis' – positions 'erectile facility … as a moral imperative' (Maddison 2007, 2); consumers become responsible neoliberal sexual subjects propping up 'natural' phallic potency (Gurevich et al. 2014, 2016). Penile dependability as a luxury consumerist project reinvigorates masculine sexual authentication as yoked to phallic control, repackaging sexual enhancement medication as a neoliberal beacon of aspirational achievements.

Notes

1. The drug Addyi (flibanserin), for the treatment of hypoactive sexual desire disorder in premenopausal women, was approved on August 18, 2015.
2. Ageing-related sexual decay messages are also promoted for purported 'low testosterone' levels. Abbott Laboratories dominates this emerging androgen deficiency market, buying out Solvay pharmaceuticals for 6.6 million dollars; Solvay's topical application AndroGel, comprised 70% of the testosterone prescription market (Watson 2013).
3. Notably, men who have sex with men are tactically omitted from sexuopharmaceutical marketing campaigns (Gurevich et al. 2016) . Empirical work on sexual enhancement medication use among men who have sex with men, as well as user accounts and health expert advice (in both mainstream and queer media) are characterised by 'an implicit assumption that MSW [men who have sex with women] are motivated by (healthy) relationship enhancing goals, while MSM [men who have sex with men] are compelled by (excessive) sexual appetites' (Gurevich et al. 2016, 15).
4. Websites were chosen as these are the most comprehensive pharmaceutical promotional sites, as well as being easily located by consumers seeking sexual health information.
5. While Levitra was intended for analysis, the site's advertising component was taken down in October 2015 for reasons unknown to the authors.

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