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Sexual dysfunction or sexual discipline? Sexuopharmaceutical use by men as prevention and proficiency

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Abstract
In the first decade following Viagra's appearance, feminist and critical scholars documented the sexuopharmaceutical expansion of definitions of erectile dysfunction and its target consumer. As we approach Viagra's 30th anniversary, while feminist scholarship on the medicalization of sexuality flourishes, the impact of erectile medication has received much less attention. This paper (re)casts a critical lens on popularized erectile medication sexual health messages in the context of current pharmaceutical marketing targeting users as neoliberal aspirational sexual subjects. Discourse analysis reveals that online advice about erectile medication use leverages the increased preoccupation with health risk assessment and prevention technologies to normalize erectile dysfunction as a risk for *all* men, irrespective of age and health status. Erectile dysfunction is presented as inevitable, pathological, and requiring vigilance and expert consultation; penile performance acts as a predictive health gauge. Erectile medication users are situated as model masculine subjects, (medically) augmenting sexual proficiency in romantic or sexually experimental contexts.

Keywords
sexuopharmaceuticals, sexual health, sexuality, masculinity, neoliberalism

The decade after Viagra's approval in 1998 prompted a robust spike in critiques of Pfizer's strategic expansion of the intended sexuopharmaceutical consumer base via targeted redefinition of ''normal,'' ''functional'' sexuality. Such work included

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feminist scholarship (e.g. Fishman & Mamo, 2002; Tiefer, 2006), media and marketing analyses (e.g. Baglia, 2005; Newman, 2006), and the medicalization of sexuality critiques (e.g. Lexchin, 2006; Moynihan & Cassels, 2005). These scholars noted that sexuopharmaceuticals marked a significant cultural turn – a ''new sexual millennium'' (Loe, 2001, p. 103). A key promotional strategy reinstalled idealized masculinity as yoked to sexual (read as erectile) mastery (Loe, 2004). In the wake of increasing gender parity, 1990s media reports declared a ''crisis of masculinity'' (Loe, 2004). The timely advent of Viagra paved the way for vigilant medical rehabilitation of threatened masculinity (Loe, 2001). Both masculine identities and male bodies (positioned as malfunctioning machines) now required reparation, joining the intensifying contemporary ''biopower'' (Foucault, 1978), with its numerous disciplinary techniques for regulating bodies. As we approach the 30th anniversary of the advent of erectile medication (EM), four more such drugs for erectile dysfunction (ED) are now on the market: Cialis, Levitra, Staxyn, and Stendra (Huang & Lie, 2013). Just seven years after Viagra's launch, 750,000 physicians had prescribed it to 23 million men (Jackson, Gillies, & Osterloh, 2005); by 2014, the global EM market was worth over $4.39 billion, with Viagra holding over 47% of that revenue (Globe Newswire, 2015).

Recreational EM use is also growing among younger men with no ED diagnosis, both for men who have sex with women (MSW) (Harte & Meston, 2012) and for men who have sex with men (MSM) (Prestage et al., 2014). Despite this installation of EM as increasingly routine, the last near decade has seen relatively fewer analyses of updated EM marketing and popularized information (see Berry, 2013; Gurevich, Leedham, Brown-Bowers, Cormier, & Mercer, 2017a; Gurevich, Mercer, Cormier, & Leedham, 2017b for exceptions). Mainstream medical and social science research on recreational EM use – sidestepping analyses of pharmaceutical messaging – is preoccupied with sexual health risks and constructing hierarchies of risky groups (Gurevich et al., 2017b). While feminist scholarship on the medicalization of (especially women's) sexuality (e.g. Cacchioni & Tiefer, 2012) is flourishing, the impact of this specific sexual technology staple has received much less recent attention (for exceptions, see Marshall, 2010, 2012; Wentzell, 2011). This paper (re)casts a critical lens on EM popularized sexual health messages in the context of current sexuopharmaceutical marketing, wherein potential EM users are hailed as responsibly informed, aspirational sexual subjects (Gurevich et al., 2017a) – key calling cards of neoliberalism (Harvey, 2005). While early critics of mainstreaming EM for ED in the absence of pathophysiology called for research tracking routinized use (Vares & Braun, 2006), little work has been done on Viagra successors. We examine online popularized EM information, as consumers increasingly rely on digital media for health and sexuality resources, and consulting sexual experts is becoming quotidian (Gupta & Cacchioni, 2013).

Three decades into the ''Viagra Age'' (Marshall, 2002), sexual health research, media, and marketing are thriving sites of ''commercial intertextuality'' (Vares & Braun, 2006, p. 328, citing Jansson, 2002). As textual sources (digital, print) and sexual authorities (sexuopharmaceutical industry, popularized sexual health experts) converge to transmit increasingly homogenous sexual stories about

optimal sexual satisfaction, it becomes difficult to dislodge sexual sediments about the ''natural'' status of (hetero)sexual bodies whose functioning can be medically reinstated (Marshall, 2010). Recreational EM is an instructive portal for exploring how scientific and popularized sexual discourses intersect with people's everyday experiences.

Consumer ''education'' and domesticating (sexuo)pharmaceutical use

Increasingly quotidian pharmaceutical consumption rates – the ''pharmaceuticalisation of daily life'' (Fox & Ward, 2008, p. 856) – or the ''transformation of human conditions, capabilities and capacities into opportunities for pharmaceutical interventions'' (Williams, Martin, & Gabe, 2011, p. 711) have been linked to the recent but now normative view that continuous health monitoring and risk assessment is mandatory for all (Dumit, 2012; Williams et al., 2011). Detecting progressively minute risk levels provides an ideal platform for pharmaceutical treatment: once ''drugs could be paired with risk factors'' (Dumit, 2012, p. 5), chronic treatment rather than cure became mainstream. Transience, benign cases, or possible non-medical responses become underemphasized (Moynihan & Mintzes, 2010). This ''continuing commercial, clinical and geographical'' pharmaceutical expansion (Williams et al., 2011, p. 711) is supported by disease redefinition, global pharmaceutical company market expansion, public ''awareness'' campaigns, and consumer group mobilization.

Sexuopharmaceuticals are optimally poised to prime ''virility surveillance'' (Marshall, 2010, p. 212) – through monitoring sexual functioning – by greater numbers of (increasingly younger) consumers, regardless of erectile difficulty etiology, duration, or diagnosis. Consumers are encouraged to detect bodily signs that require EM remediation to accomplish ''innate'' masculinity (Gurevich et al., 2017a) through a range of ''technologies of the self'' (Foucault, 1988), or ways of reworking embodied identities. EM technology is the quintessential ''biopower'' model, with its truth discourses about ''vital'' aspects of masculine sexuality (e.g. masculine mastery requires erections), its elected experts (e.g. medicine, pharmaceutical industry), its collective health interventions (e.g. patient education, media messaging), and subjectification modes requiring self-disciplining work (e.g. preventative penile vigilance) (Rabinow & Rose, 2006). From health and leisure magazine diagnostic quizzes to sexual functioning scales adapted from clinical trial pharmaceutical research, to directives about consulting physicians (Marshall, 2010), the expansive arena of ''public service'' education (Katz & Marshall, 2003) is a crucial vehicle for routinizing sexuopharmaceuticals. Sexual stories, ''narrated by the pharmaceutical imagination'' (Marshall, 2010, p. 220), are significant nodes of ''articulation between cultural ideals and bodily capacities'' (Marshall, 2010, p. 216). Initial EM campaigns focused on average older consumers (Mamo & Fishman, 2001), married older women as partners (Vares & Braun, 2006), and ''sexy seniors'' (Marshall, 2010). Early commercial expansion from older men with ED to sexual enhancement for all men was also visible in the

circulation of the *Romance Drug Viagra*, the *Masculinity Pill Viagra* (Loe, 2004), and *Party Pill Viagra* discourses (Vares & Braun, 2006). Each stressed Viagra's capacity to make sex more exciting – revitalizing relationships, even for men without ED. Given the lowest ED treatment success rates for men over 60 – the intended "target generation" – Pfizer's promotion strategy shifted from treatment to sexual and romantic enhancement (Loe, 2004).

The move from rendering aging bodies "forever functional" (Marshall & Katz, 2002) has fast-forwarded to campaigns nearly devoid of attention to older consumers. Current sexuopharmaceutical marketing has replaced earlier messages of successful sexual aging of seniors with promoting middle-aged (and younger) elite lifestyles, exclusive pleasures, "progressive relationships and a contemporary urban, fast-paced life" (Gurevich et al., 2017a, p. 422). Fluctuating masculinity discourses are also central to understanding this shift in cultural narratives about EM, sexuality, and aging.

Rebooted hegemonic (hetero)masculinity

Hegemonic masculinity functions as a contingent social capital, with domination and subordination hinging on other available resources (monetary, physical, symbolic) (Connell, 2005). While hegemonic masculinity is a situated gender "accomplishment" (Wetherell & Edley, 2014) that orders power and status, masculinity rules and rehearsals are neither static nor universal: they collude with and challenge specific geopolitical, class, race, (dis)ability, and sexual identity contexts (Messerschmidt, 2016). Various converging and competing forms of "new" masculinity have emerged in response to dilemmas posed by shifting cultural dictates about male domination and female empowerment – the sensitive, egalitarian "new man" of the 1980s making way for the postfeminist, sex- and sports-obsessed "new lad" in the 1990s (Cortese & Ling, 2011; Rogers, 2005). Characterized by his connection to product consumption – which acts as a vehicle for promoting a physically muscular, sexually confident, and consistently competent masculinity – the "new lad" is coded as the "natural" man (Cortese & Ling, 2011), defined by his "ontological stability" and preserved male privilege (Crawshaw, 2007).

This reassertion of male dominance relies on reestablishing (young and white) male sexuality as unproblematic, assured, and controlled (Rogers, 2005). Sexual conduct is organized around guidelines that are framed as scientific, with a lexicon invoking neurons, hormones, and sexual response cycles (Rogers, 2005). The maintenance of power through the acquisition of sexual knowledge, methods, and mastery is central to this figure (Toerien & Durrheim, 2001), with "turbo charged" sex (Tyler, 2004) as a chief aspirational target. While men are exhorted to reboot masculinity by ramping up their "innate" sexual proficiency, women are tasked with the sexual "labour of love" (Cacchioni, 2015). Such mandatory "sex work" (Cacchioni, 2015) entails self-disciplining sexual practices that retrain responses to heteronormative sex that women often find physically painful, undesirable, or unpleasurable. This sexual labour is encouraged by a motley crew of medical (e.g. pharmaceutical industry) and nonmedical experts (e.g. grassroots women's

health activists) who converge in their surprisingly similar and singular focus on sustaining frequent, penetrative, and orgasm-focused sexual activity as the benchmark of heterosex (Cacchioni, 2015).

Current study focus and method

One specific instance of the way commerce and sex converge upon men's meanings and practices of embodiment (Gill, Henwood, & McLean, 2005) is crystalized in popularized discourses about EM. Both popularized medical advice (Gurevich et al., 2017b) and pharmaceutical campaigns (Gurevich et al., 2017a) promote EM as a state-of-the-art new sexual capital for (increasingly younger) heterosexual men. We present a discourse analysis of online popularized EM messages. Consulting sexual experts is a quotidian obligation of modern neoliberal sexual citizenship, as sex is positioned as indispensable to relationship health (Gupta & Cacchioni, 2013; Harvey & Gill, 2011a, 2011b). Online popularized sexual health information about EM was located from the following sites: medical (http://www.webmd.com; http://biopsychiatry.com/) and public (http://www.nerve.com; http://www.slate.com); and health advice outlets (http://www.menshealth.com; http://www.healthcentral.com). Pharmaceutical industry advertising (e.g. Pfizer site) is analyzed elsewhere (Gurevich et al., 2017a).

The first 20 hits matching the selection criteria were selected for analysis (Farvid & Braun, 2013), reflecting internet exposure when lay people seek information about EM. "Online health seekers" (Fox & Duggan, 2013) – consulting quick and digestible health information – represent 72% of internet users. Among those most likely to access online health sources are women, young adults, and those with advanced degrees and higher income households. In describing the ethical considerations in analyzing online material, Farvid and Braun (2013) note that consensus criteria do not exist for such "internet-mediated research" (BPS, 2007). Usual guidelines regarding informed consent and participant identification cannot be mapped onto publicly available material, where "an implicit audience" is assumed and expected (Hookway, 2008, p. 105). Farvid and Braun (2013) propose that "blogs, opinion pieces, online news pieces" (p. 363) constitute public materials not requiring informed consent. Texts used in this paper – popularized health advice forums – were *not* collected from private (i.e. registration, password required for access) sites where users expect concealment from noncommunity members.

Theoretical and analytic approach

This work is situated within feminist poststructuralism (Weedon, 1987), which acknowledges that social meanings and practices are organized through language and other signifying systems (Gavey, 1989). Feminist poststructuralism is concerned with the ideological function of this sociosymbolic universe in organizing gender – cultural representations, social prescriptions and proscriptions, and role performance norms. Discourse analysis is used to analyze online popularized

sexual health accounts. We use the term discourse in a Foucauldian sense (Foucault, 1972), to refer to meaning-making patterns (e.g. words, texts, images, institutional structures) that form the symbolic organization of culture and social interaction (Parker, 2002). Thus, language and discourses are viewed as configuring realities (Gavey, 1989) and subjectivities (Weedon, 1987) (i.e. ways of experiencing and being in the world). This approach is useful for analyzing how collective meanings about the ''practical accomplishments'' of masculinity (Wetherell & Edley, 2014) – in our case, medical, media, and marketing discourses – shape and sustain norms about sexual health. This gender ''accomplishment'' is performed in various ways, from messages about the meanings of manhood to body regulation practices aimed at achieving masculinity ideals (Wetherell & Edley, 2014).

The following questions directed our analysis: How are erectile conditions and EM use represented? Who are the intended EM consumers? What messages about normative sexuality and masculinity are circulated by referencing EM? And how are sexual health experts deployed in constructing ED and EM use? Iterative analysis of selected data (multiple rereadings and coding) was initially done by the first author, in accordance with the analytic goals. This repeated coding resulted in two overarching discursive categories addressing the construction of erectile conditions and intended users. Additional underlying discursive strategies related to popularized representations of EM use were analyzed, in consultation with the second and third author. We tracked how sexual health experts position EM use in relation to norms about penile capacity, sexual health, and sexual satisfaction; age of potential EM users; EM efficacy and satisfaction; and authoritative advice about sexuality and EM use. Data coding and consensus focused on gendered sexual subjectivities contextualized within neoliberal sexual norms.

Analysis and discussion

Analysis of online popularized health advice about EM addressed two prominent discursive targets: constructing the condition and constructing the user. First, these medical expert messages frame ED as a common condition that nonetheless necessitates medical correction – ***normalizing while pathologizing***. The central discursive strategies used to (re)define any degree of erectile fluctuation as a common condition (called ED) and as requiring treatment are *persistent penile vigilance, penile performance as health barometer,* and *exposing to experts*. Second, the intended EM user is positioned as performing model masculinity through maximal sexual efficiency – ***model (medically augmented) masculinity.*** Key discursive constructions that promote a maximally performing masculinity are *paragon of penile proficiency, prepared romantic*, and *experimental reveler*.

Constructing the condition: Normalizing while pathologizing

Persistent penile vigilance. Analysis shows that erectile difficulty is positioned as both common and a condition requiring remediation through medication. While erectile

stability is acknowledged as unrealistic, even transient erectile unpredictability (termed erectile dysfunction) is installed as sufficiently serious to warrant sexuopharmaceutical treatment:

> Erectile dysfunction is more common in older men, but many potential Viagra users are hardly senior citizens: About 40% of 40-year-old men in the U.S. have some degree of erectile dysfunction. Most Viagra users today, according to Pfizer, are in their early to mid 50s. (Downs, 2002)

> Viagra was the first oral drug approved for erectile dysfunction, which transiently affects nearly all men at some point, but occurs on a continued basis in as many as 20 million Americans. Erectile dysfunction can occur at any age, but typically affects men after age 50. (Kirchheimer, 2004)

The normalizing narrative is simultaneously countered by a pharmaceutical solution. Transient detumescence is acknowledged while simultaneously presenting Viagra as ready option. Expanding the definition of sexual dysfunction is a key aspect of EM normalization (Tiefer, 2006). The frequently cited "simultaneously reassuring and alarmist statistics" (Gurevich et al., 2017a, p. 428) – "40% of 40-year-old men" – is based on the Massachusetts Male Aging Study (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994). Results of impotence severity self-reports (mild, moderate, complete) from men aged 40 to 70 years (in 1987–1989) were pooled during Viagra clinical trials. The qualifier "degree" conceals large data variability (partial, temporary, or occasional erectile difficulty) (Gurevich et al., 2017a), in addition to Pfizer's omission of the fact that the 40% figure is based on a single question for a small group of men recruited from a university urology clinic (Lexchin, 2006). These responses were then used to estimate prevalence for a much larger group recruited from the Boston Standard Metropolitan Statistical Area. Potential group differences (e.g. self-selection of urology clinic clients) were not addressed. This underlying study methodology and selective reporting of results by both Pfizer and subsequent sexuopharmaceutical companies are crucial to ongoing estimate inflation, with popularized medical advice acting as an effective key conduit for continuing misrepresentation and its attendant medication recommendation.

The prominent message that younger men are as likely to experience ED as older men is conveyed through the language of deteriorating physiology (e.g. restricted blood flow) and related health risks (e.g. hardened arteries). The ED taxonomy subsumes any degree of erectile variability under the ED umbrella, by invoking "minor" levels of pathology:

> "We assume all young men have normal sexual functioning, but they're really not normal," Murdock says. Hardening of the arteries, which restricts blood flow to the penis, can begin during the teen years, so that by the time a man is in his 20 s, his ability to get and keep an erection has already begun to decline. Murdock says many men who seek Viagra for recreational use actually have minor erectile dysfunction. (Downs, 2002)

> Goldstein says, some doctors may have trouble believing it could affect someone who doesn't have typical risk factors, such as high blood pressure or diabetes. "Most 18- to 20-year-olds don't have those risk factors," he says. However, he says, "there can be other reasons for blocked blood flow to the penis". (Doheny, 2012)

The central message is that erectile difficulties necessitate ongoing vigilance from an early age. Relying on the (pseudo)scientific language of early arterial blockage and restricted blood flow, erectile functioning is expected to be compromised for men in their 20s. Medical legitimacy of such EM use for increasingly younger men is conferred by a range of medical authorities on online popularized health sites (general physicians, urologists, sexologists). Notably, Irwin Goldstein – cited above – is a physician who serves as the editor-in-chief of *The Journal of Sexual Medicine* and has reported consulting work for ED manufacturers, such as Pfizer and Eli Lilly. In discussing a study on WebMD that links recreational use of Viagra among young men with lower erectile confidence (Harte & Meston, 2012), Goldstein argues that for recreational users, "perhaps the explanation is, they were too embarrassed to announce [to their doctor] they have a sexual health problem" – suggesting that even recreational users are suffering from unreported and undiagnosed ED. While this is a plausible explanation, the study's authors themselves posit a different explanatory pathway: Ongoing recreational use for young men without ED may lead to an erroneous belief that sexual performance hinges on EM use. Such intimations of undiagnosed ED among young healthy men, who require the ready remedy of EM, echo earlier attempts to induct younger men as users, by recommending daily small prophylactic doses (Moynihan & Cassels, 2005).

Penile performance as health barometer. Relatedly, penile functioning is also presented as a litmus test of general health. Tracking penile problems is allocated similar standing as chronic health conditions; early diligent concern with erectile capacity is a key exigency for health-conscious consumers (Berry, 2013):

> Erectile dysfunction may be an early predictor of heart disease. Arteriosclerosis, a condition in which fatty deposits build up inside arteries, restricts blood flow to the penis and causes erection difficulties. "The small blood vessels that go to the penis can become diseased much earlier than the [larger] vessels that go to the heart," Karen Boyle, MD, a urologist at Johns Hopkins School of Medicine, tells WebMD. "In younger or younger middle-aged men, ED is often the first sign of arteriosclerosis." (Sine, 2007)

The penis is represented as a global warning signal of anatomical calamities arising elsewhere. Indeed, the penis is the *sine qua non* of health in these messages. This penile health gauge model dovetails with mandatory health monitoring and treatment discourses (Williams et al., 2011). Linking drugs with risk factors (Dumit, 2012) and lowering thresholds for "at-risk" conditions pave the way for pharmaceutical expansion from disease to discomfort (Flower, 2004). If penile fluctuation

is converted into a chronic condition, portending other potential disorders, early sexuopharmaceutical prevention becomes normative and ''necessary.''

This equating of sexual health to general health is echoed in both medical and popular discourses that directly connect sexual activity with health status (Segal, 2012). In linking sexual health to global health in these popularized medical accounts, the analogy of a complex apparatus is advanced to explicate erectile activation:

> Getting an erection isn't crude mechanics, like inflating a balloon. It's a complex process in which blood vessels, muscles, hormones, the nervous system, and the psyche all work together. If one part isn't working well, it affects the whole apparatus. (Downs, 2005)

> Sporting serious wood is not the simple process one might assume that it is. In fact, it's about as complex as a NASA rocket launch. Kaminetsky explains the inner workings: ''Within the penis are two spongy cylinders that run parallel to the urethra. When a man becomes sexually aroused, his nervous system communicates the arousal to his penis. Blood vessels that supply the penis relax, allowing more blood to fill the spongy cylinders. That produces an erection.'' In other words, for an erection to work, it has to be all systems go, from your head to your toes. (Levin, 2008)

In contrast to the commonly invoked hydraulic model (Potts, 2002) of penile functioning, which equates male sexual desire with mechanistic physical arousal, these messages invoke a complex sexual framework. Penile capacity is positioned as requiring an ''all-systems'' harmonization process. (Stereotypically) male-friendly language is used to educate men about this complicated sexual architecture. References to ''crude mechanics,'' ''sporting serious wood,'' and a ''NASA rocket launch'' presume an audience familiar with mechanical models and signals the promise of maximal erectile efficiency. While a more sophisticated understanding of male sexual functioning is signaled, nuances vanish in the face of parallel injunctions linking these explanations to quick sexuopharmaceutical fixes. The resulting message: the penis stands in for the man (Potts, 2002).

Exposing to experts. The ''will to knowledge regarding sex'' (Foucault, 1978, p. 65) instituted by the scientific proliferation of sexuality discourses – via deployment of the confessional mode – rests on ''speaking of it [sex] *ad infinitum*, while exploiting it as *the* secret'' (Foucault, 1978, p. 35). As an arbitrary nucleus of modern western selfhood, sex retains its force as both inhibiting and liberating: ''It is through sex – in fact, an imaginary point determined by the deployment of sexuality – that each individual has to pass in order to have access to his [sic] own intelligibility'' (Foucault, 1978, p. 155). EM-related exhortations to reveal to experts are the Foucauldian archetype of the ''clinical codification of the inducement to speak'' (Foucault, 1978, p. 65):

> As Rafael Wurzel, a US physician, has put it: ''Viagra opened the door to an honest and uninhibited discussion about issues pertaining to sexual dysfunction, for

> men, for women, and for couples. I think it has been wonderful.'' (Hill & McKie, 2008)

> It helped men ''come out of the closet'' in a sense, to discuss and seek treatment for a condition that had long been regarded as an embarrassment and inevitable. It allowed clinicians to grasp the fact that many, many more men were suffering from ED than they could possibly conceive of. (Healthcentral, 2008)

EM is positioned as redeeming a taboo topic; by providing a gateway to disclosures about a range of sexual difficulties, EM leads to more candid conversations and possible resolutions. While ''issues pertaining to sexual dysfunction'' gestures toward a broader sexual spectrum, the predominant focus on ED in most popularized messages restricts the scope to erectile capacity and (implied) penetrative sex. The medicalization of confession – ''recodified as therapeutic'' (Foucault, 1978, p. 67) – is reinforced by deploying terminology that draws a definitive arc from sexual dysfunction to medical diagnosis to treatment. Stripped of its tainted status, ED is installed as unimaginably widespread, its proportions heretofore unacknowledged even by clinicians. This evolution of the ''science'' of sexual health is framed as a progressive transit toward enlightenment. As Potts (2002, p. 140) points out, there are some benefits for men in viewing their sexual problems as medical:

> Arguably, the medical construction of 'erectile dysfunction' operates by averting the possible perception by men, or women, of a failure in the rational male mind to control sexual response; in this case to control the production of a 'normal' and 'useful' erection.

Relegating ED to a singularly medical etiological and treatment terrain ensures that bodily failure does not disrupt the phallic order (i.e. the cultural and psychosocial power and privilege conferred by masculinity) (Buchbinder, 1998). Although the ''flaccid penis [is] perniciously problematic'' (Potts, 2002, p. 142) for the phallocentric equation between flesh and power (Grosz, 1990), consigning impotence to medical explanations and solutions leaves cultural masculine potency intact.

The ''healthicisation'' of sex (Gupta & Cacchioni, 2013) – which equates sexual activity with health outcomes – encourages confessional consultation with experts. Such sexual concern disclosures are viewed as maximizing sexual competence through ongoing sexual surveillance:

> Your doctor might be able to prescribe something that can really help, or least provide a valuable dose of perspective about what constitutes ''normal'' sexual performance. (Sine, 2007)

> The most important thing you can do to determine if you have a sexual problem is to talk honestly and openly about your symptoms with your health care provider .... Though these topics may seem extraordinarily private, they must be covered to

> properly evaluate sexual dysfunction and help you have a more satisfying sex life. (WebMD, 2017)

A progressive confessional imperative is emphasized, wherein diagnostic assessment is key to a satisfying sexual life. A persuasively monolithic medical lexicon is invoked to describe sexual concerns; the language of symptoms, (medical) evaluations, prescriptions, dosing, and benchmarks for ''normal'' sexual functioning all signal that the sexual arena is centrally occupied by experts (Gupta & Cacchioni, 2013). In this way, pluriform sexual experiences are transformed into a uniform code of sexual health. While the term normal is (sometimes) accorded quotation marks to denote its dubious status, questions of sexual normalcy (Tiefer, 2004) hover insistently and persistently in these popularized medical accounts.

Constructing the user: Model (medically augmented) masculinity

Paragon of penile proficiency. In contrast to discourses of the doomed penis described in the previous section – wherein early and persistent vigilance is required to sustain virility – a parallel discourse constructs the penis as infallible yet maximizable, and users are positioned as performing model masculinity through (medically augmented) sexual efficiency. Here, EM users are not fixing erectile problems; they are youthful paragons of masculinity:

> There's also a trend for younger males to want to take PDE5 inhibitors for sexual enhancement when there's nothing wrong with their functioning. They're looking to maximize their sexual experience — and sometimes that of their partner. (WebMD, 2007)

> An increasing number of men in their 20s and 30s, not diagnosed with ED, are using these drugs for, as one guy described it, ''supercharged' sexual experiences, with stronger erections, longer endurance, and less downtime in between orgasms.... ''Viagra gave me erections like when I was 13-years-old,'' says Richie, 34. ''I could go again in minutes.'' (Borzillo, 2015)

Pursuit of maximal performance is a proxy for sexual pleasure, promising frequent, ''supercharged'' sexual output for masculinity maximization through medication; this EM user (re)masters his inherently assured sexual virility (Rogers, 2005). Such pharmaceutically rebooted modern masculinity is supported by sexuopharmaceutical promotional campaigns that increasingly target younger men. For example, Staxyn's marketing explicitly targets men as young as 30 for treating sporadic erectile difficulties related to stress – labeled as ED, absent organic cause – emphasizing low cost, rapid absorption, and compatibility with alcohol as optimally aligned with the ''lifestyle needs'' (Canada Newswire, 2011) of the ''modern (younger) man on the move'' (Gurevich et al., 2017a, p. 429).

A pill-enhanced penis is the idealized reliable organ, representing ''natural'' sexual capacity, even with remedial support (Croissant, 2006). The ostensibly

natural status of erections that pharmaceutical promotions promise to reinstate relies on an "unmedicated imaginary that assumes a unity where there is diversity" (Croissant, 2006, p. 333). Younger sexual selves are retrospectively viewed as reliably performing idealized masculinity, yoked to familiar twin nodes of male potency – sports and sex (Baglia, 2005):

> Ric Margolis, a hip, 38-year-old urologist, is a popular guy. Wherever he goes – in the office, at the gym, to parties – guys in their 30s and 40s follow. . . . They want to know: Can that little blue pill he prescribes re-create those invincible college days? They all say the same thing: "'It's not as good as it used to be,' just like they're not as good at sports as they used to be," Margolis says of their sex life. "These are men who can still have sex and satisfy their partners, but they just want more. So I write them a scrip." (4-men.org, Sam Fields)

EM users without ED seek to restore an earlier time, where sexual functioning is recalled as unassailable: "the s(t)imulation of sex is a reproduction of an 'original' sex imagined to be the sex of early adulthood" (Croissant, 2006, p. 335). While their partners' sexual satisfaction is reportedly unimpeded, these men rely on EM to maximize sexual performance in the context of a neoliberal cultural scaffolding that encourages maximal sexual mastery through ongoing self-surveillance (Harvey & Gill, 2011a). Fluctuating features of penile capacity (e.g. subject to mood, fatigue, performance anxiety) are policed by cultural proscriptions (propped up by medical prescriptions). Contemporary male sexual subjects are increasingly loath to tolerate such mutability in the context of the sexuopharmaceutical "consumerist erectile economy" (Marshall & Katz 2002, p. 45), wherein "inviolable virility [is] coded as agentic and responsible" (Gurevich et al., 2017a, p. 425).

Strikingly, youthful male sexuality has been constructed by men as representing an "immature self" – directed at self-absorbed sexual gratification goals, positioning women as objects of sexual indulgence, and singularly focused on penetrative sex (Terry & Braun, 2009). This is contrasted with a "mature self" – invested in the relationship building and bonding aspects of sex. This progressive narrative is flipped in EM accounts: youthful experiences – equating satisfying sex with easy, protracted erections– are valorized as model masculinity; current sexual experiences (without EM) are positioned as inferior and requiring rehabilitation.

Prepared romantic. As sexuopharmaceutical marketing expands to target increasingly younger users, the prevalence of recreational EM use appears to be growing among younger men with no ED diagnosis, both for MSW (e.g. Harte & Meston, 2012) and for MSM (e.g. Prestage et al., 2014). Notably, popular medical representations of such recreational use position MSW as responsible partners motivated by sexual and relational enhancement goals, while MSM are depicted as sexual dissidents in pursuit of reckless, drug-fuelled sexual conquests (Gurevich et al., 2017b).

Vares and Braun (2006) identified a prominent *Romance Drug Viagra* discourse in media portrayals within the first decade following Viagra's approval, achieved

primarily through addressing couples. Pfizer's "couples campaign" (Vares & Braun, 2006) increasingly presented Viagra as a solution to enhancing relationship vitality and intimacy. This excitement-fuelled relationship enrichment is being enthusiastically embraced by a new generation of users:

> Pharmaceutical data provider Wolters Kluwer Pharma Solutions shows that during the week prior to Valentine's day of 2010, more Viagra prescriptions were written than any other time of the year. . .The spike in little-blue-pill use leading up to the February 14 holiday is not surprising. According to Debby Herbenick, of Indiana University's Center for Sexual Health Promotion, there are high expectations for having sex on Valentine's Day. "It's kind of like birthday sex or Christmas sex," she said. "This is an opportunity that only comes up occasionally and they want to be prepared." (Nerve, 2011)

> Christian, 27, who uses Viagra for special occasions like birthdays and anniversaries, says he doesn't have a hard time becoming aroused, but the drug "took my erection on a scale of 1–10 up to 11, and it was one of the most intense orgasms I ever had." (Borzillo, 2015)

For the contemporary (heterosexual, responsible) male subject, erectile fluctuation is not an option (Gurevich et al., 2017a, 2017b) and special occasions demand medically augmented sexual efficiency. The legitimacy of Viagra has been closely linked to its promotion as a relational technology for much of its campaign history (Mamo & Fishman, 2001). Current marketing by some of its competitors echoes this familiar couples-focused message with a modern twist. For example, Cialis targets a "progressive equal partner" who shares both household and sexual labour; likewise, Stendra targets a "prepared (voracious) partner" who is invested in meeting his female partner's romantic and sexual needs (Gurevich et al., 2017a, p. 431).

EM consumption for younger coupled users without ED has moved beyond the prescriptive and the prosaic: it now denotes celebratory events (e.g. birthdays, anniversaries, Valentine's day), marked by supercharged sexual performances. EM use is equated with romance, courtship, and caring; medically enhanced sexual preparedness is framed as a personal and relational obligation met through ongoing sexual self-surveillance (Harvey & Gill, 2011a). Notably, current pharmaceutical EM advertising assigns the emotional labour of sex (Cacchioni, 2015) to women, who are "alternately cast as confidant/coach and seductress/sexual partner: relaxing, reassuring, and enticing" their male partners to consume EM with the promise of superlative sexual satisfaction (Gurevich et al., 2017a, p. 427). In the popularized medical messaging analyzed above, while both the *paragon of penile proficiency* and *prepared romantic* discourses obliquely gesture toward enhancing partner pleasure (sometimes framed as a treat for special occasions), the emphasis is on restoring youthful erections, extending intercourse duration, and maximizing male orgasm. Women are a glaringly present absence; men take the drug to have sex with women but the impact on women is unasked and unknown. None of the

excerpts describe women's experience of sex with a partner who has taken EM; women's pleasures, desires, or even potential orgasmic enhancement are distinctly lacking. No male analog for women's "labour of love" (Cacchioni, 2015) is evident – the focus remains on being prepared for penetration and performance, rather than on augmenting female pleasure.

In contrast to pharma's simplistic messaging about masculine mastery through genital control, the few studies on EM experiences with treating ED (e.g. Potts, Gavey, Grace, & Vares, 2003; Potts, Grace, Gavey, & Vares, 2004) illuminate a more intricate scenario of both benefits and barriers. For example, Potts et al. (2003, 2004) found that while most female and male participants – mirroring medical sexuality discourses – commended Viagra's capacity for reinstating "youthful" erections, some men described no erectile changes, numbed erections, and delayed or suppressed orgasms. While frustrating for many men, for other men and women, Viagra's limitations enabled welcome prolonged intercourse or greater flexibility in sexual activities. Women's concerns about men's Viagra use include being excluded in medical consultations and decisions by partners, prescribers, and pharma; (feeling or experiencing) pressure to have increased or prolonged intercourse, sometimes resulting in pain or bladder/vaginal infections; diminished emphasis on noncoital sex, with efficiency eclipsing emotional connection; relationship conflict in navigating Viagra consumption; and actual and imagined infidelity (Potts et al., 2003).

Experimental reveler. As early critics of the expansion of the sexuopharmaceutical reach, Vares and Braun (2006) outlined a *Party Pill Viagra* discourse in Pfizer's media messages, in which Viagra was touted as an enhancement drug – making sex more exciting, vigorous, and fulfilling, even for men who did not need it. While the official message was (and is) that Viagra is not an aphrodisiac, Viagra was also depicted as elevating desire and pleasure. All EM variants are increasingly promoted for recreational rather than solely therapeutic use – as a fun, experimental alternative to "mundane" sex (Gurevich et al., 2017a):

> Hundreds of patients asking Dr. Parry for Viagra at his Atlanta clinic are young, healthy and virile…Cialis may be particularly attractive to young party revelers because it stays in the bloodstream for so long. "You take it at lunch on Friday and you are good all weekend," said Dr. Bruce Stein, an Atlanta urologist. (Olivero, 2004)

> "Viagra is the new party drug," he says. "It's part of the scene now. When people go out now their party checklist goes like this: Alcohol? Check! Condoms? Check! Viagra? Check. Guys ask other guys for a Viagra more than a condom now." (Borzillo, 2015)

Enhanced firmness, extended duration, smaller refractory intervals, and more intense orgasms are the target goals for this new "natural man" (Cortese & Ling, 2011). Reports of younger men without ED who use EM recreationally are

increasing in the scientific literature (e.g. Harte & Meston, 2012; Prestage et al., 2014), which is echoed by these popularized medical accounts. While the scientific papers emphasize possible dangers associated with recreational EM use (e.g. increased STI and HIV risk), popularized medical messages lean largely toward depicting EM-fuelled sex as adventurous and useful for counteracting the effects of other recreational drugs. EM in these contexts – supported by EM campaigns that act as ''retrofitted docking stations for commoditised sexual aspirationalism'' (Gurevich et al., 2017a, p. 432) – is presented as one of the many possible ''technologies of the self'' (Foucault, 1988) (i.e. corporeal and psychological self-modification) afforded to exploratory neoliberal subjects, for whom unbounded choice and consumerism (Harvey, 2005) are key entitlements. Notably, risk and recklessness are predominant motifs in popularized medical messages aimed at MSM, while relational enhancement and excitement is the MSW-geared theme (Gurevich et al., 2017b).

In what is described as scientific exploration, Nerve writer Grant Stoddard reports on a series of experiments with having sex while consuming recreational drugs, among which Viagra figures prominently. Modeling a science journal method section, he lists the hypothesis, necessary materials – types and amounts of various recreational drugs for each ''trial'', ''girlfriend (1)'' – and an erection topology is provided:

> A man experiences different types of erections, from ''The Barfly'' to ''The Thumper.'' Viagra had given me a pulsing, monster Thumper. To say it plain, my dick felt like it was going to explode. Instantly, I was in that sublime zone between being ridiculously aroused and having to think about Al ''Grandpa Munster'' Lewis on the crapper to keep from shooting my bolt. (Stoddard, 2015)

Extolling the virtues of Viagra in true scientific fashion requires a penile meter model, where erectile capacity is ranked from inconsequential and easily ignored to urgently propulsive and requiring management. The Viagra-induced type is touted as transcendent, despite his description of the experience as disembodied:

> The main difference was mental. The inherent disconnect between my genitalia and brain widened exponentially. Penises are often referred to as tools, and that's exactly what mine felt like: a woodlike, dildonic prosthesis that was being ridden with little emotional or physical input from me. The experience was strangely feminizing: for the first time, I was a passive partner during sex, able to fuck without necessarily being turned on or even having my head in the game. (Stoddard, 2015)

In contrast to the enhanced control promised by sexuopharmaceutical advertising – depicted as distinctively masculine (Gurevich et al., 2017a) – this description emphasizes the passive, coded as feminizing, features of EM use. The emphasis here is on mentally detached performance (by an artificial, robotic appendage), which is ascribed a distinctively feminine quality, while also gesturing to women's experiences of consenting to sex that is not wanted or pleasurable (Thomas, Stelzl,

& Lafrance, 2017). The links between women's constitution as passive sexual subjects and romance discourses guiding femininity (Harvey & Gill, 2011a; Potts, 2002) are not addressed. Paradoxically, while disembodied sex is framed as a prototypically feminine sexual possibility by this Nerve writer, dominant western discourses typically emphasize men's ability to experience sex as external to the man's mind: "the external penis is granted interiority; that is, consciousness, a mind (will) of its own" (Potts, 2002, p. 108). The myth of the "man with two brains" (Potts, 2002, p. 102) – a rational brain-mind and an unruly penis-mind – is depicted in numerous cultural representations. While Stoddard does accord his Viagra-activated penis a separateness from his mind, this detached corporeality is marked as feminine. In this flip of the usual metaphysical demarcation between male and female sexuality – where men's genitals are viewed as external and detachable from their minds and women's genitals are interiorized and connected to their minds (Potts, 2002) – being able to have sex like a woman is equated with having disconnected genitals that can function independently of mental participation.

Conclusions

The rise in recreational EM consumption by increasingly younger consumers (e.g. Harte & Meston, 2012; Prestage et al., 2014) and its promotion by medical authorities and sexual experts marks a significant turn in the "sexual mode of production" (Rogers, 2005, p. 186 citing Hawkes, 1996) engendered by sexual technologies. Pharmaceutical promotion strategies target personalized risk, expert consultation, and cultivating enduring relationships with the public (Dumit, 2012). Our analysis of popularized advice about EM use documents the continuing successful commercial and social reach (Williams et al., 2011) of sexuopharmaceuticals. Popularized sexual health information illuminates how sexual discourses (about "healthy" bodies and "normal" sex) are both perpetuated and contested. The emerging model "of sexual dysfunction as a discrete, unnatural, organic disorder, rather than as a byproduct of natural aging or psychological distress" (Katz & Marshall, 2003, p. 10) has ramped up to capture a widening net of potential "at-risk" consumers – younger men and those without ED diagnoses.

At the same time, the biomedicalization of sexuality (and aging) is "not a simple process of pharmaceutical imperialism" (Marshall, 2010, p. 215). EM success, as Fox and Ward (2008, p. 862) note, "rests not only on its capacity to achieve an effect, but on its interaction with cultural and social forces that define a condition as warranting a pharmaceutical resolution." The reciprocal links among biotechnology, consumer interests, and (popularized) medical authorities provide a solid platform for increasing reliance on drugs to achieve psychosocial ends through technoscientific means, as health becomes experienced and evaluated through the twin prisms of risk and surveillance (Clarke, Mamo, Fosket, Fishman, & Shim, 2010). Sexuopharmaceutical marketing, with its expanding orbit of potential consumers (Gurevich et al., 2017a), is optimally aligned with the increasing emphasis on consulting sexual experts as the foundation of responsible neoliberal sexual citizenship (Gupta & Cacchioni, 2013).

In this cultural climate, occasional or regular EM users – irrespective of the duration, etiology, or specific diagnosis of erectile concerns – become ''sexual entrepreneurs'' (Harvey & Gill, 2011a, 2011b). Earlier EM promotion emphasized restoring youthful sexual functioning and control among older men (Marshall, 2010), albeit with occasional depictions of younger, athletic men (Loe, 2004). While invigorating idealized masculinity quickly became an EM promotional cornerstone (Loe, 2001, 2004), current discourses layer mandatory health monitoring onto other masculinity mandates. As our analysis reveals, popularized medical accounts of EM use leverage increased preoccupation with ongoing psychological and bodily self-surveillance, risk assessment, and prevention technologies (Dumit, 2012; Williams et al., 2011) to normalize ED as a potential (and imminent) risk for *all* men, irrespective of age and health status. ED is presented as both inevitable (if transient) and as a pathological condition that requires persistent vigilance and expert consultation, where penile performance acts as a predictive health gauge. In tandem with this normalizing (while pathologizing) discourse, EM users are situated as model masculine subjects, properly (medically) augmenting their sexual proficiency, in obligatorily romantic or sexually experimental contexts. They are positioned by sexual health experts as proactively averting potential sexual decline and optimizing sexual health, satisfaction, and relationship quality. These discourses are consistent with recently revised representations by pharmaceutical companies that also depict younger men (and women) in pursuit of luxury leisure activities and exclusive sexual pleasures (Gurevich et al., 2017a). EM consumers, likewise, extol the virtues of drugs that promise (and mandate) phallic uniformity and mastery as maximal masculinity accomplishments: ''all penises must measure up to the (con)firm(ed) organ of 'dominance''' (Potts, 2002, p. 121). Notably, women's potential enhanced pleasures are implied (never heard) by EM users in this study, as well as by other user testimonials, popularized medical advice (Gurevich et al., 2017b), and by pharmaceutical advertising (Gurevich et al., 2017a). While EM use descriptions allude to men's sexual ''labour of love'' (Cacchioni, 2015), women's (implied, absent) bodies are represented as mere props for perfecting phallic performance.

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