Better Loving through Chemistry: How New Impotence Treatment Technologies Promise to Change Male Sexuality

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Better Loving through Chemistry: How New Impotence Treatment Technologies Promise to Change Male Sexuality

...the penis — insofar as it is capable of being soft as well as hard, injured as well as injuring, helpless as well as proud, emotionally needy as well as cold with will, insofar as it is vulnerable, perishable body — haunts the phallus, threatens its undoing. Patriarchal culture generally wants it out of sight (Bordo 33).

Introduction

One of the most interesting new developments in biotechnology are advancements in impotence treatment which allow men to defy accepted notions of what is natural about sexual performance. New treatment technologies like Viagra, the first orally administered pill to be approved for impotence, and self-injection therapy essentially disrupt or even eliminate "naturally-occurring" erections. For many men, these technologies challenge and expand limitations that once characterized sexual performance in their lives. Like cosmetic surgery, the new impotence treatment technologies offer consumers an opportunity to redesign aspects of their bodies, however temporary, in a way that is more consistent with their ideal self-image. It seems
that the penis, like chins, noses, breasts and a myriad of other isolated body parts, is increasingly becoming a phenomenon of options and choices (Giddens, Balsamo).

To reach a fuller understanding of this development, one must situate it within the broader cultural context of which it is a part, because the contextual dimension shapes not only the form these technologies take but the possible meanings attributed to them and the manner by which they are used. As Wajcman argues, "technology is more than a set of physical objects or artefacts. It also fundamentally embodies a culture or social relations made up of certain sorts of knowledge, beliefs, desires, and practices" (qtd. in Balsamo 10). Nowhere is culture's role in shaping technology more evident than in the products of the impotence treatment industry. While developments in treatment technologies appear to expand the choices men have to fashion their sexual behavior, they do so within a narrowly defined realm of sexuality. Treatment technologies are designed with a specific standard of sexuality in mind, one rooted in traditional and ideological assumptions about masculinity. The decision among men to use these technologies may stem from no more than a desire to move beyond the limitations of their sexual performance. But in making that decision, men simultaneously reproduce the standard of male sexuality that made so many of them feel sexually limited and in need of change in the first place. They also reinforce the notions of masculinity upon which that sexual standard is based. Rather than breaking apart the socially prescribed boundaries of male sexuality and their social ties to masculinity, recent developments in the impotence treatment industry help to guard and reproduce them.

According to Tiefer, the specific definition of sexuality promoted through treatment technologies is a phallocentric definition, i.e., a pre-occupying interest and focus on the penis/phallus in sexual discourse. In a broad sense, phallocentrism is a language system that places the phallus at the center of cultural signification. In a more strict sexual sense, the term phallocentric refers to sexuality that takes intercourse, vaginal or anal, as the objective to be achieved in sexual encounters.

Central to the satisfactory performance of this objective is the presence of the male erection — one hard and potent enough for penetration. As suggested by the term phallocentric, the image of the erect penis assumes the symbolic characteristics of a phallus, an object used less as an organ of sexual union than as a tool capable of sexual conquest. While the image of a phallus may not reflect the reality of the male organ, it nevertheless functions as the idealization of the erect penis. By emphasizing the significance of the erect penis in sexual discourse, phallocentrism not only defines male sexuality but, by extension, female sexuality. In this definition, the only sexual encounters that count as "sex", both for men and women, are those in which an erect penis is present and used in a way that ends in intercourse. Therefore, the presence or absence of an erect penis becomes the fixed point of reference for any sexual encounter.

According to this perspective, the phallic image, or what the penis is like at erection, also functions as the idealization of an individual's masculine self-definition. In other words, the male body, or rather a particular version of it — the erect penis — is taken as a metaphorical springboard for the construction of masculinity. To be masculine is to be like the erect penis or phallus: "potent, penetrating, outward thrusting, initiating, forging ahead into virgin territory, opening the way, swordlike, able to cut through, able to clear or differentiate, goal-oriented, to the point, focused, directive, effective, aimed, hitting the mark, [and] strong ..." (qtd. in Flannigan-Saint-Aubin 241). Anything that does not conform to the phallic metaphor and with this version of masculinity — e.g., having doubts or weaknesses, showing tenderness, yielding, dependency — is automatically considered "other", that is, feminine (Flannigan-Saint-Aubin 239). The phallic metaphor and its association with the penis thus serves as a central principle for differentiating the sexes and structuring erotic relations between them.

For men who define themselves and their sexuality according to phallocentric terms, the stakes regarding their sexual performance are extremely high, as is the anxiety about performance failure (Frecher and Kimmel 369). According to this perspective, a man's status as a masculine subject depends on his sexual performance. As new impotence treatment technologies continue to flood the market, the ante on the high stakes game of phallocentric performance may eventually rise. Treatment technologies not only promise men the ability to comply with the phallocentric sexual script but they may in fact increase the demands of the script rather than encouraging analysis of or challenges to the script (Tiefer 1987, 181). If the demands of sexual adequacy for men increases, so will the premium placed on men's sexual performance (phallocentrism), and, for that matter, the pressure on men to invest time, money and effort to achieve prevailing standards of sexual adequacy. Arguably, as access to treatment technologies expands, especially in their pill form, individual men may not only become more conscious and aware of their own bodily and sexual states but also more vulnerable to the allure of the impotence treatment industry, inducing them to seek out technical rather than social solutions for sexual insecurities (Wienke).
In this paper, I explore the relationship between new biomedical impotence treatment technologies and male sexuality. In particular, the paper examines how “male sexuality” is mediated in public information about impotence treatment technologies. I develop this focus through a critical analysis of medical literature (e.g., a patient brochure and Impotents Anonymous literature) and media representations found in major magazines and newspapers to examine what the meanings encoded into public information about impotence treatment technologies say about “male sexuality.” I suggest that this focus will help to shed light on at least two important questions concerning the ideological content of treatment technologies. First, how is “male sexuality” defined and conceived in texts disseminating information about treatment technologies? And second, how do these texts call upon readers to identify certain definitions of sexuality as “male sexuality” which prevent alternative definitions from gaining cultural definition and recognition? The paper identifies several communication strategies used to present information about treatment technologies and to contextualize male sexuality to raise issues for discussion, rather than to present a finished argument. I begin with a background review of male sexuality and impotence and, after a brief account of the methods used in the analysis, present the findings and conclude with some thoughts on the political implications of treatment technologies as viewed from the perspective of feminism.

**Background**

Men living in the contemporary West learn through sexual socialization that heterosexual performance, or more generally, sexual virility is part — perhaps the central part — of masculine identity. For many men, sex means much more than an occasional act of pleasure, intimacy, or tension release — it is a focus of identity in which masculinity provides the framework of men’s sexual organization, and sexuality provides the ground upon which men confirm their gender. “In men, gender appears to ‘lean’ on sexuality.... In women, gender identity and self-worth can be consolidated by other means” (qtd. in Segal 211).

Within the sexual domain, the erection signifies the presence of appropriate masculinity. Consequently, men learn that the male sexual universe revolves around the erect penis, and that the erection should be treated as the necessary element enabling compliance with male sexual performance. As mentioned, phallocentrism informs this approach to sexuality. In this account, men are required to “penetrate” and satisfy their partners by transforming the penis from an organ of sexual pleasure into a “tool,” an instrument by which sexual pleasure is carried out, a thing simultaneously separate from the self but integral to the perception of self. This implies that “proper” erectile functioning — “the normal erection is defined implicitly [by medical experts] as ‘hard enough for penetration’ and lasting ‘until ejaculation,’” informally that means a few minutes” (Tiefer 1994, 372) — is not only an essential feature along which many men map out their sexual identities, but also a resource from which many men fashion the meanings of their lives.

If sexual virility — the ability to fulfill the conjugal duty, the ability to procreate, sexual power, potency — is a marker of masculinity and thereby everywhere a requirement of masculine identity, then “impotence”— the inability to maintain an erection long enough for sexual penetration — is everywhere a matter of concern (Tiefer 1987, 165). From a phallocentric perspective, when men encounter impotence, they encounter more than just a sexual problem; they encounter their self-image as men. As Person argues, “An impotent man always feels that his masculinity, and not just his sexuality, is threatened” (qtd. in Segal 211).

Although few attempts have been made to study men’s specific concerns with and experiences of sexual performance (or lack of it), there has been some research on the extent and occurrence of sexual “problems” in men’s lives. For example, recent medical studies indicate that approximately 52 percent of American men between the ages of 40 and 70 — 20 to 30 million men — experience some level of impotence. Impotence or what health experts call erectile dysfunction also affects 10 percent of men in their twenties and thirties. As the population ages and life expectancy rates rise, the “problem” will likely become an increasingly common complaint (Horvitz 30).

Although impotence has been considered a problem for centuries, only recently, with the rise of sexology in the nineteenth century, has it been explicitly defined and categorized as a medical problem, a situation in which medical processes have transformed unacceptable erectile performance into a subject/object for medical analysis and management (see Hall, Tiefer 1994). The history of impotence is similar to the history of (male) homosexuality (cf. Foucault, Weeks), in that the “impotent man” as a type of person or as a matter of identity was literally invented in scientific discourse only in the late nineteenth century:

The word impotent is used to describe the man who does not get an erection, not just his penis. When a man is told by his doctor that he is impotent or when the man turns to his partner and says he is impotent: they are saying a lot more than that the penis cannot become erect (qtd. in Tiefer 1987, 165).
Prior to the late nineteenth century, impotence was often treated as an unwelcome experience, an unacceptable behavior, a personal trouble, an irregularity, even a sign of perversion. The focus was more on the behavior than on organic sexual differences. For example, in the 1800s, “an anonymous writer in the Lancet gave warnings against advising men with ‘questionable powers’ to marry... describing them as ‘as a rule, inexpressibly nasty’” (qtd. in Hall 115). This writer, like others at the time, attributed this behavior to the effects of long-continued masturbation and previous excessive intercourse, both of which violated the codes of sexual respectability and the ethic of self-discipline (Hall). Only when impotence was redefined as a medical problem did people come to see it as a distinct, pathological condition associated with individual identity. When the focus shifted from the behavior to the individual man, impotence was no longer be considered a perverted act. It would now be considered a sickness, either psychologically or physically, that requires medical attention (see Tiefer 1987). In other words, the phenomenon marked as “impotence” may in fact be a universal experience, even if it may not always be marked as such, if marked at all. But coupling the phenomenon marked as “impotence” with identity (and pathology) is historically specific, socially constructed, and a relatively recent occurrence.

The construction of impotence as a medical problem was, until recently, thought, in most instances, to be a psychological problem and thus the domain of sexology, psychiatry, and therapeutic interventions which emphasize treatment for the couple. In recent years, however, the diagnosis and the subsequent treatment of impotence has moved to the physiological domain because biomedical experts were able to isolate the physical conditions responsible for the presence of erections. In the following quote, Dr. J. Francois Eid, head of the Erectile Dysfunction Unit at New York Hospital-Cornell Medical Center, describes the physiological production of the erection in mechanistic terms:

sexually arousing stimuli triggers messages from the brain down the spinal cord to the penis, where local nerves release nitric oxide, a gaseous molecule that prompts the smooth-muscle cells inside to relax. This facilitates the flow of blood into the corpora cavernosa, the two large chambers inside the penis. As the cavities in the corpora fill with the blood, they expand and flatten the exit veins, through which blood normally exits the area. With these exits closed, the penis gets longer, wider, and harder (qtd. in Friedman 107-8).

One result of this shift in medical thought has been the development of a range of technologies designed to treat erectile dysfunction, from injections to erection pills to aphrodisiacs like Yohimbine hydrochloride to surgical implants. Indeed, the chemical erection, as one author puts it (Friedman 104), has become the leading edge of America’s nearly $700 million impotence-treatment industry, an industry expected to exceed at least two billion in the coming years. Some Wall Street analysts predict an even rosier sales picture now that the FDA has approved the sale of Viagra, the first pill to be approved for impotence treatment. Viagra itself is expected to eventually top $4.5 billion, easily making it one of the world’s best-selling drugs (Morrow 3). According to one estimate, Viagra will cost consumers approximately $8 wholesale a pill, making it reasonably inexpensive compared to other existing treatment methods like implants and injections, and given its form, the pill also promises to be less painful and invasive (Morrow 3).

Viagra’s advantage in both cost and convenience in comparison to other methods has led to some suspicion that the pill will not only aid “impotent men” but will also be consumed for recreational use by so-called “normal,” “healthy” men. Some predict that as much as 80 percent of Viagra’s worldwide sales will eventually be to men who do not really suffer from regular impotence but who will use it instead to engage in sex more frequently and insure their sexual performance” (Morrow 3). According to the reports of several heterosexual men who have tried impotence medication, the drugs virtually allow men to be “hard on demand, hard after orgasm, hard for hours, hard enough to satisfy the most demanding women. Even a bunch of them” (Friedman 106).

Some industry officials and doctors warn that Viagra is not an aphrodisiac but a medical treatment aimed at aiding men who suffer erectile dysfunction. Of course, the same logic was initially applied to silicon breast implants, which were originally developed for women with “real” disfigurements. New implant surgery is widely available to most anyone. Like breast implants, erection drugs will likely create and play on insecurities that only they can relieve, growing their market in the process (Leland 64).

Leonore Tiefer, a feminist sexologist, represents one of the few voices who have attempted to respond critically to the “medicalization of impotence” and its relationship to male sexuality. Medicalization occurs when a previously common life event (e.g., pregnancy, baldness, memory problems) is redefined as a medical problem. Such is the case with impotence, insofar as medicalization has transformed a life experience not previously considered medical into a sexual “condition” placed under medical jurisdiction. Rather than advocating the authority of human subjectivity and personal experience in matters of sexuality,
medicalized discourse positions them as subordinate to the authority of medical expertise. In the case of impotence, medicalization offers men an explanation which removes control, and therefore responsibility and blame, for “sexual failure” and places it on their physiology. This thus permits men, at least in theory, to escape an inquiry into self-blame and individual failure, even in the face of impotence (Tiefer 1987, 177).

Tiefer contends that the medicalization of impotence reinforces phallocentrism as the defining characteristic of male sexuality. Whereas phallocentrism treats the presence of an erection as a sign of appropriate masculinity during sexual encounters, medicalization treats it as the necessary component for “healthy” male sexual behavior. Impotence or the absence of an erection during sexual encounters is thus taken to be a sign of “pathology” or “abnormality,” a deviation from what is an otherwise healthy male activity. As this suggests, medicalization reifies erections as “natural,” “normal,” and thus enviable features of men’s sexual performance.

Of course, the medicalization of impotence not only ties into men’s sexuality but also has consequences for women’s sexuality. In Tiefer’s view, medicalization, with its link to phallocentrism, “literally and symbolically perpetuates women’s sexual subordination through silencing and invisibility: thus it operates to preserve male power” (Tiefer 1994, 364). In other words, definitions of male sexuality based on the assumptions of medicalization and phallocentrism not only specific the position men should occupy in the sexual domain but, by implication, the position women should occupy. Women are thus given no room or autonomy to define their sexuality, because female sexuality is defined by male sexuality.

According to Tiefer, the contemporary investment in the biomedical construction of male sexuality derives from an indirect coalition between urologists, the medical industry, mass media, various entrepreneurs, and the intense demands of the normative male sexual script. She also suggests that some women collaborate in the medicalization of men’s sexuality by subscribing to a medicalized and phallocentric construction of sexuality and expressing post-medicalization sexual and relationship satisfaction (1994, 371). The interests served by this development include the medical industry, which sustains its power through medicalization and the promotion and internalization of the medical gaze; capitalism, which thrives on the creation of desires and the commercialization of the body for profit; and patriarchy, which prospers by creating vested interests in the status quo. All men, “whatever their rank in the patriarchy, are bought off by being able to control at least some women” (Hartmann 193). Defining sexuality in phallocentric terms allows men to maintain some control over women (as well as delivering some men control over other men).

Methods

In the present analysis, I follow the lead of Leonore Tiefer in exploring the cultural and political implications of biomedical impotence treatment technologies for male sexuality. I base the analysis primarily on my reading of current texts embodying the medicalized discourses of male sexual behavior and impotence treatment. The focus is on texts that attempt to provide the public with general, factual information about impotence treatment technologies. This includes the patient brochure on impotence treatment from the Advanced Vascular Clinic in Pittsburgh, a medical center that specializes in men’s sexual “dysfunctions,” and an information pack from Impotents Anonymous, an advocacy group organized on behalf of impotence treatment. Both organizations recommend medical treatment for impotence. Along with these texts, I also focus on media representations of impotence treatment found in popular periodicals like the Pittsburgh Post-Gazette, Time, Newsweek, and Esquire. The purpose of analyzing these texts is to identify how medical discussions of treatment technologies standardize and contribute to the cultural context of male sexuality.

Public Information about Impotence Treatment Technologies

The texts I selected for close reading rely heavily on the presupposition that what is being conveyed to readers represents a “natural state of affairs” (White and Gillett 25). As readers, we can “make sense” of these texts precisely because they direct a certain set of possibilities toward us, encouraging us toward an intended or preferred reading of the texts and the encoded meanings contained within (25-6). While texts cannot guarantee the decoding of those meanings, readers are unlikely to be able to ignore the preferred reading (Smith xv). As Duncan notes, “responsible textual studies do not assert with absolute certainty how particular texts are interpreted. But they suggest the kinds of interpretations that may take place, based on the available evidence and likely interpretations of a particular text. Ultimately these interpretations must be judged on the basis of the persuasiveness and logic of the researcher’s discussion” (qtd. in White and Gillett 23).

Establishing Expertise

My research shows that several communication strategies are used to organize information about treatment technologies. These strategies
A central role in shaping potential interpretations of treatment technologies. One strategy addresses readers in the language of scientific expertise constitutes readers as lacking sufficient knowledge regarding the phenomena of impotence and male sexuality. The discursive positioning of readers as scientifically uninformed works to frame the meaning of impotence and sexuality from the perspective of medicalization by juxtaposing the seemingly unknowledgeable readers with the competent and adept medical expert whose voice informs the texts. This strategy compels readers to surrender authority in sexual matters to biomedical conceptions, models, and metaphors. For example, one of the Impotents Anonymous brochures, entitled “Answers To The Most Often Asked Questions About Impotence,” gives readers answers to what the “experts” conceive as commonly asked questions about impotence. Some of the eleven questions and answers include the following:

What is impotence? Impotence is the inability to achieve and maintain an erection firm enough for sexual intercourse...

Is age a factor in impotence? No. Some men under 30 are affected; others over 80 are not. The aging processes (e.g., atherosclerosis, or hardening of the arteries), not “age,” is a more accurate cause of impotence.

Is chronic impotence “all in your head?” No. A few years ago it was thought that 90 percent of all chronic impotence stemmed from psychological causes. Recent studies now show that up to 80 percent of all chronic impotence is a result of physical causes; a portion of which include psychological overlays. The remaining group suffers from psychological causes...

Can chronic impotence be treated? Yes. Proper diagnosis should be made before treatment. Physicians who specialize in impotence diagnosis and treatment are recommended. They can determine whether the cause is physical or psychological or a combination of both.

One way to bring out the discursive or ideological implications of this text is to recognize that part of the ideological work of any form of media is impression management. In this case, the authors, in their attempt to clarify a complex phenomenon, manage to portray themselves as spokespersons of neutral, objective reality by assuming the standpoint of impartial, disinterested, medical experts. The text thus interpellates readers as subjects of the experts’ ideological discourse, encouraging and directing a particular reading and identification of the meaning of impotence. The authors give the impression that they are looking out for the readers’ best interests by providing readers with a seemingly informative, conscientious, exhaustive, and up-to-date service about an alleged “concern,” one that is in line with the current findings of the “experts.” In managing the “objective” view of science and medicine and presenting themselves as good citizens imparting valuable information, the authors establish the standpoint necessary for the construction of impotence as an abnormality or pathology among men or of male sexuality. They present impotence as a problem for men, an exception to the otherwise smooth performance of (normative, phallocentric) male sexuality (see Morton).

The authors’ use of the question and answer format frames understandings about how to discuss, think about, and respond to impotence. Rather than including more substantive or critically-oriented questions related to impotency, the authors reduce impotence to a set of fairly straightforward, carefully phrased, largely non-threatening, and essentially apolitical and ahistorical questions, accompanied with equally sterilized “answers.” Because questions of individual differences, personality, relationship, context, values, expectations, life experiences, or culture are silent, notions of male sexuality that contradict the medical model are excluded. This strategy also constitutes readers as subjects who are seeking clear, rational, simple answers to a set of common questions, as if the text itself were reflecting the questions of its readers rather than constructing them. Accordingly, the text reassures its readers that, while it is “normal” to have questions about impotence, as subjects of the medical experts’ ideological discourse they can expect to find answers to their questions because the “experts” know the “truth” about impotence and male sexuality.

The opening section of the vascular clinic’s patient brochure provides another example of the strategy of establishing expertise. The section, entitled “Welcome,” begins with the following statement:

We are a general practice clinic limited to the medical enhancement of erections. An erection is an engorgement of blood to the penis. There are many causes of impotency. These include: impaired circulation, nerve damage, emotional stress, excessive smoking, alcohol use, use of street or prescription type medication and hormonal imbalances. Often, impotence is due to more than one cause. Treatments include switching medication (if you are taking a medication that causes impotence) administration of hormones, penile injections, or urethral medications, use of medi-
cal devises that produce an erection, surgical procedures to correct blood flow in the penis, penile implants, psychological counseling, and external vacuum pump.

During your consultation, the doctor will discuss non-surgical treatments to enhance erections . . . Physicians who practice with our clinics are general medical doctors, who predominantly limit their practice to the treatment of impotency.

Here the authors explicitly define an erection as a product of neurology and blood flow. Although the authors allude to psychological causes of impotence, they emphasize physiological origins and cater to biomedical and technological solutions for impotency, implying that with a few office visits and medication rather than, say, sexual counseling, the patient can return to his "normal" sex life. Similar to the previous quote, readers are made to feel comfortable and "welcome" to discuss the implications of impotence by the text's external appearance of protective outreach. The text also encourages readers to expect full recovery from the medically-diagnosed problem of impotence.

The strategy of establishing expertise was central not only in the clinic's patient brochure and Impotents Anonymous literature, but also in magazine and newspaper stories on impotence interventions, at least insofar as the authors of these stories yielded authority to medical experts in establishing knowledge over impotence and male sexuality. In each article I reviewed, the authors relied upon or quoted urologists or other impotence treatment "experts" to provide an authoritative view of the issue.

In many respects, media stories of treatment technologies operate as free publicity, or even advertising for the impotence treatment industry. Most articles convey medicalized information on the "problem" of impotence, discuss the specific physical causes of impotence, identify the methods used to distinguish between physical and psychological impotence, and list solutions for impotence, with an emphasis on specific technological interventions. Several articles also include the estimated price of the technologies, describe the costs and benefits of specific technologies, provide stories of men who have "overcome" impotence using the technologies, and give information on how and where to purchase technologies.

In connection with the recent FDA approval of Viagra, *Time* magazine ran several articles that discussed how Viagra helps men to relieve impotence and enhance erections. Among the entries was a visual chart (see figure 1) used to illustrate the precise function of Viagra and its effect on the male organ. The written text accompanying the visual reads as follows:

1) When things are working right, sexy signals from the brain stimulate the release of a chemical in the penis, cyclic GMP, that causes muscles to relax and the arteries to expand. 2) Blood rushes into the newly opened spaces and the penis begins to stiffen. A full erection occurs, however, only after veins that normally drain blood away have been squeezed shut. 3) In impotent men, the erectile tissue doesn't expand far enough to plug the veins, due to a shortage of cyclic GMP. Blood flows out of the penis as fast as it flows in, and the erection flags. 4) Viagra works by prolonging the effects of cyclic GMP (by blocking an enzyme that breaks it down). So that even a little chemistry can go a long way (Handy 52).

According to this description, which is reminiscent of Cartesian thought, the male body, including particular parts of that body (the penis), functions as a container for the controlling mind. The mind is like a control tower and the body is like a machine that receives signals containing messages about appropriate physiological behavior. Once the body processes those signals, it then formulates a set of responses, directing other signals to particular compartments of the body (the penis), thereby invoking the operation of certain bodily functions (the erection). Malfunctions in one aspect of this interrelated system generates an all-encompassing, systematic breakdown. This is where science intervenes. Science isolates the malfunction and then services it with chemicals (Viagra), which, in turn, enable the smooth functioning of bodily and sexual performance.
The visual accompanying the written text transforms the material body, or at least a part of that body (the penis), into a visual medium from which to observe the application of Viagra. The visual isolates the penis by function. In doing so, the isolated body part (the penis), along with the rest of the material body comes to embody the characteristics of the technological image (Balsamo 56). The technological image (the visual) thus operates as a disciplinary gaze that breaks down the material body, in this case the male body, into isolated body parts, in this case the penis, and then redefines the isolated parts (the penis) as inherently flawed and pathological (impotent) (56). Balsamo reports, “When a [man] internalizes a fragmented body image and accepts its ‘flawed’ identity, each part of the body then becomes a site for the ‘fixing’ of [his] physical abnormality” (56-7). In effect, the technological image compels its readers to redefine the male body in general and the penis in particular as objects for technological reconstruction (57). In another sense, the visual offers readers an opportunity to see “with their own eyes” an unfiltered, objective view of impotence and the role of medicine (Viagra) in enhancing erections. It thus aids in establishing the expertise of the medical model.

Of course, despite the media’s overwhelming acceptance and replication of the medical model, not all media accounts of impotence treatment technologies whole-heartedly embrace the “miracles” of modern medicine. Several articles express ambivalence over the implications of the treatment technologies (see Friedman, Sheehy). Some articles raise questions about consumer exploitation(see Handy, Morrow). Yet, few media stories, if any, raise serious questions regarding the use of the medical model for the interpretation and assessment of erections, impotence, or male sexuality. In excluding such questions, the mass media reinforces both medicalization and phallocentrism.

Promising Change

Another communication strategy used to disseminate information about impotence treatment technologies is to emphasize physical transformation as a consequence of technological consumption. Medical texts tend to talk about these technologies in terms of the transformative possibilities they offer to men seeking to recover their former sexual selves or overcome current sexual limitations. At the very least, the texts promise “normal” sexual functioning as a consequence of consuming impotence treatment technologies. For example, the Impotents Anonymous brochure proclaims in bold-faced text that: “More than 10 million men plus their partners suffer from chronic impotence needlessly, because... Impotence IS Treatable.” A urologist cited in an Esquire article also announced the possibility of transformation: “the medical enhancement of erections offers the only complete, reliable solution” (qtd. in Friedman 106). Another urologist cited in the same Esquire article declared: “We are challenging the penis” (109). A doctor cited in a Newsweek article said:

People are looking for a fountain of youth, including sexual function. There’s no question that... [Viagra] is going to make a lot of people feel like a teenager again — including yourself and myself (qtd. in Leland 63).

A urologist cited in another Newsweek article concluded: “We can get most men erections” (qtd. in Sheehy 70).

The texts I analyzed often juxtaposed the promise of transformation with descriptions of men’s sexual experiences prior to the use of technological treatment. In highlighting this, the texts inform readers of the insecurities of men who do not meet the phallocentric standard of sexuality, and the power and self-confidence of men who do conform to the standard, albeit through the use of treatment products. This strategy, whether intended or not, obliges readers to assess men’s pre-medicalized sex lives in negative terms (White and Gillett 30). A striking example of this is found in the Impotents Anonymous news bulletin. In the process of discussing the findings of a new study on the positive impact of impotence intervention, the news bulletin brings attention to the supposed negative effects of impotence on men and their partners:

The emotional impact was very strong for both the men and his spouse/partner. Men expressed feelings of inadequacy, frustration, depression, insecurity, anger, anxiety and loss of sexual identity. Also expressed by the men, especially by those under fifty years of age, was a concern for their partners and fear for the relationship... Both the men and spouses/partners perceived negative changes in their relationship attributed to impotence. The changes reported did not just focus on sexual issues, but appeared to impact the entire relationship. Those men who indicated their entire relationship was affected, faced the serious result of a break up of their marriage and/or relationships.

By juxtaposing the dread of impotence and the triumph of impotence treatment technologies, these texts effectively signify the promise of change and renewed power to consumers. On the other hand, the juxtaposition of positive and negative sexual experiences may trigger insecurities in readers who are uncertain of whether they measure up the medical standard of sexual prowess. Whether intended or not, statements about the negative consequences of not measuring up help to or-
ganize consumer discontent and desire for gratification.

Statements from men about the benefits of technological consumption were also found in several texts. For example, in one of the *Time* magazine articles, the author uses quotes from formerly "impotent men" now using Viagra to reveal the transformative potential of medical intervention:

Not only is the frequency of our sex greater, but for me it is much more intense than it was without the medication. The quality is so much better. Much firmer, stronger erections, and the orgasm is much more explosive, much more satisfying.

I've been using it everyday. It makes me feel like I'm in my 30s. I don't worry about the risks (Handy, 57).

The author of a recent edition of *Newsweek* also quotes formerly "impotent men" now using Viagra. In one quote, a man says that "If you use the stuff, you'll last all night" (qtd. in Leland 65). Another man, sounding as if he were describing the handling of an automobile rather than a pharmaceutical drug, mentions that "You'll just keep going all night ... The performance is unbelievable" (qtd. in Leland 65).

Alongside stories of change, the *Time* article also provides an observation from a man unable to transform his sexual performance through the consumption of Viagra: "I hear that it works for 2 out 3 men. Maybe I'm the one [person of the three who doesn't receive the transformative benefits of Viagra]" (qtd. in Handy 57). While on the surface this example may serve to challenge the transformative promise of Viagra, it also appears to reinforce the development of transformative technologies, at least insofar as this man seems willing to subject himself to the consumption of technological solutions.

One of the *Newsweek* articles also provides an example of an experience with Viagra that seemingly contests its transformative potential. The article begins with a discussion of Viagra's role in changing men's sexual lives. It then describes the story of a man, not previously inhibited by impotence, who became impotent by literally overdosing on Viagra, producing what medical experts call priapism. Priapism occurs when a man develops an erection that lasts anywhere from four to six hours or more. Untreated, priapism can lead to tissue damage and even impotence. After his overdose on Viagra, the man was left impotent. He now says he feels "less than a man" (qtd. in Leland 65). Ironically, in order for him to engage in conventional phallocentric sex he needs the very drug that caused impotence in the first place. While this story may serve as a warning to some men regarding the costs of impotence treat-

ment technologies, it may also serve to illuminate in rather extraordinary detail the transformative power that these technologies seem to promise. In this sense, the above example reinforces the transformative promise of treatment technologies while it indicates the risks involved.

Textual representations of treatment products may give the impression that consumers have control (individual rather than societal) over their sexual performance. Yet, their sexual performance depends on the use of technology, along with the medical assumptions that inform that use. The physiological effect of treatment products may be transformative, but only within the confines of societal and cultural constraints. The textual representations of treatment products tend to reify technology as power: although treatment technologies promise men sexual power, their use enhances the medical establishment's power to survey, regulate, and control men's lives.

Using Humor

Humor is another common strategy used in the conveyance of information about impotence treatment technologies. Humorous or playful manners were common in stories and images found in newspapers and magazines. For example, several articles lead with amusing, farcical, and, on occasion, derisive titles: "Are you man enough to handle a four-hour erection? The impotence industry is about to take us all to hard-on heaven" (Friedman 104), "Rx for Profit: Boomer Feel-better Pills" (Morrow 3), and "Drug Quest: Magic Bullets for Boomers" (Greenwald 54). Titles like these invite readers' amusement at the development of technologies that promise to deliver hard-ons for men who supposedly cannot arrive at them on their own. Accordingly, the humor comes at the expense of men who fall outside the boundaries of conventional masculine sexuality, thus reinscribing phallocentrism as the standard understanding of male sexuality, while providing men with a justification to use them to attain "normal" sexual functioning.

Since 1997's FDA approval of Viagra, the discussion of treatment technologies in joke form has become increasingly common. For example, the May 4, 1998 addition of *Time* ran several comics that satirize Viagra. In one comic (see figure 2), the readers see two figures: an elderly man and a young, attractive woman, each of whom are having a drink while sitting at a bar. Below the image appear the words "Don't worry — I'm on the pill." The caption, obviously a take off on women's use of the birth control pill, suggests to readers that just moments earlier the man had propositioned the women and was now making an effort to reassure her that, despite his outward appearance of an elderly
man, he remains physically able to meet her sexual demands, thanks to Viagra. As we learn in the article that accompanies the comic, Viagra promises to make even the oldest of men “potent” again. The comic thus pokes fun at the potential implications of Viagra for men’s (and women’s) sexual lives, playing upon normative assumptions of sexuality (an elderly man is not supposed to be able to “satisfy” a young woman). While advocating phallocentric sex, it, moreover, alerts the reader to the transformative potential of the drug, implying that sexual exchanges that may have seemed unlikely prior to the development of Viagra now may be feasible, since even men advanced in age can become young again, at least in the sexual domain.

Another comic (see figure 3) shows a man talking on a cellular phone as he sits in the driver’s seat of an apparently brand new sport utility vehicle. Despite the potency signified by his rugged all-terrain automobile, the man and his automobile are literally stuck in traffic. The image of power is thus countered with that of powerlessness. The caption reads: “You think I would have sunk forty thousand clams into this lemon if I had known they were coming out with a nine-dollar boner pill?” The humor here stems from the reference to the myth of male mid-life crisis. According to the myth, when men — men here mean typical middle-class, heterosexual, white men — reach mid-life, they often confront a crisis over their identity. In order to deal with and respond to this crisis, men seek out symbolic resources with which to rebuild their identity and regain their youth. A stereotypical response for making over the male identity is to purchase an expensive, ornamental or rugged automobile, one that signifies youthful virility. The comic vis-

ibly identifies this method of redress, but it also plays with it, remarking facetiously that with the development of Viagra men have another, more accessible resource to address their mid-life crises. Here impotence drugs are simultaneously ridiculed and celebrated as they are shown to have a special appeal to aging men who, like the purchaser of an expensive automobile, remain performance-con-
scious in every way and obsessed with staying young and virile.

If we take Freud’s view that humor is used to relieve anxiety caused by repressed, unwelcome, taboo, or contradictory meanings, then Viagra and other treatment technologies make fitting targets for humorous relief. On the one hand, their utility is at odds with prevailing ideas of male sexuality (phallocentrism). Joking about treatment technologies thus serves to relieve anxiety over practices that contradict those ideas. On the other hand, information about treatment technologies, in general, brings into view the contradictory experiences, differences, confusions, uncertainties, fears, and frustrations in male sexuality. In poking fun at treatment technologies, jokes negotiate tensions which could disrupt the hegemony of prevailing ideas of male sexuality (see Lyman). Although jokes about treatment technologies play with accepted ideas about male sexuality, they ultimately reaffirm and preserve those ideas as normative. Paradoxically, then, jokes about treatment technologies provide men with a justification to use them, since the technologies promise “normal” sexual functioning as a consequence of using them.


Discussion and Conclusion

The crux of my analysis illustrates how the meanings encoded into public information about impotence treatment technologies contextualize male sexuality, embracing those aspects of male sexuality which replicate phallocentrism, while stigmatizing or excluding those which pose a challenge to that hegemonic or "common sense" definition. The texts I analyzed represent normal sexuality as phallocentric by "naturalizing" the erection as the central feature of sexual performance while "pathologizing" impotence as disruptive to "normal" male sexuality. Public information about impotence treatment technologies promotes this standard of male sexuality as not only "normal" but enviable, as it promises, through the consumption of treatment technologies, to convert men who do not conform to it.

In many respects my analysis confirms Leonore Tiefer's contention that biomedical impotence treatment technologies, and the public information about them, reinforce and reproduce a phallocentric definition of men's sexuality. I have shown that there are at least three strategies used in conveying information about impotence treatment technologies, all of which call upon readers to identify with this very traditionally gendered definition of male sexuality. They include: 1) the establishment of expertise, whereby texts emphasize scientific and medical explanations of impotence, male sexuality and treatment technologies while silencing possible alternative explanations; 2) the promise of sexual transformation through the consumption of technologies, whereby texts contrast the insecurities of men who do not meet the phallocentric standard of sexuality with the power and self-confidence of men who do conform to the standard, albeit through their use of treatment products; and 3) the ridiculing of treatment technologies, whereby texts relieve tensions over contradictory descriptions of male sexuality. This strategy reinscribes the prevailing assumptions of male sexuality, while giving men a justification to use technologies.

From the perspective of feminism, some of what I have said about impotence interventions might sound discordant: it is. At a time when men's privileges are on the decline and women have made significant social and political gains, men now have a new toy in which to prop up their sagging masculine identities, to preserve some semblance of traditional male-female differences, and to ward off the erosion of male power by defining sexuality in a way that generally preserves men's conception of sexual pleasure and satisfaction. Moreover, through the medicalization of impotence, men are given an explanation of male sexuality that tends to correspond with and helps to strengthen and reproduce definitions and interests upon which patriarchal ideologies are based.

Of course, the development of impotence treatment technologies has multiple social implications, not all of which need to be viewed negatively from feminist standpoints. I suggest that feminists use the public discourse on the development of impotence treatment technologies to their advantage, since this discourse can be employed to facilitate new and potentially progressive possibilities for male (and female) sexuality and identity. Consider, for instance, the recent media attention given to the FDA approval of Viagra. In many respects the public discourse on Viagra has the potential to facilitate a widespread discussion and debate about men and male sexuality(ies). The attention given to Viagra brings into public view contradictory experiences of male sexuality and thus the fragility of phallocentric imagery. In hearing about Viagra, the public has heard stories of men's sexual "problems," differences, confusions, uncertainties, fears, and frustrations. Prior to this, the only images of male sexuality typically heard in public on any regular basis were those taken from pornographic fantasies. Treatment technologies highlight both the diversity and tensions in men's sexual experiences, even while they work to guard against that diversity and set of tensions. Despite the cultural, economic, and political implications of Viagra's development, efforts to medicalize impotence point to, in a public sense, the tensions and contradictions many men encounter between the standards of normative (phallocentric) male sexuality and their lived experiences of male sexuality. The fact that Viagra, which has only been on the market for a short time, was initially "being prescribed at the rate of at least 10,000 scripts a day, outpacing such famous quick starters as the antidepressant Prozac (which went on to become one of the biggest-selling drugs in America)" (Handy 50), suggests that impotence or at least the feeling of sexual inadequacy is a widespread phenomenon. By drawing attention to these strains and differences, feminists have an opportunity to challenge the narrow boundaries that are placed on men's (and women's) sexual behaviors. While the development of treatment technologies like Viagra may pose additional problems for feminist struggles, it also opens up new terrains of activity, giving rise to possibilities for new forms of organized politics, inspection, criticism, and discussion, especially around issues of male sexuality. By engaging the contested terrains constituted by the emerging discourse on the development of Viagra, feminists can continue to imagine new and diverse sexual realities.

In conclusion, I agree with feminist men's studies scholars like Lynne Segal, who advocate the need to play up the tensions and con-
traditions in men's lives. In making these tensions and contradictions visible, we reveal not only where men are most vulnerable to pressure for change, but also where feminist methods could be used to promote change. Given the contradictions between the phallocentric ideal of male sexuality and men's lived experiences of sexuality, male sexuality represents a key site for the mobilization of feminist-inspired changes. Only by exposing the tensions and contradictions in male sexuality can we fully address the important task of challenging the regime of phallocentric sexuality in men's (and women's) lives.

Notes

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1 Fracher and Kimmel argue that phallocentrism is the prevailing approach to male sexuality, regardless of sexual preference, since, in their view, gender identity is the key reference point around which the organization of men's sexualities develop (370).

2 Although much of the discussion of impotence treatment technologies presupposes heterosexuality, industry officials expect that men interested in homosexuality will make up a significant portion of the consumer market (Morrow, 3).

3 Kimmel expands on this observation, noting that some heterosexual men are intimidated by women's growing sexual prerogative, but don't want to admit that fear. Medicalization promises men permanent freedom from such fears as it allows men to maintain the requirements of the male sexual script and satisfy, at least in theory, even the most sexually demanding of women (see also Leland).
Weinke

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