Men Talking about Viagra

An Exploratory Study with Focus Groups

RONA RUBIN
Canterbury Christ Church University College

The aim of this study was to explore men's attitudes to Viagra in a social context. Two focus groups were established. The first comprised six members of a sports club; the second included three patients attending a clinic for men with erectile dysfunction, aged between 45 and 65. Each group met for one hour. Interpretative phenomenological analysis was used to identify themes. Analysis indicated the overriding theme for the first group of maintaining a masculine image through denial of any deliberate knowledge of or interest in the topic; for the second group, there was a theme of sadness at being unable to "confess" their problem because of potential loss of masculine image. Men in group contexts talk about Viagra in ways that serve to project a masculine image. Masculine image may be more important to men than their health.

Key words: sexual dysfunction; masculine image; Viagra

Interest and research into the health of mature men has developed relatively recently in comparison to research into the health of mature women. It has been suggested that this is an area of health inequality that ought to be addressed (Cameron and Bernardes 1998). It has also been demonstrated that men's health is intricately bound up with notions of masculinity. This article reports research in an area where masculinity and health are particularly entwined—that is, how men talk about a new impotence drug, sildenafil, also known as Viagra.

Erectile dysfunction, defined as "the persistent or recurrent inability to attain or maintain an erection sufficient to complete sexual intercourse or another chosen sexual activity" (Impotence Association 1999) is a growing problem, not only for the men concerned but also for their partners (Morganteler 1999). Recent estimates from the United States suggest 30 million men suffer from this (Mulcahy 2000) and that the likely number by the year 2025 will be 322 million (Aytac, McKinlay, and Krane 2000). Evidence from both the United States and the United Kingdom suggest that only a very small percentage with the problem are ever sent to a urologist, perhaps only 10% of the population who suffer. If we consider the general reluctance of

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men to present themselves to their general practitioner (GP) with any health problems—both in the United States, where Tudiver's research has shown that key reasons for not seeking help include "man's traditional role" (Tudiver and Talbot 1999, 47), and in the United Kingdom (for an overview of evidence, see Lloyd 1996)—then the issues around impotence are bound to cause particularly severe problems.

In 1998, the drug Viagra was cleared for public use by the U.S. Food and Drug Administration, thus giving rise to a plethora of media discussions on its uses and potential abuses.

Despite its potential, little is known about men's attitudes to this drug. This exploratory research study was initially conducted to find out what men's expectations were about Viagra, what they knew about it, and what were their sources of information.

METHOD

Design

A focus group design was identified as the most suitable method. This design has been used recently and relatively extensively to investigate how women feel about health and related matters, as it has been identified by feminist psychologists as a method whereby the principles of equality of power for researcher and participants can be more easily approached (for a discussion, see Kitzinger 1994; Wilkinson 1999). However, the method should also be an ideal way to conduct exploratory research in men's health, where it would be unwise to make any assumptions a priori about the participants' attitudes and feelings about the topic. According to Morganteler (p. 1713), "widespread media coverage of sildenafil citrate (Viagra) . . . has propelled the topic of impotence into casual conversation." Therefore, we wanted to replicate this casual conversation.

Participants

Two groups of men aged forty-five to sixty-five were selected (this being the age group on which most research on impotence has been carried out). One was a group of six volunteers from a sports club who knew one another. They were contacted by snowballing, a method whereby initial members of a target group are asked to suggest others whom they know are in the target group and that is frequently used in qualitative studies where no sample frame exists and none can be created (Bowling 1997). The second group comprised three men from a group of patients at a urology clinic who volunteered to take part. While it is recognized that this type of sampling is not

ideal, it is considered acceptable in preliminary investigations (Drummond 1996).

Questionnaire

A semistructured questionnaire was used with only three questions. The groups were asked to discuss what they knew about Viagra, how they knew it, and what they thought about it.

Procedure

The first group meeting took place in the house of one of the participants, and the (female) researcher was present. All were assured of confidentiality and agreed to the conversation being tape-recorded. After the initial questions, the group was left to take the conversation in any direction, with occasional probes from the researcher, such as, "Could you say a bit more about that?" or "Why do you think that happens?" The second group met in a seminar room with the same researcher present on the grounds of the hospital where the clinic took place. The intention in both cases was to replicate as closely as possible the environment in which these groups might meet and where the question of Viagra might arise casually. At various points during the discussions, the researcher summarized for the participants what she understood the main points were that they had made, checking out the participants' meanings and inviting clarification. They were also asked how they felt discussing these issues with a woman present. It is interesting that they responded that they felt more comfortable talking about sensitive issues with women.

Ethical Concerns

Several conditions were imposed by the relevant ethics committee, including total confidentiality within the group and written agreement by the participants to have the recordings used for publication.

DATA ANALYSIS

It was decided that the most useful and valid method of analyzing these qualitative data was interpretative phenomenological analysis (Smith 1996). Smith describes his method as "committed to understanding and foregrounding the patient's perspective" while recognizing that this is "only possible through the interpretative analytic work of the investigator." Although this method was originally designed for understanding one-to-one interviews, it

was thought that its emphasis on understanding the perspectives of the participants while acknowledging the role of the researcher's own theoretical background was still the best available method. Therefore, the data were analyzed according to Smith's (1996) criteria. The conversations were transcribed and read by two researchers, themes that emerged were noted, transcripts were reread several times, recurrent themes were identified, comparisons were made between the researchers for reliability, relationships between themes were noted, and literature was sought that explained the findings. With its emphasis on the perspectives of the participants, this method does not allow for a priori coding of responses or a priori theorizing. When the researchers had identified tentative themes, the transcripts were sent to all the participants with the thematic observations. Also included were stamped return envelopes inviting comment. None were returned, and it was concluded that the participants were therefore in broad agreement with the tentative analysis.

RESULTS

Three overriding themes emerged from the transcripts: (1) knowledge as accidental, (2) maintaining a masculine image, and (3) denial. The first two themes will be presented with verbatim examples from the transcripts of the two groups. The third theme will be seen as recurring throughout the examples and therefore will not be presented separately.

Knowledge as Accidental

Group 1

The group from the sports club took great pains to make sure that any knowledge they professed was hedged by statements that meant they had not sought any information and had no intention of seeking information. This can be seen when they were asked whether they had ever seen any reference to Viagra on television:

> Funny enough, I saw a program about it yesterday. I was having to sit down with a cold compress on my knee.

If we look at the first phrase, we see that there is strong suggestion of coincidence here, and it could be interpreted as, "it is strange that you ask me that because normally, I would say no; but by some strange coincidence, because I was being forced to sit down, which is not my usual situation, I happened to see a program about Viagra." It is also possible that the justification of the knee hints at a sports injury.

Other participants, when asked if they would watch a program on Viagra that happened to be on, offered the following:

> I'd watch it, so long as there wasn't any sport on or anything, of course;

and

> Oh yeah, but I wouldn't go out of my way . . . if I was flicking through and it came on . . .

But this was too strong a statement of willingness for another participant, who went to great lengths to justify any such viewing behavior:

> In my case, not necessarily, because I quite like documentaries. I watch a whole range of documentaries; it wouldn't be that different for me, anything to do with electronics or computers.

Here, Viagra is put in the same category as computers—as a justifiable male interest in anything scientific.

Another way of dealing with information exchange while not owning knowledge is to use a questioning or tentative style. There are some examples of this too:

> And can they do testosterone in a drug form or injection form to overcome all these problems?
> That's what I understood . . . that it perks you up a bit, sexually, well presumably, when you're having difficulties with an erection.

Here, he emphasizes that he does not really know about treatments for impotence.

> Perhaps there is a midlife crisis, male menopause, that's what they were sort of saying.

Once again, there is a suggestion of not really paying close attention to the information heard.

Next, we have a good example of a more general attitude to acquiring knowledge and the lack of proclaimed relevance:

> It's a bit of a joker subject, isn't it really; to be quite honest, I haven't heard a discussion about Viagra at work or at the cricket club or the hockey club. I think I've probably heard a few jokes about Viagra, but that's as far as it's gone. I don't know anybody who's taking it, or anybody who is interested to be quite honest.

As it is impossible for this participant to know who is interested, we need to take this statement as an indication that he is not the kind of person who knows the kind of person who is interested in the subject.

Group 2

This group comprised men who were taking Viagra and who knew that the other participants also were attending the clinic. They all said that they had known about Viagra as a treatment for impotence and had read and heard about it over the last few years.

Identification of a Masculine Identity

Group 1

The following examples demonstrate some of the ways in which these participants establish who they are by comparing their attitudes to that of women:

> I don't know if I've ever actually met a man who said he was in midlife crisis. I've definitely met a lot of women who have said that.
> They're in permanent crisis, aren't they? [*laughter*] That was a bit sexist, sorry [*turning towards the female researcher*].
> I get the impression that more—how should I say—forty- to fifty-year-old ladies are not too bothered about sex, whereas as some of us are still trying to cling to our youth a bit, to prove that we're still able to [*laughter*]–that we can go all night.
> Well, I don't know many forty- to fifty-year-old females who are still nymphomaniacs.

It is clear from the last two quotes that the image held of mature women is that they are no longer interested in sex, and therefore, Viagra is not to their benefit. However, one man proclaimed:

> Of course, he might want it for his skivvy down the office [*much laughter and nodding*].

What is this man actually doing by this statement? He is able to give the impression that he is a man of the world, that he knows that not all men are faithful, and that, perhaps, there is just a hint of suggestion that he might do that himself.

Group 2

In contrast to the above examples, all three men in the second group agreed that sex was very important in their relationship with their wives, as can be seen by the following conversation:

I think, speaking personally, if you've had an active sex life for however many years—and in my case it's been 35 odd years—and something starts going wrong, it's terribly bloody stressful.
The more you think about it, the worse the problem gets.
And yes, that's the other thing, you get completely wound up about it, and, of course, that makes things worse.
Yeah.
And so it escalates really. To have something like Viagra available, which, as I say, in my case works, is a hell of a relief, you know, I mean, it really sort of . . . If you've got a sexually motivated partner and you can't perform you know, it must be just as frustrating for them as it is for the likes of ourselves.

Group 1

Of wider interest, however, is the way in which the groups described their attitudes toward their own health with reference to being a man. One participant suggested that men do not go to the doctor unless acutely ill. The others respond as follows:

I'd totally agree with that, and certainly whilst I was working, not to go to the doctor at all if I could avoid it.
I think that if you were at work and you had an appointment with a consultant to talk about a heart problem, you would tell the people at work why you were going if they asked you. But if you were going with a problem related to . . .
down there . . .
You would make some other excuse, wouldn't you?

Now, we have a clear statement about this participant's opinion on men who have sexual problems:

I think a lot of people who have these problems are people who are perhaps rather lonely people, haven't many interests, and don't do very much and spend a lot of time thinking about themselves and their problems. . . . I may be wrong.

Group 2

The second group sees things differently:

Women are always talking about their health, men don't. You don't go down the pub and talk about . . .
No, no, no.
I would never dream of doing it.
I think they'd all fall about laughing; it's a macho thing—"What? Can't you do it without some help?"
If you had a problem with your sex life, you would just never do it, never dream of doing it [that is, talk about it].
Well yes, I think you could in certain situations, on a one-to-one basis, you are aware between you that each of you have a problem and one's tried something, and the other is wondering how it works. There can be times when you feel that you would like to unburden yourself, but you don't. Ooh, I don't want to talk

about that really. I think there are times when we all wish we could be more open.

Denial

The third theme identified, denial, is best described as a way of understanding the other two themes. The men in the first group denied they knew anything about Viagra, denied that they were interested in it, denied they knew anyone who might be interested in it, and denied that the topic of impotence could ever have anything to do with them. Given the statistics quoted earlier and the fact that impotence is generally a result of medical conditions such as diabetes, hypertension, or heart disease, this seems to be a classic case of psychological denial.

DISCUSSION

What is striking from the above conversations is that men do not talk about Viagra in casual conversation in any meaningful way. The first group demonstrates that even when urged to do so, no information was exchanged about the drug. What, then, was going on? Clearly, the participants' behavior was consistent. There was a pattern of exchange of information, but the information was about what the group norms were regarding sexual health and performance, not about Viagra itself. The norm was clearly understood and reiterated by the second group, who were in no position to say they knew nothing. As this group comprised men who were taking Viagra and who knew that the other participants were also attending the clinic, they had no option of denying knowledge. What then became interesting was whether they said that they had had knowledge prior to having erectile dysfunction. If they had no previous knowledge, it could be argued that the first group genuinely knew nothing. However, as they all said they had known about Viagra as a treatment for impotence and had read and heard about it over the past few years, it cast some doubt on what was actually going on in the first discussion.

Their reference to "macho" men emphasized this. These men clearly both recognized and regretted the fact that their problem must never be discussed with others if they want to retain their masculine image. There was a general feeling of sadness expressed that they would like things to be otherwise.

Cameron and Bernardes mentioned that one of their participants said that he had not discussed his impotence problems even with his GP, who he thought would "turn his head down in embarrassment" (1998, 683). Much of their qualitative analysis establishes similar themes of men not seeking help and the importance of masculinity relative to health. Our research suggests that men may be impeding the process of advances in their own health care by clinging to the macho stereotype. The importance of this image can be

exemplified by the researcher's observation that the first thing the participants from the clinic did on entering the seminar room for the discussion was to comment on the football match that was taking place that evening.

CONCLUSION

This study was only a small, exploratory project, the results of which seem to confirm the emphasis men place on their masculine image. What is needed is to develop studies in men's health areas to reach an understanding of the ways in which they may be encouraged to place more importance on their health than on their image. In this way, perhaps the numbers of men able to benefit from advances in impotence treatment will rise from the estimated 10 percent of sufferers reporting to their GP.

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Rona Rubin is a senior lecturer in the Department of Occupational Therapy at Canterbury Christ Church University College in the United Kingdom. She is a chartered psychologist, with particular interest in the health of mature adults. She has moved from researching women's experience at menopause to researching men's health in maturity and how this interacts with social expectations of masculinity. She has presented conference papers on both subjects at national and international levels. One recent publication is Attitude, Subjective Norm and Perceived Behavioural Control as Predictors of Women's Intention to Use Hormone Replacement Therapy.