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Chemistries of Love. Impotence, erectile dysfunction and Viagra in *Läkartidningen*

Abstract

This article examines the discourse surrounding impotence, erectile dysfunction and Viagra in the Swedish medical journal *Läkartidningen*. It draws on articles published from 1990 to 2006, the eight years prior to and after Viagra's 1998 introduction. Close reading of the articles has shown changes over this time period in how the impotent patient is defined. It has also revealed a transition in the discourse from the term impotence to erectile dysfunction. In these articles the role of the (female) partner in finding a solution to impotence and the social aspects of impotence also change dramatically once Viagra is available. Results from this study are contextualized against similar research that has examined the medical discourse around erectile dysfunction in the international arena.

Keywords

Impotence, erectile dysfunction, *Läkartidningen*, Viagra, medicalization

Chemistries of Love. Impotence, erectile dysfunction and Viagra in *Läkartidningen*[1]

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Medicalizing the aging male

The inability to achieve and maintain an erection has had many causes and many cures. Ancient Greeks attributed it to a diet of dry, cooling foods. During the European Middle Ages, impotency could be the result of a curse – dealt out by one's enemies, a witch or a slighted lover who tied knots in a string. Later, sexual excess, youthful indulgences, and masturbation were blamed. During the nineteenth century both a wife's aversion to sex and her desire for it could cause impotence, as well as a glimpse of her 'unattractive' female genitals. The stress of modern, urban living was (and still is) made a culprit. Then, of course, is the litany of Oedipal urges, domineering mothers, incestuous fixations, and the Freudian analysts needed to cure these. In the mid twentieth century, especially in the US, therapists looked to relationship issues for a cause and the point of treatment, while in a wider arena impotence was variously attributed to feminism, the sexual revolution, and the contraceptive pill. And most recently, impotence has become a vascular issue (for a cultural history of impotence, see McLaren 2007).

Tracing the changing expectations of men's potency and vitality in Europe and North America shows how male sexuality has, with time, become more and more medicalized. This is true of sexuality in general. It has slowly gained recognition as a field in medicine: conferences are being held about various aspects of sexuality, medical journals on the subject are sprouting up, medical schools are offering courses in sexuality and some are even opening entire departments in the field; doctors are being encouraged to speak with their patients about sexual histories during routine medical exams, and pharmaceutical solutions to sexual 'problems' help define these problems as medical (Fishman & Mamo 2001, 181; Tiefer 2006, 274f). At the same time, non-medical experts are flourishing, offering sexual advice on the Internet, radio talk shows and TV, in magazines and newspapers (Tiefer 2006, 275). But while female reproductive health has traditionally been a focus of medical intervention (see Martin 1992; Oudshoorn 1994; Dugdale 2000), for men it has been virility, with strength and vitality instead of reproductive capacity, that has long attracted medical attention (Sengoopta 2006; McLaren 2007).

Sexuality is not the only area of life to be medicalized, particularly through the development of pharmaceutical solutions to health problems. The process of medicalization is dependent on the social and technical networks within which people and diseases are placed. As Oudshoorn states, "health problems can only be classified as illness and be medicalized if there exists a cultural climate and a medical infrastructure that actively transforms health complaints into diseases" (Oudshoorn 1997, 143). Thus, solutions to problems like depression, anxiety, obesity, hair loss, and aging can become medical solutions when both the medical community and general population recognise them as such. This process is not uncontroversial, however, and the pharmaceutical solutions to obesity, hair loss and aging can be grouped together with the treatment for erectile dysfunction in the category of drugs sometimes called life style drugs (Mamo & Fishman 2001, 16; Elliott 2003; Loe 2004a; Moynihan & Cassels 2005). While some of these cures are addressing problems that most people would at least nowadays call diseases (like depression), the disease status of others is more contested and their development has spawned the term 'disease mongering' to denote the process of medicalization that uses medical practice and medical technologies to promote a concept of improvement unto perfection and the idea of medication for instant, scientific solutions for medical and psychological distress (see Fishman 2004, 193; Tiefer 2006, 274). Disease mongering not only serves the purposes of pharmaceutical companies looking for conditions that can fit their pharmaceutical cures, it also expands the areas of life that doctors can claim as their territory – and for which they can charge consultation fees and sell drugs.

Some of these life style drugs and diseases are related to a change in attitudes towards activity, sexual and otherwise, in older age. The concept of successful aging allows the medical community to offer medical solutions to health problems traditionally associated with aging, problems like hair loss, menopause and, as will be discussed in this article, erectile dysfunction. As the medical community claims these areas as their domain (rather than the domain of diet, witchcraft, anti-social behaviour or psychoanalysis, for example), the problems become diseases and the solutions are often decidedly medical, in the form of surgeries, drugs and physiological treatments. Because these solutions to aging are creating diseases out of changes during the life span, the idea of getting older successfully has been critiqued for promoting an idea of aging that really means not aging at all (Marshall 2006, 350). Viagra and its promise of returning male sexual performance to a youthful, erection-on-demand state, so that anyone can have sexual intercourse at anytime and any age is currently one of the most talked about treatments for successful aging.

This is a development that should be placed in the history of medicalized male vitality. In the early part of the 20th century, it was thought that the secret to masculine vitality was found in the sex glands, and much research about these glands, in both people and animals, was conducted (see Oudshoorn 1994; Marshall 2006; Sengoopta 2006). One of

the medical treatments developed during the 1920s (sometimes called the decade of the testicle because of the intensity of research into testicles during this time) to treat a loss of vitality in aging men was the Steinach operation. Developed by Austrian Eugen Steinach, and said to have been performed on both Freud and Yeats, the operation redirected fluid from the testicles to be reabsorbed into the body rather than released outside. This fluid was then thought to help revitalize the patients (Marshall 2006, 347; Sengoopta 2006; McLaren 2007).

In the 1930s and 40s, male rejuvenation treatments moved into more mainstream medical practices and began to reflect new knowledge about testosterone. Hormone therapy, i.e. testosterone treatment, was developed as a treatment for the 'male climacteric'. But again, the goal of treatment was general male vitality as displayed through physical and mental, but not necessarily sexual, prowess. In fact, increased sexual function was sometimes seen almost as an undesired and slightly embarrassing side effect of treatments (Marshall 2006, 347f).

In the middle of the 20th century, new research into sexuality and sexual behaviour changed the way sex and sexual dysfunction was perceived and treated. No longer was sexual decline in the male thought to be a natural part of aging. Experts asserted that sexual activity and sexual intercourse were important parts of healthy aging (Marshall 2006, 349). Impotence was thought to often be caused by a fear of impotence. It was perceived as something that could be avoided and treated through therapy, often involving the partner, rather than through biomedical interventions (Tiefer 2006, 283). During the middle of the century and up into at least the 1980s, it was generally agreed that in 80% of impotence cases the problem was psychological and therapy was the best treatment.

According to feminist sex therapist Tiefter (2006), the psychology based approach to sexuality in general and sexual dysfunction in particular changed during the 1980s. She notes that in the US, several different factors contributed to a shift. For one thing, the American Psychiatric Association (APA) decided to define sexual problems as disorders in performing a sequence of genital functions, which coincided with a broader acceptance of a biomedical and psychopharmacological model of mental health. At the same time, the APA manual and its definition of sexual (dys)function began to be used by the health insurance industry when determining which diseases would be eligible for reimbursement (Tiefer 2006, 283). Shortly thereafter, urology specialists also began to take on more sexual dysfunction cases, which served to cement the idea that impotence was a biophysical issue of the penis, and led to examinations and treatments for sexual dysfunction that did not include the involvement of wives or partners (Tiefer 2006, 285).

Thus, impotence, which only a decade before had been called a psychological problem with physiological results began to be seen as a physiological problem that could lead to psychological suffering (Marshall 2006, 350). The 1990s also saw other changes in the view of sexual dysfunction. Impotence became known as erectile dysfunction (ED), specifically

located in the penis. By the late 1990s, and largely thanks to research and advertising funded by Viagra's maker, Pfizer, the new reigning explanation for impotence stated that 70–80% of cases stemmed from physical causes, a direct reversal of the earlier ideas and one which supported medical consultations and prescription based solutions rather than behavioural therapy and couples counselling (Plante 2006, 379). Sexual function was no longer seen as a controversial side effect of anti-aging treatments, it was now the main goal.

The above narrative of impotence and ED within the US context is also relevant to what has happened in Sweden, though with a bit of delay on some points. To examine recent changes in this discourse in Sweden, I have analysed articles dealing with impotence and erectile dysfunction in the generalist medical journal *Läkartidningen*[2]. I have looked at the articles published in the eight years before and after Viagra's introduction in 1998. Doing so shows that the construction of impotence, erectile dysfunction and male sexuality in *Läkartidningen* in some ways follows very closely with how these ideas have been framed in the international medical community, despite the framework of socialized medicine within which *Läkartidningen* publishes and the debates about subsidies of Viagra which have surrounded its introduction to the Swedish market. For example, in *Läkartidningen* the discourse has moved from social causes of impotence to a focus on mechanical and molecular aspects of ED, as has also happened in English language journals. Reports in *Läkartidningen* from studies about impotence are also frequently linked to pharmaceutical funding after the introduction of Viagra, and there seems to be more column space granted to these discussions than there was before Viagra. However, at the very end of the time period analysed here, one study has been published in *Läkartidningen* which once again reaffirms that there are social aspects of ED that contribute to the individual's treatment options. This suggests that a broader definition and re-evaluation of male sexuality may be appearing in the Swedish discourse.

Below I will present my analysis drawn from a careful reading of the *Läkartidningen* articles. In examining the articles, I have looked at the construction of patients and symptoms associated with impotence, as well as the way that impotence and its cure(s) is/are defined and proposed by the authors. I have then contextualized this against results of similar analysis of the international discourse on impotence and ED. The articles studied have been found using the search words: impotence, impotence treatment, penis erection, erectile dysfunction, erectile difficulties, potency treatment, Viagra, and Sildenafil.[3] A total of thirty-six articles were sourced for the years 1990–2006. Twenty-eight of these were published after Viagra was introduced.

Impotent patients before and after Viagra

Prior to Viagra, impotence was presented in *Läkartidningen* as a combination of psychological and physiological conditions. It was also something 'natural'. This understanding

of the condition is reflected in an 1993 book review which asserts that, "Approximately ten percent of western men suffer from sexual difficulties associated with impotence, and if men can stay healthy and live long enough, they all become old-age-impotent"[4] (Mellgren 1993, 984). Old-age-impotence, my translation for *åldersimpotent*, can be read as a specific type of impotence, and one that seems to disappear from the discourse after the arrival of Viagra and the presentation of the term erectile dysfunction. Also of note is that this number, ten percent, is very low compared to Pfizer statistics that begin to appear with the introduction of Viagra. (On the Viagra website[5], ED is said to afflict over half of men over forty.)

Impotence, if natural, was, however, already a medicalized condition before Viagra arrived, though for fewer people. Pre-Viagra, impotence was also very complex in *Läkartidningen*. In an article about the causes of impotence from 1990, the authors spend an entire section speaking about feelings. They discuss the way men, particularly after not engaging in sex for a longer period of time, can want to have sex, but still not have sexual urges. They explain this by stating that, "many people interpret desire as the same thing as libido. But desire and libido are not the same thing"[6] (Olsson *et al.* 1990, 4456). Five year later, in an article written by two of the same authors from the 1990 article, the following quote shows how the pre-Viagra discourse even denied the feasibility and benefit of distinguishing between physical and emotional causes of impotence, something which Viagra relies upon. "To create a distinction between somatic and psychological cases of impotence has been shown to match poorly with reality. Instead, one must for every patient evaluate both biological factors and his feelings, his relationship to his partner, his family and work" (Olsson *et al.* 1995, 313).[7] Thus, pre-Viagra, impotence is a result of a combination of (mostly social and emotional) factors.

It is not just the number of impotent patients and the emotional causes of it that change through the 1990s in *Läkartidningen*; the definition of an impotent patient also proves to be flexible. In the above mentioned pre-Viagra article about impotence from 1995 (Olsson *et al.*), impotent patients are constructed as a heterogeneous group, within which one finds some patients who are easier to treat than others. Those most likely to respond successfully to treatments are men in long-term relationships, and when discussing them, this 'patient' is frequently spoken about as the couple. More difficult to treat are single men, of which the authors identify three types: the young, shy man; the older man who has been sexually inactive for a while; and the loner who is carrying a secret. Of these, the older, sexually inactive man is seen as the easiest to treat (Olsson *et al.* 1995, 314). This typology of patients is based on social factors, and focuses on the men's relationships with others, not on the biological or mechanical causes of impotence. Respect for the social aspects of impotence also appears when, in the same article, the authors discuss reasons why it can be difficult to treat impotent patients: because some impotent men can have rigid stereotypes about normal sexuality; they can find intimacy threaten-

ing; they think that sex is about performance and thus develop performance anxiety; they are unable to recognize their own emotional signals; they see the ability to have intercourse as a sign of power; and/or because some of them experience impotence as shameful (Olsson *et al.* 1995, 314). And, as the authors later go on to say, the most difficult thing to deal with as a doctor is the rage that some patients feel and can at times project upon the doctor when treating impotence.

After the appearance of Viagra, there are still types or groups of patients discussed in association with ED in *Läkartidningen*, but usually these are connected to individuals who have diseases whose symptoms can include, or whose treatments can induce, impotence, i.e. diabetes, multiple sclerosis, anxiety attacks, and heart disease. Thus patients are distinguished into categories based on medical diseases rather than social factors. This later discussion of the types of ED patients in *Läkartidningen* is probably triggered by the debates that were raging after the introduction of Viagra over whom should receive subsidies for the prescriptions of Viagra (see Landtblom & Ertzgaard 2000, Örn 2001). Using Viagra in these cases is presented as a solution to ED for patients with a legitimate need of the drug. I use the word legitimate because it is in these cases that the Swedish courts have heard arguments for and against the subsidized use of Viagra as a treatment for severe ED.[8]

Sexual Problems and Pharmaceuticals

From their studies of US cases, sociologists Mamo & Fishman note that prescribing drugs like Viagra can, in some cases, lead to and justify polypharmica (Mamo & Fishman 2001, 27). The occurrence of polypharmica is also taken up by *Läkartidningen*. Three years before the introduction of Viagra, the discussion of sexual difficulties and pharmaceuticals is raised in *Läkartidningen* in an article called 'Sex life and pharmaceuticals' (Lundberg 1995). In it, Lundberg discusses both how pharmaceuticals have been developed to treat sexual problems, and also how pharmaceuticals taken for other reasons can influence one's sex life. Thus, by 1995, use of pharmacological solutions to sexual problems was gaining acceptance within the Swedish medical community. But it also shows that the understanding of the concept sexual problems was very broad before Viagra. In this article, a great deal of time is spent discussing the influence of other drugs (i.e. dopamine and serotonin blockers) on desire rather than on the mechanical ability to have sex, both for men and women. Most interestingly, however, is the way that sex is defined more widely than it often is in post-Viagra discussions. For example, sex is presented as involving not just intercourse but also orgasms, even for women. And after noting that serotonin blockers can make orgasm difficult for women, the author states, "There are, however, few reports of orgasm difficulties in men using this type of antidepressant. We do not know if there is a sex-specific difference or if the problem is hidden in men because of the

difficulties in differentiating between ejaculation and orgasm" (Lundberg 1995, 2745).[9] The idea that men could experience ejaculation without orgasm is completely absent from any later discussions of Viagra, as is the possibility of having an erection without ejaculation. But in the 1995 article, a nuanced way of discussing pharmaceuticals and sexual health is presented, one that involves desire, ability and pleasure. Much of this nuance is lost with the arrival of Viagra, and discussions about libido and desire also tend to disappear in the literature about ED, in *Läkartidningen* and other medical journals, despite the fact that the makers of Viagra insist that it will not produce an erection without sexual stimulation. But, as many social scientists and critics have noted about Viagra in general, it relies on the traditional understanding of male sexuality, that men *always* want sex (see Fishman & Mamo 2001, 183; Loe 2004b; Mamo & Fishman 2001, 23; Marshall 2002, 2006; Tiefer 2006).

Returning to the discourse in *Läkartidningen*, libido only appears in connection with impotence post-Viagra in the 2004 column 'Pharmaceutical questions' (Kimland & Ståhle 2004), which is a brief compilation of topics discussed at regional pharmaceutical information centres. There, in 2004, the terms libido and impotence appear together when reporting a study that examined these in connection with the use of Lithium (as the 1995 Lundberg article did when talking about sexual problems and pharmaceuticals). But this mention can be read as a special case dealing with the effects of a different drug rather than the use of Viagra for a wider population.

Pharmaceuticals and Erectile Dysfunction

Pharmaceutical solutions for impotence existed prior to Viagra's arrival in 1998, though most of these involved needles or catheters inserted directly into the penis and were therefore not as easy to administer as a pill. However, in a *Läkartidningen* article from 1997 (Hedelin & Abramsson), the use of orally ingested medicine for erectile dysfunction is discussed and their pending introduction to the market predicted. In this article, the term erectile dysfunction[10] is first used in *Läkartidningen*, rather than impotence.[11] With this term, the discussion is shifted to the mechanical aspects of blood flow, vascular systems and muscle cells. Men have 'erectile difficulties' and these can be treated. The authors start the article with the statement, "The ability for a man to have an erection that facilitates intercourse and insemination is a prerequisite for the continuation of the human race" (Hedelin & Abramsson 1997, 2548),[12] and then go on to discuss various possibilities for treatment to be subsidised by the Swedish state, a discussion that later takes on enormous proportions in *Läkartidningen* (Hedelin 1998; Sjöstrand 1998; Beerman 2000; Byström 2000a, 2000b; Landtblom & Ertzgaard 2000; Landtblom 2004; Ströberg, Hedelin & Bergström 2006).[13]

In 1998, Viagra appears in *Läkartidningen*, with articles about the drug itself and about the way it is being received in the USA (Bergström 1998; Branke 1998), its introduction to Sweden, specifics of its use, and questions of its costs to the individual and society (Hedelin 1998), and warnings that it is being sold illegally through the mail (Aldstedt 1998). It is at this point that impotence, which in the 1990 and 1995 articles was broadly defined, often with social causes, and which occurred in many different types of patients, including couples, is now directly equated with ED. The article 'New Treatment for Impotence,'[14] written by the above mentioned urologist Hans Hedelin, articulates this discursive coupling when he writes in the introduction of his 1998 article, "Erectile dysfunction (impotence), that is the inability to achieve and maintain an erection for a sufficiently long period for sexual activity, is the most common form of sexual functioning problems" (Hedelin 1998, 4558).[15]

To better contextualize his use of the term erectile dysfunction, it is important to note that the discursive sliding between, and in some cases conflation of, impotence and ED has a history outside of the Swedish context, largely in the field of urology and closely connected to the development of pharmaceutical therapies. Social scientist Barbara Marshall, in her work on Viagra, relays the story of how Dr. Giles Brindley in 1983, and in front of an audience of medical peers, injected his penis with phenoxybenzamine and obtained an erection, essentially removing the connection between emotional or tactile stimulation and erection. Ten years later, in 1993, the US National Institute of Health created consensus around the use of the term erectile dysfunction (Marshall 2002, 136). In Sweden, in the 1998 Hedelin article, erectile dysfunction becomes equated with impotence in *Läkartidningen*.

Susan Bordo claims that impotence as a term reflects a characteristic of the person, not a disease – one says of a man, 'he is impotent' while one would not say 'he is a headache' (Bordo 1998, 87). And, as Loe (2004a) has noted, the shift in English from impotence to ED can be quite comfortable for the individual. ED allows the man to maintain his identity and self untainted, and only treat the penis. Potts notes this as well, that "This term [impotence] infers that a man loses power through his 'failure' to achieve an erection, and demonstrates how important a notion of 'potency' is in constructions of conventional masculine sexuality. Consequently, an inability to produce erections may be perceived as tantamount to a destruction of the male self" (Potts 2004, 23). With the introduction of ED and Viagra, a pill and a medical term exist that can prevent damage to the individual and erase blame for the failure to produce an erection on demand (Haiken 2000, 404). These comments on terminology are also applicable to the Swedish usages of impotence and ED.

Another interesting observation in connection with the use of the term erectile dysfunction is that, in the 1998 *Läkartidningen* article, Hedelin asserts that ED is 'the most common form of sexual function problems' around the world. This is a statement that

was very common in 1998, internationally. That ED became the most common form of sexual function problem just when a medicine to cure it was introduced, has been discussed elsewhere in relation to medicalization and biomedicalization (Elliott 2003; Loe 2004a; Mamo & Fishman 2001, 16; Moynihan & Cassels 2005). In *Läkartidningen*, articles thereafter spend a great deal of time talking about the physiology of erections, their molecular and biological aspects, and very little, if any time discussing counselling, couples therapy and the social or relationship issues related to impotence.

Perhaps most indicative of the direction articles about impotence and ED in *Läkartidningen* took after the introduction of Viagra is the (2000) article 'Viagra is the first option for treating erectile dysfunction,'[16] co-authored by urologist Hans Hedelin (who defined erectile dysfunction as impotence above) and Pfizer employee Lena Jacobsson (2000). In this article they discuss a study which compared treatments in Sweden for ED. Gone from this study are all questions about the emotional or social aspects of impotence, or even the fact that sexual problems can take other forms than ED. Instead the study only focuses on how ED can be treated pharmacologically. The authors start their article by stating, "In the last few years different methods to successfully treat erectile dysfunction (ED) have appeared, methods which work largely unrelated to the cause of the erectile problems and which demand a minimum of evaluation before the treatment can be initiated" (Hedelin & Jacobsson 2000, 2616).[17] Thus, the treatment for ED (which impotence had become) is suddenly a relatively simple procedure, rather than one which, as suggested in a 1995 article, demands an empathetic doctor who can give hope and understanding, and who can spend sufficient time with the patient to discuss his/their problems, often over a period of several consultations (Olsson *et al.* 1995, 313). Likewise, in articles appearing prior to Viagra, references to alternative treatments like self-injections to the penis and the use of penis pumps and surgical implants appear, but these were often suggested as later-stage complements to couples therapy (see Olsson *et al.* 1995). This is particularly true with the penis implant, which is discussed with the warning, "Those patients who expect that an implant will not only create erections but also improve their relationship with their partner and bring them closer to a harmonic life are often disappointed" (Olsson *et al.* 1995, 316).[18] However, this is exactly what Viagra promises, as noted in a 1998 article in *Läkartidningen*, which argues for subsidies for Viagra because its use cures two patients, not just one, i.e. also the partner of the man suffering from ED (Sjöstrand 1998). Potts *et al.* (2006) have shown how this idea is also prevalent in English language commercials for Viagra.[19]

That this shift in the use of the term impotence to ED occurs in *Läkartidningen*, and that these post-Viagra articles are written largely by urologists is not unique. It is in line with what has occurred in other journals and media outlets internationally. As Tiefer notes in her critique of the English language use of the term, "erectile dysfunction, a condition in the man's genitalia, has become the only acknowledged focus of interest, focus

of evaluation, and focus of treatment. This represents a substantial narrowing from sex therapy – erasing the partner, erasing subjective meaning, and, ironically, perpetuating the obsession with penile hardness which many sex therapists have argued is itself a primary cause of sexual unhappiness" (Tiefer 2000, 278).

Examples of the same refocusing of the discourse in Sweden can be seen happening in *Läkartidningen*. Prior to Viagra, mention is made of another closely related sexual problem: premature ejaculation (Olsson *et al.* 1990). But after Viagra, this problem is not discussed again in connection with sexual difficulties until 2006, when a notice about a new drug treatment is presented (Hansen 2006), and in which it is mentioned that 20–30 percent of men suffer from premature ejaculation. (Compare with the pre-Viagra book review that states an estimated 10% of men suffer from impotence (Mellgren 1993).) This seems to confirm Marshall's assertion, drawn from her analysis of English language articles about Viagra, that "even though premature ejaculation (an 'orgasmic disorder') has higher prevalence rates than 'erectile dysfunction' in many studies, we do not hear of an 'epidemic' of premature ejaculation" (Marshall 2002, 137). Viagra has shifted the focus onto ED, and redirected attention away from other sexual difficulties, including early ejaculation and a lack of libido, internationally and also in the Swedish medical discourse.

The impotent man, the partner patient and a woman's responsibility

Before Viagra, in several of the *Läkartidningen* articles about impotence, the patient is presented as the partner unit. For example, in an article from 1995, the roles of each partner in dealing with impotence are narrowly defined. "Conversation with the couple is the most important diagnostic and therapeutic instrument. One should strive to work with the couple rather than the man alone, though one should never try to force the partner's cooperation. Men and women have different ways of expressing themselves and therefore misunderstandings can easily arise. Women must learn to be clearer and men to be more receptive" (Olsson *et al.* 1995, 313).[20] In addition to charging each partner with a specific way of communicating and the responsibility to change this, the article also notes that, "The best help for a man with disappointing erections is, besides his own courage to speak about it, an understanding and sensual partner who is sexually keen but not demanding" (Olsson *et al.* 1995, 314).[21] Though, as the authors go on say, "of course, this isn't always enough" (Olsson *et al.* 1995, 314).[22]

The couple-patient is also present when talking about other sexual problems pre-Viagra, as here, when discussing early ejaculation: "Naturally, the sexual act can easily be a failure in these situations unless the female partner is wise and possibly experienced, and can focus primary attention on physical contact and intimacy, and reduce the importance of genital contact" (Olsson *et al.* 1990, 4456).[23] The woman is charged with respon-

sibility for ensuring that the sexual act is a success, despite the man's sexual problems. This is slightly different than when speaking about impotence as a partner issue or presenting the impotent patient as a partner constellation. Instead, the solution to the sexual problem is in the hands of the female partner. This same shift of responsibility for curing the patient occurs in the discussion about (male) libido. When expanding on the difference between desire and libido, and their relationship to impotence, the authors state that, "Naturally, even here the female partner's behaviour is very important" (Olsson *et al.* 1990, 4456).[24] Also of note is the distinct sense that impotence only occurs in heterosexual relations. And, as the discussion about men and women's communication issues above implies, not only is the patient a heterosexual couple, it is a couple with very stereotypical, gender-specific interaction patterns.

In 1998, after the introduction of Viagra, the definition of the patient with ED shifts from the couple to the man in *Läkartidningen*. The only article which suggests the presence of a female Viagra patient is the aforementioned 1998 article which argues that the debate about whether or not to subsidize Viagra should take into consideration that the pill helps two patients, not one (Sjöstrand 1998).[25] Other than this aside, however, the post-Viagra ED patient is primarily the man prescribed the pills, and often only the genitals of that man.

The assumption of heterosexual patients in the Swedish case is not unique and mirrors a wider heteronormativity in the English language discussions about Viagra and impotence, this despite the widespread use of Viagra within homosexual communities, and despite the use of the gender neutral term 'partner' in Pfizer advertising. For further discussion, see McLaren 2007; Vares & Braun 2006.

Re-opening the debate

It is not until the very end of the period studied that the partner-patient of ED appears again in the post-Viagra *Läkartidningen*. In 2006 the partner becomes one of the people who should be asked about evaluation of the treatment and one of the reasons patients chose to discontinue treatment (Ströberg, Hedelin & Ljunggren 2006, 1107). While the integration of the partner in the discourse can be related to his/her presence in the pre-Viagra articles, this is a somewhat new role for the partner. Rather than being part of the cure, as in the articles from the early 1990s, now the partner is part of the wider context that influences a patient's decision to follow a medical cure. It is also in this 2006 article that the social factors behind ED are finally re-introduced to the discourse, after having been absent for eight years. In the discussion about the discontinuation of pharmaceutical treatments for ED, the results of the Pfizer-funded study showed that over half of the patients prescribed Sildenafil stopped using it within two years. To explain this, the authors report that, "Often the reasons are multi-factoral and factors like increasing age, di-

minished libido, relationship problems, health problems, social and cultural background all together can influence the decision to stop treatment" (Ströberg, Hedelin & Bergström 2006, 2866).[26] Issues concerning the physiology of ED were not the only, or even primary, answers they received from patients. This article in *Läkartidningen* shows that when a study is conducted which actually asks Viagra patients about their experiences and the reasons for their use or disuse of the drug, a disjuncture of the drug's patients and their medically prescribed sexual identities and practices begins to (re)appear.

That international research about the use of pharmaceutical treatments for ED is focused on biological, mechanical or molecular aspects of erections has been noted. As Teifer wrote in 2000, "There's little attention to the person or couple attached to the penis, or recognition that relational factors might modify the meaning or importance of penile rigidity or sexual intercourse in a couple's sexual script. It would appear that industry-sponsored research wishes simply to wave away the complexities introduced by the psychosocial context of sexuality" (Tiefer 2000, 278). As an example of medicalization, the case of Viagra before the 2006 study complicates the typical assumption that medicine is trying to constantly expand the domain over which it reigns. The examples of medical intervention for impotence in the pre-Viagra articles in *Läkartidningen* suggest that doctors were willing to intervene in the biomedical and social aspects of their patients' sexuality. After Viagra's appearance, medical intervention is narrowed to biomechanical functions of a man's penis, a narrowing which runs counter to some expected processes of medicalization, even as it predictably tries to confine the condition to one disease with a universal treatment.

This tendency makes the Pfizer funded Ströberg, Hedelin & Bergström (2006) study in *Läkartidningen* even more noteworthy, as it perhaps suggests that Viagra has not successfully reduced impotence to ED. Their article reopens the discussion of factors that can influence sexual health and simultaneously remedicalizes the larger context of the patient's sexual health. Perhaps it also signals a return to a more nuanced discussion of sexual problems and their treatments within *Läkartidningen*.[27]

Acknowledging that there may be diverse reasons for patients to discontinue treatment with Viagra and the other medications similar to it may lead the medical discourse to include aspects from the early 1990s, i.e. recognition that there are different types of patients who have different reasons and understandings of their impotence, along with the existence of a pill. This may even lead to acknowledgement that there is no one-size-fits-all cure. By comparison, it is relatively uncomplicated to assert that women's sexualities are complex and context dependent, and that they are influenced by feelings and emotions, even with older women (see for example Loe's (2004b) study). I can hope that this most recent article in *Läkartidningen* is a sign that soon Swedish men, too, will also be granted the right to (once again) own a complicated and context dependent sexuality that is influenced by feelings, emotions, and social situations, not just kicked into action

with a drug. And perhaps in future articles there will even be authors brave enough to reiterate a statement that seemed, if somewhat cheesy, also entirely logical in 1990, eight years before the arrival of Viagra to the scene: that when dealing with impotence, "The chemistry which is called love should not be forgotten, either" (Olsson *et al.* 1990, 4456).[28]

References

Aldstedt, Eva. 1998. Viagra säljs olagligt via postorder. *Läkartidningen* Vol. 95(51–52):5859.

Beerman, Björn. 2000. Rabattering är en politisk fråga. *Läkartidningen* Vol. 97(8):870.

Bergström, Leif. 1998. Potensmedel tar USA med storm. *Läkartidningen* Vol. 95(25):2927–2929.

Bordo, Susan. 1998. Pills and Power Tools. *Men and Masculinities* Vol. 1(1):87–90.

Branke, Karlis. 1998. Allehanda om Parjehanda. En personlig reflektion äver USAs nya potensdebatt. *Läkartidningen* Vol. 95(25):3016.

Byström, Jan. 2000a. Impotensmedicin på "nöjeskontot"?. *Läkartidningen* Vol. 97(3):214.

Byström, Jan. 2000b. Visst rekommenderar Läkermedelsverket. *Läkartidningen* Vol. 97(8):870.

Dugdale, Anni. 2000. Intrauterine Contraceptive Devices, Situated Knowledges, and the Making of Women's Bodies. *Australian Feminist Studies* Vol. 15(32):165–176.

Elliott, Carl. 2003. *Better than Well. American Medicine Meets the American Dream*. New York: W.W. Norton and Company.

Fishman, Jennifer and Laura Mamo. 2001. What's in a Disorder: A Cultural Analysis of Medical and Pharmaceutical Constructions of Male and Female Sexual Dysfunction. *Women & Therapy* Vol. 24(1/2):179–193.

Gunnarsdotter, Sara. 2005. Erektil dysfunktion kan tyda på hjärt-kärlsjukdom. *Läkartidningen* Vol. 102(36):2458.

Hansen, Anders. 2006. Nytt preparat mott för tidig utlösning. *Läkartidningen* Vol. 103(40):2943.

Hedelin, Hans and Leif Abramsson. 1997. Vem Skall Behandla Erektil Dysfunktion?. *Läkaretidningen* Vol. 94(28–29):2548–2552.

Hedelin, Hans. 1998. Nytt medel mot impotens. *Läkartidningen* Vol. 95(42):4558–4560.

Hedelin, Hans and Lena Jacobsson. 2000. Viagra förstahandsmedel mot erektil dysfunktion. *Läkartidningen* Vol. 97(21):2616–2617.

Johnson, Ericka and Cecilia Åsberg. (forthcoming). Imaging the Swedish Viagra Man.

Kimland, Elin and Lars Ståhle. 2004. Läkemedelsfrågan. *Läkartidningen* Vol. 101(10):910.

Landtblom, Anne-Marie and Per Ertzgaard. 2000. Tillståndet – inte läkemedlet – ska avgöra frågan om subventionering. *Läkartidningen* Vol. 97(21):2612–2614.

Landtblom, Anne-Marie. 2004. Stöd permanent rabatt av Viagra och Cialis vid MS!. *Läkartidningen* Vol. 101(35):2666–7.

Loe, Meika. 2004a. *The rise of Viagra: How the Little Blue Pill Changes Sex in America*. New York: New York University Press.

Loe, Meika. 2004b. Sex and the Senior Woman: Pleasure and Danger in the Viagra Era. *Sexualities* Vol. 7(3):303–326.

Lundberg, P.O. 1995. Sexualliv och Läkemedel. *Läkartidningen* Vol. 92(28–29):2742–2747.

Mamo, Laura and Jennifer Fishman. 2001. Potency in All the Right Places: Viagra as a Technology of the Gendered Body. *Body & Society* Vol. 7(4):13–35.

Marshall, Barbara. 2002. 'Hard Science': Gender Constructions of Sexual Dysfunction in the 'Viagra Age'. *Sexualities* Vol. 5(2):131–158.

Marshall, Barbara. 2006. The New Virility: Viagra, Male Aging and Sexual Function. *Sexualities* Vol. 9(3):345–362.

Marshall, Barbara and Stephen Katz. 2002. "Forever Functional" Sexual fitness and the Aging Male Body. *Body & Society* Vol. 8(4):3–70.

Martin, Emily. 1992. *The woman in the Body: A Cultural Analysis of Reproduction*. Boston: Beacon Press.

McLaren, Angus. 2007. *Impotence. A Cultural History*. Chicago and London: University of Chicago Press.

Mellgren, Arne. 1993. Ny behandling of impotens review of the book *Psychosomatik der Impotenz* by D Langer, U Hartmann. *Läkartidningen* Vol. 90(10):984.

Moynihan, Ray and Alan Cassels. 2005. *Selling Sickness. How Drug Companies are turning us all into Patients.* Crows Nest Australia: Allen & Unwin.

Olsson, Arne M, Lillemor Forsberg, Torvald Höjerback, Annalisa Nilsson. 1990. Impotens på grund av arteriell insufficiens kan ha funktionella orsaker. *Läkartidningen* Vol. 87(51–52):4456.

Olsson, Arne M., Leif Abramsson, Torvald Häjerback, Lars Malmberg, Jörgen Pedersen. 1995. Är det Möjligt att bota impotens?. *Läkartidningen* Vol. 92(4):313–316.

Oudshoorn, Nelly. 1994. *Beyond the natural body: an archaeology of sex hormones.* London: Routledge.

Oudshoorn, Nelly. 1997. Menopause only for women? The social construction of menopause as an exclusively female condition. *Journal of Psychosomatic Obstetrics and Gynecology* Vol. 18:137–144.

Plante, Rebecca. 2006. Review of Loe, Meika, *The rise of Viagra: How the Little Blue Pill Changes Sex in America*. *Sexualities* Vol. 9(3):379–380.

Potts, Annie. 2004. Deleuze on Viagra (Or, What can a 'Viagra-Body' Do?). *Body & Society* Vol. 10(1):17–36.

Potts, Annie, Victoria Grace, Tiina Vares, Nicola Gavey. 2006. 'Sex for Life'? Men's counter-stories on 'erectile dysfunction', male sexuality and ageing. *Sociology of Health & Illness* Vol. 28(3):306–329.

Potts, Annie and Leonore Tiefer. 2006. Introduction. *Sexualities* Vol. 9(3):267–272.

Sengoopta, Chandak. 2006. *The Most Secret Quintessence of Life.* Chicago and London: The University of Chicago Press.

Sjöstrand, Magdalena. 1998. Förbättring av erektionssvikt oftast bra för *två* personer!. *Läkartidningen* Vol. 95(46):5139.

Ströberg, Peter, Hans Hedelin and Christina Ljunggren. 2006. Behandling av erektil dysfunktion med PDE-5-hämmare. *Läkartidningen* Vol. 103(14):1107–1111.

Ströberg, Peter, Hans Hedelin, Annbritt Bergström. 2006. Sex – bara för rika och friska?. *Läkartidningen* Vol. 103(39):2865–6.

Tiefer, Leonore. 2000. Sexology and the Pharmaceutical Industry: The Threat of Co-optation. *The Journal of Sex Research* Vol. 37(3):273–283.

Tiefer, Leonore. 2006. The Viagra Phenomenon. *Sexualities* Vol. 9(3):273–294.

Vares, Tiina and Virginia Braun. 2006. Spreading the Word, but What Word is That? Viagra and Male Sexuality in Popular Culture. *Sexualities* Vol. 9(3):315–332.

Örn, Peter. 2001. Fler får dispens för läkemedel mot fetma. *Läkartidningen* Vol. 98(47):5294.

Notes

1 Portions of this paper were presented at the 'Manlighetskonferens' Linköping University, 30 November 2006. The author would like to thank Boel Berner, Anders Persson, Göran Sundqvist and the anonymous reviewers for their helpful suggestions.

2 *Läkartidningen* is the trade journal of the Swedish Medical Association (*Läkarförbund*). It is published about once a week and covers international and Swedish developments in medicine and medical care.

3 In Swedish: *Impotens, impotensmedel, peniserektion, erektil dysfunktion, erektil svårigheter, potensmedel, Viagra, Sildenafil.*

4 "Ungefär 10 percent av västerländska män anses lida av sexuella störningar av impotenstyp, och får männen bara vara friska och leva tillräckligt länge blir alla åldersimpotenta" (Mellgren 1993, 984).
5 www.viagra.com (4 August 2007).
6 "Att ha längtan tolkar många som att man har libido. Längtan och libido är dock inte samma sak" (Olsson *et al.* 1990, 4456).
7 "Att försöka göra en uppdelning i somatiska och psykogena fall har visat sig stämma illa med verkligheten. Istället måste man hos varje patient värdera såväl biologiska faktorer som mannens känslor i sammanhanget och hans relationer till partner, familj och arbete" (Olsson *et al.* 1995, 313).
8 A final ruling by the Swedish Supreme Administrative Court, 14 March 2008, decided against subsidizing Viagra, even in cases of severe ED.
9 "Det finns däremot få rapporter om orgasmsvårigheter hos män med denna typ av antidepressiva. Här vet vi ej om det föreligger en könsspecifik skillnad eller om problemet är dolt hos män på grund av svårigheterna att skilja på begreppen ejakulation och orgasm" (Lundberg 1995, 2745).
10 Much later, in 2005, an interesting shift is made when erectile dysfunction, which had been a side effect of some diseases, also becomes a symptom. *Läkartidningen* reported that erectile dysfunction may be a symptom of undiagnosed heart disease and encouraged doctors who have a patient with ED to find out if that patient actually has heart disease (Gunnarsdottar 2005).
11 Erectile dysfunction was used by Masters and Johnson in the 1950s (McLaren 2007, 221). However, it was generally not taken up by the medical community until adopted by urologists and popularized by Pfizer (see Loe 2004a; Marshall 2002).
12 "Förmågan hos mannen att få en penil erektion som tillåter samlag och befruktning är en förutsättning för släktets fortbestånd" (Hedelin & Abramsson 1997, 2548).
13 The discussion and debate surrounding subsidizing of Viagra within the nationalized health care system in Sweden received much coverage in *Läkartidningen*. Analysis of this debate, both in *Läkartidningen* and general media warrants a separate study.
14 *Nytt medel mot impotens*
15 "Erektions dysfunktion (impotens), dvs bristande förmåga att få och behålla erektion under tillräckligt lång tid för sexuell aktivitet, är den vanligaste formen av sexuell funktionsrubbning" (Hedelin 1998, 4558).
16 'Viagra Förstahandsmedel mot erektil dysfunktion' (Hedelin & Jacobsson 2000).
17 "Under de allra senaste åren har flera olika metoder att framgångsrikt behandla erektil dysfunktion (ED) tillkommit, metoder som fungerar i stort sett oberoende av orsaken till erektionsproblemen och där det krävs ett minimum av utredning innan behandlingen initieras" (Hedelin & Jacobsson 2000, 2616).
18 "De som förväntar sig att implantatet, förutom att skapa erektion, också skall förbättra relationen till partnern och återföra dem till ett harmoniskt samliv blir ofta besvikna" (Olsson *et al.* 1995, 316).
19 See Johnson and Åsberg (forthcoming) for an analysis of this in Swedish language Pfizer funded websites.
20 "Samtalet med paret är det viktigaste instrumentet för diagnostick och terapi… Man bör sträva efter att arbeta med partet snarare än med mannen ensam, men aldrig försöka tvinga med partnern. Män och kvinnor har olika sätt att uttrycka sig och därför uppstår lätt missförstånd. Kvinnor måste lära sig att bli tydligare och män att bli mer lyhörda" (Olsson *et al.* 1995, 313).
21 "Den bästa hjälpen för en man med sviktande erektion är, förutom det egna modet att våga prata om problemet, en förstående och sensuell partner, som är sexuellt intresserad men inte krävande" (Olsson *et al.* 1995, 313).

22 "Detta räcker naturligtvis inte alltid" (Olsson *et al.* 1995, 314).
23 "Naturligtvis kan den sexuella akten i denna situation lätt bli ett misslyckande om inte den kvinnliga partner är klok och kanske erfaren, och kan få den kroppsliga närheten och intimiteten att bli det primära och därmed minska vikten av den genitala kontakten" (Olsson *et al.* 1990, 4456).
24 "Naturligtvis har den kvinnliga partners agerande även här största betydelse" (Olsson *et al.* 1990, 4456).
25 See Loe 2004b for an analysis of senior women in the US and the drug.
26 "Oftast är orsaken multifaktoriell, och faktorer som stigande ålder, minskande libido, relationsstörningar, sviktande hälsa, socialt och kulturellt ursprung påverkar tillsammans beslutet om behandlingsavbrott" (Ströberg, Hedelin & Bergström 2006, 2866).
27 The search words presented no articles about impotence during 2007.
28 "Den kemi som kallas kärlek skall heller inte glömmas bort" (Olsson *et al.* 1990, 4456).

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