PSYCHD

"If I've Got the Solution in my Pocket, Why do I Need to Talk About it?"

Young Men's Experiences of Using Pills like Viagra to Manage Erection Difficulties, an Interpretative Phenomenological Analysis

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“If I’ve Got the Solution in my Pocket, Why do I Need to Talk About it?": Young Men’s Experiences of Using Pills like Viagra to Manage Erection Difficulties, an Interpretative Phenomenological Analysis

By

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Contents

Abstract

Aim: Erection difficulties (ED) are predominantly considered in medicine as secondary to physical illnesses associated with aging. Current NICE guidelines suggest treating all cases of ED with pills called phosphodiesterase 5 inhibitors (PDE-5is) which increase blood-flow to the penis, regardless of suspected cause. However, recent research suggests growing numbers of younger men are seeking treatment for ED which appears to be primarily psychological in origin. This study responds to the current absence of any qualitative research into this population. It examines how ED is experienced by younger men and considers whether PDE-5is, which target ED at a purely biological level, are suitable for this population.

Method: Semi-structured interviews were conducted with six men under 40 who had used PDE-5is to manage ED. Data was analysed using Interpretative Phenomenological Analysis (IPA).

Results: Three superordinate themes were identified: "Anxious Preoccupation with Sexual Performance", "Concerns About Viagra Dependence" and "Struggles with Communication". Participants experienced considerable anxiety regarding the social and psychological consequences of poor sexual performance, using PDE-5is to protect against these feared outcomes. However, using PDE-5is often introduced new psychological complications, including a pull towards dependence and a felt sense of alienation from "natural" sex. Participants reported struggling to discuss their difficulties with others but found opportunities to do so highly beneficial.

Implications: These results call into question the suitability of PDE-5is for younger men with ED, challenging NICE guidelines and raising ethical questions about their current ease of access. They suggest that more research into possible alternatives such as psychological interventions is required. They also indicate that a greater number of opportunities for open communication about sexual

difficulties would be beneficial for younger men, calling for policymakers and practitioners to respond accordingly.

1 Introduction

1.1 Chapter Overview

This chapter serves as an introduction to the recent history of Western understandings and interventions for erection difficulties (ED). In situating these within different trends of conceptualisation, it examines some of the tensions between psychological, biomedical, and social-constructionist frameworks, and how these have shaped today's treatment landscape.

1.2 A Brief History of the Treatment Landscape for Erection Difficulties

ED has been conceptualised in a multitude of ways depending on the historical moment. Historically termed *impotence*, denoting an absence of sexual power, attempts to restore and strengthen erections are recorded as early as the seventh century BCE (McLaren, 2008). Much of Western history saw metaphysical explanations treated with herbal and spiritual remedies, until the 17th and 18th centuries paved the way for current scientific approaches focussing on physiological and psychological explanations (Berry, 2013).

Today, ED is primarily conceptualised biomedically within the field of urology. Studies of global prevalence vary widely due to discrepancy in diagnostic definitions and tools, so ED is thought to impact anywhere between 3–76.5% of men at some point in their lives (Kessler et al., 2019). Given the diagnostic label *erectile dysfunction* in the ICD-11 (World Health Organisation, 2019), it is regarded as a discrete physical symptom secondary to diagnoses which restrict blood flow to the penis. Many of these diagnoses increase with age, including cardiovascular problems (Raheem et al., 2017), diabetes (Deepak & Patil, 2020), hypertension (Ning & Yang, 2017) and endocrine disorders (Soran & Wu, 2005). Indeed, increasing age is the strongest predictive factor (Schreiber, 2019) meaning existing literature is weighted heavily towards studies involving older men (Landripet & Stulhofer, 2015). ED with a predominant physiological aetiology is labelled *organic*, and medical treatments include

phosphodiesterase 5 inhibitors pills (PDE-5is) like Pfizer's sildenafil citrate product *Viagra*, vacuum pumps and inflatable implants, all aimed at restoring physical function.

However, even within disciplines which privilege physiological understandings, many cases are recognised as being psychological in origin (Aghighi et al., 2015). Such instances are termed *psychogenic* and defined by their "situational" character, occurring only during partnered sexual scenarios, with anxiety thought to play a central role in arousal disruption (Masters & Johnson, 1970). Psychological factors are thought to contribute to a substantial number of cases in combination with organic factors (Pollets et al., 1999; Pustuszak, 2014), meaning multiple contributing factors are often interlinked and difficult to disentangle (Kessler et al., 2019).

Because of this recognised psychological component, *erectile dysfunction* has a psychiatric diagnosis in the DSM-5, defined as the recurrent inability to maintain an adequate erection during partnered sexual activities (American Psychiatric Association, 2013). Indeed, psychological formulations with a focus on intrapsychic and relational contributing factors predate the biomedical interventions of today's treatment landscape (Berry, 2013).

Psychological understandings of ED are particularly relevant when it comes to younger men, the subject of this study, for whom ED is understood as being predominantly psychological in origin (Rastrelli & Magi, 2017). The following section will therefore set out the main psychological formulations and treatments for ED, examining their evidence base in comparison with dominant, biomedical interventions.

1.2.1 *Sex Therapy*

For most of the twentieth century, psychological interventions were the primary mode of conceptualising and treating ED, regardless of age (Berry, 2012; Loe, 2004). Following the sexual revolution and feminist movement of the 1960s and '70s, sexual research and therapy grew in popularity (McLaren, 2007). Masters and Johnson's modality of sex therapy (1970) emerged from this

period, formulating ED as being caused by *performance anxiety* (PA), whereby preoccupation with the quality of sexual performance interrupts physiological arousal. PA leads to *spectatoring* — anxiously evaluating sexual performance, causing distraction from erotic cues and diverting attention from the enjoyment of sexual stimuli.

Central to treatment is a course of *sensate focus* exercises: the gradually staged receiving of erotic touch with penetration explicitly avoided. Exercises aim to re-sensitise couples to enjoy erotic interactions with PA removed, with a secondary goal of expanding the couple's sexual repertoire beyond intercourse alone. Helen Singer Kaplan advanced these ideas in *The New Sex Therapy* (1974), combining sensate focus with the psychoanalytic idea that early experiences associating shame, guilt, or anxiety with sex could give rise to ED-inducing anxieties. Kaplan also sought to examine and alter destructive interpersonal couple dynamics.

A clear limitation of these approaches is that they require a partner. Masters and Johnson sought to overcome this with surrogate-assisted sex therapy. However, this was abandoned for the legal and ethical complexity of paying surrogates for a sexual service within the therapeutic process (Freckleton, 2013). The lack of accommodation for single men therefore remains a major shortcoming. Nevertheless, they remain highly influential, with most psychological interventions for ED involving some variation on sensate focus, as well as examining how interpersonal interactions and intrapsychic conflicts contribute to ED-inducing anxieties.

1.2.2 *Cognitive Behavioural Therapy*

Throughout the 1980s, David H. Barlow and colleagues combined cognitive theory with the concepts of PA and spectatoring, designing experiments to investigate how attention, cognitive interference and anxiety differed between men who did and did not experience ED (Abrahamson et al., 1985; Barlow et al., 1983; Sakheim et al., 1984). From these experiments, Barlow (1986) proposed a cognitive-affective model of inhibited sexual excitement hypothesising that anxiety and cognitive interference diminish the capacity to focus on erotic stimuli in men with ED. This leads to

preoccupation with the social consequences of erection failure, generating more anxiety which further increases autonomic arousal, further diminishing sexual arousal. A cycle of avoidance follows, with the prospect of sexual encounters becoming increasingly threatening.

More recent cognitive behavioural models for ED, such as John Wincze and Michael Carey's (2001), combine sensate focus with cognitive restructuring: the recognising and challenging of irrational and unhelpful thoughts before and during sexual scenarios. Pedro Nobre's (2017) cognitive-emotional model pays particular attention to the function of sexual beliefs, or *sexual myths* (McCarthy & McCarthy, 1998; Wince & Barlow, 1997), as a predisposing factor. Such beliefs concern excessive sexual demands, e.g., "a real man has sex very often", as well as preoccupation with a partner's sexual satisfaction and their reaction to erection failure, e.g., "the quality of an erection is what most satisfies a woman" (Nobre & Pinto-Gouveia, 2006). Nobre also hypothesises that negative automatic thoughts experienced by men with ED stem from negative self-schemas (ideas about oneself, others, and the future) activated during sexual events. These lead to the interpretation of such events as a confirmation of failure or incompetence (Nobre, 2010).

1.2.3 *The efficacy of psychological interventions*

Despite widespread recognition of the role psychological factors play in ED, Nobre (2017) notes that "the transference of this knowledge to the development of evidence-based treatments…is still scarce" (p.44). Indeed, robust research evidence into the efficacy of these interventions is in short supply. One relatively old review of empirically validated treatments for sexual dysfunction — including cognitive behavioural therapy (CBT), sensate focus and systematic desensitisation — comments that study designs have historically been poor, identifying only five studies which compared treatments to controlled outcomes (Heiman & Meson, 1997). They note the lack of clearly defined treatment manuals as a major shortcoming, with interventions using variations on techniques borrowed from various models without one standardised form, making treatments difficult to

compare. They also comment on a lack of funding for large randomised controlled trials (RCTs), meaning trials remain modest in size and complexity.

Treatments have also been difficult to evaluate due to poorly defined target variables, lack of consensus on ED diagnosis and outcome measures that lack information on their psychometric properties (McCabe, 2001). The International Index for Erectile Function (IIEF; Rosen et al., 1997) — and its abridged five-item version, the IIEF-5 (Rosen et al., 1999) — have been adopted as the "gold-standard" for outcome measures for pharmaceutical ED medication trials, due to their meeting psychometric criteria for test reliability and validity, as well as their high degree of sensitivity and specificity, and correlation with other measures (Rosen et al., 2002). However, these have rarely and only recently been used in trials for psychological interventions.

There are nevertheless a few recent meta-analyses which examine the efficacy of controlled clinical trials for psychological interventions. A Cochrane systematic review (Melnik et al., 2007) looked at nine RCTs and two quasi-RCTs involving couple sex therapy, group sex therapy, systematic desensitization, CBT and psychoeducation. A meta-analysis revealed a statistically significant improvement in erectile function compared to a waiting list control in all but the psychoeducational intervention. However, authors recognised the need for larger RCTs with longer follow-ups, commenting on a general lack of design quality and calling for clearly stated methods of randomisation, allocation concealment, blinding, and power calculations prior to treatment.

Ciocanel, Power & Eriksen (2019) completed an overview of the existing systematic reviews on interventions for ED, which included clearly defined and validated outcome measures such as the IIEF and IIEF-5. Interventions included couple sex therapy, marital therapy, group sex therapy, and psychoeducational approaches. Overall, evidence for the efficacy of psychological interventions was limited. Masters and Johnson's model was found to be somewhat effective in comparison with a waiting list control group (d= 0.21), but educational and marital therapies demonstrated either

negative results or very small effect sizes. Reviewers also commented on the modest sample size of most meta-analyses (16–235 participants).

1.2.4 *The impact of Viagra on the treatment landscape*

The lack of high-quality research into psychological interventions has been significantly impacted by the revolutionary introduction of Pfizer's phosphodiesterase 5 inhibitor (PDE-5i) product Viagra in 1998, a cheap and easily distributable pill demonstrating positive outcomes with large effect sizes (Leoni et al., 2013; Lyseng-Williamson & Wagstaff, 2002). Pharmacological treatments lend themselves to large RCTs financially backed by wealthy pharmaceutical corporations.

The demonstrable efficacy of PDE-5is has effectively foreclosed ongoing research into psychological interventions for ED. Given that items such as "How often were you able to get an erection during sexual activity?" on the IIEF and IIEF-5 consider a positive outcome as the physical capacity to obtain an erection, successful treatment is now defined solely on the basis of biological functionality. Since a drug now exists that can restore function, the way that ED is now predominantly treated is as a correctable medical symptom.

Given that empirical testing has demonstrated that ED can be corrected using PDE-5is, the issue risks being considered resolved. This appears to have closed down exploration into potential underlying social or psychological mechanisms that may contribute to ED, but that are less easily empirically captured. Indeed, concern has been raised even from within the field of urology that PDE-5is are being overprescribed, with fears that using PDE-5is alone to treat ED ignores relational, psychological or social contributing factors (Barnett et al., 2012; Bodie et al., 2003).

1.2.5 *Feminist critiques of Viagra*

Criticism of this biomedicalisation of ED also comes from feminist perspectives within social-constructionist epistemologies. Such voices argue that ED as a medical condition is culturally constructed within a gendered discourse wherein masculinity revolves around the necessity of

penetrative intercourse. Annie Potts (2000), for examples, argues that pharmacological treatments like Viagra are used as means of overcoming a threat to masculine identity, but that their use colludes with the problematic belief that sexual intercourse is paramount.

Leonore Tiefer (1994) argues that the financial interests of urology, the media and the medical industry have generated an overly-medicalised discourse that promises an impossible "perfectible erection". This promise encourages falsely universal visions of male sexuality which are not reflective of true experience, redefining "normal" erection performance and expanding the category of what is "broken" and in need of treatment

The close relationship between treatment and entrepreneurship in the case of Viagra has led Mika Loe (2004) to argue that "it is increasingly difficult to separate sexual medicine 'experts' from pharmaceutical marketers" (p.27). Purported need is shaped by financial incentive and marketability, with companies like Pfizer benefitting from the expansion of concern that advertising campaigns help create. Loe (2001) also argues that Viagra goes beyond functioning as a technology to fix the male body, but also serves to *extend* bodily function beyond its unaided physical capabilities.

Peggy Kleinplatz (2004) suggests that the turn to PDE-5is as primary treatment has shifted the discourse around erections to become dominated by metaphors of hydraulics and mechanics. This has led to what she calls *The Viagra Mindset*: a subjective shift in men's experiences of their own sexual functioning. The primary concern for Kleinplatz is men's alienation from a more holistic understanding of sexuality and desire: a preoccupation with fixing the mechanics without considering *why* the mechanics "aren't working".

The insufficiency of a pill to address the non-biological aspects of ED is potentially evidenced by the high rates of discontinuation of PDE-5i use, with an estimated 60–70% of men discontinuing use despite a reported 70% efficacy rate (Althof, 2006; Althof, 2010; Rosen et al., 2004). High discontinuation rates suggest PDE-5is may not be the "magic bullet" technology that men have spent

centuries in search of (McLaren, 2007), evidencing — as Berry (2013) argues — that a broader, biopsychosocial conceptualisation may be required.

1.3 Current Treatment Recommendations

The National Institute for Health and Care Excellence guidelines (NICE, 2013) for ED treatment reflects the current biomedically dominated research landscape, with PDE-5is suggested as the first mode of treatment regardless of suspected cause. The guidelines also recommend secondary referral to mental health services for "psychogenic cases" of ED, with CBT and sex therapy recommended by the NHS (NHS, 2020).

However, following the expiry of Pfizer's patent in 2017, generic versions of PDE-5is have been available without prescription via discreet postal delivery from online pharmacies. This means men with ED with a strong psychological component are able to access pharmacological treatments without engagement with psychological services, which may in turn inhibit help-seeking for associated psychological difficulties.

The ease of access to PDE-5is is of particular concern for younger men, for whom ED is thought to be psychogenic in origin for the majority (Rastrelli & Magi, 2017). The following literature review is therefore an attempt to evaluate what the current research literature tells us about the experiences of younger men with ED.

2 Literature Review

2.1 Chapter Overview

This chapter seeks to review existing research literature on the experiences of ED in men under 40. It seeks to elucidate what current research perspectives tell us about younger men with ED and considers what epistemological perspectives would be beneficial in expanding our understanding of this population. It finishes by arguing that the lens of counselling psychology (CoP) offers a unique contribution to further research in this area, presenting three research questions for investigation.

2.2 Search Strategy

A literature search was carried out using the following databases: PsychInfo, Medline, Pubmed, Cochrane, Academic Search Premier and CNAHL with full text. The following Boolean search string was used to search titles, abstracts and keywords in all databases:

(young* men OR young* males OR male youth OR male teenagers OR male adolescents)

AND

(erectile dysfunction OR erectile difficulties OR erectile disorder OR erection difficulties OR impotence)

The inclusion and exclusion criteria used were as follows:

2.2.1 *Inclusion criteria*

1. Mean age of participants ≤ 40[1]
2. Participants with ED with a psychogenic aetiology
3. Participants for whom ED is not due to a pre-existing physical condition

[1] ≤40 was chosen as it represents the widely recognised age threshold for the identification of younger ED patients in the existing literature (Pozzi et al., 2020).

4. Studies based in Europe or the United States[2]

2.2.2 *Exclusion criteria*

1. Mean age >40
2. Participants with ED with an organic aetiology
3. Studies based outside of US or Europe
4. Studies not in English

A total number of 4,049 papers were retrieved from databases and exported to RefWorks. Titles and abstracts were scanned for those which met the inclusion criteria. Included papers (n=45) were checked for duplicates using the RefWorks tool. Twenty-nine duplicates were removed. Another 6 papers were removed as closer inspection revealed they did not meet inclusion criteria. This left 10 papers suitable for review. For a table detailing selected papers, see Appendix A.

2.3 Prevalence and Demographics – Highlighting the Connection to Poor Mental Health

Five of the retrieved papers examined the prevalence and associated factors of ED in younger men (Akre et al. 2014; Capogosso et al., 2013; Jern et al., 2012; Mialon et al., 2012; Pozzi et al., 2020). All were from the perspective of urology, and therefore conceptualised both ED and mental health difficulties from a diagnostic, biomedical perspective. All five also commented that central to their rationale was the overwhelming weighting of ED research towards older men and subsequent overlooking of younger populations.

Two of these were cross-sectional and longitudinal studies of the same cohort (Akre et al., 2015; Mialon et al., 2020), examining the prevalence of ED in an otherwise healthy, non-clinical population of young men. They also examined which medical and behavioural factors commonly associated with ED in older men correlated with the IIEF-5.

[2] The original criteria included only papers published in the UK. However, no UK based studies were retrieved. Therefore, Europe and United States were selected for inclusion as the most culturally similar environments in which participants would be situated.

Mialon et al. (2012) examined the prevalence of ED amongst a large sample (n= 3886) of Swiss young men (mean age 19.58) and found a prevalence of 29.9% of "at least mild" (a score of 21 or below) on the IIEF-5. Bivariate analysis comparing variables between participants who did and did not meet clinical levels on the IIEF-5 revealed Major Depression Inventory (MDI; Bech et al., 2001) to be the strongest associated factor (p=.001) — 9.5% of the ED group met clinical levels of depression compared to 4.9% in the non-ED group. Sexual inexperience was also found to be significantly associated (p=.001) — 40.1% of the ED group reported <2 years of sexual experience compared to 31.5% of the non-ED group. Use of medication without prescription was also significantly associated (p=.002).

Given the link found between diagnostic levels of ED and sexual inexperience, the same cohort was examined longitudinally using the same questionnaire at 15-month follow up (Akre et al., 2014). This study tested the hypothesis that ED would reduce with increased levels of sexual experience and assessed which factors differentiated those who did and did not continue to experience clinical levels of ED over time. Results showed 51% of those who initially met diagnostic levels on the IIEF-5 continued to do so, while a further 14.4% developed diagnostic levels of ED in the interim. That 49% experienced reduced IIEF-5 scores without intervention provides evidence that ED in some men may reduce with increased sexual experience or improve spontaneously. However, that 65.4% either continued to meet diagnostic IIEF-5 levels or developed clinical ED over time paints a complex picture, suggesting that for many young men sexual experience alone is insufficient to resolve ED.

A bivariate analysis using the chi-squared test of independence comparing variables between those who continued to have ED at baseline and follow up revealed those with ongoing ED were statistically significantly more likely to have newly met or continue to meet clinical levels of depression on the MDI (p=.001), to be less likely to have had multiple sexual partners (p=.041), and to be older at first intercourse (p=.049). These significant variables were entered into a logistic regression, controlling for age and duration of sexual experience. Analysis demonstrated new and continued

levels of depression on the MDI to be significant predictor variables for ED (adjusted odds ratios 1.69 and 2.59 respectively), strengthening evidence for the apparent link between ED and poor mental health.

In a similar cohort questionnaire study, Jern et al. (2012) sought to examine correlations between anxiety, depression and clinical levels of ED on the IIEF in a non-clinical cohort of 3,480 Finnish men (mean age 30.3). Anxiety and depression were measured with the Brief Symptom Inventory-18 (Derogatis, 2001) and ED with the IIEF-5. This study also examined the relationship between current ED and ED at first sexual intercourse (ED-1st), using a four-item retrospective instrument (Santtila et al., 2009). It sought to explore whether ED-1st might act as a predictor for ongoing ED, and whether ED may reduce over time.

Reported prevalence of ED-1st was 22.3%, while current ED was 15.2%, indicating some decline over time. However, this 15.2% did not include participants who reported having *not* engaged in sexual intercourse since first intercourse. When these participants were included, the prevalence rose from 15.2% to 22%, with 2.7% experiencing "severe" IIEF-5 scores (between 1–7) and 5.6% experiencing "moderate" scores (between 8–11). This indicates a link between ED and sexual inactivity and highlights the importance of including sexually inactive men in ongoing research.

Analysis revealed weak but statistically significant correlations between symptoms of both anxiety and depression with current ED (R=.204 and R=.174 respectively) and ED-1st (R=.140 and R.151 respectively). That ED-1st was measured via a retrospective self-report leaves open the possibility for recall bias given that it relies upon accurate memory of a historical event. Nevertheless, this provides further indication that psychological difficulties are common in the experiences of younger men with ED.

While these previous studies gathered data from non-clinical populations, Pozzi et al. (2018) and Capogrosso et al. (2013) applied similar designs to men seeking ED treatment. Capogrosso et al. (2013) found that 25.9% of those amongst a sample of 407 ED patients were below the age of 40, with

48.8% of these experiencing “severe” (<8) IIEF-5 scores. Men <40 also experienced far fewer physical comorbidities than older men, measured using the Charlson Comorbidity Index (CCI: Charlson et al., 1987), supporting the hypothesis that ED in younger men is typically linked to psychological rather than physiological factors. Psychological measures were not tested however, and it would have been valuable to have psychological data from young men experiencing “severe” IIEF-5 scores, especially since data from non-clinical cohort studies revealed predominantly “mild” to “moderate” IIEF-5 scores. Comparisons in psychological profiles between clinical and non-clinical groups would make an interesting addition.

Pozzi et al. (2018) carried out a similar study of 307 patients <40 years old seeking first medical help for ED, examining physical comorbidities on the CCI, but also factoring in the Beck Depression Inventory (BDI; Beck et al., 1996). They found 97.4% had no physical comorbidities, 55% scored at least “mild to moderate” on the IIEF-5, with 29% scoring “severe”. Furthermore, a total of 33.3% of patients showed BDI scores suggestive of clinical depression, with a logistic regression revealing BDI scores to be the only significant predictive variable for ED (odds ratio 1.08, 95% confidence interval 1.02–1.13, p=.001).

Another curious finding was that one in four seeking ED treatment did not meet the clinical criteria for ED on the IIEF-5, meaning 78 men sought clinical help for a subclinical problem. Studies examining the attitudes of men who consider a clinically “normal” level of functioning to be dysfunctional would be interesting — it is possible that this trend reflects Tiefer’s (1994) argument that gender norms have encouraged unrealistically high erection standards.

These cohort studies consistently demonstrate correlational links between diagnoses of anxiety and depression with ED in younger men. However, large-scale deductive study designs use diagnostic protocols as the only way of capturing the psychological experiences of participants, meaning these experiences are reduced to statistical variables based on pre-defined diagnostic criteria. Though helpful in capturing broad trends across large populations, they provide limited insight

into the process of how experiences of ED and psychological health might be interacting, nor do they give much detail into the experiences of particular individuals.

2.4 ED and Sexual Dissatisfaction

Two of the papers identified (Posavec et al., 2018; Tambling & Reckert, 2014) employed cross-sectional designs to examine ED prevalence, as well as its relationship with sexual satisfaction, amongst undergraduates in Croatia and the United States, respectively. Both studies argue that sexual education should include sexual wellbeing concerns, and that if ED results in a reduction in sexual wellbeing, then it should be treated as a public health concern.

Posavec et al. (2018) retrieved questionnaire data from a sample of 174 students with a mean age of 19. They examined the link between self-perceived ED (with participants answering "yes" or "no" as to whether they had experienced erectile difficulties), IIEF-5, and sexual satisfaction on a 5-point scale (from 1=completely dissatisfied to 5=completely satisfied). Overall levels of "at least mild" (<22) on the IIEF-5 were 17.8%, with regression analysis showing sexual dissatisfaction to be a significant predictor variable for ED on the IIEF-5 (odds ratio 1.73, standard error 0.51, p=0.001).

Results showed a curious discrepancy between self-perceived levels of erection difficulties (4.6%) and clinically recognised IIEF-5 scores (17.6%): 13% of the students surveyed met diagnostic levels of ED that they did not self-report. That the direction of this trend is opposite to that found by Pozzi et al. (2018), where young men presented with perceived ED but did not reach clinical levels, is also interesting, suggesting there are groups of young men who are both over- and under-confident in their erectile function. Explorations into differences in young men's' perceived erectile functioning appears to be another interesting research avenue.

Tambling et al. (2014) examined a cross-section of 112 American students using a range of different sexual function measures including the IIEF. What differentiated this study from others mentioned was the inclusion of sexual functioning *concerns* that did not meet clinical levels:

participants were not separated into discrete dysfunctional/functional subgroups based on diagnostic threshold. This pivot of focus away from biological functionality towards emotional concerns related to ED is inclusive of men such as those Pozzi et al. (2018) found to believe they had ED despite being subclinical.

Analysis revealed a significant correlation between IIEF scores and sexual quality of life (R=.405, p=.000) on the Sexual Quality of Life- Men measure (SQOL-M; Abraham, Symonds & Morris, 2008), as well as significant inverse correlations between IIEF scores and MDI scores (R =−.300, p =.001), with lower erection functioning once again indicating higher depression scores.

Both of these studies suggest that young men experiencing either clinical or perceived erection problems are experiencing lower levels of sexual satisfaction, which appears to have some relationship to mood. However, though reducing the complex and dynamic nature of sexual satisfaction to questionnaire scales allows for the comparison of large data samples, it does not tell us of the detailed nature and quality of experiences that may be impacting on sexual quality of life and the way that sex, satisfaction, and mood interact. Studies which afford in-depth, idiographic detail exploring the experiences and sexual satisfaction of young men with erectile difficulties would be beneficial.

2.5 The Use and Abuse of PDE-5is

Two of the retrieved studies explored prevalence of PDE-5i use amongst younger men, examining the contexts of use and whether PDE-5is might contribute to ED.

Musacchio, Hartrich and Garofalo (2006) surveyed 234 sexually active American undergraduates aged 18–25 for frequency of self-reported ED, asking “Have you ever had difficulty getting or keeping an erection”. Thirteen percent answered “yes”, only one of whom had reported this to a professional. Six percent reported PDE-5i use — 54% obtained these from peers, 39% from other non-medical sources, and only a single participant obtained them medically. Fifty-seven percent

used PDE-5is to manage erection difficulties, while 29% reported using them to enhance sexual performance. Additionally, 64% mixed PDE-5is with other illegal substances and 36% with multiple other drugs: behaviours which have been linked to unsafe sex and dangerous chemical interactions (Chan et al., 2015).

These data seem to suggest two possible trends with regards to PDE-5i use in younger men. The first is that younger men who experience ED do not appear to be seeking treatment medically but may instead be self-medicating. The second is that PDE-5is may be being used to "enhance" sexual performance, which is concurrent with Loe's (2001) argument of their use as a tool for biological augmentation. Given these findings, it would seem valuable to examine in more detail the attitudes and experiences of young men in both of these groups that cannot be garnered statistically.

Harte & Meston (2014) sought to examine how unprescribed PDE-5i use might contribute to psychogenic ED, seeking to understand the mediating role erectile confidence has in overall erection capacity. They hypothesised that PDE-5is function as a psychological safety mechanism to protect from performance anxiety (PA). However, this diminishes confidence in unaided erectile capacity, inadvertently worsening ED.

A cohort of 1,207 sexually active American undergraduates (mean age 21.9) was surveyed. The IIEF was taken, with Item 15 used to measure erectile confidence. Frequency of PDE-5i use (prescribed or unprescribed) was taken, with the cohort split into three subgroups: recreational users, prescribed users, and non-users. General linear modelling was used to compare group scores. Eight percent reported PDE-5i use in the last four weeks: 6% recreationally and 2% with prescription. Recreational users and non-users reported similar IIEF scores, suggesting PDE-5is were not necessarily being used to self-medicate for clinical ED. However, when erectile *confidence* was examined, both recreational and prescription users had similarly low levels of erectile confidence (both $p<0.01$), with the two groups not differing significantly ($p=0.14$), while those who had never used PDE-5is showed higher levels of erection confidence. When analyses of mediation were conducted amongst the

subsample of recreational users, frequency of PDE-5i use was found to inversely predict erectile confidence (*B*=-0.26, S=0.13, p=0.05), with erectile confidence positively predicting erection functioning (*B*=8.29, SE=1.28, p<0.001).

Finding PDE-5is to be a significant predictor variable for erection confidence is problematic given their status as the recommended treatment for all cases of ED within the NICE guidelines (NICE, 2013), and the central role that erection confidence is proposed to play in psychological ED formulations. That the cohort contained a relatively large number who demonstrate low levels of erection confidence, use PDE-5is recreationally and are sexually dissatisfied despite clinically 'normal' erection functioning is also notable. This evidence supports Tambling et al. (2014) suggesting that sexual functioning concerns and clinical dysfunction do not necessarily overlap. The psychological implications of those with non-clinical concerns risk being overlooked if ED is assessed purely on biological functionality. Further research should include subclinical populations, investigating why some young men experience diminished erectile confidence, and how this diminished confidence impacts psychological wellbeing.

2.6 Genital Self-Image and Sexual Anxiety

One study (Wilcox et al., 2015) was designed around Masters and Johnson's theory that sexual anxiety (SA) plays a pivotal role in ED. Researchers cited previous evidence that preoccupation with poor genital self-image among men (MGSI) serves as a distractor during sexual activity, increasing SA and negatively impacting sexual arousal (Morrison et al., 2005). Researchers examined the relationship between SA, ED and MGSI, hypothesising that greater levels of MGSI will predict lower levels of both ED and SA, lower levels of SA will predict lower levels of ED, and SA will mediate the effect of MGSI on ED.

These hypotheses were tested on a sample of 367 American military personnel aged 21–40. The IIEF-5 measured ED, the MGSI scale (Herbenick et al., 2013) measured MGSI, and SA was measured with a subscale of the Sexual Needs Scale (Davis et al., 2006). Hierarchical regression showed 6% of

variance in MGSI was explained by SA, meaning greater MGSI predicted lower levels of SA: a small but significant effect. Twenty-three percent of variance of MGSI was explained by ED, suggesting those with greater MGSI had lower IIEF-5 scores: a small to medium effect. Thirty-one percent of the variance of SA was explained by ED, a medium effect, demonstrating that SA significantly predicted ED and supporting the central thesis for psychological ED formulations in Chapter One.

Though the effects were not large, these data suggest poor MGSI may be characteristic of the experiences of younger men with ED. These experiences have psychological implications which warrant a greater depth of exploration than the reduction to statistical variables, and further research into younger men with ED should consider the potential for MGSI concerns to be built into research designs.

2.7 Conclusions and Implications

The studies reviewed demonstrate a reasonably high prevalence (mean 20.65%) of young men with either some degree of clinical ED, or a degree of subclinical sexual functioning concern, which appear closely connected with wellbeing. The epidemiological nature of many of these studies paints a broad clinical profile of younger men with ED which appears to differ from older populations. Risk-associated behaviours such as self-medication, drug abuse, and recreational PDE-5i use emerge as central to the experiences of younger ED sufferers, while physical comorbidities are broadly insignificant. Poor mental health is repeatedly central, making this a population of particular concern for CoPs.

That these clinical differences between older and younger men are only recently emerging highlights the risk of *ontological monovalence* (Bhaskar, 1975): the experiences/aetiologies of two distinct populations risk being confused because the same *symptom* is observable. This also highlights a limit of hypothetico-deductive approaches, as hypotheses tested on younger populations often came from existing studies involving older men. Inductive methodologies could help by generating

data unique to the experiences of younger men with ED and contribute to new hypotheses more appropriate to this population.

The reviewed papers come almost exclusively from the biomedical, positivistic epistemological perspectives of urology and sexual medicine, reflecting the landscape of treatment discussed in Chapter 1. These are disciplines for which psychological factors are not of primary concern, and that view mental health through the lens of symptomology. The examination of the contribution of sociocultural and relational factors in the genesis of ED were largely absent from the reviewed studies, as were social-constructionist perspectives. The importance of psychological factors was widely acknowledged, yet the gap is open for CoP researchers to explore in more nuanced ways how psychology and physiology might interact in cases of ED, as well as examining the psychological *impact* on those who experience this phenomenon.

The literature is also somewhat methodologically homogeneous, consisting of cross-sectional questionnaire designs of medium-to-large cohorts. The benefit of these kinds of studies is in their capacity to examine trends over large populations, but they do not test causality, limiting the scope of the data. From a deductive perspective, more targeted designs which test causal relationships between ED and mental health diagnoses would make a valuable contribution.

Statistical designs also reduce experience into numerical data, erasing the nuance that constitutes lived subjectivity. They also risk assuming a somewhat naive directional relationship between factors — that ED *causes* depression, or vice versa. As will be discussed further in Chapter 3, a critical-realist perspective argues that a phenomenon like ED exists in an open and complex system of shifting biological, psychological and relational contributing forces (Bhaskar & Norrie, 1998). Although it is impossible to capture the exact nature and relationship of these forces, research is best served by attempting to understand a phenomenon at multiple levels from a range of perspectives.

There is therefore an opening for this population to be studied from a much wider variety of methodological angles. Qualitative methodologies, for example, are entirely absent from the existing

literature. This is notable given that ED is an embodied phenomenon which, as well as being a physiological event, takes place within an individual's conscious experience. The consideration of what it is actually *like* to experience ED as a younger man — the quality and the nature of the experience, as well as how these men make sense of these experiences — is overlooked. The examination of smaller samples in greater, idiographic detail afforded by qualitative designs which privilege the voices of individuals experiencing ED would be a valuable contribution to knowledge.

Furthermore, the lack of any research into younger men's experiences using PDE-5is is concerning given their ease of availability through both medical and non-medical channels, their recommendation as a treatment in the NICE guidelines, and evidence that use may in fact worsen ED by impeding erectile confidence (Harte & Meston, 2014).

2.8 Research Questions

Given these gaps in research, the following questions emerge as valuable avenues for exploration for the present study:

1. What are young men's experiences of erection difficulties?

2. How do young men who experience erection difficulties make sense of their experiences?

3. What are young men's experiences of using PDE-5is to treat erection difficulties?

3 Methodology

3.1 Chapter Overview

This chapter serves to introduce critical realism (CR) as the ontological position of this research and to provide a rationale for the chosen methodology: Interpretative Phenomenological Analysis (IPA; Smith et al., 2009). It will briefly introduce the core philosophical tenets of CR, followed by arguing that phenomenology is a valuable epistemological tool within a multidisciplinary CR framework. It will explore the history and philosophical principles of IPA, providing a rationale for why IPA was selected as the most suitable methodology to answer the research questions.

3.2 Ontology

3.2.1 *Critical realism and philosophical under-labouring*

As outlined by its architect Roy Bhaskar, the primary purpose of CR is to do the work of "philosophical under-labouring" for scientific investigation (Bhaskar, 2016a, pp.1–4). By this, Bhaskar implies that much philosophy actually distracts from the generation of useful knowledge and, after John Locke, suggests the function of philosophy should be to "clear the ground a little and remove some of the rubbish that lies in the way of knowledge" (Locke, 1690/1990, p.13), in order to generate knowledge that is common-sensical and applicable.

In the spirit of this mission, this chapter will begin with a critical discussion justifying Interpretative Phenomenological Analysis (IPA: Smith et al., 2009) as the chosen methodology. The discussion aims at "clearing out" the limitations of existing knowledge that the epistemological positions reviewed in the literature have told us about ED and PDE-5i use in younger men. In doing so, it seeks to demonstrate how IPA might be used to generate new, useful, and applicable psychological data.

3.2.2 *The holy trinity of critical realism*

CR is best understood through three axioms which Bhaskar called the "holy trinity of critical realism" (Bhaskar, 2016b, p.21). The first of these is *ontological realism* — a call for a return to the examination of what exists beyond human perception: a mind-independent world existing "out there", regardless of our experience of it. Aspects of reality are witnessed by us; these aspects constitute a realm that Bhaskar called "the empirical". In addition, aspects of the world will also reveal themselves and yet evade our witnessing, which he called "the actual". Finally, for Bhaskar, there are further underlying mechanisms which do not reveal themselves at all, but exist nonetheless: "the real" (Pilgrim, 2020).

The second core axiom is *epistemological relativity*: recognising that, given our limited access to reality, there are multiple, competing ways in which we can understand and talk about the world (Bhaskar, 2016b, p.20). Such relativity is demonstrated by the differing lenses through which ED is conceptualised in Chapter 1, be it biomedical, psychological or constructionist.

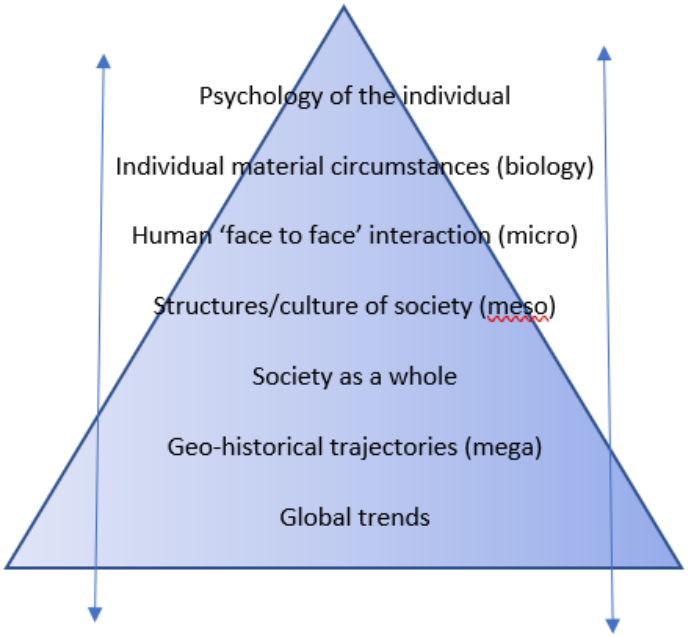
What we do with these sometimes-contradictory perspectives depends on Bhaskar's third axiom, *judgemental rationality* — the need to make sensible and informed judgements regarding what is most likely to be true, given what our limited methods tell us about a phenomenon (Bhaskar, 2016b). This encourages adopting a *both-and perspective*: inviting epistemological pluralism with a critical edge. Bhaskar also believed that scientific investigation should be completed from a position of "epistemic humility" (Pilgrim, 2020), mindful of the limitations of all epistemological tools, and open to what other perspectives might contribute.

3.2.3 *Reality as laminated*

Bhaskar saw the world as a series of complex, open systems, whose behaviour depends on a multitude of forces in constant flux. Attempting to capture this complexity, he introduced a model of a "laminated reality", depicting seven mutually influencing ontological layers within which social events unfold (Bhaskar et al., 2017).

Figure 1

Bhaskar's Seven Laminations Explaining Social Phenomena (Bhaskar, 2016b, p.45).



This model is complicated further by what Bhaskar calls "the transitive nature of reality" (Bhaskar, 2016b): the idea that humans have agency which can impact what happens within these interlocking systems. Humans thus serve to "amplify the unpredictability within reality's open systems" (Pilgrim, 2020, p.26).

This makes any social phenomena — ED included — highly complex from a CR perspective. Attempting to develop a comprehensive understanding requires data on all seven of Bhaskar's laminations, exploring how layers influence one another, and how these systems are impacted by transitive agency.

Given CR's embrace of ontological complexity, it is highly critical of any form of reductionism. This includes positivism, considered by Bhaskar as a kind of "naïve realism" (Pilgrim, 2020). CR is particularly critical of the positivist view that the world could be reduced to "universal covering laws" (Friel, 2014), which could be captured using experimental research designs alone. Bhaskar felt this

position created the illusion of what he called "ontological monovalence" (Bhaskar & Norrie, 2013): a shallow, oversimplified description of reality which overlooks things that are ontologically real but not easily empirically captured.

CR is equally critical of social constructionism's reductionist tendencies, particularly of privileging language at the expense of other social forces (Pilgrim, 2020). For Bhaskar, the relativist ontology which underpins social constructionism disavows reality's complexity. Reducing reality to linguistic structures alone presents its own form of *ontological monovalence*, committing what Sayer (2000) calls "ontological vandalism".

Yet much of the existing ED literature falls into one of these epistemological categories, focusing either on ED as a physical symptom — examined using positivist designs — or in the ways in which ED is constructed on a social level — examined through a constructionist lens (Tiefer, 1995; Tolman et al., 2014).

Mapped onto Bhaskar's laminations, this translates into a focus on the levels of "individual material circumstances" and of "structures/culture of society", with little insight into other laminations, nor their interactions. This is problematic given the literature indicates a strong psychological component to ED in younger men (Akre et al., 2014; Jern et al., 2012; Mialon et al., 2012; Pozzi et al., 2018); a greater depth of focus on the level of "psychology of the individual" is paramount to honour Bhaskar's mission of generating useful, applicable knowledge.

3.3 Epistemology – Phenomenological Realism

As identified in Chapter 2, there are currently no qualitative investigations into the subjective experiences of younger men with ED, nor of their use of PDE-5is. This absence is not problematic from perspectives which do not consider subjective descriptions valuable data. But if subjective experience is considered *real*, this would justify qualitative explorations of lived experience as providing insight into the lamination of the "psychology of the individual".

An argument for phenomenology within a CR framework — an epistemology I will term *phenomenological realism* — can be drawn from Thomas Nagel's (1974) thought experiment. Nagel invites us to imagine that a bat, as a living creature, must have its own unique, subjective experience. This subjectivity remains entirely inaccessible to the realms of human imagination nor to our existing epistemological tools but is nevertheless real. For Nagel, then, the world contains "phenomenological facts" (p.442) which exist beyond the limits of our perception.

This can be extended to the differing subjective realities that exist between humans. Each individual has their own unique subjectivity known only to them. The difference is that humans have tools like language through which, using processes like detailed description, we attempt to translate and communicate our internal realities to others.

David Pilgrim (2020) demonstrates how private experiences can be translated into emergent, external representations using the example of the creative process of a songwriter:

> During their internal experiment, unknown to anyone other than themselves, real though transitory possibilities emerge and are discarded as options. Nobody else has access to that aspect of their reality but it could be the basis for producing a pristine song for others to eventually appreciate when performed… It was unobservable by others, but it was undoubtedly real (Pilgrim, 2020, p.19).

Here, Pilgrim links the intransitive (or fixed) inner reality of the individual to the transitive reality by which an individual can enact change on the world. We see how private experiences on the lamination of the "psychological of the individual" (the creation of the song) are linked to social "human face-to-face interactions" (the performance of the song), demonstrating laminations interacting. We also see the importance of what internal, psychological experiences can tell us about the nature of the emergent product. We could not learn the same things about how the song came into existence by examining the activity of the songwriter's brain in an MRI scanner as we could by simply asking the songwriter to *describe* the choices they made in the process of creation.

From a CR perspective, the same pluralism should be applied when attempting to understand ED: the lived subjective experience of those with erection difficulties should be considered ontologically real and not be discarded because of its elusiveness. Phenomenological methodologies therefore constitute a valuable contribution within a CR framework because they attempt to systematically capture the subjective nature of experience. Nevertheless, any phenomenological approach should be equally cautious not to incorrectly assume it provides direct, unfettered access to the subjective reality of others. Recognising the limitations of such a methodology — Bhaskar's "epistemic humility" — must be upheld.

3.4 Methodology

3.4.1 *Interpretative Phenomenological Analysis*

IPA emerged within the world of health psychology from similar epistemological frustrations as those held by Bhaskar. In *Beyond the Divide between Cognition and Discourse,* Jonathan Smith (1996) comments on the binary of epistemological approaches that dominated the field of health psychology at the time: cognitive psychology, with a positivist focus on the quantification of mental processes, and discourse analysis, a social constructionist epistemology "attempting to elucidate the interactive tasks being performed by verbal statements" (p.262).

As I have argued in the case of the ED literature, Smith felt the subjective perception of the physical body had been overlooked, accounts of which he believed "provide an excellent crucible for research… [as] bodies and illnesses provide a useful background against which to compare different accounts of physical processes" (Smith, 1996, p.265). IPA thus sprung out of a particular interest in the examination of *embodied* lived experience, and in how individuals may uniquely experience and make sense of their bodies. Its epistemology can be best encapsulated using the following three theoretical axioms (Smith et al., 2009):

3.4.2 *Axiom 1 - phenomenology*

IPA's philosophical roots lie in the phenomenology of Edmund Husserl, who called for the necessity to go "back to things themselves" (1927). This meant pivoting away from the *natural attitude* — the everyday mode through which we experience our lives — to a *phenomenological attitude*: consciously attending to the texture of moment-to-moment experience (Tufford & Newman, 2010). This necessitated what Husserl called *bracketing*: putting aside all acquired knowledge and concepts to experience the world "as given in consciousness" (Husserl, 1927: para. 3). Using phenomenological descriptions, Husserl aimed to capture the essential characteristics of consciousness.

The work of Martin Heidegger also heavily influenced IPA. Though inspired by Husserl, he challenged the idea that simply adopting the phenomenological attitude could provide unfettered access to the content of consciousness (Overgaard, 2003). Here we see the beginnings of the IPA's interpretative stance; Heidegger's *Being and Time* (1927) introduced the concept of *Dasein* — the idea that we are "thrown into a pre-existing world of people and objects, language, and culture, and cannot meaningfully detach from this" (Smith et al, 2009., p.17). For Heidegger, subjective experience cannot be thought of as separate from the world around us; we are intrinsically, intersubjectively embedded in a social world. Heidegger's is a phenomenology that cannot be separated from context. It concerns the way in which us humans interact with and makes sense of our society.

From a CR perspective, Husserl's phenomenology might be considered something of a naive form of phenomenological realism. In contrast, Heidegger's embeddedness within a multifaceted social reality aligns with Bhaskar's laminated reality, much of which lies beyond our understanding.

Given ED is an embodied phenomenon, the work of Merleau-Ponty is also worth mentioning. Merleau-Ponty's *Phenomenology of Perception* (1962) highlights the primacy of the body as the boundary through which we relate to the world: "The body is no longer conceived as an object in the world but as our means of communication with it" (p.106). For Merleau-Ponty, it does not make sense to discuss experience without relating it to the body. The legacy of embodiment theory has been

influential for phenomenological researchers on sexuality. Embodiment theorists recognise the *experienced* body as the permeable boundary separating the individual subject from the society into which they are thrown (Tolman et al., 2014), enabling researchers to "reformulate research inquiries that are anchored in and about bodily experiences of the sexual and of sexuality" (p.759).

3.4.3 *Axiom 2 - hermeneutics*

The second axiom of IPA is *hermeneutics*, or a focus on interpretation. As Heidegger articulated, we do not have direct access to our lived reality, nor the capacity to perfectly translate it into language that can easily be decoded. Humans are sense-making creatures in an ongoing process of interpreting the world. This aligns with CR's recognition of the limitations of our epistemological tools; we find ourselves embedded in a material reality to which we have only limited access and understanding.

IPA subscribes to a *double hermeneutic* stance (Smith et al., 2009) whereby the participant describing their experience is in a process of interpreting it as they recount it (the first level of interpretation). The researcher then engages in their own process of interpretation of the account (the second interpretative level). However, IPA sees interpretation not as a limitation but as an epistemological tool with the capacity to reveal greater depths of understanding of which the participant themselves may be unconscious. This relies upon a degree of shared understanding between humans, or "the fact that every person… has a receptivity for all other people" (Schleiermacher, 1998, pp.92–3). We can speak to shared realities which we recognise as collective, echoing Bhaskar's (1994) concept of the *concrete singularity*: universally shared commonalities between things.

With this focus on interpretation, we see IPA's recognition of the importance of the detailed examination of language as key to its epistemology. But it diverges from poststructuralist, discourse-focussed epistemologies in that language is seen as a mode of attempting to depict a subjective reality, rather than as a form of social action and construction itself.

IPA also uses the hermeneutic circle (Smith et al., 2009), encouraging an iterative relationship between part and whole. Any part of a text can only be made sense of when considered in the context of the whole. Likewise, the whole can only be understood in dynamic interplay with its parts. Whether this be a word within a sentence, a sentence within an extract, or an extract within the entire text, interpretation requires a cyclical process of moving back and forth between levels.

3.4.4 *Axiom 3 - idiography*

The third axiom of IPA is *idiography*: a detailed focus on the particular (Smith, 1995). This is in part a response to the dominance of nomothetic data in psychological research and attempts to generate laws by studying humans at the group level (Willig, 2013). Nomothetical research often has a theoretical grounding in positivism, whereby unique details of individuals are disregarded in pursuit of generating the "universal covering laws" which empiricism seeks to establish. Yet this level of investigation risks what Bhaskar calls "the epistemic fallacy" (Bhaskar, 2016b): mistakenly conflating what has been captured epistemologically (epistemological statements) for what is real (ontological statements). For example, within the literature review, the nomothetic focus on large cohorts of younger men experiencing ED quantifies individual experience. Since the same diagnostic measures are used to compare older and younger men, what emerges makes for an easy comparison, but is insufficient to tell us *how* or *why* experiences differ.

IPA therefore selects small and purposive samples. Cases are examined in depth individually before cautiously making comparisons across cases. The particular and the general are considered alongside one another in order to develop a clearer picture of the phenomenon. This is because each of these epistemologies examine different stratifications of Bhaskar's laminated reality; IPA encourages another parallel, iterative process between part and whole, in this case between the general and the particular.

3.5 *Consideration of alternative methodologies*

The choice of IPA was influenced first and foremost by the phenomenological nature of the research questions. IPA was chosen over a descriptive phenomenological approach (e.g., Giorgi, 2009), as its interpretative stance was considered suitable for addressing the research question "How do young men who experience erection difficulties make sense of their experiences?". Descriptive phenomenology, as discussed regarding the work of Husserl, was considered insufficient to capture the ontological complexity of a CR framework.

Thematic analysis (TA) was also considered. However, TA seeks to identify converging, thematic patterns *across* accounts (Braun & Clarke, 2006), while IPA is also concerned with the in-depth subjective focus of *individual* accounts of their experiences as sense-making creatures who are always "formulating their own biographical stories into a form that makes sense to them" (Brooks & Wearden, 2006, p3). Therefore, IPA was considered a more suitable methodology for addressing the current lack of *individual* accounts of younger men's experiences of ED within the literature. Furthermore, IPA's popularity within health psychology (Smith et al., 1999) reflects its capacity to examine individual perceptions and interpretations of bodily experiences and the meanings assigned to these (Leventhal et al., 1984). This makes it suitable for the embodied nature of ED. TA is also considered a method rather than a methodology (Braun & Clarke, 2006; Clarke & Braun, 2013), meaning it can be used flexibly with different theoretical underpinnings. Given the research questions are phenomenological, a phenomenological epistemology would need to be adopted to adequately address these if using TA (Willig, 2013). This phenomenological epistemology is already inherent within IPA.

Grounded theory (GT; Strauss & Corbin, 1990) was also considered. GT generates data-driven explanatory theories of social and psychological processes. This makes it a suitable methodology within a CR framework — given its attempt to uncover underlying ontological forces — but not for the present research questions. GT may have been suitable had the research question been concerned with generating an explanation for the underlying processes that contribute to erection difficulties in younger men, or *why* younger men may turn to PDE-5is over other treatments. However, the research

questions proposed are concerned with the description and interpretation of experience, making IPA more appropriate.

Other methodologies which have a social constructionist epistemological underpinning, such as narrative analysis, discourse analysis, or conversation analysis, were excluded because they were felt to be incompatible with the proposed research questions. While such approaches may help illuminate the way language is used by participants to construct their accounts and experiences, the aim of the present study is a focus on individual subjective experiences. The proposed research questions also assume that participants have some degree of access to their own lived reality which, although subject to a degree of interpretation, is real in an ontological sense and can be expressed to a degree through participant description.

4 Methods

4.1 Chapter Overview

This chapter serves as a detailed description of the research techniques used and how they were employed. It includes information on methods of recruitment, the recruitment criteria, information about the participants, information on how the data was collected and analysed, and finally, a section on the ethical considerations of the research process.

4.2 Recruitment

This study aimed to recruit a sample of men below the age of 40 who had experienced ED and used PDE-5is to manage these. Participants were recruited in a manner theoretically consistent with IPA. Participants were recruited purposively: selected with the purpose of providing insight into having experienced ED and using PDE-5is as a treatment. Participants were also recruited based on a degree of homogeneity, using uniform criteria allowing for the examination of convergence and divergence across cases (Smith et al., 2009).

4.3 Inclusion/Exclusion Criteria

In order to recruit a purposive, homogeneous sample, inclusion criteria were devised requiring that participants:

1. Be a cisgender man between the ages of 18–40.
2. Identify as having used PDE-5is at least once to address difficulty getting and/or maintaining an erection.
3. Live in the UK.
4. Be willing and able to share and discuss their experiences around this topic with the researcher.

The age range was selected based on the definition of "young men" in the reviewed literature (Pozzi et al., 2020). Criteria 1 and 2 were designed to ensure a degree of experiential homogeneity between participants, meaning they could sufficiently address the research questions. A formal diagnosis of "erectile dysfunction" was not required, so as not to exclude men who had obtained PDE5-is without a prescription. Criterion 3 was designed to ensure that data would be applicable to the development of future UK-based service provisions and aimed to assure a degree of cultural homogeneity between participants. Criterion 4 was included as an ethical consideration to mitigate against the risk of participant discomfort and emotional harm.

It was decided that participants be excluded if:

1. They do not meet the above inclusion criteria.
2. They attribute their erection difficulties to a physical condition, given the phenomenon under investigation is erection difficulties linked to a psychological component.
3. They are currently experiencing serious mental health problems and/or suicidal feelings.

To rule out participants who fell under criterion 3 of the exclusion criteria, a brief risk assessment was carried out at the beginning of each interview. The researcher asked each participant if they had ever experienced any suicidal thoughts or behaviours, how they were currently feeling within themselves, and if they had any formal diagnoses of mental health problems. The interview was only proceeded with once the researcher was confident that the participants posed no risk to themselves and were psychologically robust enough to take part in the interview.

4.4 Procedure

4.4.1 *Recruitment strategy*

In accordance with Smith, Flowers and Larkin's (2009) suggestion for a professional doctoral project sample size, six men were recruited for participation.

A digital recruitment animation was created in collaboration with an animator, detailing the nature and aims of the study as well as an abbreviated form of the inclusion criteria (Appendix B).

The advertisement was shared via popular online social media platforms such as Facebook, Instagram, Twitter and LinkedIn. The decision to recruit via social media was made due to evidence that younger men are more likely to first engage with help-seeking around sexual issues via the internet (Jiang et al., 2020; Zhang et al., 2014). The decision to use a digital animation was made because it was felt to be more compatible with social media platforms and more likely to capture users' attention than a still image.

The researcher sought digital spaces in which young men were already openly discussing mental health difficulties and sexual difficulties, such as men's mental health support groups and groups discussing sexual problems. This decision was made to maximise the likelihood of reaching men who may be experiencing ED or associated mental health difficulties, and who were comfortable discussing these issues. All six participants were recruited via men's mental health support groups on Facebook.

The researcher had first been concerned that recruitment would be difficult because of the sensitive nature of the topic at hand. Nevertheless, recruitment was completed within five weeks, suggesting either that there were more men who fell within the inclusion criteria than was originally anticipated, or that men were more willing to discuss the topic than was initially anticipated.

4.4.2 *Recruitment process*

The recruitment advertisement invited those interested to contact the researcher via his university email address for more information (Appendix C). Those interested were sent a standardised email response with the Participant Information Sheet (Appendix C) attached. The Participant Information Sheet provided the complete inclusion/exclusion criteria as well as a thorough

description of involvement, in order that participants be fully informed before providing consent. Participants were also provided the Data Privacy Notice for Research Participants to ensure they were aware of how their personal data would be handled.

Once the participants confirmed having read these documents and were clear about the nature of participation, they were sent a digital copy of the Participant Consent Form (Appendix D) to sign and return by email.

A mutually convenient time for the interview was agreed by email. All interviews were conducted via Zoom due to ongoing Covid-19 restrictions. The researcher emailed an invitation containing the meeting ID, password, and an active link ahead of the meeting.

4.4.3 *Participants*

The first six participants who made contact all met the inclusion criteria and were invited for interview. The following table outlines participants' basic demographic information collected ahead of interviews. Participants were asked to self-define their ethnicity, sexuality, and method by which they first acquired PDE-5is. Participants are listed in the order in which they were interviewed. The table also includes participants' assigned pseudonyms. Participant age range was between 26 and 31 (M= 30.67, SD= 3.68).

Table 1

Summary of participant demographics

Pseudonym	Age	Ethnicity	Sexuality	Method of acquiring PDE-5is
Seb	29	White British	Heterosexual	Online pharmacy
Ben	38	White British	Homosexual	GP Prescription
Sam	31	White British	Homosexual	From sexual partners
Ash	31	British Asian	Heterosexual	Online pharmacy
Daniel	26	Black British	Heterosexual	Online pharmacy

Farouk	29	British Asian	Homosexual	Online pharmacy

4.4.4 *Data collection*

Data were collected using one-to-one, semi-structured interviews. Interviews lasted between 60 and 90 minutes, guided by the unique arc of each participant (Willig, 2013). Two password-encrypted voice recorders were used to record the interview in case one was faulty.

An interview schedule of eight open questions with prompts was devised to guide participants in addressing the research questions (Appendix E). Questions were designed to capture the necessarily "rich" data required for IPA analysis, allowing participants "the opportunity to tell their stories, to speak freely and reflectively, and to develop their ideas" (Smith et al., 2009, p.56). Questions invited participants to describe their experiences of erection difficulties (e.g., "Can you share what typically happens when you experience erection difficulties?"), how they made sense of their erection difficulties (e.g., "What do you understand the causes of your erection difficulties to be?"), and to share their experiences of PDE-5i use (e.g., "How have you found using pills like Viagra?").

4.4.5 *Data analysis*

Following manual transcription, interviews were analysed using Smith et al.'s (2009) steps for IPA analysis. Transcripts were first read and re-read several times for familiarity. Detailed descriptive, linguistic, and conceptual notes were then taken seeking to capture both phenomenological detail and interpretative processes (see example Appendix F). These notes were then analysed to develop emergent themes. Connections across emergent themes were then labelled leading to the development of superordinate themes. Mind maps detailing the superordinate themes for each individual participant were then drawn up using the digital mindmap software SimpleMind Pro (SimpleApps). Patterns across different participants were then sought, with recurrent themes identified if they appear across multiple transcripts. Superordinate themes which were present in over half of the sample were included in the write-up. See Appendix G for a more detailed account of the process of analysis.

4.4.6 Ethics

The research gained full ethical approval from the University of Roehampton Ethics Committee. Enabling informed consent was prioritised throughout recruitment. The Participant Information Sheet (Appendix B) was designed to fully inform participants about what participation would involve before agreeing to partake. It included details of study rationale, inclusion/exclusion criteria, and the practicalities of the interview process. It also included a summary of topics likely to be discussed at interview. It included information on recording and transcription processes, pseudonymisation and the limits of confidentiality. The sheet also informed participants of the potential advantages/disadvantages of participation and their right to withdraw up to the point of data aggregation. Participants were also invited to ask further questions to clarify if anything included in the Participant Information Sheet was unclear.

Once participants had read and confirmed that they understood the Participant Information Sheet, they were asked to sign the Participant Consent Form confirming they had given informed consent.

The issue of maintaining participant confidentiality was also taken seriously throughout the process. Given the nature of collecting data via recorded interviews, it was not possible to fully anonymise data given that participant voices and some personal details that arose in interviews may be identifiable. During transcription, participants were given pseudonyms and all other identifiable information was changed to minimise the likelihood of identification.

The researcher was vigilant with regard to the unequal power dynamic that exists between researcher and participant, which can lead to feelings of pressure and coercion during the research process (Berg et al., 2001). The researcher was mindful to avoid any unnecessary pressure during the research process. During recruitment, the risk of coercion was minimised by presenting participants with the Participant Information Form in a standardised email format without any additional pressure.

The Participant Information Sheet (Appendix A) informed participants about likely interview topics with the goal that participants be made aware and were emotionally prepared for what would be discussed. Where unexpected or sensitive topics arose, the researcher sought additional verbal consent. The researcher also used his therapeutic skills, remaining attuned to participant discomfort throughout the process.

A full debrief was provided following interviews, including an emotional check in and invitation to ask further questions. Participants were provided with the Participant Debrief Sheet (Appendix H) detailing follow-up information and services they could contact for support if required. This also reminded participants of their right to withdraw their data after the interview. At debrief, participants were provided with their participant ID number, and it was explained that they were to present this should they decide to withdraw data before analysis commenced.

The researcher remained attuned to his own emotional wellbeing throughout the process, drawing on his own personal therapy and daily mindfulness practice as means of emotional support.

5 Results

5.1 Chapter Overview

This chapter details the results that emerged from the IPA analysis. Three superordinate themes emerged, each with their own subordinate themes. These themes are detailed in Table 1 below. The chapter goes on to present a narrative account of the themes in more detail, providing verbatim quotations from the six participants in support.

5.2 Table Outlining Superordinate and Subordinate Themes

Table 1

Superordinate theme	Subordinate theme
Anxious Preoccupation with Sexual Performance	Experiencing the body as mechanically failing
	The destructive impact of self-imposed performance pressure
	Viagra as a talisman to revive and enhance performance
Concerns About Viagra Dependence	Experiencing a pull towards needing Viagra
	Losing touch with "natural" sex
Struggling with Communication	The difficulty of sharing experience
	The healing power of sharing experience

Superordinate and subordinate themes

5.3 Superordinate Theme 1 — Anxious Preoccupation with Sexual Performance

5.3.1 Experiencing the body as mechanically failing

In their descriptions of erection difficulties (ED), when asked the question "can you share what typically happens when you experience erection difficulties?" all six participants experienced themselves as unable to provide a crucial mechanical bodily ingredient necessary to facilitate

penetrative sex. Feelings of loss underpinned this breakdown: loss of a mechanical ability to provide, loss of ability to carry out a crucial masculine function, and a loss of relationship with oneself, with the penis becoming something separate and other in its unpredictability.

The language used often echoed masculine gendered expectations concerning possession and provision: to "get", "have" or "deliver" an erection, something they saw themselves as failing at:

> *I can't even get it hard enough to actually go inside him. And that makes things really difficult, it makes things sad…* (Ben, 418–421)
>
> *…I tried to have sex with her, but my dick was not working…there was no connection from my mind to my penis at all.* (Daniel, 92–94)
>
> *…I just wouldn't be able to deliver because I wouldn't be able to get it up.* (Farouk, 644–646)

This perceived failure in provision was felt as a serious shortcoming, often experienced as a profound loss of masculinity. This was particularly the case for Seb, who describes ED as a kind of castration, feeling "like a sort of eunuch" (673):

> *You feel pathetic and like a beta male. Not "the man" …I feel anxious, and I feel like I'm not performing, and I'm inadequate somehow…* (Seb, 143–146).

Ben reported similar shame in an ability to provide something crucially masculine:

> *…I feel shame there. I feel less of a man because I can't get hard. It's not a great feeling…It questions "who am I?" and if I'm a real man.* (Ben, 103–113)

While for Farouk and Sam, both of whom identify as gay, the embarrassment of mechanical failure was magnified by visible contrast with a partner whose penis was seen as functioning correctly:

> *…one person has a boner; one person doesn't have a boner. There's no way of like hiding any of that.* (Sam, 620–622)
>
> *…he was very, very able to get an erection and sustain it really, really easily…and then in comparison for me it was just not happening, and it was really quite obvious...* (Farouk, 111–115)

Further panic arose from the unpredictability of erections: all of a sudden and as if without explanation, they seemed to vanish. This was particularly the case for Ash, when a disappearance act struck at a critical juncture with a potential new partner:

> *…we went back to hers; we were just kind of fooling around and we were about to have sex, and I had an erection, and then it just went…and I was like "shit, shit, shit"* ... (Ash, 240–247)

Daniel too experienced his penis as inexplicably losing consciousness when he most needed its co-operation, as if his penis had become separate from himself, with a will entirely of its own:

> *[I was] trying to shake it awake, trying to have a like one-to-one conversation with my dick, just like "please man, please just for me now, please".* (Daniel, 109–112)

Seb experienced similar humiliation witnessing his partner's hopeless attempts to resuscitate his lifeless penis:

> *… when I've had an erection and then lost an erection, there'll be this kind of moment where my partner will be trying to do all the things to get it going again, and it just makes it worse.* (Seb, 289–292)

In these descriptions, there is a breakdown between an intention to engage sexually and the required bodily response. A frustrating non-cooperation between mind and body was felt acutely by Sam too, who felt his body as endlessly lagging behind his intention. To counter this disconnect, Sam described taking a managerial position with his non-cooperative body. Again, the language is masculine and business-like: he must deliver, sex is a "job" to be "finished". The penis is like a useless employee which the mind must keep under strict control:

> *Well like my mind is there but my body's not catching up…my mind has to lead my body constantly. So, it has to be like "right, ok, well I'm gonna get you hard because we're gonna finish the job" and then that's when you employ the strategies.* (Sam, 319–332)

Daniel deployed similar psychological "strategies" to facilitate bodily co-operation, though his inner monologue sounds less managerial and more like the overwhelmed, underconfident employee:

> *…in my head I'm like "don't fuck this up, don't fuck this up, don't fuck this up" …and then sometimes you might even close your eyes to think about something just to make sure that it stays.* (Daniel, 610–617)

Feelings of unpredictability and breakdown were intensified by not having a clear explanation of why their bodies were not "working". Indeed, although the interview schedule explicitly questioned participants on their understanding of what they thought had *caused* their ED, none were actually able to provide a clear-cut answer. This uncertainty often generated greater levels of anxiety.

This was felt keenly by Farouk, for whom ED arrived alongside chronic fatigue and anxiety and who experienced the inexplicable nature of these difficulties as frightening:

> *…I just wasn't sure what was happening really. I just felt really tired all the time, and I knew that the days I felt more tired, the days I couldn't really get it up as much.* (Farouk, 512–515)

While Ash first dismissed his ED to occasional cocaine use, he described how "slowly it started to seep into sober sex as well" (12–13), eradicating the comfort of an external cause to blame:

> *I think it's just a whole load of different factors, the coke thing…and then maybe some hormonal stuff … I don't know what it is, I'm just trying to find various reasons for what it could be.* (Ash, 645–651)

Similarly, Ben found himself sifting through a multitude of different possible psychological factors and medications, struggling to isolate one identifiable cause:

> *I think the reason is because I've got depression, and I've got anxiety, so I'm on medications. But most of that is epilepsy medications, I'm epileptic, I'm on quite a lot of epilepsy medications as well as antidepressants. And that's affected my sex drive and low libido. But also, I've had an alcohol addiction as well, and a sex addiction, and body image, and low confidence, and that all kind of multiplies.* (Ben, 46–55)

And while Daniel came later to understand ED as common side effect of taking the drug ecstasy, not having this knowledge to hand when he first experienced ED meant he did not have a clear explanation of what was happening, causing panic:

> *… I didn't know that this was a common side effect of ecstasy or taking too much of anything. The connection's gone, you're just all lovey but you just can't do anything with it… She was asleep, and I was just up in bed next to her just like "Ah, I can't believe this is happening."* (Daniel, 101–109)

5.3.2 The destructive impact of self-imposed performance pressure

When asked the question "what do you understand the causes of your erection difficulties to be?", though participants often lacked clarity as to what first caused their ED, there was a consensus that subsequent anxious preoccupation with losing an erection led to a "self-fulfilling prophecy" (Sam, 197), creating a cycle that was difficult to escape. This meant although they could not necessarily identify what had first caused their difficulties, they went on to recognise anxiety as the most potent contributing factor:

> *…when it started happening, the more I was really conscious of it, and the more I was worrying about it, which led to a vicious cycle.* (Farouk, 150–153)

> *…it would be like a feedback loop…maybe [it] just wasn't quite as hard as it could be, or it wasn't going up to command. And then you'd think about it, and then you'd stress about it, and then it would make it worse.* (Seb, 36–42*)*

The military language Seb borrows here evokes a commander unable to control a mutinous soldier. Anxiety stemming from a felt lack of control was evident across participants, as was a recognition of anxiety's *causal* role in ED. Daniel used a thought experiment to demonstrate the destructive potential of intrusive anxious thinking:

> *It's the famous thing of "don't think of a pink elephant" and then you'll be thinking of a pink elephant. So, in my head I was thinking "don't get ED" so that I would be like "oh, shit. Ok, woah, hold on, hold on, hold on".* (Daniel 709–714)

When exploring their anxiety, participants regularly conceptualised sex as a performance and ED as performance failure. This was often linked to imagined catastrophic outcomes: relationship breakdown, negative partner perceptions, diminishing masculinity, or feeling strange and different.

Ash, who had sex solely in casual contexts, had initially prided himself in the high quality of his sexual performance. Sensing his performance decline took a significant psychological toll:

> *… as soon as you realise that "oh shit, I'm not going to be able to perform" it just kind of felt like I was falling into a hole. It's just so embarrassing.* (Ash, 84–49)

Farouk conceptualised performance failure as indicative of strangeness compared to other men who he imagined performed with ease, leaving him feeling undeserving:

> *…I'm not a person that deserves to be in a relationship or have gratification of long-term sexual happiness, because I'm not able to perform something that's really, really fundamental …* (Farouk, 250–254)

Seb similarly linked performance failure with a fundamental masculine shortcoming:

> *I would kind of feel a little bit like not manly enough and feel like I have to do it and be "right, I need to have sex now" and then not performing, and then getting more stressed…* (Seb, 63–67)

Sam described similar anxiety about how a poor sexual performance risked derailing the necessary forward motion of a burgeoning new relationship:

> *… if it's gone well, I feel intense relief because it's like I've been able to check that box and keep the train moving.* (Sam, 262–267)

The catastrophic fears linked to perceived poor sexual performance explain the heavy weight of anxiety linked to ED. For most of the participants, however, these fears were never realised. This was not the case for Daniel, who was explicitly shamed on Twitter by a casual partner, an incident he calls "the bad dick report". In Daniel's description of this incident, which he identifies as the genesis of his difficulties, he links sexual performance failure, a damaged sexual reputation amongst his female peers and diminishing self-worth:

> *… in my head my world crumbled…all I was just hearing was girls in the group chat laughing about it… like "oh my god, he's actually not even really good at sex, how dare you, you're just chatting all that good game" …* (Daniel, 58–68)

Ben was the only participant not to mention sexual performance, perhaps as he was the only participant who only experienced ED within an established long-term relationship. Performance anxiety seemed most acute in casual hook-ups, or in the early stages of relationships where sexual performance failure might impact that relationship's future:

> *I saw this fledgling relationship, and I wanted to keep up this expectation that we'd have sex a lot, and it would be getting better and better…* (Seb, 785–790)

5.3.3 Viagra as a talisman to revive and enhance performance

Experiencing their bodies as mechanically breaking down and battling the feared catastrophic outcomes of performance failure, when asked "how have you found using pills like Viagra[3]?" participants reported using the drug for its ability to restore bodily function and revive waning sexual performance. This was in part to counteract the uncomfortable psychological consequences of sexual decline. As for Seb, Viagra was sometimes reached for impulsively as a simple, quick solution in a moment where frustration became intolerable:

> *There was one or two times where I was like "oh my god, I really wish I was able to get an erection" but I couldn't. So, I bought some Viagra."* (Seb, 16–20)

Participants' stated reasons for seeking Viagra often mirrored the content of their greatest anxieties. Ash, for example, connected seeking Viagra with protecting his sexual reputation amongst peers following a particularly embarrassing incidence of ED:

[3] Within this chapter, the name 'Viagra' is used as a catch all term for all PDE-5is, reflecting the way in which participants used the word and how it is used in culture more broadly.

> *I just felt super paranoid that it was just really bad and awkward and she'd tell my friends and stuff…So that was the final straw, and then I thought "you know what, I need to just look into this" and then that's when I took Viagra.* (Ash, 264–273)

In such cases, Viagra functioned as a kind of talisman kept close at all times to protect against the painful and humiliating emotional consequences of ED. Daniel was equally explicit about reaching for Viagra to defend against a repeat humiliation of "the bad dick report":

> *…on my way back home, I was thinking "I never want to be in that situation again…". So as soon as I got home, I put Incognito onto my laptop, started to find out ways for me to order Viagra…* (Daniel, 122–128)

Both acknowledged the psychological function Viagra played for them, with Viagra used to fend off difficult emotions. For Ash, Viagra's presence was a means of comfort and reassurance, the metaphor of a safety blanket imbuing the relationship with an almost child-like dependence:

> *…I guess that's why I have a Viagra on me is it's kind of a bit of a safety blanket now at times.* (Ash, 228–230)

Meanwhile, for Daniel, it was a weapon to fend off a repeat of the humiliation of being witnessed as impotent and to protect his sexual reputation. Daniel's Viagra talisman, then, was something hypermasculine and powerful, but also potentially dangerous:

> *Do you know how people say they have guns for protection? So, I needed to have a Viagra just in case.* (Daniel, 216–218)

For Farouk, who worried that a declining body would deem him incapable of sustaining relationships, Viagra's power was sought to restore a sense of normalcy and secure relational futures:

> *That is the reason why I took Viagra…to feel normal again…so I would be able to meet a partner again and we wouldn't have these issues because I'd be able to perform sexually, consistently…* (Farouk, 534–538)

For Seb and Ben, who both felt that their experiences with ED had drained their masculinity, the mechanical restoration that Viagra provided was experienced as masculinity restored:

> *… at that point you feel like it's there, it's big, you're the man and you kind of find it hot that you can do this.* (Seb, 937–941)
>
> *…it gives me that power to be that man.* (Ben, 469–470)

The mechanical security that Viagra provided liberated participants from the anxious cycle of self-focus that maintained their difficulties. As internal noise quietened, participants were better able to be present and enjoy their sexual experiences:

> *…it was one less thing to worry about, so I would be able to get out of that cycle, get out of that headspace and just enjoy things for what it is*. (Farouk, 839–843)

The psychological benefits of Viagra use were felt most acutely by Ben, whose ED was most severe, and who suffered for several years before seeking help. The repercussions of Viagra's restorative powers were so transformational for Ben that he imbued it with pseudo-religious characteristics, as "an absolute miracle…an absolute godsend." (505–506):

> *It's amazing how a drug that makes you have an erection can give you so much confidence and relieve so many worries and stresses in your life. Because you're able to do things that you weren't able to do before.* (Ben, 850–858)

For Ash, relief extended to the moments approaching sex, where fears of anticipated performance failure had left him feeling preoccupied and disconnected. Having a pill nearby provided psychological reassurance permitting presence and peace:

> *I'm myself, and not worried about the elephant in the room. Cause I know I can just pop a pill on the way to either mine or her house, and we can have sex comfortably and enjoy it knowing that there's a kind of 100% solution there.* (Ash, 907–912)

Seb was more sceptical of Viagra's capacities though, disappointed that it only rectified bodily functioning and failed to reinvigorate his depleted sexual appetite:

> *If you can't get an erection, it can do the mechanical thing…. So, it does functionally work, but it's not a wonder-cure…It's just a kind of tool*. (Seb, 1337–1342)

Sam's patterns of Viagra use differed significantly from the others. Though he experienced acute anxiety around his ED, he resisted using Viagra in sober sex. Sam spoke of attending so-called "chemsex parties", using recreational drugs like the central nervous system depressant Gamma hydroxybutyrate (GHB) and the stimulant mephedrone to facilitate a disinhibited sexual space, liberated from the neuroses of erection anxieties. Viagra then was part of a cocktail of substances which both silenced anxious thoughts and ensured consistent sexual function:

> *…I was just like on drugs, so I was just very much forward about everything. But there was also Viagra there, so it didn't matter, because then you didn't have to worry about it...* (Sam, 407–412)

Though Viagra was always first sought to restore mechanical functioning, some participants went on to experience a body extended, finding their sexual performance enhanced, lengthened and magnified. This felt thrilling in comparison to previous feelings of absence and failure. Ben, for example, felt Viagra transformed him into a sexual superhero:

> *It's like a super drug…It gives me more than an erection, it gives me that stamina to actually go on and have more sexual intercourse…* (Ben, 569–584)

Viagra's capacity to extend was also experienced by Sam as suitable within the context of "chemsex" parties, where Viagra was one of many substances facilitating sexual excess:

> *I just wanted to have sex and do loads of drugs, and have sex with as many nice, hot people as I could, and do as many drugs as I could.* (Sam, 1024–1029)

Viagra's performance-enhancing capacities meant the boundaries between Viagra as a treatment and Viagra as a recreational drug began to merge for Farouk:

> *…I'll just maybe like nibble on half a pill… that's enough to both satiate my underlying confidence issues… But also just purely on the fun basis of it, on the enjoyment basis of it.* (Farouk, 910–915)

Viagra's use to *enhance* performance was notably absent from Ash or Daniel's accounts, despite their performance focus. This was perhaps because the quality of performance that Viagra provided was seen as the baseline, rather than something superhuman. Daniel hints at this here, suggesting the ability to "give rounds" as the key ingredient to protect against a repeat Twitter shaming. Though Daniel refers here to having sex multiple times in a row, the linguistic association with the power/danger of gunfire is once again present

> *… I was like alright cool, pop one, I'll be good…I know I'm ready to go give rounds, make sure that I'm never going to have a bad dick report again* (Daniel, 132–141)

5.4 Superordinate Theme 2 — Concerns About Viagra Dependence

5.4.1 Experiencing a pull towards needing Viagra

Given Viagra's power to restore mechanical function and enhance performance, all participants wrestled to varying degrees with a pull towards becoming dependent on using Viagra. Though Viagra was felt to reverse some of the psychological strains associated with ED, dependence introduced a new psychological complication, recasting Viagra's role from a rescuer to a menace.

To avoid becoming dependent, Sam kept Viagra use inside the already chemically saturated environment of chemsex parties, vigilant not to let use spill over into sober sex:

> *… I didn't want to become dependent on it, I didn't want to be like "I have to have this pill to be able to have sober sex" … I don't want to then have some sort of reliance on something that can be bought and is chemical…* (Sam, 828–838)

Seb set similar boundaries, limiting himself to "special occasion" use to avoid the additional shame that dependence would generate:

> *I didn't want to make it my go-to to take a Viagra, it was just like a special occasion thing… I thought that if I was just taking it on a Wednesday night, Thursday night, that I would feel really like I was just somehow reliant on it.* (Seb, 1014–1055)

The severity of his difficulties meant Ben couldn't choose as and when to use Viagra, leaving him battling with the likelihood of lifelong use. This was difficult as Ben already felt begrudgingly dependent on various medications for depression and epilepsy which he suspected were responsible for *causing* his ED. Nevertheless, the psychological risks of discontinuation were felt keenly as a potential frightening loss of sex and intimacy:

> *… will I have to be taking this drug for the rest of my life? The answer is possibly yes…if that drug was taken away, I would struggle. It would leave me in a very dark place…possibly being suicidal.* (Ben, 507–532)

Ash grappled with psychological rather than physical dependence, calling Viagra his "training wheels" (1116) keeping him physically/emotionally stable in and around sex. Like any child learning to ride a bike, he longed to cast off these stabilisers, hoping to take a frightening but necessary leap of faith to reengage in sex without Viagra as an emotional crutch:

> *…the only way to kind of dismantle [Viagra dependence] is to just break through it, kind of jump and hope you fly, right? And part of me thinks that actually I just need to leave the Viagra at home, and just trust myself. But I've now become a bit too dependent on it, and that fills me with anxiety.* (Ash, 568–575)

The psychological complication of dependence for Ash is clear in his description of how he would feel if sex was likely and he didn't have a pill to hand, leaving him exposed and having to confess:

> *Worry. Panic. And I would probably have to say that I've been having problems, and this is a possibility, and it's not them.* (Ash, 556–560)

Daniel experienced a strikingly similar psychological dependence to Ash, but the panic of not having a Viagra when he needed one had been the catalyst for Daniel to stop using Viagra altogether:

> *… I started to see you kind of have a mental crutch, like you need it there. If it's not there you can start panicking… that's when I was like "yeah, nah, this needs to get nipped in the bud".* (Daniel, 255–266)

Both Ash and Daniel came to recognise they had an emotional attachment to Viagra, but that it was something they probably did not actually need. Viagra thus shifted from being the solution to the problem. Indeed, following discontinuation, Daniel became highly critical of Viagra as a surface-level treatment which left the underlying emotional processes unaddressed, reinforcing a cycle of dependence:

> *… Viagra is only a quick fix, it's a plaster on a massive gaping wound. It's not gonna work forever…instead of solving the actual issue or what's causing me to have ED, I'm just getting a solution. … It's just now I'm reliant on this Viagra every time my dick's not working.* (Daniel, 971–979)

Farouk was the participant who reported least concern around dependence. In his responses, Farouk reported some of the similar psychological mechanisms which enticed other participants towards regular use — perceived performance enhancement and intensified sexual pleasure — but retained a relaxed and non-judgemental stance towards Viagra use, lessening the psychological burden of regular use:

> *…it's always been in the back of my mind when I'm having sex, you know on one of those days: "yeah I'm performing fine, but could perform a little bit better, or this could be a little bit more fun, have a little bit of a kick to it by taking Viagra to maybe just improve the experience". Yeah, sometimes I have done that, sometimes I haven't done that. And it's a bit fine either way, I guess.* (Farouk, 890–897)

5.4.2 Losing touch with "natural" sex

For several participants, dependence or regular use brought about another unpleasant psychological side effect: a growing sense of alienation from what "natural" sex and "natural" erections felt like. While Viagra was at first felt to give something back to participants which they felt

they had lost, a connection with "natural" sexuality was gradually recognised as the trade-off for this mechanical security.

For Seb and Sam, the desire to remain connected with "natural" erections was another mitigating factor against regular use. Symbolically, regular use felt like it would transform them into someone they weren't ready to become. For Seb, it indicated losing touch with his youthful virility by signifying "natural" erectile incapability:

> *… there's this part of me that always wanted to prove myself that I could still get natural erections… in my head it's like an old man's thing. And I wasn't quite ready to be that guy that can't get an erection.* (Seb, 1060–1064)

While Sam was comfortable using chemicals at parties, the idea of introducing Viagra into sober sex felt like giving himself over to chemicals entirely in a way that would deem the experience inauthentic and unreal, robbing him of contact with his true sexual self:

> *… it's almost like I'm not able to, like I don't have a sexual self. You know when people are like "you're only funny when you're drunk", it's similar to that. It's like, you have to have something else to make you this other person that you like being or want to be…it's like a fiction.* (Sam, 983–985)

While alienation from "natural" sex remained a fear for Seb and Sam, it was experienced first-hand by those who used Viagra consistently. Ben fluctuated between positions of relief with a revived sexual capacity and frustration that it wasn't truly him who was achieving this. He felt he was being gifted these abilities by something external, as if cheating, unable to own these improvements as his:

> *It is great, but it's not you. You're like the Viagra robot, the Viagra Ben, you know. It's not you. It's something else that's giving you that pleasure, and the ability to do that.* (Ben, 1045–1054)

Ben's description of himself as the "Viagra robot" echoes Seb and Sam's fears that dependence would transform them into something unrecognisably other. He tried to lessen the impact of feeling sexually automated by reattempting penetration without Viagra, but the renewed discovery that this wasn't possible reinflicted the psychological wound of dependence:

> *…I will try again to have sex without it, and I will repeatedly keep doing it…because I don't want to have to rely on a drug for the rest of my life… It is, it's a difficult one. Because you still want the sexual intercourse, but you want your natural erections.* (Ben, 1026–1063)

A sense of "natural" sexuality fading into the distant past as a result of repetitive Viagra use was also articulated by Ash:

> *…every time I take [Viagra] it's one less time that I could be having a natural erection…I guess sex is like one of the most natural things you can do, when you can't do it, it feels very unnatural, and you want to return back to that natural feeling.* (Ash, 893–931)

The ease with which erections were possible using Viagra meant Daniel began to doubt whether he was even actually attracted to the women he was with, and subsequently why he was having sex at all:

> *…on Viagra, it wouldn't take much for you to get an erection, like fucking the wind would blow and then next thing you know you have an erection. So, do you genuinely like this person? And then you start questioning why you're having sex with them.* (Daniel, 235–240)

Unease with the "unnatural" nature of Viagra use was also felt by some in the secretive nature with which they used it. Those who were not open about taking Viagra would swallow the pill secretly at moments when they felt sex was possible. For some participants, this felt problematic in two ways. First, the covert nature of this kind of use felt like anticipating sex without prior discussion or consent, which sat uncomfortably with their values:

> *…now as well I find if I am on a date or if I'm with a girl and I know we might have sex, I will swallow a pill in secret. And I don't want to do that.* (Ash, 770–773)
>
> *You wouldn't know whether you were going to try and have sex, so you'd have to like pre-emptively take a Viagra on your way home with someone, and that's not…I don't know, it just wasn't the kind of thing that I would do.* (Seb, 595–600)

Secondly, there was an unwelcome clunkiness to either having to openly plan sex, or deliberating stalling a sexual experience to provide opportunity to covertly take a pill and allow

enough time for it to take effect. This preparatory routine felt unnatural and abnormal compared to the spontaneous "natural" sex they felt they should be having:

> *… quite often sex isn't a plannable thing, so I seem to remember that one time being like "ok, now we're gonna have sex in half an hour" or something… but it's quite weird that you do sort of have to plan it a little bit, you can't be quite as spontaneous with it.* (Seb, 589–593)

> *... any man who has been offered with spontaneous sex would be like "yes please!" Me, I'm just there thinking "I need to prepare, shit I need to have this, ah fuck. Can we wait thirty minutes?" It takes the spontaneity out of it.* (Daniel, 1023–1027)

> *…about having to sneak it, and having to think "ok, I think we might have sex in half an hour" and then having to do it, and it's all kind of pre-emptive and weird. And I feel like I'm hiding it as if it's like, it just feels like it's weird to hide that…* (Ash, 778-783)

While Daniel initially sought Viagra to avoid a repeat public humiliation, secretive use generated a new humiliating fantasy: the fear of being publicly "outed". The shame at the core of this fantasy is in being caught cheating, like an athlete failing a drug test, as if — like with Ben — the superpowers of a superior sexual performance were revealed to be induced unnaturally:

> *…it was the possible embarrassment of me going to a club, having my wallet searched and then someone pulling out a fucking Viagra and having to explain myself…as if I was like Superman without his cape. It's like "no, I've gone out without my glasses, they know who I am, ah shit. The cat's out of the bag now."* (Daniel, 1009–1019)

Farouk was the one participant who did not express experiencing Viagra as feeling unnatural. In Farouk's conceptualisation of ED as one of many symptoms belonging to a sick body, Viagra was a welcome antidote, particularly in contrast to his other long-term conditions which lacked the convenient fix of such an effective medicine:

> *.. I have a number of long-term health conditions where there's no real medication or fix…And I think using Viagra is quite nice because it maybe is that more quick-fix medication that a lot of conditions don't necessarily have.* (Farouk, 936–943)

5.5 Superordinate Theme 3 — Struggling with Communication

5.5.1 *The difficulties of sharing experiences*

All six participants struggled at different stages to discuss their difficulties with casual and longer-term partners. Conversation was often avoided entirely or put off significantly. Some participants feared their partners would be offended, interpreting ED or Viagra use to mean they were considered unattractive.

Seb and Sam, for example, articulated the inner struggle they experienced in having to contain their thoughts for fear of a negative impact:

> *… you don't want them to feel somehow vulnerable, as if you're turning them down. And even when you really, really want it, there's a lot going on in your head, and it's just very hard to communicate it to a partner.* (Seb, 151–161)
>
> *I've never had somebody say "oh, are you just not into this?", but that's probably the unspoken thing. And I'm thinking "I am into this, but this is what happens to me", but I'm not going to say it with somebody I don't trust.* (Sam, 632–637)

While Daniel eventually became very open about using Viagra, he recounts how discussion in the early stages of Viagra use felt like opening up a relational "can of worms" — something disgusting and unmanageable. Adamant that disclosure would devastate any partner, he was determined to keep his use a secret:

> *Never. I could never…because that would open up a whole can of worms. Because literally, at the end of the day, it's hard for people to get out of their own heads…they would take it as an insult. So, I would just never tell anybody at all, yeah.* (Daniel, 876–888)

For Ben and Farouk, ED arose in the context of existing relationships, making discussion trickier to avoid. In both cases, their partners did indeed interpret their ED as rejection, leading to the very relational strain that Seb, Sam and Daniel had been keen to avoid:

> *…I always knew that my partner was disappointed…it was always "ok, have I done this? Have I caused this? Do you not find me attractive?" And it caused a bit of kind of chaos…I would just reassure him, basically, that "it's not you at all, it's just that I have problems".* (Ben, 285–296)
>
> *… [He] also took it very personal. He was like "oh, I'm not attractive enough for you, you don't want to have sex with me". And for me, not really knowing what was going on both in my mind and my body, I didn't really know how to respond to that…* (Farouk, 557–564)

While both eventually came to clearer understandings of the causes of their difficulties via helpful GP consultations, in the early stages neither knew what was happening. This added additional communicative difficulty as neither could provide a distilled explanation for their partner's reassurance.

The implication underlying these partner responses — either anticipated or real — is that an erection is something that *should* always be present in a sexual circumstance where you find the partner attractive. Implied too in this assumption is that young men should both want to and be able to have sex at any time. Thus, ED cannot be explained by anything other than finding a sexual partner unattractive. This belief is latent in Ash's reasoning for avoiding talking about his ED; he can't imagine this is something his partner has experienced with another man in his demographic:

> *… I was embarrassed that this was happening…And I just felt like "this is probably very alien to her". Just demographically for the guys she sleeps with...* (Ash, 325–333)

Indeed, for Ash, it was preferable to lie about having experienced rapid ejaculation — a sexual dysfunction more typically associated with the uncontainable arousal of youth — than be honest about the alien arousal absence of ED:

> *…if I'd hooked up with someone and I wasn't planning on it and I hadn't taken the Viagra with me, and I can't get it up then I would make an excuse like "I've come too quickly" or something like that.* (Ash, 396–400)

For Seb, there was also something ruinous about bringing vulnerable and anxious feelings into the performance-focussed sexual space. By invoking the possibility of "defeat", military language is once again deployed here: keen to cling onto the possibility of a sexual "victory", any attention drawn to erectile failure risks bringing about the shattering of a fantasy as fragile as glass:

> *…I feel like I'm treading glass. It's very hard to just say "I can't get an erection" … I'm still trying to hold on to a fantasy of myself in my head, and if I talk about it, it's somehow admitting defeat, and bringing a conversation into sex is just going to make it unsexy.* (Seb, 176–182)

Daniel made a similar connection between admitting difficulties to a partner and the shattered fantasy of being a superior performer:

> *… I would be nervous and shy to tell a new partner … I would think "oh my god, she's going to be disappointed in me. She was expecting to have the night of her life…"* (Daniel, 534–538)

Ash felt similarly that in performance-focussed sexual encounters, there was no room for unwelcome feelings and discussion:

> *It's just like an unnecessary complication to what should be a spontaneous and fun event, so why do I want to even bring that up when I don't need to? If I've got the solution in my pocket, why do I need to talk about it?…* (*Ash, 816–21)*

Viagra for Ash thus also provided a defensive function against the need to have uncomfortable and unsexy conversations, a sentiment echoed by Daniel:

> *…I didn't speak to anyone because the resolution was the Viagra. There was no way I could talk myself out of it.* (Daniel, 861–862)

While discussion with partners felt like a communicative minefield, participants also noted finding little space or safety to seek support elsewhere. Seb, Ben and Sam noted the difficulty in sharing openly with friends for lack of understanding, maturity, or discourse permitting sexual vulnerability:

> *… I wouldn't talk about it in a serious way with my friends. In fact, just thinking I've never spoken about it with my counsellor either. I've never really spoken about it in an earnest way with anyone…I'll always end up bringing it up in quite a performative, jokey way with friends* (Seb, 1090–1097)
>
> *I find that, with myself anyway, I don't want to talk to others, like my pals, about this because they probably would laugh to be honest.* (Ben, 716–717)
>
> *… I had gay friends at the time, but we weren't mature enough to be able to talk frankly about stuff…I was just younger, so I had less experience of the world.* (Sam, 716–720)

Farouk, like Sam, had seen a therapist regularly, but never brought up his ED in the space, indicating he did not feel comfortable bringing in sexual concerns:

I haven't actually ever talked about this with my CBT therapist…I never talked about ED or erections, because I think I was a bit embarrassed.... (Farouk, 989–1000)

For Ash, the only participant who had neither sought professional help nor discussed with partners or friends, our interview was by far the most time he had ever dedicated to discussing his difficulties:

…we've been chatting for an hour and I think that's 59 minutes more than I've actually probably spoken about it with anyone. (Ash, 1320–1322)

The difficulty in opening up about their experiences seemed to be exacerbated by a widespread perception that ED was an older man's condition, and that Viagra was for older men. When responding to the question "what were your perceptions of pills like Viagra before using them?" participant responses suggested they universally associated the drug with older men, revealing that a core component of their shame was feeling that they did not fit the associated clinical profile. This left them feeling particularly odd or strange and less likely to discuss their difficulties:

I felt like it was for old men. That it was something to be embarrassed and ashamed about...it's reputation is definitely something for older people, and even then only if you're desperate. It had all these negative connotations to it. (Ash, 738-759)

I perceived it as a laughable experience for like old people. You know, the picture was an old, white man. Like a silver fox his head in his hands, like a stock photo. I can picture it so well. Yeah. *But that just wasn't me.* (Sam, 800-804)

Being what age was I, being 28 or something and put on Viagra in your twenties, and when you think or when your perception is, because that's the way the media perceives it, as being an older man's condition… you just think "ah, what's wrong with me?" (Ben, 879-885)

I think of an old man who doesn't look after himself, lives a stressful life, drinks too much, smokes too much, and then that effects their erectile dysfunction. Whilst I see myself as someone who's like young, really healthy...yeah I'm young and healthy, and I haven't dedicated my whole life to my job. That was my perception of Viagra. (Seb, 1022-1030)

5.5.2 The healing power of sharing experience

Despite their catastrophic predictions, several participants found their partners surprisingly receptive to discussing their difficulties, with alternative perspectives that were often affirming and reassuring.

When discussing Viagra use with his partner, Seb experienced a dissonance between how problematic his ED felt to him versus how insignificant they were to his partner:

> *So, it's quite amazing, the reaction from my partner…She just was like, it doesn't matter either way, which I thought was a really good reaction from her…Well, that's the way [she] communicated it to me…I still have a seed of doubt...I think what a person says is not what they think.* (Seb, 1203–1239)

However, Seb struggled to fully believe her perspective, suggesting perhaps the power of internalised sexual expectations to override partner reassurance.

Such doubts were not shared by Sam, who in time found explicit communication was the greatest remedy for overcoming his ED. Sam recognised a correlation between his difficulties and new relationship anxiety, and when given reassurance about the future of the relationship, anxiety related to ED would vanish, as if his erection no longer carried the heavy burden of keeping the relationship alive:

> *… essentially I said "I'm not going to get a boner when we first hook up." …[and] he was courageous and was like "I don't care, I see a future with us"…and then instantly I didn't think about it or worry about it.* (Sam, 644–655)

While Daniel had first found the thought of open communication terrifying, he had over time become very open with previous Viagra use. This shift was catalysed in part by a conversation he had had with a previous sexual partner with whom he had used Viagra, comparing perspectives of their first sexual experience. Learning that his partner had experienced performance anxiety too, he had

come to consider "good sex" as a collaborative and communicative endeavour, not the individual performance he had previously thought:

> *…me talking about my issues and my anxiety, that opened up the discourse to talk about sex anxiety as a whole, all of the issues that both [sexual partners] go through. I was like "oh shit, oh my days".* (Daniel, 918–923)

Daniel had since become an outspoken advocate for a communicative rather than performative approach to sex, though he partially attributed this transformation to being embedded in a secure long-term relationship:

> *…I've been in a long-term relationship so it's been something where if there was any issues we can just talk about it there... But communication was the biggest thing I needed to break out of the whole relying-on-Viagra type thing.* (Daniel, 514–522)

As Ash had been single for the duration of his ED and Viagra use, he lacked the relational safety that had facilitated liberating conversations for these participants. He was however aware of an inner longing to share, be heard and lessen his feelings of isolation:

> *To be honest I just wanted someone like you to talk about it, like a professional. And also, just kind of hear how other men might, do they have shared experiences, how do they come out of it and things like that.* (Ash, 1304–1310)

Indeed, transformational conversations about ED didn't just come from conversations with partners, but in help-seeking contexts too. Though Ben and Farouk both struggled with partner communication, both had had consultations with GPs which had felt normalising, validating and relieving. For Ben, part of this reassurance came in being told that having ED is both common and possible in his age bracket:

> *…the doctor was amazing; the doctor was really great. And he says "don't worry, everybody, every man gets erectile dysfunction at some point in life. Everybody at all ages gets it, and it's not just what you think as being a later generation".* (Ben, 223–228)

For Farouk, much of his distress stemmed from an initial lack of understanding as to what was causing his ED. A positive GP consultation provided relieving diagnostic clarity by proposing a link between ED and anxiety, which made sense to Farouk:

> *… I was diagnosed with generalised anxiety disorder, and my GP said that you know a lot of these earlier experiences with ED probably stemmed from that…having that diagnosis and talking it through holistically with my GP for the first time, it did make a lot of sense…* (Farouk, 168–185)

In receiving diagnostic clarity from a medical authority figure, Farouk was better able to accept what had previously been confusing and frustrating, and in accepting the explanation of a link between ED and anxiety, he could deduce a probable commonality in experience with other men his age, lessening his isolation:

> *…certainly men, younger men have a lot of mental health problems that they don't tell people, which then leads to symptoms of ED as well. So, I don't feel ashamed or like I'm the only one anymore, as I did maybe when I was in my early twenties. I just feel like it's just part and parcel of life.* (Farouk, 704–717)

Indeed, many participants appeared to be aware of the different ways in which sharing experiences may have served as a powerful intervention even before they had reached out for help or spoken to others. Despite the fact that most participants sought Viagra as the fix to their ED, when asked the question "how you think support for younger men with erection difficulties could be improve?", many recognised that wider systemic visibility, active questioning from professionals and open discussion between peers would been most beneficial whilst they had been suffering.

Participants came forward with different ideas for how this might be achieved. For Farouk, active questions from professionals as part of routine assessments would have been vital to enable such discussion. He spoke about how he would happily have engaged psychosexual services but that, despite regularly attending sexual health clinics for check-ups, he had never been asked questions around his sexual wellbeing which may have led to a referral.

> *So, I actually didn't know you could be referred to any service…only recently I think did I eventually become aware of psychosexual services. I just thought I wouldn't be eligible. I never get asked questions about ED or sexual health or even mental health actually… I don't think I've ever been asked those questions.* (Farouk, 1121-1133)

Despite not having shared his experiences with anyone before our interview, Ash reported a similar desire to speak openly with a professional about his difficulties and how this might have eased the psychological burden and loneliness of his experiences:

> *To be honest I just wanted someone like you to talk about it, like a professional. And also, just to kind of hear how other men might…do they have shared experiences? How do they come out of it? Things like that.* (Ash, 1304-1310)

For Sam and Ben, open and honest discussion in groups of peers who may have suffered from ED, or peer-led conversations about sex more generally, would have proven the most helpful intervention:

> *The most helpful thing would have been my peers openly talking about it and kind of sharing experiences and normalising it. That would have been the most helpful thing. It needs to be normalised. We as men need to be able to talk about this as it's a common thing that inflicts us.* (Sam, 1089-1092)

> *We need to have conversations around that as men, because that's something that we don't talk about, sex and sexuality, sexual problems. We don't. And it can drive people crazy, it can drive people to the brink, it can drive people to suicide*. (Ben, 1121-1124)

For Seb, actively building in a more relational focus into the sexual education syllabus would have helped alleviate the detrimental performative focus on sex which he felt had exacerbated his ED:

> *Maybe sort of teaching in school that it wasn't all on you. So, developing an understanding in society that it takes two to tango, and it wasn't all on you. You weren't the key to having sex. Really letting young people feel that would be great.* (Seb, 1202-1207)

Indeed, when asked the question "what interested you in taking part in this study?", several participants shared that they themselves had wanted to contribute to a dialogue which they felt was

missing, hoping to shift the perception that ED was something which only impacted older men. Through their contributions, participants sought to use their experiences as a means of helping other younger men who might be going through the same difficult experiences that they themselves had struggled with:

> *…the best thing we can do is kind of own it, deal with it, and kind of help provide psychological support to other people going through the same thing. I wish that when it was happening to me things were more normalised to speak about then. Through this discussion I want to be part of that.* (Ash, 975-992)

> *Why I'm interested? I feel like this topic specifically is quite common for men under 30 and 40. I feel like there's a barrier that's still there, particularly with younger men, that they're still overcoming…so I thought it was quite interesting when I saw the advert for this, maybe it might be quite informative for myself just talking it through, but also to use my experiences to help others.* (Farouk, 7-21)

> *I think it's important for yourself to learn as much as possible and to get as much experience. And I wanted somebody like yourself to do that because I know how difficult it can be for a people out there, because I've been in that situation. I think it's an issue that not a lot of men talk about. And it's very embarrassing, and it's very difficult. And I wanted to help…to stop the ridiculous stigma related to that.* (Ben, 23-32)

5.6 Reflexive Interlude – Finding Myself in the Data

To be a reflexive researcher means investigating how one's "experiences and contexts…inform the process and outcomes of inquiry" (Etherington, 2004, pp.21–32). The following is therefore an attempt to situate myself[4] within the topic and consider how my own experiences might have shaped the way I felt, thought, and responded on this journey of research.

As a teenager, I experienced considerable self-doubt and anxiety about sex. These feelings were incongruous with cultural messages presented to me, from which I understood that young men should be confident, competent, dominant, and have limitless sexual appetite. That my experience did not match these messages meant concluding that I was in some way defective.

[4] Though most of this project is written in the third person, it was deemed important given the personal nature of this statement to write from a first-person perspective.

The ways in which sex was discussed by my peers reinforced these anxieties — bravado, bragging about sexual conquests and casual misogyny thrived. To be part of these social circles meant engaging in such discourses, deepening the gulf between my actual experience and how it seemed I *should* feel and behave. Pornography too was an imposing force on my sexual education: the hyper-masculine bodies, dominant sexual behaviours and gender relations enacted therein all crystallised deeply unrealistic sexual expectations before I gained the opportunity to learn from real-life encounters.

Within this landscape, there was no representation of the vulnerability, confusion, or insecurity that I experienced, nor were there openings for me to ask the questions that might have helped normalise such feelings. Sexual education exclusively covered biological concerns — sexually transmitted infections and pregnancy prevention — with no discussion of the difficult emotions which inevitably accompany early sexual experiences. Pornography was never discussed, nor were cultural presentations of masculinity or gender relations ever critiqued.

As I have matured, gained experience, and spoken openly about my concerns with partners, peers, and therapists, I have come to learn how common these anxieties are. This has been a relief, but I have also felt sadness over how these anxieties may have softened earlier had there been previous openings for discussion.

But as a reflexive researcher, I should strive not only to situate myself in relationship to my chosen topic but scrutinise the ways in which this relationship might have impacted on the process (Kasket, 2012). I began this research imagining that the kinds of anxieties I experienced in my youth may be shared by my participants, and there have undoubtedly been aspects of participants' accounts that speak to my own experience. The issue of performance anxiety particularly resonated, as did the felt sense of a lack of opportunities to discuss sex beyond the biological level alone.

There have been moments throughout the research process where I have been inadvertently reminded of my demographic similarity to my participants. During recruitment, for example, I began to receive large amounts of targeted advertising for purchasing PDE-5is to my social media accounts,

with artificial intelligence bots obviously identifying me as belonging to a social group likely to make a purchase. These similarities mean there has been a risk of over-identifying with participants in whom I recognise my own narrative, neglecting seeing them as individuals with their own experiences, and overlooking data which does not align with my expectations.

Driven by an increased passion in the subject of this project, I also began a placement in a psychosexual service in my third year of training, working with several young men with ED, some of whom had used PDE-5is. I am aware therefore that this situates me in something of a biased position towards psychological formulations/interventions for ED, of which I have had to be vigilant in my analysis and discussion of the data.

The difficulty in managing these positions has been in trying to tease out what might be the result of my own bias versus what might be genuine shared experience. I have worked hard on a parallel journey of personal reflection here, utilising personal therapy and research supervision to hone my process of bracketing. This has not always been easy, and entirely removing myself to become a passive and neutral researcher would have been an impossible and perhaps unhelpful endeavour. There will always be elements of my own story involved in the construction of the data which I think speak to the commonality of shared human experience.

6 Discussion

6.1 Chapter Overview

This chapter begins by considering the results in light of the existing literature discussed in Chapters 1 and 2. It will explore the implications of these findings for policymakers and practitioners working with this population. It will finish by suggesting possible future avenues of research grounded in the findings of this study, concluding with a summary of the study and its implications.

6.2 The Epistemological Challenges of Synthesis

A core rationale of this study was to explore in greater depth what might be happening experientially for younger men with ED, so as to gather, from a critical realist (CR) perspective, further knowledge at the level of the "psychology of the individual" (Bhaskar, 2016b). The justification for this exploration was based on epidemiological studies which suggested a link between various concerning factors and ED in this population, such as anxiety and depression diagnoses, poor genital self-image and risky sexual behaviour (Akre et al., 2014; Capogosso et al., 2013; Jern et al., 2012; Mialon et al., 2012; Posavec et al., 2018; Pozzi et al., 2020; Tambling & Reckert, 2014).

However, since IPA is concerned with the texture and meaning of lived experience (Smith et al., 2009), discussion of these findings will require synthesis with a body of pre-existing data that is primarily quantitative in nature and thus grounded in a different epistemological framework. This is a difficult task, and so the researcher approaches it with Bhaskar's position of epistemic humility (Pilgrim, 2020) in mind, acknowledging that the available findings across both qualitative and quantitative studies the conclusions drawn can only reflect a limited representation of a highly complex phenomenon.

6.3 Situating Findings Within the Current Literature

6.3.1 *Elucidating the relationship between ED and wellbeing*

Diagnostic measures for anxiety and depression were not used in this study since they are incongruous with IPA's epistemology (Smith et al., 2009). Nevertheless, given the often intense and

difficult emotions shared in relation to participants' experiences of ED, it is unsurprising that epidemiological studies consistently found close ties between ED and mood disorders (Akre et al., 2014; Capogosso et al., 2013; Jern et al., 2012; Mialon et al., 2012; Pozzi et al., 2020). That three participants in the present study were using selective serotonin reuptake inhibitors (SSRIs) and one was diagnosed with generalised anxiety disorder (GAD), alongside experiencing ED, suggests a similar trend here.

When considering the interplay between ED and wellbeing, it is clear that feelings of anxiety were central to ED experiences. The subordinate theme of "the destructive impact of self-imposed performance pressure", and the maintaining "negative feedback loop" described by participants bears notable similarities to the existing formulations of *psychogenic* ED discussed in Chapter 1. Evidence of Masters & Johnson's (1970) *spectatoring* — the anxious evaluation of self at the expense of focus on erotic cues — is evident in abundance in descriptions. So too is their concept of performance anxiety (PA): participants regularly conceptualised penetrative sex as a performance to impress a partner, with ED seen as performance failure.

This preoccupation with performance and self also maps onto Barlow's (1986) cognitive-affective model of diminished sexual excitement. Participants' attentional focus whilst experiencing ED lay almost exclusively on their own bodies and, when experiencing their bodies as non-cooperative, shifted to the preoccupation with the social consequences of this perceived failure.

Aligning with Barlow's model, it was these feared social consequences of ED which participants were most anxious about and which most negatively impacted wellbeing. The feared responses of partners and peers seem to reflect the sexual myths, beliefs and demands which, according to later CBT treatment models, maintain ED (McCarthy & McCarthy, 1998; Nobre & Pinto-Gouveia, 2006; Wincze & Barlow, 1997). Of particular concern was a felt loss of masculinity, suggesting participants held a sexual belief that consistent and reliable erections were the masculine norm, and a lack thereof meant not being "man enough". Other recurrent and potentially problematic beliefs

included defining sex solely as penetration, believing sex was something to be "good at", that an erection is necessary for sexual contact, and that what most pleases a sexual partner is a strong erection.

The content of these beliefs echoes the contemporary masculine norms subjected to various critiques by feminist scholars, as discussed in Chapter 1: what Potts (2000) labels the "phallocentric imperatives constituting hegemonic masculinity" (p.88). This is a masculinity in which the presence and function of an erection is imbued with great symbolic and emotional significance, one that is rather fixed, one-dimensional, and not open to critique. The strength with which participants seemed to subscribe to these beliefs implies societal masculine norms may be being internalised by younger men, subsequently playing out in how they experience their bodies in sexual contexts.

That the two participants most attached to the quality of their sexual performance seemed most psychologically threatened by its decline is further evidence for this. This is worth considering alongside Noble's (2010) concept of negative self-schemas — ideas about oneself, others and the future triggered during ED experiences. It is possible that young men who place particular weight on the quality of their sexual performance, linking this to their self-worth, may be particularly prone to interpreting ED as a confirmation of failure and incompetence. The strength of such schemas, as Nobre & Pinto-Gouveia (2009) argue, may be a predisposing factor for ED in this population, as well as the degree to which ED negatively impacts wellbeing.

6.3.2 *Inside the confines of the "Viagra Mindset"*

In participant descriptions, there is a notable absence of sexual content. Sexual partners and their contributions are rarely mentioned, nor is there much description of what participants find psychologically arousing or physically pleasurable. There is little talk of what happens *between* bodies, as if participants are alone and isolated in their sexual encounters.

These descriptions suggest little experiential pleasure in sexual contexts. It is unsurprising therefore that previous research found low levels of sexual satisfaction in this population (Tamling & Reckert, 2014; Posavec et al., 2018). Participants often described sex as feared and potentially humiliating, with clear negative implications for mood, reflecting established links between sexual satisfaction and wellbeing (Buczak-Stec et al., 2019).

These low levels of sexual satisfaction might be viewed through the lens of subjectivities proposed by the social-constructionist perspectives discussed in Chapter 1. Loe (2004) discusses contemporary conceptualisations of ED as a "poorly functioning male machine", and under the subordinate theme "experiencing the body as mechanically failing", participants repeatedly described their bodies as being like machines with vital parts in disrepair: non-cooperative, unpredictable, and sometimes almost disembodied or "other". Such a mechanistic perspective indicates that participants experience their bodies as just another type of object in a world of objects, which need to be mastered and controlled by technological means, such as with PDE-5is.

This subjectivity also recalls Kleinplatz's (2004) "Viagra Mindset", in which an overly mechanical focus means the "subjective, interpersonal and social aspects of sexual experience are overshadowed…" (p.217). Kleinplatz argues for a more humanistic and relational turn in sex therapy, indicating the need for a subjective shift away from the physiological paradigm towards consideration about interaction, pairing, how people come together sexually and what a partner contributes to a sexual situation.

6.3.3 *A biological tool for a biopsychosocial phenomenon*

The subordinate theme "Viagra as a talisman to revive and enhance performance" represents the idea that PDE-5is — a biological tool — are sought to overcome psychological and relational anxieties. Thus, although PDE-5is work via a purely biological mechanism, they were used by participants as a form of *psychological* and *social* treatment.

This suggests psychological and social factors are relevant in the consideration of ED among younger men, providing support for Berry's (2013) argument that a biopsychosocial conceptualisation of ED is appropriate. This also indicates — as discussed in Chapter 3 — that conceptualising ED purely at the biological level of 'individual material circumstances' risks committing Bhaskar's (2016b) "epistemic fallacy": mistakenly conflating what is captured epistemologically for the entire ontological reality of a phenomenon.

Indeed, there is a growing consensus within the disciplines of urology and sexual medicine that ED should be thought of as biopsychosocial (Dewitte et al., 2021). Nevertheless, as evidenced by existing NICE guidelines (NICE, 2013), a predominantly biological targeting of ED-as-symptom prevails.

A biological treatment for a biopsychosocial issue would not necessarily be problematic if the biological resolution were to successfully alleviate related psychological and social difficulties. Indeed, this is evidenced to some degree in the data. Some participants experienced a reduction in PA and a greater ability to focus on erotic cues, while others found PDE-5is afforded the capacity to connect sexually with partners in consistent and meaningful ways, improving relationship quality. For some men, particularly those like Ben who require PDE-5is to maintain an erection in any circumstance, treating ED at the biological level may indeed have positive ongoing social and psychological benefits which should certainly be taken into clinical consideration.

However, participants' attempts to manage social and psychological difficulties using PDE-5is seemed generally insufficient in the longer term. One way in which PDE-5i use worsened psychological wellbeing was demonstrated under the "pull towards Viagra dependence" subordinate theme. The contents of this subordinate theme evidence Harte & Meston's (2014) hypothesis that PDE-5is are used as a psychological safety mechanism to protect against PA. Whilst this study cannot causally evidence Harte & Meston's hypothesis that PDE-5is actually worsen ED by impeding unaided erectile confidence, there does appear to be a relationship between participants who were psychologically dependant on PDE-5is and high levels of anxiety, often described as "panic", in relation to penetrative

sex without PDE-5is. The data from the present study suggests that it seems possible that using PDE-5is to alleviate PA may inadvertently worsen ED by maximising anxiety in incidences where PDE-5is are unavailable.

This relationship between PDE-5i dependence and PA also suggests that strong sexual beliefs and schemas might impact the urgency with which participants sought PDE-5is to address the feared consequences of ED. Daniel, who described experiencing significant PA, bought PDE-5is immediately after just a single incident of ED and subsequently developed a psychological dependence. Others, such as Seb and Sam, seemed more able to tolerate ED-related anxieties, avoiding ongoing PDE-5i use and overcoming difficulties by other means.

6.3.4 *The novel emergence of "unnatural" sex*

The second core negative psychological side effect that participants reported as resulting from PDE-5i use, "losing touch with 'natural' sex", seems to be an original finding not mentioned in previous literature. This may reflect the strength of qualitative research methodologies like IPA in this field, which privilege participant descriptions. Such a nuanced, subjective impact of PDE-5i use could not be captured on quantitative outcome measures that pre-define successful outcomes as improved erectile confidence and function, without considering how it may *feel* or what it might *mean* for a man to be medicated in a sexual context. The lack of previous qualitative studies on this population may explain why this finding has thus far been absent from research.

The feelings participants described under this theme could again be considered in light of sexual beliefs and myths, and how these impact wellbeing. It seems participants held beliefs that sex should be spontaneous, unaided and "natural", and the incongruity of PDE-5i use with these core values led to psychological distress. This calls into question the capacity of any biomedical intervention to overcome these psychological hurdles, since it was simply the fact that they perceived themselves as relying on medication to undertake something they felt should be fundamentally "natural" which generated distress.

The negative psychological side effects of PDE-5i discussed here may indicate why there are high levels of discontinuation amongst prescribed PDE-5i users (Althof, 2006; Althof, 2010; Rosen et al., 2004). It may be the case that while PDE-5is are highly effective at a biological level, the potentially complicating psychological and social difficulties associated with their use mean many men eventually decide that the negatives of use outweigh the benefits.

6.3.5 *Impediments to help-seeking*

Despite participants recognising the role that psychological factors played in ED, it is notable that none of the participants sought psychological help for the issue. Indeed, those in counselling and psychotherapy at the time explicitly noted not discussing ED, indicating that they found it either uncomfortable or inappropriate to do so.

That almost all participants managed their difficulties using PDE-5is rather than psychological support mirrors the research and treatment landscape discussed in Chapter 1, where biomedical solutions are perceived as the most accessible and effective treatment option. That four participants ordered PDE-5is online and one acquired them from peers also reflects trends noted by Musacchio et al. (2006) whereby very few young men receive PDE-5is through medical avenues. This behaviour also mirrors general help-seeking trends indicating younger men with ED tend to avoid seeking professional help, preferring to turn to the internet for advice and guidance (Jiang et al., 2020; Zhang et al., 2014). Only one participant was prescribed PDE-5is, and that was after five years of putting off seeking help.

It thus seems important to consider why young men are not seeking psychological help. Under "the difficulty of sharing experience" subordinate theme, participants expressed that their avoidance of help-seeking was due in part to feelings of shame and embarrassment. It may thus be the case that it is simply less emotionally strenuous to order a pill online than undergo anxiety-inducing conversations with practitioners.

However, participants also explicitly reported *wanting* to talk about their difficulties, feeling unsure of where to turn for support, and seeking PDE-5is as the only advertised option. This perceived absence of support indicates that better representation of available sources of help is necessary to facilitate help-seeking.

Participants' perceptions that ED amongst men their age was rare and atypical is incongruous with the data discussed in Chapter 2 indicating the relatively high and increasing numbers of younger men reporting ED (Capogrosso et al., 2013; Pozzi et al., 2018). This would suggest that greater public awareness of these statistics may be beneficial, since participants also reported that greater visibility of men their age with ED would have minimised distress.

It also seems concerning that for those participants who did reach out to GPs for support, the implication from these GPs that the participants' ED was likely psychological in origin nevertheless did not lead to their being referred on to psychosexual services in line with NICE guidelines (NICE, 2013). This also raises questions about the degree to which GPs are familiar with these guidelines and whether referral pathways are being followed correctly.

6.3.6 *Improvements within a relational context*

As discussed in Chapter 1, sex therapy and CBT formulations for ED encourage skills that can help shift the focus of sex away from something performative towards something relational. For several participants, particularly those no longer experiencing ED, the context of a positive ongoing relationship seemed to help minimise anxiety and improve sexual wellbeing. Single participants, however, seemed more likely to continue experiencing ED-related anxieties and using PDE-5is.

The improvement of ED based on relational context is worth considering in the light of Akre et al.'s (2014) findings that some young men's levels of ED reduce as their sexual experience increases, while others see no improvement. The findings of this study suggest it may not be the *amount* of sexual experience but rather the *nature* of that experience — in terms of finding a safe relational

context in which anxieties can be discussed — which minimises ongoing ED. Perhaps men who gain sexual experience with multiple casual partners do not find the opportunities to discuss and alleviate these anxieties, meaning they lack the relief linked to open communication described under "the healing power of sharing experience" subordinate theme.

Given this possibility, particular consideration in future research and treatment should be placed on those sexually active outside of ongoing relationships, especially since, as mentioned in Chapter 1, existing psychological interventions often require partner input, meaning single men risk being clinically neglected. Indeed, it could be argued that existing CBT and sex therapy interventions are rather conservative and exclusionary in their privileging of long-term monogamous relationships. In the development of future interventions, alternative relationship arrangements such as consensual non-monogamy should also be considered.

6.3.7 *Broad definitions of erectile normality*

Since diagnostic measures were not used in this study, ED severity could not be compared quantitatively between participants. However, participant descriptions suggest severity varied somewhat between participants. But severity did not seem to have a clear relationship with the degree of distress that participants experienced from ED. This seems to support Tambling et al.'s (2014) finding that sexual functioning *concerns* and actual clinical levels of dysfunction do not necessarily overlap, as well as Harte & Meston's (2014) finding that it is low erection *confidence* rather than actual clinical erectile dysfunction which is the common factor between prescribed and non-prescribed PDE-5i users. This data would also support their argument that younger men with low erection confidence but non-diagnostic levels of ED are self-medicating a *perceived* rather than clinical problem using PDE-5is.

This blurring of perceived pathological boundaries calls into question younger men's knowledge of what constitutes normal erection functioning. It would appear to support Tiefer's (1994)

argument that there is a disconnect between men's sexual expectations and what is biologically typical, indicating an expansion of the boundary of what is thought of as pathological.

This data is also worth considering alongside Musacchio et al.'s (2006) finding that 29% men were using PDE-5is to *enhance* sexual performance. While their study used questionnaires to divide categories of men into those who use PDE-5is for "treatment" and "enhancement", participant descriptions under the "Viagra as a talisman to revive and enhance performance" subordinate theme suggest the boundaries of these categories are not necessarily clearly defined. Participants regularly reported both revival *and* enhancement in their intention to use and experience of PDE-5is.

6.3.8 *The omission of medication as contributing factor*

It is notable that two of the participants in the present study attributed their ED in part as caused by prescribed medications. However, correlations between ED and these medications were not explored in the studies retrieved in Chapter 2. Only Mialon et al. (2012) explored medication, and this was medication use *without* a prescription.

This seems a worrisome omission, since sexual difficulties like ED are well-established potential side effects of anti-convulsive epilepsy medications (Yang & Wang, 2015; Yogorajah & Mula, 2017) and of SSRIs (Jing & Straw-Wilson, 2016). Furthermore, both participants reported *reduced* quality of life resulting from the ED they attributed to medications intended to *improve* quality of life. This finding suggests that considering the potential impact of medication on sexual function is fundamental when prescribing these drugs.

Given the relationship between SSRIs and ED, it seems possible that the link between mood disorders and ED found in epidemiological studies may be mediated in part by the side effects of SSRIs. This complicates the picture of interplay between mood, medication, and sexual function, requiring nuanced exploration of the interplay between these factors that goes beyond a simplistic organic/psychogenic binary.

6.4 Critical Evaluation of the Present Study

As discussed in Chapter 3, the purpose of IPA is to garner very in-depth detailed descriptions of a few participants' experiences and of their sense-making processes (Smith et al., 2009) and consider how this may be transferable. Results thus cannot be thought of as necessarily representing the overall experience of *all* men who meet these inclusion criteria, but to consider what *may* be happening for men within this group and used as guidance for further possible areas of research and treatment. Within a critical realist (CR) context, this data should be thought of as one of many possible lenses of examination, part of a multidisciplinary research approach combining multiple epistemological lenses working towards generating as clear as possible a representation of the phenomenon.

IPA uses interpretation as a core part of its epistemology, considering it capable of revealing greater depths of understanding from participant descriptions (Willig, 2013). However, in the process of interpretation, the researcher is "seeing [the data] through the researcher's own, experientially informed lens" (Smith et al., 2009, p. 36). IPA's process of *bracketing* involves an attempt to set aside one's assumptions in order not to project too much of one's expectations onto the data. The researcher has practised reflexivity, utilising supervision and personal therapy, alongside the hermeneutic circle — shifting between interpretations of individual parts and the contextual whole — to maximise awareness of his own presuppositions and minimise the degree to which these might spill over into the analysis (Smith, 2007). However, it is unrealistic to suggest that the researcher has entirely detached himself from the data, especially since — as discussed in the reflexive interlude — he belongs to a similar cohort to his participants, in terms of age, gender, and socio-cultural background.

IPA's use of a purposive sample means that participants had to meet particular inclusion/exclusion criteria, setting limitations on the data. Since neither the International Index for Erectile Functioning (IIEF; Rosen et al., 1997) nor the IIEF-5 (Rosen et al., 1999) were used, and only

one participant actually received a diagnosis of ED from a medical professional, it is not known whether participants would meet diagnostic criteria for *erectile dysfunction*. Results thus more accurately reflect combined experiences of both *perceived* and *diagnostic* levels of sexual dysfunction. A purposive sample also requires that it is the men themselves who come forward to take part, meaning the sample is subject to self-selection bias (Robinson, 2014).

The inclusion/exclusion criteria relied upon participants rather than medical professionals to determine their ED as psychogenic. Since participants had not had the necessary diagnostic tests to rule out an organic cause, it is possible that the sample includes data from men who were unknowingly experiencing ED with an organic component. Indeed, this may have been the case for Ben, whose experiencing ED in all contexts does not fit the "situational" character used to determine typical psychogenic ED (Masters & Johnson, 1970). However, research suggests many cases of ED have both biological and psychological contributing factors (Pollets et al., 1999; Pustuszak, 2014). With this in mind, alongside emerging evidence of the potential contribution of certain medications, perhaps the organic/psychogenic binary reflected in the inclusion criteria is oversimplistic, and a more nuanced criteria open to multifactorial aetiologies should be considered for future recruitment.

Given that difficulty discussing ED arose as a theme within the study, it seems possible that there are many men who would meet all of the inclusion criteria besides being "willing and able to discuss their experiences around this topic with the researcher". This exclusion of such men means the experiences of those who are acutely uncomfortable sharing their experiences may be unrepresented here. Equally, that it was deemed ethically appropriate to exclude those who were acutely mentally unwell or experiencing suicidal feelings means the voices of men who fit this category are also unrepresented.

The discomfort in talking about sex that participants reported may also have limited what participants felt comfortable sharing with the researcher, meaning experiences or details which were relevant but felt too difficult to discuss were omitted.

The inclusion criteria also meant that only those who had used PDE-5is were interviewed. This meant that younger men who had experienced ED but might have sought other types of treatment, such as psychosexual therapy or no treatment at all, were left out. This is important, since results seemed to indicate that PDE-5is were an easier and more accessible treatment to seek out than therapeutic interventions, yet this finding may in part have been biased by the inclusion criteria.

Although the age range specified was 18–40, the youngest participant to come forward was 26, perhaps reflecting a reticence to discuss these issues in particularly young men. This meant younger men's voices within this age bracket were not represented. Furthermore, although a range of cultural backgrounds and sexuality preferences were represented in the sample, these differences were not explicitly addressed when devising the interview schedule, since such differences were not explored in the literature which formed the study rationale. Differences along cultural or sexuality lines may be worth considering in future research.

This study has focussed on the experiences of cisgender men as the trends in the existing research which formed the rationale for this study focussed specifically on cisgender men. However, ED and PDE-5i use are also relevant phenomena for people with penises within non-binary and transgender communities, whose cultural contexts and experiences are likely to differ. The transferability of these results to these communities is limited and future research should go towards privileging the unique experiences of these groups.

The inclusion and exclusion criteria limited recruitment to the UK. This localised approach was intended to maximise applicability of data to UK treatment provisions, but it also limits applicability outside of the UK.

Finally, literature review for this project involved using specific search-terms such as "erectile dysfunction", "erectile disorder" and "impotence" (see chapter 2). These are terms used primarily within the paradigms of urology and sexual medicine and belong to specific, biomedical discourses. These terms were chosen because this is how ED is discussed within the NICE guidelines (NICE, 2013)

and the intention was to make the research as applicable as possible to current treatment recommendations. Nevertheless, using these terms risks inadvertently excluding literature which discusses ED using different, less commonly used terminology.

6.5 Clinical Implications

6.5.1 *Implications for practice*

As this project forms part of a professional doctorate in counselling psychology (CoP), the results are intended to contribute to knowledge specifically for this discipline. However, these clinical implications are transferable to any healthcare professionals working with younger men, particularly in a psychotherapeutic or mental health-focussed capacity.

Given the difficulty that young men experienced discussing sexual difficulties, and the tendency towards an avoidance of help-seeking evident in this and past research, practitioners should be proactive and open in communication about sex with younger male clients. That participants felt it inappropriate to ask existing therapists about ED suggests practitioners should not wait for clients to raise sexual functioning concerns but should facilitate conditions of safety and permission by addressing them openly. Given the evidenced close ties between ED and negative wellbeing, it may in fact be advisable to introduce questions about the quality of sex and relationships into routine mental health assessments in clinical settings. Given the positive impact of open communication about sex reported by participants, alongside the sense that such opportunities were scarce, simply providing young men with the opportunity to discuss sexual concerns may act as a protective factor against the development of difficulties like ED.

Some practitioners may find conversations about sex difficult or awkward, with evidence suggesting this can impact a patient's likelihood to broach sex as a topic (Cruz et al., 2017). It is thus imperative that practitioners work towards overcoming any embarrassment around discussing sex, so

as to minimise a collective avoidance of topics closely linked to wellbeing. This will require an honest and reflexive self-awareness by practitioners, who may also feel unskilled in this area given that sexual problems may not form a part of their core training. It may be tempting for practitioners to assume that the treatment of sexual difficulties should remain within the realm of those with specialist training. However, since the results of this study suggest younger men are unlikely to seek therapy specifically for sexual problems, non-specialist practitioners should be proactive in educating themselves and communicating with their clients to avoid clinical neglect. They should also familiarise themselves with possible NHS, private and third-sector referral pathways should clients require more specialist intervention.

To aid practitioners to these ends, those designing therapeutic training provisions may wish to consider building a focus on sex and sexual difficulties into training. Those already trained may want to consider continuing personal development (CPD) in this area. However, since a relatively basic normalisation of difficulties was a powerful intervention for participants who sought help, it would be beneficial for practitioners to simply familiarise themselves with the existing data on younger men with ED alongside psychoeducation on the ties between ED and poor mental health. It may also be helpful for practitioners to familiarise themselves with existing formulations of ED, and even with techniques such as sensate focus. Self-education in this area would be relatively straightforward and not require intensive or expensive additional training.

Practitioners should be vigilant to younger male clients who discuss sex and sexual difficulties primarily through a mechanistic or biomedical lens. They should take the opportunity to broaden understanding, introducing some of the potential social and psychological contributing factors to help clients begin to think about sex as biopsychosocial. The aim of this is encouraging a perspective of sexual difficulties that goes beyond medicalisation towards something relational and holistic. This perspective is congruent with CoP's value to prioritise growth and self-actualisation rather than focussing on diagnosis and pathology (Cooper, 2009).

Practitioners should be aware of the possible negative psychological implications of PDE-5i use and be prepared to discuss these openly, particularly if already working with young men with ED or other sexual difficulties. They should be aware of how easy PDE-5is are to access, that some may have a tendency towards psychological dependence, and that younger men using PDE-5is are unlikely to explicitly disclose this. Being curious and non-judgemental about the possibility of use should help facilitate discussion here. Practitioners working with younger men who they know to be using PDE-5is should also be aware of potential associated feelings of the shame of use, or an alienation from "natural" sex, and be proactive in discussing these psychological implications openly.

Given the high likelihood that many mental health practitioners including CoPs will be working with clients using SSRIs, they should fully familiarise themselves with the possible side effects of these medications, particularly associated sexual difficulties. It may be the case that the side effects had not been shared with clients, and so simple psychoeducation could provide an important intervention. This is similarly the case for those working with young men on anti-convulsive epileptic medications. Indeed, practitioners working with men with any sexual difficulties should be curious about *any* medication use and fully educate themselves on the possibility of negative side effects which may negatively impact wellbeing.

6.5.2 *Implications for PDE-5i availability and prescription*

The results of this study, particularly the potential negative psychological effects of PDE-5i use, have important implications for the ease of access of PDE-5is amongst younger men. There is no current information available on any potential negative psychological implications of PDE-5i use, which should be flagged as concerning. These findings suggest it may be important for those prescribing PDE-5is, such as GPs or urologists, to openly discuss potential negative implications of use with patients. It may be useful, for example, to provide clinical follow-ups for young men prescribed PDE-5is.

Given the majority of participants accessed PDE-5is without prescription, it seems vital to review the current information provided to those ordering PDE-5is via online pharmacies. It may be the case that the potential negative implications of PDE-5i use mean this ease of availability is highly problematic and requires review. Furthermore, advertising strategies which present PDE-5is as a quick and easy solution may need to be called into question as potentially problematic and ethically questionable given their omission of potentially complicating psychological side effects. Further research seems vital here to avoid potential harm of inappropriate use or overuse of PDE-5is.

Results indicate that GPs and urologists would benefit from conducting more biopsychosocial assessments of ED in younger men, ensuring that they are familiar with potential psychological and social contributing factors, and that these are not overlooked in treatment. They should also ensure that they are familiar with referral pathways for different kinds of treatment, so that if PDE-5is are found to be insufficient or to cause complications, they are aware of other potential options such as psychosexual therapy and can provide onward referrals accordingly.

6.5.3 *Implications for policy*

That PDE-5is were found to be insufficient for the majority of participants, and that they often brought about additional complications for users, suggests a potential need to review current NICE guidelines that PDE-5is should be used for ED regardless of suspected cause (NICE, 2013). Further research looking at larger populations of younger men using PDE-5is would be helpful here.

Given these findings, there is also a potential preventative role to be played in the design of sexual education programmes. Sex education could involve a greater psychological and relational component, for example. It may be beneficial for younger people to be educated earlier on the link between anxiety and sexual difficulties. Young people could also be taught about the range of possible sexual difficulties and the reality of these existing across multiple age groups, so as to normalise their experiences and minimise confusion and distress. These topics are currently not included in the

statutory guidance on relationships and sex education provided by the UK government (Department for Education, 2019).

Sex education could also provide a valuable space to examine norms and expectations that young people hold about sex, such as what constitutes "normal" erection functioning, and provide evidence-based information to help bring views more in line with representative data. It could place greater focus on developing communication skills for young people around sex, including how to discuss anxieties and difficulties with sexual partners, and how to overcome embarrassment and shame in order to seek help when needed. Finally, it could equip younger people with knowledge of what kind of help is available, and how to access this if necessary.

6.6 Valuable Areas for Future Research

Given the results of this study, the following areas are recommended for future research and should be considered by CoP researchers to maximise clinical benefit for this population:

1. ***Assessing psychological interventions:*** Given the formulations for participants' experiences of ED seemed congruent with existing psychological models, as well as the negative psychological impact of PDE-5is as a treatment, there is a renewed necessity to test the efficacy of psychological interventions as potential alternatives or addendums to PDE-5is in this population. This research should address some of the limitations mentioned in Chapter 1 — standardised and manualised forms of CBT or sex therapy interventions could be developed and tested in randomised control trials. If efficacious, they could be used instead of or alongside PDE-5is in order to diversity the intervention strategy. If found ineffective, it will be necessary to understand why and work to develop more impactful, non-pharmacological alternatives.

2. ***More nuanced outcome measures:*** The IIEF (Rosen et al., 1997) and IIEF-5 (Rosen et al., 1999) focus on biological function as the primary outcome, creating a bias towards the biological level

of ED. Given results indicate that psychological and social factors are central both in the maintenance of ED and its impact on wellbeing, there is space to develop nuanced outcome measures which consider social and psychological outcomes. The fact that psychological and social side effects appear to emerge from PDE-5i use, alongside the role that these may play in PDE-5i discontinuation, mean such outcome measures could also be beneficial in testing the efficacy of PDE-5is from a biopsychosocial perspective.

3. ***Sexual beliefs and expectations:*** Given that the results of this study indicate a relationship between ED, PDE-5i use, wellbeing, and sexual beliefs and schemas, more targeted research could go into exploring the relationship between these factors. Research could also explore young men's understandings of what constitutes "normal" erection functioning, comparing these against statistical norms. If men are found to have internalised unrealistic sexual expectations, and especially if this is negatively impacting wellbeing, research could also explore where such beliefs have come from, working towards generating alternative perspectives to reduce unnecessary self-pathology.

4. ***PDE-5i dependence:*** Future research could recruit young men who identify as having become dependent on PDE-5is in order to better understand the psychological impacts of dependence, as well as examining what factors which might predispose an individual towards dependence. Given that results potentially suggest a relationship between PDE-5i dependence and the strength of performance-related sexual beliefs, research could also explore the relationship between sexual beliefs and PDE-5i use in young men. Comparisons could be made with men who have used PDE-5is without becoming dependent, in order to begin to clarify these different profiles. Given the availability of PDE-5is, this research would be clinically beneficial to elucidate the under-explored psychological side effects of PDE-5i use. This could help develop an understanding of which men

may not be suited to using PDE-5is and why, so as to guide prescribers and develop clear strategies to communicate a comprehensive range of potential side effects.

5. ***Communication and help-seeking:*** Given the struggles that younger men reported in discussing sex with professional and partners, further research could go into understanding why these kinds of conversations feel difficult and how they could be better facilitated. Research could explore if there are particular feelings or beliefs which impede communication. Research could target men who have struggled with or avoided help-seeking, specifically in order to clarify why this may be the case, as well as exploring which elements of help-seeking have been particularly helpful. Results could go towards helping healthcare professionals, including CoPs, develop more approachable methods to engage young men, as well as helping them develop the skills and confidence to communicate more openly with partners and professionals.

6. ***Medication and ED:*** Given the apparent link between epilepsy medications and SSRIs with ED that emerged from this study, as well as the absence of an exploration of these factors in existing literature, further research should target cohorts of younger men who are using these medications. This research could explore potential impacts of these medications on sexual functioning and how these side effects go on to interact with mood and wellbeing.

6.8 Conclusion

This was the first qualitative, phenomenological exploration into the experiences and sense-making processes of younger men who have used PDE-5is to manage ED. Participants' descriptions suggested that they experienced their bodies as unpredictable machines breaking down, generating anxieties about their quality of sexual performance linked to a subjective loss of masculinity and self-worth, and negatively impacting wellbeing. Participants sought PDE-5is as a means of managing and controlling their bodies in sexual contexts, so as to alleviate some of the social and psychological

anxieties related to ED. Though PDE-5is were helpful in alleviating anxieties to a degree, participants found that new and unexpected side effects arose as a result of use, including a pull towards psychological dependence, meaning most had either stopped or intended to stop using them. Participants also reported difficulty in finding both the courage and opportunities to discuss their difficulties but found open communication with either peers or professionals to be a powerful intervention.

These results challenge the dominant physiological paradigm within which ED is thought about and treated, calling for a greater consideration of those psychological and social factors which biomedical treatments overlook. Results also call into question the suitability of PDE-5is for this population, challenging the existing NICE guidelines (2013) for treatment. Results also raise ethical questions about the current ease of access of PDE-5is, suggesting this requires review. They indicate that greater opportunity for communication around sexual difficulties would be helpful and necessary in this population, calling for policymakers and practitioners to respond accordingly. Results also indicate renewed necessity for research and development into possible alternative treatments such as psychological interventions.

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APPENDIX A

Table of Papers Included in the Literature Review

The table below provides brief details of the ten papers selected for literature review. The aim of the review was to explore what existing research literature has found about the specific population of men under 40 experiencing ED. It was felt important that papers from a variety of disciplines were included so as to ascertain what epistemological perspectives and methodologies had been used in the exploration of this population, and thus to develop research questions which might make a valuable and original contribution to the existing body of literature. Therefore, *any* paper found which explored the phenomenon of ED specifically within the population of men under 40 was included that fell within the inclusion criteria. That the majority of papers came from the disciplines of urology and sexual medicine should be seen as reflecting the dominance of these disciplines within treatment and research of this population.

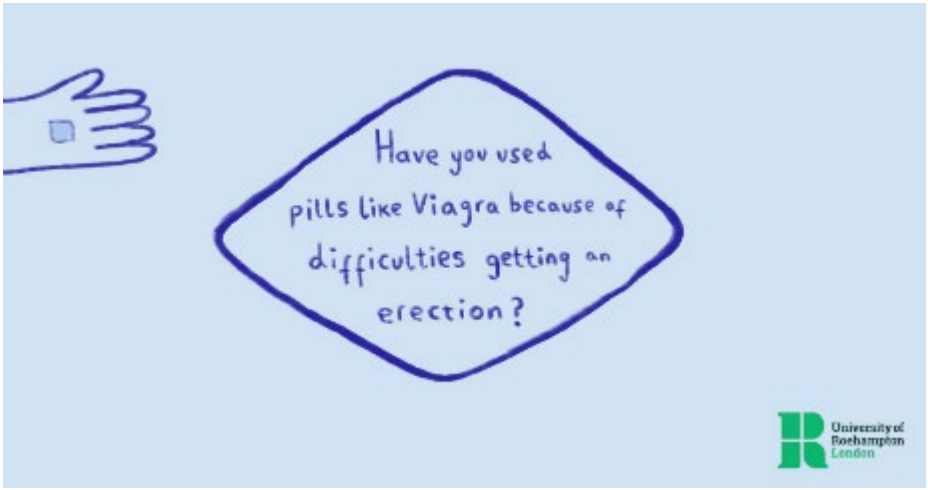
Title	Journal	Authors	Year	Country	Discipline	Brief Summary
Sexual dysfunctions among young men: prevalence and associated factors	Journal of Adolescent Health	Mialon et al.	2012	Switzerland	Sexual Medicine	A cross-sectional design finding high levels of ED in otherwise healthy younger men which statistically correlated with poor mental health outcomes.
The evolution of sexual dysfunction in young men aged 18-25 years	Journal of Adolescent Health	Akre et al.	2014	Switzerland	Sexual Medicine	A longitudinal design finding poor mental health and medication use to be predictor variables of ED in otherwise healthy young men.
Are early and current erectile problems associated with anxiety and depression in young men?	Journal of Sex & Marital Therapy	Jern et al.	2012	Finland	Psychology	A retrospective self-report study finding high levels of ED during early sexual experiences and finding anxiety and depression to be significant predictor variables of ED in otherwise healthy young men.

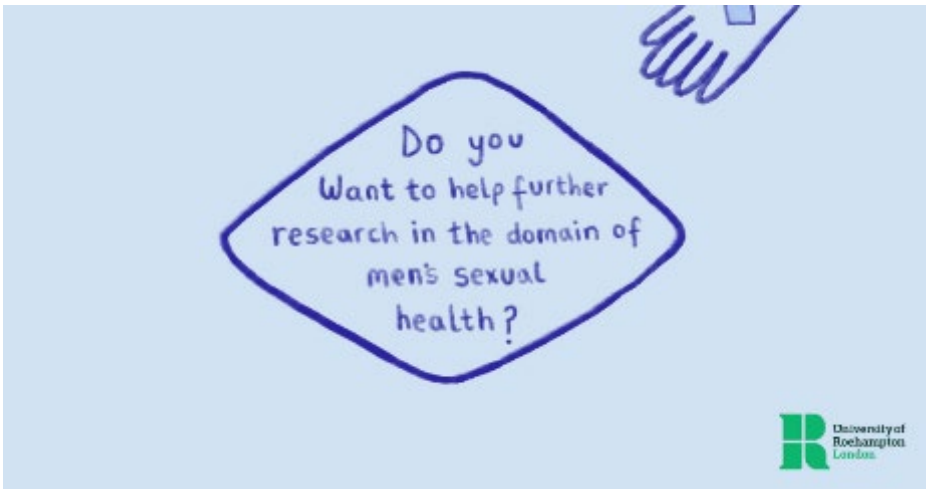
One patient out of four with newly diagnosed erectile dysfunction is a young man – worrisome picture from everyday clinical practice	The Journal of Sexual Medicine	Capogrosso et al.	2013	Italy	Urology	A cross-sectional study finding that physical comorbidities are not significantly associated with ED in younger men seeking treatment.
Clinical profile of young patients with erectile dysfunction: preliminary findings from a real-life cross-sectional study	European Urology Focus	Pozzi et al.	2020	Italy	Urology	A cross-sectional design finding high levels of depression scores to correlate with high levels in ED in younger men seeking ED treatment.
Sexual dysfunction and sexual life satisfaction among male students	Croatian Paediatric Journal	Posavec et al.	2018	Croatia	Sexual Medicine	A cross-sectional design finding low levels of sexual satisfaction to be a significant predictor variable for ED in otherwise healthy adolescent students.
Self-reported sexual functioning concerns among undergraduate students	American Journal of Sexuality Education	Tambling & Reckert	2014	USA	Sexual Education	A cross-sectional design finding significant correlations between ED and depression, and ED and low levels of sexual quality of life amongst American students.
Erectile dysfunction and Viagra use: what's up with college-age males?	Journal of Adolescent Health	Musacchio et al.	2006	USA	Sexual Medicine	A cross-sectional design finding high levels of ED in younger men, as well as high levels of non-prescription PDE-5i use, often in combination with illegal substances.

Recreational use of erectile dysfunction medications and its effects on erectile function in young men: the mediating role of confidence in erectile ability	The Journal of Sexual Medicine	Harte & Meston	2014	USA	Sexual Medicine	A cross-sectional design examining the relationship between ED, PDE-5i use and erectile confidence. Frequency of PDE-5i use was found to inversely predict erectile confidence, and erectile confidence to positively predict erectile functioning, thus suggesting that frequency of PDE-5i use may negative impact erectile function.
Genital image, sexual anxiety, and erectile dysfunction among young male military personnel	The Journal of Sexual Medicine	Wilcox et al.	2015	USA	Psychology	A cross- sectional design examining the relationship between genital self-image, sexual anxiety and ED. Results found low levels of genital self-image predicted higher levels of sexual anxiety, which in turn predicted higher levels of ED.

Appendix B

Recruitment Video Screenshot Stills






We are recruiting participants for a doctoral study about Viagra use in men under 40.
University of Roehampton London


WHO CAN TAKE PART?
You're eligible if you:
• Have used pills like Viagra at least Once for difficulties getting an erection
• Are a man
• Are between the ages of 18 and 40
• Live in the UK
University of Roehampton London

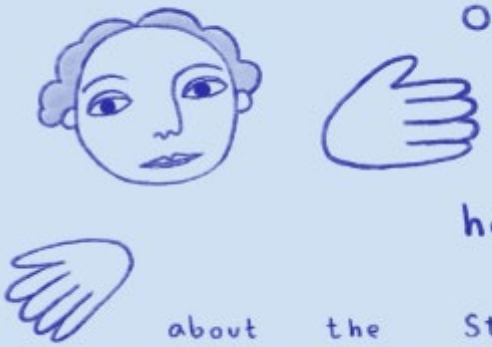

WHAT WILL BE INVOLVED?
participation will involve a 60 to 90 minute interview with a trainee psychologist Over Zoom
University of Roehampton London

WHAT WILL BE INVOLVED?

The interview will involve Sharing your experiences of erection difficulties and using pills like Viagra to help with these.

University of Roehampton London

INTERESTED IN TAKING PART ?



Or want to hear more about the Study ?

University of Roehampton London

Email James Andrewes at

andrewej@roehampton.ac.uk

University of Roehampton London

Appendix C

PARTICIPANT INFORMATION SHEET

Title of research project: Exploring young men's experiences using pills like Viagra to treat erection difficulties.

This sheet provides information about this research project to help you to make an informed decision about whether you want to take part in this study.

If you have any questions or would like any further information, please do not hesitate to contact me at andrewej@roehampton.ac.uk

What is the aim of this research?

I am a doctoral student undertaking this research as part of my training in counselling psychology. Through this research, I am aiming to gain greater insight into what erection difficulties are like for men below 40. I also want to better understand whether pills like Viagra are felt to be a suitable treatment by those using them, and whether they feel other forms of treatment may be required.

Why is this research being done?

Evidence suggests increasing numbers of men below the age of 40 are seeking treatment for erection difficulties, but there is little research done on this population.

Pills like Viagra are currently the recommended treatment for men who seek help for erection difficulties within the NHS, yet there is no current research evidence exploring how men under 40 have found using these drugs.

Who can take part in the study?

To be eligible to take part in this study, you must:

- Be between the ages of 18-40.
- Be a cisgender man (meaning you were born male, rather than being a transgender man).
- Live in the UK.

- Have used a pill like Viagra (sildenafil, or similar) to help with erection difficulties. You can have used these pills just once or on multiple occasions.
- Be willing and able to share and discuss your experiences around this topic in an interview.
- Your erection difficulties should **not** be because of a known existing physical condition such as diabetes or high blood pressure.
- You should **not** currently be experiencing serious mental health problems and/or be feeling suicidal.

What will taking part involve?

You will be invited for an interview with me to talk about your experiences. Interviews will last between 60-90 minutes.

Given ongoing COVID-19 restrictions, it is likely that interviews will take place remotely via Zoom. You will therefore need access to a device on which you can run Zoom. If you need assistance with setting this up, I am happy to help.

It is important that you can be in a quiet and confidential space during the Zoom interview to ensure you feel comfortable to talk freely, such as a private room at home.

In the case of restrictions being lifted, I will invite you to choose a comfortable private place where we could meet, or we can meet in a private room on the University of Roehampton campus if you prefer. The interview will take place at a time and a place that works for us both.

The interview will be audio-recorded, and we will have an opportunity to discuss the interview process once recording has stopped.

What will we talk about in the interview?

The interview will be an opportunity for you to share your experiences of erection difficulties and having used pills like Viagra. I will ask questions that invite you to discuss what experiencing erection difficulties has been like for you. I will ask you to discuss sexual encounters in which you have experienced erection difficulties. I will also ask about what you think caused your erection difficulties and how they may have impacted you. I will also ask

you about how you have found using pills like Viagra to help with these difficulties, about whether they are helpful and if you have sought other forms of treatment or advice.

Are there any disadvantages of taking part?

The research project has been designed to be as safe as possible with minimal risk of harm to participants. Nevertheless, discussing a personal and sensitive topic such as sexual encounters and sexual difficulties might sometimes bring up difficult and uncomfortable feelings or memories. It is important that you know that if you are becoming uncomfortable with the discussion then you are welcome to request a break during the interview or to stop the interview at any point, without needing to explain your choice to do so. We will have a debrief afterwards to discuss how you have found the interview and if you would like any follow up support.

Are there any advantages of taking part?

In taking part you would be contributing to furthering knowledge about erection difficulties in younger men, the suitability of drugs like Viagra as a treatment and what kinds of interventions are deemed suitable for this population in the future. You may also find talking about your experiences insightful and beneficial.

Will anyone be able to identify me?

Only I will have access to the recordings of the interview, so no one else be able to identify you.

Zoom is a fully encrypted videotelephone software, meaning the company does not have access to the calls. Interviews which take place on Zoom are therefore confidential. Zoom's privacy statement discussing how they handle personal data can be found at zoom.us/privacy.

The audio recordings will be transcribed. When transcribing the interviews and writing up the study, all the information that I have collected will be made non-identifiable. This means that all identifying information from the interviews including your name, others' names and names of places will be changed.

In the rare instance that you were to reveal that you were intending to harm either yourself or someone else then confidentiality may need to be broken in accordance with the law. In the incidence that you revealed intention to harm yourself, I would work with you on a plan to ensure your safety. This may include encouraging you to book an emergency GP appointment, providing you with crisis support numbers, or encouraging you to visit A&E.

What will happen with the audio recording?

Once recordings they have been transcribed, they will be stored in accordance with the UK Data Protection Act (2018), EU's General Data Protection Regulation or GDPR (Council of the European Union, 2018), and the University of Roehampton's Data Protection Guidance for Researchers. Other than myself, the only people who will have access to the recordings are my research supervisors, and the examiners.

What are data protection laws?

These laws ensure that people process personal data lawfully, e.g. that organisations do not sell on people's personal information to third-parties without permission and that people's personal information is erased in the appropriate timeframe. In this study and in accordance with GDPR and the UK Data Protection Act (2018), personal data (such as name, age etc.) will be stored securely for ten years after completion, after which it will be destroyed. All other data will be pseudonymised and will be kept for ten years after which it will be destroyed. Signed consent forms will be kept for six years, after which they will be destroyed. Pseudonymised means that any information which might reveal your identity (e.g. names of others or locations) has been changed. No data will be shared with any third parties at any point during the research process.

How long will my data be stored for?

The audio recordings will be securely stored for a maximum of ten years after completion of the research project, after which they will be destroyed. The consent forms will be stored for a maximum of six years after completing the project, after which they will be destroyed.

What happens with the findings of the research?

The results of the study will be written up and submitted as part of the doctoral thesis which will be available through the University of Roehampton library. It also possible that the research will be published in an abbreviated form in academic journals or presented as part of academic conferences. If so, all data will be kept confidential and will be pseudonymised at publication.

What if I change my mind later on?

You do not have to take part in this study, participation is voluntary. Even if you agree to take part now you can withdraw at a later stage.

If you decide not to take part at a stage prior to the interview, simply contact me via email and I will cancel the interview. Should you decide to withdraw during the interview process, let me know and I will terminate the interview immediately. If you decide to withdraw from the research process after the interview, please contact me as soon as possible via email and

provide me with your unique participant ID number that will be provided to you on the debrief sheet following the interview so I can remove your data before analysis.

I will contact you as soon as data analysis has begun to keep you informed. If you decide to withdraw *after data analysis begins*, then your data will only be used in an anonymised form as part of an aggregated data set.

If you have any concerns or need clarification about any of this, do not hesitate to contact me via email at andrewej@roehampton.ac.uk

Please note: If you have any concerns about any aspect of your participation or any other queries then please raise this with the main researcher (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Head of Department/ Director of School.

Director of Studies contact details:	**Head of Department contact details:**
Dr Mark Donati	Dr Yannis Fronimos
Department of Psychology	Department of Psychology
3030, Whitelands Campus	Whitelands Campus
University of Roehampton	University of Roehampton
Parkstead House	Parkstead House
Holybourne Avenue	Holybourne Avenue
SW5 4JD	SW5 4JD
mark.donati@roehampton.ac.uk	Yannis.fronimos@roehampton.ac.uk

+44 (0)20 8392 3626

Should the Head of Department change over the lifecycle of the research project the new Head of Department will become the independent contact. Contact details for the new Head of Department can be obtained from the investigator.

Appendix D

PARTICIPANT CONSENT FORM

Title of research project: Exploring young men's experiences using pills like Viagra to treat erection difficulties.

If you have any questions or would like any further information, please do not hesitate to contact me at andrewej@roehampton.ac.uk

Brief description of research project:

I am a student in counselling psychology completing this research project as part of my doctoral training. By interviewing 6-8 men, this study aims to investigate how men below the age of 40 have found using pills like Viagra to treat erection difficulties.

Evidence suggests increasing numbers of men below the age of 40 are seeking treatment for erection difficulties, but there is little research done on this population.

Pills like Viagra are currently the recommended treatment for men who seek help for erection difficulties within the NHS, yet there is no current research evidence exploring how men under 40 have found using these drugs.

Taking part would involve a remote, one-to-one interview with me via the online teleconferencing platform Zoom. When speaking on Zoom, we will both be speaking from a confidential, safe space such as a private room at home. All interviews (whether face-to-face or on Zoom) will be audio recorded.

If the University of Roehampton and government coronavirus restrictions on face-to-face contact are lifted by the time of the interview, you would be offered the choice of a face-to-face interview. You would be invited to choose a private place for interviews to take place, as well as the option of a booked room on the University of Roehampton campus. In this case, you will be given the university telephone number should you need assistance finding the venue.

The interview should last between 60 and 90 minutes, during which we would discuss your experiences of erection difficulties and how you have found using pharmaceutical treatments.

The study will adhere to the UK Data Protection Act (2018), as well as the EU's General Data Protection Regulation or GDPR (Council of the European Union, 2018). These laws ensure that people process personal data lawfully, e.g. that organisations do not sell on people's personal information to third-parties without permission and that people's personal information is erased in the appropriate timeframe. In this study and in accordance with GDPR and the UK Data Protection Act (2018), personal data (such as name, age etc.) will be stored securely for ten years after completion, after which it will be destroyed. All other data will be pseudonymised and will be kept for ten years after which it will be destroyed. Signed consent forms will be kept for six years, after which they will be destroyed. Pseudonymised means that any information which might reveal your identity (e.g. names of others or locations) has been changed. No data will be shared with any third parties at any point during the research process.

The results of the study may be published in research papers or presented at conferences or seminars. All data will be kept confidential and will be pseudonymised at publication.

More information on the university's data privacy policy can be found at the university's Data Privacy Notice for Research Participants which is provided alongside this form.

You have the right to withdraw from the study without having to give a reason up until the point of data analysis. At the point of analysis, data will be pseudonymised. If you wish to withdraw during the interview, let me know and we will end the interview immediately. Should you decide to withdraw after the interview, please let me know by contacting the email address below and providing the unique ID number which appears on the Participant Debrief Sheet given to you after the interview. If you contact me before data analysis has begun, then your data will not be included in the analysis. If you contact me after data analysis has begun, then your data may still be included but will be used in an anonymised form as part of an aggregated data set. All participants will be contacted when the data analysis process begins.

Investigator contact details: James Andrewes

Department of Psychology

Whitelands college

Parkstead House

Holybourne Ave

Roehampton

SW15 4JD

andrewej@roehampton.ac.uk

Consent statement:

I agree to take part in this research and am aware that I am free to withdraw at any point without giving a reason by contacting James Andrewes. I understand that if I do withdraw, my data may not be erased but will only be used in an anonymised form as part of an aggregated dataset. I understand that the personal data collected from me during the course of the project will be used for the purposes outlined above in the public interest.

By signing this form you are confirming that you have been informed about and understand the University's Data Privacy Notice for Research Participants. If you have been provided this form digitally, please ensure you have read this notice by following the hyperlink.

If you have been provided with a hard copy of this participant consent form, then University's Data Privacy Notice for Research Participants will be given to you as a hard copy alongside this form. If you have not been provided with a hard copy please contact the Research Office: ResearchOffice@roehampton.ac.uk

The information you have provided will be treated in confidence by the researcher and your identity will be protected in the publication of any findings. The purpose of the research may change over time, and your data may be re-used for research projects by the University in the future. If this is the case, you will normally be provided with additional information about the new project.

Name ……

Signature ……

Date ……

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Head of Department/ Director of School.

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Should the Head of Department change over the lifecycle of the research project the new Head of Department will become the independent contact. Contact details for the new Head of Department can be obtained from the investigator.

Appendix E

INTERVIEW SCHEDULE

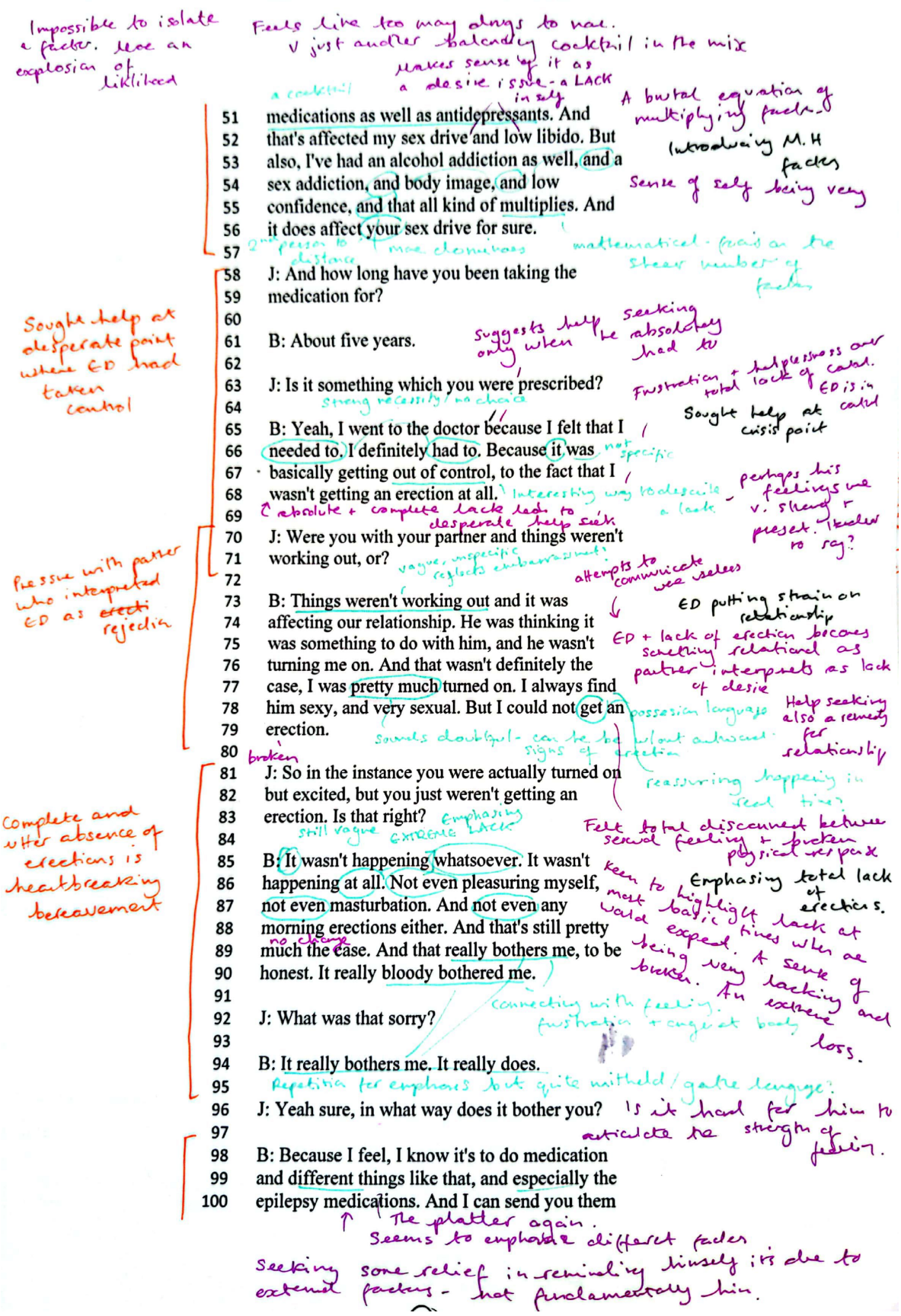
The following questions should be used loosely to guide the flow of the conversation. The interview should start with question 1, and end with question 8. Otherwise, questions after can be addressed in any order guided by the direction of the interview.

You should aim to gather information that answers all of these questions. You may not need to ask them all if the information is covered elsewhere. Prompts should be used to encourage participants to expand on their answers if necessary.

1. **What interested you in taking part in the study?**
    - Can you tell me more about the experiences that led you to using pills like Viagra
2. **Can you share what typically happens when you experience erection difficulties?**
    - Could you recall a memorable experience?
3. **What do you understand the causes of your erection difficulties to be?**
4. **How have these difficulties impacted your life or relationships, if at all?**
    - Have you discussed with your partners/friends?
5. **What were your perceptions of pills like Viagra before using them?**
6. **How have you found using pills like Viagra?**
    - How were they helpful/unhelpful?
    - How have the impacted your life or relationships?
7. **How do you think support for younger men with erection difficulties could be improved?**
8. **Is there anything else you'd like to discuss which we haven't mentioned?**

Appendix F

Example of Analysis



J: And how long have you been taking the medication for?

B: About five years.

J: Is it something which you were prescribed?

B: Yeah, I went to the doctor because I felt that I needed to, I definitely had to. Because it was basically getting out of control, to the fact that I wasn't getting an erection at all.

J: Were you with your partner and things weren't working out, or?

B: Things weren't working out and it was affecting our relationship. He was thinking it was something to do with him, and he wasn't turning me on. And that wasn't definitely the case, I was pretty much turned on. I always find him sexy, and very sexual. But I could not get an erection.

J: So in the instance you were actually turned on but excited, but you just weren't getting an erection. Is that right?

B: It wasn't happening whatsoever. It wasn't happening at all. Not even pleasuring myself, not even masturbation. And not even any morning erections either. And that's still pretty much the case. And that really bothers me, to be honest. It really bloody bothered me.

J: What was that sorry?

B: It really bothers me. It really does.

J: Yeah sure, in what way does it bother you?

B: Because I feel, I know it's to do medication and different things like that, and especially the epilepsy medications. And I can send you them

APPENDIX G

Details of the Process of Analysis

The aim of this appendix is to set out in more detail the process of analysis and how mind maps were used to arrange the emergent themes from individual participants into subordinate and superordinate themes across participants. Firstly, all of the emergent themes from each of the participants were listed in chronological order, including line numbers to make quotations easy to locate when returning to the transcripts (see Figure F1). The researcher then paid close attention to the research questions when deciding which emergent themes to group into superordinate themes across participants. Emergent themes which were considered irrelevant to the research questions were discarded at this stage. Themes across participants which appeared to have some thematic similarity were then copied and pasted into three separate mind maps. Three superordinate themes began to emerge across participants: one regarding performance anxieties, one regarding dependence anxieties, and one regarding communication anxieties. An extensive process of arranging and rearranging emergent themes into subordinate groupings then ensued. Emergent theme quotations which best represented each theme from each participant were retained. Emergent themes which were felt to be less thematically relevant to the subordinate/superordinate themes were discarded. Names of superordinate and subordinate themes came about via extensive discussions in supervision. The eventual names were felt to best capture the phenomenological experiences of participants for each theme. Screenshots of the final thematic mind maps can be found below (Figures F2, F3 and F4).

Figure F1

Screenshots from the mind map listing emergent themes for all participants.

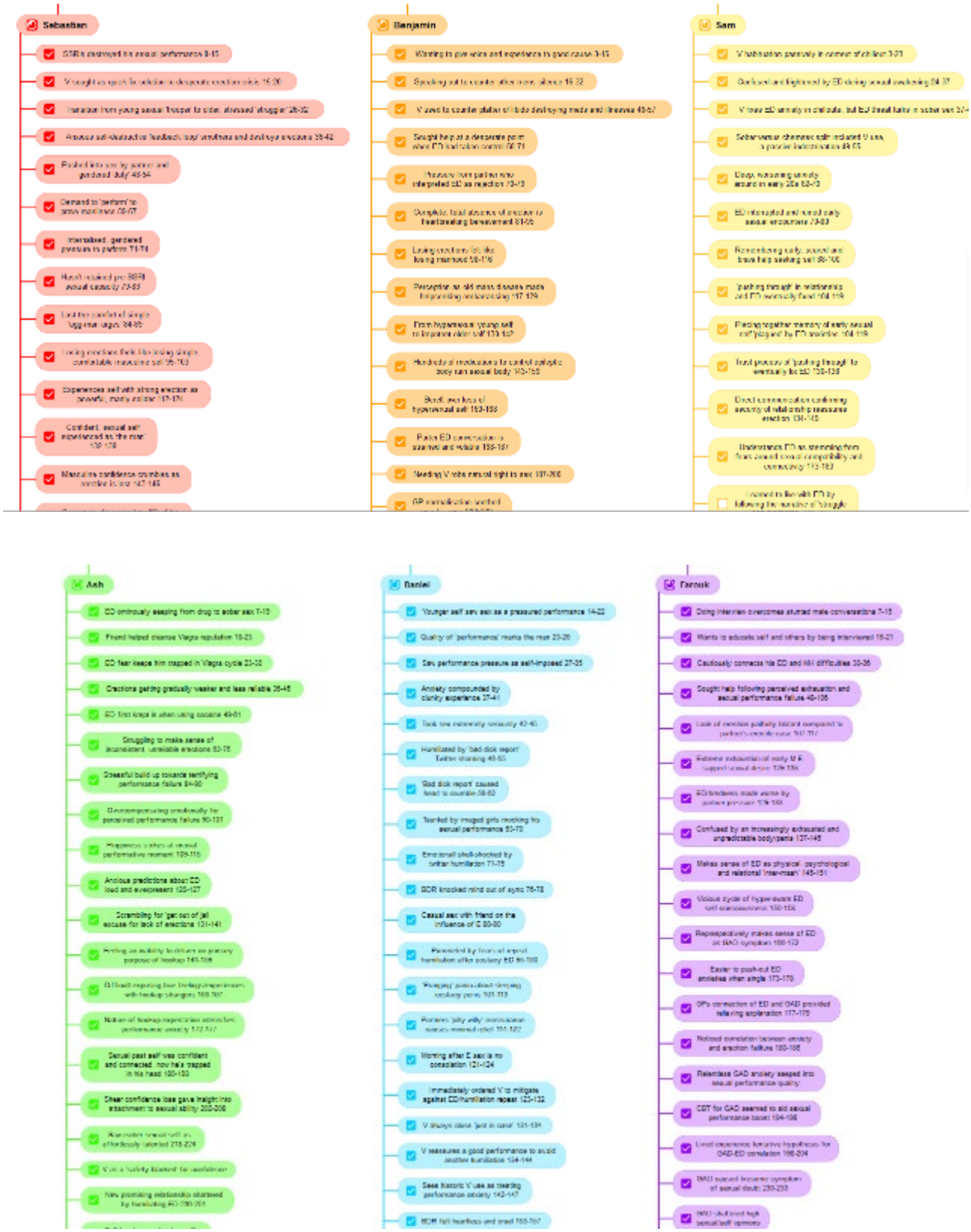
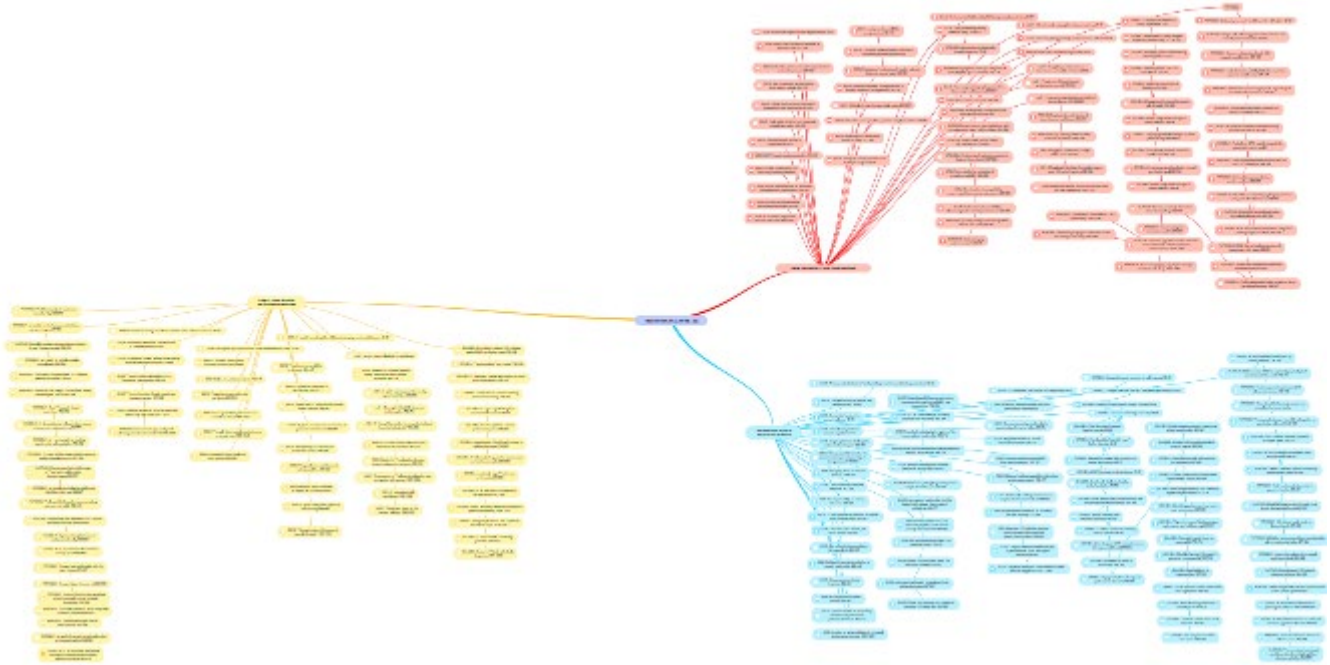
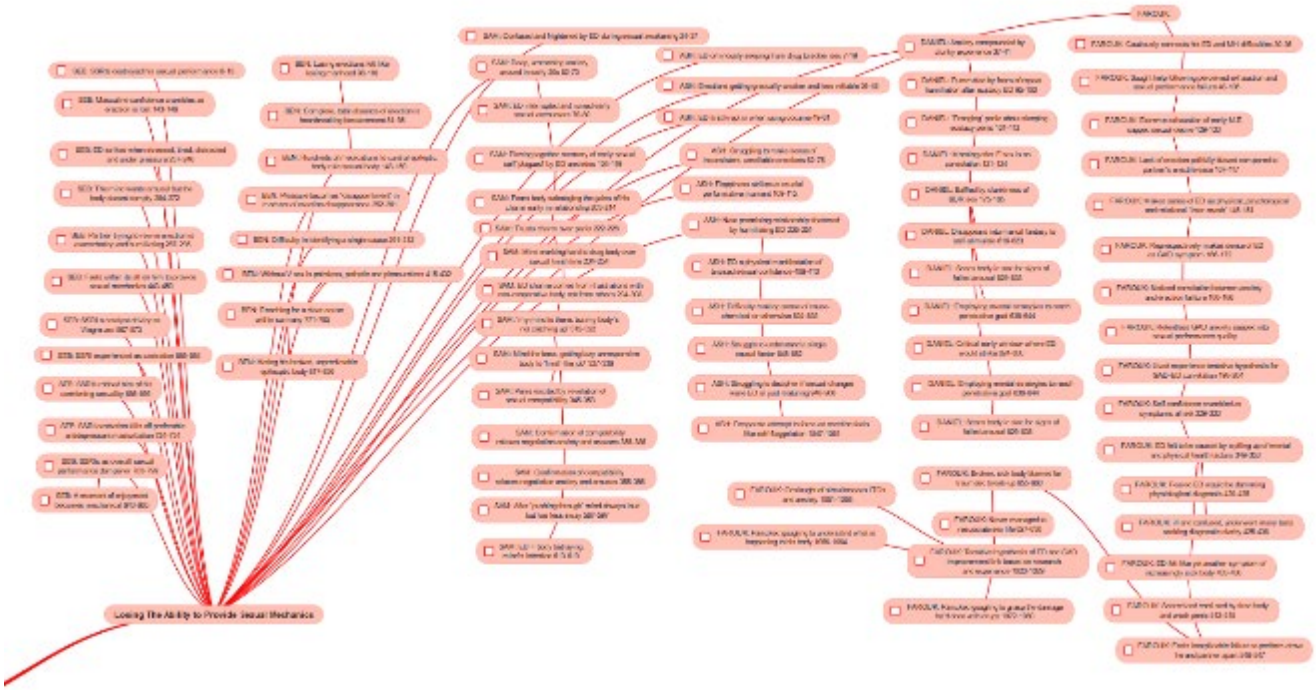


Figure F2

Screenshots from the mind map for the superordinate theme which became known as "Anxious Preoccupation with Sexual Performance", including close-ups of subordinate theme groupings.






The Destructive Impact of Performance Pressure

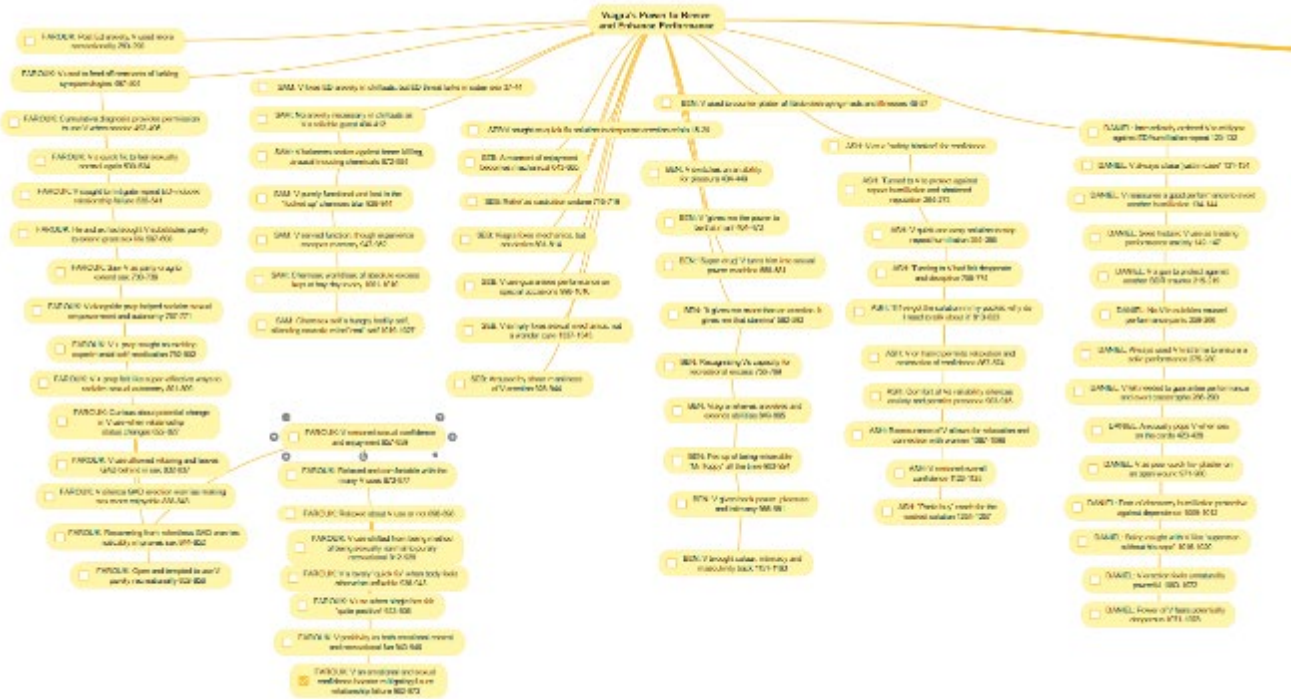

Viagra's Power to Revive and Release Performance

Figure F3

Screenshots from the mind map for the superordinate theme which became known as "Concerns About Viagra Dependence", including close-ups of subordinate theme groupings.

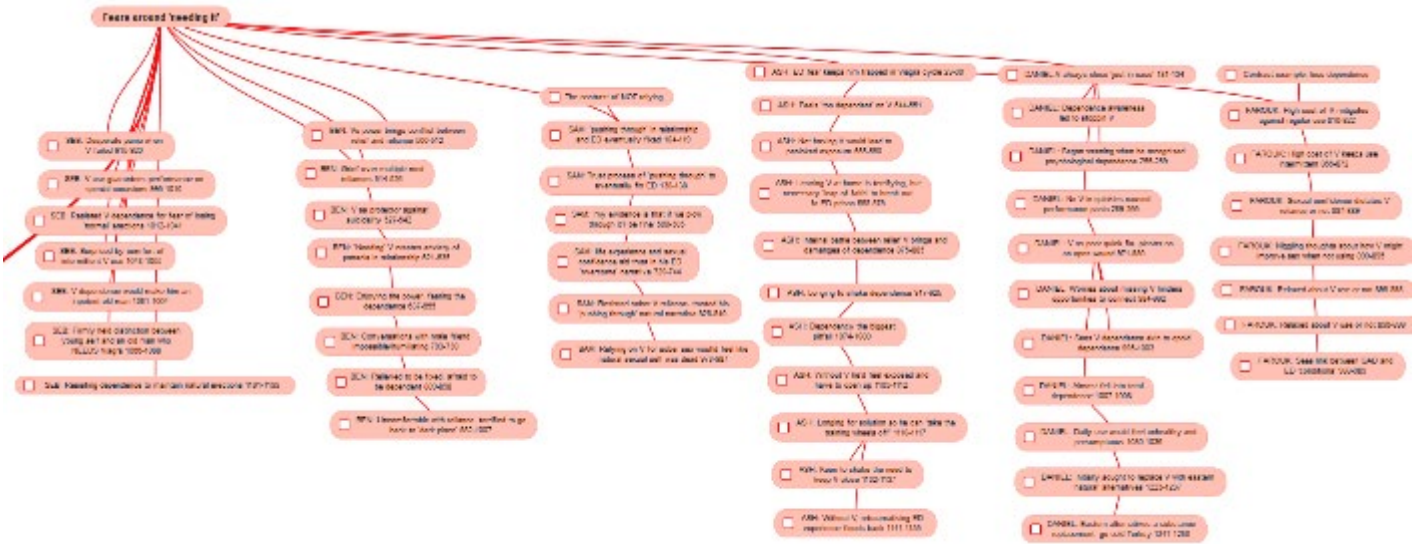
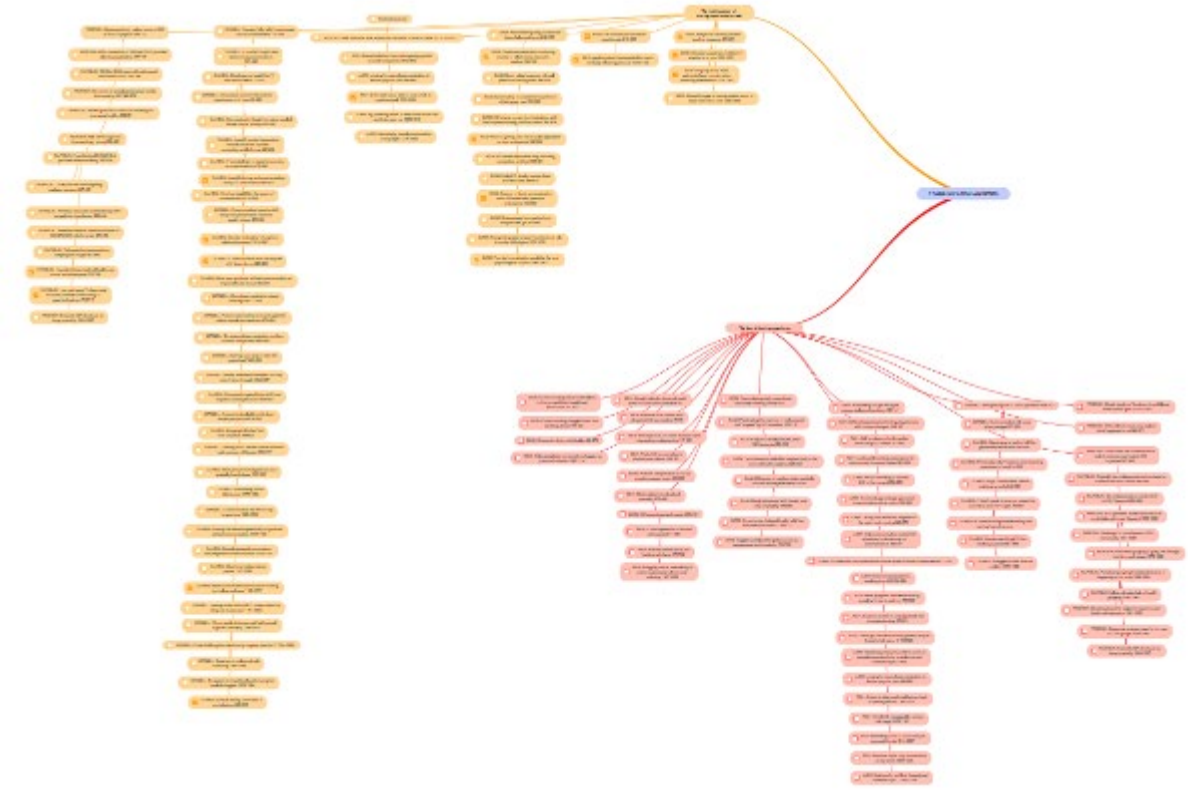
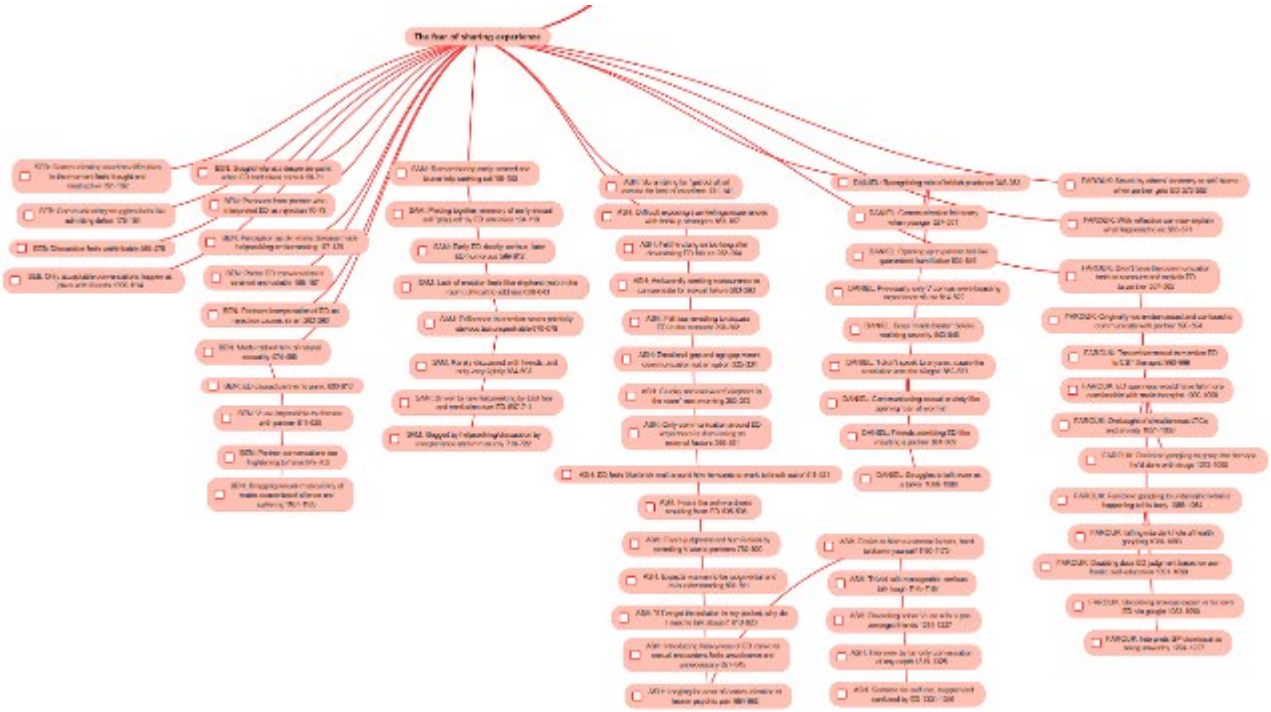


Figure F4

Screenshots from the mind map for the superordinate theme which became known as "Struggling with Communication", including close-ups of subordinate theme groupings.




The fear of sharing experience


The healing power of sharing experience (or not)

Appendix H

PARTICIPANT DEBRIEF SHEET

& USEFUL CONTACTS

Debrief

Thank you for taking part in today's interview. I hope you have found being involved in this project a valuable experience and I am grateful for your input.

It is possible that some of the topics we discussed today may have brought up difficult feelings, memories, or questions for you which you might want to follow up on now that we have finished recording.

If you have any questions or concerns with what has come up in today's interview, I would be very happy to discuss these with you now.

You may want to think about:

- How you felt during the interview and how you are feeling now.
- Was there anything that came up in the interview which you would like to discuss further?
- Do you have any further questions for me about the research process?
- Would you like any advice or guidance on how you can seek further support either for your sexual difficulties or for your overall wellbeing?

At the bottom of these sheet, I have provided some useful contacts of services which provide help with sexual difficulties as well as psychological support services should you feel further support would be valuable.

Data

If you change your mind about wanting to withdraw your data from the study at a later date, then you will need to contact me by email as soon as possible and provide the following participant ID number:

This enables us to locate your data and remove it from the analysis. If you change your mind after data analysis, then your data may not be erased but will only be used in an anonymised

form as part of an aggregated dataset. I will contact you when we get to the stage of data analysis, just so you are kept informed.

If you think of any questions you would like to ask once we finish today, or if you need further support, then you can contact me:

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Please note: If you have any concerns about any aspect of your participation or any other queries then please raise this with the main researcher (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Head of Department/ Director of School.

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USEFUL CONTACTS & INFORMATION

Your GP: If you feel you should require follow up support with either your sexual difficulties or psychological wellbeing, you can speak to your GP who will be able to assess your situation and refer you to a suitable service. The NHS provides psychosexual support services as well as mental health services.

The NHS information on male sexual difficulties can be found at:

https://www.nhs.uk/live-well/sexual-health/male-sexual-problems/

56 Dean Street Sexual Health Clinic provides information for erection difficulties:

dean.st/psychosexual/confidence-with-erections/

Men's Health Forum- Provides stress support for men by text, chat and email

Website: www.menshealthforum.org.uk

Relate- The UK's largest provider for relationship support.

Website: www.relate.org.uk

Sexwise- Charity providing advice on issues of sexual health and wellbeing

Website: https://www.sexwise.org.uk/

The Samaritans – National Offers confidential non-judgmental emotional support, 24 hours a day, for people who are experiencing feelings of distress or despair, including those which could lead to suicide. Tel: 08457 90 90 90

SANEline – National Offering non-judgemental and compassionate emotional support, guidance and information to anyone affected by mental illness, including families, friends and carers. A

confidential service for anyone who is 16 years or older. Open every day of the year, from 4.30pm-10.30pm. Tel: 0300 304 7000

Rethink - National A mental health advice and information service, offering practical help on a wide range of mental health topics. Open 9:30am to 4pm Monday to Friday. Tel: 0300 5000 927

Mind – National An information line, providing a signposting service regarding mental health problems and getting help near you. Open 9am-6pm, Monday to Friday. Tel: 0300 123 3393

Emergency Contacts

If you feel you are a risk or danger to yourself or to others, here is a list of steps you can take:

1. First, contact your GP. They are your first port of call if you are feeling worse, both physically and mentally, or if you feel you require medication or need to change your medication.

2. If your GP practice is closed, then contact the Mental Health Support Line (Crisis Line). This is a telephone helpline when you are unable to contact your GP out of hours. Tel: 0800 028 8000 (Mon-Fri, 5pm-9am; Sat, Sun & Bank Holiday, 24 hours)

3. If you already have an established connection with mental health services, call your local community mental health team or your crisis team.

4. Go to Accident & Emergency if you need immediate help. If you feel absolutely desperate and feel you are at immediate risk either from yourself or others, then go to A&E or ring 999.