Title: Aging Respectably by Rejecting Medicalization: Mexican Men's Reasons for Not Using Erectile Dysfunction Drugs
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As lifestyle drug production and medical interest in geriatrics increase, the medicalization of aging and sexuality have become intertwined. Drugs like Viagra naturalize lifelong performance of phallocentric sex as a marker of healthy aging. Yet despite the ubiquity of medical aids for having “youthful” sex in older age, this article argues that having no or less sex can be a conscious strategy for embodying respectable aging. Based on ethnographic research in a Cuernavaca, Mexico, hospital urology department, this article shows that despite the traditional association of penetrative sex with successful masculinity, many older, working-class Mexican men faced with erectile difficulty reject “youthful” sexuality and drugs that facilitate it in order to embody a “mature” masculinity focused on home and family. This article argues that social encouragement and structural disincentives for medicalizing erectile difficulty encouraged men to interpret decreasing erectile function as natural and appropriate. [aging, masculinity, erectile dysfunction, sexuality, Mexico]

“Lifestyle” drugs, treatments for bodily changes that cause more social distress than physical harm, are increasingly marketed and sold worldwide (Applbaum 2006; Szymczak and Conrad 2006). Although these treatments can reduce social suffering, they also naturalize the norms that generate it, reinforcing the distress posed by nonideal bodies and the need to medically alter them (Clarke et al. 2003). In the context of global population aging, lifestyle drugs increasingly offer cures for bodily changes previously considered normal in older age, medicalizing aging itself (Fishman et al. 2008). Anthropologists have criticized this development, both for generating profit by naturalizing Western cultural stigma against growing old (Binstock et al. 2006; Estes and Binney 1989) and for framing aging as a set biological trajectory rather than a social act (Kaufman 1994). In opposition to this medical model of aging, anthropologists understand moments in “the life course” as ways of enacting personhood shaped by local culture, structure, and individual bodies and life histories (Johnson-Hanks 2002; Lamb 2005; Lynch and Danely 2013. This perspective can shed light on the reasons why people come to see particular bodily changes as normal or pathological, and seek or reject lifestyle drugs that could mediate these changes. It can also be used to investigate relationships between cultural ideals regarding age-related change in particular body practices, like sexual activity, and the drugs that can help people enact or defy these social expectations.

Changes in sexual function and practice have become a key target of anti-aging interventions (Featherstone and Hepworth 2006; Marshall 2011). Like aging, sexuality is an often naturalized life area that anthropologists understand as a social space for enacting cultural norms for personhood (Lancaster 2003; Parker and Gagnon 1995). Sexuality is also frequently medicalized. Nonnormative or socially undesirable sexual practices are often pathologized, and
medical treatments offer assistance in enacting sexual practices seen as socially desirable (Rubin 1992; Tiefer 1996). Since the 1998 introduction of Viagra, which spurred a global reframing of decreased erectile function as the biomedical pathology “erectile dysfunction” (ED), the medicalization of aging and of sexuality have become increasingly interlinked (Tiefer 2006). Although understanding erectile decrease as treatable rather than natural counters the damaging stereotype that older people should not be sexual (Hodson and Skeen 1994), this view conflates sexual desire and intercourse. This conflation narrows the “healthy” sexuality as the unceasing ability to perform penile-vaginal intercourse, which may not reflect individuals’ desires and the sexual possibilities open to them (Gott 2005). The medicalization of older people’s sexual health brings together social distaste for aging and devaluation of nonpenetrative sexual practice, offering the medical possibility of performing—and the pressure to use products to embody—youthful and normative sexuality (Katz and Marshall 2002). It also represents the globalization of Western cultural views of aging and the body, which now figure aging as mechanical breakdown (Grace et al. 2006).

The heavily gendered nature of such sexual health treatments has inspired calls for investigation of the relationships between medicalization and people’s enactment of gender norms across the life course, especially in terms of the relatively new sexual health treatments aimed at men (Kampf et al. 2012; Riska 2003; Rosenfeld and Faircloth 2006). In light of the increasing and increasingly sexualized medicalization of male aging, Barbara Marshall writes: “We need to be more attentive to the role of age in formations of hegemonic masculinities and to the manner in which these are configured by the new biology of the body that has emerged in relation to pharmaceutical therapies and consumer lifestyles geared toward functionality and performance” (2007:510).

Although rich research has been done on the ways that men use medical intervention to perform specific kinds of masculinity (c.f. Tiefer 2008), treatment users are not the only ones influenced by this “new biology.” Viagra is a household name worldwide, but most men experiencing decreased erectile function choose not to use ED drugs, or are unable to afford or access them. It is thus equally important to investigate what not using ubiquitous anti-aging drugs might mean for men, and whether rejection of these treatments, like their use, can enable people to live out particular forms of gendered personhood. Non-users’ experiences may challenge the medical model of sexual decrease or cessation as a simple lack, and reveal how having no, less, or different sex over time can be a conscious social practice through which people embody respectable aging. These experiences can also reveal how aspects of social and structural context encourage people to adopt particular ideas about how sexuality should change over one’s life course, which may encourage people to embrace or medicalize age-related sexual changes.

Using data from a study of over 250 working-class, urban Mexican men receiving treatment for urologic problems in a government-run hospital, this article investigates the causes and consequences of men’s decisions not to use ED drugs when they experienced decreased erectile function. Although study participants used medical treatment for certain problems, lived in a city where ED drugs were readily available over the counter, and often described penetrative sex as a key way of demonstrating manliness, the vast majority did not understand their erectile function change as a medical problem. Instead, in a life-course shift so common that one study participant called it “the Mexican classic,” most participants came to view decreasing erections as a physical prompt to renounce the frequent, penetrative sex they associated with youth and machismo, and to begin to live out a more “mature” masculinity enacted through emotional
interactions with family rather than sex. This article argues that accepting age-related decrease in erectile function as “natural” enabled participants to embody locally respectable older manhood. Further, specific social and structural factors influenced men’s adoption of this life-course narrative: most participants were both encouraged by their wives to act out respectable older masculinity and deterred from seeking medical ED treatment by drug cost and the structure of government-funded medical care.

Aging, Sex, and Gendered Selfhood Worldwide and in Mexico

To ask whether having less or no sex can be a way to live out specific forms of masculinity requires understanding sexual nonparticipation as a practice rather than an absence. Matthew Gutmann, discussing the literature on male sexuality in Mexico, writes that "relatively little has been written . . . about heterosexual men not enjoying sex, not enjoying it often, and not missing sex when they do not have it" (2007:36). This critique holds true for anthropological studies of sexuality more broadly. Health and sexological literature on sexual practice has been critiqued for its phallocentrism (Irvine 1990; Tiefer 1995), and social scientific studies of the topic appear to suffer from a similarly narrow focus (Okami and Pendleton 1995; Vance 1991). As a social construct, the category of “the sexual” includes different acts and desires in different cultural settings (Herdt 1981; Herdt and Stoller 1990; Pigg and Adams 2005), yet penetration has historically been valorized in the West as the most legitimate form of sexuality (Laqueur 2004; Rubin 1992). Perhaps because of this phallocentrism, very little has been written on abstinence, celibacy, and other forms of sexual nonparticipation. This state of affairs both fails to contest recent medical framings of celibacy as a pathological lack and obscures the social significance of opting out of sex. For instance, Elisa Sobo and Sandra Bell argue: “various expressions of celibacy are connected not merely through a shared negative feature (nonparticipation in sex) but also, and more important, through notions and experiences surrounding desire, power and control, social cohesion, social productivity, and the social good” (2001:4).

In keeping with this insight, ethnography from many world regions has shown that ceasing or decreasing sex in older age can be a way of embodying locally valued forms of gendered personhood. In India, Sarah Lamb found that women’s socially positive purity was thought to be increased by age-related bodily changes, like menopause, and by cessation of sex itself (Lamb 2000). Sjak van der Geest found that rural Ghanian elders of both sexes believed decreasing sexual activity to be crucial to embodying age-appropriate “respectability,” and to protecting bodies that suffered diminished strength after years of work. They expected gendered differences in aging sexuality, believing that women would eventually lose interest in sex, whereas men would retain some desire but should curtail sexual activities that could cause intergenerational problems, like competing with their sons for new wives (2001). Similarly, Katrina L. Moore found that older Japanese couples also expected sex to wane over time in gender-specific ways. Women welcomed a shift to more “sibling-like” relationships, whereas men accepted decreased sex but felt their masculinity to be compromised by the loss of work-related opportunities for affairs (2010). These examples show that the notion that having less or no sex helps one to be a “good” older person is common worldwide, and they also demonstrate that specific expectations regarding how, when, and why sexual practice should decrease are heavily influenced by local culture, gender norms, and specific social and structural factors.

Cultural expectations that respectable older people have less sex now co-exist with the medical possibility of using drugs such as Viagra to demonstrate virility despite advancing age.
For those who can afford and access these treatments, deciding whether to treat or accept age-related changes in sexual function can thus be a key way of asserting a particular form of gendered personhood. To make these decisions, people must make sense of conflicting cultural narratives regarding aging and sexuality. For example, medical framing of decreased erectile function as dysfunction suggests that it is healthy and normative for men to perform penetrative sex into later life (Katz and Marshall 2002; Marshall and Katz 2002), but people may also feel that continuing “youthful” sex is inappropriate, silly and even stigmatizing in older age (de Vries 2009). Researchers from the United States and New Zealand, where ED drugs are marketed directly to consumers, found that many men and male–female couples were ambivalent about using these drugs to continue “youthful” sexuality. Some men reported joy at being able to continue frequent, penetrative sex (frequently with younger extramarital partners); other men and many women felt that the drugs precluded a “natural” change toward a less energetic but more intimate practice of marital sex, although some felt pressure to use ED drugs despite this concern (Loe 2004; Potts et al. 2004).

In Mexico, men use or reject ED drugs amid heated national debate about what constitutes “good” masculinity. Gender roles and attitudes are being contested in the context of a national discourse calling for “modernization” and gender equity, increasing idealization of companionate marriage, and changing gender divisions of labor facilitated by decreasing fertility rates and increasing female workforce participation (Carillo 2007; García and de Oliveira 2004; Hirsch 2003; INEGI 2009). Calls for change are set against the backdrop of the powerful cultural discourse of machismo, a patriarchal style of masculinity marked by high sexual desire, a predisposition to womanize, and emotional closure. The belief that machismo is “traditional” to Mexico is actually relatively new, popularized by poet Octavio Paz in the 1950s (Paz 1985). However, machismo is widely understood in Mexico to be innate, transmitted either biologically or culturally from conquistador ancestors who raped indigenous women (Gutmann 1996; McKee Irwin 2003; Paz 1985). Individual Mexican men have complex relationships to the discourse of machismo, which may change over time in relation to their own experiences (Brandes 2002; Ramirez 2009). Men participating in the present study viewed machismo in many different ways, ranging from decrying it as a racist stereotype, to seeing it as a prevalent and problematic cultural force, to understanding it as a biologically innate aspect of Mexicanness. Nevertheless, the majority of participants characterized “the Mexican man” in the abstract as a sex-obsessed macho, and attributed some of their youthful sexual practices to machismo (Inhorn and Wentzell 2011). They also conflated sexual function with sexual desire, based on the assumption that innate machismo meant that if a man could physically have sex, he would want to.

Guided by this cultural preoccupation with machismo and its demonstration through sexual activity, the anthropological literature on manliness in Mexico has focused heavily on penetrative sex as a self-making practice (Gutmann 2007). Sexual penetration certainly is one key way of defining oneself as a Mexican man (Melhuus 1998), or alternatively of demasculinizing another male (Prieur 1996), and it is a key practice and topic of conversation in the homosocial interactions through which men assert and negotiate masculinity (Hirsch and Meneses Navarro 2009; Peña 1991). However, previous ethnographic research has shown that ideas of responsibility, honor, and appropriate behavior are central to many Mexican men’s understandings of good masculinity throughout the life course, sometimes supplanting and sometimes co-existing with desires to express manliness through sexual dominance (Gutmann 1996; Núñez Noriega 2007). Other studies of Mexican masculinity reveal that different performances of manliness seem appropriate to men at different phases of life (de Keijzer and
Further, men may view bodily changes, including reproductive health interventions like vasectomy, as ways of embodying “responsible” masculinity that they see as appropriate to both their maturing selves and “modern” ways of being a Mexican man (Gutmann 2005; Huerta Rojas 2007). Thus, ceasing to perform frequent penetrative sex may be a powerful way in which men disassociate themselves from macho masculinities and begin to live out alternative forms of manliness associated with respectable aging (Wentzell 2011).

However, the wide availability of ED drugs means that men may also use medical means to continue penetrative sex despite aging or illness. Viagra was introduced to Mexico in 1998, and it and subsequent ED drugs quickly became widely available without a prescription. ED is a major topic of conversation, for example figuring prominently in TV comedy, and the label “Viagra” is frequently attached to food items thought to have reinvigorating properties, like the ostensibly aphrodisiac sea urchin “Viagra” soup. Both ED pharmaceuticals and herbal copycats, such as “Powersex” and “Himcaps,” are advertised widely, with signs visible on most pharmacy walls. “M-force,” the most heavily marketed ED supplement, advertises frequently on Mexican network television, and a private clinic specializing in ED treatment runs regular ads in cities’ local newspapers. Thus, men experiencing decreasing erectile function in Mexico cannot help but know that their condition could be labeled as the medical pathology ED and treated with drugs.

ED drug costs are moderate but not cheap, and thus beyond the financial reach of many in a country with marked economic inequality. One dose of Viagra costs 120 pesos (about US$9, or the cost of a lunch at the upscale Chili’s restaurant in Cuernavaca, the city where this research took place). ED medications have even been dispensed free of charge to older men in nearby Mexico City in a government attempt to raise morale among the aged (CNN 2008). An ED pharmaceutical has also been included in the list of drugs that government hospitals must provide cost-free to eligible patients (IMSS 2010). Thus, working-class urban Mexican men make treatment decisions regarding decreased erectile function in a context where ED drugs are ubiquitous but may be financially difficult to access.

**Study Site and Methods**

This study was based in the urology department of a government-run hospital that provided primary and specialty care to the central Mexican city of Cuernavaca. The hospital is part of the Mexican social security system (*Instituto Mexicano del Seguro Social*, or IMSS), a government program that offers health care to privately employed workers and their families, or almost 40 percent of the Mexican population (INEGI 2005). Although the IMSS system is an outgrowth of revolution-era efforts to ensure citizens’ rights to basic services including health care, it has been critiqued for chronic underfunding and failure to restructure in response to demographic changes such as increased life expectancy and population growth (Moreno et al. 2009). In the Cuernavaca hospital, patient care was hampered by a lack of resources ranging from writing paper to surgical equipment, and patients were faced with long waits for treatment. Due to overcrowding, consultations were very brief, and study participants often reported frustration with the system and a lack of rapport with their doctors. For these reasons, IMSS-eligible patients who can afford to seek private medical care often do so, meaning that IMSS patients are generally working-class and do not perceive themselves to have extra money available for health care.
This site was chosen as the basis for a study of the relationships among Mexican men’s experiences of decreasing erectile function, masculinity, and medical treatment for several reasons. Most importantly, this site made it socially acceptable to discuss these issues. Although people in Mexico often resort to “sexual silence” to avoid socially uncomfortable discussions of potentially stigmatizing sexual experience, ethnographers have noted that people often feel quite comfortable discussing health problems (Carillo 2002:139; Finkler 1991). Thus, relating issues of sexuality and selfhood to health makes these topics easier to discuss. The hospital setting also made it socially acceptable for a female, American researcher to talk with Mexican men about sex. In a context of rushed medical appointments, the vast majority of participants reported that they were happy to talk about their experiences with someone who wanted to listen. Being a woman facilitated these conversations, as men reported that they felt more able to reveal intimate and emotional information than they would with another man. Being American also helped, since participants often stated that they expected American women to be more sexually knowledgeable than Mexican women, and thus they did not feel ashamed to frankly discuss even stigmatized sexual experience.

Researching men’s experiences of decreased erectile function in the IMSS also enabled investigation of the influence of this specific medical system on illness experience. As urology patients, study participants were all using biomedicine to treat specific problems; this site enabled investigation of which urologic changes men came to see as medical issues versus natural changes, and how their medical experiences influenced those judgments. Finally, basing this research in the IMSS was also a practical decision, since this site provided access to a large group of men who were likely to have experienced decreased erectile function.

The study involved over 250 Spanish-language interviews with male patients, about 50 of which included accompanying wives or family members. The doctors asked patients who they believed might suffer from decreased erectile function if they would like to participate in a study on health-related changes in sexuality. Participants engaged in semi-structured ethnographic interviews, held in the urology department immediately following their medical appointment, which ranged from 15 minutes to over an hour. Interviews addressed their health problems, life histories, sexual function changes, and experiences of medical treatment. Study participants ranged in age from their early twenties to mid-nineties, but most were in their fifties and sixties. Over 60 percent had come to the urology department because of prostate problems, and about 30 percent also suffered from other chronic illnesses, most commonly type 2 diabetes and heart disease; both these illnesses and their treatments can hamper erectile function. Almost 70 percent of participants reported some decrease in their erectile function, although only 11 percent sought medical treatment for this change. To highlight the ways that men understood decreasing erectile function to relate to the life course, this article focuses on the experiences of men who had decreased erectile function and did not seek medical treatment for it; this group represents the majority of study participants.

Respectable Aging and Decreasing Sexual Activity

All study participants were undergoing biomedical treatment for urologic health concerns, but although they often saw erectile function changes as partially caused by illness, most did not view these changes as a medical concern. Instead, they tended to describe decreased erectile function as a “normal” aspect of aging. An 81-year-old retired factory worker who came to the IMSS for a prostate checkup but also reported changes in sexual function joked that prostate tests
would reveal “what happened to my youth.” This equation of the capacity for frequent sexual penetration with youth was common; the majority of study participants reported that their erectile function had to some degree diminished over time and that they accepted this change as natural. The most common response to questions about sexual function was, “it’s not like before;” instead of a lament over lost youth or virility, this was generally a matter-of-fact statement that not men’s bodies, desires, nor social lives were the same as when they were younger. A 55-year-old delivery truck driver reported that he now experienced erections only infrequently, but that this was a normal consequence of age and hard work: “My work is a little rough, heavy. I carry a lot, so I feel a little tiredness. Now, I can’t have as much sex as before. This is normal. Now it’s not the same—when I was young, more potency. Now with my age, not anymore.” Similarly, a retired electrician in his late sixties equated cessation of sex explicitly with the end of youthful occupation, joking, “It’s part of being retired—I can’t work anymore!”

Rather than focusing on a practice, like penetrative sex, as universally definitive of successful masculinity, participants valued respectably age-appropriate performances of manhood. They said that for young men, “good” masculinity included frequent, often extramarital penetrative sex, but only in the context of hard work and responsible economic provision for one’s family. Although it was seen as befitting for younger men to be highly and extramaritally sexually active—to the point where a man who had been faithful to his wife apologized that he knew this practice was “not normal”—men saw persistent performance of youthful sexuality as somewhat absurd in older age. In response to a question about whether he continued to engage in sex, a 68-year-old barber laughed and said, “Here in Mexico, we have a saying: ‘After old age, chickenpox’ . . . it means that some things become silly when one is older.” This absurdity stemmed from the idea that “good” older masculinity centered on family and home rather than on friends and lovers. Although older men were still expected to provide for their families financially and to work hard, they believed that this work should become domestically oriented. Participants said that as older men, they felt duty-bound to provide emotional support and family leadership—for instance, in terms of being a “role model” for grandchildren—which they had not seen as important to being “good” men or husbands in their younger years. Thus, although forms of masculinity seen as appropriate to younger and older men were all somewhat patriarchal in nature, they were thought to ideally shift over time from a focus on physical activity in work and social settings, to emotional labor within the family.

For instance, a 56-year-old planned the following after his retirement from the public health service: “I will dedicate myself to my wife, the house, gardening, caring for the grandchildren—the Mexican classic.” Participants frequently described this change of focus as a “second stage” or “other level” of life. They said that erectile function change was a natural element of this stage because it signaled that their youth had ended. Thus, they discussed frequent, penetrative sex as a pleasurable practice that had been crucial to their past understandings of themselves as men, but was no longer an important focus in their lives. A 75-year-old retired factory worker stated, “Erectile dysfunction isn’t important. When I was young, it would have been, but not now.” Similarly, a 64-year-old retired mechanic stated that his “sex life now doesn’t exist, doesn’t exist. But, I’m satisfied, from my youth. I don’t miss it.” Many participants reported that their onset of erectile difficulty was the catalyst that prompted them to “mature.”

Thus, rather than using the same set of practices to enact masculinity throughout the life course, study participants sought respectability in different ways, which they considered to be age appropriate at different times. They described these practices, and their ability to act age
appropriately through them, as making them “feel good.” These practices included having frequent sex when younger, and curtailing their sex lives to focus on home and family as they aged. They often explicitly characterized this shift as part of a growth process. For example, a 68-year-old appliance repairman reported frequent extramarital sex in his youth, but said that he is now largely faithful, explaining the change as a function of an age-related increase in thoughtfulness. He said, “Youth is another harmony—you don’t think about anything. With age, you start to think more.”

This thoughtfulness extended to the ways men treated their bodies. They often described ways that both overwork and carousing in their youth had damaged their “organism,” for instance attributing current heart disease to a history of anger and violence, or decreased erectile function to the exhaustion caused by decades of grueling physical labor. Although they sought medical treatment for specific diseases, such as type 2 diabetes, that they saw as linked to this damage, most believed that general bodily slowing was natural. Furthermore, they saw the reduction in general and sexual energy that they experienced as part of older age as an aid to embodying the decorousness befitting older men. Many participants thus believed that ED drugs would artificially “accelerate” one’s body, putting it through both socially and physically inappropriate paces that could hasten aging and potentially cause premature death (for further discussion of these fears, see Wentzell and Salmeron 2009a).

Relationships That Encourage “Mature” Masculinity

Study participants reported that aging had deepened their emotional relationships with wives. These relationships were also crucial to men’s adoption of the “mature” aging narrative. Men who had centered their youthful masculinities around extramarital sex generally said that they had come to see decreased erectile function as a prompt to change their ways and focus on developing a deeper emotional bond with wives they considered long-suffering and now deserving of better treatment. For example, a 55-year-old retired laundry worker stated, “I was a womanizer. [EW: Are you still?] The truth is, now I don’t have the same capacity. I’m 55, I know what I am. I don’t want problems with my wife. Like I deserve respect from her, she deserves it from me as well.” Similarly, after learning from the doctor that a prostate operation might end his erectile function, a 68-year-old retired power company worker reported that he was not bothered by this prognosis: “I’m satisfied, I passed my best years, I’m happy. We’ve enjoyed ourselves.” He went on to say that cessation of erectile function would cause a shift in his relationship with his wife, in which he would not only be faithful, but strive to support and appreciate her more fully: “Now, I will completely dedicate myself to her. Recognize that she has done everything for me, whatever I did she has always been with me. She cares for me, and I care for her too, and we have to get along well.”

Men who had already made this shift reported increasing contentment in their relationships. A 90-year-old retired bodyguard, reporting that he had not had sex with his wife for six years, said that “Life, love, compassion all grow. With time, they are deeper.” Rather than feeling like successful men because of their sexual conquests, study participants stated that they now took pride in being loving, emotionally present husbands, fathers and grandfathers. A 67-year-old bakery owner summed up this notion, saying, “Married life [meaning marital sexuality] is like a plant that dries up over time, the force ceases. When you get old, you’re more tired—spending time together is more important. Spending time together happily.”
Although men who saw themselves as successfully “mature” tended not to bemoan the loss or decrease of erectile function, many men first experienced this change as a serious threat to their gendered selfhood. Some men said that they had expected their lives to change in the ways discussed above but were nevertheless caught off-guard when they became less able to achieve the erections that had been a key marker of their successful masculinity. At these life points, conversations with wives and other family members were crucial for men’s rethinking of the relationship between sex and their masculinity. For example, in a joint interview with a 68-year-old laborer and his wife, the husband said that he had recently been experiencing less firm erections and that he was bothered by this change, adding that he believed that his wife “doesn’t like it.” She corrected him with the common narrative that naturalizes sexual function change as an aspect of aging, saying, “It wasn’t the same, but it’s not serious, it happens with age and health problems.”

Most older women interviewed, including those who said that they enjoyed sex, described its cessation as part of the natural life course and reported that helping their husbands feel good about bodily changes was more important to them than continuing to have penetrative sex. Many said that emotional tenderness and physical closeness, without penetration, was satisfying and appropriate for this phase of their marriage. Women who had not enjoyed their marital sex lives more emphatically encouraged their husbands to adopt “mature” masculinities that did not involve sexual contact. When a retired husband in his sixties somewhat wistfully revealed, “the machinery of erection has broken down,” his wife interjected, “Now we don’t want any more!” Less frequently, participants reported that their own parents or their adult children had asked them to focus more closely on the family, and that these conversations had convinced them to “live well” by curtailing extramarital sex and developing closer bonds with their wives and families.

Exemplifying this process of change, a 61-year-old construction worker reported that he initially experienced decreasing sexual function as a devastating threat to both his masculine selfhood and the marriage he had based on it. However, he said that interactions with his wife led him to see this shift as socially, mentally, and physically beneficial. When his erectile function began to wane, he said, “I thought, I’ll be useless, my wife will cheat on me. But now, I’ve changed. I don’t want to wander the streets, I’m dedicated to the home.” He reported that his wife convinced him over time that communication and enjoying shared activities were more important to her, and for their marriage, than sex. As the importance of sex to his masculine sense of self lessened and he and his wife grew emotionally closer, he noted that their sex life underwent a “beautiful change.” They had sex on the less frequent schedule that she desired, and she “sets the conditions” for their sexual activity. He said that sex became more pleasurable for them both, rather than an obligation for her. Further, he reported relief at no longer having the “sick mind” that led him to constantly desire sex in his youth, the frequency of which he believes stressed his prostate and caused his current health problems. In contrast, those few study participants who did seek ED treatment did not receive social encouragement to alter their sexuality as they aged, often because they lacked close relationships with family members, wished to “stay young,” or felt unsuccessful at youthful masculinity (for further discussion of both perspectives, see Wentzell 2013).
Structural Encouragements to “Mature” instead of Medicate

A range of barriers appeared to discourage study participants from accessing ED drugs and likely encouraged most men to accept their wives’ suggestions to view decreasing erectile function as an opportunity to live out mature masculinity. In interviews, participants often complained about the rushed, impersonal nature of IMSS appointments. These brief appointments, a consequence of resource scarcity within the IMSS, deterred doctors from diagnosing sexual health problems, and patients from raising intimate issues. Economic hardship also influenced the kinds of medical treatments that the IMSS pharmacy supplied and doctors offered. Similarly, patients’ financial difficulties deterred them from seeing sexual health treatment, or purchasing ED drugs, outside the IMSS.

Due to high patient volume and limited resources, IMSS urologists had heavy patient loads. Their schedules required that consultations be brief and discouraged physicians from attending to anything but patients’ most pressing health problems. Thus, the conditions for which most patients had been referred to urology, like prostate enlargement or cancer, were the main focus of time-limited doctor–patient interactions. Despite the fact that most patients suffered from chronic illnesses such as type 2 diabetes, which could hamper erectile function, the urologists usually did not ask about patients’ sex lives. When observing consultations, I noted that when they did raise such questions, it was usually as the coda to a series of cursory questions following a physical exam: “How are you peeing? . . . And any pain? . . . And your sex life?” Posed at the end of rushed and socially hierarchal encounters, these questions elicited brief answers and did not encourage men to broach sexual health problems.

An IMSS family medicine doctor, interviewed when he was a patient in the urology service, asserted that sexual health treatment, specifically, had suffered from institutional expectations that physicians would see increasing numbers of patients in shorter appointments. He explained that he saw sexual health as an important but too-often ignored topic and had made a conscious effort to raise related issues with his patients. In earlier years when his schedule was lighter, he believed he had been successful at creating trusting interactions where patients could talk about sexual issues. However, he said, his growing patient roster meant that he simply no longer had time to have these discussions. The IMSS urologists felt similarly. All had private practices to supplement their low IMSS salaries, and frequently said that they were able to give a higher level of care and to get to know patients better in lengthier private appointments. They also reported treating erectile dysfunction much more frequently in these interactions, since they had the time and rapport to ask if it was an issue, and their patients had the resources to treat it.

The same economic forces that led to brief IMSS appointments also made the Cuernavaca hospital pharmacy unable to stock all the drugs it was supposed to. Although ED drugs are supposed to be dispensed free of charge to all patients prescribed them, the urologists told me that since ED was not life-threatening or commonly diagnosed at the hospital, the pharmacy saved money by not buying ED drugs. The knowledge that their patients could not receive free ED drugs even if they were prescribed deterred IMSS urologists from assessing their erectile difficulty, or diagnosing it as a medical problem if it was present. Thus, although they described themselves as likely to diagnose ED when seeing private patients with decreased erectile function, economic constraints within the IMSS led the doctors to characterize study participants’ erectile function change as a natural consequence of aging, and to understand this bodily change as part of a normal masculine life course.
Just as the nature of IMSS appointments deterred doctors from medicalizing decreased erectile function, it deterred patients from seeking medical treatment for this change. Study participants frequently reported decreased erectile function in their ethnographic interviews but said that they had failed to mention this change to their doctors because they were embarrassed. They said that discussion of sensitive topics required a basis of confianza, or trust, built up over time through conversation and respect, and that their brief appointments failed to generate this. For example, a 71-year-old factory worker awaiting a prostate operation felt comfortable expressing concerns about its sexual consequences with the researcher but not with his doctor. He said, “What I really want to know, and I want you to be totally honest, is if the operation will hurt my sex life. [EW: Did you ask the doctor about this?] No, but now that we’re talking openly, I feel comfortable asking you.”

Even in the rare instances when IMSS doctors did prescribe ED drugs and offered patients free drug samples that they had been given by drug sales representatives, men who felt little confianza with their physicians often rejected the idea. Many participants in this situation said that they believed their doctors did not know them well enough to understand how ED treatment would interact with their other health problems. For example, a 59-year-old truck driver said, “I was prescribed pills, but I haven’t used them. As a diabetic, I could have a heart attack.” Given the rumors about the dangers of ED drugs discussed above, as well as the availability of cultural narratives that figured decreased erectile function as normal and age appropriate, patients who did not trust their doctors were often unwilling to accept diagnoses of decreased erectile function as ED.

In addition to financial hardships within the IMSS system, patients’ economic difficulties also predisposed them to understand decreased erectile function as normal and age appropriate. Most study participants reported financial insecurity that increased as they aged and were less able to work. The fact that they did not seek private treatment, despite the inconvenience of long waits and brief appointments in the IMSS, demonstrated that they did not perceive themselves to have extra money available for health care. Although participants tended to focus on social rather than economic reasons for rejecting ED drugs in our interviews, the lack of money to pay for ED treatments likely encouraged them to accept rather than try to medicate changes in erectile function.

It is telling that at the onset of erectile difficulty, many participants said that they tried inexpensive, nonmedical interventions like lifestyle change, “invigorating” foods, and vitamins to increase general bodily strength and promote erection. In effect, these interventions were a way to see whether they could cheaply and safely stave off the onset of erectile difficulty and a shift to an older style of sexuality. A 77-year-old retiree started to exercise and eat healthily when he began to experience decreased erectile function and other “problems of age,” explaining, “Your body is like a car—the older it gets, the more problems you’ve got.” He saw these lifestyle changes as akin to car maintenance; routines that might not prevent, but could mitigate age-related changes. A few participants went further, trying dietary supplements or home remedies touted as erection aids. However, if these failed to work, men tended to characterize decreased erectile function as a bodily sign that they should “mature.” They adopted this life-course narrative, often at their wives’ suggestion, in a context where failure to do so would involve significant expense or uncomfortable social interactions in IMSS appointments.
Discussion and Conclusion

Overall, men’s rejections of ED treatment were multifactorial. Study participants experienced decreased erectile function in a cultural context where it could be understood as either a failure of masculinity that required medical treatment, or an embodied marker of manly maturity. Their inability to afford private medical care channeled them into medical encounters that did not encourage the medicalization of non-life-threatening sexual health issues. When deciding how to respond to this bodily change, they were swayed by wives’ suggestions that they enact respectable older sexuality, coupled with their doctors’ frequent silence on the matter. They evaluated these suggestions and silences, as well as the possibility of using widely marketed but purportedly dangerous ED treatments, in the context of economic disincentives to seek ED treatment.

Thus, medical- and ED drug–marketing narratives asserting that “healthy” aging entails unceasing penetrative sex have not generated desire for continued erectile function in most of the older, working-class Mexican men who participated in this study. Instead, for many of these men, decreasing penetrative sex—lived out in ways ranging from cessation of all sexual practice, to newfound fidelity, to less frequent but more tender sex with wives—became a practice through which they enacted a masculinity focused on affective family relationships rather than sexual conquest. For these men, rejecting drugs such as Viagra enabled the adoption of a socially recognized and valued life path, in which formerly “macho” men become more faithful and family-oriented in a respectable older age. Their experience highlights the inadequacy of medical models of sexuality and aging that do not account for cultural context, obscure the possibility that decreasing sexual function and practice may be experienced as desirable and appropriate rather than “dysfunctional,” and generate artificially high statistics regarding sexual dysfunction prevalence by measuring bodily change rather than emotional distress related to that change (for a critique of this phenomenon in research on erectile dysfunction prevalence in Mexico, see Wentzell and Salmerón 2009b). People may use bodily changes that could be diagnosed as “dysfunction” to enact gender norms they see as socially positive, and this finding is crucial for combating the pathologization of bodily and sexual diversity articulated in increasingly broad and decontextualized definitions of sexual dysfunction (c.f. Hatzimouratidis et al. 2010). This sort of finding also supports attempts to reveal and undermine the profit structures being built upon these definitions (Kaschak and Tiefer 2001; Lexchin 2006; Moynihan 2003).

In addition to highlighting the need for attention to context in medical definition and estimation of age-related change in sexual function and practice, the present findings support calls for reframing sexual nonparticipation and sexual decrease as practices through which people might self-consciously assert desirable forms of masculinity or femininity, rather than simple lacks of activity. Over the past few decades, anthropological research on sexuality has expanded, encompassing a diversity of sexual practices across cultural contexts and shedding light on the ways that people can enact identity through sex (Davis and Whitten 1987; Parker et al. 2000). A burgeoning body of research on the social meanings of celibacy serves as a reminder that deliberate sexual nonparticipation can be equally key for asserting gendered selfhood (Alter 1997; Khandelwal 2009; Sobo and Bell 2001). The present findings show that sexual decrease or change over time can also involve socially meaningful practices. By explicitly incorporating decreased erectile function into their enaction of “mature” masculinities, study participants were able to frame having less sex as a way of living out socially valued gender norms. Their experiences are in keeping with ethnographic findings that people in many societies expect that
sexuality should change or slow—in context-specific and gendered ways—with older age. Despite the increasing global reach of biomedical understandings of sexual function that pathologize decrease in erectile function, desire, or sexual frequency, having less sex in older age appears to remain an important way that people in some societies can act out socially appropriate maturity.

Thus, men’s experiences of decreased erectile function as a bodily prompt to embrace the “Mexican classic” shift also demonstrate the importance of understanding non-use of ubiquitous lifestyle pharmaceuticals as a potentially deliberate practice. Most study participants chose not to use ED pharmaceuticals in a context where drugs such as Viagra were widely discussed, readily available, and commonly thought to enable the macho sexuality that many Mexicans see as an intrinsic—if problematic—part of being a man. While importantly mediated by their social and structural contexts, participants’ non-use of ED drugs physically enabled, and socially represented, their decision to enact age-appropriate manliness. This finding shows that investigating the reasons that people do not use common lifestyle drugs can reveal both the cultural narratives through which they might make sense of the bodily changes those drugs treat, and the contextual elements that encourage people to identify with a particular narrative.

The fact that narratives of expected change over time in manly sexuality were crucial to participants’ rejection of ED drugs demonstrates the utility of a life-course perspective for investigating, and drawing connections between, sexual nonparticipation and non-use of ubiquitous lifestyle drugs. In keeping with prior research on ED drug users’ ambivalence toward drugs that may enable desirable virility, but preclude normative age-related changes in sexuality and relationships, study participants rejected medical aid for performing “youthful” sexuality that simply seemed inappropriate for them as older men. Their adoption of a “Mexican classic” life-course narrative enabled them to define decreased erectile function as a bodily prompt to mature, rather than as a failure to perform “good” manly sexuality. This specific cultural notion of how men’s sex lives and romantic relationships should change as they age was thus central to their reactions to erectile difficulty. This finding underscores the need to examine local cultural expectations for how bodies and gendered body practices change over time when investigating people’s responses to physical change and to drugs that might mediate it.

Using a life-course perspective to understand non-use of common anti-aging drugs can also shed light on the complexities of people’s understandings of how specific body practices demonstrate “good” or appropriate masculinity and femininity. Through the life-course lens, it becomes apparent that study participants saw moving through several different forms of masculinity at appropriate life points, rather than living out one ideal form of masculinity for as long as possible, as the way to be a “good” man overall. This means that men’s shift in focus from sexual to emotional bonds in later life did not destabilize the traditional power dynamics of male-female relationships, or make success as a patriarch less important to demonstrating manliness. Rather than representing a radical turn away from penetrative sex as important to manliness, “the Mexican classic” life path requires men to perform enough youthful sex that they are sufficiently “satisfied” in their youths to then focus on emotional relationships in older age. Men’s self-conscious adoption of this life-course narrative enabled them to incorporate sexual changes, which might have compromised their youthful ways of enacting masculinity, into overarching claims that they had been “good,” men, in age-appropriate ways, over time. This approach is useful both for understanding why individuals might not choose to medicalize bodily changes that can be reversed with pharmaceuticals, and for de-medicalizing sex and aging research.
Overall, the present findings reveal the importance of local cultural ideals for the gendered life course to individuals’ desires to have more, less, or no sex, and to use or reject anti-aging sexuopharmaceuticals, over the courses of their lives. This analysis demonstrates the utility of the life-course perspective for finding meaning in easily overlooked phenomena—like decreases in sexual activity and non-use of common lifestyle drugs—that might be ignored if researchers focus only on having sex or using drugs. This approach can provide a contextualizing counterpoint to the application of medical models for “healthy” aging and sexuality that pathologize changes that individuals may see as age-appropriate revisions of sexual practice.

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