

“I want to feel like a full man”: Conceptualizing Gay, Bisexual, and Heterosexual Men's
Sexual Difficulties

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Abstract

Current understandings of sexual difficulties originate from a model which is based on the study of heterosexual men and women. Most research has focused on sexual difficulties experienced by heterosexual men incapable of engaging in vaginal penetration. To better understand men's perceptions and experiences of sexual difficulties, seven focus groups and 29 individual interviews were conducted with gay ($n = 22$), bisexual ($n = 5$), and heterosexual ($n = 25$) men. Additionally, the extent to which difficulties reported by gay and bisexual men differ from heterosexual men was explored. Data were analysed using thematic analysis applying an inductive approach. Two intercorrelated conceptualisations were identified: penis function (themes: medicalization, masculine identity, psychological consequences, and coping mechanisms) and pain (themes: penile pain and pain during receptive anal sex). For the most part, gay, bisexual, and heterosexual men reported similar sexual difficulties; differences were evident regarding alternative masculinity, penis size competition, and pain during receptive anal sex. The results of this study demonstrate the complexity of men's sexual difficulties and the important role of sociocultural, interpersonal, and psychological factors. Limitations and suggested directions for future research are outlined.

Keywords: qualitative research, thematic analysis, sexual dysfunction, sexual difficulties, gay men, bisexual men

Introduction

Sexual difficulties, or reduced sexual function (Rowland, 2007), have the potential to negatively impair a man's social and psychological well-being and quality of life (e.g., Althof, 2002; Laumann, Paik, & Rosen, 1999). Traditionally, sexual functioning refers to the human sexual response cycle which is the sequence of physiological responses that occur during sexual stimulation (including intercourse and masturbation; Basson, 2015; Masters & Johnson, 1966). The term "sexual dysfunction" refers to a persistent or recurrent disturbance in sexual function which causes distress; it is also used to describe sexual difficulties when a clinical diagnosis has been made (Wincze & Weisberg, 2015). The term "sexual difficulty", on the other hand, refers to the more general concept of low sexual function, where the presence of distress is not clear and has not been clinically diagnosed (Hayes, Bennett, Fairley, & Dennerstein, 2006). Over time, however, a sexual difficulty may develop into a sexual dysfunction and can play a role in the maintenance of a sexual dysfunction (Brotto et al., 2016).

Most research on sexual difficulties and sexual dysfunctions is anchored in Masters and Johnson's (1966) human sexual response model, a model derived from the study of heterosexual men and women. This theory was further revised; the first revision was primarily to incorporate the sexual desire phase to the cycle (Kaplan, 1974), and the second revision was to reflect the psychopathological perspective of the time; that is, seeking to treat or change non-heterosexuality (Masters & Johnson, 1979; Sandfort & de Keizer, 2001). Although homosexuality was removed from the Diagnostic and Statistical Manual for Mental Disorders (DSM) in 1973 (American Psychiatric Association [APA], 1973), a heterocentric and phallogocentric perspective has prevailed, with most research focusing on sexual difficulties experienced by heterosexual men incapable of engaging in vaginal penetration (Hollows, 2007). Despite a conceptual shift from the DSM-IV-TR (APA, 2000) to the most

recent iteration, the DSM-5 (APA, 2013), appropriate inclusion or consideration of non-heterosexuality has still not occurred (McCabe et al., 2016; Sungur & Gündüz, 2013). To illustrate: one sexual dysfunction in the DSM-5 concerns men's issues with premature ejaculation "approximately 1 minute after vaginal penetration" (APA, 2013, p. 442). An additional note is included in the DSM-5 stating that a diagnosis of early (premature) ejaculation can be applied to individuals engaging in "non-vaginal sexual activities;" however, a specific time-frame has not been established for non-vaginal sex.

Critique of the Heteronormative Perspective

Examining gay men's sexuality from a heteronormative perspective is inappropriate for a number of reasons. First, gay and heterosexual men differ regarding the context through which they develop their sexuality (Campbell & Whiteley, 2006). Heterosexual men operate in accordance with a heterosexual script which they are taught from childhood regarding how to act, feel, and behave in sexual experiences (Sandfort & de Keizer, 2001). In contrast, gay men define their sexuality through the coming out process, which consists of rejecting the heterosexual script (Campbell & Whiteley, 2006). Second, the sexual acts performed between a man and a woman or between two men may appear similar but encompass divergent power dynamics (Philaretou & Allen, 2001; Underwood, 2003). Heterosexual men are expected to be the active partner whereas heterosexual women are expected to be the receptive partner (Sandfort & de Keizer, 2001). In sexual encounters between two men, power dynamics are more complex (Kippax & Smith, 2001). Further, while sexual practices can be guided by normative understandings of masculinity and femininity, adoption of certain "roles" (i.e., "top" or "bottom") may stem from the physical pleasure one receives from a particular position (Johns, Pingel, Eisenberg, Santana, & Bauermeister, 2012; Moskowitz & Hart, 2011). Third, in contrast to heterosexual relationships, in same-sex interactions non-coital sexual activity, such as genital touching (manual stimulation) and oral sex, is more common

and there is generally no *a priori* assumption that penetration will occur (e.g., Blumstein & Schwartz, 1983; Grulich et al., 2014; Laumann, Gagnon, Michael, & Michaels, 1994). For example, Grulich et al. (2014) reported that in a sample of 400 men, genital touching (manual stimulation) was the most common sexual practice during participants' most recent sexual encounters (manual stimulation of participant = 81%; manual stimulation of partner = 84%). This was followed by oral sex (receiving oral sex = 71%; giving oral sex = 72%), with anal intercourse being the least reported sexual practice (insertive anal intercourse = 20%; receptive anal intercourse = 16%; Grulich et al., 2014). Discernibly, the differences between gay and heterosexual intercourse can be discussed on many levels – anatomical, medical, behavioral, motivational, psychological and, gender-related – as such, diagnostic and classification comparisons may be erroneous (Hollows, 2007). It would follow, then, that further research is required to shed light on the sexual difficulties gay, bisexual, and heterosexual men face (McDonagh, Bishop, Brockman, & Morrison, 2014; McDonagh, Stewart, Morrison, & Morrison, 2016).

Epidemiology of Sexual Difficulties

Previous research in this area has been conducted through quantitative methodologies; that is, by way of self-report questionnaires (e.g., Cove & Boyle, 2002; Hirshfield et al., 2010; Lau, Kim, & Tsui, 2008; Mao et al., 2009). Several authors have pointed to differences in prevalence rates (e.g., Hirshfield et al., 2010; Lau, Kim, & Tsui, 2005; Lau et al., 2008; Laumann et al., 1999; Mao et al., 2009) and experiences (e.g., Bancroft, Carnes, Janssen, Goodrich, & Long, 2005; Cove & Boyle, 2002; Damon & Rosser, 2005; Rosser, Metz, Bockting, & Buroker, 1997; Rosser, Short, Thurmes, & Coleman, 1998; Ussher et al., 2016) of sexual difficulties between heterosexual and gay men. In studies examining heterosexual men, experiences of having at least one sexual difficulty in the previous year vary from 31% (Laumann et al., 1999) to 51% (Lau et al., 2005). Rates of sexual difficulties appear to be

even higher among gay men, varying from 43% (Lau et al., 2008) to 79% (Hirshfield et al., 2010) in the past year. In a recent prevalence study, pain during receptive anal sex and lack of sexual desire were the most frequently reported issues for gay men while premature ejaculation was at the forefront for heterosexual men (Peixoto & Nobre, 2015). According to Peixoto and Nobre (2015), their findings suggest that issues concerning one's penis might be more acute for heterosexual men, whereas pain during receptive anal sex – something entirely absent from the DSM-5 (APA, 2013) – is a core issue for gay men. At the same time, both groups of men reported concerns over erectile difficulties at comparable rates. Thus, both similarities and differences have been highlighted, but qualitative aspects of these findings remain unclear (except for men who have a lift-threatening illness – see Ussher et al., 2016; Ussher, Rose, & Perz, 2016). Scholars have argued that further exploration of the social, cultural, and physical aspects (Hirshfield et al., 2010) of sexual difficulties of men who have sex with men, especially pain during anal sex (Rosser et al., 1998), is crucial for more accurate assessment and refinement of criteria.

There is an apparent gap in our knowledge base in relation to gay men's sexual functioning; what is known is based on a model using heterosexual men and women (see McDonagh et al., 2014; McDonagh et al., 2016). This has a direct influence on what is considered to be a sexual dysfunction or sexual difficulty (Cove & Boyle, 2002), which is problematic when assessing sexual functioning in non-heterosexuals. Quantitative methodologies are advantageous when examining a well-established topic; however, these methodologies are limited if researchers are uncertain as to what precisely constitutes the focus of interest. If researchers decide a priori what issues are to be considered, participants are unable to provide their own interpretation of what constitutes a sexual difficulty.

Due to a reliance on quantitative methods employed within a heterosexist framework, many key questions have gone unanswered. For example: What exactly do gay men consider

to be sexual difficulties? How do they characterize or conceptualize these problems? How are these accounts (dis)similar compared to those of heterosexual men? The best means to answer such questions and achieve a more in-depth understanding of sexual difficulties would be to ask gay men, in their own words, to particularise what this concept means to them (e.g., Nassar-McMillan, Wyer, Oliver-Hoyo, & Ryder-Burge, 2010; Singh, 2008).

Qualitative Inquiry

The use of qualitative methods of data collection (i.e., open-ended discussions) and analysis (i.e., thematic categorization) could broaden understandings of gay men's sexual difficulties. Qualitative methods are particularly valuable in the early stages of theory development when a topic needs to be explored in great detail with no boundaries on its conceptualisation. Notably, qualitative research allows for results that go beyond the forced response formats of the questionnaire, to participants' own framing of an issue (Braun & Clarke, 2013). Qualitative researchers explore the context and social meaning of a phenomenon, and how it affects individuals (Rowan & Wulff, 2007). This type of inquiry is flexible, allowing novel areas relevant to the research topic to arise which were not necessarily predicted by the researcher. These areas can be further probed, enhancing the overall purpose and outcomes of the research and allowing a more holistic view of the phenomenon under investigation.

Numerous authors have argued for the combined use of multiple qualitative methods (such as interviews and focus groups) to enhance the analysis of a subject and expand its conceptualisation (e.g., Gothberg et al., 2013; Lambert & Loiselle, 2008; Linhorst, 2002). In particular, while both methods permit participants to give detailed accounts of their experience in their own words, this multifaceted approach is beneficial in providing a range of general overviews (focus groups) as well as in-depth descriptions (individual interviews) of personal experiences (Lambert & Loiselle, 2008). Focus groups can provide a setting

where certain individuals feel more comfortable discussing sensitive issues in comparison to one-on-one interviews (van Teijlingen & Pitchforth, 2006). A large body of work suggests that focus groups can enhance the disclosure of sex-related information in numerous ways (e.g., Frith, 2000; Janssen, McBride, Yarber, Hill, & Butler, 2008; Newman, Tepjan, & Rubincam, 2017; Överlien, Aronsson, & Hydén, 2005). For example, for some people, the conversational ambience experienced within a focus group may feel less daunting in comparison to a one-on-one interview with a researcher. Awareness of common and shared experiences between group members may encourage participants to feel more comfortable or secure, and less on guard, when discussing sensitive issues. Data from interviews and focus groups can reveal overlapping yet complementary findings, which contribute to a more nuanced understanding of a topic. If applied to men's sexual functioning, the use of both interviews and focus groups may further enrich conceptualisations of this construct.

Current Study: Inductive Thematic Analysis

An inductive approach to qualitative research aims to generate analysis from the bottom (the data) up (Braun & Clarke, 2006, 2013). The current study aimed to give voice to a topic/group of people with little existing understanding. This study was geared toward identifying patterns of meanings across the dataset. For these reasons, inductive thematic analysis was employed. Participants' interpretations were prioritized over existing knowledge in the field; thus, themes bear close resemblance to the data (Braun & Clarke, 2006, 2013). With this being said, disciplinary knowledge will always, to some extent, influence the research; hence, our positions as psychologists were used advantageously to determine themes and patterns in the data.

Gaining understanding about the social, cultural, and physical aspects of sexual difficulty symptoms in gay and bisexual men will help researchers and clinicians to more accurately assess and refine criteria for sexual difficulties as it relates to this group. The two

aims of this study were to qualitatively explore men's sexual difficulties and examine how these difficulties are conceptualised, and to explore possible differences and similarities among heterosexual, gay, and bisexual men. Although research suggests there are differences in the experiences of sexual difficulties between heterosexual and non-heterosexual men (e.g., Cove & Boyle, 2002; Damon & Rosser, 2005; Rosser et al., 1997; Rosser et al., 1998), this assumption has not been explored qualitatively; thus, heterosexual men were included in this study. The exploratory and inductive nature of this understudied topic was such that we did not want to exclude any men's understandings. In a similar vein, within this exploratory project, both focus group and interview methods were employed to ensure depth and breadth of discussion and to elicit data that might be derived from different techniques. One-on-one interviews were used to gain in-depth descriptions of personal experiences and focus groups were used to gain general overviews of the area. Furthermore, providing participants with options as to *how* they share their experiences (i.e., via individual interviews or focus groups) meant that men who may have been reluctant about taking part could be reached.

In short, the desired outcome was to capture a full range of experiences and accounts on this neglected topic of research. Our specific research questions were:

1. What do men consider sexual difficulties to be and how are these difficulties conceptualized?
2. What are the differences and similarities in experiences of sexual difficulties among heterosexual, gay, and bisexual men?

Method

Participants

Fifty-two men between the ages of 18 and 66 years ($M = 35.38$, $SD = 12.62$) participated in 29 individual interviews (15 heterosexual; 12 gay; and, two bisexual) and seven focus groups (consisting of one group of two discussants; three groups of three

discussants; and three groups of four discussants). Focus groups were composed exclusively of heterosexual (focus groups 1, 2, 3; two groups of four, one group of three), gay (focus groups 4, 5, 6; one group of four, one of three, one group of two), or bisexual (focus group 7; one group of three) men; that is, participants were grouped according to sexual orientation. All of the focus groups were constructed, meaning that none of the groups were naturally occurring (i.e., participants had never met before). Constructed focus group discussions have been found to be more animated and enthusiastic, with greater divergent views and more complexities of the topic explored in comparison to natural occurring groups (Leask, Hawe, & Chapman, 2001). The participants were recruited in Ireland and included men resident in all four provinces: Connaught (19 participants), Leinster (16 participants), Munster (13 participants), and Ulster (four participants). This geographic sampling strategy was executed in order to capture a range of accounts in the Irish context. The demographic characteristics of the sample are presented in Table 1.

Insert Table 1 around here

Data Collection

Participants were recruited through a variety of means. A national campaign was launched seeking participation from all men aged 18 years and over. Advertisements were placed in local and national newspapers ($n = 8$ participants recruited via this method) and on Irish websites ($n = 2$). The research was discussed on the national television news ($n = 2$) and on national and local radio stations ($n = 11$). In addition, information on the study was distributed at LGBT pride events around the country ($n = 6$). Irish LGBT organisations (e.g., GLEN, GiGSoc) were contacted and asked to distribute information about the study to members ($n = 8$). Chain-referral sampling also was used whereby acquaintances of the first author were asked to inform other men about the study ($n = 15$). All advertisements and invitations clearly stated that the purpose of the study was to explore men's understandings of

sexual difficulties and stressed that no personal experience with sexual difficulties was required (although that personal experience was welcome). This ensured that men could not have self-selected into the study based on their experience of sexual difficulties.

Procedure

Interviews and focus groups were conducted by the first author (LMD) either in person (17 interviews; two focus groups) or over the phone (12 interviews; five focus groups), and in a variety of settings (depending on the needs of the participants). Locations included on-campus laboratories situated at multiple universities in Ireland, as well as participants' homes. Phone focus groups were facilitated by web conferencing technology (*Skype*) which provided participants with the option of a voice (anonymous) or video call.

Telephone and in-person interviews and focus groups. All contributors were given the option of participating over the phone or in person, and in a one-on-one interview or a focus group for two reasons. First, it was important to enable men from a variety of geographical locations throughout Ireland to participate, particularly to access hard-to-reach populations such as those living in remote rural areas, and those who would be reluctant to participate in person (Fielding, Lee, & Blank, 2008; Frazier et al., 2010; Miller, 1995; Sturges & Hanrahan, 2004; Tausig & Freeman, 1988). Second, due to the sensitive nature of the topic, some participants are more comfortable discussing embarrassing topics while remaining anonymous. Phone interviews (Fenig, Levav, Kohn, & Yelin, 1993; Greenfield, Midanik, & Rogers, 2000; Sturges & Hanrahan, 2004) and phone focus groups (Cooper, Jorgensen, & Merritt, 2003; Frazier et al., 2010; Krueger & Casey, 2014; Smith, Sullivan, & Baxter, 2009a) have been found to increase participants' perceptions of anonymity which in turn may increase data quality. To illustrate, a direct comparison of phone interviews vs. in-person interviews transcripts data found no significant differences in data (i.e., both produced similar data; Sturges & Hanrahan, 2004). Regarding telephone focus groups, one common

concern is that the lack of nonverbal cues could limit interactions and dynamics amongst participants. However, lack of visual contact can work in a positive way for some people, especially for sensitive topics. For example, in comparing telephone focus groups and in-person focus groups, Frazier et al. (2010) demonstrated that interactions occurred in both and similar elements of experiences were discussed across the two types of groups. Importantly, participants only disclosed certain emotionally sensitive experiences during the telephone focus groups. While relatively uncommon in the psychological literature to date, it is important to note that phone focus groups have been used in other health research fields, such as public health, for the past decade (Chong, Alayli-Goebbels, Webel-Edgar, Muir, & Manson, 2015; Gothberg et al., 2013; Horowitz, Siriphant, Canto, & Child, 2002; Koskan et al., 2014; Ross, Stroud, Rose, & Jorgensen, 2006; Smith et al., 2009b; Smith, 2014).

Topic Guide. A semi-structured interview guide was developed to guide discussions. The same guide was used in interviews and focus groups. Participants were asked about sexual dysfunctions and sexual difficulties separately, using the same questions for each. The interviewer briefly communicated the distinction between the two concepts prior to the interview commencing. The questions focused on: 1) the types of sexual difficulties and sexual dysfunctions men could experience; 2) the effects of these difficulties and dysfunctions; and 3) coping strategies for sexual difficulties and sexual dysfunctions. To promote participant comfort and disclosure, a funnelling technique (Smith & Osborn, 2008) was used; that is, the interviewer began by asking general questions (e.g., “What are the sexual dysfunctions that men may experience?”) before asking those that were more personal in nature (e.g., “Have you ever experienced a sexual difficulty?”). The topic guide (i.e., the set of guiding questions used to facilitate discussion of relevant topics) is provided in Table 2.

Insert Table 2 around here

Ethical considerations. Ethical approval was obtained from the Research Ethics Committee of the university of the first author (LMD). For face to face interviews and focus groups, participants were provided with an information sheet and consent form. Men participating via telephone were emailed a copy of the information sheet and consent form at least one day before the interview; consent was completed verbally and digitally recorded. Focus group participants were asked to be respectful of others, and not to share information discussed within the group with other people. To maintain confidentiality, all names provided in the quoted material are pseudonyms. Upon completion, participants could enter a competition to win one of four gift vouchers worth €50 each.

Data Analysis

On average, interviews lasted 57 minutes and focus groups lasted 120 minutes. Interviews and focus groups were transcribed verbatim (i.e., paralinguistic cues such as “em” and “um” were included). The data were subject to inductive thematic analysis employing Braun and Clarke’s (2006) recommendations. Due to time constraints, data collection and data analysis was conducted simultaneously by the first author (LMD). Transcripts from interviews and focus groups were analysed using the same procedure; this analysis did not probe for group interaction as the purpose of conducting focus groups and interviews was to encourage participant’s confidence in ability to share sensitive experiences. Specifically, the following procedure was employed.

Step one, data familiarization: The first interview (Interview 01) was transcribed by the first author and the transcription was checked for accuracy (i.e., the researcher listened to the audio recording while reading the transcript). Next, the field notes for Interview 01 were read; these were notes created by the researcher after conducting the interview regarding behaviors, activities, events, and other features of the interaction. The field notes were not

used as data, but were used to supplement the interview data by setting the scene for the context in which it took place. Next, the transcript was read several times to increase familiarity with the data. During the first several readings, notes were made regarding initial thoughts and interesting points made by the interviewee. This was initially done using pen and paper, and was then transferred to NVivo to aid data management in the next step.

Step two, generating initial codes: The use of the statistical software package NVivo9 aided in managing the coding of the data set; once familiar with the data for Interview 01, the transcript was loaded onto the software which then facilitated the organization and structuring of the coding process. The first author then read the transcript again, selecting important sections of discussion and attached a label – or a code – which described them. A code is “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p. 63). To illustrate, the following extract from was coded as “Viagra[®]”:

Participant: I guess then when you get older then you actually, the muscles are no longer working and it's not getting it up and that's when you move to Viagra. Which has its own implications. I'd say actually people who are on Viagra probably have a lot of issues about it.

Interviewer: Yeah?

Participant: Thinking that you have to take a pill in order to perform, especially if you, ya know, I think it's associated, Viagra is associated with old people so if you end up having to go on it in your 30's or, you know, something like that, then I'd say that would cause a lot of dysfunctions or possibly becoming dependent on it.

At this stage, sections of text were assigned multiple codes where relevant. Similarly to Step one, memos were used to record any interesting thoughts regarding the data. Steps one and

two were repeated for each transcript. Once all transcripts were coded, the first author revisited each transcript, starting at Interview 01, to ensure all relevant text was coded.

Step three, searching for themes: Once all the data were coded, a list of all of the different codes identified across the data set was constructed. The codes on the list were sorted into provisional themes and subthemes (i.e., codes were examined for potential overlap to form an overarching theme). In this way, the themes and subthemes identified were strongly linked to the data themselves; no pre-existing coding framework was used. Some codes did not belong within any provisional themes or subtheme but were not deleted; these were categorised under the theme of "Other" as we believed they could be important for Step 4. Diagrams and mind maps were used as a way to make sense of and visualise the connections between themes and subthemes (similar to the refined map in Figure 1). For example, the codes "Viagra[®]" and "mechanistic view/get fixed" were categorised under the theme "Phallocentrism."

Step four, reviewing themes: This involved the refinement of the list of themes. The researcher returned to the coded data and transcripts for each theme to review whether the theme adequately represented the data. Further connections between the coding and the theme were sought. At this stage, the sexual orientation of participants represented in the coded data was examined for commonalities and differences within the themes. If a theme did not have enough data to support it was collapsed into another related theme. Some themes were found to be too complex and were broken down into separate themes. An example from this stage of analysis is that "Viagra[®]" "mechanistic views" and "phallocentrism" were collapsed into the theme of "Medicalization", which was grouped under the overarching theme of "Physical Function."

Step five, defining and naming themes: When all transcripts were analysed, a final refined list of themes and subordinate themes was created. A detailed analytical description

was written about each theme describing what that theme means and represents. At this stage, how each theme and subtheme fitted into the overall story about the entire data set in relation to the research questions was considered. The wording of themes was also reconsidered. For example, the “Physical Function” overarching theme was renamed “Penis Function.” To validate emergent findings and ensure a rigorous analysis was achieved (Braun & Clarke, 2013), a subset of transcripts (ten in total) was reviewed and analysed using the same procedure by the last author (TG). Resultant codes and themes were compared. Minor discrepancies were discussed and jointly altered. The wider team of co-authors was then consulted to ensure the data was represented and displayed in a meaningful and useful manner.

Results

Across the three subgroups (heterosexual, gay, and bisexual) of participants, a distinction was made between sexual difficulties in terms of penis functioning and pain. For each broad category, salient themes and subthemes emerged which speak to the complexity surrounding sexual difficulties for men. An overview of themes and related subthemes is presented in Figure 1. A list of key themes and respective illustrative quotations are given in Tables 3 and 4.

Insert Table 3 around here

Insert Table 4 around here

Penis Functioning

Participants' responses were characterized by phallocentrism (i.e., the focus was on the physical functioning of the penis). A “functioning penis” was defined as one that could get erect, stay erect, and ejaculate (neither prematurely nor “too late”). These three difficulties were further examined in relation to: 1) medicalization; 2) the role of masculine

standards; 3) psychological consequences (i.e., damage to confidence); and 4) coping mechanisms (i.e., over-compensation).

Medicalization. For all subgroups of men (heterosexual, gay, and bisexual) sexual difficulties were conceptualized in a very mechanistic way. For example, the phrases “get it fixed” and “get it sorted” were mentioned frequently. Pharmaceutical interventions such as erectile disorder (ED) drugs were the primary means of resolving physical sexual difficulties. The belief that physical sexual difficulties, erectile difficulties in particular, are “easy to address” (Alexander, 35 years, heterosexual, interviewee) and “rectifiable” (Eddie, 27 years, heterosexual, focus group 1) surfaced.

Men who had taken ED drugs for erectile disorder expressed a sense of relief after taking them. Martin (52 years, bisexual, focus group 7) felt anxious before taking the medication, afraid that it might not be effective. While acknowledging that his erectile difficulties may be attributable to a deeper underlying psychological condition, he hoped the cause was a physical one. He explained that “within an hour and a half, there it [his erection] was looking at me, so I was more than delighted! Relief!” In this interaction, Ian (60 years, bisexual, focus group 7) agreed with Martin by saying “Yeah, it is definitely a relief to have that monster in your hand... seeing an erection is part of being a guy.”

However, not all participants had positive views of ED drugs. Although it was commonly conceived as an “easy solution” to sexual difficulties, some men expressed concerns over having to rely on medication for sexual activity. To illustrate, Colm (53 years, heterosexual, focus group 2) and Kevin (44 years, heterosexual, focus group 2) discussed their concerns regarding medication reliance and stated: “I think it would have a serious effect on my confidence anyway, serious... I don't want to need any feekin' Viagra®.”

Masculine Identity. All heterosexual, bisexual, and some gay participants made connections between masculinity and a functioning penis. Penis functioning was viewed as

an integral part of one's identity, and thus any impairment was seen as a loss of one's identity as a man. To illustrate, Keith (33 years, heterosexual, interviewee) explained that "your sexual side is part of your identity... it's the most integral thing in one way; I mean, in one way, it is the most integral thing about yourself." Harry (55 years, heterosexual, focus group 3), who had experienced erectile difficulties due to low levels of testosterone, revealed the impacts this had on his identity. He stated "I was no Romeo or Don Juan but I'd still have a drive and I feel that drive now has diminished, and that bothers me because I want to feel like a full man." He disclosed feeling as though he was bordering on depression because this very important part of himself was beginning to wane. For him, evidently, erectile difficulties led to a loss of his sense of self and masculine identity.

In focus group five, Cormac (30 years, gay) and Ben (35 years, gay) discussed masculinity and a crystallized gay identity. Some gay men defined themselves by the sexual roles and positions (i.e., top, bottom, versatile) they preferred; 'top' refers to those who engage in the penetrative/insertive role during sexual activity; 'bottom' refers to those who engage in the receptive role; and versatile refers to those who engage in both roles (Underwood, 2003). If, as a result of impaired sexual functioning, a gay man cannot assume the role he identifies with, according to Cormac, he will not only experience a loss of identity as a man but also "a loss of identity because, like, they can't regard themselves as an active gay man." Ben agreed but went on to say "there are a lot of other things that make up who you are... I think society would probably make them feel like, you know, men are supposed to be kind of virile and shagging everything that moves and... if you're not doing that and can't do it ...I can kind of understand why somebody would feel less of a man."

Penis Size Concerns. Concerns over penis size emerged as an influence on men's sexual functioning; these concerns were salient across heterosexual, gay, and bisexual, participants. The desire for a bigger penis was believed to be a natural and common concern.

For example, Peter (28 years, gay, interviewee) commented, "I think most guys probably aren't confident about the size of their penis, even like guys who are average. I just think like most people would like a bigger penis." The sources of these concerns (e.g., competition with sexual partners for gay men, pornographic films), in addition to the psychological and physical impact of being concerned about one's penis size were discussed.

Competition and Gay Men. The main difficulty expressed by gay and bisexual participants in relation to penis size concerns occurred due to physical comparisons with their sexual partners. As same-sex partners have the same anatomy, in contrast to other-sex partners, there is an obvious "direct comparison" (Aaron, 25 years, bisexual, interviewee). Aaron, who had dated both men and women, felt less self-conscious about his penis size when he was with women, compared to when he was with men. In his experience with men, "everything's a competition," including physique, kissing, sexual performance and penis size, which can cause anxiety for some gay men. Evidently, physical comparisons men make to their partners in same-sex relationships have the potential to make them feel inferior and inadequate.

Pornography. When articulating possible reasons for why men have concerns about penis size, several participants held the pornography industry responsible. Similar to comparisons between same-sex partners discussed previously, many participants spoke about comparisons between their penis and those depicted in pornography. For example, Peter (28 years, gay, interviewee) stated, "I'd say it's probably porn's fault actually because all men in porn have like massive penises and most guys kind of compare themselves to them." Furthermore, Tim (26 years, heterosexual, interviewee) referred to large penises shown in pornography, and described the actors as resembling a "tripod." The findings suggest that expectations to perform according to pornographic ideals (i.e., physique, performance) and

trying to meet these standards could greatly affect sexual performance and detract from sexual satisfaction.

Psychological Impact of Concern over Penis Size. Feelings associated with these concerns were inadequacy, anxiety, and embarrassment. The perception that a large penis is needed to sexually satisfy a partner was evident throughout the discussions, particularly among heterosexual participants. Men spoke about feeling inadequate if their penis was not deemed large enough to be able to please their partner: "is it an adequate size for a woman, or what will she think when he takes his shirt off and his pants off, will she laugh?" (Andrew, 29 years, heterosexual, interviewee). Peter (28 years, gay, interviewee) discussed how anxiety and embarrassment associated with penis size could prevent a man from seeking out a sexual partner: "it stops them trying to sleep with people or having a relationship or anything because they don't think that any girl or man would want to be with someone that has a small penis."

In contrast to the belief that a large penis was needed to satisfy a partner, some gay men preferred their sexual partner to have a smaller penis than their own. Various reasons were posited for this. Peter (28 years, gay, interviewee) made it clear that a large penis is not always desirable: "I would much rather sleep with a guy if he had like six, seven inches, to someone who had ten or eleven, because it would just be painful and not pleasant." Members of a focus group also spoke about the desire to have a sexual partner with a small penis. Their reasoning for this desire was to boost one's own confidence: "it just kind of makes them more secure about themselves" (Jimmy, 31 years, gay, focus group 4). Interestingly, although some men believed a large penis was needed to sexually satisfy their partner, they themselves did not need their partner to have a large penis for their own personal satisfaction.

Physical Influence on Sexual Functioning. Concerns over penis size were deemed to have a major influence over one's physical sexual functioning and were conceived to be a

causal factor in a variety of sexual difficulties. For example, Aaron (25 years, bisexual, interviewee) commented “if someone is concerned about the size of his penis, he is less likely to enjoy sex and, therefore, may not be able to reach orgasm.” Fergal (23 years, gay, interviewee) noted that, “people could feel they’re inadequately endowed and have a lot of hang-ups from that, and that would feed back into sexual dysfunction.” To complete the theme of “masculine identity,” the next two subthemes speak to men’s ways of dealing with the sexual difficulties outlined thus far.

Restrictive Emotionality. Another significant subtheme of “masculine identity” was the difficulty expressing one’s feelings (i.e., restrictive emotionality) which was reported in a similar way by heterosexual, gay, and bisexual participants. When discussing how men could cope with sexual difficulties, most participants believed that men would “suffer in silence” (Andrew, 29 years, heterosexual, interviewee). The common perception was that men would not be willing to discuss sexual difficulties with their partner, friends, or doctor.

These beliefs conform to the masculine social norm that men should not talk about their emotions or problems (e.g., Courtenay, 2000). For example, Austin (25 years, heterosexual, interviewee) remarked “men are pretty emotionless creatures and they don’t express themselves very much so they just get on with it.” The rationale for restrictive emotionality was, again, linked to the perceived masculine ideal of having a functioning penis. Participants revealed men would be too embarrassed to deviate from this “ideal.” Participants recognized that men *should* seek help from a doctor if they experienced a physical sexual difficulty; however, many participants admitted that men are generally unwilling to do so. Again, this reflected the idea that is it not “manly” to seek help from a doctor for sexual issues. Andy (26 years, gay, focus group 4) painted an illustrative picture when he stated:

Whenever you go to the GP it's because you're bleeding or near dead you know, it's not about going to talk about your problems usually... you're a man and you should be out all day cutting trees and you know going and talking about your feelings just doesn't fit in.

Members of a focus group also reflected on this issue. For example, Ian (60 years, bisexual, focus group 7) commented:

I don't think people would be running to their doctor with this [sexual difficulty]. It's a male thing. You don't go to the doctor with something like that; you go if you've got a stake in your chest and it needs pulling out.

Extreme discourse was used to communicate the severity of masculine norms vis-à-vis sexual difficulties. The desire to be self-reliant reflects another societal masculine standard, and reinforces the norm that men should be too embarrassed to admit to others that their penis is not "fully" functioning.

Alternative Masculinity. In contrast to the views discussed above, some men spoke about how the functioning of the penis is not (and should not be) a representation of one's manhood. Interestingly, all participants who explicitly expressed this viewpoint were gay men. For example, Pat (34 years, gay, interviewee) commented "It doesn't reduce them as a man if they're having trouble maintaining an erection." Frank (56 years, gay, interviewee) spoke in detail about his own personal experience with erectile difficulties. Due to medical complications at a young age, Frank has always experienced some difficulty maintaining his erection. When relaying his experience, he stated "I guess it's affected me but not terribly, no... I think that it's very interesting in terms of the fact that certainly if I'd been a straight man, this would have been something of a disaster." This mirrors research which has found penetrative intercourse to be rather infrequent in same-sex sexual encounters, in contrast to heterosexual sexual encounters where it is considered to be the central focus (e.g., Grulich et

al., 2014). There is a lot more flexibility in gay relationships, particularly in terms of individuals' sexual preferences. For example, Frank stated "there are other ways to have a sexual experience than somebody's got to have a stiff penis." Evidently, for some participants, penis functioning was not an essential part of their masculine identity.

Psychosocial Consequences. The main psychological consequence of experiencing difficulties related to penis function reported by participants from all subgroups was damage to one's confidence, which was represented by distress, embarrassment, and depression. The impact on confidence was not solely due to a loss of sexual abilities, but also due to a loss of masculinity, as discussed above. When describing how distressing it would be to experience sexual difficulties, Jamie (66 years, gay, interviewee) drew an analogy: "I think that'd be pretty desperate. It'd be like having eyes and not being able to see or something." Andrew (29 years, heterosexual, interviewee) explained that if a man could not perform sexually it would be "like a serious kick to them, kinda like the carpet being pulled underneath their feet, so they're kind of soul destroyed if they can't."

Embarrassment could be felt for various reasons. First, a man would be embarrassed because he would feel that he had failed himself as a man. When relaying his own experience with erectile difficulties, James (22 years, heterosexual, interviewee) revealed, "it's quite shameful, or humiliating, embarrassing." Second, some men thought it would be embarrassing for their sexual partner to know of their perceived failings as a man. For example, Fred (24 years, gay, interviewee) stated "if there was a case that happened to a partner of mine then I'm sure it was very embarrassing [for] them if they were in the company of another person." Third, many men spoke of the embarrassment of having to explain a sexual difficulty to a doctor: "you have the embarrassment of having to go to your doctor and saying, basically admitting, to – most likely – another man that you can't perform sexually, which would cause a lot of anxiety in life" (Aaron, 25 years, bisexual, interviewee).

Undoubtedly, the experience of sexual difficulties relating to penis function could have a profound impact on men's social and psychological well-being (e.g., Althof, 2002; Laumann et al., 1999).

Coping Mechanisms. Regarding the consequences of a physical sexual difficulty, many heterosexual and bisexual participants suggested that men would likely overcompensate for the perceived loss of "manliness." As a result of feeling less masculine, some suggested that emotions, such as anger and rage, would increase and would manifest physically:

Well, if I can't maintain an erection then I'm *obviously* not a man and I can't do other manly things like lifting boxes, I dunno, so it's probably gonna go the other way and they are gonna start overcompensating in the rest of life and coming across as being possibly over[ly] aggressive to show that they are a man (Aaron, 25 years, bisexual, interviewee).

Keith (33 years, heterosexual, interviewee) also spoke of increased hostility and violence having a negative impact on one's relationships when he stated, "Find another way to prove your manliness; go and beat the head off somebody, or beat your wife."

None of the participants reported engaging in these compensatory mechanisms, but they contemplated why they theorized that other men would react this way. The rationale provided was that a man would want to conceal his perceived "failings" as a man. Some spoke of one's sexual abilities as being invisible to others (except a sexual partner) and, therefore, deficiencies can be hidden through appearing "manly" in other areas of life, a practice which is often referred to as "masculine capital" in the literature (Anderson, 2002; de Visser & McDonnell, 2013; de Visser, Smith, & McDonnell, 2009). Participants appeared to believe that by becoming successful in activities that are perceived as highly masculine (e.g., playing sport, abusing steroids and consuming excessive amounts of alcohol), a man offers

“proof” to others – and, critically, to himself – that he is still a “man” (James, 22 years, heterosexual, interviewee).

The latter two penis functioning themes explored (i.e., “psychological consequences” and “coping mechanisms”) had implications on both an individual (i.e., psychological) and collective (i.e., sociocultural) level. The other broad category, “pain,” details another sexual difficulty which emerged over the course of analysis. It should be noted that *all* sexual difficulties are biopsychosocial phenomena, i.e., they involve an interaction between biological, psychological, and social factors, although the extent to which their cause is determined by these factors varies.

Pain

Two difficulties related to pain during sexual activity emerged throughout: 1) penile pain; and, 2) experiences of pain during receptive anal sex.

Penile Pain. Penile pain was described by participants as pain of the penis caused by a tight foreskin (also known as phimosis). Five participants (three gay men, one heterosexual man, and one bisexual man) disclosed personal experiences with phimosis and had a circumcision as a result. In all cases, this difficulty was viewed as a medical condition which could be “surgically sorted out” (Gregor, 46 years, gay, focus group 6). Compared to other physical sexual difficulties, penile pain was deemed “an easy enough one to sort out” because there is a surgical solution (Ted, 32 years, gay, interviewee).

Physical Impact. Despite having a surgical solution, phimosis was considered to have a major impact on one's sexual functioning, mainly because sexual activity, including masturbation, would be extremely painful. According to Albert (23 years, gay, interviewee), assuming the insertive role in anal sex would be incredibly difficult “because there's a lot of pressure being put on that particular part of the body.” In addition, Peter (28 years, gay, interviewee), who was circumcised because of phimosis, found anal sex “nearly impossible”

and consequently avoided that sexual behavior; “even now [after circumcision] I don’t particularly like it, maybe because I just wasn’t used to it when I was younger.” Phimosis also was associated with difficulties in reaching orgasm and maintaining an erection. For example, Robert (27 years, heterosexual, interviewee) expressed having difficulty reaching orgasm, which he attributed to experiencing penile pain over a long period. Even after having a circumcision, he believed he is still psychologically scarred from his experience.

Psychological Impact. The psychological impacts of phimosis included frustration and embarrassment. Jason (24 years, gay, interviewee) commented that it would be “very frustrating because obviously you can get aroused and get an erection but then like, obviously, you can’t like really ejaculate.” Jason went on to discuss his relationship with a man who had a “non-retractable foreskin.” This was a source of great frustration due to lack of sexual intimacy. Trevor (23 years, gay, interviewee) also spoke of his relationship with a previous partner who had phimosis. He felt he and his partner’s sexual needs were not being met: “they’re not enjoying it so then I’m not really enjoying it.” However, due to embarrassment, he did not discuss the matter with his partner. He found this very “puzzling” because without discussing the topic, the situation could not be resolved.

Peter (28 years, gay, interviewee), who had this condition, conveyed his embarrassment: “that’s why I didn’t get circumcised earlier; I was too embarrassed to go to the doctor basically.” Before he started having sex with men, he didn’t realize he had a problem. It was not until he was with someone who looked at his penis with “disgust” that he realized there was a problem. The emotional hurt he felt as a result motivated him to seek help. He spoke of the first time he ejaculated after the surgery which caused the stitches in his penis to burst. He was too embarrassed to go back to the hospital to seek help. Johnny’s (50 years, bisexual, focus group 7) narration of medical intervention for penile pain starkly contrasts Peter’s:

Once I was circumcised it felt like I was grown up, I was dealing with the full deck! (*Laughs*). I was slightly embarrassed by the penis that I had. I felt it wasn't the way that it should be... Because I wasn't having anal sex, or penetrative sex, there wasn't an occasion where it would have caused a problem. When I started having experiences with men, that's when I realized something was wrong... I'm absolutely thrilled I had it done, it's fantastic.

The extracts provided to illustrate penile pain harkens back to the above penis functioning themes of "medicalization" (e.g., the "get it fixed" mentality) and "masculine identity" (i.e., restrictive emotionality) and thus display the intercorrelated nature of the findings. The final theme concerns pain of a different erogenous zone.

Pain during Receptive Anal Sex. Many of the gay and bisexual participants introduced the topic of pain during receptive anal sex as a sexual difficulty; unsurprisingly, it was not raised by heterosexual participants. Participants expressed different views on how pain during receptive anal sex should be classified (i.e., as a sexual difficulty, an interpersonal difficulty, or undecided). This finding reflects disagreement over its classification found in the literature (e.g., Hollows, 2007). One participant, for example, contrasted it to erectile disorder. He observed that erectile disorder is "seen as there is something wrong with me;" however, experiencing pain during receptive anal sex "isn't your fault... these things just happen" (Aaron, 25 years, bisexual, interviewee).

It must be noted that experiencing pain during receptive anal sex was not considered an issue for all gay and bisexual participants and many spoke about flexibility in their sexual behavior. For instance, Jason (24 years, gay, interviewee) explained if anal sex "isn't working, you can just do other things and it's probably not a big deal." Larry (34 years, gay, interviewee) believed that anal sex is not part of every gay man's sex life. This echoes earlier discussions regarding penis function and the infrequency of penetrative intercourse in same-

sex sexual encounters (e.g., Grulich et al., 2014). Conceptualisations of anal pain (i.e., acceptance), the physical and psychological determinants of pain, and the most common coping strategy (i.e., avoidance) were identified as subthemes.

Acceptance. Several participants conceptualized pain during receptive anal sex as “normal” – as something to be expected. To illustrate, Gary (20 years, gay, interviewee) commented, “It’s nothing that is to be embarrassed by, ya know, some people can and some people can’t.” According to Fergal (23 years, gay, interviewee) “with the best will in the world, and doing everything properly, and using appropriate lubrication and so on, you’re still going to have some degree of pain during penetrative sex.” The explanation for this line of thinking was that the anus is not perceived as an appropriate sex organ, or “it is not made for sex” (Aaron, 25 years, bisexual, interviewee). For example, Jamie (66 years, gay, interviewee) spoke of how someone experiencing pain during receptive anal sex would be unwilling to seek help from a doctor because the anus “isn’t [seen as] a proper sex organ.” He contrasted this experience to a woman suffering from vaginal pain during sex. He believed pain during vaginal sex was a typical occurrence and “not completely off the planet”. Others mirrored this opinion with comments such as “the ass isn’t exactly built for stuff going up it” (Peter, 28 years, gay, interviewee) and “it’s a muscle that shouldn’t be doing that” (Albert, 23 years, gay, interviewee). For many, pain during anal sex was simply accepted as something to be expected.

Physical Determinants of Pain. Physical factors, which can influence the experience of pain, included: one’s physique; sexual preparation; and medical conditions.

Physique. The experience of pain during anal sex was attributed to physical characteristics of the receptive partner (i.e., having a tight anus) or of the insertive partner (i.e., having a large penis). For example, Fred disclosed his inability to have anal sex with his ex-partner because “his arse wasn’t big enough basically to take it.” He voiced his

dissatisfaction with their sexual encounters when he said they were “as boring as watching paint dry.”

Preparation. Practical preparation techniques for anal sex were discussed by the majority of participants as being essential for pain free anal intercourse, such as the need to use “plenty of lubrication” (Peter, 28 years, gay, interviewee) and loosening the anus using toys or digital stimulation (i.e., “get fingered beforehand to loosen you up”: Cormac, 30 years, gay, focus group 5). Poppers (i.e., alkyl nitrites) also were suggested to help relax anal muscles but some men expressed concern over their use. For example, two men (Fred, 24 years, gay, interviewee; Andy, 26 years, gay, focus group 4) spoke of men being overly reliant on poppers. Additionally, Albert (23 years, gay, interviewee) expressed concern over the lack of information on the long term effects of using poppers and revealed his usage resulted in a skin rash.

Medical Conditions. Other participants mentioned that pain could be caused by medical issues such as colon cancer, haemorrhoids or anal warts. Fergal (23 years, gay, interviewee) conversed about his partner who had haemorrhoids which caused “horribly excessive pain” during sexual intercourse. Participants highlighted such cases should be assessed by a doctor but, again, the reluctance to discuss this issue with a medical professional was apparent.

Psychological and Interpersonal Determinants of Pain. Several psychological and interpersonal factors which could influence the experience of pain were described, specifically: one's sexual partner; fear of pain; and sexual guilt.

Sexual Partner. The presence of a considerate and trustworthy sexual partner was considered to be of utmost importance when faced with pain during anal sex. According to the participants, having a partner who understands the possible issues associated with anal sex allows men to actively and effectively deal with the situation. Through sexual flexibility

(e.g., engaging in a variety of sexual practices together) and mutual trust, a natural state of relaxation could be achieved which would aid in minimizing anal pain. Other participants reinforced the idea that when a man experiences difficulties with anal pain, his partner plays a vital role: "You need to be completely relaxed and complexly trust the person you're with" (Ian, 60 years, bisexual, focus group 7); "If someone is rough and they just kinda shove it up there then your muscles don't have time to relax" (Peter, 28 years, gay, interviewee).

The general consensus was that pain is part of anal sex (although not always) and the couple can usually work together to resolve the issue. Participants in this study stated that they would be understanding should this situation occur. Participants who relayed their own experience with pain during anal sex made statements such as "it's not your fault" and "these things happen."

Fear of Pain. For some men, the issue raised was the fear of pain as opposed to actually experiencing pain. For example, Sean (25 years, gay, interviewee) remarked, "I know people who haven't experienced that at all and who would shy away from it [anal sex] because they think it is going to be painful." Thus, without ever having engaged in anal intercourse, some men may avoid that activity solely due to the fear of being hurt physically. Some participants suggested that this is more common in younger men who have less experience and less knowledge of participating in anal sex. Others suggested that the expectation of pain will result in pain: "They are going to be gripping the table, like having a tooth pulled" (Gregor, 46 years, gay, focus group 6).

Sexual Guilt. One participant discussed the possibility that if individuals are brought up to believe that it is "wrong for two men to have sex" (Henry, 33 years, gay, focus group 4), the experience of pain during anal sex may reinforce that view. This, in turn, could lead to feelings of guilt about their sexual behavior and their sexuality: "they're not supposed to be doing it [anal sex]." Ultimately, he concluded it can cause a constant internal struggle and

real “psychological battle” for individuals. It is possible that this concern stems from the influence of the Catholic Church in Ireland; this will be explored further in the discussion.

Coping Mechanisms. For a substantial number of participants, the most commonly suggested method for coping with pain during receptive anal sex was to avoid it. Some men mentioned that avoidance would be a very common response for someone who had a painful experience during their first time, which as a result would “put them off” receptive anal sex in the future. Cormac (30 years, gay, focus group 5) summarized this view succinctly when he said: “If you stick your hand into the fire and feel pain, you are hardly gonna go back and do it again.”

Discussion

The current study qualitatively explored conceptualisations of sexual difficulties among heterosexual, gay, and bisexual men. Two intercorrelated strands of conceptualisations were identified: 1) penis function, with nested themes of medicalization, masculine identity, psychological consequences, and coping mechanisms); and 2) pain, with nested themes of penile pain and pain during receptive anal sex. Several difficulties were identified which are currently not recognised as sexual difficulties, i.e., these were difficulties relating to penile pain (relevant across all sexual orientations) and pain during receptive anal sex (gay and bisexual men). Overall the results demonstrate that men’s sexual difficulties are complex phenomena with an interplay of biological, social, and psychological factors.

Pain

The findings suggest that the current understanding of sexual difficulties does not provide a complete picture when it comes to the experiences of gay and bisexual men (such as pain during anal intercourse) and, indeed of heterosexual men also (penile pain). This supports previous quantitative research in the area (Cove & Boyle, 2002; Sandfort & de Keizer, 2001). Similarly to Hollows’ (2007) argument, it is unclear whether pain during anal

sex should be considered a sexual dysfunction *per se* but it is clearly a sexual difficulty facing some gay men. On the whole, pain during sex experienced by men has been neglected in the literature (Davis, Binik, & Carrier, 2009). Perhaps trying to define pain during receptive anal sex in terms of “dysfunction” or “non-dysfunction” may not be as important as understanding the impact this pain has on individuals, the distress associated with it, and how it relates to general health and well-being. For example, how does sexual function impact distress and general wellbeing? Further work is required regarding men's subjective experience of pain and associated subjective feelings of distress to greater understand why impaired sexual function causes distress for some and not for others.

Demographic Comparisons

On the whole, gay, bisexual, and heterosexual men reported similar sexual difficulties. For example, physical sexual difficulties were viewed in a mechanistic manner across the subgroups of men; penis size concerns were common, and experiences of penile pain were similarly described. Differences were noted between gay, bisexual and heterosexual participants regarding three aspects of sexual function: 1) Gay and bisexual men reported experiences of pain during receptive anal sex; unsurprisingly this was not raised by heterosexual men. 2) Regarding masculinity, in contrast to heterosexual men, gay and bisexual made a distinction between manhood and penis function. 3) Gay and bisexual men reported experiencing concerns over penis size due to physical comparisons with sexual partners. One cannot conclude that gay and bisexual men have poorer sexual function than heterosexual men (or vice versa), which one could infer from comparing prevalence rates of sexual difficulties (e.g., 31% in heterosexual men reported by Laumann et al. [1999] vs. 79% in men who have sex with men reported by Hirshfield et al. [2010]). Instead, our findings illustrate that they may be affected by different issues, consistent with other research in the field (e.g., Damon & Rosser, 2005; Hollows, 2007; Rosser et al., 1997, 1998) and asserts that

we should not be viewing gay and bisexual men's function from a heteronormative viewpoint.

It is interesting to note, that some generational differences were noted between participants. Difficulties relating to pain during anal sex were more commonly raised by younger participants, similar to findings by Hirshfield et al. (2010). In contrast, erectile difficulties discussed via the medicalization of sexual function were more commonly discussed among older participants, congruent with previous research in this field (e.g., Bancroft et al., 2005). This finding is in line with previous research on age and sexual function and can be explained by the natural processes associated with aging (e.g., Laumann et al., 1999).

Penis function and Masculinity

The pivotal role of societal and cultural standards of masculinity was evident in the interviews and focus groups. This result supports previous research linking penis functioning and masculinity (Brubaker & Johnson, 2008; Potts, 2004; Rubin, 2004; Zilbergeld, 1992). An "ill-performing" penis is seen as a failure of masculinity because men feel they are not living up to cultural expectations of "being a man" (Tiefer, 1986; Zilbergeld, 1978, 1992). Abiding by the standards of hegemonic masculinity can have dangerous consequences for men's psychological and physical health (de Visser & McDonnell, 2013; Goldberg, 1976; Harrison, Chin, & Ficarrotto, 1992; Pollack, 1998). Early in life, boys are taught that "their manhood is tied to their penis, and having and using erections has something to do with masculinity" (Zilbergeld, 1992, p. 32). Normative masculine sexuality and sexual identity are defined so specifically that the action (attainment, sustainment and penetration) of an erect penis is essential (e.g., Brubaker & Johnson, 2008; Potts, 2004; Rubin, 2004). Sexual difficulties which result from feelings of incompatibility with a partner can present a challenge to one's masculinity and result in lower levels of sexual satisfaction. Participants in this study viewed

penis function as integral to one's identity as a man, and impairment to sexual function was seen as a loss of one's masculine identity. The current findings also echo previous work on "masculine capital"; whereby men report striving for success in (or engagement with) one masculine domain to use as "credit" to counteract a lack of competence in (or refusal to engage with) other masculine domains (Anderson, 2002; de Visser & Smith, 2006; de Visser & McDonnell, 2013; de Visser et al., 2009). For example, participants in the present study reported that men would possibly attempt to accrue masculine capital by engaging in violence (e.g., physical abuse) and self-destructive behaviors (e.g., alcohol and drug abuse) as coping strategies when faced with penile difficulties (nonmasculinity). Thus far, available research has not examined endorsement of masculine standards in relation to sexual difficulties in men, except in those who do not have a life-threatening illness (Gray, Fitch, Fergus, Mykhalovskiy, & Church, 2002; Oliffe, 2005; Ussher et al., 2016; Ussher et al., 2016).

Complex contradictions

Several findings (e.g., penis size concerns, alternative masculinity, acceptance of pain during receptive anal sex) from this study reveal the complexity and, at times, the contradictory nature of sexual difficulties among men. These surprising results warrant further attention as they appear to trouble lay understandings, gender and sexual scripts, and existing psychiatric taxonomies (e.g., the DSM). Participants did converse about penis size in culturally predictable ways i.e., calling upon the ingrained notion that "bigger is better" (Drummond & Filiault, 2007; Grov, Parsons, & Bimbi, 2010). Moreover, the current study supports other research which showed that self-reported small penis size can negatively affect gay men's psychosocial adjustment (e.g., Grov et al., 2010). Although the subtheme of "competition among gay men" emerged, discussants also provided various reasons for why they might actually prefer a sexual partner with a smaller penis. This incongruity in terms of size (i.e., men want bigger penises for themselves but not for their partners) has important

implications considering increases in penile augmentation procedures (Ghanem, Glina, Assalian, & Buvat, 2013). For example, future researchers might endeavour to ask men: Who exactly is this surgery for?

“Alternative masculinity” was another novel finding; again, participants who explicitly expressed alternative viewpoints on masculinity with respect to penis functioning were gay men. These men (whose ages ranged greatly) did not necessarily equate erections with manhood nor deem erectile difficulties as catastrophic – “something of a disaster” – within the context of sexual encounters. Rather, discussions focused on the flexibility in gay relationships which appear to buffer against the culturally imagined penetrative imperative. Indeed, not all gay and bisexual men participate in anal sex (Hollows, 2007). Given that masculinity is a multidimensional construct (e.g., Connell, 1992; de Visser & McDonnell, 2013; Halkitis, 2001; Levant, 1996; Levant et al., 2007) it is possible that sexual difficulties may be more strongly associated with other expressions of masculinity, such as restricted emotionality, sexual prowess, anti-femininity, and internalized homophobia (Levant et al., 2007). While a select few recent media depictions have presented gay male sex as nuanced and full of foibles (see Nielsen, 2015), this finding requires further empirical attention on an experiential level.

Lastly, the subtheme of “acceptance” of pain during receptive anal intercourse problematizes commonplace understandings of pain as uniformly negative (i.e., that it is problematic and should be minimized/eliminated). In discussing pain during receptive anal sex, Hollows (2007) noted that distress may essentially be the consequence of unmet needs or expectations rather than pain itself. Indeed, the current finding that the *fear of* pain may be more disconcerting than pain itself speaks to the important distinction Hollows (2007) made. By listening to the accounts of gay men who engage in receptive anal intercourse, the results of this study showed that pain, in some cases, is expected, manageable, and, with the “right”

partner, hardly cause for concern (see “physique,” “preparation,” and “sexual partner” from above). At the same time, the discourse from this subtheme (and that within the finding of “sexual guilt”) reveals participants’ conditioning in a heterosexist society. Traces of internalized homonegativity (Mayfield, 2001) are arguably perceptible when they vet anal intercourse as somehow inappropriate, improper, or unnatural. Hence, we maintain that the complexities contained within the current findings have crucial implications for better understanding and treatment of men’s sexual difficulties and sexual dysfunctions.

Limitations

Several limitations warrant discussion. First, participants who are interviewed in person may underreport true experiences of sexual difficulties due to concerns about social stigmatisation and lack of privacy (Lau et al., 2008; Laumann et al., 1999). However, participants in this study were willing to detail and report both abstract and personal sexual difficulties and sexual dysfunctions. Similarly, Hirshfield et al. (2010) found men who have sex with men were willing to report and describe their personal sexual functioning.

Second, some may consider the use of phone interviews and focus groups to be a limitation due the absence of visual and nonverbal cues. However, we felt the advantages of using these methods (wider geographic coverage and increased sense of anonymity and comfort for participants disclosing on a sensitive topic) outweighed the disadvantages which warranted their use in the current study. It is worth noting that in this study face-to-face and phone discussions produced similar data (although conducting a comparative methodological analysis is beyond the scope of this paper). Providing participants with options as to *how* they could take part in the research of such a sensitive topic meant that many men were reached who would have otherwise been reluctant to share their thoughts and experiences.

Third, the cultural context of the current study must be noted. Specifically, all participants were Irish citizens, residing in Ireland. Since 1993, when homosexuality was

decriminalized in the Republic of Ireland, the country has slowly made advances in achieving equality for sexual minorities (Mac Gréil, 2011). However, there is still strong evidence of discrimination and stigma towards sexual minorities (Connolly & Lynch, 2016; Gibbons, Manandhar, Gleeson, & Mullan, 2007; Higgins et al., 2016). These attitudes have been influenced by numerous factors, the most significant of which is the Catholic Church, which ruled social and cultural thinking in Ireland for the greater part of the twentieth century. Furthermore, given this context, it is plausible – indeed, likely – that some issues which are relevant in other cultural settings may not have emerged, as they may not be as relevant within an Irish context. For example, although the use of alkyl nitrites (i.e., poppers) was discussed by some participants, the use of illicit substances (e.g., methamphetamine, cocaine, marijuana) and their relationship to sexual function was not raised. Across the international literature, substance use has been positively associated with sexual difficulties among both heterosexual and sexual minority samples (e.g., Christensen, Grønbaek, Pedersen, Graugaard, & Frisch, 2011; Johnson, Phelps, & Cottler, 2004; Lau et al., 2005; Lau et al., 2008). Although participants in the current study were not specifically asked about illicit substance use, future research could benefit from the inclusion of such inquiries.

Fourth, all interviews and focus groups were conducted by a young female researcher. Researchers examining men's health have found that interviewer gender can shape men's talk during interviews (e.g., Broom, 2004; Broom, Hand, & Tovey, 2009; Oliffe & Mroz, 2005). Men may avoid saying, or may emphasize, certain things depending on the gender of the interviewer (Arendell, 1997; Pini, 2005; Williams & Heikes, 1993). For example, Broom et al. (2009) reported that when men were interviewed by a male, masculine traits were emphasized. In contrast, when men were interviewed by a female, expressions of heightened "professionalism" and self-credentialing were evident. The authors hypothesized that such portrayals were an attempt by participants to match the perceived professional status of the

female interviewer (Broom et al., 2009). Thus, we recommend future researchers utilize both male and female interviewers and then identify similarities and differences across transcripts.

Conclusions

The present findings have implications for how sexual difficulties are classified and understood in clinical practice and research. The findings reinforce the argument made at the beginning of the paper that current understandings of sexual difficulties are biased by a heterosexist understanding of sexual function. It is evident that the meaning, contexts, and experiences of sexual difficulties differ for gay or bisexual men in comparison to heterosexual men; however, as discussed, there are also important similarities.

In this study, several difficulties were identified which are not currently acknowledged as sexual difficulties; specifically, these were difficulties relating to penile pain and pain during receptive anal sex. Furthermore, several sexual dysfunctions as categorized by the DSM-5 (APA, 2013) did not emerge as sexual dysfunctions, or even as sexual difficulties, for the present sample of men. In particular, these were premature ejaculation, delayed ejaculation, and low sexual desire. This is not to say that these are not sexual dysfunctions or sexual difficulties in their own right, but perhaps the context in which they occur is more important for some men. Nonetheless, these findings pose a challenge to how sexual dysfunctions and sexual difficulties are categorized, suggesting our current understanding and explanations of reduced sexual function needs to be broadened.

The current findings pose important challenges for clinical practice and research where sexual difficulties are assessed. The absence of understanding of sexual difficulties among sexual minority men has been emphasized. If inadequate conceptualisations of sexual functioning continue to be used, a full understanding of the complexities of gay men's sexual difficulties will not be achieved. Researchers and clinicians alike need to consider the factors that affect the sexual functioning of gay men. For example, a sex therapist who focuses on a

heterosexist understanding of sexual difficulties when conducting sex therapy with a gay man may neglect to consider how other psychosocial factors (e.g., masculine standards, personal level of distress, interpersonal relationships) may influence his sexual difficulties. Broadening our understanding of sexual difficulties to include psychological, social, and physical factors pertinent to gay men will better equip clinicians in providing the appropriate treatment to those affected.

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Figure 1 Graphical Illustration of Themes and Sub-themes

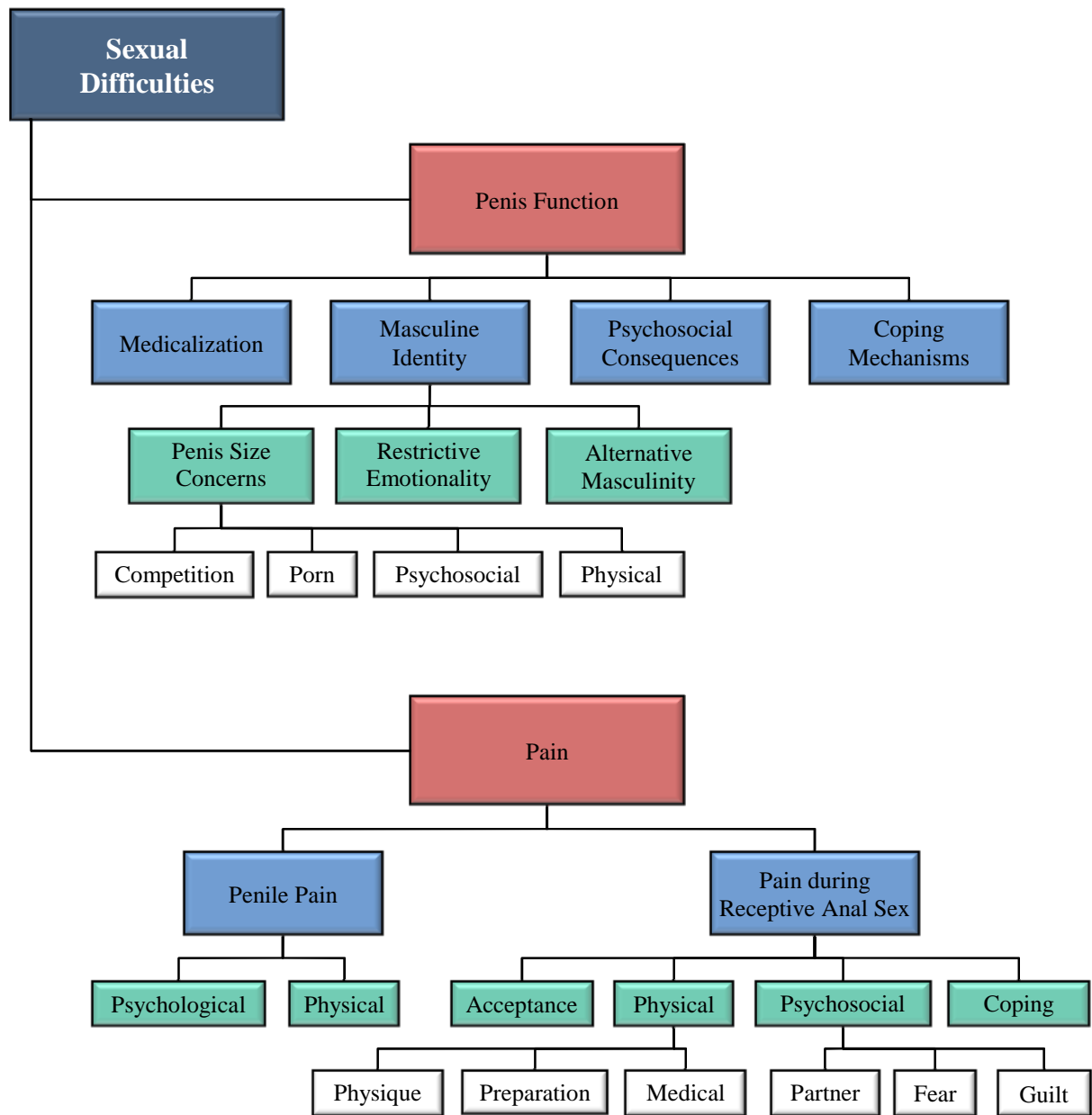


Table 1

Demographic Characteristics of Sample

Demographics	<i>n</i>	%
Age range		
18-29 years	22	42
30-39 years	14	27
40-49 years	5	10
50+ years	11	21
Sexual Orientation		
Heterosexual	25	48
Gay	22	42
Bisexual	5	10
Relationship Status		
Single	16	31
Casually dating one or more people	1	2
Dating one person exclusively	13	25
Cohabiting	8	15
Engaged or planning to marry	1	2
Married or civil partnership	7	13
Divorced or separated	6	12
Current Occupation		
Student	14	26
Government workers	10	19
Sales and Services	10	19
Financial Services	4	8
Health Services	2	4
Trades	2	4
Communication (media)	2	4
Unemployed	4	8
Retired	4	8
Religiosity		
Very religious	2	4
Somewhat religious	8	15
Not very religious	15	29
Not at all religious	27	52

Table 2

Topic Guide for Interviews and Focus Groups

Begin by explaining what is mean by the terms sexual dysfunction and sexual difficulties.

Men in general:

1. What do you think a sexual dysfunction could be for men?
 - a. *[Alternative wording]* What would count as a sexual dysfunction for men? Can you give examples?
2. How could this impact a man's life?
 - a. *[Alternative wording]* What are the consequences of these problems for men? Can you tell me more...
3. How do you think men cope with this problem?
 - a. *[Alternative wording]* How do you think men deal with this type of issue?

Experiences of people they know:

4. Do you know anyone who has ever experienced this dysfunction?
5. What impact did it have on their life?
6. How did they cope/deal with it?

Personal experience:

7. Have you ever experienced a sexual dysfunction? Can you tell me about it?
8. What impact did this have on your life?
9. How did you deal with it?
10. What characteristics or qualities might help a man deal with a sexual dysfunction?

Same questions for sexual difficulties.

Go through list of issues not raised (below).

Closing: Is there anything else you think I should know that we haven't discussed already?

Additional areas to probe on if not raised by participant. Apply questions above to each.

1. Desire: Lack of interest in being sexual and in engaging in sexual relations by oneself or with a partner
 2. Arousal: Difficulty achieving and maintaining an erection
 3. Orgasm: Premature ejaculation/ coming too soon
 4. Orgasm: Not able to reach orgasm
 5. Pain: Pain during sex (dyspareunia)
 6. Pain: Pain during anal sex
 7. Body image self-consciousness
 8. Hyper-vigilance re partners satisfaction
 9. Differences in type of sexual behaviour desired
 10. Differences in type of relationship wanted
 11. Differences in age of partners
 12. Frequency of sex (not having enough casual sex/ relationship)
 13. Inhibiting psychological state (before or during sex)
 14. Negative psychological state during/after the encounter
 15. General dislike of casual sex
 16. Anxiety about sexual performance
 17. Fear of contracting STDs
 18. Fear of getting partner pregnant
 19. Unsuitable locations (cold)
 20. Fear of discovery
 21. Fear of arrest/assault/blackmail
 22. Partner's psychological problems
 23. Differences in sexual experience of the partners
 24. Differences in attraction to partner
 25. Communication difficulties
 26. Decrease in sexual feelings/satisfaction with partner
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Table 3

Penis Function Themes and Respective Illustrative Quotations

Theme	Illustrative quotation
Medicalization	"If you can't get an erection surely a doctor can sort that." James (22 years, heterosexual, interviewee)
Masculine Identity	"I think erectile dysfunction would be even linked to their sense of self and their sense of masculinity." Aaron (25 years, bisexual, interviewee)
<i>Penis Size Concerns</i>	"Whether it's big, small, long, ya know, thick or thin... I just think it is an issue for people always." Larry (34 years, gay, interviewee)
Competition	"If they see another guy with a bigger cock they feel a little inadequate." Ben (35 years, gay, focus group 5)
Pornography	"I'd say it's probably porn's fault actually (<i>laughs</i>) because everyone, like all men in porn have like massive penises and most guys kind of compare themselves to them." Peter (28 years, gay, interviewee)
Psychosocial Impact	"For some people it can be a horrible hit to self-confidence." Fergal (23 years, gay, interviewee)
Physical Impact	"They're more worried about what the other person thinks of them... and therefore they can no longer enjoy it [sex] and then they end up with a dysfunction of no orgasms." Aaron (25 years, bisexual, interviewee)
<i>Restrictive Emotionality</i>	"Men are very backwards in coming forward." Keith (33 years, heterosexual, interviewee)
<i>Alternative Masculinity</i>	Well, I suppose somebody that might recognise this [erectile disorder] as a biological issue and isn't an indication of their virility or their manhood." Pat (34 years, gay, interviewee)
Psychosocial Consequences	"Not being able to get an erection would be hugely damaging on self-confidence, I think that's the main thing." Ted (32 years, bisexual, interviewee)
Coping Mechanisms	"Try and counter act it possibly, by acting more masculine, trying to hide it that way." (James, 22 years, heterosexual, interviewee)

Table 4

Pain Themes and Respective Illustrative Quotations

Theme	Illustrative quotation
Penile Pain	“Well, one that I had myself two years ago was that my foreskin was very tight and I had to go and get an operation.” Robert (27 years, heterosexual, interviewee)
<i>Physical Impact</i>	“He couldn’t have anal sex or say couldn’t really do... couldn’t even really masturbate because it was too painful.” Jason (24 years, gay, interviewee)
<i>Psychological Impact</i>	“I think frustration would be a major thing.” Albert (23 years, gay, interviewee)
Pain during Anal Sex	“Well pain during sex, so for a gay man it could be if you’re receiving anal sex, the pain of penetration.” Trevor (23 years, gay, interviewee)
<i>Acceptance</i>	“It [pain] probably comes with the territory. Yeah... if there is anal sex going to go on, there probably is going to be pain, one comes with the other.” Ted (32 years, bisexual, interviewee)
<i>Physical Determinants</i>	Physique: “I suppose it depends on the size of the penis as well, like if it’s very large it’s gonna hurt more.” Trevor (23 years, gay, interviewee) Preparation: “People assume the type of thing you see in porn movies where they just kind of open the door and fling each other against the wall and start fucking, I don’t think in reality it really works like that, there has to be some sort of preparation time.” Ben (35 years, gay, focus group 5) Medical Conditions: “If there is a lot of anal pain, then that could be medical problem, like colon cancer or something like that, which is something else you need to look at.” Ian (60 years, bisexual, focus group 7)
<i>Psychological Determinants</i>	Sexual Partner: “Usually you can work around it, people are normally quite considerate of it. I think people are a lot more willing if it is going to cause extreme pain to say no.” Aaron (25 years, bisexual, interviewee) Fear: “They might be feeling a tiny bit of pain but they imagine it as a load cos they are freaking out.” Scott (18 years, gay, focus group 6) Sexual Guilt: “If people are brought up to believe that it’s wrong for two men to have sex and they’re constantly struggling with that, and a lot of men are, that the pain might be reinforced that they’re not supposed to be doing it.” Henry (33 years, gay, focus group 4)
<i>Coping Mechanisms</i>	“If it hurts, it hurts... I say find ways to get around it.” Albert (23 years, gay, interviewee)