Prostate cancer: embodied experience and perceptions of masculinity
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Abstract While some argue that gender differences, which refer to the social classification into ‘masculine’ and ‘feminine’, have their source in ‘culture’, others argue there is no need to have an absolute dichotomy between culture and nature, or between constructionist and anti-constructionist epistemologies. Although there has been much theorising about the body, until recently little attention has been paid to empirical evidence. This paper looks at the way in which prostate cancer and its treatment affects men’s bodies, their roles and sense of masculinity. Interviews were conducted with 52 men, exploring their experiences of prostate cancer. Findings suggest that many men are reluctant to consult their doctors, because ‘men don’t cry’, thus reinforcing the notion that ‘masculinity’ is a social construction. However, while the illness and the side effects of surgical and radiotherapy treatments sometimes led to impotence and incontinence, the treatments that involved hormones were reported to have an additional, sometimes profound effect on libido, energy, ability to work, body shape and competitiveness. These side effects reduced some men’s sense of masculinity. We conclude that the physical body as well as culture should be considered when trying to explain what it means to be masculine, and how illness may affect men’s sense of masculinity.

Keywords: gender, masculinity, prostate cancer, impotence, incontinence

Introduction

In the United Kingdom prostate cancer is now the most common male cancer (Prior and Waxman 2000). It usually affects men over the age of 50, and is sometimes difficult to diagnose because the symptoms of prostate enlargement are common both to benign prostatic hyperplasia and to prostate...
cancer. Symptoms include poor urine stream, hesitancy, terminal dribbling, retention and uraemia. Once diagnosed, some men decide to opt for ‘watchful waiting’ rather than rush into any form of active treatment. This is because no one has demonstrated that treatments for prostate cancer improve overall survival (Tannock 2000). Most men, however, want to ‘do’ something about their cancer, and choose an active treatment.

The type of treatment offered depends on the stage at which the cancer is diagnosed. About 40 per cent of men are diagnosed when the cancer is still in the early pre-invasive phase (Prior and Waxman 2000), and these men are usually offered a wide range of treatments, including external beam radiation, brachytherapy and radical prostatectomy. Hormone therapy may also be prescribed for weeks or months just before radiotherapy or prostatectomy, in order to ‘shrink’ the tumour. This makes it easier to operate or direct the radiotherapy to the area where it is most needed. However, 60 per cent of patients are diagnosed with metastatic disease, where the cancer has already spread throughout the body (Prior and Waxman 2000). Treatment choice is then more limited. Many of these patients opt for orchidectomy or hormonal therapy, which improves local control of the disease, but as mentioned above, may not necessarily improve overall survival. Hormone therapy blocks the production of the male sex hormone testosterone and thus slows the growth of the cancer.

All the treatments for prostate cancer have some unwanted side effects (Tannock 2000). Men with prostate cancer sometimes become aware of the problem because of incontinence; this is, however, also among the side effects of treatment. During radiotherapy and prostatectomy nerves may be damaged, leading to incontinence or impotence, and radiotherapy may cause damage to other tissues, such as the bowel or bladder. Hormone treatment and orchidectomy lead to loss of libido and potency. These side effects may occur immediately, though sometimes after a period of time. Hormone treatment and orchidectomy also lead to other side effects such as hot flushes, breast enlargement and a reduction in physical and mental energy (Schroder 1999).

We believe that the changes that are experienced by men who have had active treatments for prostate cancer provide a unique perspective on the ‘taken-for-granted’ nature of the masculine body. Moreover, whereas the effect of surgical techniques (for example, mastectomy) on femininity has been investigated extensively, there has been little research into the effect of prostate cancer on male gender identity (Kiss and Meryn 2001).

**Masculinity: a social construction or physical difference?**

During the 19th and early 20th centuries theorists asserted that men and women’s social roles were grounded in nature, by virtue of the dictates of their bodies (see Martin 1989). However, during the 1960s and 1970s many social theorists argued that while sex differences were natural, gender differences, which referred to the distinction between ‘masculine’ and ‘feminine’, had their source in ‘culture’ and were essentially social constructions (de
Beauvoir 1972, Oakley 1972). They argued that the manner of their construction explained the position of women in society as inferior and subordinate. Many feminists, in particular, resisted the idea that ‘the natural biological body’ might be central to women’s oppression (see Witz 2000). Others have argued that the development of knowledge itself was shaped by cultural norms about men and women and that assigning the labels ‘male and female’ to hormones, which are present to varying degrees in both genders, was simply a social construction (Oudshoorn 1994).

Today there is still some consensus that ‘while sexual differences are grounded in a physical (anatomical, biological and physiological) differentiation of reproductive functions, gender is a socio-cultural differentiation of male and female functions and roles’ (Featherstone and Turner 1995: 4). Certainly, as sociologists, before starting our research on prostate cancer, we also subscribed to this point of view, believing gender to be a social construction. However, like Turner (1992: 41), who points out that it would be wrong to construe his sociology of the body as ‘merely a social constructionist viewpoint’, and who argues that although for the sociologist ‘the social’ must remain the most important, we do not think there should be an absolute dichotomy between culture and nature, or between constructionist and anti-constructionist epistemologies. Although Turner was not specifically referring to the debate about gender, he suggests that it appears ‘bizarre’ to argue that there are no organic foundations to human activity. He asserts that sociological theory has effectively neglected the importance of the human body in understanding social action and social interaction (Turner 1992: 34). Shilling (1993: 13) also points out that although social relations may profoundly affect the development of the body, the latter remains a material, physical and biological entity which ‘forms a basis for and contributes towards these relations’ (italics in the original). Thus, when looking at our data (see below), we were able to consider the possibility that prostate cancer, and physical changes in the body caused by the symptoms and side effects of treatment, might affect men’s self-identity and sense of masculinity.

Much theorising about the body
Over the last two decades there has been much theorising about the body (e.g. Turner 1984, Frank 1990, Leder 1990, Morgan and Scott 1993, Oudshoorn 1994, Shilling 1993, Hughes and Witz 1997, Harrison and Hood-Williams 1997). Some post-structuralists have challenged the very existence of separate bodies, male and female, preferring to see bodies as ‘fluid’ rather than ‘solid’, with no clearly defined boundaries (see Williams 1998). Like Williams, however, we prefer to think of bodies as ‘real fleshy entities’, and our experience suggests that in everyday life most other people regard the body as ‘solid’ and ‘real’, rather than simply as part of a ‘process of becoming’ or decaying and dying. Other theorists, such as Leder (1990: 84) have suggested that much of the time we take our bodies for granted, and are not acutely aware of them. The body is effectively ‘absent’, and only seizes

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our attention at times of dysfunction, or when we are hungry, thirsty, have excretory needs, or when experiencing strong emotion. However, as Shilling (1993) points out, in recent times men and women have become more conscious of their bodies, taking part in exercise regimens, reconstructing their bodies in line with notions of youthfulness, masculinity and femininity.

**Empirical evidence**

To counter the overly theoretical trend within the sociology of the body, a range of empirical studies have examined how people actually experience their bodies or construct masculinity during periods of social change (Connell 1995, Nettleton and Watson 1998, Watson 2000). Relatively little attention, however, has been paid to men's perceptions of their bodies, or their changing sense of masculinity, when disease affects their genital organs. With notable exceptions (Gordon 1995, Korda 1996, Clark et al. 1997, Cameron and Bernades 1998, Moynihan 1987, 1998, Gray et al. 2000), there are few accounts or research reports grounded in the everyday experiences of men. Previously, problems affecting the female body and female reproductive system have received most sociological attention (for example, Douglas 1966, Scambler and Scambler 1985, Buckley and Gottlieb 1988, Coulter et al. 1988, Martin 1989, Laws 1990, Chapple 1999, 2001; Chapple et al. 2001). This may be partly because of the many issues that are associated with childbirth and menstruation. Women's bodies have been seen as 'leaky and messy' compared with men's bodies, which have been regarded as 'relatively unproblematic' (de Beauvoir 1972, Hepworth and Featherstone 1998). However, the rising incidence of prostate and testicular cancer in the USA and the UK, and men's reluctance to consult their doctors, has caught the public attention, and male health is now very much in the news (Lee-Potter 2000, Stuttaford 2000, 2001, Neustatter 2001).

**The meaning of masculinity**

Personality theorists and social psychologists have developed several trait inventories to measure masculinity (Helgeson 1995). For example, men are said to conceal emotions, to be the breadwinner, admired and respected, tough and ready for violence and adventure. Although men may seek status and prestige, however, they do it in many different ways, and how they attain status and prestige depends hugely on the culture in which they live. Moreover, men are not all alike, and many would argue that there are ' masculinities', some hegemonic, some marginalised, some stigmatised and some consumption-led, rather than a single 'masculinity' (Morgan 1993, Connell 1995, Sabo and Gordon 1995, Seidler 1997). Indeed, Connell (1995: 185) argues that ‘Masculinities come into existence at particular times and places and are always subject to change’.

Bearing these arguments in mind, this paper looks at the ways in which prostate cancer and its treatment affect men's perceptions of themselves, their bodies, their roles and sense of masculinity. While medical text books,
web sites and pamphlets list the likely side effects of treatment, relatively little is known about men’s sense of embodiment and notions of masculinity when seeking help and being treated for prostate cancer.

Method

The sample
After reviewing the literature, and having obtained ethics committee approval, we invited participation from men with suspected or confirmed prostate cancer, recruited through GPs, hospital consultants and support groups. Men described many aspects of their experience of illness, but here we report only what men said about help seeking, and about the side effects of their treatment. Other aspects of the men’s experience of prostate cancer have been reported elsewhere (Chapple et al. 2002 and in press).

Men were given a choice of male or female interviewer (or either), but only one chose a male. Purposive sampling (Coyne 1997) was used to ensure a wide range of experiences and views. We had intended to interview about 40 men, but interviewing continued until the sample included men at different stages of diagnosis, with experience of a wide range of treatment, and until no new themes emerged from the data. Eventually, 52 men were recruited. All the men were over 50 years of age because, as noted in the introduction, prostate cancer rarely affects younger men, and we were unable to find anyone so affected in younger age groups (see Table 1 for sample characteristics).

The interviews
The interviews were conducted throughout the UK, almost all in men’s homes, during late 2000 and early 2001. Interviews were sought with men on their own, but in a few cases wives were present during the interviews. All the interviews were audio-taped for analysis, were relatively unstructured and lasted one to three hours. Men were asked to tell their story, from when they first had a PSA (prostate specific antigen) test or noticed their symptoms. Key questions, identified from the review of the literature, were also incorporated into the interview guide. For example, men were asked to describe reasons why they had gone to their doctors in the first place, their experiences of treatment and its side effects. Many men spoke spontaneously about problems that affected their sense of masculinity. As the study progressed and ‘masculinity’ emerged as a theme to explore, men were asked to comment on whether or not their experience had affected their image of themselves as men. Men also brought up the subject of forced retirement spontaneously. They were not specifically asked to comment on the effect of retirement on self-identity.

Analysis
The interviews were fully transcribed, and then each transcript was returned to the respondent for review. A few men wanted words or sections removed
from their transcripts. For example, one man, who was unable to have an erection, wanted to delete his description of the sexual activity that occurred between him and his wife. Analysis, using NUD*IST, started soon after the first interview (Tesch 1990). Inter-rater reliability scores were not developed as the interviews were relatively unstructured (Morse 1997), but the authors regularly discussed the coding and results. Summaries of the main themes concerning men’s experiences of prostate cancer and relevant sections of the transcripts are available on the DIPEx database of individual patients’ experiences (www.dipex.org) internet site which also contains audio and video-clips from interviews (with the patients’ consent), information about treatments and details of other resources (Herxheimer et al. 2000).

Table 1  Sample characteristics of 52 men interviewed about prostate cancer

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. of men</th>
</tr>
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<tbody>
<tr>
<td>Age (years)</td>
<td></td>
</tr>
<tr>
<td>50–60</td>
<td>10</td>
</tr>
<tr>
<td>61–70</td>
<td>21</td>
</tr>
<tr>
<td>71–85</td>
<td>21</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>48</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1</td>
</tr>
<tr>
<td>Black Nigerian</td>
<td>1</td>
</tr>
<tr>
<td>Indian</td>
<td>1</td>
</tr>
<tr>
<td>Czechoslovakian</td>
<td>1</td>
</tr>
<tr>
<td>Employment (includes those retired)</td>
<td></td>
</tr>
<tr>
<td>Professional/higher managerial</td>
<td>24</td>
</tr>
<tr>
<td>Other non manual</td>
<td>19</td>
</tr>
<tr>
<td>Skilled manual</td>
<td>8</td>
</tr>
<tr>
<td>Unskilled manual</td>
<td>1</td>
</tr>
<tr>
<td>Type of treatment (some have had more than one treatment)</td>
<td></td>
</tr>
<tr>
<td>No treatment because cancer not confirmed</td>
<td>2</td>
</tr>
<tr>
<td>Watchful waiting</td>
<td>4</td>
</tr>
<tr>
<td>Radical prostatectomy</td>
<td>7</td>
</tr>
<tr>
<td>External beam radiation</td>
<td>20</td>
</tr>
<tr>
<td>Brachytherapy (seeds left in and seeds removed)</td>
<td>5</td>
</tr>
<tr>
<td>Hormone treatment</td>
<td>32</td>
</tr>
<tr>
<td>Orchidectomy</td>
<td>3</td>
</tr>
<tr>
<td>Vaccine trial/antigen therapy</td>
<td>2</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>1</td>
</tr>
<tr>
<td>Transurethral resection</td>
<td>18</td>
</tr>
<tr>
<td>Cryosurgery</td>
<td>3</td>
</tr>
</tbody>
</table>

The figures include those who had hormone treatment for a short while before radiotherapy, or surgery, and those who had external beam radiation for bone pain.
Findings

The findings are presented in five sections. First, we discuss the men’s reluctance to seek medical help or admit to a health problem. We then discuss in turn how the treatment side effects of incontinence, lack of energy, impotence and changes in body shape affect men’s self-identity, and contrast the experiences of those who had only surgical and radiotherapy treatment with the more profound side effects described by men who have had hormonal treatments.

Men’s health behaviour

Many men said they were reluctant to consult doctors. Seidler (1997) suggests that now that so many of the traditional supports of a masculine identity have been eroded, it is hardly surprising that men are afraid of expressing their emotions and admitting that they need help in any way. He argues that men do not like to be considered ‘weak’, for this is a threat to their masculinity. Also, in British culture men have traditionally been seen as more ‘rational’ than women, who are thought to be more emotional and closer to ‘nature’ (Seidler 1997).

During the interviews some men suggested that it was not ‘macho’ to seek help for health problems. Other explanations raised by the men included the notion that ‘boys don’t cry’ and the belief that it was not masculine to admit to weakness:

R: Er is there a reluctance then, from the male gender, now to say ‘Well I am hurting, I do need to elaborate on it’? I don’t know there’s still I feel certain restriction from the male gender again. Men like, not like myself because I’m quite open about it, to say no, I don’t do that, we don’t do that, we don’t cry (P26, aged 63).

R: I think, I don’t know whether it’s macho, I think generally men are more reluctant to talk about their bodies and they certainly don’t want to go to the doctor unless an arm has fallen off or something really serious like that. But I don’t know, I think possibly they’ve got this image of being tougher than women (P36, aged 70).

A few respondents suggested that women find it easier to consult doctors because women are used to seeking help for their children or for pregnancy and menstrual problems:

R: The majority of men don’t want to know anything about their health. You cannot discuss health matters. Unlike women who are aware of their bodies from puberty, some men very rarely have seen a doctor in their life and consequently they don’t want to talk about it (P30, aged 70).
R: Er I don’t know, is it because of previous generations where the male gender went out to work, his partner or shall I say his wife then in those days stayed at home. If there was any illness within the family or with children she took the children to the doctor, the husband never did it. Whether it’s from that or not I don’t know (P26, aged 63).

When looking at the data more closely it became clear that the ‘embarrassing’ nature of the symptoms of prostate cancer also contributed to a reluctance to seek medical help in this group of men.

The effects of treatment: incontinence

People are expected to exert more or less control over their bodies, ‘consistent with requirements of time and place’ (Morgan and Scott 1993: 14). In Western society, control of the body is seen as fundamental to the maintenance of self-identity (Shilling 1993), and in social situations we are expected to act appropriately, often with propriety and decorum. Lack of muscular control, whether it leads to incontinence, yawning, farting, belching, or scratching may convey not only incapacity, but also impropriety or disrespect to others (Goffman 1959). The consequences of a lack of control may be even more extreme: Lawton’s (1998) participant observation study of a hospice suggests that it is the inability to control the emissions of smells and effluence from the body that leads to the social withdrawal and sequestration of some patients with advanced cancer.

Morgan (1993) suggests that in modern Western culture men are expected to exert bodily self-control to a greater extent than women, perhaps because men are more likely to occupy centre stage on ceremonial and public occasions than women. We would question Morgan’s suggestion, and believe that possession of a ‘physically bounded body’ (Lawton 1998: 131) is vitally important for both men and women, and that incontinence affects women’s sense of self-identity and social status as adults in our society in much the same way that incontinence might affect men.

Prostate cancer and its treatments certainly lead to situations when there is lack of control over bodily functions. For example, both before and after treatment many of the men had urinary symptoms, such as urgency, or frequency. Men became conscious of bodily functions and dared not take the body for granted (Leder 1990). They described the embarrassment and inconvenience of having to search for lavatories while out shopping or when travelling:

R: The other problem that we have, not every man but a lot of prostate cancer patients, particularly those who are incontinent, if you go on a journey you’ve got to plan it via toilets, the comfort stops ( . . . ). If you really are caught out you can go into a shop, ask if you can use their toilet because it’s quite embarrassing, it’s embarrassing may be for other people (P32, aged 70, prostatectomy and radiotherapy).
One man also explained that after his operation he lacked control over where he directed his stream of urine:

R: And another problem you can have is passing water itself, because as the surgeon explained to me, they are tubes that have been replaced, they’re not the real thing. And sometimes they can tighten up a little bit and when you go to the toilet you know you don’t have full control. Although you pass water (laughs), pardon me saying, you don’t know where it’s going to go sometimes (P9, aged 57 prostatectomy, radiotherapy and some hormones).

External beam radiation also led to disturbing side effects and lack of control over bodily functions and fluids. For example, some men developed diarrhoea after treatment. Also anal bleeding was quite common, which sometimes continued for many years:

R: There were 20 sessions of that [radiotherapy] and it was halfway through that I discovered that I was having problems with the back passage ( . . . ). And that gradually got worse, even when the treatment finished that got worse and that lasted for er, well it’s still there and I am told that it will never heal up ( . . . ). And also the frequency is increased, instead of possibly just going once or even twice a day, you know, at the extreme you might have to go three times a day ( . . . ). It’s just that if you need a toilet, particularly for the bowels you need to get to a toilet (P24, aged 70 radiotherapy).

One man, who had had both brachytherapy and hormone treatment felt that his male role was threatened by his urinary symptoms, and by his lack of energy. He spoke about lack of confidence, and why, as a man, he felt mentally unable to cope with lack of control:

R: I experienced this pain in the bladder and trouble passing water and passing water far too often to get involved in doing anything else and this obviously leads to a lack of confidence and you don’t feel like leaving home ( . . . ).

Having discussed his urinary problems and his lack of energy (see below), he concluded:

R: I don’t believe that men are stronger than women or women are stronger than men. I think obviously they’re very equal but I think that the mental state of man is such that he feels more let down by anything he cannot control than a woman would (P41, aged 59).

As noted above, Lawton’s (1998) work suggests that control over bodily effluent is as important for women as for men when in the advanced stages
of cancer. However, in our study this 59-year-old man (P41) spontaneously suggested that men are more affected than women by lack of control over bodily functions. Although our data are inadequate to explore this further, it is possible that there may be generational differences in norms and attitudes to bodily control, perhaps related to the extent to which the age group, as well as gender, is in the public sphere (Morgan 1993).

The effects of treatment: lack of energy
In British society work has traditionally been seen as a major source of status and identity, especially for men (Morgan 1992). Masculinity has come to be associated with being a breadwinner, though this may not be the case in other cultures (Connell 1995). It is striking that many men said that when they heard the diagnosis one of their primary concerns was how they would continue to provide financially for their wives (and sometimes children):

R: I was mostly concerned, not with my own wellbeing I suppose, but it was my wife. I was more concerned about her. How if anything went wrong what would she do in this and that and financially as well (...). So there’s a lot of things go through your mind at the time, the financial one is one of them. Will I ever work again? Which at that time I didn’t think I would be working again (P01, aged 55).

Although some of the men continued working during treatment, or returned to work soon afterwards, others found they had to retire earlier than planned. One man, who felt he had lost his masculinity (see section on impotence), also complained that treatment had affected his ability to work:

I: Have the hormone injections had other side effects?
R: I don’t know, I think so in that I, now I can’t think of the word, you’d know the word, I’m ever so lazy, I don’t want to do anything, if it weren’t for my wife I wouldn’t even get up in the morning, I’m too bone idle.
I: Do you think that might be the side effects of the injections?
R: Yes I do, I do, because I used to be someone, I carried on teaching and this is a boast, not full time but when I was 72 (...) teaching A level physics, and enjoying it. Now I can’t remember Ohm’s Law, I could no more teach than fly. But this terrible, I mean when you’ve gone I must get on and finish digging over that little bit outside, I’m dreading it.
I: The digging?
R: Just forking it over, planting a few wallflowers over, doing anything is a chore, I don’t enjoy it, I used to love it. I mean I used to get up early in the morning, work solidly until I dropped into bed, I have led a very active life, very active, even with my new hip and so on. I felt I’d never stop work (P18, aged 80, hormone treatment).
Ability to play sport is also seen as an important aspect of masculinity, though Connell (1995: 30) asserts that this is not ‘natural’, but historically produced. Although some men continued with sporting and leisure activities such as bowls, others had to give up the sport they once enjoyed:

R: The other big problem that I found throughout my illness is that you do get very fatigued, you get very tired from time to time, well particularly after the first three years. I found that I had to stop doing things. I found that I got too tired to play golf ( . . . ). That was about the time that I decided to stop working. I was by then 63 years old. I hadn't originally thought that I would work longer than 60, [but] because I enjoyed my work I thought well, I want to go on for as long as I possibly can. But eventually I found that the pain that I was in was causing me to lose concentration, and to start making mistakes ( . . . ) so I thought well the time has come to stop working (P31, aged 65, hormonal treatment).

Another man (also quoted earlier) made it quite clear that he did not think his forced inactivity was compatible with what he regarded as his male role:

R: You don’t feel inclined to do an awful lot of things. I asked the doctor if I’d be able to play golf; he said ‘Certainly, but you might not feel like winning’, and I think that covered it. Er also you can after being on the tablets for any amount of time, I’ve been on for six months and I’m now getting itchy nipples and a certain bit of breast enlargement which goes when you stop taking the tablets. ( . . . ) Er, the effects of the tablet do make you feel a little inadequate. I feel that I should be busier, I feel that I should be, I mean for goodness sake I’m the male, I should be the head of the house and doing all these things but I just don’t feel like it ( . . . ). I think as a male where you’ve always been the head of the family you have a guilt complex about lack of input, unable to do you know most of the chores. You spend most of your time, a certain amount of inactivity so it is a problem and the only thing that reassures you is the fact that it’s not a long-term problem ( . . . ). I think that men are more, I don’t know if the word provider, but more supportive, they think that they ought to be looking after the family, looking after the female side of it so they daren’t have any down side on their part and I just think this is you know it’s a mental thing (P41, aged 59, brachytherapy and hormone treatment).

Elsewhere this man mentioned that his children had noticed that he had been unable to tend to their gardens for the past six months. Although he said that his children had accepted this, he was anxious to finish his hormone treatment so that he could regain his energy and help with the gardening and heavy chores when needed.
The effects of treatment: impotence

The treatments for prostate cancer often cause impotence, and many of the men interviewed had long-term sexual difficulties. Morgan (1993: 74) suggests that we are reminded of the connections between patriarchal power and men's bodies when we see popular or pornographic representations of the erect and thrusting penis. All except one of the 11 men who had active treatment without any hormone therapy reported limited sexual function. However, unlike the men who had hormone treatment (see below) they did not talk about this affecting their sense of masculinity. Several explicitly described the impotence as a 'small price to pay':

I: You talked a little bit earlier about men, in particular men you'd spoken to in America, saying how it [prostate cancer] affected their sense of masculinity, has it affected yours in any way would you say?

R: Er, not as such. I don't have any concerns about it. It [brachytherapy] has affected potency, which doesn't bother me in the slightest, so no. . . . Its affected me but I think it's a wonderfully small price to pay for being able to sit here and say [that]

(P46, aged 63).

It's become almost impossible to either have an erection or maintain an erection. That isn't a huge problem to me or my wife but we've learnt to come to terms with it, it was something we didn't want and would have preferred not to have had but I think ( . . . ) its been secondary to everything else. We are here, both of us are here . . . and we get on with our life (P26, aged 63).

Most of these men had tried Viagra or other techniques to address erectile dysfunction, with varying degrees of success. Perhaps crucially to their sense of masculinity, the impotence they described was confined to the lack of ability to maintain an erection, not the loss of interest in sex:

All sort of sexual feelings and lust or whatever are exactly the same, but the only difference is and it may be a fairly major one but the only difference is you don't get an erection. Er you even feel as though you are coming as well sometimes which is very odd without an erection but it is a very strange thing. So it's disappointing but its not a tragedy

(P07, 56 years old).

In contrast, and importantly for our discussion, the men who had long-term hormonal treatment described the greatest change to their libido, reporting that they had lost all interest in sex and felt changed, not only physically, but also psychologically:
One of the side effects was supposed to be that you lose your sex drive, well, I certainly did that. There was no, you know, even inclination to even sort of think about sex or anything like that (P05 aged 68).

One man described how he had not felt prepared for the impact of the hormones, which had been prescribed for six months before his radiotherapy. He reported that the hormones had made him feel generally unwell, and that they made his whole body feel painful and tender. He also found the situation psychologically painful:

R: But the thing is you don’t know until it happens because you keep taking [the drugs], you don’t know what your reaction is going to be and the doctor will say to you ‘Alright you know you’ll feel uncomfortable, you’ll swell up, your breasts will get painful and you’ll be impotent over a period of time, if at all,’ but you don’t know what it’s like until it happens to you and then when it does it can be very, very uncomfortable and painful really, psychologically painful as well (P20, aged 71 hormone treatment followed by radiotherapy).

Having completed the six-month course of hormones he said that if the radiotherapy failed to halt the spread of his cancer he might not be able to face further ‘hormonal castration’. Perhaps this was partly because he was ‘certain’ that hormone treatment could affect relationships.

During the analysis we were careful to look for ‘deviant cases’, any views expressed that were different or at odds with the dominant view (Silverman 1994: 44). Impotence was not seen to be a disaster by all the men who had had hormonal treatments. This man's comments illustrate this, and also demonstrate the fact that surgical and hormone treatments had very different impacts:

R: After I had the operation [trans-urethral resection] of course, no you don’t lose your sexual instincts then, but since I’ve been taking, having this implant [hormones] he did say to me ‘You’ll become impotent’, and lo and behold I have. But at 70 I’m not that worried, it hasn’t altered any relationship between myself and my wife. I mean by the time we were reaching 70 it wasn’t exactly the end of the world and it’s just something, it just doesn’t happen any more that’s all. I mean you don’t think about it, I mean I’m, I think our relationship is fine, we’re just as affectionate as we always were but no there isn’t any sexual activity (P08, aged 71).

Some of the older respondents suggested that at their age it was no longer a problem, although it would be to a younger man:

R: Well they [hormone injections] make you totally impotent, which would not matter to me at my age, but would certainly matter to a younger man at 30, 35 or 40.
I: Did that affect your perception of self and self image or would you say it didn’t matter?
R: Oh not really, not when you get to 70, it doesn’t matter that much (P52, aged 72).

The extent to which the impotence was seen as a problem could be expected to relate to the perspective of the man’s partner. This man suggested that the hormone treatment might have improved his relationship by reducing his libido and making him more even-tempered:

R: Well in a younger man I think the impotence would worry them because it might affect their married life, it depends how the relationship between the husband and the wife is. In my case as I say we’ve got three grown-up daughters now and the wife isn’t bothered in any way so it doesn’t interest her any more so we get along quite well together you know. She says, actually the hormone, she thinks the hormone therapy has done me good because I’m more even-tempered (laughs) (P30, aged 70).

Other effects of hormone treatment

Men who had hormone treatment described additional affects on their ability to fulfil what they perceived to be the male role. The following account is of particular interest as the respondent attributes to the hormone injections his complete lack of sexual interest as well as his inability to fulfil ‘his role as a husband’:

I: And the side effects of the injections, can you tell me a bit about that?
R: Well this again it’s not easy for me to talk about but I mean of course I am totally impotent and I’m even worse than that in that I am disgusted by anything sort of sexual.

I: Right.
R: If I see, and you can’t avoid it on television, not explicit sex but very nearly, I’m disgusted. I think that you know this country is absolutely going down hill desperately fast. To me I have enjoyed what I hope my wife would confirm an exceedingly good sexual life, no hang ups, no nothing like that. But now I think being impotent is a, you don’t know it but I think it psychologically affects you. I mean it’s really got now that I am disgusted by anything at all of that nature.

I: How does that make you feel, would you prefer that things were different?
R: Yes, yes I mean I feel that I’ve lost all masculinity, I’m not a man any more. I mean I’m just not. I mean if I were walking along with my wife, very slowly these days, and somebody accosted her I would sort of run away. I have no masculinity left.

I: How does that make you feel?
R: Awful, I think that really, that is the worst side effect by far ( . . . )
I no longer fulfill my function as a husband you know (P18, aged 80,
hormone treatment).

This man said that he felt even worse when his brother-in-law suggested that
he should go to his doctor for some Viagra. However, he said that he did
not ‘have the nerve’ to raise the subject with his doctor, and he could not
discuss the subject with his wife. It is possible that the illness and relatively
advanced age of this respondent may have had an independent effect. The
man himself reflected on this possibility later in the interview, when asked if
he thought that the hormones were responsible for his many problems. He
responded:

R: I think so, but I don’t know. I said to my GP, ‘What is my trouble, old
age, psychological, or the cancer?’ and he said, ‘Yes’.

A younger man also spoke powerfully of the dramatic impact of the hor-
mone therapy on his sense of masculinity, as well as the lack of understand-
ing shown by his consultant. He had hoped to take a new drug, Casodex,
having read that it would not affect his sex life. However, because of a
misunderstanding and a mistake at the hospital he had been injected with
Zoladex, a hormone therapy that affected his libido and ability to have an
errection, and made him feel he had hermaphrodite status. He also said that
on reflection some of his problems were similar to the problems suffered by
women when they undergo mastectomies:

R: The problem with these hormone drugs is that psychologically they
are you know hugely aggressive, they attack a man in every
department you know where he feels that he is a man. They are, they
are horrible, you cannot really put it any other way but since you’re
ill, since you want to live you have to make some comprises like
anybody else who’s ill and so you roll with it ( . . . . ) Sex life is a
disaster and er you know you can see that you’re basically turning
into some hermaphrodite status which is you know not very happy,
so what do you do? ( . . . ) My NHS consultant was hugely insensitive
on these issues. He said ‘Oh yes I can see that you’re taking on
the form of a woman now, it’s these drugs, don’t worry’, you know,
in this sort of happy-go-lucky way (P27, aged 58, hormone
treatment).

This man said that his consultant’s attitude made him feel terrible. He was
in a particularly bad situation because his cancer had spread to the bone in
his leg. At the time of the interview he had just undergone major surgery, and
was using a stick while convalescing at home. Previously he had run a successful
business, but as the result of his illness he had had to close his business and
give up his work. He commented that his change in circumstances added to his feelings of depression and misery. It is likely that his reduced sex drive, his changing body shape, combined with his incapacity and his inability to work had all contributed to his feeling that he no longer held the status of a man.

Many men who had hormone treatments described changes in body shape, and many reported hot flushes, and mood changes, which they sometimes described as similar to those experienced by their wives:

R: When I started having the Stilboestrol, Stilboestrol stopped the hot flushes (laughs) so that was a benefit of having the Stilboestrol, but the Stilboestrol caused breast swelling and breast pain, breast tenderness (P31, aged 65, hormone treatment).

One man (P19) reported that the hormones gave him PMT [pre-menstrual tension], with hot flushes, enlarged breasts and sickness. He had, however, only had a short course of hormones while waiting for radiotherapy, and he was able to look back on that episode of his treatment with amusement, and laugh about his irritable behaviour, which he described as similar to that he had had to put up with for 40 years while his wife suffered from PMT. Other men appeared to be much more distressed by their experience:

I: How did that make you feel as a man having female hormones?
R: Terrible, that’s when your masculinity really goes. Forget about the sex drive when you get them implanted in you. You just get a crazy mixed up kid for want of a better word because you’re doing these terrible things. You know it’s not you, you know it’s not part and parcel of your upbringing because as I said you’ll snap, you’ll rant and rave, your total outlook on life is different. It changes your attitude and your attitude to the ones that you’re living with, your attitude to your family, you just don’t want to know them (P25, hormone treatment and radiotherapy, age 60).

It should be noted that almost all the men who were having hormone treatment reported that they experienced at least one of the side effects that we have described in the sections above, usually including impotence and loss of libido. There were, however, exceptions. For example, one man, who at the time of the interview, had only had hormone treatment for a month while waiting for radiotherapy, only experienced abnormal sweating, which he said may have been caused by exercise. Another man, aged 83, denied that the hormone treatment had any effect at all. He was, however, taking a number of other medications for a heart condition, which he said made him have hot flushes, and it is possible that there may have been some confusion about which medicines were causing the side effects he described.
Discussion

In this interview study most men made comments about masculinity spontaneously without being asked about it specifically. Some men, however, may have felt that prostate cancer and its treatment had affected aspects of their sense of masculinity, which they felt unable to discuss. For example, perhaps some men had not experienced a reduced libido but thought it was socially unacceptable to say so; older men may have thought that an interest in penetrative sex was incompatible with their age. As Bury (2001: 282) points out, chronic illness narratives might be called ‘factions’ rather than either ‘fact’ or ‘fiction’ because the author always chooses what to divulge.

This was a relatively small study, and findings might have been different had we interviewed a different sample of men. Connell (1995: 75) points out that gender ‘interacts with race and class’ and that ‘white men’s masculinities are constructed not only in relation to white women but also in relation to black men’. In our study over three-quarters of the men interviewed were middle class and white, and many lived in rural areas far from areas where there were large ethnic minority communities. Additional issues might have been identified had we interviewed more men with manual occupations, and more men living in multi-racial areas.

Much of the data presented here reinforces the notion that masculinity is to some extent culturally produced, or simply a social construction. For example, many men suggested that the ‘macho’ image is adversely affected if illness means that they have to seek help or become dependent on others. Men felt uneasy about consulting their doctor with their symptoms because, as some said, ‘men don’t cry’. As Charmaz (1995: 268) has noted ‘Illness can reduce a man’s status in masculine hierarchies, shift his power relations with women and raise his self-doubts about masculinity’.

It is interesting to note that when Gordon (1995) and Moynihan (1987, 1998) interviewed younger men who had had testicular cancer they found that men denied that their illness had any long-term effect on their feelings of masculinity. Gordon’s (1995) explanation is that once treatment for testicular cancer was completed men were almost always able to return to whatever activities they were involved in before their cancer appeared, and none lost their jobs. They were able to perform their male roles. Furthermore, men who had been treated for testicular cancer could resume sexual activities once they had recovered from surgery or chemotherapy, and treatment left no long-term visible traces. Chemotherapy for testicular cancer may lead to loss of hair, but hair will grow again once treatment is over (Frank 1991). Moynihan’s (1998) account confirms the idea that the ability to work maybe a key aspect of male self-identity. Although the men in her sample also denied that their masculinity had been affected, they became anxious when the subject of work was raised, and they reported that they hid the fact that they were ill from their colleagues at work. The men in our
study who had been treated for prostate cancer were in a different situation. Although most were aged over 60, some of them retired early because of the side effects of treatment, and many of them had become impotent. Also, the effects of treatment for prostate cancer were often visible, because men taking hormonal treatments such as Zoladex experienced hot flushes, increased body weight and some developed breasts. Men may have hormone treatment for many years, so these were not short-term side effects. Some also suffered the long-term effects of incontinence and lack of control, and two had permanent catheters.

The results of this study suggest that while the ability to have an erection may be an important part of male identity, men whose treatment only affects their sexual function were able to reframe this as ‘a small price to pay’. It is possible that the wide awareness of the drug Viagra, and other techniques for combating erectile dysfunction, may have served to reduce concern about this side effect. The greatest sense of loss is described by men who have had hormone treatments that are described as affecting their interest in sex as well as their physical function. Men who have hormone treatments may also be older and have metastatic disease, which means that it may be difficult to attribute correctly the side effects of hormone treatment. However, the accounts of these men do provide a remarkable insight into what is thought to be masculine behaviour in our culture (Radley and Billig 1996). Thus, as well as being described as having a dramatic influence on libido and sexual function, hormone treatment is blamed for affecting energy levels and ‘enthusiasm’ for work, reducing the feeling of being ‘in control’, reducing competitiveness, and is also accused of undermining one man’s sense that he is able to protect his wife. These side effects that men describe suggest a shared understanding of the plausible impact of altering the balance of hormones in a man’s body. It is possible, though we do not think it is likely, that the changes described were psychosomatic, provoked by the awareness that they were taking ‘female’ hormones. Work on the social construction of hormones (Oudshoorn 1994) suggests that if the ‘female hormones’ that men were given were described as a substance (e.g. chemical R) with no gender association, then the reported side effects might have been different. We find this an intriguing possibility, but are struck by the difference in the experience of impotence described by men whose treatment did and did not include hormones. Men did not appear to have been alerted to the possibility that the hormonal treatments could cause a dramatic fall in libido as well as difficulty maintaining an erection. Our findings suggest that this is a distinction that many men may want to consider before deciding whether to have hormone treatment for prostate cancer.

It could be said that all our concepts are social constructions. Indeed, we noted earlier in the introduction to this paper, that even the very notion of separate bodies, male and female, has been challenged, and some prefer to see bodies as fluid rather than solid with no defined boundaries. However, some concepts, such as male and female, appear to be grounded in the
physical (anatomy and physiology) to a greater extent than other concepts, and probably most sociologists would argue that while 'male' and 'female' are in some sense 'natural', the concepts we define as 'masculine' and 'feminine' (male and female functions and roles) are socially constructed. It is not in our interests to make ideological statements that in any way perpetuate gender inequalities, and we would agree that masculinity is largely a social construction. Whilst, however, acknowledging that the men we interviewed may sometimes have confused the concept of masculinity with that of potency, our data suggest that male hormones may play at least a small part in what it means to be masculine in our society. Although the symptoms and treatments for prostate cancer may cause incontinence and impotence, it is the addition of hormone therapy that appears to intrude most on male self-identity. We are not arguing that hormones determine what it means to be masculine, only that they may subtly affect the way men and women react to each other, and how roles are played. Clearly, much more research is needed, but we believe it is important that over the past 10 years the body has been 'brought back in' to sociological debate about gender. These issues require closer links between theory and research to explore how the physical body, as well as culture, should be taken into account when trying to explain what it means to be masculine, and how illness may affect men's sense of masculinity.

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