The Aging Male

ISSN: 1368-5538 (Print) 1473-0790 (Online) Journal homepage: informahealthcare.com/journals/itam20

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To cite this article: Kenneth Gannon, Monica Guerro-Blanco, Anup Patel & Paul Abel (2010) Re-constructing masculinity following radical prostatectomy for prostate cancer, The Aging Male, 13:4, 258-264, DOI: 10.3109/13685538.2010.487554

To link to this article: https://doi.org/10.3109/13685538.2010.487554

The Aging Male, December 2010; 13(4): 258–264

informa
healthcare

Re-constructing masculinity following radical prostatectomy for prostate cancer

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(Received 11 February 2010; revised 25 March 2010; accepted 29 March 2010)

Abstract
Prostate cancer is common in older men. Surgical treatment involving removal of the prostate can result in temporary or permanent erectile dysfunction (ED) and incontinence and have a major impact on men's masculine identity. Seven men were interviewed about their experiences and concerns following prostatectomy, and the transcripts were analysed employing Foucauldian Discourse Analysis to identify the ways in which they constructed their masculinity. Participants drew upon four main discourses when discussing the impact of surgical treatment on their sense of masculinity: masculine identity and sexual activity, ED as a normative experience, mental resilience and vulnerability. Penetrative sex was constructed as central to a masculine identity, but inability to achieve this was normalised in terms of the ageing process. Stereotypically masculine qualities of emotional control and rationality were drawn on in describing their reaction to the diagnosis and treatment of cancer but they also experienced a new-found sense of physical vulnerability. The findings are discussed in terms of their implications for the clinical management of ED post-surgery and helping men adjust to life following treatment.

Keywords: *Prostate cancer, prostatectomy, erectile dysfunction, masculinity, discourse*

Introduction

Cancer of the prostate is the most common type of tumour in men in many developed countries. For example, in the UK there are around 35,000 new cases of prostate cancer each year and the number of men dying from prostate cancer has been estimated to be 10,000 per year [1].

The type of treatment offered in cases of prostate cancer depends, to a large extent, on the stage at which the cancer is diagnosed. Options include surgery, external beam radiation, brachytherapy and watchful waiting. Because of the function and position of the prostate all treatments (apart from active surveillance) usually result in unpleasant and distressing side effects including erectile dysfunction (ED), urinary incontinence, reduction in the length of the penis and infertility due to dry ejaculations [2]. For example, Stanford et al. [3] measured changes in urinary and sexual function in a sample of 1291 men following a radical prostatectomy. At 18 months post-surgery, 8.4% of men were incontinent and 59.9% reported ED. Siegel et al. [4] also followed up men who underwent radical prostatectomy for localised disease and reported that more than 80% of men reported ED at a mean follow up interval of 53 months.

The growing interest in the ways in which men conceptualise and manage their health and cope with illness [5–7] has resulted in greater attention being paid to such side-effects. This interest has focussed on the gendered aspects of beliefs about health and responses to illness, and the concept of hegemonic masculinity has been particularly influential in this regard [8]. Hegemonic masculinity refers to the dominant understanding of what it is to be a man at a given place and time and represents the model of masculinity that a particular society considers as 'true' maleness [8]. Men in developed Western societies, it is argued, are characterised by suppression of needs and refusal to acknowledge pain, denial of weakness or vulnerability, emotional and physical control, the appearance of being strong and robust, reluctance to seek help, interest in and focus on penetrative sex and the display of aggressive behaviour linked to physical dominance [5,6]. Within this framework having erections is considered fundamental to what it means to be a man [9] and central to what has been termed the phallocentric model of male sexuality [10]. This approach to conceptualising

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ISSN 1368-5538 print/ISSN 1473-0790 online
DOI: 10.3109/13685538.2010.487554

masculinity has resulted in a growing awareness of the potential impact of treatment for prostate cancer on men's sense of themselves as men.

In general, there has been little consideration of the ways in which the experience of prostate cancer links to men's expressions of masculinity [11] and, in particular, how men renegotiate their view of masculinity after treatment [11]. This reflects broader ignorance of the everyday experiences of men and their changing sense of masculinity when disease affects their genital organs [12]. The existing evidence is mixed. Fergus et al. [13] found that prostate cancer and its treatment pose a significant threat to masculine identity and has a negative effect on men's sense of masculinity, while Chapple and Ziebland [12] reported no major effects. It seems plausible that men's masculine identity is likely to be challenged by the experience of having prostate cancer and, in particular, by the consequences of surgical treatment. The side-effects of radical prostatectomy, whether temporary or permanent, affect precisely those areas of control and performance that are central to what it is to be a man in Western societies. In addition, men with prostate cancer are likely to be older, given that the incidence of prostate cancer increases with age. As men age they lose several of the attributes associated with hegemonic masculinity, such as physical strength and prowess and they may also experience difficulties in the area of sexual functioning [14]. These changes can result in a subordinate status in cultures in which youthful attributes are highly valued [15]. Therefore, older men with prostate cancer are likely to experience particular challenges in relation to their status within the masculine hierarchy. For these reasons understanding the impact of ED resulting from surgical treatment of prostate cancer is important to assist men in adapting following surgery. In addition, because all treatments for localised prostate cancer can result in unpleasant and distressing side-effects, it is important to understand the psychological impact of treatment to be able to counsel men who are making decisions concerning treatment.

This qualitative study aimed to investigate how men attempt to construct and re-construct masculinity following radical prostatectomy for prostate cancer. The perspective adopted is a social constructionist one within which men and women are seen as acting in the way they do because of concepts of femininity and masculinity that they adopt from their culture. Under this view gender is conceptualised in terms of relationships rather than rigid and unchanging categories [16] and as being played out in the course of social interactions [17]. A corollary of this is that behaviours, beliefs and attitudes related to health can be understood, at least in part, as a way in which gender is enacted and constructed. As Messerschmidt [18] argues, health behaviour 'may be invoked as a practice through which masculinities (and men and women) are differentiated from one another'. One way of addressing these issues is to focus on the language used in speaking about health, illness and gender. Discourses are ways of talking about things and are viewed as not simply descriptive but as constitutive, that is serving to construct the things that are being spoken of. They are conceived of as productive of psychological experience and as shaping institutional practices and power relationships [19]. Analysis of discourses is, therefore, a way of understanding how objects and events are socially constructed, and it is therefore a useful approach to understanding how changes in the body are related to constructions of masculinity. There are a number of different approaches to analysing discourse, but this study used an approach that draws on the work of Foucault, a so-called Foucauldian Discourse Analysis (FDA). This was chosen because Foucault emphasised the way in which talk can serve to construct power relationships and, given that hegemonic masculinity is associated with cultural authority and dominance over competing or alternative masculinities [5], we considered it appropriate to the aim of the study.

Method

Participants

Seven participants were recruited through the Urology Department of a teaching hospital in London. The inclusion criteria were that they had been treated for localised prostate cancer by radical prostatectomy, they had no concurrent medical condition that could be affecting their sexual functioning, there was no evidence of relapse at the time they were seen for interview and they were fluent English speakers. The men were interviewed between 7 and 15 months post surgery. On the basis of self report, all the men in this sample had none to minimal erectile functioning following their treatment for prostate cancer, although all but one had been sexually active before the operation. Most men had visited their doctors and received different types of medical aid for their ED, except for one of the participants who was arranging an appointment to see his consultant 7 months after he had the operation. All of the men were heterosexual. Other demographic characteristics of the participants are summarised in Table I.

Procedures

Ethical approval was sought and obtained from the relevant NHS and University ethics committees. A list of patients who met the inclusion criteria was prepared by two clinical nurse specialists. Men who met the criteria were sent information concerning the study by post and contacted a week later by telephone to ask if they wanted to take part and to answer their questions about the study. Of the 13 people contacted, eight agreed to take part and were interviewed, although the data from one of the participants was not used as the cancer had returned

Table I. Participant information.

	Nationality	Age	Retired	Married/ partner	Symptoms before the operation	Months since operation	Sexually active before operation	Side-effects at time of interview
P1	British	70	Yes	Yes	No	11	Yes	Erectile dysfunction
P2	Irish	58	No	No	Yes	8	Yes	Erectile dysfunction and incontinence
P3	British	58	Yes	No	Yes	12	Yes	Erectile dysfunction
P4	British	63	No	Yes	No	12	No	Erectile dysfunction and incontinence
P5	African	66	Yes	Yes	No	7	Yes	Erectile dysfunction
P6	British	65	Yes	Yes	No	7	Yes	Erectile dysfunction
P7	Asian	63	Yes	Yes	No	15	Yes	Erectile dysfunction

and he was undergoing further treatment. Of the five who declined to participate one did not give a reason, three did not want to take time off work and one said that his recovery was 'slow and difficult' and he did not want to talk about it. Participants were interviewed individually on the hospital premises by a female researcher. Issues of consent and confidentiality were discussed and participants signed a consent form before the interview started. The interviews lasted from 45 min to 2 h and were tape-recorded and transcribed. The interviews were guided by a semi-structured interview schedule divided into three sections: (a) brief introduction where the participants were encouraged to talk about themselves generally; (b) questions about their life before treatment; and (c) questions about how they felt after treatment. The rationale was to allow participants to contrast their experience before and after treatment and to talk about any changes that they had observed.

Analysis

The analysis was guided by the method for conducting an FDA described by Willig [19]. The ways in which participants referred to masculinity and ED and made sense of these experiences were identified, and the positions that the discourses offered to the participants were explored along with the possibilities for action entailed by the discursive constructions. We also focussed on the subjective experience linked to the various subject positions identified.

Results

Participants drew upon four main discourses when describing the impact of surgical treatment on their sense of masculinity. These were: masculine identity and sexual activity, impotence as a normative experience, mental resilience and vulnerability. In the excerpts from transcripts presented below 'I' refers to the interviewer and 'P' to the participant.

Masculine identity and sexual activity

A capacity for penetrative sexual activity was presented as central to masculine identity. For example:

> **I**: And in terms of your lack of erection ... I was wondering how important that is to you ...
> **P5**: It is very important to me. As a man you see ... I have been doing this thing all my life before and now all of the sudden because of the surgery ... started to come off. Whether you have a woman beside you or not as a man you must be active but you don't know when.
> **I**: So what does it mean to be a man?
> **P5**: Being a man means that sexually you must be active. ... nothing so important apart from that.

For this man sexual activity was synonymous with masculinity and was framed in terms of penetrative sex. The man is the active partner in sex and, to fulfill this role, erections must be spontaneous and reliable; in fact the absence of an ability to have spontaneous erections is presented as depriving the man of his sexual purpose:

> **P6**: .... as a sexual partner I have no function now. At present at least. I have been prescribed viagra but I won't use it.
> **I**: So that means that you don't have sexual desire or that you don't have a sexual response or ... what do you mean?
> **P6**: I suppose being just as any man I look but don't touch ... if that makes any sense ... I am sure I am interested in ... let's say if I see a pretty woman or a pretty girl on TV or something, it is nice but ... I just think that is nice. Before probably could feel it was nice. At the moment it is purely in the mind, I think is nice but before I used to probably get some little feeling in the body, some little motion that something was nice, but now there is absolutely nothing like that.

In this account the erection serves to confirm the identity of the speaker as someone who is capable of sexual activity. Viagra is rejected, possibly because the sexual response must be spontaneous to be valid. Such spontaneously arising erections provide important confirmation of masculine identity. The pre-operative physical response to an attractive woman provided not only reassurance about the ability to perform should an opportunity present itself but was intrinsic to the appreciation

of erotic stimuli. Now there is an intellectual appreciation of female beauty, but the physical response is absent.

So central are erections to masculine identity that their absence compromised this identity and had to be concealed:

> **P2**: That (sexual problems) is the only thing I don't seem to be able to talk about . . . nobody seems to want to know . . . Well . . . I won't tell many people around me just two or three people know . . . because that can be embarrassing you know . . .
> **I**: May I ask what is embarrassing? What you mean?
> **P2**: Because I know I can't do it and I feel inadequate . . . I am not the same I used to be. I can't perform so I don't go to places where I may meet people . . . I won't go out socially. I have a lot of friends and I have been invited to go to parties and I said no . . . which I would have never said before, because I am not sexually active. My social life has changed because of you know . . . I can't do it anymore and I won't be able to stay the night.
> **I**: Do you think people will feel differently about you if they knew?
> **P2**: Yes . . . it wouldn't be the same. They will think that I am not good in bed. . . . being a bachelor . . . well a single man . . . that is a big part of who I am. And I get invited to parties but I won't go because I can't . . . and I would say 'well I am too tired or whatever' . . . make some excuse and that is really the only worry that I have . . .

For this man the ability to be sexually active was a central aspect of his identity and when this was lost the identity became challenged to the extent that certain social situations were avoided. The pressure for men to perform sexually is located clearly in relation to social expectations, and there is a fear of discovery in the absence of a plausible justification for unavailability, such as being in a relationship.

However, some men drew on alternatives to penetrative sex as a way of constructing a masculine gender identity:

> **P3**: I don't feel any less of a man (because of ED) because obviously it depends on your partner. There are other ways of pleasing a woman apart from actually entering her. You can use your tongue or use your hands . . . or that sort of thing. So if you are satisfying her then your feedback would be that you are still capable of giving her pleasure and I always felt that if you can give somebody pleasure in the relationship then you know that is where you masculinity comes not from the fact that . . . boom bang boom bang thank you ma'am sort of thing.

Here masculinity is reformulated as the capacity for giving pleasure and is explicitly distinguished from constructions in which the chief focus is on the man's pleasure.

Normalising impotence

The discourse that identified the ability to spontaneously and readily achieve erections as a central component of the masculine identity was resisted by one in which ED was presented as a developmentally normative experience and intrinsic to being a man:

> **P3**: The area where I have a problem, although it is not a practical problem because I haven't got a partner, is the erectile side. I haven't had an erection since the operation at all. The documentation my doctor gave me . . . gave me the impression I would be lucky if I got anything much before a year after the operation. It can be . . . well depends on age as much. The older you are . . . the erectile side as I understand it tends to drop off anyway.

This man accounts for absence of erections using two strategies: in the medium term by an appeal to expert knowledge (the doctor) relating to the effects of surgery, and in the longer term to unspecified sources of information that emphasise the natural process of aging.

In addition to age other factors were also called upon to explain the inability to achieve an erection:

> **P4**: ..I haven't had an erection for some time . . . - even before I had the operation. . . . around 5 years . . . because we both work and as you get older you get more tired . . . and all those other things that we do . . .
> **I**: So you think this is a result of the kind of life you have . . .
> **P4**: Well yes, I don't think it is just me but a general thing that happens . . . because people live longer . . . you . . . people expect to do the normal things in life until much older but I suppose it affects individuals in different ways.

For this man the inability to have erections predated the operation and is accounted for in terms of lack of opportunity and fatigue. This is linked with the ageing discourse to produce a mutually reinforcing justification. In this context the inability to have an erection following the surgery is presented as 'more of the same' and linked to the presumed experience of people generally. Nevertheless, this account is implicitly acknowledged to be problematic because a generally increased life-span is associated with increased expectations for maintaining functioning in a range of areas, including the sexual.

That the construction of impotence as a normative experience as men age can be problematic is illustrated further in the following extract:

I: So that means you are not having any sexual activity now?
P7: I don't bother with it. I can't so I just don't bother. And my wife understands so there is no problem with it. I am 62 years of age I am not a teenage boy you know.
I: So that means that sexual activity is not very important to you at this stage in your life ...
P7: To me it is not. I don't worry about it and I don't let it become a problem. That is the only thing that it has daunted me since the operation. And it is not in me to take this or take that. I just don't want to take viagra to have sex. I want to have sex naturally ... why do I have to do that?

Here the interviewee employs an extreme case formulation ('I am 62 years of age I am not a teenage boy you know'.) to position himself as someone of whom it would be unrealistic and inappropriate to expect a high level of sexual interest and performance. The fact that this is not solely a self-serving account is vouchsafed with reference to the views of his wife. Nevertheless, there is an acknowledgement that this construction reflects an accommodation with the reality of the situation ('I can't so I just don't bother'), and the issue is then reformulated as a desire for 'natural' rather than assisted sex. This relates back to the discourse surrounding sexual identity and masculinity and serves to construct sexual performance as more than the simple fact of having erections but rather as an arena for the performance of masculinity within which the source of an erection (natural vs. assisted/endogenous vs. exogenous) becomes as important as the presence of one.

The normalising discourse helps to defend masculinity against an experience of loss of control and loss of performance. Other discourses are drawn upon to emphasise the retention of stereotypically masculine qualities.

Mental resilience

P3: I think generally I was ... what is the word? Pretty much accepting, stoical? You are accepting of life sort of thing. I did not have a mad panic attack. In fact I was talking to somebody about it later on and I was quite matter of fact about it and he was surprised how matter of fact I was. After I had the PSA result ... between that and having the biopsy done ... I actually did a bit of reading on it and I think that helps in a way if you know a little bit about it ... it takes your mind off worrying about something you know nothing about. I am not saying that I am an expert but I know a bit about it. And that way you can ask the right questions. And I talked to different doctors and they reassured me ...

This man's response to the diagnosis of prostate cancer presented the opportunity to enact masculine qualities of control, rationality and emotional restraint. His immediate reaction to the news was one of calm acceptance. There is an implied contrast here of the unemotional rationality of the masculine response to a stereotypically feminine hysterical one (a 'mad panic attack'). Sources of authority (books and doctors) are consulted and the speaker identifies himself as someone who is knowledgeable about his condition. This strategy of accessing expert knowledge has been identified in research on web sites for men with prostate cancer and differentiates them to some extent from sites aimed at women that deal with, for example, breast cancer, where the emphasis is on sharing emotions [20].

This emotional restraint, verging on disengagement, was articulated even more powerfully by other speakers, for example:

Int: I was wondering how you took the news when you were told you had cancer, how you reacted ...
P6: Well to be honest ... I couldn't care less. However my wife was absolutely horrified as you can understand ... and said why are you laughing at such a serious thing? And I said well if I've got it I've got it and so what? You know you have two choices you get it or you don't in life and if you do ... tough and if you don't well ... praise God. So it did not have an effect on me at all.

Again masculine restraint and an implicit stoicism are favourably contrasted with female emotionality and, paradoxically, the presence of a disease that challenges masculine norms and assumptions serves as an opportunity for the display of stereotypically masculine qualities of emotional control and rationality.

Together the normalising and the mental resilience discourses serve to present a potentially threatening consequence of surgery (ED) as part of the common experience of older men and to reframe the inability to perform sexually as an opportunity to enact masculine characteristics. Nevertheless, prostate cancer and its treatment challenge constructions of masculinity in domains other than the sexual.

Vulnerability and caution

One characteristic of hegemonic masculinity is physical dominance. For some men this construction was challenged by a new-found sense of vulnerability following their illness and treatment.

P3: I used to play a lot of rugby and that sort of thing when I was younger so physical confrontation is part of that game and obviously that can sometimes spill out to life outside the game of rugby. You know bangs and somebody bangs into you. This sort of thing ... without looking for fights if you know what I mean. I suppose it is in

the back of my mind I feel slightly more vulnerable than I would have done before the operation possibly . . .
I: In which way do you feel more vulnerable?
P3: I suspect that if I have an argument I would be less aggressive in the argument. Generally I don't get into arguments but you know it would be at the back of my mind that I may be more vulnerable and therefore I would be more careful in how aggressive I was. You know . . . I stand my ground but I just would be a little bit more wary as to how far I push that situation if I happen to defend that area.

In this instance, the interviewee provides a description of involvement in a sporting activity involving physical risk and the possibility of conflict which positions him as someone who formerly displayed traditional masculine qualities. Following the illness there is a newfound sense of vulnerability and a greater sense of caution where there is potential for conflict.

Another consequence of this sense of vulnerability is increased vigilance and attention to the self:

P5: Because I am alone now I try to take a good care of myself. When you are alone you should know how to take care of yourself because you are alone. If anything goes wrong, there is nobody to help so you must be on your guard all the time . . . more than you would like.

Although a sense of vulnerability is acknowledged, a counter discourse is advanced simultaneously. The man is presented as reliant on his own resources and, consequently, as having to assume greater responsibility for his welfare, perhaps more than is desirable. As with the mental resilience discourse the vulnerability discourse offers the opportunity for the enactment of male characteristics, such as control:

P6: that caution in the physical side is governed by the psychological side. My mind tells me . . . pulls me back from doing things I would normally do. Although I know I am not doing them because of physical condition . . . as I said the mind and the body work together.

The rational mind serves to over-ride the impulsive, emotional responses and thus serves to protect the man.

Discussion

The findings provide an insight into the way in which men construct masculinity after radical prostatectomy. Masculine identity was strongly linked with sexual performance, particularly a capacity for penetrative sex. Concerns about the ability to achieve 'natural', spontaneous erections and an emphasis on the importance of penetrative sex have also been reported in a study of men who had been treated with androgen deprivation therapy for advanced prostate cancer [20]. As in this study, some men in Oliffe's study [20] drew on discourses that emphasised closeness, warmth and, to some extent, role reversals (in terms of who is the active and who is the passive partner) as a way of moving beyond a construction of sex as involving an active male penetrating a passive female. Resistance to this construction was achieved by a representation of reduced capacity for and interest in sexual activity as being a normal part of the ageing process and by an emphasis on mental toughness and stoicism. A similar strategy of normalisation was identified in a study of African-American and Latino men following treatment for prostate cancer [17]. The men in Oliffe's study [20] also drew on the normalisation discourse to construct a declining interest in and a reduced ability to perform sex as a normal consequence of ageing rather than as solely a consequence of their disease or its treatment. It may be that ageing is less threatening than the consequences of treatment for life-threatening illness or that such discourses are more readily available and serve to align the speaker with a large number of men who are in a similar situation. Despite such discursive strategies, the challenge to masculinity was reflected in a newfound sense of physical vulnerability and an increased wariness about becoming involved in conflict.

The loss of erectile function as a consequence of side effects of treatment of prostate cancer clearly has a significant impact on men's masculine identity. They experience an acute and ongoing sense of loss, not only of the ability to engage in penetrative sex but also of the physical response to erotic stimuli. While men can attempt to normalise these experiences, in terms of them being a natural consequence of the ageing process, this strategy can result in a dilemma as it places them in another category of men (older men) who do not meet the hegemonic ideal. The new-found sense of vulnerability also serves to challenge their masculine identity and represents one way in which loss of hegemonic status can impact on men's perceived position in power relationships.

An important clinical implication of these findings is that health care professionals working with these men should assist them to challenge the dominant discourses of masculinity both before and after surgery. Approaches to doing this include introducing alternative discourses of masculinity related to sexuality, caring and emotional expression. Men could be encouraged to explore non-penetrative ways of achieving sexual satisfaction for themselves and their partners. It is important, too, to recognise that medical discourses are powerful and can influence the way men construct masculinity. By prescribing medication, such as Viagra, and physical aids, such as

vacuum pumps, medical practitioners are, in a sense, colluding with powerful discourses that construct male sexuality in terms of penetrative sex. Healthcare practitioners need to be aware of how this practice can constrain the process of reconstructing masculinity and should be tentative in how they offer such interventions. By presenting medication or mechanically-assisted erections as the main options, they may be closing down alternative ways of enacting masculinity in the sexual arena that do not involve penetration and that might be more appropriate for men with ED, particularly given the apparent resistance of many men to 'artificial' aids. Men could also be encouraged to acknowledge and share concerns and distress with their partners or appropriate others. There is evidence that the partners of men with prostate cancer are distressed by men's unwillingness to discuss their feelings [21] and the finding that some men in this study disclaimed any distress following their diagnosis supports this. It is also possible that such apparent indifference could mask distress, so clinicians should not take it as evidence that emotional support is unnecessary.

There are also some broader implications for services. Early detection of prostate cancer by means of self-reporting symptoms could be jeopardised by the constructions of masculinity these men employed. Symptoms may be discounted if they are constructed as a natural consequence of ageing, for example. One way of dealing with this could be to design information leaflets to explain the urinary and sexual changes that can be expected in prostate cancer. It should be made clear that those changes are not necessarily part of healthy aging and that men should visit their doctor if they experience them.

Acknowledgements

We wish to express our gratitude to the men who gave their time and shared intimate experiences and feelings with us.

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