Prostate Cancer and the Social Construction of Masculine Sexual Identity

(BRIEF REPORT)

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Perhaps no other disease illustrates the social construction of masculine identity more vividly than prostate cancer, an illness whose common symptoms and treatment effects (for example, erectile dysfunction and incontinence) leave men with a diminished sense of agency over their bodies. This loss of agency reveals the ways in which societal norms regarding appropriate masculine sexual behavior and identity are cultural creations, not biological absolutes. Recalling prior studies of prostate cancer narratives and studies of prostate cancer support groups, this article inquires not only into dominant constructions of sexuality, but also into the possibilities of redefining sexuality and masculinity among prostate cancer survivors.

Keywords: men, prostate cancer, masculinity, social construction, gender, sexuality

From January, 1997 to February, 2001, I observed monthly meetings of a Florida chapter of Man-to-Man, a national support group for prostate cancer survivors. What began as a research project on social support grew into a series of research projects that investigated not only social support (Arrington, Grant, & Vanderford, 2005) but also illness narratives that addressed the stigma and attendant identity changes elicited by prostate cancer, the impact of the disease on relationships with partners and friends (Arrington & Goodier, 2004; Arrington, 2005), the impact of the disease on men’s interactions with health care providers (Goodier & Arrington, 2007), and the impact of the illness on sexual identities (Arrington, 2000a, 2000b, 2003, 2004). These studies employed a variety of theoretical perspectives (the narrative paradigm, grounded theory) and research methods (narrative analysis, the constant comparison method). As I reflected on the project and its various components, it became clear that many of my...
findings dealt with ways in which prostate cancer survivors sometimes perpetuate and rarely resist the dominant society’s definitions of masculine sexual identity.

Prostate Cancer and Its Effects

Common symptoms and treatment effects of prostate cancer leave survivors with a diminished sense of agency over their bodies. Survivors often face difficulty in confronting the losses of control of their bodies, schedules, lifestyles, and relationships, and of course, the looming possibility of death, that is, the larger loss of their very lives. Medical treatments often lead to erectile dysfunction, which at best redefines and at worst restricts the survivor’s sex life.

Post-surgical side effects include erectile dysfunction and incontinence (Bostwick, MacLennan, & Larson, 1996). Other possible side effects include urethral stricture, cardiovascular problems, blood clots in the legs, damage to the urethra, and rectal injury. Side effects also occur with other treatment options. Men who opt for radiation therapy risk intestinal problems, rectal irritation, and diarrhea, in addition to erectile dysfunction and incontinence. Rectal ejaculation and rectal bleeding are also potential side effects of radiation treatment (Carson & Akwari, 1980; Hanlon et al., 1997). Hormonal therapy reduces the amount of testosterone in the body but also leads to erectile dysfunction, hot flushes, diarrhea, liver toxicity, gynecomastia and breast tenderness, and decreased libido (Bostwick et al., 1996; Clark et al., 1997).

The painful physical changes caused by prostate cancer often pale in comparison to the emotional hurt and psychological effects inflicted by the disease (Fitch, Gray, Franssen, & Johnson, 2000). To put it mildly, prostate cancer scares people. Korda (1997) wrote specifically about men’s fear of prostate cancer:

[T]he biggest fear of most men. It carries with it not only the fear of dying, like all cancer, but fears that go to the very core of masculinity – for the treatment of prostate cancer, whatever form it takes, almost invariably carries with it well-known risks of incontinence and impotence that strike directly at any man’s self-image, pride, and enjoyment of life, and which, by their very nature, tend to make men reticent on the subject. (pp. 3-4)

Fear is often accompanied by depression, which frequently follows a single upsetting event such as a diagnosis of serious illness (Phillips, 1994). An unsatisfied need for control, a feeling of helplessness, changes in lifestyle, and a lost sense of immortality all contribute to depression among men with prostate cancer (Phillips, 1994). These complications of the disease exert a cumulative force on men, often leaving them feeling helpless or inadequate.

Prostate Cancer and Masculine Sexual Identity

The loss of agency caused by prostate cancer reveals the ways in which societal norms regarding appropriate masculine sexual behavior and identity are cultural cre-
ations, not biological absolutes. Consequently, the men’s illness narratives and interactions in support group meetings suggest that few men contest those norms and create new identities for themselves in the wake of the disease. Most men choose or see no other valid choice than to accept the social definition of masculinity and, consequently, perceive themselves as less masculine than they were before the diagnosis. The remainder of this article will illustrate the limits imposed by current cultural norms and the potential for thinking beyond those limits.

Perpetuating the Dominant Definition

After observing group discussions in the Man-to-Man group, I found that many group members spoke in a manner that confirmed a definition of sexual behavior that required sexual acts to be spontaneous actions involving penile vaginal penetration and that denounced anything else as phony at worst and incomplete at best. Among these men, talk about sex and sexuality took the form of a drama in which the men characterized prostate cancer as an evil agent that robbed them of their sexual identity. For instance, several group members who opted for hormone therapy complained of being “castrated” by their medications, in spite of their decision not to undergo the process of having their testicles removed. Because of the dominant definition of masculine sexuality, these men often spoke of going to great lengths to maintain the ability to have sex as it was defined for them.

Neil was a cancer patient for roughly four years. During that time, he had his urethra restructured and experienced some incontinence after his surgery. He underwent hormone therapy, after which his genitals shrunk to prepubescent levels. He experienced nerve damage and received a prescription for a “vacuum device.” However, the pump did not work for him. He then tried injections of medication, but to no avail. Neil asked his physician about Viagra but was told that the medication would not work for him at this point.

Neil began his story by discussing incontinence but spent most of his time discussing the numerous procedures he had undergone in an attempt to restore his sexual potency. Support group members also conveyed the power of society’s dominant definition of masculine sexual behavior when they described the reasoning behind their respective choices of treatment methods.

In a one-on-one interview, for example, another group member, Mark, explained his choice of treatment options and the impact of sex on his decision:

This is what [my physician] told me. So I opted on the radiation, because, it seemed like that would have less effect upon the sex life, than an operation ... I had heard anyway that the chances that, of losing your ability to have sex was much greater than just by radiation. So I went through the radiation.

In this case, as in many others, the patient based his treatment decision solely on the likelihood of maintaining his prior sex life, which allowed him to act in a manner consistent with cultural norms of masculine sexuality.
Sex as Spontaneous

A popular notion among men was that sex was the spontaneous result of a simultaneous urge between partners. It followed that anything other than that was something less than “real” sex. Consider, for instance, the moment when Bob told us about the pump he bought four years ago but had not yet used.

In fact, he never even took it out of the box. He did not feel comfortable using the apparatus because it made sex less than spontaneous. “It’s gotta be spontaneous,” he stated firmly. At this point, he appeared defensive and uncomfortable with the conversation, noting that it was easy for people without a given problem to talk about that problem.

I sensed that the statement was directed at Brooks, the group facilitator, who did not have prostate cancer. Brooks responded by asking a question that he said psychologists often asked: “What’s the alternative? Non-spontaneous sex is likely better than none at all. Open the box and talk with your wife.” “Without the urge?” Bob asked. “If I had the urge, I’d open the box.” “The urge is mental,” Al noted.

Bob argued that sex, by definition, must be a spontaneous event. Consequently, because of Bob’s inability to achieve an erection without the aid of the pump, he felt incapable of having sex at all. Brooks suggested, in contrast, that sex still could have been enjoyable for Bob and that Bob still could engage in sexual activity even if doing so required sacrificing a degree of spontaneity in exchange for the ability to achieve an erection.

Brooks’s comment conveyed a watered-down version of Tiefer’s (1994) claim that the notion of spontaneity in sex is nothing more than a myth. On several occasions, Brooks and Bradley, two men who facilitated one of the discussion groups, attempted to challenge the notion of sex as spontaneous. In a moment representative of many of the later meetings, Brooks brought up the idea of “partial” or “limited” sex as the rule, not the exception.

Contrary to the mediated messages we might have seen, couples are not constantly “hot and heavy” for one another, he claimed. He asked Al whether he had talked with his wife about sex. They had started to talk, Al answered, but the conversation never got very far.

In this instance, Brooks challenged the notion of sex as a spontaneous action by dismissing that image as an unrealistic media construction. In addition, he questioned the notion by exhorting group members to confer with their partners about prostate cancer’s effects on the couples’ sex lives. Brooks’s reference to alternative sexual acts as “partial” was problematic, however, in that it suggested that those acts were somehow incomplete.

In another meeting, Bradley attempted to question the spontaneity of sex. Without mentioning specific studies or researchers, he claimed that research verified that men get in the mood for sex, or “warm up,” more quickly than their female partners. On average, a woman takes fourteen minutes to warm up, while a man takes only two minutes, Brooks stated.
“Or if you’re Italian, about two seconds,” he added, lightening the mood with a joke about his own cultural background. Bradley went on to note that while those measures change with age, they do not necessitate the termination of the men’s lives as sexual, sexual beings. So while Brooks tended to dismiss the dominant definition of sex as a spontaneous act, Bradley endeavored to redefine this aspect as an age-related construct that simply changed slightly over time, but not with the effect of eliminating sex altogether. Each group leader in his own way propounded a reconsideration of any spontaneity involved in sexual activity.

Sex as Penetration

Brooks, likely recalling a prior group meeting that included a discussion of the penile pump, stated that the apparatus might lessen the spontaneous aspects of sex. John interjected with a laugh, acknowledging that he could no longer have sex at all: “Maybe I’ve had my quota already.” Brooks noted that there were other ways to share and show love for one’s relationship partner.

When John claimed that he could no longer have sex, he might have meant that he could not achieve or maintain an erection or that he could not achieve an orgasm. Regardless, because the remark appeared during a discussion of the merits and limitations of the penile pump, it was reasonable to assume that he actually was referring to erectile dysfunction. Such a claim, then, assumed that an erection was a necessary element of sexual intercourse and the implied definition of “real sex.” Along with an erection, penetration was implied as a necessary component of sex and sexuality. Prostate cancer survivors who experienced erectile dysfunction as a side effect of treatments often feel that their chances of maintaining a healthy sex life deteriorates along with their capacity for an erection.

The definition of sex as penetration emerged even more clearly in the amount of effort Brooks and Bradley expended in defining acts as sexual and intimate. Rather than being solely a physiological act, Brooks asserted, sex occurred primarily between the ears. Brooks also noted that perceptions and definitions of sex were affected by variables of ethnicity, socioeconomic status, and religion, including the repression of sexuality often brought about by those influences. He introduced himself as a PhD in psychology, not a physician. His background and interest in sex implied, as he occasionally stated, that there was more to sex than “plumbing” and the physiology of the human body.

On a different occasion, Brooks explained that although men with erectile dysfunction might not be able to achieve or maintain an erection, they are still quite capable of maintaining sexual relations with their partners through various means. “For example, we see nothing wrong with mutual masturbation . . . in a marriage relationship.” However, his failure to explain the identity of the aforementioned “we” was problematic in that the statement might have contradicted the religious beliefs of some group members. This possibility is especially noteworthy because the meetings were held in a church.
In another meeting, Bradley advocated alternative means of sexual contact still available to group members dealing with erectile dysfunction. Nathan entered the conversation, asking whether women were more apt to miss orgasms than men were. He also asked about the merits of abstinence for older people. While he only might have needed to hold hands with his wife to be satisfied in terms of intimacy, he explained, she might also require clitoral stimulation. Bradley’s answer included a reference to religious taboos against “fingering.”

Although Bradley made an effort to encourage group members to experiment with other means of experiencing sexual intimacy, he also crossed into the more problematic area of marginalizing the men’s new sexual options, as the next passage suggests.

“What about self-stimulation?” Nathan inquired. It was certainly not preferable to “the real McCoy,” according to Bradley. “After all,” he continued, “we would rather have a good piece of ass than masturbate.” He added that it was never too late to be creative in one’s sex life and made a vague (not too controversial, he hoped) reference to oral sex, describing the sixty-nine position as including digital arousal but failing to mention oral stimulation.

Though Bradley’s intentions might have been admirable, he perpetuated the notion of sex sans penetration as somehow incomplete when he suggested that autoeroticism was inferior to “the real McCoy.” The fact that neither Bradley nor the other members ever discussed cunnilingus as a sexual option was also worth noting. I concluded that either cunnilingus had not been part of the men’s prior sex lives or that it was a taboo topic, not to be mentioned outside the marital dyad.

Contesting the Dominant Definition. Toward a Transcendent View of Sexual Identity

Most of the men who spoke with me defined masculine sexuality solely in terms of the ability and willingness to perform penile vaginal intercourse, which they perceived as the sexual act. The men’s comments inform us about what it means to be a man whose sex life has changed because of prostate cancer and what it means to be an older person whose sexual identity is altered by the disease. On a more universal level, the narratives presented also have implications for the broader concept of sexual identity and the sometimes contradictory meanings which we assign to it.

One way to understand how sex is socially constructed is to compare it to race. West (1993) wrote of three ways to talk about race. Americans, he claimed, tended either to essentialize issues of race, making race the primary cause of interethnic differences, or ignore race, pretending that ethnic differences hold no significance in inter- and intra-ethnic interaction. However, West added, far too few of us consider a third way of dealing with race. We need to develop a way of talking about race that neither essentializes nor ignores it, but transcends it. What we lack, he explained, is a way to acknowledge race for what it is and for what it is not. Such an approach would acknowledge that structures and behavior are inseparable, and that institutions and values go hand in hand. How people act and live are shaped (though in no way dictated or determined) by the larger circumstances in which they find themselves. These cir-
cumstances can be changed and their limits attenuated by positive actions to elevate living conditions (West, 1993, pp. 18-19).

A transcendent view of sexuality would require us to consider the role of culture in our definitions and experiences of sexuality. Culture is “as much a structure as the economy or politics; it is rooted in institutions such as families, schools, churches, synagogues, mosques, and communication industries (television, radio, video, music).” Like economics and politics, West continues, culture is “not only influenced by values but also promote[s] particular . . . ideals of the good life and good society” (West, 1993, p. 19).

The same can be said about our views of sex and sexuality. Most prostate cancer survivors do not discuss sexuality in a way that acknowledges the broad potential of the concept. Like race, sexuality is a social construction:

> What we define as ‘sexuality’ is an historical construction, which brings together a host of different biological and mental possibilities – gender identity, bodily differences, reproductive capacities, needs, desires and fantasies – which need not be linked together, and in other cultures have not been. (Weeks, 1987, p. 15)

In the absence of a story that transcends sexuality, prostate cancer survivors seem trapped between conflicting messages about the significance of sex and sexuality. Either sex comprises the bulk of their identities, as evidenced by the fact that preserving their sex life was a primary value in treatment decisions, or sex means little to them, as downplayed in post-treatment accounts when there were no effective means of restoring prior sexual potency. Hence, what we need are new ways and a new willingness to talk about sex and identity, ways that reveal the fallacy of thinking about sex and gender as dichotomies rather than conceiving each as a located along a broad-ranging continuum of meanings.

**References**


