

Male sexuality in theory and practice

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This article focuses on the importance of sexual function in the context of prostate cancer. Embodiment may be defined as the practical, subjective experience of the body in everyday life and is basis on which male sexuality will be considered [1]. Theorists have argued that while there is a better understanding about women's embodiment and health over their lifecourse, this is partly as a result of focusing on their accounts of health and illness. There has been a paucity of attention to men's experience in the same manner, however [2]. Researchers who have worked with men also support this view:

A methodological challenge for a sociology of embodiment is to start addressing the need for conceptual tools that would enable the articulation of lay ideas about the experiences of the body and have previously been treated as inexpressible [3].

Complex human attributes, such as sexuality, go beyond the realm of physiology or psychology. Instead, the social and cultural worlds that men inhabit need to be taken into account, as this is likely to shape their views about their bodies and the intimate, sexual dimensions of their lives [4]. It has been argued consistently that masculine embodiment is comprised of biological, social and cultural dimensions [5]. Prostate cancer, which arises in the genital area, threatens the area of the body most closely concerned with sexual function and body waste. Consequently, any disruption to these functions adversely effects men's place in the gender order, as the body is expected to conform to social norms [6,7].

Some argue that sexuality (as well as madness, criminality, sickness, and death) have been sequestered in today's world, hidden away from everyday social life, because they involve complicated questions of morality and

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generate feelings of discomfort [8]. Furthermore, sexuality may itself not be considered a legitimate concern in acute illness contexts, as attention routinely is focused on the nonsexualised body [9].

With these background issues in mind, the aim of this article is to explore some of the more vulnerable aspects of male sexuality by considering the impact of prostate cancer on the sexual dimension of men's lives. By presenting their views on impotence, it will be argued that sexuality is more than a theoretical concern. Instead, it emerged as sufficiently important to shape decisions about cancer treatment and nursing care. Although some men freely relinquished sexual function in return for cure, others never felt content until this aspect of their life had been returned. Insights gained from this study also will be relevant for men with other conditions impacting the male sexual organs.

In the company of men

This study was conducted at a London Cancer Centre between 1996 and 2001 (Kelly, unpublished data, 2002). The researcher desired to explore the impact of prostate cancer on men's bodies and their everyday lives. This topic had interested the researcher for some time, as there were so few empirical studies available, particularly compared with breast cancer [10].

Following approval by the local human ethics committee, interviews were initiated with five heterosexual Caucasian men who had completed treatment for prostate cancer within the last 3 years. An unstructured interview approach was adopted, and the men were invited to tell about how prostate cancer had affected them [11]. Having tape-recorded and transcribed these initial interactions, the researcher listened to recordings and reread the scripts a number of times. Using an inductive approach to analyze the interview data on a line-by-line basis, it was possible to recognize an emphasis on what was eventually termed the "embodied impact" of prostate cancer [12]. It became clear that biopsies, treatments, and adverse effects had been milestones in these men's experiences. Not all, however, recounted the same level of detail in their accounts, which led the author to consider Spradley's argument that some information may be expressed explicitly through language by research participants, while a large part may be tacit, or hidden from view [12]. Men's silences in studies on other topics, such as infertility, also have been noted and their significance questioned [13].

An ethnographic approach was used to witness events in the context of their occurrence [14]. Ten more men from diverse backgrounds who were about to start treatment for prostate cancer were recruited to be followed through treatment. One later withdrew because his condition deteriorated. The final sample consisted of 14 men. The sample's ages ranged from 52 to 77 years.

An ethnographic approach to data collection was adopted in the main study by accompanying men to medical and nursing consultations,

diagnostic clinics, and radiotherapy treatment areas. Periods of observation were interspersed with ongoing discussions and interviews with the men and five professional participants (one surgeon, one radiotherapist, and three nurse specialists). Field notes were compiled by focusing on place, actors, and activities suggested by Spradley:

Every social situation can be identified by three primary elements: a place, actors and activities. . . These primary elements do not exhaust the social and cultural meaning of social situations, but they do serve as a springboard into understanding them [12].

The narrative and observational data were combined to produce broad data categories until sufficient data were obtained to produce a detailed account. A selection of media reports about prostate cancer also was considered. Published analyses of the reporting of prostate cancer suggested this was an important issue to consider [15]. Debates about related biomedical developments, such as the launch of sildenafil citrate (Viagra), also were included, as they complemented the empirical findings. The study findings illustrate the importance of sexuality in the prostate cancer experience.

The body in the balance: sexual function and decision making

Uncertainty and decision-making and the negotiation of responsibility about choice of treatment emerged as key findings. Prostate cancer can be managed by a range of medical interventions depending on the stage and aggressiveness of the tumor. These include surgery, radiotherapy, hormone therapy, and close monitoring. Each, however, has adverse effects and limitations [16,17].

With such a range of options available, choosing between them was a demanding task. Professionals preferred to share such decisions with men in this setting. By employing such an open and collaborative approach, however, professionals also had to acknowledge uncertainty. As the surgeon said:

“You go to different hospitals, you get different treatments; you go to different countries, you get different treatments. . . it’s such a loaded area. . . it’s like a machine, and it’s almost unstoppable. . .”

Uncertainty about which treatment option to accept for early stage cancer was shaped by men’s personal feelings about impotence and incontinence. The backstage concerns of professionals concerning the lack of definitive evidence on which to base decisions, resonated with the men’s own uncertainty and the difficulties they faced at this time. Importantly, most men sought additional information from the Internet or self-help organizations. Others spoke about having to reconcile equally undesirable outcomes.

For example, Simon described talking to both a surgeon and a radiotherapist when first diagnosed:

“Mr. X seemed to indicate that it was as easy to do radiation as it was to do surgery. . .and surgery truly sounded god awful. . .he put it to me that if you were in America they, would take it out, if you were in Sweden they wouldn’t take it out, and here in England sometimes we take it out, and sometimes we don’t take it out, and I tried to get a definitive ‘Well which is best?’ and he said ‘It’s six of one and half a dozen of the other.’ So there was quite a long time of where, you know, ‘We’re not sure what we should be doing.’ Mr. X said ‘Yes, whip it out,’ and Mr. Y said ‘No, no reason to whip it out. . . .’”

Bob, the only gay man in the study, also recounted feeling unable to make such a decision when he experienced depression following the death of his partner:

“People started to talk to me and said you really must do something about it before it’s too late, so I went to see a specialist . . .who suggested a total prostatectomy.”

“Yeah?”

“And I asked about all the side effects and, I mean, it’s always a question of hit and miss, you know; it can be alright, or it can leave you impotent” . . .

“Right.”

“And I thought, Oh no, I just don’t want to know. . .

“Mmm.”

“So I let it ride a bit longer and didn’t do anything about it, and they started to pester me from the hospital. When I say pester, I don’t mean pester, you know, they started to say, you know, you’d better come and see us, you must come and see us. . .So I did, I saw Dr Y, the radiotherapist.”

Information seeking and the clarification of treatment choices were common themes in the decision-making phase. Although the clinic itself was an important source of information at this time, most men also looked elsewhere for additional support. Detailed personal accounts of the uncertainty surrounding prostate cancer treatment emphasize the frustration and fear that such a situation can provoke [18].

Facing the reality of impotence or incontinence

The risk of impotence or incontinence meant that some treatments could be rejected outright. In other instances, men spoke of reduced levels of sexual function caused by advancing age. Jack, a man of 70, who could be considered one of the more traditionally stoical men in the study, exemplified the latter situation:

“They gave me a choice of A, B, or C and said that they would recommend radiotherapy. I’d have to go along the impotent road, although I’ve been impotent for some years.”

“You said you were impotent before all this started. If you hadn’t been, would that have been something you would have taken into account?”

“I’m 70 years old with five grown up children. Why should I worry about it?”

“It’s not an issue at all?”

“At my age? I think not.”

The range of reactions to impotence, even in this small group of men, suggests that a highly individual relationship existed between attitudes to sexual function and men’s sense of self [19]. This finding should be considered in relation to many theoretical claims that a functioning penis is central to masculine embodiment [20–22].

Some men certainly did feel strongly about preserving their sexual function. Bob, for instance, insisted that it was not something he would be willing to trade for an increased chance of survival. Others spoke of impotence as being less important, however, as their relationships were no longer sexual. This situation was true of Frank:

“We weren’t having intercourse at the time; we sleep at different times. I mean I go to bed at 3 or 4 and get up at 12, and my wife goes to bed at 11, so it’s really much better that we don’t sleep together. We stopped sleeping together that year I came back from America, which was in April ’92, and I felt we were both better like that.”

An important point to note is that Frank had also become incontinent, and now stored boxes of incontinence pads in his bedroom. The separate sleeping arrangements had coincided with his cancer treatment.

When it did occur, impotence provoked some of the men to question their own, and others, reactions toward it. For instance, John did not think impotence was a particularly big issue; however, other people were more intrigued:

“It isn’t a big issue for me, which probably says a lot about my own sexuality. My therapist’s reaction was surprise that it wasn’t a big issue. A woman that my wife and I were talking to, when I said it, she reacted not with fascination, but her reaction was very different from the men’s. Hers was just one of, ‘Oh poor thing,’ kind of thing. That kind of reaction.”

Similarly, when John’s impotence was discussed at his men’s group, the others seemed fascinated by his revelations and wanted to know more:

“The age range there is between 28 through to, well I think I’m the oldest at 55, so that’s quite a big age range. . . I know the reaction was quite shocked; you could see it from their body language change. . . they wanted to know how it affected my sex life. How it had affected my relationship with my wife. How we coped with it, really a lot of details about it. You know, what, how did it feel, how we coped with it, lots of things really. Even they hadn’t realized that because of the operation you no longer ejaculate. So we got onto that as well. So it was really a fascination with all things sexual.”

The range of reactions to impotence emphasizes the need for caution when considering men's views about sexual function. Even from an initial reading of the transcripts, it became clear that impotence was being viewed in many ways.

For those who had become impotent, vacuum devices or injections were used most commonly. Kenneth, for example, had become impotent following radiotherapy. He now used a vacuum device to obtain an erection. Despite the mechanistic nature of the procedure, it had become a normal part of his sexual repertoire. His impotence, and the means of its management, had been accepted gradually:

“In the end I ended up with the Erectaid, you know the vacuum, which you know, you have to accept. It has some advantages, you know (laughs). No drinker's droop!”

Given that impotence and incontinence were the main embodied consequences of prostate cancer, the previous examples illustrate men's capacity to adapt. These insights help to address Connell's claim for a better understanding of “the body as used or the body-I-am” [5].

A fuller understanding of impotence, however, requires some consideration of theoretical and experiential perspectives:

Contemporary treatment of the body has mainly been theoretical rather than empirical, focused on the social body rather than the physical body, and tended to interpret the body from an etic (outsider/social science) perspective rather from the emic (insider/lay perspective). By contrast, female embodiment has, to an extent, been reclaimed and reassessed in the context of lay experience [3].

The following section explores impotence further from both etic and emic perspectives.

Impotence: an etic view

Around the time of this writing, an article appeared in *The Guardian* by Lynne Segal concerning the World Congress of Sexology that took place in Paris [23]. The World Congress of Sexology is a professional meeting supported by the World Health Organization. Segal recounts how, at the same time as the “triumphal reinstatement of the Christian right in the White House,” the Surgeon General had advocated widespread sex education, contraception for young people, and the abolition of discrimination against lesbians and gays. Segal's primary concern, however, was the pervasive presence of drug companies at the meeting:

Only troublesome feminists (were) objecting to the raging conceptual epidemic of ED (erectile dysfunction) and the augmenting medicalization of sexual desire, huge funding is being spent of erectile auditing. But then sexuality in the private sphere was commodified long before the commercial

world so successfully targeted the public academic sector, or packaged the latest crisis of masculinity as a readily remedial erectile disorder.

Despite these concerns, Segal also conceded that: “the commodification of impotence is based on the tragic reality, at least in commercial terms, that while 50% of men over 40 years of age suffer from the agonizing effects of erectile dysfunction, it is estimated that only less than 10% seek treatments.”

The potential of sildenafil citrate to restore male sexual potency is thus emblematic, in Segal’s opinion, of the desire to maintain and reaffirm masculine power more generally. This stems from her earlier work that explored the role of the public school in instilling idealized constructions of masculine values based on physical fitness, courage, and audacity [24].

Presenting male impotence as an embodied tragedy may indeed be an effective marketing strategy to boost sales [25]. The emerging politicization of impotence, however, exemplified by feminists such as Segal, can be countered by the lack of attention paid to it in particularly vulnerable groups of men, such as those with prostate cancer or heart disease (Kelly, unpublished data, 2002) [26,27].

Regardless of critical interpretations, sildenafil citrate was a highly significant development during the study. Since its launch in the late 1990s, it has become one of the main noninvasive treatments for impotence [28]. There are also several alternatives now available [29]. The explosion in the consumption of sildenafil citrate has: “surpassed all previous products and services; despite physicians’ insistence that it is not an aphrodisiac and should not be used in ‘healthy’ men, there are already hundreds of Web sites that purport to document Viagra’s cosmetic benefit” [30].

The same author has also questioned the cultural symbolism that the drug has already acquired:

By defining erectile dysfunction as merely a chemical equation gone wrong, this simple pill (as Pfizer advertisements describe it) absolves men of blame for failure to achieve an erection. At the same time, however, it encourages men to define masculinity narrowly, as a penis that responds when it is supposed to. And by ignoring the complex constellation of cultural values and socioeconomic pressures that shape the way we think about and define terms such as manhood and masculinity, it replicates the way that our formulations of these concepts have contracted. Ironically, this little pill may represent the ultimate shrinking man [30].

Alternatively, an article by Thomas Stuttaford, a medical columnist living with prostate cancer himself, provides a more personal view of impotence [31]. The piece profiles a female consultant radiotherapist who advocates the use of brachytherapy and hormone therapy for men with prostate cancer that is unlikely to respond to surgery or traditional external beam radiotherapy. By manipulating male hormone levels using specific doses or combinations of medications, men are less likely to experience effects such as enlarged breasts and loss of libido. This, in Stuttaford’s view, counteracts the opinions of

those who “consider that libido at the tail end of a man’s life should be no more important than a good cup of tea” [31].

Unlike feminist critiques that present impotence as a symbol of a threatened form of hegemony, Stuttaford argues for sexual function to be recognized as a central component of masculinity:

People who discount libido ignore the sexual frisson that exists between men and women that is displayed in everyday life. It brightens up the day and gives an edge to social relations, which makes dinner parties, drinks, and even political party conferences more exhilarating. Fortunately patients and their doctors now have a choice... [31]

In Western imagination, the penis long has been considered a taboo body part. The strength of such taboos, together with the new emphasis that has emerged since the discovery of sildenafil citrate, means that the function of the penis literally has been exposed to renewed scrutiny. Although theorists such as Segal consider sildenafil citrate to symbolize the restoration of a vulnerable facet of masculinity, Stuttaford argues for a better understanding of the role that libido plays in men’s everyday lives (albeit from his own traditionally white, middle class, heterosexual perspective).

In biomedical discourses (another component of the etic view), impotence is presented merely as a physiological event, rather than a personal problem or theoretical issue. Treatment for erectile dysfunction is described in objective language:

The medication produces a natural erection causing the blood vessels in the penis to dilate and stay engorged for 30 minutes to 2 hours. Each man receives a test dose first to determine the proper amount of medication necessary to achieve and maintain an erection for a sufficient length of time. Priapism (an erection which lasts longer than 4 to 6 hours, which is generally considered too long) may require reversal of the dilation. Reversal may be achieved by a variety of methods (ie, manual masturbation; application of ice; injection of epinephrine; Aramine (metaraminol), or NeoSynephrine (phenylephrine hydrochloride); corporeal litigation; or the use of oral antihistamines [32].

This mechanistic account of penile function belies the organ’s symbolic qualities and its centrality to male embodiment [33]. The metaphorical qualities of the functioning penis are emphasized by theorists who have considered its relationship to masculinity:

Potent, penetrating, outward thrusting, initiating, forging ahead into virgin territory, opening the way, swordlike, able to cut through, able to clear or differentiate, goal-oriented, to the point, focused, directive, effective, aimed, hitting the mark, strong, erect [34].

Such theoretical (etic) constructions of impotence seem far-removed from the experience itself. Prostate cancer, however, is a condition that allows impotence to be understood in relation to individual men and their life circumstances.

Impotence: an emic view

This study's data provided rich insights into men's reactions to the embodied outcomes of prostate cancer. Impotence was a central concern from the initial diagnostic consultations onwards, particularly for those men who wanted to preserve sexual function, or who viewed the risk as personally significant.

Following radical surgery, Simon, for instance, used the term "capon" in relation to himself. He balanced his feelings about becoming impotent, however, with the fact that he was still alive. This extract also emphasizes the shock he experienced on ejaculating blood following a transrectal biopsy of his prostate:

"It simply reinforced to me the fact, you know, that things had changed, and you're not who you were, and that's the best that I could get to. I tell you, nothing coming out sure as hell beats blood coming out. But at least I feel like I haven't lost as much as I would have. On the other hand, psychologically, I feel like a capon, you know? And that, no, I wasn't really planning on having any more children, well I didn't have any, so I wasn't planning on having any, and now we know I'm not going to. But you know, I'm not going to play for Liverpool either as a left winger. You know, it's one thing to know I'm probably not going to do that; it's another thing when they say that you can't. So there's a kind of definitiveness about it. That's a bit difficult. But like I said, I don't want to discuss it with too many people. I don't feel it's going to get a whole lot better, and I feel it's just part of the scar, and that's the way it is."

Simon's reaction to impotence switched between acknowledging his sense of loss and feeling uncomfortable about talking so openly. He emphasized that impotence was only one of a number of physical changes he had encountered since the surgery:

"Well, I am slower than I was. I get more tired I think. . . In terms of the sheer physicality, we wound up with a little bulge in my belly and that's more psychological than anything else. Being impotent is sort of like a constant reminder, but so is the scar come to that. I mean I probably have more psychic problems than physical problems, and I try to keep the psychic ones under restraint as well."

His scars (both physical and emotional) were reminders of all he had been through. Although impotence and incontinence were difficult issues to verbalize, both were considered the price to be paid:

"Mr. X didn't quite explain to me that the new (bladder) sphincter would not be exactly dynamite like the old sphincter. . . But then again it's not terrible, and it's the price you pay, you know; it's the price I'm paying to be alive as far as I can see."

For Joseph, impotence was an option he simply could not contemplate. As a political refugee who wanted to return to South Africa to stand for

election to Parliament, impotence would have been a major drawback. As he was not yet married, this would have been impossible if cancer treatment had resulted in impotence:

“So you saw the surgeon, Mr. X?”

“Yes.”

“And did they suggest surgery or radiotherapy?”

“They suggested the two, surgery or radiotherapy, but both of them I didn’t try. Because both of them were going to interfere with my normal life.”

“Even if they could guarantee a percentage risk, like a 20% risk, or whatever?”

“Yes, they gave me all those, but they didn’t satisfy me.”

“Too much of a risk?”

“Too much of a risk, yes, too much of a risk, and you see culturally I’m not married. Culturally at the moment I’m not married, and culturally I must marry (laughs). Culturally I must marry for tradition, and if I’m going to be in public life if I’m not married, forget about it . . .”

“So you must be married, and you must have children?”

“Well, that’s not essential, but married is essential, an essential condition for . . .”

“And you couldn’t marry if you were impotent?”

“No, I couldn’t marry; what would be the use? Why go and interfere with other people’s, somebody’s life? I can’t, simply I cannot contemplate it; that was out of the question.”

“So that was a big part of your decision?”

“That was a big part of it; that was the major thing.”

“More than the incontinence?”

“More than the incontinence. All of them would interfere with my lifestyle, but that was the major thing and very important.”

Other men’s response to the threat, or reality, of impotence also confirmed that some considered it too high price to pay. Gerry, a man who had worked as a manual laborer all his life, emphasized the value he placed on sex. He spoke of the potential loss as he might about a close friend. This finally made him opt for radiotherapy, as it appeared to involve a lower risk of impotence than surgery:

“Well, the thing was, what I was really worried about really, was the sexual side of, you know. Because I’ve always been sort of sexually active, you know? You know and then, all of a sudden, just to lose everything. I was just worried about that . . .”

“Has it gone?”

“Gone, yeah, finished. They told me that you know. I’ve also spoken to one other person John, you know him? He’s got the same problems as me and two or three people at the hospital that I know. They’ve all got prostate trouble, and everyone has said the same, that the sexual is hard to get back.”

However, Gerry also knew that treatments did exist for impotence that provided him with some hope for the future:

“So I’m like in a no-win situation. What they’re saying to me is get all the prostate sorted out and then go back and see about the other thing.”

Other men were less concerned about impotence. Peter, whose first symptom of cancer had been severe pain during ejaculation, had simply stopped having sex. When the author asked him about becoming impotent after the surgery, his reaction had been similarly accepting:

“Can I ask you about the operation. Did it affect your ability to have sex?”

“Ah, well, it took everything away, mm, I was made, what do you call it?”

“Impotent?”

“Impotent. I’ve no feelings down there.”

“How did that, how did you adjust to that?”

“Que sera sera.”

Charles was unique among the men, as he had been widowed recently. For him, impotence did not seem to be a major consideration. Instead, he further exemplified those who thought of themselves as being at a point in life where sexual function was no longer so important:

“Some of the men I’ve spoken to have found that one of the side effects of surgery is impotence. Is that a problem, have you noticed any change?”

“No. I’m a widower, so there’s no problem there.”

“Would that be something you would think about?”

“Not at my age I don’t think. I like women’s company, but it wouldn’t bother me.”

“Some people say that if they were told they would be impotent they wouldn’t want to have treatment.”

“I can understand a younger man who’s still got a partner.”

“Do you think it’s something people should talk about? Is it too private to talk to doctors about?”

“No. I’ll talk about it if I want to, but it’s not a problem with me now.”

“It’s not a big issue?”

“No, not at all. . .”

Alternatively, Bob the one gay man in the study, initially had rejected both surgery and radiotherapy as the preservation of sexual function had been so important to him. He eventually opted for hormone therapy but found that this also resulted in general weakness and loss of libido:

“Is the libido thing different for you, or is it the strength that’s more important?”

“I think that I find the most distressing thing for me is the, my libido going. I think maybe if my libido didn’t go, I probably could possibly cope with it all. Although I hate being tired. I don’t like to be tired, losing my stamina in a sense but er, I think the libido was very important to me, terribly important. Ermm, that seemed to be the most important thing of all actually. After 3 months I just went down and down and down; I felt absolutely dreadful, had no stamina. . .”

“Yeah?”

“My libido went clean out of the window, and I just felt so utterly miserable. I just felt totally miserable, totally useless, I mean it had the most dreadful psychological effect on me, and...”

“Was this something you were warned about? Did you know that this was possible?”

“Actually, no. No.”

These data further suggest that views about impotence reflected the value placed on sexual function by individual men [35]. For some, sexuality was highly treasured. For others, it was viewed as an inevitable loss. This range of opinions suggests that assumptions about sexuality in older people always should be open to question [36].

The commodification of impotence

For men who did become impotent, this commodification highlighted several additional important issues. One of the most relevant, particularly in relation to the timing of the study, was the fact that to obtain sildenafil citrate, men relied on the cooperation of their doctor, normally their general practitioner (GP). Professionals in the clinic also would suggest sildenafil citrate in summary letters sent to the GP after follow-up consultations. Sildenafil citrate was subject to tight controls (because of cost) in the publicly funded British National Health Service at this time, and only about 6 to 10 tablets would be prescribed on a monthly basis. There are few, if any, formal programs of rehabilitation for such men [37].

At the time, Bob was the only man in the study who had used sildenafil citrate. He described the reaction of his GP when he first approached him to request a prescription. Bob had been taking hormone therapy intermittently and had learned about the benefits of sildenafil citrate from newspaper reports:

“I went to see my own doctor, and that doctor was pretty reticent. He wasn’t happy about the idea at all, so he gave me eight. He said ‘I’ll give you a prescription for eight, and we’ll just see how it goes.’”

“Did he say why he was reticent?”

“He said, ‘It’s new.’”

“Right.”

“He wanted to see what effects it had on me. I mean other than, er, the erection and things ‘cause it can have other side effects. I mean we have to sort of play it gently, and he gave me a thorough examination; my heart and my blood pressure were very good, so that was fine and so, I’ve still got about, about two left.”

He then described having to request repeat prescriptions and the barriers to be negotiated during this process. He related one incident when he tried to obtain a further supply of sildenafil citrate before leaving for a holiday with a new partner:

“I was due to go away today funnily enough to Venice with this guy I’ve met, but his sister died, so we had to cancel the whole thing. Before that I had written to Dr Y, my doctor, saying would he let me have some more and er, I gave him a stamp-addressed envelope asking if he would reissue a prescription. So far, he hasn’t let me have any so whether he’s being cautious or whether he’s away, I mean, I dunno.”

He also spoke about the action of sildenafil citrate on his body:

“Do the Viagra work? Do they work for you?”

“Yeah, yeah. I mean, Viagra will only work if I’m actually sexually aroused. I mean it won’t, I mean it’s not an aphrodisiac at all you know. It doesn’t make you feel like it. If you’re aroused, then everything will work but it isn’t an aphrodisiac. But I mean, I’m quite happy with that. As to the future I don’t know...”

Bob’s determination to access sildenafil citrate to regain control of his sexual function resonates with Giddens’ views about the self and the way that seemingly insignificant actions reflect, and contribute to, wider social change:

The self is not a passive entity, determined by external influences; in forging their self-identities, no matter how local their specific contexts of action, individuals contribute to and directly promote social influences that are global in their consequences and implications [8].

In Bob’s case, his individual actions to obtain medication reflect a gradual shift in attitudes toward impotence and acceptance that it need not be an inevitable consequence of conditions like prostate cancer.

Professional views of impotence

The surgeon’s skill was seen as an important variable when men were weighing up the risk of becoming impotent. These risks usually were presented as percentages in relation to the number of patients treated. This issue was discussed during the professional’s interviews. The surgeon spoke at some length about sexual function as a valuable dimension of masculinity. As such, he felt it should be treated “with respect.” The risk of impotence or other adverse effects was balanced against the probability of succumbing to the cancer. Meeting the expectations of a rising number of patients, however, was becoming demanding:

“I think in terms of meeting demands by providing a good service can get increasingly difficult. It’s just getting stretched now. One feels exhausted at the end of the clinic, because you just can’t meet demand. You feel you’re not doing a good job.”

In addition to viewing low rates of impotence as an indicator of a high-quality prostate cancer service, on a more personal level, impotence was something the surgeon did not want to inflict on another man without careful discussion. Although there may have been a reflexive component to

this view, it also reflected the style of working in this clinic. Consultations were characterized by repeated behaviors that included information-giving, emotional support, and a collaborative approach to decision-making. The work appeared to be demanding of those involved.

Despite such effort, the radiotherapist expressed a common concern:

“We don’t know if it made any difference treating someone with a PSA (prostate-specific antigen) of two. We treat them but they have to live with the side effects. I think we’re going to have a lot of young men living with impotence and bowel disturbances and urinary incontinence...”

Bill also summed up this dilemma when he spoke of opting for radical surgery, despite his personal horror of impotence and incontinence:

“I had to go for it ‘cause there are only two alternatives. Either you do, or you get killed by it; those are the only two choices. Really it’s a Hobson’s choice...”

Summary

Male sexuality is a complex phenomenon shaped by personal, cultural, and social factors. This article has argued that male sexual function is an important consideration in conditions such as prostate cancer. There are surely other conditions where it is understood even more poorly. Although theorists tend to explore male sexuality in relation to vague concepts such as power, phallocentrism, and aggression [21,29], sexuality becomes a personal reality in illness contexts. Using insights from a study into prostate cancer, it has been suggested that men assess embodied risks, such as impotence, in highly individual ways. The uncertainty that characterizes this cancer further compounds the difficulties involved, despite attempts of professionals to provide adequate levels of information and support.

Researchers and practitioners alike should begin to question the gap between theoretical constructions of male sexuality and its reality in health care situations. More attention should be paid to understanding the importance of sexual function for men who are living with conditions such as prostate cancer.

Those men who face up to the threat of such embodied changes, and who learn to cope with physical and emotional (and sexual) vulnerability, may learn to evaluate their lives in new ways. As Kenneth, one of the participants in this study said of his experience of cancer, “It just seems unnecessary for them to have to go through that to learn and understand themselves and be honest with themselves about what is really important.”

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