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Changed Men: The Embodied Impact of Prostate Cancer

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Prostate cancer is a uniquely problematic male health issue. Findings from a study employing an ethnographic approach are presented to describe the ways in which 14 men's lives were changed as a result of this experience. The theoretical basis of the study centered on embodiment to explore the personal impact of prostate cancer, its treatment, and its side effects. The findings suggest that cancer was experienced sequentially, beginning at the time of diagnosis with the problematizing of the normally "silent" male body. This trajectory of experience progressed to emphasize the importance placed on treatment side effects, embodied vulnerability, and the impact of the cancer on men's "embodied" lives. In this article, I focus on the final phase of the illness experience and illustrate how the men confronted existential threat alongside physical changes, and the way each change resulted in a new outlook on life and its priorities following cancer.

Keywords: *cancer; psychosocial aspects; death and dying; embodiment/bodily experiences; illness and disease, experiences; men's health; recovery; sexual health; sexuality*

The importance of prostate cancer as a key public health issue is likely to increase as the recorded incidence continues to rise because of improvements in screening and diagnostic techniques (Kelly, 2004). Treatments for prostate cancer include radical surgery, pelvic radiotherapy, hormone manipulation, and monitoring the disease through a process of "watchful waiting." Each involves different assaults on the body, as well as on men's embodied lives. Within the medical literature, however, there is a lack of definitive evidence regarding which treatment is most appropriate for which stage of prostate cancer (Jacobs, Banthia, Robins, Sadler, & Varni, 2002).

Disagreements compound the controversy already existing about prostate cancer treatment and the merits of screening. As Souhami & Tobias (1995) state, "There are few areas in clinical cancer management today where such diversity of opinion exists, even amongst experts" (p. 367). This means that men diagnosed with prostate cancer might have to weigh the (sometimes conflicting) advice of professionals, or seek out additional information to decide which treatment is most acceptable to them (Grove, 1996).

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Beyond the uncertainty underpinning the biomedical basis of prostate cancer lies the psychological paradigm from which a specific discourse has also evolved (Brock, 1993). Within this context, the cancer experience is usually considered against a range of predetermined—and usually uncontested—normative categorizations such as "anxiety and depression" or "quality of life" (Antaki & Rapley, 1996). Although these might be criticized for failing to accommodate the more nuanced, individual consequences of cancer, the importance attached to them has grown in the past 20 years, as treatment and resource decisions might be made on the basis of outcomes from such studies (Antaki & Rapley, 1996). Alternatively, qualitative research might seek depth of insight into the impact of cancer at the individual or small group levels, and it is within this paradigm that the present study was located.

The Centrality of Embodiment

The theoretical underpinnings of this study relate to embodiment to appreciate the impact of uniquely male illness experiences such as prostate cancer. According to Howson (1998), embodiment may be understood as

A dialectical process between embodied experience and the language available to articulate such an

experience. Hence, the notion of embodiment refers to a process of transformation and mediation in which embodied experience is authentic and articulated through cultural categories. (p. 237)

The importance of embodiment in relation to health and illness contexts is reinforced by authors such as Watson (2000), who argue for greater awareness of biographical experience across the lifecourse—through events such as work, marriage, parenthood, and bereavement. The experience of cancer lends itself to a richer understanding from the standpoint of embodied change, and explains the impetus of the present study.

I set out to explore this issue by exploring physical, emotional, and social (gendered) experiences associated with prostate cancer (Chowdrow, 1994). Initial interest in the topic emerged from clinical experience in cancer care, and as a man increasingly aware of other men facing the reality of prostate cancer.

Social researchers who have explored men's experience of illness from a qualitative perspective often begin by emphasizing masculinity as a product of social construction. A common criticism of such work, however, is the privileging of theoretical, rather than "everyday" or "recognisable" perspectives (Watson, 2000). Notwithstanding this criticism, a point to stress is the small number of empirical studies that can be drawn upon at all (Cameron & Bernardes, 1998; Oliffe, 2004; Sabo & Gordon, 1995).

An area of key concern is the dominance of hegemonic images of masculinity within men's health campaigns that serve to reinforce strength and competence, rather than acknowledging men's emotional or physical vulnerability (Flanigan Saint-Aubin, 1994; Gray, Fitch, Fergus, Myhalovskiy, & Church, 2002). Silence and secrecy thrives in such a situation, with emotional or supportive care needs remaining underresearched and poorly resourced. However, some researchers are questioning hegemonic constructions of masculinity, and are suggesting that

[m]asculinity is not conferred by nature or biology and that it is not fixed. Rather, it is constructed by actors within a meaningful social context and in response to life experiences. (Gordon, 1995, p. 263)

If cancer is accepted as one of the most significant of all life experiences, it is important to explore the reality of masculinity in this particular context. This also responds to a challenge posed by Watson (2000) following research into the way men construct and

understand the concept of health "[t]o discern whether and how masculinity operates within daily lives" (p. 36).

Of particular relevance are questions around manhood and power, the impact of cancer on the body, the social meaning of cancer of the male reproductive system, and how each interacts in health settings (Stacey, 1997). Some work has emerged examining communication patterns within patient-professional dyads, suggesting that humor, reassurance, compassion, and the development of trust are important elements of communication strategies employed in prostate cancer consultations (Oliffe & Thorne, 2007). To date, however, more emphasis has been placed on female cancers from which it has been possible to appreciate the roles that gender and embodiment play when women experience cancer (Potts, 2000). Less attention, however, has been paid to the experiences of men. This has resulted in a lack of understanding about the ways men cope with physical or emotional vulnerability, or how health services should be developed to address their needs (Nancarrow-Clarke, 1999).

At the time of this writing, the impact of prostate cancer was coincidentally reflected in a radio account of the fate of Mobuto, the former dictator of Zaire. Toward the end of his reign he had been diagnosed with this cancer and had undergone surgery, which left him incontinent. When he was finally overthrown and fled the country, rebels ransacked his house and removed anything of value, including the water taps from the kitchen and the bathroom. Water poured from the broken pipes and flooded the house. When troops finally entered the building they were met with the sight of hundreds of disposable nappies (diapers) floating on the surface of the water—a scene which the reporter described as Mobuto's "final humiliation."

Methods

The study focused on examining masculine embodiment in the context of prostate cancer. As Watson argues, embodiment provides a useful means of exploring health-related experience, as it "provides the ground on which the dynamics of gender are made personal and the tensions of agency and structure are realised" (2000, p. 109).

An ethnographic approach was employed to examine the experience of cancer in a diverse group of 14 men (Kleinman, 1992). Recruitment of participants was largely opportunistic, with men who were

recently diagnosed with prostate cancer attending each clinic identified in advance and then approached by the researcher. In addition, five professionals (1 surgeon, 1 radiotherapist, and 3 specialist nurses) were invited to take part in single interviews, and agreement was requested for their consultations with patients to be observed over an 18-month period.

Following exploratory interviews with 5 heterosexual White men recovering from prostate cancer, I decided to include observations of significant events (such as diagnostic consultations and radiotherapy treatments) they described. This was intended to allow the cancer experience to be documented in more detail and required an ethnographic approach. In common with many ethnographic studies, a range of data sources were accessed (Hammersley, 1990). In this case I included face-to-face interviews with the participants; observation of consultations, treatment areas, and waiting rooms; as well as an analysis of recent media accounts of prostate cancer. I also broadened the interview sample to include 3 men of color, 1 man who identified as gay, 3 single men, and 2 widowed men. Over a period of 18 months I accompanied the men to clinic appointments or treatment episodes such as radiotherapy, as well as observing medical or nursing consultations. Data were drawn from observing prostate cancer-related procedures (such as rectal biopsies) that have not been documented previously—a situation that accords with the views of Lawler (1991, p. 4):

Aspects of corporeal and embodied existence which have been privatised and designated as dirty work in social life and which therefore have been largely ignored in academia.

As the study focused on the perspectives of individual men, as well as professionals involved in their care, the research aims reflected the breadth of information required. The research questions included:

- What is the impact of prostate cancer on masculine embodiment?
- How do these concerns change over the course of the disease?
- How do men and professionals manage the embodied consequences of prostate cancer?
- What implications are raised for service development and future research in this area?

Prior to data collection, ethical approval was granted by the research ethics committees of the hospitals

where the study took place, and written consent was obtained from all participants. All names were changed when the data were reported.

Analysis

Data analysis began at the time of the first interview. This involved an initial review and line-by-line coding of the transcripts and fieldnotes. Initial codes were then shared with a research colleague and supervisor, who confirmed the emphasis being placed on embodied experiences—such as initial urinary symptoms or the residual effects of treatment on erectile function. Significant “units of meaning” (phrases, sentences, paragraphs) were highlighted, and interpretative codes created (Miles & Huberman, 1994). In a subsequent exercise, the responses were read and reread to explore and refine tentative categories. Patterns, themes, and regularities were noted, as well as contrasts, paradoxes, and irregularities. Categories were then merged or added to, and interpretations refined to allow similarities and divergences of opinion to be recorded and grouped together using initial codes such as “initial symptoms,” “entry into the medical system,” and “uncertainty” (Delamont, 1992).

As further interviews took place, extracts were grouped under the broad temporal themes that best characterized men’s dynamic experience of cancer. Similarities and deviations were noted and used as a way of illustrating individual differences. As the interviews progressed, the men were asked to comment on issues that had been identified to confirm their importance. The impact of incontinence and impotence are examples of key concerns that emerged early, and were later clarified in more detail in subsequent interviews. This allowed a process of comparative analysis to be achieved across this group of men (Silverman, 2000). The same approach was applied to the professional interviews.

Observation data were collected using the “place, actors, events” framework proposed by Spradley (1980). The primary purpose of these data was to supplement insights obtained from the interviews. Although time was limited, the observations and subsequent fieldnotes provided nuanced accounts of events that characterized each phase of the prostate cancer experience. For example, diagnostic consultations were observed to differ significantly in content and in character from those concerned with treatment decision making. Key extracts from the field-

notes were identified to help bring the men's experiences to life on the page (an example is included later in this article).

The process of data analysis required categories to be compared with related theoretical sources as a form of verification (Silverman, 2000). This was further reflected in the approach used to report the findings. The importance of embodiment emerged when the emphasis being placed on the body, and the impact of prostate cancer on the more intimate aspects of men's lives, proved to be a consistent theme in all data sources. The following findings are based on the men's reflections of prostate cancer, and I use their own words to describe its impact.

Physical Change: Living With a New Body

It was found that after prostate cancer men were left with a body which was essentially different—a situation that served to emphasize its previous taken-for-granted nature. Some expressed ambiguity about having survived, despite the cost in terms of being left impotent. For others, their body was now less valuable in a social and personal sense—a finding that reinforces the extent to which prostate cancer requires men to engage in trading aspects of masculine embodiment in return for cure. Their bodies now failed to conform to many conventional standards of masculinity, a situation which impacted on them in different ways.

The first concerned the way they now defined their new sense of self. This finding supports the work of Seymour (1998), who examined similar concerns in people who had experienced traumatic spinal cord injury:

The project of reconstitution occurs not so much through the discursive reconstitution of language as through the disruptive, ambiguous, reflective and creative possibilities of embodiment. (p.179)

When I invited the men to reflect on the final outcome, they talked of having weighed cure against maintaining an acceptable degree of biographical continuity. For some, this involved relinquishing aspects of their former selves (such as sexual function), and seeking ways to assimilate these limitations into their new lives. Sexual function was a particularly concerning loss for some; for others, incontinence had been more disruptive. Both outcomes, however, evoked a range of reactions from stoical acceptance to the adoption of a more active role in obtaining help to manage these lost dimensions of "competent" masculine embodiment.

This process began when the treatment decision was made, with professionals playing a key role at this time by forewarning men about the changes they might expect. With time, and as they became more familiar with the cancer and the threat that it posed, these losses were gradually re-evaluated in relation to individual situations. Comparisons were drawn between the changed body and the one they had enjoyed prior to cancer. This was often accompanied by comments about having failed to take better care of their healthy body. As a result, some sought to strengthen their bodies as much as possible after cancer, or focused on a future that would accommodate its limitations. Some accepted impotence, for example, by affirming that the task of fathering children had been achieved. Successful adaptation appeared to rely, at least in part, on them having received sufficient information about the cancer, treatment options, and side effects in advance. When this had been the case, the professionals were seen as having done the best they could.

One man spoke of how becoming familiar with the details of his cancer allowed him to regain a degree of personal control. By preparing himself for the changes he would face, he felt better able to cope with the reality:

I had to find out, after I was told I had it I had done some medical studies, but then this one was really strange, you know, a strange animal [laughs] . . . and I'd got it.

His decision to decline surgery had been influenced by his determination not to become incontinent. This had allowed him to maintain a body which was still "acceptable." Without this, survival would have been meaningless:

Participant: The word prostate cancer is such a shock and a dread. The treatment, the radiotherapy and surgery and then being incontinent. Then you are going to lose, I mean incontinence is very, very . . . I mean nobody would like it . . . this part of your life is over and you feel you need to have to some future. That is exactly what is important because you must look so much for a treatment and then put it to the test. I had it and that would still be my choice now. I did not want my testicles operated on and become incontinent. That would be the end of my life and I would rather go . . .

Interviewer: You would rather die?

Participant: I would rather die.

As a political refugee, this man, by avoiding incontinence, had also ensured that he might still have a future in politics, as an incontinent body would have disallowed this. The culture of the prostate clinic appeared to have been influential in encouraging men to become involved in decision making to weigh the acceptability of treatment options in relation to their own priorities. However, men who had not been treated in this way expressed considerable anger and frustration toward a medical system that they felt had failed them. They focused on the damage imposed on their body and the frustration of having been left to live with the consequences.

The refugee's determination that this would happen to him meant that he was one of the first to undergo brachytherapy in the hospital (where needles are implanted directly into the prostate tissue via the perineum to deliver radiotherapy). He described the procedure as "very painful," but less invasive, or disruptive, than surgery would have been. Thus he had managed to achieve an acceptable level of embodied change that allowed him to look forward with minimal disruption to his social standing and personal ambitions. He had sought brachytherapy to lessen the risk of incontinence and allow him to enter politics. Despite what he described as the "very, very painful" experience of having needles inserted directly into his prostate, he had remained continent and the failings of his body would not be so immediately evident to others. The fact that he would rather have died from cancer than be left with an incontinent body confirms the extent to which masculine embodiment, though personally experienced, is also imbued with cultural and social significance.

Diagnosis

The following extract from the fieldnotes exemplifies further the nature of the embodied impact of prostate cancer interventions on men's bodies—even during the initial diagnostic procedures:

The doctor enters the room quickly and immediately touches the man gently on the hip. "Okay, I'm just going to take a look at your prostate now and try to get some tissue to let us know what's going on. It might be uncomfortable but it shouldn't hurt, okay?"

The man is lying with his hands under his head and nods in agreement. "Okay."

To the side of the bed is a metal trolley and computer screen. Various wires connect this to a phallic-shaped

plastic object with a trigger device attached to one side. This is the ultrasound probe which will be inserted into the man's rectum to visualize the prostate. On the end of the probe is a concealed needle which is fired into the prostate through the wall of the rectum when the trigger is pulled. This extracts tissue samples, which are sent to the pathology lab for analysis. The nurse transfers the tissue specimens into containers after the procedure. Also arranged on the trolley are disposable gloves, condoms, sachets of lubricant, and gauze swabs. The monitor is already switched on and humming, although the image on the screen is a grey fog at present.

The doctor then opens a pack of rubber gloves and snaps them into place. The nurse covers the probe with a condom and smears lubricant over its surface. The doctor takes the probe from the nurse and approaches the man. "Okay now, this will be uncomfortable; just try to take a deep breath and relax as much as you can."

The nurse then rests his hand on the man's hip as the doctor bends to insert the probe into the man's rectum. At this point an ultrasound image begins to form on the screen. The doctor looks at the screen and slowly moves the probe in a circular motion until he locates the prostate. Eventually this occurs. "Ah, there we go."

The doctor invites the man to look at the screen. To do so he has to lift his head and shoulders up off the couch. "Oh yes," he replies quietly. The cancer appears as a slightly darker area among the moving lines of grey. It looks innocuous. The doctor then turns to point it out to me. "Can you see it?" he asks. "Yes," I reply. The doctor appears pleased to have located the cancer. The size and definition of the tumor is commented on before the biopsies are taken.

During the procedure I became acutely aware of the penetration of the man's body and the traumatic nature of this event. I remembered some of the men having talked about this procedure in the interviews and made a mental note to follow up with this. Most had described it as unpleasant and embarrassing rather than painful. To continue:

Eventually, the doctor decides to take the biopsies. After moving the probe around, he pulls the trigger, which emits a sharp snapping sound as the needle enters the prostate and removes a sample of tissue. This is repeated six times before the probe is finally removed. The needle is disconnected by the nurse and the condom covering the probe discarded. "There we are then. We got some cells which we

need to examine. How are you feeling?" "Okay," the man replies. "I'm glad it's over; it really nips." "Well, you get your things together and come back out and we'll go over what happens next."

The nature of the rectal biopsy can be interpreted from a number of perspectives. First, the highly intimate nature of the procedure confirms the extent to which the work of the prostate clinic involves the boundaries of interpersonal intimacy being transgressed, particularly those that exist between heterosexual men. It also confirms the threat existing from an internal, and poorly understood, organ that has only recently come to the men's attention in a life-threatening context.

Restoring the Masculine Self

The data indicated the extent to which cancer was viewed by the men, after treatment, as an alien entity in the body. It was perceived as "other," separate, yet inextricably linked with the self. Its removal, however, required a significant physical, social, and emotional price to be paid. One man, for example, spoke of how much he resented the cancer and the limitations it had placed upon him:

Partly because of the person I am I resented the cancer, and I resented having to rely on other people. I resented the dependency which is something that I fight and have always fought. I now understand why I do it, but that's another story. So it was very hard for me to go through this process, without creating this shell around me that said, "Yeah, I can beat this. Yeah, I'm fit. Yes, I've got all this other help as well which is, and as soon as I can drive I'm going to drive and as soon as I can and so on."

Whereas other men also expressed similar feelings of resentment toward their cancer, a more fatalistic stance is also evident in another respondent's comment:

Prostate disease is one of those things. My father had his prostate removed when he was seventy but he lived another twenty years. . . . When you come in here you see people who are obviously very, very ill. It's best just to calm down and forget yourself because the oncologists will deal with it. Other than that, nothing to add.

The range of reactions that traumatic life events such as cancer can evoke are also underlined in Stacey's (1997) personal account of ovarian cancer:

In the face of cancer there is a compulsive desire to identify the net gain. Having had cancer I must be older, now. (p. 244)

Some men did not find it easy to put the impact of cancer into words. One man distanced himself from emotional disclosure about having to wear incontinence pads on a daily basis following a radical prostatectomy:

Well, I was lucky, it was seven years ago. I don't know if there's much awareness left. There's certainly awareness amongst the people I know because I've had it, but I don't think like that.

Instead, he focused on presenting a version of his professional self, particularly in the earlier parts of the interview. By being a retired general practitioner he felt this should mark him out as someone who should be able to "cope" with the demands of prostate cancer:

It's probably a class thing too, because I don't [know] what the gutter press say about this cancer, the tabloids sometimes cause a scare but obviously the middle classes are much more aware, aren't they, of what might happen to them? Well they seem to be . . .

A common finding concerning the after-effects of treatment was the tendency for some men to emphasize former masculine identities. I interpreted this as a coping strategy that allowed them to view the overall experience as less threatening. This was most common in men with early-stage cancer that had been successfully treated. The following extract illustrates such a reaction:

Interviewer: And how did the surgery go, how did you find the whole experience?

Participant: Well, I wouldn't recommend it for fun and pleasure, but on the other hand, well, it wasn't that bad. It's like anything else, once you've done it you can say well that wasn't so bad. In many ways it wasn't so bad. I mean they cut you open. I'm terribly pain sensitive and shy so that was always a worry. I haven't told anybody this, or at least very few people. I had a bit of a setback that I had what's called a stitch and the tube closed and they had to redo it again. I had to catheterise myself for about four months. That was nasty, but I mean, I was a manager of a football team, and part of the job was to pick up athletic supports and that's not a very nice thing to do. You know, by the third day you could do it with your teeth. Well that's the same thing with catheterisation,

it's terrible but by the third day you just get used to anything. So all in all, on balance, it was not terrible.

The extent of the embodied crisis that had been faced was also tempered in less threatening terms during the interview with other men. Images of one man's former self were superimposed onto his fatalistic view of other health risks, such as smoking:

I'd stopped smoking for [a] long time when I found out I'd got [it] and, I mean, no sooner I'd got it I thought what the hell, I'm going to start smoking again. I enjoy smoking. What the hell, you know, I'm going to [laughs] die eventually anyway, so you know, so what? But you know I've got to the stage where smoking is starting to effect my lungs 'cos I can feel it and I think I am being really stupid. Stupid, stupid, you know? So I might stop smoking again [laughs] err, I mean I want to stay healthy as [long as] I possibly can and, you know, and just hope I'm lucky. Because as my own doctor said so many men die of other things long before the cancer ever actually gets to them . . . err . . . so I just hope that I'll be lucky. . . . I keep hoping it will go away, it won't of course.

Another participant also emphasized having lost control of his body during cancer treatment. He now saw physical fitness as a way of reclaiming vestiges of his former self. Cancer had required him to place his body in others' hands (although he had never been willing to be a victim of fate). His reaction to this situation had shaped the way he now presented this new "changed self" to the world:

Participant: My body was very much the means by which I made myself worthy in a way—my body and my mind—In the marathon which was a cross country, it was awful weather, it was hailing and blowing a gale and I was feeling fine and then I started getting cramp which I never get, cramp, and suddenly it all flooded in on me it was quite a surprise to me that everything just kind of came "boom." I started getting cramp, my body was letting me down again and I started crying, I was running along crying and I was just, I didn't want to control it.

Interviewer: And how did you manage that?

Participant: I was just letting it all go and that lasted for about five minutes then I was fine, I still had cramp, but I finished the race, just a bit slower than I expected. And afterwards I was driving home and interestingly I was by myself. . . . I felt so bad about myself at that time.

The vulnerability in this man's account, together with his having felt abandoned when his body had "let him down," illustrates how some men learn to appreciate their body more after cancer.

This was also illustrated in another case when a man spoke about protecting his body from a recurrence of cancer by eating a healthy diet and taking vitamin supplements. His body was now viewed more as a valuable commodity which, in the context of risk, had to be maintained:

If I had known thirty, forty, fifty years ago that by the turn of the century, the year two thousand, at least sixty percent of the men between the age of forty and sixty would have some form of prostate problem, they may not be aware of it, they may never be aware of it, but they have. And basically that is because we're not aware of it, we have no knowledge of it, we treat our bodies so badly in the western world, err, you know we eat the wrong things. I spent thirty years on a Diner's Card when I was in business over here, eating raw steak. You know, followed by cheese. So the one thing I would say to people is, yes, take supplements.

A second example also illustrates how men attempted to return the body to an optimal functional level after cancer treatment. One participant now followed a daily fitness routine and took vitamin supplements regularly:

I do about three quarters of an hour exercise every morning . . . to keep myself in a fit state. They're not weight-bearing exercises they're just sort of loosening exercises and stretching and things like that, err, just to try to keep myself as healthy as I can be. And the vitamins I take [laughs], it's a wonder I don't blow up!

Despite these efforts, he was also aware of the impact of cancer on his body (over which he attempted to maintain control through the intermittent use of hormone therapy), as well as the likelihood of its gradual decline:

Well, you see for me I'm somewhat lucky because I'm not having any pain and nothing strange is happening apart from the fact that, I mean, my urine stream is quite thin sometimes, but I'm not in pain. I feel quite healthy once I'm off the hormones. Although I do get tired . . . I'm working in a fairly hectic job, lots of responsibility and lots of running around to do, and I am seventy.

This man's decision to continue working in the face of cancer suggests that for some, independence and the preservation of social role might be important considerations when treatment options are considered. For younger men, this might be an even more relevant concern. The above response had been marked throughout by this man's determination to maintain active control and to preserve his sexual self. He had managed to achieve this by his approach to hormone therapy. As was the case with the man earlier who managed to access brachytherapy, he had also found a way of preserving an acceptable state of masculine embodiment.

Working With Changed Men

The importance of the changes imposed on the male body by prostate cancer was also acknowledged by the professionals when they talked about their work. One female radiotherapist, for example, spoke of being aware that men risked losing social status, as well as their health, during prostate cancer. This illustrates the value attached to the "competence and strength" model of embodiment and the way masculinity is defined in society (Connell, 1995). The professional was cognizant of the relationship between embodied and social dimensions of masculinity when men opted for radiotherapy:

I think men on the whole feel more let down by being ill. Maybe that's the old provider bit that once you've got to know them and talk to them more you are actually concerned that they've got to keep going because they take their wives to the shops in the car, or they've got grandchildren who are dependent on them. I think they see themselves very much if something goes wrong with them, especially the younger ones, it's very difficult. I think in some ways for women with child-birth and child rearing etcetera, they know that their bodies are going to turn round and give them pain at stages. . . . I think men have this capacity, especially the older ones, that I've got to keep going because I'm the pivotal member of the family. You know, if something happens to me it will all collapse.

The gradual physical decline that occurs over the life course was also important in relation to how the professionals approached the men. The identities of patients were shaped by advancing age, and cancer was contextualized in relation to the coexisting demands of general physical decline. The potential of the clinic as a focus for the management of other health concerns was emphasized by the surgeon. He

stressed the lack of a coordinated approach to men's health in general, and suggested the need to question the present fragmented approach:

It's being stunted by the fact that a man who is diseased will be looked after by a variety of professionals who never talk to each other, they never meet at a conference or a workshop, even in the hospital. I've never been into the orthopaedic office or the cardiology office and yet if you look at afflictions of men, it's trauma early on, suicide then it's lung cancer, prostate cancer, heart disease, and again it's suicide in the late 70s and 80s. The cardiologists know nothing about the prostate, the prostate people know nothing about the management of depression or just picking up the early signs of someone who's depressed because their partner's died or they are overworking or the marriage is disintegrating. . . . So you have all these specialists looking after essentially men but there's no cross-communication at all.

This problematic nature of men's health care is magnified when particular conditions, such as prostate cancer, are considered. The clinic not only had to educate individual men about their disease, but also other professionals and agencies who might also be involved in supporting men with a range of health and social needs. As a result of attending the clinic or receiving treatment, the men also talked about being more aware of the way less fortunate men had died from prostate cancer.

Survival of the Fittest

The manner of other men's deaths was referred to in certain interviews as a way of emphasizing survival. Gratitude was often expressed when the fate of others was considered. One of the men, for instance, although being weak and debilitated himself, compared his present problems with friends who had already died:

By that time I was sixty wasn't I, or sixty one, so I just thought to myself, "Well, I'm still here." I've got so many friends that have had this kind of thing and didn't last very long. That's when I started with my bad back and I thought, "Oh here we go," because I had a friend who was taken ill with prostate cancer . . . years and years ago and he started with a backache. He didn't have any prostate troubles or waterworks, or anything like that. He just started with this terrific backache, they took him in and he never came out. It was so far advanced—gone into the bone. So I'm just relieved.

Despite the emotional impact of cancer, another of the men also valued survival and contrasted this with a male acquaintance who, once told he had cancer, had retreated from the world to die alone:

My parents had a friend, he got cancer at forty-five and he died pretty quickly, fairly quick, six months, eight months, he didn't want to see a soul. He felt like, you know, you need to feel sorry for him, he didn't want any of it. And I sort of had those feelings too. I didn't really want, you really picked the short straw. I think that as much as anything.

This man's emotional isolation, and the perception that cancer had meant he had lost in the "game of life," was a significant theme throughout the interview. He emphasized feeling "singled out" for a cancer that, in his view, was uniquely stigmatizing:

I felt like a fool and it has all those qualities to it and then in this particular case it has the double impact and, yes, that really is painful. I think I would have told other people if it was another kind of cancer, afterwards.

His sense of shame and separation emphasize Schilling's (1993, p. 167) point that embodied difference "leaves people alone with their body."

According to Johnson (1992), such isolation is not restricted to men with cancer. Writing from a psychoanalytical perspective, he makes the case that socialization processes can reinforce the avoidance of emotional expression in men more generally:

A man, we are told, is to stand on his own two feet, apart from the crowd, unbent either by the opinions of others or by untrustworthy feelings. (p. 75)

An experience like prostate cancer threatens to disrupt traditional masculine behavior when insecurities surface and emotional support is needed. In the extract above, the disclosure that took place during the interview might have provided some degree of catharsis. This became evident when he told me that he had not discussed his experiences with anyone else prior to our meeting, despite the fact it had been 2 years since his surgery. His reaction corresponds to the form of masculinity that Johnson (1992) describes:

Men are characteristically encouraged to become so indifferent to their own perceptions and needs that they are ready in a moment to follow the directions of their commanders or bosses. The soldier and worker

are disciplined to detach themselves from their bodily feelings so that they can carry out their tasks obediently, without the distraction of those human impulses that might counter the needs of war and profit. The scientist is thought to require freedom from the sway of impulses that might contaminate his experimental conclusions. While advocates of biomedicine asserted the authority of empirical reason against religious authority, they retained religion's detached attitudes toward the natural world of the body, the physical environment, and women. (p. 78)

Changes to the physical body were the means by which these men made sense of cancer and the existential threat they faced. By reflecting on the former self, or considering the fates of other men, they came closer to comprehending their own situation. The importance placed on particular facets of embodied competence, such as sexual function, was dependent on the extent to which they impinged on self-identity in relation to the threatened self.

Although Watson's (2000) work emphasized the importance of a "pragmatic male body" that functioned sufficiently well for "normal everyday life," insights from men like the one discussed above suggest that prostate cancer not only results in a changed body, but can also lead to a disruption of traditional masculine emotional control (Seidler, 1998).

Professionals' continued emphasis on preserving urologic and sexual functions (particularly during decision making consultations) emphasized the way that side effects were balanced against the value placed on these embodied aspects of masculinity (Haiken, 2000). This was weighed against stressing that men should also be dissuaded from blaming themselves for missing the initial symptoms of cancer, or for failing to take better care of their body. As one of the professionals said,

I think the worst thing for anybody with cancer is to look back and say, "If only I'd done this it would all have been different." I think that's an awful thing. Obviously everybody does that and tries to put a reason to it, why it's happened and rationalise it, but I think we try to prevent as many "if onlys." I think it's still important that they don't take full responsibility for that, you then hate yourself as well as having to deal with cancer, and you think it's your fault.

This provides evidence of a uniquely gendered caring/supportive role which the professionals adopted in this setting. Emotional care of the men was directed mainly toward embodied threats arising

from the cancer and its treatment. Help was focused on supporting such “changed men” to see a way forward, rather than looking back with regret.

This contrasts with the standard “do-it-yourself” approach that Beck (1994) claims to be characteristic of the present risk society. Although self-determination and collaboration were certainly features of this setting, the professionals also provided support that was seen as “appropriate to men.” This involved the professionals in a form of emotional labor that was shaped by particular needs of men, and suggested that a particular form of gendered caring was taking place in the clinic (Hochschild, 1983). One of the men, for instance, recounted how the professionals encouraged him to endure radiotherapy, despite the fact that he was experiencing a number of significant side effects including the leakage of feces, rectal bleeding, impotence, and fatigue. They helped him to look forward and shared the goals of the treatment with him:

Participant: They said your life span would be cut short, but they didn’t give the stage, they didn’t say how many years it would be cut short, you know, so I thought I can’t live forever. So when I had the results they showed me that luckily mine had been contained. They said hopefully after radiotherapy there will be a better life for you and, hopefully, you will be back to normal again.

Interviewer: What, for you, is a good quality of life?

Participant: Being back to normal, you know, then I start thinking about the cancer again, but I can’t, just forget about it. It’s gone, finished, you know, you see?

A New Male Identity

For the majority of the men, their “new body” was marked by its limitations and inability to function as it had before. Although the professional responses to such changes have formed the focus of much of the psychological research (particularly in terms of the impact on mood or quality of life), more personal accounts are rare except within the self-help literature. Impotence, in particular, was a key concern for most of the men. Whereas some chose not to discuss the impact of this outcome in any depth, others provided deeper insights into this relinquished aspect of masculinity (Potts, 2000). When disclosure did occur, this confirmed Johnson’s (1992) point that

A man can learn to discern those critical moments when that image interferes with his values. In the

moment of being noticed, those artificial boundaries lose their grip. (p. 79)

The dynamics of each interview, and the relationship I managed to establish with each man, probably influenced the extent to which such intimate concerns were revealed. The legitimacy of impotence as a topic for discussion, for instance, varied from man to man, and some chose not to discuss it in any depth with someone who was, after all, not directly involved in their care. It is also possible, given the complexity of masculinity and how it is played out in particular social contexts, that disclosure might have been perceived as allowing me to judge them as less “masculine” than myself. Qualitative research such as this highlights the importance of remaining aware of the relationship between the public and private selves, and the challenge of raising sensitive or taboo topics in an interview situation. Following this experience, I would support the value of employing additional methods, such as observation or longitudinal designs, when such issues are being explored.

The data also revealed the extent to which the men’s concerns had changed in other ways. These are considered in relation to Giddens’ (2001) point that certain “lifecourse crises” play significant roles in shaping dynamic (re)constitutions of the self:

A “crisis” exists whenever activities concerned with important goals in life of an individual or a collectivity suddenly appear inadequate. Crises in this sense become a “normal” part of life, but by definition they cannot be routinised. (p. 184)

The “crisis” of prostate cancer has been demonstrated to challenge fundamental aspects of masculine embodiment such as continence and sexuality. As a result, men emerged from the experience with different perceptions. As Giddens (2001) also argues, reactions to such events will be shaped by past experience and the extent to which an individual’s role can be recovered. The range of reactions to the threat of impotence or incontinence, even in this small group of men, illustrates this point well (from stoical acceptance to preservation of the function, above all else).

When the wider consequences of cancer were also considered it became apparent that some men had also started to question fundamental assumptions about masculinity, and life itself. This finding concurs with Gordon (1995), who interviewed survivors of testicular cancer and noted that men displayed reactions ranging from traditional stoicism to more

overt expressions of loss and insight into their own, and other men's, suffering.

Seeing Other Men in the World

The experience of cancer seemed to play a significant role in provoking men to question fundamental aspects of their gendered lives. This was illustrated on several occasions when I asked them whether, and in what ways, prostate cancer had affected them. As had been the case throughout, some were more open about this issue than others. Several suggested that prostate cancer had led them to question the traditional masculine role and, in some cases, this was replaced by new awareness of vulnerability. This point usually emerged in discussions about the need to raise more awareness about prostate cancer, as well as the lack of support that had been available during treatment.

One man, for example, had decided to write a book about prostate cancer to explain it to other men. This reflected his perception of male cancers being poorly understood, as well as his questioning of socialization practices that discouraged men from acknowledging frailty. Reflecting on his own experience, he gradually challenged a situation that, in his own words, had required the establishment of a "cultural grammar" of prostate cancer. He emphasized how, for some men, a diagnosis of prostate cancer was itself tantamount to an admission of defeat:

I think it's basically the whole upbringing. I mean I'm exactly the same, I go back twenty years to my old uncle. I hadn't even thought of mentioning it to him, far too embarrassing really, no way! It never crosses your mind to talk about it, or think about it. And I think even now we grow up with it, you know, you can't burst into at the dinner table or when you're in the pub with a few fellows and you say, "By the way, any of you fellows suffering because you can't pee properly?" You don't do that. You can't say that, you know, well you could, but it never comes into your mind to bring it up, you know.

Such sentiments reinforce the link between the sequestration of prostate cancer and the personal impact of being given the diagnosis. These subjective views of the experience also add a new level of explanation for the mood changes often described in the psychology literature. However, his response also suggests that some men do question traditional constructions of masculinity and express the desire to change things for the better. Taken together, the embodied and

emotional impacts of prostate cancer emphasize that personal constructions and experiences of masculinity are far from static. Instead, they are primarily reflexive, and emerge primarily from concerns of self-identity and personal ontology (Giddens, 2001). These data also illustrate how relationships with other men also came to be questioned as a result of having shared a common experience. Others questioned why they had shared their feelings with so few people.

One of the most important findings in this regard was that the interviews offered the first opportunity for many of the men to talk about their cancer in any depth. An obvious exception was one man who already belonged to a men's group, and was undertaking psychotherapy training to explore his personal reaction to cancer. His view of masculinity had shifted as a result of witnessing other men during his stay in hospital. From his vantage point as a more "self-aware" man, he talked about the way men reacted to finding themselves in extremis. To him this had suggested the existence of a form of "male dignity" in the face of impending death:

One thing I haven't mentioned as a man is what a rewarding experience it was actually being in the ward I was in. Whether that was particularly because of the group of people that were there at that time I have no way of telling, but seeing one or two of the other people in that ward and the way they coped with their cancer really made me realise how necessary it is to be open about these things. There was a young boy who came in with testicular cancer, 19 years old, he went to the doctor because he had a cough and he had no idea, he was totally just, gob-smacked—a hockey international. There was a man of eighty-two and he was dealing with it with such dignity and such inner strength it was a revelation to me it just seems a shame that you need something like cancer to focus men's self-worth in a way. You see the real essence of the men and not the shell that we put on because we're all stripped naked, we're all there with tubes sticking out of us. It just seems unnecessary for them to have to go through all that to learn and understand themselves and [be] able to be honest with themselves about what is really important to them.

This account is poignant in suggesting a dimension of masculinity that has received little attention. This description of life in the hospital ward suggests that there might be potential in questioning this issue further in relation to masculinity, and how it is played

out in specific illness contexts. The male self within the cancer ward requires vulnerability and dependency to be both experienced and managed. A “changed” form of masculinity emerged in these contexts, without many of the traditional facets of “competence and force” described by social theorists such as Connell (1987) and Seidler (1998). Men in the cancer ward had certainly changed and were coping with a more “natural” masculine self in response to physical (and emotional) threat.

Professionals also spoke of the subtle, yet important, changes they had noticed in the men they worked with. They stressed the importance of establishing trusting relationships to overcome communication barriers. For example, one of the nurses talked about learning not to expect immediate emotional disclosure from men. Instead, she employed particular conversational strategies similar to those witnessed in the diagnostic and decision-focused consultations:

Sometimes I think they do open up. When people come into hospital or when they come to the ward, you go through an admission process. There are set questions you ask and you would then elaborate on those questions. Once you get into things like looking at urinary symptoms and start discussing that, people will talk about how long it's been going on for and how they've adapted their lives to fit around that, so people start opening up to some degree.

The account above of the young man with testicular cancer finding himself alongside older men who were dying “with such dignity” also suggests the emergence of a paradoxical and complex form of changed masculinity. Hospital life requires the adoption of different gendered rules from those in society, and new states of masculine embodiment must be accommodated (described by one of the participants as “men with tubes sticking out”), which become the norm in the context of the cancer ward.

Discussion

This article has demonstrated that the changes brought about by prostate cancer are unique and multifaceted as men respond to the experience. Although this should limit the use of blanket generalizations, men's support needs do need to be addressed in a practical sense. This is already happening, as witnessed by the fact that professionals provided support in response to the needs of individual men in specific situations.

Following treatment, men sought ways to strengthen their bodies and to preserve, or restore, aspects of their former physical selves. In the majority of cases the ability to cope with physical change relied on being knowledgeable about their cancer, and to some extent, being in control of the decisions to be made concerning treatment. Whereas many were able to negotiate this process successfully, those who had lacked control directed considerable anger and frustration toward a medical system that they felt had failed them. The open nature of decision making in the clinic was significant in terms of promoting outcomes that would be acceptable to individual men; impotence and incontinence were the most important concerns in this regard.

Though limited to one group of men in one geographical location, the insights from this study also suggest that the experience of prostate cancer led some men to question traditional forms of masculinity. Gender might be considered one of the main anchoring points for the individual in society; however, the insights gained from witnessing the suffering of other men during treatment had contributed to new insights of their own, as well as others', vulnerability. Other men, however, were more concerned with maintaining privacy and dealt with the embodied and emotional costs of prostate cancer in isolation. These data suggest that there might be value in questioning the role of gender in other illness contexts and situations (including the gendered dimensions of physical frailty and dying). These and related topics exploring the physical, social, and emotional impact require further attention from researchers.

Finally, these findings suggest that the existential threat of cancer resulted in men questioning their priorities in life, and focusing on the future with new insights and hopes. The fact that most participants were older increased the likelihood that they had already been exposed to the deaths of friends or partners. As a result, dying had become a familiar and inevitable reality. Some men reflected on their future in a fatalistic way and seemed to accept that, despite the professionals' best efforts, they would succumb to their cancer eventually. As one of them said,

I mean if I said to you or you said to me you've got an hour and a half and then you're going to die, I don't think anybody can really help you, finally you have to do it yourself. I mean, I certainly got depressed, I sort of slowed down and didn't want to do that much for a while, but in a sense you're just assimilating it, don't you think?

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