

Constructions of masculinity following prostatectomy-induced impotence

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Abstract

Large numbers of Australian men are diagnosed and treated for prostate cancer each year. The incidence is exceeding mortality, and men are living longer with prostate cancer and the common treatment[s] side effect of impotence. Despite these epidemiological trends there is little research about men's experiences of impotence following treatment. An ethnographic study of Anglo-Australian men with localized prostate cancer explored participants' experiences of impotence following prostatectomy. In-depth semi-structured interviews with 15 men were analyzed using a social constructionist gendered framework. In particular, the effect of impotence on participants' masculinity, sexuality and intimate relationships was explored. The findings show that participants rationalized forgoing potency prior to surgery as a way of living longer. However, diverse complex reactions accompanied impotence. Whilst most participants redefined masculine ideals of phallocentric sex, the way in which this occurred varied greatly. The findings disrupt essentialist constructions of male sexuality and impotence, and provide valuable insight for clinical practice.

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Introduction

Apart from non-melanoma skin cancer, cancer of the prostate is the most commonly diagnosed cancer in Australian males (Cancer Council Australia, 2001). Although the cause of prostate cancer is unknown, Australia's aging population is likely to result in increased numbers of men being diagnosed and treated for prostate cancer. Many men are also living longer with prostate cancer, as indicated by the death rate which is significantly lower than the incidence rate (Australian Institute of Health and Welfare (AIHW), 2000). Current trends in the epidemiological data suggest that, in the future, greater numbers of Aus-

tralian men will be living with prostate cancer and its treatment side effects.

Prostatectomy (surgical removal of the prostate gland) offers the best prognosis for localized prostate cancer [cancers confined to the prostate gland that have not spread to other parts of the body] (Australian Cancer Network, 2001). However, treatment side effects can occur and the Australian Cancer Network (2001) estimates that the incidence of urinary incontinence is 5–35%, and impotence 30–90% following prostatectomy. Much of the research about prostatectomy-induced impotence is biomedical. In particular, there have been extensive reporting of the effectiveness of treatments such as vacuum erection device (VED), Sildenafil (ViagraTM), Alprostadil Intracavernosal (CavajectTM penile injections), topical gels and penile implants (Coleman, 1998) and men's treatment compliance (Bassing, 1998).

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Little research exists about men's experiences of impotence following prostatectomy (Butler, Downe-Wamboldt, Marsh, Bell, & Jarvi, 2001). A meta-analysis of 'quality of life' research by Meuleman and Mulders (2003) revealed a mismatch between the high rate of impotence and low impact on sexual quality of life reported by men following prostatectomy. One study suggested that men accepted impotence when initially diagnosed and treated for prostate cancer; however, most men experienced difficulties adjusting to long-term impotence (Yong, 1998).

Recently, researchers have begun to explore treatment-induced impotence using social constructionist gendered frameworks. A grounded theory study by Fergus, Gray, and Fitch (2002a) used a masculinity framework to investigate men's adjustment to impotence and found that most men redefined their sexuality and preference for penetrative sex when potency was lost. A narrative analysis of three men's experiences of prostate cancer and the connections with hegemonic masculinity was reported by Gray, Fitch, Fergus, Mykhalovskiy, and Church (2002). They concluded that impotence can "be a big deal for some men, and is at least a concern for most" (Gray et al., 2002, p. 55). Chapple and Ziebland (2002, p. 831) reported that prostatectomy induced impotence did not affect participants' sense of masculinity, and it was generally perceived as a "small price to pay".

Theoretical framework

Men's experiences of illness are increasingly being recognized as socially constructed and greatly influenced by how men and their communities define masculinity (Bergman, 1995; Charmaz, 1995; Connell, 1995, 2000; Courtenay, 2000; Gordon, 1995; Gordon & Cerami, 2000; Huggins, 1998; Moynihan, 1998; Oliffe, 2002). Central to social constructionist frameworks is the concept that masculinity is influenced by society, history, social class and culture (Courtenay, 2000). The type of masculinity the dominant group performs is referred to as hegemonic masculinity. Many men align with characteristics such as stoicism and sexual prowess, and seek to emulate hegemonic forms of masculinity that are equated with being successful, capable, reliable and in control (Cheng, 1999). Hegemonic masculinity also signifies a position of cultural authority and leadership (Connell, 1987, 1995, 2000), not just in relation to other masculinities, but in relation to the gender order as a whole. In summary, hegemonic masculinity represents the "culturally idealised form of masculine behaviour" (Connell, 1987, p. 83).

In the context of sexuality and intimate relationships, hegemonic masculinity prescribes that proper sexual activity must be initiated by a man and involve the

insertion of the penis into the female partner's bodily orifice (Lee & Owens, 2002). Most heterosexual men's dominant pattern of sex is erection, penetration and climax, which is due to "men's inability to express themselves and their lack of emotional language" (Metcalf, 1985, p. 4). Boys learn early that "their manhood is tied to their penis, and having and using erections has something to do with masculinity" (Zilbergeld, 1992, p. 32). The penis and testes are bodily signifiers of distinction from femininity (Martino & Pallotta-Chiarolli, 2003). Moreover, the size of a man's penis and its penetrative, ejaculate ability represents his masculine status and power (Edgar, 1997). Many married men have concerns about their penis being smaller than that of the average man (Lee, 1996), and Lee and Owens (2002) suggest that men's concerns about size inadequacy are widespread, and strongly influenced by cultural expectations.

Penis-centered sexuality can create confusion between personhood or identity and one's sexual organ, and when the penis does not operate according to dominant ideals, men equate this with loss of manhood (Zilbergeld, 1992). Physical performance forms the basis for this construction of sex, a version that relies heavily on sexual competence. Men who are unable to perform sexually are affected in deeply gendered ways, and embody marginalized, subordinate forms of masculinity that result in humiliation and despair (Flood, 2002; Lee & Owens, 2002; Tiefer, 1987). Male sexuality confirms gender and masculinity is enacted through sexuality. Therefore, failure to perform sexually can challenge the fundamentals of masculinity, and make heterosexual men believe they are not 'real men' (Kimmel, 1987, 1990).

There is a general expectancy that men should initiate sexual activity (Kilmartin, 2000; Lee & Owens, 2002), and that insatiable desire and libido are a measure of manhood in terms of the capacity for penetrative sex (Edgar, 1997). Failure to desire and initiate sex and enact dominant cultural expectations about men's sexual needs results in feelings of inadequacy for many men (Lee & Owens, 2002). In summary, hegemonic masculinity idealizes the embodiment of hyper libido and fantasy-based sexual equipment, functionality and performance, the inverse of which results in the "fiction" of a dysfunctional non-penetrative male sexuality (Potts, 2000).

Individuals differ in how strongly they hold hegemonic masculine attitudes and beliefs (Good, Borst, & Wallace, 1994) and there is no one pattern of masculinity, but rather plural masculinities based on different cultures and periods of history that construct gender differently (Connell, 1995). Connell rejects the construction of sexuality based on the notion that the sexual encounter begins with an erection and ends with ejaculation. He labels this as phallicentric and argues

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