Culture, Health & Sexuality
An International Journal for Research, Intervention and Care

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/tchs20

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To cite this article: Anna-Maija Talvitie, Hanna Ojala, Teuvo Tammela & Ilkka Pietilä (04 Sep 2023): Prostate cancer-related sexual dysfunction – the significance of social relations in men's reconstructions of masculinity, Culture, Health & Sexuality, DOI: 10.1080/13691058.2023.2250410

To link to this article: https://doi.org/10.1080/13691058.2023.2250410

CULTURE, HEALTH & SEXUALITY
https://doi.org/10.1080/13691058.2023.2250410

Prostate cancer-related sexual dysfunction – the significance of social relations in men's reconstructions of masculinity

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ABSTRACT

Narrating illness experiences in a culturally acceptable manner is essential for retaining quality of life after the disruptive event of being diagnosed for prostate cancer. Psychological pressures caused by treatment side-effects such as erectile dysfunction require reinterpretation of the meanings and impacts of these side-effects on masculinity. This helps maintain coherence in men's lives. We studied how men employ culturally available discursive strategies (compensation, redefinition, recontextualisation, and normalisation) in reconstructing masculinity and sexuality. Our data consists of 22 interviews of heterosexual Finnish prostate cancer patients who had undergone surgery. The aim was to analyse the ways in which various life situations and social relations shaped and limited the use of these strategies. Discourse analysis revealed that older age, a supportive spouse, children, supportive male friends, and good health – were key elements men used in reconstructing a coherent new self-image and conception of life following cancer treatment. Men with sexually active male friends, men without families, younger men and men with new intimate relationships struggled to develop a new version of their masculinity. Being able to effectively utilise certain aspects of one's life situation in re-constructing masculinity is important in maintaining quality of life despite troublesome treatment side-effects.

ARTICLE HISTORY
Received 17 April 2023
Accepted 17 August 2023

KEYWORDS
Masculinity; prostate cancer; erectile dysfunction; health-related quality of life; discourse analysis

Introduction

When experiencing chronic illness, many taken-for-granted features of everyday life become disrupted, both in terms of daily practice and plans for future. A chronic disease involves, to a variable degree, recognition of suffering, and even the possibility of death, which are normally considered only as distant threats to one's life (Turner and Kelly 2000). Prostate cancer offers an example of a chronic disease that poses emotional and psychological challenges for patients and threatens their experience

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of quality of life (qol) (Spendelow et al. 2018). Feelings of helplessness, a lost sense of immortality, and an unsatisfied need of control are examples of emotional harm related to the disease (Arrington 2003). Men with prostate cancer also face stressful episodes, starting with cancer diagnosis and treatment choice. Even after treatment, fear of cancer recurrence and uncertainty regarding recovery from treatment side-effects remain a psychological challenge (Shaha et al. 2008), which leaves men in a liminal state where the uncertainty may disrupt one's life profoundly (Pietilä et al. 2018).

Prostate cancer is the most prevalent cancer in men worldwide (Ferlay et al. 2020). In Finland, where this study took place, every year over 5,200 men are diagnosed with prostate cancer, with the incidence rate being 195/100,000 in this population in 2019 (Finnish Cancer Registry n.d.). In localised prostate cancer where cancer has not spread outside the prostate gland, treatment options include surgical removal of the prostate (prostatectomy), radiation therapy and active surveillance with no immediate treatment. Radical treatment options commonly cause erectile dysfunction and urinary incontinence that pose significant challenges to patients' qol (Spendelow et al. 2018). Incontinence often leaves patients feeling powerless, whereas erectile dysfunction restricts or at the very least redefines sexuality (Arrington 2003). Coping with these possible functional limitations and other difficulties related to the illness may require changes in patients' lifestyles and aspirations (Turner and Kelly 2000).

Initially, when prostate cancer is diagnosed, many men tend to accept the possibility of erectile dysfunction as a risk worth taking (Oliffe 2005; Fergus, Gray, and Fitch 2002). Meuleman and Mulders (2003) suggest that men with prostate cancer trade-off the chance of erectile dysfunction against their chance of recovering from cancer. This view simplifies treatment choice into a simple cost-benefit analysis in which life comes with a price tag, the price being sexual functioning. However, sacrificing one's potency for a longer life is never as simple as it first appears. Sexuality is not an isolated phenomenon but rather an integral component of a man's identity and lifestyle (Fergus, Gray, and Fitch 2002) which is not easily set aside.

According to Oliffe (2005), men's experiences of illness and treatment side-effects are influenced by how society and men themselves define masculinity. Although masculinities are multiple, in Western cultures (heterosexual) men's sexuality is largely defined in terms of the ability to engage in penetrative intercourse. As a result, some prostate cancer patients may believe they are no longer real men if they are unable to have penetrative sex. Hegemonic masculine ideals suggest men must be naturally virile and powerful (Oliffe 2005). In Arrington's interview study (2003) some prostate cancer patients rejected erectile aids because they wanted to maintain an ideal of 'real sex' and 'real men' as naturally potent. This kind of standards for sexual performance may threaten the sense masculinity of a man experiencing sexual difficulties (Fergus, Gray, and Fitch 2002).

However, contrary to the earlier discussion, reviews such as the one conducted by Meuleman and Mulders (2003) have identified an incongruity between a high level of erectile dysfunction and its relatively low impact on sexual qol. It seems to us that the reduced or lost ability to have an erection itself does not determine the experience of qol for all men. What seems to matter is the extent to which men are able to come to terms with such a change. As prostate cancer diagnosis, treatment and subsequent change can have a major effect on a man, both mentally and physically,

an individual's life story needs to be reconstructed in a way that brings the disease into alignment with other aspects of life.

Discursive strategies in narrative reconstructions of masculinity and life with illness

This study draws on previous work by Gareth Williams (1984) and his theory of narrative reconstruction, which suggests that individuals have a need of sustaining a coherent life story, or narrative, describing an orderly sequence of facts concerning what initially happened in their lives and what then subsequently occurred. Events, such as a death in the family or serious illness may cause this narrative to be broken and one's life course to be lost for a time. Chronic illness, such as prostate cancer, is a disruptive event in which narratives require reconstruction in order to cope with the consequences of the disease (Williams 1984). Coping with chronic illness is a cognitive process in which an individual learns to tolerate its effects in a manner that enables coherence to be maintained, despite the disruptive experience of illness. Confronting chronic illness requires individuals to re-examine the expectations they hold for the future, and, to rethink their biography and self-concept (Bury 1982, 169).

Several diseases are known to cause challenges for men's identity and sense of masculinity. As O'Brien, Hart, and Hunt (2007) have discussed, especially in the case of prostate cancer, coronary heart disease and depression, some men negotiate aspects of masculinity to cope with the medical and psychological consequences of the disease. These negotiations necessitate redefining certain aspects of manhood so that perceived threats no longer jeopardise a man's sense of self (O'Brien, Hart, and Hunt 2007). Previous studies of men's health have also highlighted the importance of certain linguistic strategies that play a crucial role in men's attempts to make sense of their illness. These discursive strategies (Gannon et al. 2010), include compensation (De Visser, Smith, and McDonnell 2009), recontextualisation (Pietilä et al. 2018), redefinition (Oliffe 2005; Fergus, Gray, and Fitch 2002), and normalisation (Gannon et al. 2010). For men to be able to narrate their illness in a way that does not threaten their sense of masculinity, issues such as erectile dysfunction and the meaning of sexuality need to be framed in a way that stresses the positive side of life while not denying the existence of trouble.

At the core of narrative reconstruction is the idea that illness and its consequences need to be positioned in a revised life story (Williams 1984). Such narratives are not constructed in a social vacuum, and in narrating their illness people must find a place for it not only in their personal lives but also in their social relationships. This is especially relevant to prostate cancer, which most often affects men's sexual lives. Therefore, the use of discursive strategies mentioned above vary across different social situations. Narrative reconstruction is closely linked to the wider social environment and its norms defining how masculinity may be represented, and which features and values can be attached to manhood. Social relationships may thus become either essential elements of a narrative reconstruction of a man's life or, alternatively, factors that make it difficult for man to construct a positive interpretation of life following prostate cancer treatment.

Men's experiences of prostate cancer, its side-effects and sexuality have been approached from a narrative perspective in previous work (e.g. Arrington 2003; Pietilä et al. 2018). Instead of wider narrative structures of men's narration of their illness, in this qualitative study we focus on the four discursive strategies described above that are often the crucial elements and turning points in men's accounts of their condition. The aim of this study was to analyse the ways in which various life events and social relations shape and limit the use of these strategies. We also consider how the ability to narrate an illness experience in a socially acceptable ways may be connected to men's perceived qol.

Materials and methods

Participants

Study participants consisted of 22 Finnish prostate cancer patients, who had undergone surgery and were interviewed one year afterwards in 2012–2013. Men were recruited by phoning them personally after they had participated in a one-year post-surgery visit to a University Hospital. All invited men reported having both erectile dysfunction and urinary incontinence and were either very satisfied or very dissatisfied with their lives based on an initial survey concerning the prevalence of treatment side-effects and self-rated qol. Our primary interest was in why some men were satisfied with their lives while others with the same symptoms were dissatisfied. The men who accepted the invitation gave written consent after receiving information about the study. The final number of interviews that took place was based on data saturation.

Interviewees' age ranged from 55–71 years at the time of interviews with a median age of 63 years. All men were white and heterosexual. All men had had a radical prostatectomy, and, in addition, one patient had received radiotherapy and hormonal therapy. The interviewees had different life situations: 13 were married, nine were unmarried of which six were either single or divorced. Most men ($n = 16$) had grown-up children. Only three interviewees had no children. Ten interviewees were still working at least part-time at the time of the interviews, whereas 12 men had already retired. The participants came from various occupational and educational backgrounds.

Procedure

The interview data were gathered as part of a larger multi-method study concerning patients' quality of life after cancer treatment which had been approved by Tampere University Hospital Ethics Committee (4/17/2012, R12025). All interviews were digitally recorded following written informed consent from the interviewees, transcribed verbatim by a professional transcription service, and validated by the study investigators to ensure accurate and complete transcription. All the names used in the data excerpts are pseudonyms.

The individual semi-structured open-ended interviews, that lasted for an average of 67 min, covered multiple topics regarding qol and everyday life with cancer. Most interviews began with an open-ended question about the participant's overall state of health and men were then encouraged to describe their experiences from cancer

diagnosis through treatment to the present. Participants were asked about the process of making treatment decisions, experiencing treatment side-effects, recovery from treatment, and the social effects of cancer. An important topic focused on in the interviews was sexuality and how it had changed after cancer treatment.

Two female researchers conducted the interviews at university premises. The interviewers' gender and younger age may have influenced patients' manner of answering questions that were of a sensitive nature. However, as qualitative researchers we accept the fact that the researcher always affects the field one enters. Considering the richness of the data elicited, especially regarding sexuality, we assume that talking to a woman was considered relatively easy.

Analysis

We used critical discursive psychology (Edley and Wetherell 1997; Wetherell and Edley 1999) to understand how men utilised shared discursive strategies in (re)constructing their masculinity in their speech and how the social environment either supported or restricted the use of various cultural resources. This approach is based on the notion that when people describe their lives, their talk is not only informed by 'ready-made or historically given set of discourses or interpretative repertoires' but these cultural resources are 'manipulated and exploited within particular rhetorical or micro-political contexts' (Edley and Wetherell 1997, 206). Throughout the analysis, we thus explored broader collective sense-making that the men draw on when verbalising their personal experiences. But alongside this we paid attention to how such discourses were adjusted to 'local pragmatics' of the interactional context (Wetherell and Edley 1999, 338) of social relationships in these men's lives. In other words, our analysis focused on how phenomena such as men's sexuality and masculinity are 'talked-into-being' in relation to their interactional and social functions (Nikander 2008).

The first stage of analysis focused on patients' descriptions of living with the treatment side-effects, and how these symptoms possibly affected their experience of being a man. The analysis was then directed to how the men described their everyday experiences of coping with changed sexual functioning as urinary incontinence seemed to exert less influence on men's conceptions of masculinity in our data. Based on multiple readings of the transcripts, the first author conducted an open coding process. The coded data were then re-read to deductively identify discursive strategies that men used to support their descriptions of masculinity. This analysis led us to note that specific circumstances in prostate cancer patients' social lives played a significant role in the use of discursive strategies. These social factors that we allowed inductively to emerge from the data, were formulated as themes (age, intimate relationship, children, interactions with other men, and patient's health and lifestyle) which are apparent below and further considered in the discussion section of this paper.

Results

As mentioned above, four discursive strategies (redefinition, recontextualisation, compensation, and normalisation) were widely used by the 22 prostate cancer patients.

In Mikael's interview, all four strategies were used simultaneously. Mikael was a retired man, who had been married for 46 years. Prior to the following interview, Mikael had told the interviewer that before surgery, he and his wife had had 'a normal sex life', but after losing his erectile ability, they ceased sexual activity. In the excerpt, it is evident how having children, grandchildren, and a long relationship, and being already older became essential elements of his reconstruction of masculinity and a new gendered life story.

Excerpt 1 (Mikael, 67 years)

Interviewer: If you think of sexuality, what kind of a meaning does it have, in your life? If you think about the past and present.

Mikael: Well, we have two girls who both have families. And the older one has four children, you know, there are two girls and then two boys who are twins. And the younger daughter, she has a son. We see each other like very often, although we have some 40 kilometres between us. Despite this, we are often in touch […] So I don't see it anymore as … Like back in the day, when we were younger, those issues were certainly in order but it's not anymore … I don't see it that way, like as it is any acute thing anymore. Now we are already in such a stage of life where we are. And I think our family matters are okay.

Interviewer: Right. If you think about age and sexuality, how does the meaning of sexuality change with ageing?

Mikael: Well, it [sexuality] certainly declines, just naturally, I would assume. And at least for us. [.] When we get this cancer treated, if possible, I consider that a lot more important thing than [sexuality]. Certainly, anything can cause you trouble if something doesn't work anymore. But I don't consider it a top priority anymore [short laugh]. And the wife doesn't consider it either, we have talked about this. There's nothing, we don't see it that way. I think everything is fine.

Here, Mikael uses several discursive strategies simultaneously to explain why sexual activity is not a significant part of his life anymore. He constructs a new masculinity of an elderly man by *redefining* both erection and intimate relationship in a way that makes the ability to have an erection less important. He also puts erection *into a new context* of a severe illness, which makes erectile dysfunction seem a lesser problem compared to losing one's life. Talk about the family in the context of sexuality is a way of placing erection into the context of the lifespan, where erection is only needed in the years of reproduction. Mikael *normalises* the decline in sexual activity as an age-related issue and claims it happens naturally. He also uses his children as a means of *compensation*, as proof of his earlier masculine prowess.

Mikael's description of his current life is convincing because he constructs a solid new masculinity after losing his erectile ability. His material and social environment (his age and marriage, together with having children and grandchildren) enable him to effectively use discursive strategies as key elements in a story of an older man, who has done several important things in his life. In this story, erection loses its significance, and even become a trivial issue. However, the discursive forms of constructions varied between individual men and their individual life circumstances. Examining our data further, we next discuss the strategies deployed by other

interviewees, including redefinition, recontextualisation, normalisation and compensation.

Redefinition

Previous research has noted that men can control the uncertainties related to recovery from erectile dysfunction by redefining erection and describing the self as having a peaceful older man's life in which sexual activity plays a lesser role (Pietilä et al. 2018). Interviewees used two types of redefinitions to re-construct their masculinity. First, as noted by Pietilä et al. (2018) and demonstrated in Mikael's excerpt, talking about one's children in the context of sexuality redefines sex and thereby erection as means of reproduction, not for personal pleasure or intimate relationships. When Mikael notes, 'we are already in such a stage of life where we are …', he demonstrates to the interviewer that sexuality and the ability to have an erection are irrelevant to him at this age. Ilpo too (56 yrs.) distanced himself from the young men to whom erectile ability is crucial when he said, 'I'm glad that I'm not a twenty-something lad with an entire life ahead of me. After all, I've had kids and seen life and experienced so much that I can just cross my hands and be thankful for all that I've received'. Redefinition of erection is thus based on distinguishing between men's different age-based identities. Second, heterosexual intimate relationships were also redefined to some extent. Some men described how, after cancer treatment, their relationship changed from a sexual one into something more caring, where the focus was on daily living and shared activities with the spouse.

In men's descriptions of their spouses' reactions to erectile dysfunction, a supportive partner was described as someone who did not expect sexual activity, did not comment on lack of sex or erections, and did not demand getting the erectile dysfunction treated. Such redefinitions of relationships allowed men to redefine the meaning of erection so as to fit in with an older-man-happily-married storyline. However, these kinds of redefinitions were based on both the man's and the spouse's acceptance of a change in their intimate relationship.

Sometimes interviewees' social environment did not allow for these new constructions. In Torsten's case, his wife's wish to maintain an active intimate relationship prevented Torsten from using similar process of redefinitions that Ilpo, Mikael and other interviewees used.

Excerpt 2 (Torsten, 60 years)

Interviewer: All things considered, is the erection such a major part of being a man?

Torsten: Well, it probably is. Thinking about it, for me at least, as I see it, that if my life partner is ready for it and stuff, when you're unable to do anything. Then you could say it's like if you needed to walk but your other leg was taken from you. So, in that sense, it's a big issue. It's not the main thing in life, but well, it's one big, big issue there in the background.

Those men whose partners still wanted to be sexually active or who expected their partner to attempt to get an erection usually reported feeling guilt and frustration about the inability to please their spouse, as Torsten did. Redefinition of

erection or intimate relationship was thus not possible for a man if his female partner did not see the relationship as a mere caring companionship.

Recontextualisation

The linguistic strategies of redefinition and recontextualisation often overlap, but it is possible to theoretically separate them. While the redefinition of erection implied altering its meaning (from satisfactory sex life to reproduction), recontextualisation of erection and sex denoted change in the place of contrast. It proved possible to distinguish three types of recontextualisation of sex and erection in our data where the loss of erection was put into the new context of either lifespan, severe illness, or everyday life to relieve feelings of harm.

As mentioned previously, nearly all interviewees stated that an active sex life was part of a younger man's life, and therefore the ability to have an erection was no longer central to their masculinity at their current stage of life. This *lifespan context*, which leads the interviewee to adopt the role of the elderly man who no longer requires erections, appeared mostly in the same phrases that a redefinition of erection did (e.g. in Mikael and Ilpo's accounts). However, it may not always be possible to adopt the role of an elderly man in a story about illness. One interviewee, Johannes, described how he had been extremely sexually active before losing his erectile ability following prostatectomy, and enjoyed having sex with new partners. In the excerpt below, he tries to explain that sex is part of a younger man's life. However, this leads to a somewhat contradictory statement as Johannes also expresses the desire to be as sexually active as before the cancer treatment. His account thus includes two different, and potentially contradictory, constructions of a masculine self.

Excerpt 4 (Johannes, 69 years)

Interviewer: How do you feel these things have changed after the operation? Does it feel like a problem or is it something that feels OK to you that has occurred as a side-effect of the operation?

Johannes: It's not a major problem, as I suppose that at seventy you should be quieting down anyway, so that it [laughs], in that way it hasn't been a significant problem. Although, it does get on my nerves sometimes that I had to give up such a good hobby.

Interviewer: What you said before… that at a certain age you should be calming down or how you put it, then what do you think about age and sexuality, like, does it change with age or does your attitude change in some way? Or how does age affect it?

Johannes: Well, at least with me, it hasn't affected it in that way. It's been more that these, should we say life circumstances and partners and things like that that have affected it more than age.

In the above account, Johannes oscillates between two goals. He mentions his age and expresses the idea that at his age a man's sexual desires 'should be quieting down', thus aiming to recontextualise these desires by locating them to a younger age. But being a single man does not provide him with the opportunity to adopt the role of an older man in a happy relationship. His attempts to

recontextualise sexual activity do not therefore have a satisfactory ending. This kind of trade-off between a new context and old desires was evident in several interviews.

A second type of recontextualisation positioned consideration of erectile dysfunction within the *context of a severe life-threatening disease*. Men often said that when they were first diagnosed with cancer, they had to choose 'which is more important, life or love life' (Keijo). Compared to the risk of dying from cancer, losing one's sex life seemed like a lesser problem. Keeping this new context in mind was associated with treatment satisfaction in the men's accounts. In our data, men who did not share this mode of verbalising their experiences regretted their treatment choice to the extent where one man (Unto) stated that he would rather be dead in a few years if he were able to remain 'a real man' until then.

The third category of recontextualisation related to positioning sex and erectile dysfunction in a broader *context of things offering pleasure in everyday life*. Many men concluded that even before their cancer treatment, sex had only been a small part of their everyday life, with a minimal amount of time devoted to sexual activities. This context was evident in phrases like: 'There's so much more to life than rolling around in bed' (Alpo). Through describing everyday tasks, housework and holiday trips they shared with their partners, such men stressed that they only lacked a very small part of their earlier life and relationships.

Normalisation

As previous research has reported, for many men tolerating the loss of an earlier sex life may become easier and less threatening in terms of manhood if a decline in sexuality is considered a normal part of ageing (Gannon et al. 2010; Gray et al. 2002). In our data, erectile dysfunction was not normalised as something that many men face at certain age, but as noted by Gannon et al. (2010), and as shown in Excerpt 1, men might normalise decline in sexual activity as an age-related issue, particularly in long-term relationships. This aligns the speaker with a large number of elderly men in a similar situation. Belonging to a male group that accepts the idea of a decline in sexuality being part of the ageing process, was often described as being important for adaptation to treatment side-effects. Men referred to other men's stories about sexual decline as an evidence of changing sex life as a part of normal life-course, instead of an individual flaw.

Once more, however, this discursive strategy was not available for all men. Some men concluded their social environment made it impossible for them to normalise ailments such as erectile dysfunction and narrate their illness in that company. In the excerpt below, Petri describes his struggle with avoiding talking about his erectile dysfunction at social events with his more sexually active male friends.

Excerpt 5 (Petri, 61 years)

Interviewer: Have you noticed it in other ways than in relation to sex, like you mentioned that it has kind of diminished your manhood, then is that visible in some other aspects of life?

> *Petri:* (–) Well males amongst themselves in groups they kind of, they express their manhood in one way or another [clears his throat]. And healthy men always talk about, all kinds of sex stuff and other such stuff… sometimes, not now, but in some groups, if someone starts it off. If you're in a group like that then it's better not to participate in that discussion. Other than talking about the past.

In Petri's account, social interaction in male company was described not only as a context that did not support the normalisation of erectile dysfunction but also an environment in which the disclosure of such ailments might lead to social exclusion. This was an example of a social environment in which erectile dysfunction carries a strong social stigma and therefore discursive strategies to deal with it cannot be used in similar ways to other contexts. Instead of explaining his situation to his friends, or trying to normalise or compensate his dysfunction, Petri actively chose either to stay silent or 'talk about the past'. If a man with erectile dysfunction is surrounded by men who emphasise their sexual activity and prowess, the only way to fit in with these local norms of masculinity is to conceal one's dysfunction. Such local norms make it difficult to verbalise an alternative version of masculinity.

Not being able to participate in a sex-related conversation or joking with friends was portrayed as a situation that highlights the harm caused by treatment side-effects and feelings of loss. Being a single man with a severe erectile dysfunction was also described as socially distressing, particularly in terms of meeting a potential partner. Kaino explained that if he meets an interesting woman, it's not possible for him to just declare, 'Yeah, so I've had cancer and the equipment isn't really working yet, so should we wait for six months'. Even older men with prostate cancer struggled with disclosing erectile dysfunction when meeting someone, as sex is often expected when developing a new romantic relationship. In such a context, there is little room for normalising erectile dysfunction and, as a result, single men often seem to lack the discursive resources with which to reconstruct a positive identity in their (sexual) relationships.

Compensation

As previous research on men's health note, men can create functioning, viable masculine identities by using competence in one masculine domain to compensate for lack in another domain (De Visser, Smith, and McDonnell 2009). For instance, ageing men may balance their declining physical capacity by stressing their knowledge and experience conducting physical work (Ojala, Pietilä, and Nikander 2016, 51). In Excerpt 1, Mikael's way of listing the number of children and grandchildren he had can be seen as similar compensation for a reduced masculinity. In respect of masculinity, children are rewards that designate that the man has once been 'a real man' who had continued his bloodline.

Two other interviewees with more severe cases of erectile dysfunction spent a significant amount of time describing their good health status and recent athletic achievements. One of these men was Johannes who said he had to end his 'extremely' active sexual life because of prostate cancer. Right from the start of the interview, he gave an exceptionally detailed description of his sporting pastimes and stressed the difference between his health status compared to peers of the same age.

Excerpt 6 (Johannes, 69 years)

Interviewer: Could we start with you describing your general health and what it is like at the moment?

Johannes: Ok, I'm an endurance athlete and participate in competitions every weekend except for this one. But I didn't get these bruises from sports, these are from the university law school alumni celebrations. But as an endurance athlete I run marathons and do all kinds of endurance sports all year round. The next three competitions coming up are ski orienteering competitions on Friday, Saturday and Sunday in Lapland. And from my age group, on average, only one in a thousand is in as good of a shape and able to compete. It's a different thing all together to compete in about ten different sports throughout the year. [lists all the sports]

Although this excerpt did not represent Johannes' or similar men's answer to a sexuality-related question, it seems that such men constructed their masculinity throughout the interviews by highlighting certain qualities that are traditionally considered masculine. These compensating strategies not only related to health status and sport, but also to social status, wealth, having a busy lifestyle, prior sexual activity, the number of children, and children's high social status. In Excerpt 6, Johannes demonstrates to the interviewer that he is an exception among men of his age because of his sporting prowess, 'one in a thousand', which ranks him above other men despite his sexual dysfunction. Using this strategy of compensation, both Mikael and Johannes managed to use culturally available discursive resources and storylines that are recognisable to people around them, to successfully reconstruct their own masculinity and life with illness and treatment side-effects.

Discussion

Literature on coping with chronic disease points to the sufferers' need to reconstruct a coherent story that situates the illness as part of their life (e.g. Williams 1984, 2000). While chronic diseases may generally threaten a person's sense of self, illnesses related to people's sexuality often influence patients' gendered identities. Therefore, prostate cancer has widely been reported to affect men's perceptions of masculinity (Tsang et al. 2019; Oliffe 2005; Gannon et al. 2010). From the perspective of narrative reconstruction, the more coherent a story that a man can develop regarding his life with treatment side-effects such as erectile dysfunction, the better he can psychologically cope with his illness. This, in turn, increases a patient's quality of life.

The aim of this study was to analyse how various social relationships and life situations shape the ways of utilising culturally available discursive strategies that men may employ to reconstruct their masculinity and self and create convincing and socially acceptable versions of their illness and its effects upon their lives. We identified five key features of the social environment and life situation that contribute to men's ability to narrate their experiences of erectile dysfunction.

First, as previous literature suggests (e.g. Oliffe 2005), perceiving oneself as an elderly man seems to offer an opportunity for reconstructing masculinity in the context of prostate cancer. By positioning themselves as older men, interviewees were able to redefine erection as a means of reproduction, recontextualise that ability to

earlier phases of lifespan, and normalise the decline in sexual activity as part of an inevitable process of biological ageing. Second, in men's accounts a supportive spouse plays an important role enabling both the redefinitions of erection and intimate relationships, in which the relationship becomes more caring and the emphasis is on a happy everyday life, instead of sexuality. Several men referred to the conversations they had with their partner in which the spouse expressed that they accepted the new sexual situation. These conversations seem to be significant turning points in men's sensemaking with respect to sexuality and masculinity and should thus be further studied. Third, having children was referred to when redefining erection as a means to reproduction or recontextualisating sexual activity into the youthful years. The number of children was also used as a compensation resource as children served as proof of earlier sexual capability. Fourth, the company and support of other men was often claimed by the interviewees to be important in coping with treatment side-effects. The experience of 'being in the same boat' is known to be essential in male friendships in the context of prostate cancer (Klaeson, Sandell, and Berterö 2013). Men in this study expressed an idea that having male friends who shared the same view of decline in sexual activity being a normal part of later life eased the emotional strain they experienced. As the men seem to have an idea of what is normal and what is 'normal sex life', as Mikael put it, it would be useful to study where these assumptions of normality come from as they affect the men's need to restore their masculinity. The fifth element that men accentuated in their descriptions of coping concerned the individual's own state of health and lifestyle. The men who were able to claim they were in better physical shape than peers of a similar age used these notions to compensate for the loss of masculinity they attached to erectile dysfunction. These five life contexts (older age, supportive spouse, having children, having supportive male friends, and having good health) enabled men to cope effectively with their condition. The more men that with prostate cancer were able to use these cultural resources and discursive strategies in narrating their life, the better qol and satisfaction with life they experienced.

However, not all prostate cancer patients have the same opportunity to use discursive resources to reconstruct their lives. While many older men were able to position sex as part of their earlier lives and better accept their current situation, there were seldom opportunities for younger men in their fifties, men without families and men in new intimate relationships to do so. The expectation and need to maintain sexual activity reduced their chances of developing a new version of their sexuality and masculinity. Another social context that did not support the reinterpretation of sexuality was the groups of sexually active male friends, where loss of erection triggered stigma and provided few opportunities to redefine the meanings of sex, sexuality and masculinity.

Taken together, our findings suggest that age and life-stage play an important role in men's ability to reconstruct their lives in socially acceptable ways. Previous studies have reported that older and married men report higher satisfaction with life after prostate cancer treatment compared to younger and single men (Chambers et al. 2017, Talvitie et al. 2019). Erectile dysfunction may certainly cause a threat to younger or single men's masculine identity, who face the pressures to maintain their sexual activity. For many men, taking the position of an 'older man' provides a secure social

identity, in which loss of sexual prowess is no more a sign of lost manhood. In this particular context, old age may become an advantage for men in their attempts to restore a masculine identity.

Previous studies of older men's sexuality (e.g. Sandberg 2013) indicate the existence of new alternative narratives on male sexuality and sexual practices that do not centre on erection and penetrative sex and are characterised more in terms of intimacy and closeness. A lost or weakened potency can push men and their partners into exploring newly satisfying alternative understandings of sex and sexuality (Andreasson, Johansson, and Danemalm-Jägervall 2023). However, there were no examples of this in our data. Quite the opposite, men who considered themselves sexually active, underscored the importance of erection and its direct significance for both heterosexual relationships and true masculinity. Only eight interviewees had used or tried using an erectile aid which underlines the ideal of a naturally potent man (Oliffe 2005). It thus seems that at least in our small sample of Finnish middle-aged and older men, conceptions of men's sexuality were based on a notably traditional understanding of masculinity.

Arrington (2003) has suggested that narrative reconstruction can help alleviate patients' feelings of deprivation when facing erectile dysfunction but, as a downside, it may also prevent men from admitting the loss and creating a new identity. Patient education can support the creation of new masculinities following the disruptive experience of prostate cancer treatment. It is important to offer psychosexual counselling for prostate cancer patients to support achieving sexual satisfaction and maintaining qol after the sexual changes. Our conclusion is in line with Klaeson, Sandell, and Berterö's (2013) suggestion of the need to include formal discussion of sexuality before, during and after prostate cancer treatment. This is especially important amongst prostate cancer patients who considered sexuality a crucial part of their lives already before cancer diagnosis.

Limitations

The interview data used in this study were gathered over ten years ago. Although surgical treatment options for prostate cancer have certainly developed during this time range, even the newer methods may cause erectile dysfunction. Moreover, perceptions of masculinity may be more diverse in more recent data. Because the ideals associated with hegemonic masculinity are still present in the Western society, and the strategies for reconstructing masculinity likely do not change that rapidly, we believe that our findings regarding men's coping with erectile dysfunction will still have relevance to similar groups of men. In this study, we examined heterosexual men's experiences on living with prostate cancer treatment side effects. Most interviewees were also married and had children, and all were white. These factors limit the diversity of our sample and hence generalisability. We encourage research on re-constructions of masculinity and sexual identity that considers the wider range of masculinities existing in Western societies.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This study was funded by Cancer Society of Pirkanmaa [12/28/2011] and Cancer Society of Finland [5/28/2014].

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