COUPLES COPING WITH PROSTATE CANCER: WOMEN AND MEN (RE)NEGOTIATING DISCOURSES OF GENDER, SEXUALITY AND INTIMATE RELATIONSHIPS

By

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Couples Coping with Prostate Cancer: Women and Men (Re)Negotiating Discourses of Gender, Sexuality and Intimate Relationships

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Abstract

This dissertation project investigates the ways in which men and their female partners navigate discourses of sex, gender, and relationships as they cope with recovery from prostate cancer and engage in penile/sexual rehabilitation. Study I involves a discourse analysis of online patient information sources for prostate cancer-related penile/sexual rehabilitation with a focus on how sex, erections, gender, patients, and relationships are depicted. Study II involves discourse analysis of in-depth interviews with prostate cancer survivors, female partners of men with prostate cancer, and couples, to explore the social norms and collective meanings they adopt when speaking about sex, their identity as a man/woman, recovery, and relationships. Analyses also explore discursive points of connection and discordance between the two studies. Penile rehabilitation is positioned in both studies as a medical imperative through close alignment with scientific empiricism. Sexual side effects (e.g., changes in erections) are framed in biomedical and mechanical terms, and penile rehabilitation is presented as a scientific and effective solution. Both Study I and Study II convey that one's health and recovery are largely individual responsibilities. Ideal patients are framed as

entrepreneurial, responsible, and informed in Study I, and Study II participants largely adopt these discourses. Online information sources situate sexuality within the realm of health and medicine so that changes in erections are positioned as medical issues best resolved using the expertise of medical specialists. The findings from Study II, however, challenge a purely biomedical or health-focused approach to erections. Many patients emphasize the relational and psychological aspects of sex and the inability of pro-erectile interventions to adequately address the injuries caused by prostate cancer treatment. Online materials from Study I reinforce narrowly defined views of masculinity/femininity and (hetero)sexuality. Masculinity and femininity are framed as complementary and distinct opposites, and intercourse is positioned as an essential sexual practice. Many participants frame prostate cancer as a major disruption to successful gender performance and to the sexual status quo. A number of participants resist medicalized/healthisized discourses of sex, and hegemonic masculine subjectivities. They espouse alternative definitions of what it means to be a lover and man/woman. Implications and recommendations are discussed.

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Table of Contents

List of Tables

List of Figures

List of Appendices

Couples Coping with Prostate Cancer: Women and Men (Re)Negotiating Discourses of Gender, Sexuality and Intimate Relationships

Prostate cancer is the most common non-melanoma skin cancer diagnosed in Canadian men (Canadian Cancer Society, 2015) and it is currently estimated that one in eight Canadian men will develop this cancer in their lifetime. Many of these men have partners and prostate cancer is commonly described as a couple's disease (e.g., Fergus, 2011; Gray, Fitch, Phillips, & Lebrecque, 2000). The most common treatments for prostate cancer are associated with subsequent changes in erectile functioning (Robinson, Moritz, & Fung, 2002), with estimated rates of treatment-related erectile dysfunction as high as 90% (Mulhall, Bella, Briganti, McCullough, & Brock, 2010). Penile rehabilitation clinics are beginning to emerge across North America to target prostate cancer-related erectile dysfunction in men (Hinh & Wang, 2008), as increasing numbers of men and their partners are living with the sexual side effects of treatment (Canadian Cancer Society, 2012). Despite the lack of expert consensus on many fundamental questions related to penile rehabilitation, it is being widely disseminated and implemented around the world.

This dissertation project investigates men and women's sense of self as sexual and gendered beings in the aftermath of treatment for prostate cancer. The focus is on the ways in which men and their female partners navigate discourses of gender, sexuality, and intimate relationships as they cope with recovery from prostate cancer treatment and engage in penile and/or sexual rehabilitation interventions. The project explores the ways in which men and women make sense of and navigate relationship and sexual changes, and the impact these changes have on their own sexual desire, pleasure, confidence, and

sense of femininity/masculinity. The project explores the interfaces between these shifting identities and experiences of men and their partners, and penile/sexual rehabilitation programs and information sources.

This project situates these accounts within the current sociocultural climate by examining the ways in which participants' narratives magnify broader social discourses of sex and gender. Two related studies were conducted. Study I involves a discourse analysis of patient materials on penile and sexual rehabilitation programs for men with prostate cancer. This study explores the ways in which penile rehabilitation is being positioned and legitimized to prostate cancer patients and their partners, and identifies cultural directives conveyed through this material about sexuality and gender. Study II involves discourse analysis of in-depth interviews with individual men, individual female partners, and couples to explore how men and women construct their sexual and relationship experiences in the context of prostate cancer, and what discourses (i.e., social norms and collective meanings) they adopt when they speak about sex, their identity as a man/woman, and their relationship.

Broadly, this project adopts a social constructionist theoretical and methodological framework (Burr, 2003). More specifically, a feminist poststructuralist approach is utilized (Baxter, 2003; Gavey, 1989; Weedon, 1987) to address the research questions.

Literature Review

The literature review will first situate the project within its core content area (i.e., relevant prostate cancer research) and will then situate the project theoretically and epistemologically through review of critical sexuality and gender research and

explication of the adopted theory and methodology. More specifically, the section begins with a general overview of prostate cancer in Canada followed by a summary of salient research on prostate cancer and couples. Next, research on the experience of female partners of men with prostate cancer will be reviewed, followed by the experiences and challenges of men with prostate cancer with a focus on sexuality and masculinity. Penile rehabilitation will be introduced and discussed as an emerging medical imperative. Links will be made to this medial practice and broader sociocultural directives around sexuality and gender. Sex and gender will be positioned as social constructions rather than biological universals. This transitions into an explication of the theoretical and epistemological approach adopted in the project.

Prostate Cancer in Canada

Prostate Cancer is the most common cancer diagnosed in Canadian men apart from non-melanoma skin cancers (Canadian Cancer Society, 2015) and it is estimated that 24,000 men will have been diagnosed with prostate cancer in 2015 (Canadian Cancer Society, 2015). Further, current estimates are that one in eight men will develop prostate cancer in their lifetime (Canadian Cancer Society, 2015). Mortality rates for prostate cancer have been on the decline since the mid-1990s (Canadian Cancer Society, 2015). Thus, rising numbers of men are being diagnosed with and successfully treated for prostate cancer. As a result of this, there is increasing focus on quality of life and survivorship issues in these men. Currently, the most common treatments for prostate cancer include radical prostatectomy and radiation therapy, both of which are associated with changes in erectile functioning (Robinson, Moritz, & Fung, 2002). Erectile dysfunction (ED) rates following prostate cancer treatment vary; however, estimates go

as high as 90% (Mulhall et al., 2010). Thus, growing numbers of men and their partners are living and coping with prostate cancer treatment-related changes in sexual functioning.

Prostate Cancer and Couples

There is a rapidly expanding body of research on prostate cancer and couples with much of the research utilizing objective, standardized measures in order to quantify the impact of prostate cancer on various individual and couple-level domains (e.g., see Couper et al., 2006; De Sousa, Sonavane & Mehta, 2012 for comprehensive reviews). For example, in a comprehensive review of the psychological aspects of prostate cancer, which drew from 189 reviews, mini-review papers, and randomized controlled trials published from 1999 to 2011, De Sousa et al. (2012) concluded that men with prostate cancer commonly experience anxiety, depression, distress, and relationship conflict related to erectile dysfunction, humiliation and social isolation related to incontinence, and more general distress from both cancer treatments and medications (e.g., hormone therapy). In addition, they found that men experience the greatest disease-specific distress related to urinary, sexual, and bowel issues. The review identified that partners experience the same level or greater overall distress when compared to men with prostate cancer. Partners experience role strain from being caregivers, and difficulty with sexual intimacy in the presence of erectile dysfunction, incontinence, and other side effects. Partners also experience loneliness, especially if their spouse becomes socially isolated as a result of cancer. Overall increases in frustration and decreases in life satisfaction were found in couples where the male partner had functional impairments as a result of cancer.

The focus of this dissertation is on the subjective experiences and constructed accounts of men with prostate cancer and their female partners. As such, the literature review below focuses on studies that have adopted qualitative approaches to understanding prostate cancer and in particular, studies that emphasize subjective experience (e.g., Arrington, 2003; Fergus, 2011; Gray et al., 2000; Harden et al., 2002; Lavery & Clarke, 1999; Maliski, Heilemann, & McCorkle, 2001, etc.).

Prostate cancer: A communal experience. Prostate cancer is commonly positioned as a couple's disease and as something that happens to couples as opposed to individual men (e.g., Fergus, 2011; Gray et al., 2000). For example, Gray et al. (2000) found that couples positioned prostate cancer as a communal and shared challenge in their in-depth interview study with 34 men with prostate cancer and their female spouses. Spouses "often talked about the challenges of prostate cancer as something 'we' are dealing with" (p. 538), as opposed to something that 'he' is dealing with.

In a study exploring couple's experiences with prostate cancer-related incontinence and impotence[1], participants distinguished between 'his work' (specific tasks that the male partner was responsible for), 'her work' (specific tasks that the female partner was responsible for), and 'our work' (shared tasks; Maliski et al., 2001). Maliski et al. (2001) conducted semi-structured interviews with 20 couples and analyzed the data using grounded theory. They were interested in understanding the meanings that couples make of both incontinence and impotence, and in the ways in which couples cope with these side effects. Patients were 3-months to 1-year post radical prostatectomy. Control and mastery emerged as key coping strategies for both partners during the prostate cancer

[1] I have adopted the language used in studies when discussing their findings. For example, when studies use the term 'impotence' I use this term. Likewise, when studies use the term 'erectile dysfunction' I adopt this term.

experience. The communal work that participants talked about was positioned as "more than just the combination of each individual's work" (p. 990). 'Communal work' involved a constant recalibration of both partners' roles and a dynamic interplay of each person's experiences and efforts to 'recover.' The shared work included establishing routines and finding ways to strengthen intimacy together.

Similarly, in her ethnographic study involving five well-adjusted couples, Fergus (2011) found that participants articulated that prostate cancer was experienced in a mutual, shared, embodied way – there was a distinct sense of "we" to the cancer. The study, which explored dyadic coping and resiliency with respect to prostate cancer, included couples that had been married an average of 31 years and were a subset of participants from a larger longitudinal study. All men had undergone a radical prostatectomy, two men had had radiation therapy, and one man was receiving hormone therapy. The cancer had spread beyond the prostate in only one of the five men. Fergus examined how the experience of going through prostate cancer affected a couple's shared intersubjective identity – "the couple's experience of being a 'we' in the world" (p. 96) – and conversely how a couples' intersubjective identity impacted their adjustment to cancer. It was found that couples adopted a sense of having a "communal body" when discussing their experiences with prostate cancer. That is, there was a shared "corporeality, to which each partner's identity and sense of self was intricately tied" (p. 95).

Couples talked about 'riding the vortex' of prostate cancer with all of the associated emotional upheaval, loss of control, and shifting perspectives and roles in the relationship (Fergus, 2011). One of the core categories identified in the study, *holding the*

communal body intact, referred to the deeply and intricately 'interwoven selves' of members of the couple, and to the various ways in which couples coped with threats to their 'entwined' identity (e.g., erectile dysfunction, the possibility of death). Couples adopted various coping strategies in order to adapt and face the challenges posed by prostate cancer. One such challenge was to redefine or renegotiate ways of being physically connected in the face of erectile changes. Intercourse, which formerly was a way to bridge the gap between their physical bodies and individual selves, was no longer possible for many couples. For some couples, loss of erectile functioning and cessation of intercourse instigated many other "affectional losses" that altered the couples' ways of being and feeling close and connected. Couples in the study reported having to work to respond to this threat to their relationship and to repair the damage caused by prostate cancer. They did so by looking "beyond intercourse" for ways to connect physically and emotionally during and outside of sex. Some couples 'left sex behind' and positioned sex as the price they had to pay for the male partner to live.

Enduring uncertainty, living with treatment effects, coping with changes together were key themes identified by couples coping with prostate cancer in a focus group study involving 22 men with prostate cancer and 20 female spouse-caregivers (Harden et al., 2002). Men ranged from being newly diagnosed (from one month to two years postdiagnosis), to immediately post first treatment, to metastatic. Couples struggled to 'endure the uncertainty' involved in picking a treatment option, dealing with this major interruption in their life, and riding the emotional roller coaster of prostate cancer. The theme of 'living with treatment effects' included difficulties coping with urinary incontinence – men talked about needing to adjust their lives to accommodate loss of

urinary control – and sexual dysfunction. Men talked about "feeling incomplete … [and they] grieved the loss of an integral part of their marriage" (p. 705). Some men said they were able to adapt sexual intimacy, whereas others had not had sex in a long time. Living with treatment effects also included coping with hormonal alterations, and the corresponding mood and body changes, and changes in self-identity and masculinity. Finally, men spoke about overwhelming fatigue and the inability to perform typical tasks; this was troubling to the men, especially if their female partners were taking on tasks that they used to be able to accomplish. Harden et al. (2002) noted that even though symptoms like incontinence, sexual dysfunction and hormonal changes "are thought of as *men's* symptoms, in reality, they are symptoms that *couples* experience" (p. 707). These challenges become shared obstacles to overcome and impact both partners. The theme of 'coping with change' included couples drawing together to cope in a mutual and shared way, shifting roles, facing anger, finding ways to control the situation, and sharing with others to seek support. Harden et al. conclude that coping with prostate cancer is "multidimensional" and "a daily struggle to balance the anxiety caused by constant uncertainty and manage the treatment effects and day-to-day responsibilities" (p. 707). Furthermore, the subjective experience of each couple is the result of interplay between "the effects of the disease process and personal expectations" (p. 707).

In a qualitative study with 12 couples, Lavery and Clarke (1999) interviewed men and their female spouses about the impact of prostate cancer on their relationship and on coping. Men had received a variety of treatments (e.g., surgery, radiation, hormone therapy), had been diagnosed an average of 24 months, and had variable stages of cancer. Men were an average of 62.4 years and spouses were an average of 57 years. Couples had

been married an average of 33 years. When asked about the impact of prostate cancer on the relationship, participants discussed both general changes (e.g., feelings of closeness), and sexual changes. Participants who were sexually active prior to diagnosis spoke overwhelmingly about negative changes in their sexual relationship, including feeling frustrated and disappointed. Notably, most of the couples were not sexually active prior to the prostate cancer diagnosis. However, the majority of participants said that their relationship was the same or had improved (e.g., they felt closer as a couple, they felt more respect for each other, etc.).

'Her Work'[2]: The Roles and Experiences of Female Partners

> "*As women, we buck up and take care of business*." (Female partner of a man with prostate cancer; Sanders, Pedro, Bantum, & Galbraith, 2006, p. 506)

Women take on key roles in the face of prostate cancer as they help their partners cope, manage their own emotions, and work to preserve the relationship (e.g., Couper et al., 2006; Fergus, 2011; Gray et al., 2000; Gray, Fitch, Fergus, Mykhalovskiy, & Church, 2002; Maliski et al., 2001; Sanders et al., 2006). The theme of 'her work' or specific tasks that female partners take on in the face of prostate cancer (Maliski et al., 2001) is consistent with findings from a number of studies. Maliski et al. (2001) found that female spouses took on the role of managing both partners' anxiety, facilitating the male partner's control over his body and recovery (e.g., with respect to incontinence), gaining perspective on impotence, and reassuring the male partner, in their qualitative study of 20 couples coping with prostate cancer. For example, "wives demonstrated understanding of their husbands' feelings about impotence and the sense of loss that the men felt. They

[2] Nearly all of the research on partners of men with prostate cancer is about female participants. The present study included only female partners of men with prostate cancer as participants. As such, the literature that is reviewed here focuses on female partners.

worked to reassure their husbands that they still loved them and that they did not consider them to be less masculine" (p. 990). Simply put, "the wives were crucial to the recovery process" (p. 990).

Likewise, Harden et al. (2002) found that female spouses take on active roles in managing the experience and effects of prostate cancer. Their focus group study found that spouses encouraged their partners to seek treatment, were the primary source of support for their husbands, and were active in helping their partners manage treatment side effects like incontinence. In a narrative study involving 18 men on links between masculinity and prostate cancer, Gray et al. (2002) found that women were central to men's experiences of prostate cancer in that they provided the majority of men's emotional support. Female partners of men with prostate cancer in a focus group study with 10 couples (Sanders et al., 2006) talked about switching roles in the relationship during prostate cancer; they went from feeling protected and cared for by their husbands to being the ones doing the "emotional caretaking" (p. 505).

In her ethnographic study of five couples, Fergus (2011) found that female partners set aside their own emotions and worries in order to focus on their partners' emotional states and needs in the aftermath of a prostate cancer diagnosis. "Quite purposefully, spouses chose to *subjugate themselves* [author emphasis] within the relationship because it was generally believed that if they exposed their own concerns and distress, it would interfere with the man's sometimes tenuous coping efforts" (p. 103). Partners have been found here and elsewhere to play a stabilizing role in the immediate and emotionally chaotic aftermath of a prostate cancer diagnosis and in helping men redefine their sense of masculinity in the face of cancer and cancer-related

side effects such as erectile difficulties (Fergus, 2011). For example, female partners in Sanders et al.'s (2006) study talked about actively working to build up their partner's sense of self or "ego" in the aftermath of diagnosis and treatment. A male prostate cancer patient in the study stated, "We play macho, but don't kid yourself, we depend on this lady, and if she's not in the equation, we're lost" (p. 506).

Marriage preservation and cultivation of couple intimacy was identified as one of four core themes in the 'adaptive work' that female spouses engage in when coping with a prostate cancer diagnosis in the relationship (Ka'opua, Gotay & Boehm, 2007). Women spoke about finding ways of affirming and preserving the relationship bond and of trying to understand problems from their husbands' perspectives, in this qualitative study of 28 elderly (mean age was 72.6 years) female spouses of prostate cancer patients (husbands had been diagnosed an average of 8.5 years before the study). Many (64%) of the women spoke about the challenges of coping with their partners' impotence or incontinence and about 18% of women reported ongoing issues with avoidance of sexual intimacy, incontinence-related anxiety, masculinity, and depression in their male partners. Adaptive coping included seeking new ways of sharing intimacy (e.g., by incorporating caressing, oral sex and baths into sex and by engaging in shared social activities).

Caring and coping: A heavy load. The significant burden shouldered by female partners is highlighted in a study on coping and support in prostate cancer couples by Gray et al. (2000). Researchers found that female partners carry a significant load when it comes to protecting the relationship and supporting men. "For the most part, support following a prostate cancer diagnosis flowed from women towards men" (p. 541). This qualitative study of 34 men with prostate cancer (mean age was 60.0 years) and their

female spouses (mean age was 57.1 years) interviewed couples at three time points: prior to surgery, eight to ten weeks post surgery, and 11 to 13 months post surgery. Participants had been married an average of 30 years. Female partners were often the primary support to men in providing multiple forms of assistance. For example, they provided key reassurance to men around loss of erectile function, they helped with medical logistics like managing the catheter and incontinence, and they were sources of emotional support to help men cope with difficult thoughts and feelings related to prostate cancer. There were costs and benefits to both partners from efforts to manage the impact of prostate cancer on their lives. Female partners in particular had a complicated job of providing support to partners who often did not want to feel that they were in need of support.

> "While many men clearly needed and wanted support from their wives, they also typically did not want to feel that they were in need of support. So the women had to find ways of giving care without appearing to be doing so. They had to comfort their men and build them up at the same time. They were reassuring about men's loss of potency, while still trying to communicate that they were attracted to their husbands. Their attempts to support their husbands often ended as exceedingly complicated dances. No wonder they ended up feeling distressed." (p. 546)

Likewise, Wootten et al. (2014) found that female partners struggle with the task of helping their male partners cope with prostate cancer, which can compound their own difficulties. In a qualitative study on the experiences of 27 female partners of men recently diagnosed with prostate cancer, Wootten et al. conducted six focus groups and one individual in-depth interview. Participants were an average of 61.6 years old and the men had been diagnosed between three months and three years prior to the study. Men

had had a range of different treatments (e.g., surgery, radiation, hormone therapy), and treatment had taken place on average 2.5 years ago. Female partners talked about supporting a man who is experiencing a loss of masculinity and while they expressed that they were aware that prostate cancer might impact their partners' masculine identity, they felt "unprepared to manage" this part of the process. Some partners reported that physical touch became less common and a source of distress for them. One spouse stated, "It [is] harder to do something [hug, or touch] that reminds you how terrible your loss is" (as in article, p. 1254). Female partners likewise talked about feeling unprepared to manage the adjustments required with sexual intimacy and expressed feeling "a sense of loss of intimacy" in the relationship (p. 1255). Notably, the loss of intimacy was not just about sex, but also more about a loss of "closeness in the relationship" (p. 1255). Some female partners also talked about trying to protect the male patient by shielding him from their own negative emotions, particularly in cases where the man had a negative response to prostate cancer. In this sense they took "responsibility" for supporting their partners and created a "cocoon-like environment" (p. 1255). These attempts to protect their partners made some women feel that they were "walking on eggshells all the time" (p. 1255). In addition to the extra emotional labour, female partners talked about shouldering more practical and logistical responsibilities in the relations (e.g., communicating with others about the cancer, supporting other family members, etc.). They commonly neglected their own self-care in the face of the growing demands and some talked about "feeling worn out" (p. 1255).

The Experiences and Challenges of Men with Prostate Cancer: A Focus on Sexuality

The most common side effects of prostate cancer – erectile dysfunction, urinary incontinence, and bowel problems – can have devastating effects on men and often result in changes to their physical, emotional, and sexual intimacy (e.g. Arrington, 2003; Bokhour, Clark, Inui, Silliman, & Talcott, 2001; Hanly, Mireskandari & Juraskova, 2014; Harden et al., 2002; Klaeson, Sandell, & Berterö, 2012, 2013; Oliffe, 2005, 2006). The impacts are experienced on both individual/intrapersonal and couple/interpersonal levels. For example, in a study of men with prostate cancer and their female partners (Harden et al., 2002), men reported feeling a deep sense of loss to both their personhood ("feeling incomplete," p. 705), but also in their marriage in response to changes in sexuality. Likewise, participants in a focus group study of 19 men expressed that prostate cancer was a threat to their sexuality and sexual intimacy with others (Klaeson et al., 2013). They positioned their bodies as having 'failed' them and stated that the sexual side effects changed their relationships with women. Men struggled to communicate openly with their partners about sex and talked about silence that emerged in the relationship with the onset of erectile difficulties. Some men ceased sexual intimacy altogether as a result of side effects.

In a focus group study of 48 men with early prostate cancer in the past 12 to 24 months (Bokhour et al., 2001), participants mentioned urinary incontinence, bowel function, and uncertainty about cancer and difficulties with sexuality as major impacts of prostate cancer on their lives. The paper focused on analysis of sexuality material. Men reported that changes in erectile function negatively impacted their sexual performance, relationships with women, experiences of sexual fantasizing, and sense of masculinity. Participants articulated a missing undercurrent of sexual possibility and a loss of

perceived sexual prowess. Whereas seeing an attractive woman in the past may had led to pleasurable and welcome sexual fantasies and a delicious sense of sexual possibility, this was greatly diminished post treatment. Some men described the potential for a sexual encounter as "well out of the question," following treatment (p. 652). Men describe trying to find ways to extricate themselves from potential sexual encounters with women in order to avoid embarrassment and they frame this as a loss of a "sexual undercurrent" in their interactions with women (p. 652).

Men also reported that sexual side effects had a profound impact on their sexual fantasizing (Bokhour et al., 2001). They described experiencing a loss of enjoyment and pleasure in this formerly satisfying activity. Men expressed that they were no longer able to imagine themselves approaching a sexually appealing woman, which greatly limited their psychic sexual imagination and foreclosed certain possibilities for pleasure. Whereas physical intimacy used to be a dependable and familiar source of comfort, pleasure, and recreation, sex had lost these associations.

A study on the psychosexual impact of prostate cancer on 21 men found that a number of participants ceased sexual activity altogether because the challenges they faced, such as erectile dysfunction, pain, and changes in penis size, ejaculation, orgasm, and sexual desire (Hanly et al., 2014). All men had been diagnosed and treated in the past five years and were over 50 years of age. Most (76%) of them were married. The men who ceased sexual intimacy following the onset of erectile dysfunction equated sex with intercourse. Participants talked about changes in their self-perception and self-esteem as they coped with side effects and sexual changes. They talked about feeling inadequate and embarrassed because of the physical changes in their bodies.

Nearly all 16 participants in a narrative analysis study on men with prostate cancer navigating changes in sexuality identified prostate cancer as "*the* turning point in their definitions of sex, their identities as sexual beings, and their sexual relationships" (Arrington, 2003, p. 35). Most participants were unable to engage in intercourse following treatment, even though many specifically chose treatments that would minimize sexual side effects. While some men positioned erectile dysfunctions "as the end of their sex lives" (p. 35), other positioned it as an opportunity to expand their sexual practices and pleasure. These different positions were linked to the value that men seemed to place on physical intimacy and to their definitions of sex. Men who defined 'natural' sex as unaided penile-vaginal penetration were more likely to equate erectile dysfunction with the end of their sex life where as men who had more flexible definitions of sexuality were more likely to maintain sexual intimacy through a process of adaptation and creativity.

Participants in an ethnographic study of 15 men treated for localized prostate cancer also talked about a process of redefining sexual intimacy so that intercourse was no longer the primary, or even one of many sexual practices (Oliffe, 2005). The study explored men's experiences of impotence following surgery. Men had received surgery and average of 21 months prior to the study and had an average age of 57. All men had partners and had been in their relationships for an average of 27 years. While many participants struggled with the impact of treatment on the appearance and functioning of their penis, some men were able to expand their definitions of sex and the scope of their sexual activities. For example, some men were able to accept a greater variability in

erectile states and to accept partial erections during sexual intimacy. In addition, men expanded on ways of being physically and emotionally close with their partners.

The disappointment of pro-erectile treatments. While many sexual technologies exist to produce erections in men (i.e. medications, vacuum pumps, penile injection), these corrective devices and treatments often disappoint men and their partners in that they do not offer acceptable solutions to the sexual disruptions posed by prostate cancer (e.g. Fergus, 2011; Klaeson et al., 2013; Oliffe, 2005). Men state that being able to achieve an erection through medical and technological means does not protect them from a sense of loss or diminishment. These treatments fall short when it comes to providing the kinds of erections ("frequent, spontaneous, natural, rigid") that "reflect the virility, desire and manliness tantamount to hegemonic masculinity" (Oliffe, 2005, p. 2255).

Both male patients and their spouses talked about the lack of spontaneity associated with using pro-erectile medications and devices during sex, in a qualitative study with 12 couples (Lavery & Clarke, 1999). Men discussed the challenges of trying to use pro-erectile aids and articulated that sex no longer felt natural or spontaneous, in a focus group study with 19 prostate cancer survivors (Klaeson et al., 2013).

In an ethnographic study of in-depth interviews with 15 men, Oliffe (2005) found that participants expressed disappointment with pro-erectile aids, which felt mechanical and artificial, and which often caused pain rather than pleasure. Many participants tried pro-erectile aids only to abandon them "due to the artificial nature, ineffectiveness and lack of spontaneity in achieving, maintaining and using their erection" (p. 2255). The anticipated "quick fixes" of medical treatment did not materialize (p. 2255).

Men in the Fergus et al. (2002) study reported that while they were able to achieve erections using various medications and mechanical devices, these were not able to fully restore their sexuality. Most men articulated that "an essential piece had gone missing" when it came to sex (p. 311). Participants reported that sex has become more mechanical and effortful and they disliked the "awkwardness and lack of spontaneity" in using various devices (p. 312).

> "The use of new sex technologies was a double-edged sword. On the one hand, they held the promise of a restored sex life, but on the other hand, they often proved to be exceedingly disappointing." (Fergus et al., 2002, p. 312)

While a few of the male participants in Klaeson et al.'s, (2012) study were able to incorporate technical aids into their sexual practices and body image, most struggled to do so. They disliked the side effects and didn't like having to "arrange everything" in advance in order to have penetrative sex. Partners sometimes were not enthusiastic about aids. This resulted in many men abandoning pro-erectile aids altogether. In addition, men felt that they were unable to express their subjective experiences using pro-erectile aids (e.g., their regret, pain, and disappointment) with their prescribing physicians. They felt unable to communicate these emotions in the face of a rational and effective medical care provider. One participant talked about playing "a false role about successfully incorporating medical and/or technical interventions into his lifeworld" (p. 1190) in the doctor's office. Each time he would visit his doctor he would get another prescription for injections that would go unused at home. "I have lots of syringes at home and so on" (p. 1190), he said.

These findings suggest that approaching erectile changes from within a medical framework is insufficient to address men's concerns. Fixing the dysfunctional body part (the penis), does not protect men from injury to their sense of identity and masculinity and does not eliminate obstacles to satisfying and pleasurable sex with their partners.

Urinary incontinence. Incontinence, which is one of the most common side effects of prostate cancer treatment, is associated with distress in men (e.g., De Sousa et al., 2012; Fan, Heyes, & King, 2012; Fergus, Gray, & Fitch, 2002; Gray et al., 2002; Hanly et al., 2014; Klaeson et al., 2013; Walsh & Hegarty, 2010). Some studies have found that men report this to be the most upsetting side effect of prostate cancer (e.g., Walsh & Hegarty, 2010), surpassing erectile dysfunction in lowering quality of life. For example, in a focus group study with 19 prostate cancer survivors, men positioned incontinence as "the most detrimental effect in terms of attractiveness and an acceptable love life" (Klaeson et al., 2013, p. 48). Men reported that it was a significant barrier to masculinity and sexual intimacy. Similarly, participants in the Fergus et al. (2002) interview study with 18 prostate cancer survivors reported that they were less distressed by and better able to cope with sexual dysfunction when they also experienced incontinence because incontinence was far worse. They reported, "as much as impotence is a nuisance, incontinence is worse" (p. 313). For these men, incontinence was a buffer against the distress related to sexual difficulties. One of the participant accounts included in Gray et al.'s (2002) narrative study echoes this sentiment, and positioning incontinence as being worse than impotence. He said, "Impotence I can deal with because I can love my kids, love my wife, I can socialize, I can flirt . . . impotence is not stopping me from

being an attractive guy" (p. 50). Incontinence was more disruptive to his life and self-identity than erectile dysfunction.

In a review of the literature on men's experiences with urinary incontinence following surgery for prostate cancer, Fan et al., (2012) found that men were shocked and unprepared for dealing with incontinence, which was experienced as a threat to masculine identity and self-esteem. One of the key themes to emerge from this thematic analysis of 12 studies was the emotional impact of coping with urinary incontinence. Men reported "feeling like a child" (p. 32), and frustration as the loss of control over their body. One study found that incontinence was positioned as the most distressing symptom following treatment for prostate cancer (Walsh & Hegarty, 2010), and another study found that men expressed suicidality as a result of their incontinence experiences (Moore & Estey, 1999). A cross study finding was the negative impact of urinary incontinence on men's social lives. Studies found that incontinence led men to limit their social activities and experience stress about locating toilets when leaving the house. Men worried about visible markers of incontinence in public (e.g., pads showing, urine leaking onto clothing, odour, etc.), and limited their fluid intake as a way of coping.

Likewise, incontinence was found to have a negative impact on quality of life for a number of participants in an in-depth interview study of 21 men diagnosed and treated for prostate cancer in the past 5 years (Hanly et al., (2014). All men were over 50 years of age and two thirds were between 60 and 69 years old, most men were married (n = 16), and identified as heterosexual (n = 20). Almost all men had received surgical treatment (n = 19) with the rest receiving a range of other treatment (e.g., brachytherapy, androgen deprivation therapy, etc.). Incontinence impacted participants' experiences of being out in

public but also their sexual intimacy; urinary leakage during sex was experienced as embarrassing and led some men and their partners to avoid physical intimacy.

Men (Re)Constructing and (Re)Negotiating Masculine Identity

There is growing recognition of the importance of constructs like self-identity and masculinity in understanding men's experiences with and distress related to prostate cancer (e.g., Bokhour et al., 2001; Gray et al., 2002; Fergus et al., 2002; Kelly, 2009; Oliffe, 2005, 2006; Wall & Kristjanson, 2005; Zaider, Manne, Nelson, Mulhall, & Kissane, 2012). Across studies, men report experiencing a threat to their sense of self and masculinity, especially in response to changes in sexual functioning and incontinence (e.g., Bokhour et al., 2001; Bokhour, Powel, & Clark, 2007; Fan et al., 2012; Fergus et al., 2002; Oliffe, 2005). Other symptoms, especially those associated with hormone therapy, also pose significant threats to men's sense of masculinity (e.g., Oliffe, 2006).

Loss of manhood. Participants in Heyman and Rosner's (1996) descriptive and cross-sectional study of 20 men with prostate cancer and 20 of their wives, described feeling a loss of 'manhood' in the later stages of their cancer experience (e.g., after the initial diagnosis and treatment) and said that this was associated with a profound sense of both loss and grief as they struggled to cope with changes. Likewise, male participants in the Bokhour et al. (2001) study who were experiencing prostate cancer-related sexual side effects also reported feeling diminished as men and said that they had lost a defining feature of manhood.

> "Sexuality is seen here as a substantial part of what defines an individual as a 'man,' and men who had lost sexual function were finding themselves challenged to redefine themselves as masculine in our society." (Bokhour et al., 2001, p. 653)

Experiences of erectile dysfunction negatively impacted how men felt about themselves and threatened their feelings of masculinity, as reported by 12 couples coping with prostate cancer in a qualitative study (Lavery & Clarke (1999). This was the case even if couples were not sexually active prior to diagnosis. In response to erectile dysfunction, one participant said, "I felt as if I was only half a man–which is ridiculous, but that is how I felt" (p. 297). This study highlighted that men's distress related to 'impotence' is not solely linked to their ability to have intercourse. It also highlights the close pairing of erections and masculinity for many men.

Klaeson et al. (2012) also focused on men's embodied experiences with masculinity following prostate cancer. They noted that changes in sexuality impacted prostate cancer survivors' sense of self and altered their experience of being in their bodies and of moving through the world. Changes in sexual ability were experienced as "a threat to their very existence," and created as sense of "otherness" in relation to their bodies (p. 1191). Their study explored how men experience sexuality from a "lifeworld perspective" (p. 1185), in other words, they explored men's everyday experiences of sexuality following a prostate cancer diagnosis. They conducted in-depth interviews with ten men, all of who had been diagnosed at least six months prior to the study. All but one of the men was in a long-term relationship with a woman and the median age was 59 years. Men had undergone a range of treatments including surgery, radiation, and hormone therapy. Participants expressed that they felt incomplete, feminized, and vulnerable. Loss of the ability to "penetrate" had widespread implications beyond sex. Men struggled with changes in their bodies' appearance and function such as "developing

enlarged breasts, regression of genital organs and muscles, gaining weight, and being forced to wear diapers because of leaking urine and/or feces" (p. 1187).

Overall, participants reported that they felt that they were not the same men they had been before prostate cancer both in terms of their physical body but also in terms of their subjective masculine identity. Sexual changes disrupted their masculine sense of self and their ability to engage in gendered practices. "Joy connected with intimacy, erotic fantasies, and sexual pleasures disappeared with diminished sexual function, and with them the normal gestural heterosexual gender display they were used to" (Klaeson et al., 2012, p. 1188). This disruption of gender display was associated with crises of identity and efforts to renegotiate, reestablish, or adapt masculine identities and practices in study participants.

Likewise, participants in an ethnographic study of 15 prostate cancer survivors talked about feeling less of a man and less masculine, worthless and invisible, while also actively challenging hegemonic ideals of masculinity (e.g., that erections are a symbol of power) and trying to establish new markers of manhood (Oliffe, 2005). Participants in this study reported being surprised and dismayed by the changes in their penis (e.g., the penis was shortened after surgery, impotence), and by the impact of these changes on their sense of self during the acute phase of recovery.

Hormone therapy: An especially damaging assault to masculinity. Men in some studies identified hormone therapy as an especially damaging assault on their sense of self. In a qualitative study of 16 men with advanced prostate cancer, Oliffe (2006) explored participants' experiences of being on androgen deprivation therapy and embodied masculinity through individual interviews. Participants were an average of 67.3

years old and were all partnered (the average length of relationship was 37.5 years). Oliffe found that "the body became a seat of transition and uncertainty" (p. 417) for men. Physical feminizing features (e.g., development of breasts, weight gain, less muscle mass, reduction in size of penis and testes) led to body shame and worries about being appraised as less manly in public spaces. In addition, men identified fatigue, hot flashes, and impotence as important aspects of their experience. "The body's internal controls malfunctioned under the influence of ADT and, with Kryptonite-like effect, many-gendered performances were abruptly ended" (p. 423). Men felt feminized when experiencing hot flushes and struggled with their "uncontrollable" fatigue. Sexual dysfunction was easier for participants to accept because they also experienced minimal or no sexual desire in response to treatment. Most men were uninterested in trying pro-erectile treatments because of their lack of interest in sex, and some men adapted their sexual practices to emphasize things like fondling and petting. Overall, Oliffe noted that treatment disrupted many ways of 'doing' masculinity and forced men to find other ways of embodying masculine ideals, such as striving to be courageous and adopting a firm commitment to "fight" the cancer with "grit" and determination.

Participants in an interview study with 52 men with prostate cancer indicated that while incontinence and impotence negatively impacted male identity, the effects of hormone therapy posed the greatest threat to masculine identity in participants. For example, one participant receiving hormone therapy said, "I feel that I've lost all masculinity, I'm not a man any more. I mean I'm just not" (Chapple & Ziebland, 2002, p. 833).

Humiliation and hiding. Male survivors of prostate cancer reported a sense of humiliation associated with treatment side effects. Men also reported a desire to hide their side effects from others so as to protect their vulnerability and to maintain a mask of masculinity. Gray et al.'s (2002) narrative study on links between masculinity and prostate cancer included 18 participants who engaged in a series of in-depth interviews. The paper included the narratives of three participants selected because of the fit between their stories and the focus of the project (e.g., enactments and renegotiation of hegemonic masculinity). Participants spoke about feeling humiliated about the loss of control of their bodies, and in particular the loss of control over urinary function and erections. One participant, whose ability to sexually entice and satisfy women was a core component of his identity as a man, struggled greatly in the aftermath of surgery, radiation, and hormone therapy treatments. He said, "On a ten-point scale, if one is your sexual best and ten is shut down completely, then I'm at eight trying like a son of a bitch to get back to seven" (p. 51). None of the men wanted other men to know about their side effects due to shame and embarrassment.

Chapple and Ziebland (2002) found that men were reluctant to seek help or consult with doctors because it was not seen as masculine to express emotion or ask for assistance, in their interview study with 52 men with prostate cancer. This reluctance was also linked to the embarrassment that men felt about the symptoms of prostate cancer (e.g., loss of bladder control, bowel incontinence and diarrhea, anal bleeding, lack of energy, loss of physical vitality and stamina, hot flashes, enlarged breasts, impotence, etc.). Exposing these symptoms felt threatening to men.

In their in-depth interview study on men's embodied experiences with masculinity following a prostate cancer diagnosis, Klaeson et al. (2012) found that participants engaged in strategies to both cope with and mask their feelings of being incomplete, feminized and vulnerable. Men reported that they felt the need to engage in "staged manhood" which occurred in male-male contexts with men who had not been through prostate cancer (e.g., at work). "The informants knew intuitively that the aftermath of their prostate cancer was a taboo topic in these contexts. Instead, they were forced into using macho jargon in which jokes with erotic undertones about women were common" (p. 1190). They felt the need to put on masculine performances in front of other men.

Paying a (high) price for life. A theme that appears across some studies is that men framed side effects as the price they had to pay for their lives. For example, an ethnographic study of 14 men recently diagnosed with prostate cancer identified a common theme of wrestling with masculine identity in the face of prostate cancer (Kelly, 2009). The study explored the impact of cancer on a man's sense of embodied masculinity. That is, the physical, emotional, and social aspects of cancer. There was diversity in ethnicity, sexual orientation, and relationship status (e.g., partnered as well as non-partnered) in participants. Data, collected over 18 months, came from face-to-face interviews, observation of patients' medical appointments and treatment settings, and analysis of medial accounts of prostate cancer. Participants reported that treatment side effects, increased vulnerabilities, fears, and needs for emotional and instrumental support all challenged and disrupted hegemonic masculinity. Men commented on having to sacrifice aspects of their masculinity for survival – this was the price they paid to live. Men reported feeling ambivalent about this 'price they paid' to treat the cancer (e.g.,

impotence, incontinence, etc.). Erectile dysfunction and incontinence were particularly difficult side effects as they were experienced as threats to masculine embodiment. Some participants expressed anger at feeling pushed into treatments without having their concerns and values adequately considered. They felt that damage had been "imposed on their body" and that they were left to cope with the resulting side effects. The price they had paid felt too high.

In their study on the impacts of prostate cancer on men's bodies, roles, and sense of masculinity, Chapple and Ziebland (2002) interviewed 52 men at varied stages of diagnosis and a range of treatment experiences. Men ranged from 50 to 85 years old, were mostly White British (92%) and middle class. Participants who lost the ability to have an erection felt that this impacted a key part of their male identity; however, many positioned impotence as 'the price you pay' to treat the cancer.

Efforts to preserve manhood. Male participants in a number of studies reported strategies to cope with their reduced sense of masculinity. The core analytic category identified in Fergus et al.'s (2002) in-depth interview study of 18 men living with sexual dysfunction following prostate cancer treatment was "preserving manhood." Men had been diagnosed an average of 3.7 years ago, and 15 of them were living with long-term partners. Using grounded theory for analysis, Fergus et al. found that men experienced "profound identity struggles arising from the sexual losses" (p. 307). This facilitated 'preservation of manhood' efforts, which was defined as "a process that entailed striving to retain one's masculine identity in the face of a decidedly emasculating experience" (p. 307). Men experienced their loss of sexual function as a profound and deep loss to their sense of self and sense of masculinity. The sexual changes were described as a disruption

in men's abilities to perform masculinity through expressions of sexual conquest, sexual appetite, and sexual virility. This disruption was associated with a loss of vitality, a loss of competitiveness with other men and a sense of inferiority when compared to other men, as well as a sense of being less of a man. For men in this study,

> "Having sex is integral to being a man. Thus the sexual 'handicap' came automatically affixed to manhood rendering it, too, impaired. Efforts to curtail nerve-damage, maintain or recapture previous sexual capacities and minimize or conceal sexual impairment, were tangible strivings toward the preservation of a threatened manhood." (Fergus et al., 2002, p. 314)

Men engaged in numerous strategies to preserve their threatened manhood, such as finding new ways of "reclaiming their sexuality" (Fergus et al., p. 312) by researching pro-erectile treatment options, by expanding sexual practices beyond penetrative sex, by using humour and minimization, and by seeking out meaning and enjoyment in life outside of sex.

In their study on the impacts of prostate cancer on men's bodies, roles, and sense of masculinity, Chapple and Ziebland (2002) interviewed 52 men at varied stages of diagnosis and a range of treatment experiences. While men experienced impotence as a threat to their masculine identity, it was not an insurmountable challenge, and some participants expressed that they were able to adapt to this side effect either by finding alternative ways to be close to their partners, or by accepting that sexual intimacy was over for them (this was more often the case in older participants).

Likewise, Bokhour et al. (2007) explored how men resolved the commonly reported identity dilemma posed by prostate cancer. Researchers engaged in discourse

analysis of 36 men's accounts of the impact of prostate cancer on their lives and sense of self as men. Participants had been diagnosed with early stage prostate cancer 12 to 24 months before the interview. Participants were asked about what it was like to live with prostate cancer and about their experiences with incontinence and erectile dysfunction. They found that for some men, prostate cancer represented a minor 'disruption' with minimal impact on their lives and sense of self-identity whereas for other men, prostate cancer had had major impact on multiple domains of life including work, social, and intimacy. For example, one of the narratives presented in the paper was of a 74-year-old retired mechanical engineer who was faced with both erectile dysfunction and incontinence following treatment. He initially positioned himself as "an accomplished, professional man," and drew upon the discourse of engineering using objective scientific language. He likewise positioned himself as a good husband and father, as responsible and as providing for his family. He experienced both erectile dysfunction and incontinence and these side effects presented significant challenges to his masculine identity. He experienced embarrassment, a sense of sexual inadequacy, and loss of control. In drawing upon his ability to provide financially for his family and to continue to contribute in meaningful ways to society, he was able to "reconstitute himself as still a man, unchanged in significant ways despite the identity challenges he faces" (p. 105). This example illustrates the ongoing process that some men go through to renegotiate what it means to be a man after a diagnosis of prostate cancer and the occurrence of treatment side effects.

In an ethnographic study of 14 men recently diagnosed with prostate cancer, Kelly (2009) found that participants adopted a range of strategies to cope with disruptions

to male identity. For example, one participant refused surgery in order to maintain continence, some participants became very physically fit and health-conscious, and others took up formerly abandoned pleasures like smoking, or drew heavily upon their professional accomplishments.

In conclusion, studies report that prostate cancer has significant effects on men, their partners, and on the couple relationship. In general, prostate cancer is framed as a shared experience that happens to both partners. Most of the research on partners has been done with female participants. Research indicates that women take on key roles in the face of prostate cancer as they help their partners to cope and work to preserve the relationship. Side effects such as erectile difficulties, urinary incontinence, bowel dysfunction, fatigue, body composition changes, etc. pose challenges to men, and impact their sexuality and sense of male identity. While some men are able to adapt and develop alternative approaches to sexual intimacy, many struggle to do so and cease sexual intimacy altogether. Changes in sexual functioning and continence are not experienced purely as a medical or health issues by men, rather they are intimately connected to a sense of loss of self, loss of identity, and loss of masculinity. Problems with erections cannot be separated from notions of self and personhood for men, and injuries to erections are experienced as injuries to men's sense of self. Finally, recovery from these bodily and psychic injuries may require more than medical technology.

Penile Rehabilitation

Broadly speaking, penile rehabilitation is a systematic approach to resolving erectile dysfunction following trauma to the penis (i.e., prostatectomy, radiation therapy; Harochaw, 2012). Penile rehabilitation programs, which emerged in the late 1990s

(Montorsi et al., 1997) as a response to prostate cancer treatment-related ED in men, rely almost exclusively on biomedical and technological tools to treat erectile dysfunction, such as phosphodiesterase type 5 inhibitors (PDE5is; i.e., Viagra, Cialis, Levitra, Staxyn), intraurethral insertion of prostaglandin, intracavernosal injection of prostaglandin, vacuum erectile devices (VEDs) – otherwise referred to as penile pumps, and/or penile prostheses (Wang, 2007).

The most common form of penile rehabilitation is the use of PDE5i. In general, studies suggest that use of PDE5is may be beneficial in the recovery of erections (e.g., Bannowsky, van Ahlen, & Loch, 2012; Montorsi et al., 2008; Nelson, Scardino, Eastham, & Mulhall, 2013; Padma-Nathan et al., 2008). However, there is disagreement on many fronts with no consensus on which PDE5i is best, when men should start and stop taking them, what dose to use, and if the medications should be taken on their own or used adjunctively with other treatments (Chung & Brock, 2013).

When PDE5i medications are not entirely effective, other penile rehabilitation options include the use of penile injections, VEDs and intraurethral suppositories. Penile injections are an effective method of producing erections (e.g., Montorsi et al., 1997; Raina et al., 2003), and some studies have found that they offer some erectile rehabilitative benefits to men (e.g., Dennis & McDougal, 1988; Montorsi et al., 1997; Nandipati, Raina, Agarwal, & Zippe, 2006; Raina et al., 2003).

VEDs are becoming first-line treatments in penile rehabilitation, especially in men who do not respond optimally to oral medications, and the various purported benefits include lower levels of erectile dysfunction, ability for vaginal intercourse, partner satisfaction, preservation of penile length and girth, and increasing penile size

prior to penile implant (Brison, Seftel & Sadeghi-Nejad, 2013; Köhler et al., 2007; Pahlajani, Raina, Jones, Ali, & Zippe, 2012; Raina et al., 2006).

The use of penile prosthetic implants is another albeit more invasive and far less common[3] option that has been studied in the context of penile rehabilitation for men with prostate cancer (e.g., Ramsawh, Morgentaler, Covino, Barlow, & DeWolf, 2005; Tal, Jacks, Elkin, & Mulhall, 2011). For example, in one study, men who received a penile prosthesis simultaneously with their radical prostatectomy reported higher satisfaction with erectile dysfunction treatment, better sexual functioning scores, and more frequent sexual contact than men who did not receive the prosthesis (Ramsawh et al., 2005).

Expert dissent. There has been a proliferation of empirical studies on the use of penile rehabilitation in men with prostate cancer since the late 1990s. What has not materialized, along with this growing body of literature is consensus among researchers and medical professionals on fundamental aspects of the intervention (Bella, 2011; Chung & Brock, 2013; Mulhall, Bivalacqua, & Becher, 2013). After reviewing evidence for the various penile rehabilitation approaches and options, Chung and Brock (2013) concluded, "While several preventive and treatment strategies for the preservation and recovery of sexual function are available, no specific recommendation or consensus guidelines exist regarding the optimal rehabilitation or treatment protocol" (p. 108). In an attempt to generate consensus guidelines, Mulhall et al. (2013) convened a committee of five international experts in the field of penile rehabilitation. The resulting recommendations are notable for what they do not include – that is, specific treatment guidelines or protocols to follow for rehabilitation, including when to start, frequency of

[3] A database review study by Tal, Jacks and Mulhall (2011) found that 0.8% of 68,558 prostate cancer patients received penile implant surgery to treat erectile dysfunction stemming from their prostate cancer surgery or radiation.

treatment, dose and timing of use of medications, duration of treatment, and which treatment option to use. The authors concluded, "the committee recognized the absence of definitive data to date and could not comment on the optimal approach to rehabilitation at this time" (p. 1687).

Nonetheless, penile rehabilitation is being widely disseminated and implemented around the world as a medical imperative. A study on the use of penile rehabilitation by sexual medicine experts around the world revealed that 87% of practitioners in 41 countries reported practicing some form of pharmacological penile rehabilitation with their prostate cancer patients (Teloken, Mesquita, Montorsi, & Mulhall, 2009). The authors remarked: "it is noteworthy that despite the lack of definitive clinical evidence and consensus in this area, penile rehabilitation is being practiced by the vast majority (87%) of respondents to this survey" (p. 2036).

Penile rehabilitation "remains controversial because the evidence on whether or not penile rehabilitation works is conflicting" (Bella, 2011, p. 2391), yet its acceptance, popularity, and institutional endorsement are spreading across hospitals, private clinics, best-seller lists, and online message boards across North America. This warrants examination. One way to explore the rapid and widespread uptake of this technology of sexuality in the absence of conclusive empirical data is to contextualize its emergence within the current sociocultural context and to explicate links between penile rehabilitation and dominant discourses (value systems, beliefs, cultural practices) of sexuality.

The emerging penile rehabilitation imperative: Turning to medical (s)experts to save your (sex) life. The academic literature on penile rehabilitation has a relatively

short history, with the first article published in 1997 (Montorsi et al., 1997). Review of this body of literature reveals widespread utilization of the biological model of sexuality to position penile rehabilitation as a natural and necessary response to erectile dysfunction. An example of the biomedical positioning of erectile dysfunction in men with prostate cancer found in the research literature is as follows:

> The absence of postoperative erections in the early period after RP [radical prostatectomy] is associated with unsatisfactory cavernous oxygenation, which can cause fibrosis of the corpora cavernosa and eventually lead to veno-occlusive dysfunction. (Bannowsky, Schulze, & Jünemann, 2010, p. 393).

In most cases, the construction of erectile dysfunction as a purely biological problem is explicit: "The advent of the use of PDE-5 inhibitors in the treatment of erectile dysfunction has clearly revolutionized the management of this medical condition" (Bannowsky et al., 2010, p. 394). In the following quote pulled from lay materials on penile rehabilitation, erections are explained as a purely biological process:

> Penile erection starts when electrical impulses from the paired cavernous nerve bundles stimulate dilation of arteries supplying blood to the penis. These nerves can be thought of as fine, spider web-like on/off switches that are attached to the prostate. (Bella, 2011, p.1)

Patient materials provide rationale for penile rehabilitation. Examination of these materials yields information about the ways in which penile rehabilitation is being justified to patients and presented as a medical imperative. An excerpt from the Stanford hospital Penile Rehabilitation Program's website reads as follows:

> We know that daily erections are natural and necessary and that without erections atrophy and scarring can develop. Thus, interventions aimed at preserving sexual function must allow regular erections.

Further evidence of the biomedical model and empirical exclusivity of the scientific method within mainstream psychological research on penile rehabilitation is the prevalence of animal research used to support penile rehabilitation (e.g., Mulhall et al. 2010; Ferrini et al., 2006; Lee et al., 2010; User, Hairston, Zelner, McKenna, & McVary, 2003). Despite arguments against this rhetorical strategy – "rats are not humans, and it is dangerous to uncritically extrapolate findings across species" (Mulhall & Morgentaler, 2007, p. 541), animal-model research continues to be employed in pro-penile rehabilitation scientific literature (e.g., Ferrini et al., 2006; Ferrini et al, 2009; Kovanecz et al., 2008; Lee et al., 2010; Mulhall et al., 2010; User et al., 2003; Vignozzi, et al., 2006).

Erections are positioned as 'healthy' and 'natural,' and warning is conveyed to men that if they don't engage in active and aggressive penile rehabilitation, then their penis will atrophy and their health, relationships, and quality of life will suffer. The positioning of erectile dysfunction as a purely physiological problem leads easily to the argument that medical intervention (i.e., penile rehabilitation) is required to fix the penis. There is little if any mention of the subjectivity of men or their partners in literature on penile rehabilitation. Likewise, there is little acknowledgement that erections are embedded within social meaning systems and webs of power that incorporate ideas around gender, sexuality, and body regulation. Within this medical model of sexuality, "there's little attention to the person or couple attached to the penis, or recognition that

relational factors might modify the meaning or importance of penile rigidity or sexual intercourse in a couple's sexual script" (Tiefer, 2004, p. 233).

Sexuality and Gender as Social Constructions Rather than Biological Universals

Penile rehabilitation resides within and thus can be said to reflect larger cultural meaning systems and discourses of sexuality and gender. "There are … a variety of discourses that surround an object, person, event, experience, each telling a different story or representing that thing in a particular or different way" (Burr, 2003, p. 63); however, not all discourses are treated as equal.

> Discourses vary in their authority. The dominant discourses appear "natural," denying their own partiality and gaining their authority by appealing to common sense. These discourses, which support and perpetuate existing power relations, tend to constitute the subjectivity of most people most of the time (in a given place and time). (Gavey, 1989, p. 464)

The proposed study will explore discourses primarily of sexuality and gender that appear within penile rehabilitation literature and will identify links between discourses embedded within penile rehabilitation and broader cultural institution. This study will explore the ways of being, identities, desires, and ways of behaving that are alternately promoted and prohibited through penile rehabilitation programs and the discourses operating around and within this intervention. It will query mainstream 'truths' about sexuality and gender, and situate penile rehabilitation within a particular discursive, and thus social and historical, context. What follows is an explication of some of the dominant discourses of (hetero)sexuality that can be thought to have provided fertile

(discursive) ground for penile rehabilitation programs to take root and flourish in both biomedical and layperson contexts.

The Biological Model of Sexuality (e.g., Segal, 1994) positions (hetero)sexuality as biologically driven and essential/natural. Sex is for reproductive purposes primarily and intercourse is positioned as a natural sex act. The Male Sexual Drive discourse (Hollway, 1984), which is part of the broader interpretive repertoire of sexuality being biologically driven, positions desire for men as a natural drive and urge that requires expression and satisfaction.

The Orgasmic Imperative (Bejin, 1986) positions orgasm as the ultimate goal of sexual activity. Orgasm is the pinnacle of sexual behaviours and is positioned as the most important event or aspect of sex. Orgasms that are absent, delayed, premature or otherwise deviant from the narrow parameters set by sexological models of sexual response are pathologized. Closely linked to the orgasmic imperative is the coital imperative (Gavey, McPhillips, & Braun, 1999), which positions intercourse, or penetration of the vagina by an engorged penis as a privileged sexual act. All other sexual acts are constructed as peripheral and secondary to coitus. Closely linked to this discourse is the synecdochal relationship between the man and his penis. That is, a properly functioning penis (i.e., a penis that can penetrate a vagina upon demand) comes to stand in for both male sexuality and masculinity (Potts, 2002).

In her critical analyses of impotence as a focus in sexology and target of treatment, Tiefer (2004) argues that the term itself is implicated in "maintaining phallocentrism in sexology" (p. 122).

> Discussion of impotence converts problems of the penis into problems of the man, converts problems with sexual performance into weakness and lack of masculine control. (Tiefer, 2004, p 122)

Tiefer (2004) also notes how dominant discourses of sexuality position sex as natural, essential, ahistorical, and universal. Sexology is infused with use of the words 'natural' and 'nature' when referring to sexual behaviours and patterns, which position these behaviours and patterns as universal and biological. According to Tiefer, deployment of this language serves a justificatory and legitimizing purpose rather than a descriptive or informative purpose. That is, these words are use to persuade people into adopting a particular way of understanding and viewing sexuality. Situating sexuality within the biomedical domain de-emphasizes sociocultural and political aspects of sexuality and the role of meaning, subjective experience, interpretation, and pleasure.

In her analysis of the increasing healthization of sexuality and the positioning of sex within the biomedical domain, Tiefer (2004) has identified a number of assumptions in circulation such as the idea of norms and deviance, which conveys that "there is such a thing as healthy sexuality that can be distinguished from nonhealthy … sexuality" (p. 189). Tiefer challenges the validity of any kind of universal, objective, clinical norms of sexuality, arguing, "There's just too much lifestyle, historical, and cultural variability in sexual behavior standards for us to be able to establish *clinical* norms of sexual activity performance, choices, frequencies, patterns, and subjectivities" (p. 190). Biomedical models of sexuality emphasize the idea of the universality of sexuality, that there are transcultural and transhistorical truths about sexuality that exist (Tiefer, 2004). In addition, sexuality is positioned within individuals (in their individual psyches and

individual biology), which deemphasizes sociocultural factors and contexts and the role of meaning making.

A social construction perspective problematizes a biologically based construction of sexuality and any notion of a natural body or natural sexuality. Rather, a social constructionism perspective asserts that such claims are fictitious (e.g., Bordo, 1988). Bodies are viewed as cultural constructs (Bordo, 1988; Foucault, 1978; Butler, 1990) and there is no such thing as a pre-cultural or natural body (Bordo, 1993; Foucault, 1978; Butler, 1990). In the words of Bordo (1988), "There is no … fundamentally stable, essential physical being, which exists prior to or apart from cultural and social practices" (Potts, 2002, p. 17, referencing Bordo, 1988).

In line with the problematization of any natural or pre-cultural body is the problematization of sex as a natural act or as having any essential nature (e.g., Tiefer, 2004; Potts, 2002; Weeks, 1985; Weedon, 1987). A critical perspective positions sex and sexuality as social practices, infused with relations of power and dominant discourses (Weeks, 1985).

> Human sexuality is not a biological given and cannot be explained in terms of reproductive biology or instinct. All human actions need a body, but only part of human sexuality has to do with actions, and even that part only requires a body in the way that playing the piano does. What is done, when, where, by whom, with whom, with what, and why – these things have almost nothing to do with biology. (Tiefer, 1995, p. 3)

Critical perspectives on gender likewise emphasize the constructedness of ideas of masculinity and femininity (e.g., Butler, 1990). Gender is positioned as a cultural artefact

rather than a pre-cultural or essential property of individuals. Butler (1990) frames gender as performativity. Gender is built upon a series of acts that we perform over and over again and it is this repeated performativity that produces the illusion of a stable, essential gendered self. In other words, gender is what one *does* not who or what one *is*.

> "The action of gender requires a performance that is *repeated* … Gender ought not to be construed as a stable identity or locus of agency from which various acts follow; rather, gender is an identity tenuously constituted in time, instituted in an exterior space through a *stylized repetition of acts*. The effect of gender is produced through the stylization of the body and, hence, must be understood as the mundane way in which bodily gestures, movements, and styles of various kinds constitute the illusion of an abiding gendered self. (Butler, 1990, p. 191, italics in original)

It is, thus, repeated acts of masculinity/femininity that produce a masculine and feminine subjectivity, rather than the other way around.

Theoretical and Epistemological Perspective

This section includes a review of the major tenets of social constructionism followed by a review of some of the distinguishing features of feminist poststructuralist discourses analysis, which falls under the broad theoretical umbrella of social constructionism. Because there is no widely agreed upon methodological template to follow when conducting feminist poststructuralist discourses analysis, general guiding methodological principles are discussed in this section. More methodological details are provided in the subsequent section as part of the write up of Studies I and II.

Broadly, social constructionism involves adopting a critical stance towards knowledge and any assertion that (scientific) knowledge is based upon objective, unbiased observation of the world, or that the true nature of things in the world can be discovered through scientific observation of them (Burr, 2003). Social constructionism problematizes the idea that we can discover objective facts about the world as it exists outside of our biases, rather it posits that we create these so-called facts about the world and that what we 'discover' is mediated by and thus shaped by our perspectives, biases, and assumptions. We can only ever know one particular perspective or way of understanding the world but never *the* truth. "Within social constructionism there can be no such things as an objective fact. All knowledge is derived from looking at the world from some perspective or other, and is in the service of some interests rather than others" (Burr, 2003, p. 6).

In addition, our understandings of the world – including the categories used to classify things in the world – are always located within their historical and cultural context, and a critical approach is taken when a particular understanding of the world or

of things in the world are depicted as being ahistorical (Burr, 2003). Knowledge is contextualized within its cultural and historical moment. This perspective asserts that knowledge is created and sustained by social processes and through language (Burr, 2003). That is, we cannot know, describe, or understand the world or ourselves except as mediated through language. Emphasis is placed on discourse and discursive construction and constitution of things in the world. Discourse here refers to "a kind of frame of reference, a conceptual backcloth against which our utterances can be interpreted" (Burr, 2003, p. 66), and we depend on discursive context in order to give meaning to what is said (Burr, 2003). Discourses appear in myriad forms: written, oral, environmental, and in daily social practices (Weedon, 1987, p 108).

Finally, social constructionism emphasizes that knowledge and social action are inseparable. For example, socially negotiated and linguistically constituted understandings of sexuality make possible and permissible certain social actions and make transgressive other social actions (Burr, 2003). Discourses of sexuality are not merely linguistic entities with no link to the real world. Rather, discourses have material implications.

Feminist Poststructuralist Discourses Analysis

Feminist poststructuralist discourse analysis (FPDA) is an epistemological approach that falls within the scope of social constructionism and that thus encompasses the tenets discussed earlier. There are, however, some additional distinguishing features of FPDA, which have theoretical and methodological implications for the present study.

For FPDA, the "goals of scholarship would include developing understandings or theories that are historically, socially, and culturally specific, and that are explicitly

related to changing oppressive gender relations" (Gavey, 1989, p. 463). Particular emphasis is placed on "disrupting and displacing dominant (oppressive) knowledges" (Gavey, 1989, p. 463) as they relate to knowledge systems and social practices based on these knowledge systems about men and women (Potts, 2002). There is a focus on analyzing "the working of power on behalf of specific interests" and "opportunities for resistance to it" (Weedon, 1987 p. 40).

As part of this emphasis on disrupting and displacing oppressive knowledges and so-called truths, FPDA aims to give voice to those who are marginalized and silenced in more dominant accounts (Baxter, 2003). Thus this approach is well suited to a project exploring the often silenced and missing accounts of female partners of men with prostate cancer. Study II includes analysis of interview material from female partners as they share their subjective experiences of coping with and making sense of prostate cancer.

A focus on power and the material implications of discourse. FPDA emphasizes links between language, social institutions, subjectivity, and power. Discourses are reproduced constantly and are in constant circulation and there are always multiple discourses, which converge and compete. However, not all discourses are given equal weight, power, and privilege. Some are positioned as more truthful, more valid, and are thus granted greater power and privilege and these tend to have strong institutional ties (Weedon, 1987). According to Foucault (1977), discourses are intimately linked to power and knowledge and have material implications. "Discourses are intimately tied to the structures and practices that are lived out in society from day to day, and it is in the interest of relatively powerful groups that some discourses and not others receive the

stamp of truth" (Burr, 2003, p. 76). Not all discourses are equal and not all carry equal legitimacy.

That is, certain discourses are imbued with greater power than others, especially those that are aligned with objectivity, empiricism, and science. Knowledge is viewed as being socially constructed and thus "transient and inherently unstable" (Gavey, 1989, p. 462) and not neutral. "It is closely associated with power. Those who have the power to regulate what counts as truth are able to maintain their access to material advantages and power" (Gavey, 1989, p. 462)

Power is not conceptualized as a top-down hierarchical construct that is possessed by some and wielded over others, but rather as fluid and as existing within and being an effect of discourse (Foucault, 1977; Baxter, 2008; Weedon, 1987). Thus, no one person is described as being either completely powerful or powerless in a given situation, but rather individuals can adopt subject positions that are more or less powerful, sometimes adopting multiple subject positions with differing access to power in a single conversation (Baxter, 2008).

> [FPDA has a] quest to challenge any simple dualism between dominant discourses representing the voices of oppressors, and oppositional discourses constituting the voices of the oppressed. It aims to reveal the complexities of participants' interactions, foregrounding the ways in which positions of power are continuously negotiated, contested and subverted, never permanently settling as 'structure'. (Baxter, 2003, p. 71)

Thus, a focus of FPDA is to identify and trace pathways of power in and through both discourses and related social practices.

The current project identifies and explores dominant 'knowledges' and discourses about sexuality and gender as they relate to prostate cancer recovery and sexual rehabilitation. Analyses examine social practices (e.g., penile rehabilitation) as they relate to these dominant knowledge systems and discourses. The study explores how certain discourses (e.g., sex as a health/medical matter; intercourse as a heterosexual imperative; masculine sexuality as requiring erections) are positioned as being more real, natural, and valid that other discourses within patient materials and participant's accounts. In addition, the material implications of dominant discourses are emphasized, such as penile rehabilitation protocols and clinics, sexual and relationship practices of participants, and difficulties participants face when their regular routines and ways of relating are disrupted.

The combined studies examine discourses of sex and gender that are embedded within and conveyed through penile rehabilitation online patient materials to understand how the prostate cancer recovery experience is framed for men and their partners. Links between these discourses and the accounts of men and their partners are made. For example, the ways in which participants adopt and reiterate dominant discourses of sex and gender are explored. The studies thus examine power structures and meaning systems that are built into the prostate cancer experience, and how individuals come to take up and internalize these meanings or discourses about sexuality and gender, and then enact these meanings and discourses in their lives.

Finally, opportunities for and examples of resistance to dominant discourse and systems of meaning are explored in both online patient materials (Study I) and participant accounts (Study II).

A focus on subjectivity. According to FPDA, identity is viewed as something that is constantly and continuously created, produced, and performed – not as something that you are (Baxter, 2003; Butler, 1990, 2004; Gavey, 1989; Weedon, 1987). Subjectivity, which refers to "the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world" (Weedon, 1987, p. 32), is viewed as being fragmentary and unstable, constantly changing and changeable.

This project privileges subjectivity and emphasizes the ways in which participants construct identity within interviews. Identity (e.g., as a prostate cancer survivor, as a man, as a partner of a man with prostate cancer, as a woman, etc.) is positioned as something that people actively and continuously generate and negotiate. This study examines how men and women construct their individual and communal couple identities through their participation in interviews.

FPDA views individuals as constantly negotiating their subjectivities in relation to available subject positions which are made available by and through discourses (Gavey, 1989; Weedon, 1987). In this way, discourses are thought to be fundamentally productive, in that they create the conditions (subject positions) for certain experiences, identities, ways of feeling, thinking, and understanding oneself, while precluding others (Burr, 2003). Subject positions are specific ways in which people come to view themselves and position themselves in relation to others and in relation to discourses. Subject positions structure the ways in which people understand, experience, interpret, make sense of, and experience things in the world. They can be both adopted and rejected by individuals. Subject positions carry varying levels of powerfulness and powerlessness

in a given context.

FPDA seeks to identify the various subject positions that are made possible and available to individuals in a given context. These subject positions are linked to discourses in circulation and operation, which provide meaning and context. For example, a FPDA approach to penile rehabilitation would seek to identify the larger discourses circulating and at play within penile rehabilitation, the cultural backdrop in which penile rehabilitation has emerged, the ways in which penile rehabilitation is positioned and legitimized, as well as the various subject positions made possible for men and their female partners through reference to these discourses. Indeed, this project examines the various subject positions made available to men and their partners through prostate cancer patient materials (e.g., the sexually diminished or disabled man, the rehabilitation coach, etc.), and the ways in which participants adopt or resist these subject positions in interviews.

A focus on gender as a site of discursive struggle. FPDA places particular emphasis on the ways in which gender differentiation is constructed, emphasized, and accomplished in texts (Baxter, 2008; Lazar, 2007). Simply put, gender is viewed as something you do rather than something you are (Baxter, 2008; Butler, 1990). The ways in which gender differences are positioned, reinforced, and achieved are analyzed and deconstructed. Gender is viewed as a "socially bestowed" identity rather than being indicative of any "essences of the person" (Burr, 2003, p. 106).

"As a shifting and contextual phenomenon, gender does not denote a substantive being, but a relative point of convergence among culturally and historically specific sets of relations" (Butler 1990, p. 14). Butler (1990) argues for gender to be viewed as a

performance that one accomplishes rather than an essence that one possesses.

Lazer (2007) reiterates the idea of gender as accomplishment by noting that "people … produce rather than reflect a priori identities as 'women' and 'men' in particular historical and cultural locations, although these produced identities are often viewed as natural, immanent, and transhistorical" (p. 150). There is an emphasis on the ways in which gender is achieved and enacted within culturally available discourse rather than viewing gender as something innate, essential or pre-cultural or as something that has any innate or essential meaning.

Rather than being viewed as fixed or stable qualities, femininity and masculinity are approached as being "constantly in process" (Weedon, 1987, p.96). "Terms such as 'masculine' and 'feminine' are notoriously changeable; there are social histories for each term; their meanings change radically depending upon geopolitical boundaries and cultural constraints on who is imagining whom, and for what purpose" (Butler, 2004, p. 10).

Gender is thus positioned as a key site of discursive struggle within FPDA (Weedon, 1987). Various subject positions are made available which offer particular ways of being a woman or being a man. And these ways of enacting femininity or masculinity are positioned as natural, desirable, and preferable in relation to other possibilities. Furthermore, these subject positions or ways of doing gender are reinforced by and conveyed through institutional practices, often sidelining alternative, less privileged ways of being a women or man (Weedon, 1987).

This project emphasizes the construct of gender and explores the ways in which gender is constructed in patient materials and interviews with participants. The ways in

which ‘successful’ masculinity is defined – and, conversely, the ways in which femininity is positioned – are explored, as are the implications of this for participants whose ability to perform successful maleness and femaleness is disrupted as a result of prostate cancer.

Interview data as a discursive product. People’s experiences, including their self-reports, interview responses, and behaviours, are treated as text that can be read and analyzed (Baxter, 2008; Gavey, 1989). Language is believed to structure experience and meaning, thus the ways in which interviewees use language to construct responses is believed to be structuring their experiences and their subjectivities. We can never get at the pure, unmediated or objective experience of something, rather a version of a person’s experience, as it is constituted through language (Weedon 1987). “This does not mean that experience does not exist or that it is not important, but rather that the ways in which we understand and express it are never independent of language” (Gavey, 1989, p. 461). Thus, the goal of FPDA in analyzing interview data is not to arrive at the essential or true experience of a person as reflected in their responses, but to explore the ways in which a person constructs their experiences, mediated through discourse, cultural context, and various webs of meaning and power. In this sense, we approach interview data “as discursive productions and not as reflections (accurate, distorted, or otherwise) of their ‘true’ experience” (Gavey, 1989, p.466). Likewise, the present study will not purport to identify the truth of the experience of women who are partners of men undergoing penile rehabilitation.

Participants’ interview transcripts will be treated as discursive products and not as objective accounts conveying some stable or universal truth about being a man with prostate cancer or being the female partner of a man going through penile rehabilitation.

Analysis will focus on the ways in which sex, intimacy, gender, recovery, and erections are represented in discourses, the various subject positions made available to participants, and the ways in which men and women adopt or resist and challenge these subject positions as they construct their accounts. In addition, analyses will examine tensions and inconsistencies within accounts as participants actively make meaning of their experiences and try to articulate these meanings.

Doing feminist poststructuralist discourse analysis. There is no monolithic methodological template to follow when doing FPDA, rather this approach involves a collection of principles that are used as guidelines to apply to a plurality of approaches (Baxter, 2003, Burr, 2003). FPDA generally involves the following (Willig, 2001):

1. Identifying the discursive constructions and patterns of meaning that are present in the text (the ways in which the object of study is being referred to), including contradictions and inconsistencies that appear.
2. Identifying the discursive backdrop of the text and thus situating the various discursive constructions present in the text within broader social, cultural, political contexts.
3. Making links between discourses and their associated dominant cultural positionings in terms of power and legitimacy.
4. Identifying what is being done and/or achieved by the particular discursive constructions that appear in the text.
5. Identifying the various subject positions that are made available by the discourses and that appear in the text, and identify the ways in which individuals position themselves in relation to these various subject

positions (what subject positions do participants take up/adopt, reject/distance themselves from; what kinds of selves do participants construct in the text? How do participants situate themselves in relation to these various subject positions?)

6. Identifying what possibilities for action are made possible by the subject positions that appear in the text.
7. Identifying what kinds of experiences, thoughts, feelings, and meanings are associated with the subject positions.

The Studies

This dissertation will explore the experiences of men and their female partners as they navigate the survivorship phase of prostate cancer (e.g., after initial treatments) and cope with various sexual and relationship changes. Emphasis will be placed on the discursive context of these experiences and on making connections between the ways in which participants make sense of changes in sexuality, gender identity, and relationship functioning and larger sociocultural discourses of sexuality, gender, intimacy, and relationships. The first study involves a discourse analysis of online information and patient materials about penile and/or sexual rehabilitation for prostate cancer. The focus is on identifying messages about sexuality, gender, relationships, and (ideal) patients. Identification of the discursive framing of sexuality, erections, recovery, relationships, and patients within patient materials is important because these sources of information may inform and shape the ways in which men and their partners navigate the post-treatment period and come to make sense of their experiences. For example, if patient materials position erections as essential for sex this may heighten feelings of anxiety and distress in men experiencing erectile changes. Study II involves discourse analysis of in-depth interviews with individual men, individual female partners, and couples to explore how men and women construct their sexual and relationship experiences in the context of prostate cancer, and what discourses (i.e., social norms and collective meanings) they adopt when they speak about sex, their identity as a man/woman, and their relationship. Links are made between the ways in which participants and patient materials frame gender, sexuality and relationships.

Study 1: Discourse Analysis of Prostate Cancer Penile & Sexual Rehabilitation Patient Materials

Overview

This study involved a discourse analysis of patient materials on penile and sexual rehabilitation programs for men with prostate cancer and on general information sources on treating sexual side effects of prostate cancer treatment. This study analyzed the materials that patients are given or have access to as they research, consider, engage in, and go through penile and sexual rehabilitation. This study examined the construction of penile rehabilitation, as well as the discourses of sexuality, gender, and intimate relationships embedded within, and employed by these materials. Discourses of sexuality, such as the coital imperative, are conveyed through and by technologies of sex(uality) (Potts, 2002). The term 'technologies of sex' draws on Foucault's (1988) concept of technologies of self which "permit individuals to effect, by their own means or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct and way of being, so as to transform themselves" (Foucault, 1988, p.18). Thus, through reliance on expert others, individuals are able to perform operations on their bodies in order to transform themselves from dysfunctional to functional, from unacceptable to acceptable, from imperfect to closer to perfection. This study positions penile rehabilitation as a (particularly powerful and privileged) technology of sex given its alignment with both science and medicine, and as such, as a vehicle for conveying cultural messages and imperatives about sexuality. This study explicates links between penile rehabilitation and dominant discourses of sexuality. The main objectives of Study I are to explore (1) the discursive construction of penile rehabilitation as a medical

imperative and (2) dominant discourses of sexuality, gender, and relationship that are being referenced and reproduced through penile rehabilitation literature.

This section includes a review of the method (e.g., materials and data analytic approach), a presentation of the analyses, and a discussion. The analysis section focuses on findings from the study data; references to past research are saved for the discussion section.

Method

Materials. Materials for this study include online patient information about specific hospital-based penile and/or sexual rehabilitation clinics and programs, as well as more general online patient information about coping with and treating the sexual side effects of prostate cancer. Sources include websites for hospitals located in Canada and the United States, and reputable prostate cancer information sources (e.g., cancer foundations, cancer societies, sources affiliated with cancer institutions, etc.) also located in Canada and the United States. Numerous Google searches were performed February 2015 using various key words and permutations of key word combinations in order to identify sources of data. Search terms included the following: penile rehabilitation, sexual rehabilitation, prostate cancer, patient material, clinic, major cancer hospitals, Canada, and North America. In addition, a list of hospitals in Canada and the United States offering formal penile and/or sexual rehabilitation to prostate cancer patients was generated and reviewed for completeness by experts working in this area. Attempts were made to locate online materials associated with these clinics. Results yielded 18 different 'documents' from 17 different online sources (9 cancer centres/hospitals and 8 cancer information websites; one website contained two different online documents that were

included in analysis). Excerpts are identified as coming from a cancer centre/hospital website or a cancer information website. Detailed comparative analyses were not done between materials from Canada and materials from the United States. However, there were no notable differences between the two. Both normative discourses and critical alternatives appeared in materials from both countries.

Data analytic approach. Data were analyzed using a feminist poststructuralist discourse analysis approach. The epistemological and methodological implications of this approach have been outlined above. Documents were read multiple times in their entirety. Both visual and textual content for each source was coded for material that related to the discursive construction of penile rehabilitation and penile rehabilitation patients, sexuality, erections, and partners/relationships. Coded material was then grouped thematically. Analysis was an iterative process that involved repeated readings of documents and of subsections of documents. Discursive constructions and patterns of meaning present in the text were identified (e.g., related to penile rehabilitation, erections, sexuality, patients, partners, etc.) including contradictions and inconsistencies. The discursive backdrop of the text was also identified and the various discursive constructions present in the text were situated within broader sociocultural contexts. Links were made between discourses and their associated dominant cultural positionings in terms of power and legitimacy. See Figure 1 for a summary of the analytic findings from Study I.

Figure 1. Study I Analytic Findings

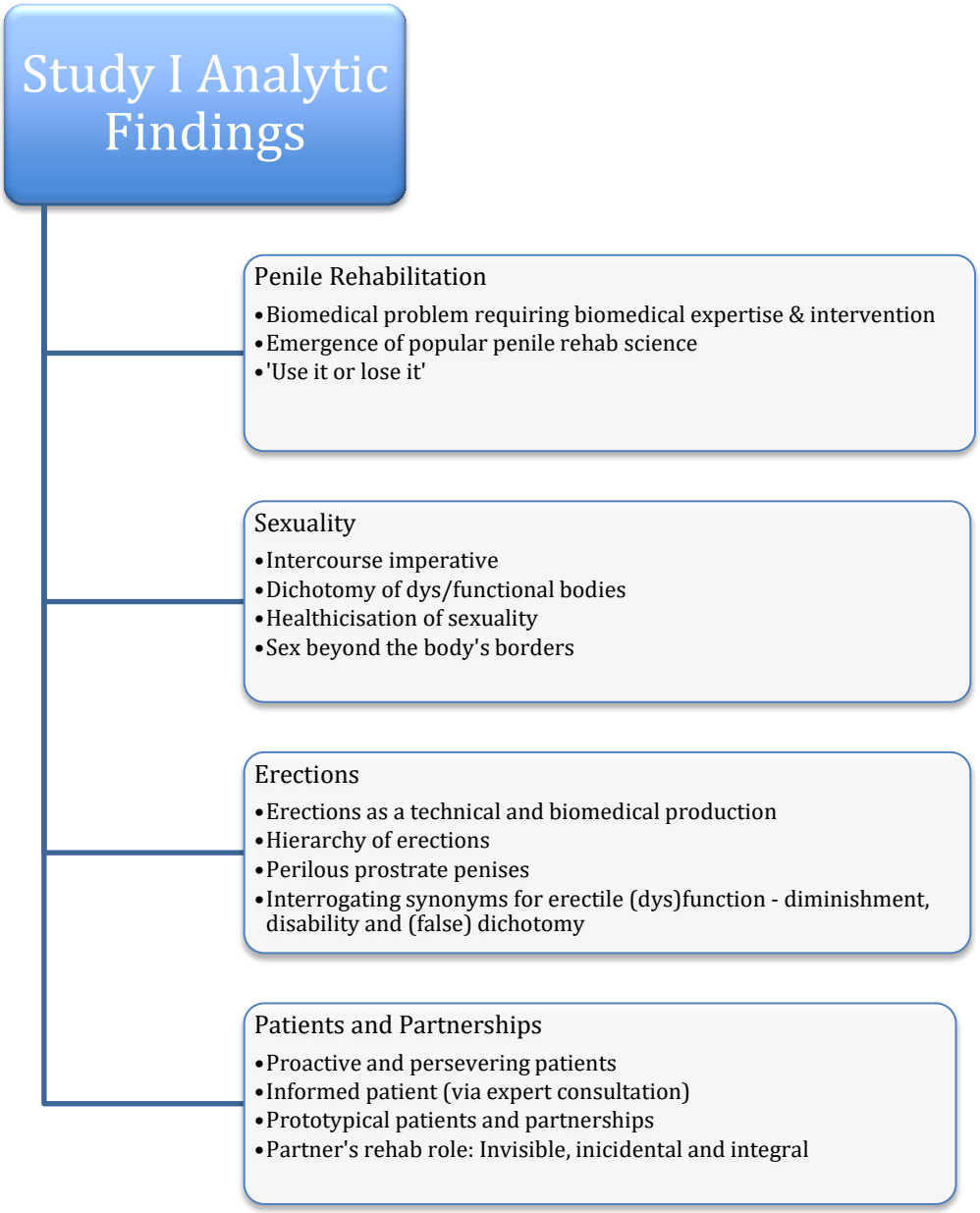


Figure 1. The analytic findings for Study I are organized by content theme and then by discourse/discursive strategy.

Analyses: Penile Rehabilitation

Online patient materials were coded for content that related to the discursive construction of penile rehabilitation programs. Analyses were guided by the following

questions: In what ways are penile rehabilitation programs being explained to patients? What rationale is provided to patients for participating in these programs? And what messages about erections, the body and sexuality are employed to explain and sanction rehabilitation programs?

The following three discursive strategies emerged:

(1) **A biomedical problem requiring biomedical expertise and intervention:** Erectile difficulty is described as a mechanical and biomedical problem and penile rehabilitation is positioned as the optimal pathway to recovery through reliance on biomedicine and scientific experts.

(2) **The emergence of popular penile rehab science:** Selective empirical evidence is used to validate penile rehabilitation to patients and to position it as a scientifically proven treatment.

(3) **Use it or lose it:** Failure to begin penile rehabilitation within a narrow window after surgery is presumed to result in permanent damage to the man's penis (e.g., degeneration of erectile capacity).

Discursive strategy 1: A biomedical problem requiring biomedical expertise & intervention. Changes in erections following prostate cancer treatment are positioned in patient materials as a complex biomedical problem requiring specialized biomedical knowledge and intervention. For example, the first two sentences of one online article with the subheadings "Living with Prostate Cancer" and "Erectile Dysfunction" read, "Regardless of whether the nerves were spared during surgery or whether the most precise dose planning was used during radiation therapy, nearly all men will experience some erectile dysfunction for the first few months after treatment. The reason for this is

simple: the nerves and blood vessels that control the physical aspect of an erection are incredibly delicate, and any trauma to the area will result in changes to the natural order" (Cancer Information Website). Thus, the patient is immediately provided with a biomedical orientation towards their experiences.

Excerpt 1:

The oral medications for erectile dysfunction, sildenafil (Viagra), tadalafil (Cialis), and vardenafil (Levitra), relax the muscles in the penis, allowing blood to rapidly flow in. On average, the drugs take about an hour to begin working; the erection helping effects of sildenafil and vardenafil last for about 8 hours and tadalafil about 36 hours. About 75% of men who undergo nerve-sparing prostatectomy or more precise forms of radiation therapy have reported successfully achieving erections after using these drugs.

…

In addition to the oral medications, there are a number of alternative treatments that might be helpful to men with erectile dysfunction.

MUSE is a medicated pellet about half the size of a grain of rice that is inserted into the urethra through the opening at the tip of the penis using a disposable plastic applicator. Like the oral medications, it, too, stimulates blood flow into the penis; an erection typically occurs within 10 minutes after insertion of the pellet, and can last for 30 to 60 minutes. About 40% of men have reported successfully achieving erections after using this drug, but the results are often inconsistent. Caverject uses the same drug that is in the MUSE pellets, but delivers it via an injection directly into the penis. It takes about 10 minutes to work and lasts for

about 30 minutes. Although nearly 90% of men using Caverject reported erections about six months after therapy, most men are not willing to inject themselves regularly, so the treatment is not often used for long periods of time. (Cancer Information Website)

Excerpt 1 provides a lengthy and detailed outline of various interventions for erectile dysfunction. This excerpt, which contains part of a much lengthier description of multiple treatment options, is an illustration of how the 'problem' is positioned in patient materials as a technical breakdown in the penis (e.g., drawing or forcing blood into the penis; stimulating blood flow; relaxing the muscles of the penis;) requiring biomedical interventions (e.g., inserting a medicated pellet into the urethra; injection into the penis; a rubber ring rolled onto the base of the penis). This orientation to erectile dysfunction and to penile rehabilitation is prominently displayed on the website for patients.

Likewise, Excerpts 2 and 3 provide outlines of interventions used in their rehabilitation protocols. These excerpts construct penile rehabilitation as a biomedical intervention. Straightforward medical protocols are outlined with systematic and sequential interventions described. Notably there is no mention of counseling or of the context of sexual changes in a man's life. The focus here is on fixing the penis and on getting erections to 'work.' Thus, both the problem and the solution are constructed as biomedical. Medicine is positioned as having the tools and capability to 'fix' the problem.

Excerpt 2:

Using an evidence-based approach, therapies incorporated into the Stanford Penile Rehabilitation Program include:

- *Oral medications*
- *Injection therapy*
- *Urethral suppositories*
- *Vacuum erection devices*
- *Testosterone replacement*

(Cancer Centre/Hospital Website)

Excerpt 3:

Our standard rehab plan, which begins before prostate cancer surgery, includes the following:

Before prostate surgery

- *Viagra 50mg nightly starting the week before surgery.*
- *A VED (vacuum erection device) prescription is provided pre-operatively.*

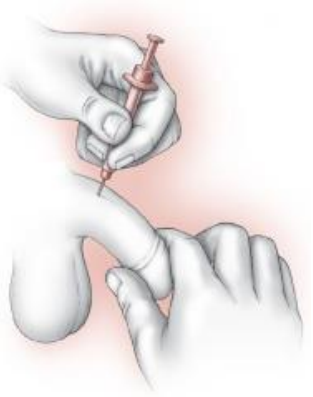
After prostate surgery

- *Resume taking nightly Viagra 50mg after discharge from the hospital.*
- *Start once-a-day usage of the VED after the removal of the catheter.*
- *Follow-up visit with rehab "coach" one week after catheter removal.*
- *Start MUSE 2x per week (VED and Viagra not used on those days).*
- *Follow-up visit at 3 months. Injection therapy will be initiated if you are not having adequate erections for intercourse.*

(Cancer Centre/Hospital Website)

Excerpt 4:

Figure 1: Injection therapy



Using a small needle (about half an inch long, the same size as those used to inject insulin), a man can inject one or more prescription drugs into the side of the penis. The injected drugs all work by relaxing the smooth muscle tissue of the penis and allowing blood to flow into the erectile tissue. (Cancer Information Website)

This combined diagram and textual explanation introduces patients to penile injection therapy. The addition of the world "therapy" constructs this as a medical treatment (and differentiates this from recreation or non-medical use). Notice also that when the needle is described it is compared to a needle that diabetics use for injecting insulin. Thus, the treatment for erectile problems is likened to treatments for chronic conditions that have evidence-based (and often self-managed) medical solutions. The description provided for how the injected medication produces an erection uses simple yet biomedical language (e.g., "relaxing the smooth muscle tissue of the penis"). This all paints a picture of injections as a straightforward medical procedure. It is prescriptive and conveys confidence that should specific steps be followed, all will be well. This contributes to a construction of sexual rehabilitation that focuses on physiology and fixing erection 'problems' using medical expertise.

Expert consultation imperative. Materials consistently convey that men would not be able to navigate rehabilitation on their own. Men are positioned as lacking the necessary knowledge and expertise to address erectile changes. Patients are thus encouraged to seek out and consult with professionals who might help them resolve this specific 'condition.' Experts are positioned as the gateway to recovery.

One cancer information website encourages men to "talk to your doctor about how your nerves were affected by surgery." It is striking that men are encouraged to talk to their doctors about how their nerves may have been affected by surgery, but not to discuss the impact of surgery on their well-being more broadly (e.g., their emotional well-being, their sexuality, their relationship, their self-confidence, etc.). This advice presumes that patients have an understanding of how their nerves have been affected, and constructs erections as a biomedical phenomenon (e.g., a product of nerve function).

Likewise, a cancer hospital website encourages patients to "Talk with your doctor. Your doctor can give you more information on what's causing any sexual dysfunction you're experiencing. From there you can discuss treatment options, such as medications, implants or devices that can facilitate an erection." The doctor (expert here) is positioned as someone who can decode a man's difficulties with sexual changes and prescribe a solution. Notably the treatments listed are either biomedical or mechanical in nature (e.g., medications, implants, devices). The possibilities for adaptation and recovery are very specific here in their scope and focus (e.g., using technology and medicine to get erections back).

An online prostate cancer publication also stresses the importance of expert consultation when addressing sexual changes: "As always, these products shouldn't be

used without first consulting your doctor … Ask your doctor what approach to penile rehabilitation he/she prescribes. Your local pharmacist can also be a valuable resource for information and support." The message conveyed through this legalese language is that adapting to and addressing sexual changes is a biomedical process that requires medical experts. The solution can be found through consultation with a doctor and/or pharmacist.

A hospital website also recommends "that both you and your partner meet with one of our sexual medicine experts (your rehab 'coaches') prior to prostate surgery," in order to receive consultation and comprehensive diagnostic examination if appropriate. The language (e.g., of coach) conjures up associations of complex maneuvering, physical exercise, and training. Navigating sexual changes following treatment is thus positioned as a complex process requiring expert guidance, strategizing, and use of performance improvement strategies. A sexual medicine expert is required in order to successfully maneuver through this complex process and to get to one's personal best. Rehabilitation is positioned as being a complex process that will involve medical diagnostic tests, experts, etc. … This is not something that can be done on one's own or with one's partner, as experts are required for successful navigation.

Excerpt 5:

Faculty Bio: [Doctor's name], MD

[Doctor's name] is a board-certified urologist, a urological prosthetic surgeon and a microscopic surgeon who specializes in sexual medicine and andrology. Since the inception of the sexual medicine clinic at the [cancer centre], [doctor's name] has streamlined the clinic to help thousands of patients with their sexual needs. The sexual medicine service provides care to all male patients who may

> *have sexual dysfunction or infertility related to their cancers, cancer treatment, or any other etiology. We offer a comprehensive penile rehabilitation program catering to men who will have or have had radical prostatectomy, radical cystectomy and any other pelvic surgeries such as surgeries for rectal cancer, sarcoma or pelvic bone cancers. Men who have received pelvic radiation or systemic chemotherapy can also benefit from our penile rehabilitation program.* (Cancer Centre/Hospital Website)

This faculty bio constructs penile rehab as something that requires scientific experts with specialized training. As part of the bio, there is an extensive list of the specialist's experience, honors, awards, and publications, with many of the studies focusing on penile rehabilitation and many involving animals. Thus, treatment for erectile difficulties is positioned as a complex medical problem that can best be addressed via expert intervention. Likewise, another cancer centre website emphasizes access to "experts" in addressing sexual changes following prostate cancer treatment: "Experts at [the cancer centre] are dedicated to supporting men as they adjust to life during and after cancer treatment. Through this challenging time, our men's sexual and reproductive medicine team can help you cope with the impact of cancer on you and your intimate relationships. We can provide therapies for dealing with the physical side effects and strategies for managing the emotional issues that may arise as a result of treatment." The emphasis on working with "experts" and the "men's sexual and reproductive medicine team" and "therapies" generate images of specialization, high-level technical and medical skills and knowledge required to help a man navigate change and adaptation. The message is that left to his own devices the man will not be able to address these problems.

That left on his own, he will not be able to resolve his sexual challenges. That medical intervention is needed from highly trained experts. Sexuality is thus taken out of the hands of the man and out of the context of his life, and placed in the domain of medicine and "sexual health."

In the online patient materials for a cancer centre , a series of videos are posted with still images of experts (see Excerpts 6-8 below). The message conveyed is that addressing sexual problems is something that is done by experts, consultants, and/or clinicians. The experts in the images are marked as professionals by their physical dress (e.g., pant suits, dress shoes), body postures (e.g., sitting erect, cross legged, etc.), and placement on raised speaker platforms.

Excerpt 6:

Getting your groove back: Sex, Reproduction, and Body Image During and After Cancer

(Cancer Centre/Hospital Website)

Excerpt 7:

Sexual Problems in the Male Cancer Patient

(Cancer Centre/Hospital Website)

Excerpt 8:

Managing the impact of radiation therapy on sexual health

(Cancer Centre/Hospital Website)

***Contextual erections*.** In the midst of dominant biomedical constructions of changes in erections there are alternative voices, which emphasize the contextual and relational nature of erections. These voices acknowledge that erections are embedded in and thus impact a man's whole person, including his body, psychology, and emotional experiences, as well as his relationship(s). This opens up the possibility for solutions that expand beyond pure physiology. Interventions that integrated biological, psychological and relational domains appear in several places.

For example, excerpt 9 describes a clinical trial being offered to men experiencing sexual dysfunction as a result of cancer treatment. The program offers access to an online repository of videos and information for patients and their partners with videos that show clinicians working with couples and talking about some of the challenges they face. Resources cover both medical and counseling topics and the website emphasizes the integration of both.

Excerpt 9:

… it has not only the medical things but the counseling things. So it actually has self-help exercises that couples can do together or a man can do if his thoughts are very negative and he wants to kind of motivate himself and change his thinking. And it, you know, really integrates the emotional the physical not just one or the other … So our hope is that these websites will be out there as a self-help resource that will give people exercises to do, the information that they need to understand their cancer and their sex lives" (Cancer Centre/Hospital Website)

Likewise another cancer centre (see Excerpt 10), while not exclusively for men with prostate cancer, positions itself as taking a broad approach to helping men resolve "sexual health problems" related to cancer.

Excerpt 10:

Your care team will take a multidisciplinary approach to discussing and addressing your physical and emotional concerns related to sexual health. We will also take a full medical history to identify additional risk factors for sexual health problems, such high blood pressure, high cholesterol, and diabetes.

We use this information to develop a personalized treatment plan to help you manage the effects of cancer on your sexual health. Our strategies include:

- *medications to treat erectile and ejaculatory dysfunction*
- *hormone replacement for low testosterone levels*
- *fertility preservation, including sperm extraction*
- *postsurgery rehabilitation programs, such as penile rehabilitation after prostate cancer surgery*
- *counseling for individuals and couples*

- *suggestions to enhance communication and intimacy with current or future partners*

Our male sexual health specialists can provide these and other treatment options to help you overcome any barriers preventing you from achieving a high quality of life when it comes to your sexual health. (Cancer Centre/Hospital Website)

Their emphasis on multidisciplinary care, and explicit mention of addressing both physical and emotional concerns suggests their model of care goes beyond the biomedical realm. Notably, however, penile rehabilitation is listed as one of the treatment strategies available and it is separated from "counselling for individuals or couples" and "suggestions to enhance communication and intimacy with current or future partners" thus, it's possible that the penile rehabilitation program is entirely biomedical in focus. No specific textual information was available online about the penile rehabilitation program. The rehabilitation program at another cancer centre (see Excerpt 3) is one of the few programs with online information that expressly advertises itself as a biopsychosocial program, weaving medical and psychological interventions together in patient care.

Excerpt 11:

Our unique program was designed to address the challenges associated with changes in sexual and urinary function that affect the majority of men following radical prostatectomy. We approach these challenges from both a biomedical and psychological standpoint in order to offer the most comprehensive care to our patients. Our program consists of:

i) A systematic biomedical erectile rehab program

ii) Psychosocial counseling and a self-help manual developed specifically for post radical prostatectomy sexual dysfunction

iii) Ongoing collection of data to ensure the highest quality care

How does the program work?

The PCRC [Prostate Cancer Rehabilitation Clinic] *incorporates biomedical treatment and psychosocial support to assist patients and their partners with rehabilitation post-surgery. Over the course of the Clinic, patients will be seen approximately 7 times (about once every 4 months), and will have access to a multi-disciplinary team consisting of a urologist, nurse, sexual health counsellor, psychologist, and clerk. Over the course of two years, the PCRC staff work with patients to encourage weekly sexual activity combined with pro-erectile therapy and assist patients and their partners in maintaining intimacy.* (Cancer Centre/Hospital Website)

The cancer centre's clinic advertises that it adopts a biopsychosocial model of care. Thus, they emphasize the importance of the psychological, emotional, and relational context in which sexual (and other) changes are occurring for the man. They state that their clinic staff are multidisciplinary, thus rehabilitation is positioned as encompassing varied facets and factors. Their program appears broader in scope than other more narrowly defined penile rehabilitation programs. Notably, the physical and psychological/social are positioned as distinct domains. Online materials for another cancer centre (see Excerpts 4-6) also positions rehabilitation as being about more than the penis and erections.

Excerpt 12:

We have found that the delay in the return of potency can be improved by several approaches. First, by employing a careful surgical technique, one is able to minimize potential trauma to the nerves. Second, by providing a comprehensive preoperative counseling program for the patient and his partner, one is able to address postoperative concerns and minimize the psychological impacts of surgery. (Cancer Centre/Hospital Education Booklet)

Excerpt 13:

Studies have shown that treatments for prostate cancer may cause sexual changes that can reduce the quality of life for patients and their partners. These changes can be a difficult for many men who already have a lifetime of sexual experience and have continuing expectations. Changes may occur to urinary continence, sexual self-esteem, libido, penile functioning, orgasm, and ejaculation. Prostate cancer patients and their partners may need to make sexual adjustments as a result of the treatment effects. As a module of the [cancer centre's prostate cancer support program], we are offering an information session that focuses on the sexual side effects of prostate cancer treatments and how sexual rehabilitation can reduce the adverse impact of prostate cancer on sexuality, sexual functioning and relationships. (Cancer Centre/Hospital Online Flyer about Prostate Cancer Program)

Excerpt 14:

For these reasons we provide an educational forum to help men and their partners learn about the strategies used to manage sexual side effects, and to ask questions. Our Sexual Health Clinician—a Rehabilitation Nurse specializing in

sexual health and chronic illness – presents this 90 minute session which is designed to:

- *Add to one's current understanding of sexual health and sexuality*
- *Inform you about the possible sexual changes caused by prostate cancer treatments*
- *Introduce penile rehabilitation*
- *Begin to review the efficacy, pros and cons of various management options for sexual changes*. (Cancer Centre/Hospital Online Flyer about Managing Prostate Cancer Side-Effects)

The program at the cancer centre is relatively broad in comparison to other programs in that they focus on sexuality, sexual functioning, and relationships. By listing these as distinct areas of impact from cancer, and as targets for the program, they distinguish between body parts functioning, sexuality more broadly, and the relational context in which all of this change is occurring. Their program does not equate sexual functioning with relationship functioning. Likewise, this suggests that they are not equating sexuality with sexual performance. In their review of the potential impacts of side effects from prostate cancer treatment, they also include sexual self-esteem, as well as things like penile functioning and ejaculation. In the brief review of their sexual rehabilitation program for prostate cancer patients, they mention a variety of components, one of which is penile rehabilitation. Thus, their construction of rehabilitation includes, but goes beyond, addressing the impact on the penis, to focusing on the impact on the patient's sexuality more broadly and to the couple context.

In summary, the changes in erections stemming from prostate cancer treatment are frequently framed using biomedical concepts and images (e.g., through descriptions of nerves, scarring, blood flow problems, etc.). In line with this, penile rehabilitation interventions often emphasize biomedical and/or mechanical therapies, which require consultation with expert clinicians. However, several resources present notable exceptions to this dominant positioning. They describe programs that emphasize the emotional, psychological, and relational domains of a patient's life, along with medical considerations.

Discursive strategy 2: The emergence of popular penile rehab science. Most texts reference empirical evidence (e.g., research studies, theories, researchers) when providing a rationale for penile rehabilitation. For example, it is common for sources to provide statistics of success rates from clinical trials for various pro-erectile treatments. Other texts reference evidence or "research" more broadly without citing any one particular study. For the most part, 'science' is used to construct a favourable picture of penile rehabilitation programs and to support early and aggressive intervention. Critical scientific voices are largely absent; however, a minority of materials acknowledge that penile rehabilitation remains controversial, and/or provide a review of scientific evidence that includes mixed findings.

Excerpt 1:

Our rehab protocol is based on research conducted at [Cancer Centre/Hospital] and other leading centers for both prostate cancer surgery and sexual medicine. (Cancer Centre/Hospital Website)

Excerpt 2:

Studies have been done in which doctors tested different methods to promote erections starting just weeks after surgery. The results of these studies suggest that these methods can help some men. (Cancer Information Website)

Both of these excerpts provide vague and general statements about research that supports penile rehabilitation. The first excerpt simply states that their rehabilitation protocol is based on "research" from reputable institutions, including their own. The second statement is less specific in that it refers to "studies which have been done" without specifying their institutional affiliation, date of publication, etc. No further details are provided to elaborate on these claims; however, they are powerful in their simplicity and conciseness. The broad reference to "research" gives the impression that the evidence is conclusively supportive of penile rehabilitation and that no further substantiation is necessary. Science is positioned as speaking for itself.

Excerpt 3:

About 75% of men who undergo nerve-sparing prostatectomy or more precise forms of radiation therapy have reported successfully achieving erections after using these drugs [sildenafil (Viagra), tadalafil (Cialis), and vardenafil (Levitra)] … About 40% of men have reported successfully achieving erections after using this drug [MUSE], but the results are often inconsistent … Although nearly 90% of men using Caverject reported erections about six months after therapy, most men are not willing to inject themselves regularly, so the treatment is not often used for long periods of time … About 80% of men find this device [vacuum pump] successful, but it, too, has a high drop-out rate …

Assuming the mechanics are working correctly, it [sugical impact] is, by definition, 100% effective, and about 70% of men remain satisfied with their implants even after 10 years. (Cancer Information Website)

Excerpt 4:

Success rate for full intercourse 40-60% [for PDE5 Inhibitors] … Success rates up to 85% [for Penile Injections] … 57% success rate [Medicated Urethral System for Erection] … Success rates 85-92% [Vacuum Constructive Devices] … 85% satisfaction rates reported [Penile Prosthesis]. (Cancer Information Website)

This series of statements lists the success rates for various penile rehabilitation interventions from a variety of research studies. Statistics for "successfully achieving erections," "success rates," "men who find this device successful," and how "effective" implants are, are scattered throughout online materials about penile rehabilitation. The use of statistics (e.g., "about 40%," "40-60%," "85-92%," "nearly 90%," "about 80%," "100%," etc.) accords these treatments legitimacy. The message conveyed is that these interventions have been tested in scientific studies and furthermore, that they have been found to be generally successful. Statistics of "success" rates, although operationally vague, often undefined and nonspecific in these online sources, are powerful strategies in allocating penile rehabilitation a sense of legitimacy.

Excerpt 5:

A study published in 2005 in the Journal of Sexual Medicine, for example, reported the results of 132 men who were followed for 18 months after radical prostatectomy. A total of 58 men enrolled in a penile rehabilitation program

within six months of surgery and took sildenafil (Viagra) or penile injection … to achieve erections three times a week. When investigators followed up 18 months later, 52% of the men in the penile rehabilitation group said they could have spontaneous erections firm enough for intercourse, compared with 19% of the men who did not seek intervention. A larger proportion of men who underwent penile rehabilitation also said they responded to sildenafil when they needed to take it: 64% of the rehabilitation group responded versus 24% of the untreated group. (Cancer Information Website)

Excerpt 6:

Studies have looked at the effectiveness of different treatment options … in trying to enhance the return of erections after surgery. Raina and coworkers evaluated the daily use of vacuum devices beginning two months after surgery (whether nerve-sparing or not). After nine months, 17% of men who used a device achieved erections sufficient for intercourse compared with 11% of those in the non-treatment group. Also, only 23% of men in the treatment group reported a decrease in penile length and circumference, versus 60% of men who didn't use vacuum devices. This is significant, because many men report penile shrinkage following prostatectomy. Montorsi and colleagues started men on alprostadil injections one month after two-sided nerve-sparing surgery. After six months, 67% of men receiving injections had erections sufficient for intercourse — a higher recovery rate than in men having no treatment. They also found that 53% of men not on treatment had venous leakage, compared with 17% of patients on injection therapy. (Cancer Information Website)

These excerpts provide detailed reviews of clinical trials for various penile rehabilitation treatments. They provide relatively more detailed information when compared to other online materials. For example, they mention sample size, group comparisons, and duration of the experiments. They also provide more specific details about and definitions of successful outcomes (e.g., having "spontaneous erections firm enough for intercourse," "decrease in penile length and circumference," and "responded to sildenafil when they needed to take it,"). The cited studies paint a positive picture of penile rehabilitation. There is no mention of participant dropouts, adverse reactions, or studies with contradictory results. Notably, the results reported are consistent with the messaging in other online patient materials; if men do not seek treatment then it is probable that their penises will degenerate (e.g., experience "venous leakage"). Notably, the language is not very easy to understand and presupposes a high level of health literacy in the patient.

***Discursive space for contradiction and controversy*.** Notably, no medicine is 100% consistent in its efficacy. Thus, it is useful to examine the ways in which this is communicated to patients (e.g., is the complex and variable reality of the efficacy data obscured for the patient, or explained to them, albeit in simplified terms?). Analysis of online patient materials suggest that they largely present a confident picture of the efficacy of penile rehabilitation. However, critical voices are present in online materials, albeit in small doses. Critical voices are defined as content that acknowledges that the research data for penile rehabilitation are not entirely consistent, that some research findings are contradictory, and that penile rehabilitation is a controversial if popular medical practice. Notably, none of the websites for institutionally based penile

rehabilitation programs include critical content, rather these messages are found on general prostate cancer information sites.

Examples include sites that state, “although the study was not randomized — and thus its results could be influenced by patient self-selection or investigator bias,” or **“**Most of these studies involved a small number of participants. In some, people chose if they wanted treatment or not; others did not compare a placebo group to a treatment group, which is considered essential to proving the benefit of treatment.”

Sometimes subtle language is used to convey that penile rehabilitation is based on a number of tentative *hypotheses* rather than incontrovertible truths (e.g., “There are only limited data to support this possibility,” “The penile rehabilitation hypothesis,” and “If this explanation is correct,” “it's a real, if unproven, program advanced by many urologists”). Other sites are more explicit in acknowledging the tenuous scientific evidence-base for penile rehabilitation (e.g., “But this therapy remains controversial … only a handful of reliable studies evaluating various types of penile rehabilitation have been published … no consensus yet exists about which approach is best for a particular patient.”).

Excerpt 7:

Although the study was not randomized — and thus its results could be influenced by patient self-selection or investigator bias — it confirmed the results of an earlier small study conducted by the European team that first pioneered the concept of penile rehabilitation … Although both studies were small, they provide evidence that early intervention to restore erectile function may be important. (Cancer Information Website)

Excerpt 8:

Most of these studies involved a small number of participants. In some, people chose if they wanted treatment or not; others did not compare a placebo group to a treatment group, which is considered essential to proving the benefit of treatment. Despite these limitations, many of their results support the findings from other studies, and more doctors are now looking at penile rehabilitation as part of the recovery process. (Cancer Information Website)

Excerpt 9:

These observations have generated the belief that frequent sexual activity helps preserve erectile function as a man ages. There are only limited data to support this possibility, but tissue oxygenation may be the reason men have erections at night … The penile rehabilitation hypothesis says that even the best nerve-sparing operation is bound to inflict some damage on the network of nerves and blood vessels that surround the prostate … If this explanation is correct, improving penile blood flow should protect sensitive tissues and promote recovery of erectile function. (Cancer Information Website)

Excerpt 10:

Indeed, it [penile rehabilitation] may sound more like a creative pick-up line than serious therapy, but it's a real, if unproven, program advanced by many urologists. (Cancer Information Website)

Excerpt 11:

But this therapy remains controversial. Although preliminary results look promising, only a handful of reliable studies evaluating various types of penile

rehabilitation have been published — and these have used different types of interventions, for different periods, so it is difficult to compare one method with another. Moreover, no consensus yet exists about which approach is best for a particular patient. (Harvard Medical School + Harvard Health Publications)

These excerpts are examples of text that acknowledge that the science behind penile rehabilitation is imperfect, inconclusive, and emerging. They note that while penile rehabilitation is at present: an "open question," "controversial," "real, if unproved," and a "hypothesis". These texts state that study results ought to be contextualized based on a number of criteria, including, for example, number of participants, the presence of a control group, the dose of treatment received, the length of follow-up, etc. The studies also note that replication of results across studies is important before conclusive statements about penile rehabilitation can be made. Finally, these excerpts acknowledge that the biomedical explanatory models upon which penile rehabilitation is based are hypotheses rather than certitudes at this point. While the Harvard Medical School patient materials acknowledge the controversy and lack of consensus that exists within penile rehab scientific literature, this is not contained on any of the actual penile or sexual rehabilitation clinic websites, which may give patients the false impression that penile rehabilitation is a thoroughly researched and tested, and uniformly effective treatment. It is possible that the authors of the Harvard group materials included more nuanced messages about the efficacy of penile rehabilitation because these online sources are not linked to a patient clinic, thus the authors did not need to 'sell' their services to patients.

In summary, many patient materials include references to science and the use of empirical data is closely paired with the rationale for penile rehabilitation. Success rate

statistics for various pro-erectile treatments are peppered through texts, which construct penile rehabilitation as a well-researched and overwhelmingly safe and effective intervention. Critical voices appear throughout some patient materials, acknowledging that many questions about penile rehabilitation have yet to be conclusively answered through empirical study. However, these voices are marginalized next to the dominant narrative of penile rehabilitation as a scientifically validated treatment.

Discursive strategy 3: 'use it or lose it.' Most of the patient materials provide a rationale for penile rehabilitation and the most frequently occurring narrative is "use it or lose it". This explanation conveys that there is a narrow window of opportunity following prostate cancer treatment within which to initiate rehabilitation in order to prevent permanent physical damage. Various metaphors involving, for example, models of atrophy, sports rehabilitation and physiotherapy, and electrical systems, are called upon to illustrate this point.

Some sources provide parameters for this window of opportunity although protocols vary in specific dates. For example, one cancer information website states that penile rehabilitation should occur within the first two years following surgery, a cancer centre/hospital education booklet suggests that patients should be trying for "at least 2 to 3 erections per week in the months after surgery," and another cancer centre/hospital protocol involves having men use a vacuum pump to generate erections a couple of weeks following surgery (immediately after the catheter is removed).

Despite variation in exact timing, materials are consistent in conveying that failure to engage in pro-erectile interventions soon after prostate cancer treatment is a medically risky, ill-advised, and irresponsible decision. Materials expressly link

nonparticipation in penile rehabilitation to a host of negative outcomes such as: weakened penile tissues (e.g., Cancer Information Website), scar tissue in the penis that kills smooth muscle cells (Cancer Information Website), loss of elasticity in erectile tissue (Cancer Information Website), atrophy of the penis (Cancer Centre/Hospital Website), long-term penile tissue damage (Cancer Centre/Hospital Website Patient Education Booklet), and damaged and unresponsive erectile tissue (Prostate Cancer Information Publication). There may be empirical evidence to support these claims; and this analysis does not posit that these claims are false or untruthful; rather, this analysis wishes to draw attention to the adjectives, metaphors, images, and other discursive strategies used in these materials to convey meaning about these claims to patients. This analysis also wishes to draw attention to the meaning given to these possible outcomes (e.g., the loss of one's sex life). Delay or inaction is constructed as coming at the cost of the return of "natural" erections (Cancer Information Website) – which are positioned as the ultimate mark of recovery and as superior to mechanically or biomedically induced erections – and ultimately at the cost of one's "sex life" (Cancer Centre/Hospital Website).

Excerpt 1:

The idea is that producing erections within weeks or months of surgery can help men recover sexual function. Any kind of erection is thought to be helpful. An erection pulls oxygen-rich blood into the tissues of the penis, helping keep this tissue healthy. As mentioned before, the recovery time for erections after surgery is about 2 years. If a man does not have an erection during this time period, the tissues in his penis may weaken. Once this happens, he will not be able to get an erection naturally. The idea of penile rehabilitation is to use some type of

medicine to be sure that a man is getting regular erections while his nerves are healing. This helps keep the tissue in the penis healthy. Most studies have suggested using medicine to get an erection hard enough for penetration about 2 to 3 times a week. The erections do not need to be used for sexual activity, the goal is to keep the tissue in the penis healthy. (Cancer Information Website)

Excerpt 2:

The average man experiences three to six erections every night of his life (lasting 10 to 15 minutes at approximately 70% rigidity). Nocturnal erections serve to protect erectile tissue during periods of sexual abstinence. Regular erections increase the blood flow and oxygen supply to feed the tissues in the erectile chambers … Without a constant supply of oxygen and other nutrients from the blood, scar tissue can develop that can kill smooth muscle cells. Damaged erectile tissue will remain unresponsive to nerve signals even with complete nerve recovery after a prostatectomy, and a man can be left with permanent erectile dysfunction.

…

At one time, men who had a nerve-sparing procedure were advised to wait for healing to occur — with no intervention. But more recently, we've started to think that not having regular erections over a prolonged period can lead to lasting harm. Studies have shown that venous leakage (the escape of blood from the penis that prevents it from forming or maintaining an erection satisfactory for penetration) can increase with time. For example, Mulhall et al found that after a nerve-sparing prostatectomy, venous leakage ranged from 14% at four months to

over 50% at 12 months. Only 9% of men with evidence of venous leakage had erections sufficient for intercourse, compared with 47% of men with normal hemodynamics (blood circulation processes)."

(Cancer Information Website)

These excerpts illustrate the imperative that is conveyed for patients to be proactive in sourcing the devices and medications necessary to produce erections in the near aftermath of surgery in order to properly tend to their penile tissue. Erections are positioned as playing an essential part in penile health as they "pull oxygen-rich blood into the tissues of the penis," keeping penile tissue healthy. Materials convey that if penile tissue does not get a regular supply of fresh blood and oxygen, it will suffer. Thus, materials indicate that if men do not 'produce' erections in short order, their penile tissue will weaken and they will lose the capacity to "get an erection naturally." Men are advised to 'step in' and temporarily take over regular production of erections while their body's natural ability to do so has been disrupted. There is an imperative to take on the penis-protecting task of engineering regular erections in the short-term for long-term preservation of "natural" erections.

Excerpt 3:

When erectile function becomes impaired following radical prostatectomy, the problem has traditionally been attributed to nerve damage. The nerves that trigger erections may become damaged during surgery (even during so-called nerve-sparing surgery), leading to a problem known as neuropraxia — a temporary loss of function that theoretically should recover in time. The problem is that it can take as long as two years for the nerves to recover sufficiently to

enable a man to have a spontaneous erection, and by then other damage may have occurred. Recent research suggests that when the penis is flaccid for long periods of time, and therefore deprived of a lot of oxygen-rich blood, the low oxygen level causes some muscle cells in the columns of erectile tissue (corpora cavernosa) to lose their flexibility and gradually change into something akin to scar tissue. This scar tissue, moreover, seems to interfere with the penis's ability to expand when it's filled with blood. In fact, imaging studies indicate that blood may drain away from the penis rather than fill it. Less research has been done about impotence after radiation therapy, but it appears that the underlying cascade of damaging events is similar to what occurs after radical prostatectomy. Radiation damages the lining of the small blood vessels, but this damage may take months or even years to manifest itself. What all this means is that the traditional advice given to men — essentially to wait for erectile function to return on its own — may not be adequate. Simply put, erections seem to work on a use-it-or-lose-it basis. To prevent the secondary damage that may occur if the penis remains flaccid for a prolonged period, researchers now think that a better approach is to intervene soon after treatment to restore erectile function. (Harvard Health Publication)

Excerpt 4:

The need for early intervention cannot be overemphasized. Every man has heard the expression "use it or lose it." There is increasing evidence that sexual rehab regimens after prostate cancer surgery help prevent irreversible long-term functional damage to the penis. (Cancer Centre/Hospital Website)

Both excerpts 3 and 4 draw upon the 'use it or lose it' narrative of penile rehabilitation. Rationale is provided for why men must act quickly to induce erections so that scar tissue, neurpraxia, and small blood vessel damage does not occur. A flaccid penis is constructed as a "deprived" penis. It is deprived of the nutrients, oxygen, and life–sustaining fuel that is necessary for healthy maintenance. A penis that remains flaccid over time is said to become less flexible, less lithe, and less responsive. Materials indicate that scar tissue develops, which constricts the penis and prevents it from becoming erect. The more the penis suffers from deprivation, the less able the penis is to receive the life-sustaining substances it needs (e.g., blood becomes more likely to drain away than to rush in), which becomes a vicious circle of dysfunction and deterioration. Men who fail to "use it" risk that they will "lose it." The consequence of inaction or delayed action is "irreversible long-term functional damage to the penis." Thus, failing to participate in penile rehab may result in a penis that does not work properly. "Increasing evidence" is mentioned as support for these claims.

There is a notable contradiction in these excerpts. One cancer information website publication states that penile function should "theoretically recovery in time," and they refer to "*temporary* loss of function" following surgery, where as a cancer centre/hospital website's materials emphasize that "early intervention cannot be overemphasized" to prevent "irreversible *long-term* functional damage." Nonetheless, patients are told that traditional recovery advice to 'wait and see' does not apply to prostate cancer recovery. To wait and see, (i.e., to leave the flaccid penis alone to recovery in its own time) results in a penis that may never awake, reanimate or recover. Men are implored not to rely on common wisdom or conventional advice when it comes to their erections following

prostate cancer treatment. If left alone the penis may fall into decay and disrepair. Thus men are implored to take their erectile health into their own hands via engaging in penile rehabilitation.

Excerpt 5:

> *After pelvic cancer (e.g., prostate, bladder, rectal) treatment, the normal physiology of penile erections can be altered. Nerve and blood vessel injury or manipulation can impair normal erections, penile oxygenation, and long-term penile and sexual health. The goal of penile rehabilitation is to help minimize the negative impacts on a man's sexual function and expedite recovery of sexual function. Our program begins either weeks before your surgery or afterwards. We know that daily erections are natural and necessary and that without erections atrophy and scarring can develop. Thus, interventions aimed at preserving sexual function must allow regular erections. We tailor a specific treatment regimen to each patient based on baseline erectile function and the patients [sic] own goals. We welcome input and assistance from the patients [sic] partner in order to help maximize rehabilitation success. Clincal [sic] studies support early and aggressive therapies for post therapy erectile dysfunction which can help more rapid and complete recovery of sexual function.* (Cancer Information Website)

The message conveyed here is that "normal physiology" of the penis is negatively impacted by cancer treatment and thus expert intervention is required in order to prevent long-term damage to both penile and sexual health. Sexual health is positioned as something that is rooted in "normal physiology" of the penis, nerves, and blood vessels. This excerpt contains strong endorsement of penile rehabilitation by drawing upon

dominant discourses of ‘normal’ and ‘natural’ sexuality (e.g., “we know that daily erections are natural and necessary”). In this excerpt, frequent erections are said to stave off scarring, atrophy, and other negative outcomes. Erections are thus positioned as mandatory components of sexual health for men. This erectile imperative legitimizes aggressive medical intervention for men whose erections have been impacted by prostate cancer treatment. The positioning of erections as promoting health and preventing decay makes it both possible and palatable to men to engage in invasive intervention for erections. Likewise, the messaging conveyed in patient materials leaves little room for men who wish to remain sexual but who may choose to engage in a broader range of sexual practices that do not rely upon erections. There is little room for these men to adopt a ‘healthy’/‘normal’ sexual subjectivity, rather they are positioned as physically and sexually scarred, damaged, and dysfunctional.

To conclude, patient materials provide rationale for engaging in penile rehabilitation. Various metaphors and other rhetorical strategies are adopted to explain the reasons men ought to promptly enter penile rehabilitation. The most common justification provided is preventing penile atrophy. Patients are informed that if they fail to act (e.g., they do not engage in penile rehabilitation), their “sexual health” will suffer myriad negative outcomes such as atrophy, scarring, weakening of the penis, and irreversible damage resulting in a penis that does not work the way it is supposed to work. The phrase ‘use it or lose it’ appears across texts; men are frequently and pointedly reminded that adopting a passive stance when it comes to their penis is dangerous and unhealthy.

Analyses: Sexuality

Online patient materials were coded for content that related to the discursive construction of sexuality. Analyses were guided by the following questions: How is sexuality being constructed? What messages are being conveyed about 'healthy' and/or 'normal' sexuality? What kinds of activities, experiences, desires and/or fantasies are emphasized and endorsed and which ones are overlooked or denigrated? Notably, there was minimal mention of urinary incontinence or other side effects such as bowel incontinence, which could detract as much or more from sexual confidence, satisfaction and willingness to engage in sexual intimacy than erectile changes. Five of 18 documents analyzed mentioned "incontinence" in text and only one of these sources was a hospital offering formal penile/sexual rehabilitation. This points to the primacy of the penis and the intensity of the focus on erections when it comes to sexuality for men.

The following 3 discourses emerged:

(1) **The Intercourse Imperative**: Sex is equated with penetration, and more specifically with intercourse.

(2) **Dichotomy of Dys/Functional Bodies**: Sexuality is set up as a dichotomy of functional/dysfunctional bodies and body parts. Patients who fall short of ideal standards of function are positioned as dysfunctional.

(3) **The Healthicisation of Sexuality**: Sex is equated with one's health status. Sex is positioned as being about 'healthy' and 'properly' functioning bodies.

(4) **Sex Beyond the Body's Borders**: Critical voices emerged which position sex and sexuality as expansive constructs involving the body, mind, emotions, subjectivity, relationships, etc.

Discourse 1: Intercourse imperative

There was a general privileging of both penetrative sex and intercourse throughout patient materials. Sex is often equated with penetration involving the penis, and more specifically with penile-vaginal penetration.

Excerpt 1:

Penis pumps might counter sexual effects of certain health conditions. In some men with an underlying health problem, such as diabetes, a penis pump might help regain or maintain normal sexual function. (Cancer Centre/Hospital Website)

Excerpt 2:

Using a penis pump won't cure erectile dysfunction, but it might create an erection firm enough for you to have sexual intercourse. (Cancer Centre/Hospital Website)

Excerpt 3:

Using a penis pump requires a few simple steps … The erection typically lasts long enough to have sex. (Cancer Centre/Hospital Website)

These excerpts illustrate the equation of sex with intercourse. Materials state, for example, “In some men with an underlying health problem, such as diabetes, a penis pump might help regain or maintain normal sexual function” (Cancer Centre/Hospital Website), thus equating erections and penetrative sexual activity with ‘normal’ sexuality. In another place, this cancer centre/hospital’s materials state, “Using a penis pump won't cure erectile dysfunction, but it might create an erection firm enough for you to have sexual intercourse,” which suggests that intercourse is the ideal or optimal goal when it

comes to sexuality. The site also states, “A penis pump is one of a few treatment options for the inability to get or maintain an erection sufficient for sex,” and “the erection typically lasts long enough to have sex,” which emphasizes erection-focused and erection-dependent constructions of sex. Sex here is equated with penetration by the erect penis of another body. These examples illustrate how patient materials privilege certain forms and aspects of sexuality while ignoring others.

Excerpt 4:

Some men use the pump before starting sexual touching, but others find it works better after some foreplay has produced a partial erection. The erection from a vacuum device is usually firm, but may swivel at the base of the penis, which can limit comfortable positions for sex. (Cancer Information Website)

In their review of penile pumps, this cancer information website’s materials mention that erections may pivot at the base “which can limit comfortable positions for sex.” Thus, their consideration of the pros and cons of the penile pump is related to how well it facilitates penile-vaginal intercourse; sex is pared with penetration. Intercourse becomes obligatory sexuality activity.

Excerpt 5:

Follow-up visit at 3 months. Injection therapy will be initiated if you are not having adequate erections for intercourse. (Cancer Centre/Hospital Website)

Excerpt 6:

Our goal is to help you minimize the extent and duration of the dysfunction. With our current 'bag of tricks', there is no reason for you not to resume assisted

penetrative sexual activity within six weeks of prostate cancer surgery, if you and your partner are so motivated. (Cancer Centre/Hospital Website)

Examples of emphasis placed on intercourse appear also on another cancer centre/ hospital's website. Materials state that injections are started in patients "if you are not having adequate erections for intercourse," by 3 months post surgery. Materials also state, "With our current 'bag of tricks', there is no reason for you not to resume assisted penetrative sexual activity within six weeks of prostate cancer surgery." Thus, penetrative sex is positioned as the ideal marker of recovery and the end goal that patients are working towards. Emphasis is placed on getting the penis to work properly so that the patient can get back to regular penetrative sex. Other expressions of sexuality are largely invisible.

Excerpt 7:

When can I have intercourse? You may have intercourse as soon as you are comfortable to do so. Remember that you may not lift anything heavier than a laptop computer for 6 weeks following surgery. Intercourse, therefore, should be appropriately tailored. (Cancer Centre/Hospital Website Education Booklet)

This cancer centre's Patient Education Booklet includes a Q & A in which a hypothetical patient asks: "When can I have intercourse?" The response begins: "You may have intercourse as soon as you are comfortable to do so." There are no questions about oral or anal sex or other possible ways of being sexual. This is another example of the privileging of and emphasis placed on penetrative sex and intercourse, and the relative silencing of other ways of being sexual. The excerpt advises that patients should not lift anything heavier than a laptop computer for 6 weeks, but encourages couples to

engage in penile-vaginal sex. This juxtaposition is remarkable. Patients are instructed to tailor intercourse appropriately; however, there is no mention of "appropriately" tailoring other kinds of sexual practices such as anal sex or oral sex.

Excerpt 8:

In the first year of penile rehabilitation treatment, 76% of men who underwent brachytherapy responded to sildenafil, and 60% reported erections firm enough for intercourse, compared with a 68% response rate among men who underwent external beam radiation therapy, with 50% reporting erections firm enough for intercourse. (Cancer Information Website)

Excerpt 9:

After nine months, 17% of men who used a device achieved erections sufficient for intercourse … After six months, 67% of men receiving injections had erections sufficient for intercourse (Cancer Information Website)

Excerpt 10:

The average time until recovery of erections sufficient for intercourse is 4 to 24 months, but in some men it takes longer. (Cancer Information Website)

The term 'erectile dysfunction' itself is intimately connected to intercourse. Erections that can penetrate a vagina are functional and those that can't or that can't do so for an acceptable period of time are dysfunctional. When reviewing outcomes from various clinical trials, emphasis is placed on how well a penis is able to facilitate 'intercourse.' For example, emphasized outcomes include "erections firm enough for intercourse" (Cancer Information Website), "spontaneous erections firm enough for intercourse" (Cancer Information Website), "erections sufficient for intercourse"

(Prostate Cancer Patient Publication; Cancer Information Website). Thus, intercourse is positioned as obligatory and axial sexual activity.

In conclusion, patient materials frequently equate sex with penetrative activity and more specifically with intercourse. Other forms of sexual experience and activity are largely absent from materials.

Discourse 2: Dichotomy of dys/functional bodies. Patient materials construct sexuality as a dichotomy of function and dysfunction; sexual bodies are positioned as in operation or as inoperative. Precise operational definitions of sexual (dys)function are most often not provided for patients but these markers are closely linked to what the body can *do* in sex and to how body parts *perform* during sex. For example, the demarcation between sexual function and dysfunction is frequently associated with the penis' capacity to become erect and penetrate.

Excerpt 1:

The sexual medicine service is devoted to the restoration of the patient's sexual function, thereby enhancing their qualities of life. (Cancer Centre/Hospital Website)

Excerpt 2:

We are excited to have the opportunity to help with this vitally important challenge, and we are dedicated to helping you retain your sexual function after your prostate surgery. (Cancer Centre/Hospital Website)

Patient materials use dichotomous language to construct this discourse of (dys)function for example, "talking to patients about sexual function" (Cancer Centre/Hospital Website); "preserving their sexual function" (Cancer Information

Website); “restoration of the patient’s sexual function” (Cancer Centre/Hospital Website), and “helping you retain your sexual function” (Cancer Centre/Hospital Website). Language indicates that function is lost and regained based on measurable markers, and that it can be preserved and protected. Positioning sexuality within a dichotomy of working/not working closely aligns with medical models of sexual health whereby people are identified as sick or healthy, ill or cured of their sexual problems. Thus, positioning someone as having or embodying sexual dysfunction is a way of marking them as being in need of intervention (e.g., penile rehabilitation) which medicine is optimally positioned to provide.

There is overlap with this discourse and the discourse of the false dichotomy of penises as being either functional or dysfunctional; however, this discourse refers to sexuality more broadly, as opposed to focusing only on the penis. They are closely related and often linked in patient materials. ‘Sexual function’ is something that is constructed as needing preserving and warranting attention, as well as something that is possible to restore through strategic and expert help following loss of a ‘functional’ status.

Excerpt 3:

Studies indicate that anywhere from 30% to 70% of men who undergo radical prostatectomy or external beam radiation therapy, and 30% to 50% of men who opt for brachytherapy, will develop impotence after treatment. Recent insights into why this happens have led to a whole new approach in treating men who are interested in preserving their sexual function. (Cancer Information Website)

Excerpt 4:

We provide counseling to the patient and his partner about anticipated changes in sexual function and try to predict the likelihood of preserving and recovering sexual function after prostate cancer treatment. (Cancer Centre/Hospital Online Patient Education Booklet)

For example, materials from a cancer information website state that high numbers of men treated for prostate cancer "will develop impotence after treatment" and that there is treatment available for "men who are interested in preserving their sexual function." Impotence is established as a marker of sexual dysfunction, and penile rehabilitation is positioned as a means of preserving a man's 'functional' status. A cancer centre's online Prostate Centre Patient Education Booklet likewise states "We provide counseling to the patient and his partner about anticipated changes in sexual function and try to predict the likelihood of preserving and recovering sexual function" (see Excerpt 9). Emphasis is placed on being able to anticipate and predict sexual function outcomes. Other materials state, "The sexual medicine service is devoted to the restoration of the patient's sexual function" (Cancer Centre/Hospital Website). Patients who become 'dysfunctional' through cancer treatments are able to transition back to a state of sexual function through expert treatment.

Excerpt 5:

Regaining sexual function is an important part of physiological and psychological recovery after treatment for prostate cancer. (Prostate Cancer Online Patient Publication)

Excerpt 6:

> *The goal of penile rehabilitation is to help minimize the negative impacts on a man's sexual function and expedite recovery of sexual function. Our program begins either weeks before your surgery or afterwards*. (Cancer Centre/Hospital Website)

A cancer centre/hospital's online materials state "we are dedicated to helping you retain your sexual function after your prostate surgery." Thus, a state of sexual function is positioned as something that is possible to retain or re-attain for patients. Problems that emerge are transformed into states of function. Bodies that are not working properly can be refashioned into bodies that work and capacities that were lost can be regained. For example, a cancer centre/hospital's online materials state that penile rehabilitation aims to "expedite recovery of sexual function," for men.

To conclude, sexuality is discursively constructed as a binary between function and dysfunction. Markers of dysfunction include "impotence" and erections that fail to 'perform' in particular ways. Men are positioned as being at risk for dysfunctional status through prostate cancer treatments. However, reinstatement of a functional status is made possible through penile rehabilitation treatments. A functional status is to be protected; passivity may result in erosion of sexual function and crossover to dysfunctional category.

Discourse 3: The healthicisation of sexuality. There is a close pairing of sexuality with health and medicine; the healthicisation of sex (Tiefer, 2004) is achieved through repeatedly situating sex within the domain of health. There is an emphasis on the physical and behavioural aspects of sexuality and an anchoring of sexuality primarily in

the body vs. the mind, emotions, psyche or sociocultural realm. Sexuality is closely linked to an individual's personal wellness.

Excerpt 1:

Your care team will take a multidisciplinary approach to discussing and addressing your physical and emotional concerns related to sexual health. We will also take a full medical history to identify additional risk factors for sexual health problems, such high blood pressure, high cholesterol, and diabetes.

(Cancer Centre/Hospital Website)

This and other excerpts provide indicators of the healthicisation of sexuality and a discourse of sex as folded into (physical) health. For example, a cancer centre/hospital's website mentions "Personalized Sexual Health Resources," and "male sexual health specialists" available through their "Male Sexual & Reproductive Medicine Program," to help patients "overcome any barriers preventing [them] from achieving a high quality of life when it comes to [their] sexual health." The close and repeated pairing of sexual and health is notable and repeatedly anchors sexuality to the body and to ideas of functional bodies and body parts. Clinic titles don't conjure up thoughts of sexuality; rather, they are more readily linked to bodily functions (e.g., urination, bowel functioning, penile tumescence) and bodily outputs (e.g., sperm, urine). The idea is conveyed that there is such a thing as optimal sexual health and that deviations from that standard are both unhealthy and fixable through knowledgeable "sexual health specialists." Clinics are predominantly populated with urologists and other medical specialists, which reinforces a medicalized view of sexuality. There is also a message that high quality of life when it comes to sexual health is possible through fixing problems (deviations from a standard

level of functioning). A cancer centre/hospital promises to "take a full medical history to identify additional risk factors for sexual health problems, such high blood pressure, high cholesterol, and diabetes," reinforcing the idea that optimal sexuality is rooted in (healthy) bodies.

Excerpt 2:

[Cancer Centre/Hospital's] Sexual Health Program is committed to addressing patients' concerns about sexual health as an integral part of their care, from diagnosis and treatment through survivorship. The program provides education, consultation, and personalized rehabilitation counseling for patients and their partners who have experienced changes in sexual health during and after cancer treatment. (Cancer Centre/Hospital Website)

Excerpt 3:

Treatment for prostate cancer often raises questions about your sexual health and relationships. [Cancer Centre/Hospital] offers private, expert counseling and education to help you and your partner manage any sexual health concerns or issues that arise before, during, or after cancer treatment. (Cancer Centre/Hospital Website)

Excerpt 4:

Our male sexual health specialists can provide these and other treatment options to help you overcome any barriers preventing you from achieving a high quality of life when it comes to your sexual health. (Cancer Centre/Hospital Website)

Excerpt 5:

Treatment for certain cancers can affect your sexuality, causing a range of signs

and symptoms that can make sex with your partner more difficult. But that doesn't mean you can't have a healthy sex life after cancer treatment. (Cancer Centre/Hospital Website)

Terms linked to sexual health are often used in place of sexuality. For example, one cancer centre/hospital's online materials state, "[Cancer Centre/Hospital's] Sexual Health Program is committed to addressing patients' concerns about sexual health," and elsewhere note that the centre "offers private, expert counseling and education to help you and your partner manage any sexual health concerns." Likewise, "healthy sex life" (Cancer Centre/Hospital Website) and "quality of life when it comes to your sexual health" (Cancer Centre/Hospital Website) are used in place of sexuality.

There is a link here between this particular biomedical/physical construction of (healthy) sexuality, and the construction of penile rehabilitation as an intervention. If sexual changes are constructed as sexual health issues, rooted in mechanical/biomedical processes gone awry in the body, then medicine is well-positioned to offer a solution to the problem and to restore patients' (sexual) health and wholeness. Notably, penile and sexual rehabilitation services for patients are called "sexual health program(s)" run by "sexual health specialists" as opposed to 'sexuality programs' run by 'sexuality specialists.'

To sum up, sexuality is anchored in the domains of health and medicine. The physical and biological aspects of sex are emphasized in patient materials, and problems with sex are equated with problems with one's health. This construction of sexuality validates biomedical interventions in order to reestablish good sexual health for patients.

Discourse 4: Sex beyond the body's borders. Alternative constructions of sexuality are present in patient materials. These constructions position sexuality as broad, expansive, and as encompassing the physical body as well as the psyche, emotions, relationships, subjectivity, and sociocultural meanings associated with a person.

Excerpt 1:

> *Living with prostate cancer can affect many aspects of a person's life including sexuality, sexual functioning and personal relationships. Studies have shown that treatments for prostate cancer may cause sexual changes that can reduce the quality of life for patients and their partners. These changes can be a difficult for many men who already have a lifetime of sexual experience and have continuing expectations. Changes may occur to urinary continence, sexual self-esteem, libido, penile functioning, orgasm, and ejaculation. Prostate cancer patients and their partners may need to make sexual adjustments as a result of the treatment*. (Cancer Centre/Hospital Online Flyer About Prostate Cancer Supportive Care Program)

This excerpt is an example of materials that adopt a relatively broader view of sexuality. For example, a cancer centre/hospital's flyer distinguishes between sexuality, sexual functioning, and personal relationships. Thus, a person's sexual function is positioned as part of but not all of their sexuality. In addition, this flyer includes a broad range of possible sexual changes following prostate cancer treatment that expand beyond body parts and physical capacity to perform certain sexual acts. "Sexual self-esteem" is included as a possible sexual change following prostate cancer treatment, which is distinct from things like "penile functioning," and "orgasm." This broad approach to

sexuality opens up possibilities for intervention that go beyond a focus on fixing erections. There is room for different possibilities and different ways of pursuing recovery. This excerpt mentions "adjustments" that couples may need to make as a result of treatment. This opens up the possibility of emphasizing adaptation vs. recovery for couples. Specifically, this opens up the possibility of an emphasis on alternative forms of pleasure and satisfaction rather than focusing on getting the patient back to their baseline functioning. This excerpt is one of few sources that mention incontinence as one of the side effects from treatment that may have an impact of sexuality. Most other sources focus on the penis and erections as the central focus of sexual difficulty.

Excerpt 2:

[Name of cancer/sexuality expert 1]: I know that we found out particularly with smoking but also with, you know, sexual problems that it is not just about the pill or the drug or the pump. (Cancer Centre/Hospital Website)

Excerpt 3:

[Name of doctor who is a cancer/sexuality expert]: Definitely. As I said, men tend to be very technically oriented. Just fix the physical problem and everything will be OK. And we know now from many years of research that that is often not true. That you need to look at the emotions and the relationship or the dating issues as well as fixing the physical problem and the sexual communication issues. (Cancer Centre/Hospital Website)

Excerpt 4:

Having a penile implant can't solve any other problems, such as low sexual desire, lack of sensation on the skin of the penis, or trouble reaching orgasm. It

can't turn a poor sexual relationship into a great one. A couple needs to talk openly before they have sex after implant surgery. You may need to experiment with different kinds of touching or with different positions. Make sure you are truly excited before trying to have sex, rather than starting sex just because your penis is erect. Couples who have maintained mutual touching, even if an erection problem prevented penetration, tend to adjust more easily to the prosthesis. (Cancer Information Website)

Various materials also acknowledge that recovery is not just about fixing erections and that a mechanical or biomedical solution may not be enough to respond to the difficulties men and their partners' experience. For example, a cancer centre/hospital's materials state, "it is not just about the pill or the drug or the pump." Materials also state that just resolving the "physical problem" is insufficient; "you need to look at the emotions and the relationship or the dating issues as well as fixing the physical problem and the sexual communication issues." A cancer information website also adopts the perspective that mechanical or biomedical solutions to changes in erections are specific and limited in their scope. For example, the materials state, "having a penile impact … can't turn a poor sexual relationship into a great one." They stress that a good sexual relationship expands beyond (and may or may not include) erections.

Excerpt 5:

There is no denying the importance of erections, both for sexual satisfaction and for reproduction. Still, it's a mistake to equate an erect penis with manliness, which is why the old term impotence (literally "loss of power") has been replaced by the medical diagnosis of erectile dysfunction. Even so, many people still don't

understand that sexual fulfillment does not necessarily depend on a good erection. Many men with good erections fail to satisfy their partners or themselves, and the converse can be true for men with ED. And some men can even experience orgasms despite having ED following prostate surgery.

Mae West famously declared that "a hard man is good to find." It's fine to have a laugh about erections, but men facing treatment for prostate cancer should understand that there are other ways, ranging from cuddling, to manual or oral sex and sex "toys," to achieve mutual satisfaction. Most important of all is the intimacy and love that develop from honesty, sharing, understanding, and respect. (Cancer Information Website)

This broad construction of patient difficulties offers an alternative construction of sexuality. Emphasis is placed on the subjectivity of the patient and on the way in which patients experience sexual changes rather than assuming that a physical fix leaves their sexuality unaffected. A cancer information website offers the most explicit challenge to traditional and dominant constructions of male sexuality as being erection-focused. Materials read, "it's a mistake to equate an erect penis with manliness … many people still don't understand that sexual fulfillment does not necessarily depend on a good erection. Many men with good erections fail to satisfy their partners or themselves, and the converse can be true for men with ED." This quote emphasizes that functional, healthy, pleasurable, and satisfying sexuality can be about more than body parts that work in certain ways. This opens up space for patients to think about sexuality and sexual health/wellness differently. Sexual health or positive, pleasurable, and functional sexuality is possible even in the face of sexual changes or changes in erections. Within

this construction, men may not have to resolve or reverse the changes in their erections in order to adopt the subject position of whole, competent, and successful lover.

Excerpt 6:

Do some experimenting. You may find that certain situations reignite your sexual desire or help you get an erection. Pay attention to what works — whether it's stimulating your penis yourself or thinking about sexual fantasies. You might find your orgasms are more intense if you spend more time on foreplay. After certain operations or treatments, different sexual positions may be helpful. (Cancer Centre/Hospital Website)

This and other patient materials offer solutions to working with sexual changes that are broad and that reflect a broad and expansive approach to sexuality. For example, patients are encouraged to "do some experimenting … [and to] Pay attention to what works — whether it's stimulating your penis yourself or thinking about sexual fantasies" (Cancer Centre/Hospital Website), to "look at the emotions and the relationship or the dating issues" (Cancer Centre/Hospital Website), and to "talk openly … [and] experiment with different kinds of touching or with different positions" (Cancer Information Website). These interventions expand beyond medications and other biomedical interventions and acknowledge the emotional, psychological, and relational context of sexuality.

Analyses: Erections

Online patient materials were coded for content that related to the discursive construction of erections. Analyses were guided by the following questions: In what ways are erections being described in patient materials? What kinds of erections are positioned

as being important for sex/sexual health/recovery? What kinds of erections are positioned as desirable vs. problematic?

The following four discursive strategies relate to erections:

(4) **Erections as technical and biomedical entities**: Erections are positioned as technical and biomedical entities; relational, subjective, or psychological factors are largely invisible.

(5) **Erection hierarchies:** Erections are organized and graded according to metrics of function and form; 'natural,' spontaneous, firm and 'functional' erections are ranked highly.

(6) **Perilous prostrate (non-erect) penises:** The dangers of non-erect penises are emphasized.

(7) **Erectile changes as diminishment and disability**: Examination of the various synonyms used for erectile difficulties revealed that changes in erections were equated with diminishment and disability, and propped up a false dichotomy of functional/dysfunctional penises.

Discourse 1: Erections as a technical and biomedical production. Erections are largely constructed as being a technical production involving complex biomedical and mechanical functions and system. Individual physiology is emphasized with minimal attention paid to a person's subjectivity or relationships. In other words, erections are framed as physiological productions rather than social or psychological products. This discourse overlaps with the discursive construction of penile rehabilitation as being a fitting biomedical solution to the complex technical breakdown of erectile function

following prostate cancer treatment. The distinction is that in this discourse, the focus is on the discursive construction of erections themselves as technical products.

Excerpt 1

Nitric oxide is essential for a normal erection, but it does not act alone. It signals the arterial cells to produce cyclic guanosine monophosphate (cGMP), the chemical that increases the flow of blood to the penis. But the tissues of the penis also produce phosphodiesterase-5 (PDE5), an enzyme that breaks down cGMP. In normal circumstances, the penis generates enough cGMP to produce a rigid erection and enough PDE5 to end the erection when ejaculation is complete. But in many men with ED, this intricate system is out of balance, and one of the ED pills may set things right. They all inhibit PDE5, increasing the supply of cGMP and improving erectile function. (Cancer Information Website)

Excerpt 2

Mechanics of an erection

In a flaccid (non-erect) penis, arterial blood (mainly from the cavernous artery) enters the erectile chambers (corpora cavernosa) and leaves through the dorsal vein. When a man is sexually stimulated, the brain and areas within the spinal cord signal the release of a number of neurotransmitters. Stimulation of the cavernosal nerve in particular releases a chemical called nitric oxide, setting off a whole sequence of events. Nitric oxide causes the smooth muscles in the erectile chambers to relax, the blood flow increases, and the sinusoid spaces within the erectile tissue are allowed to fill. The dramatic increase in pressure inside the erectile chambers "pinches" the veins (preventing blood from leaving)

and voilà: an erection is formed.

Injury to cavernous nerves can result from diabetes, cigarette smoking, radiation therapy or chronic absence of erections. Factors affecting the health of erectile smooth muscle include high blood pressure, high cholesterol, diabetes, smoking, and deficient oxygen and blood supply due to lack of regular erections. (Prostate Cancer Online Patient Publication)

The "mechanics of an erection" are couched in biomedical terms. Explanatory models involve "nitric oxide," "arterial blood," "the cavernous artery," "erectile chambers," and "neurotransmitters," "arterial cells," "guanosine monophosphate," and "phosphodiasterase-5." Other patient materials reproduce the emphasis on mechanics and physiology with discussions of "severed nerves" and "blood flow" (Cancer Centre/Hospital Website), "low testosterone" (Cancer Centre/Hospital Website), "erectile nerves," "tiny valves at the base of the penis," (Cancer InformationWebsite), erectile "smooth muscle," and "a constant supply of oxygen" (Prostate Cancer Online Patient Publication).

The process of obtaining an erection is described as a linear process whereby arousal triggers results in a cascade of complex processes in the body. For example, a cancer information website states "Erections occur because of stimulation through the nerves that run adjacent to the prostate and send signals to dilate the blood vessels in the penis, allowing it to fill with blood and become rigid" (Cancer Information Website). The detailed and sequential model evokes images of a factory production line where breakdown can occur at any juncture. The role of meaning, experience, and subjectivity are largely missing from these excerpts. The role of desire in this process is largely

absent. It is as though desire is either presumed to always already be there, or it is positioned as irrelevant to the process.

Some materials state that the initial trigger for the erectile process is "when a man is sexually aroused" (e.g., Cancer Information Website), thus embedding the man's experience of his body in the process; however, dominant narratives rely on biomedical terms and meanings (Cancer Information Website); patient materials talk more about *nerves* being stimulated as opposed to *men*, *men's bodies,* or *men's minds*. The language positions men outside of their bodies and encourages an externalized, clinical stance towards their erections. Erections are described as something that happens to them via nerve triggers. While materials describe what happens to body parts, they do not include descriptions of what it is like to be a desiring body. Sexual desire and the subjective experiences of men are notably absent from these models. For example, mention is made in patient materials that anxiety and stress can impair erections; however, the explanation given is rooted in biomedicine (e.g., materials explain that the stress hormone adrenaline negatively impacts erections). The explanation is rooted in physiology rather than a man's psychology and subjective experience of stress (Cancer Centre/Hospital Website).

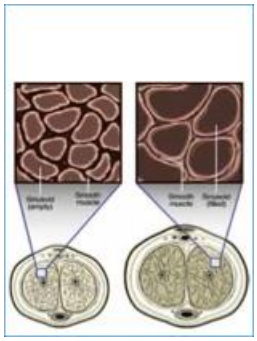
The privileging of a technical construction of erections is evident in the following excerpt from the following cancer centre/hospital's online materials, where a distinction is made between physical aspects of sexuality (i.e., erections) and non-physical/psychological aspects of sexuality (i.e., desire):

Excerpt 3

Whether you are facing physical consequences such as erectile dysfunction or emotional effects such as lack of interest in sexual activity, you are not alone. (Cancer Centre/Hospital Website)

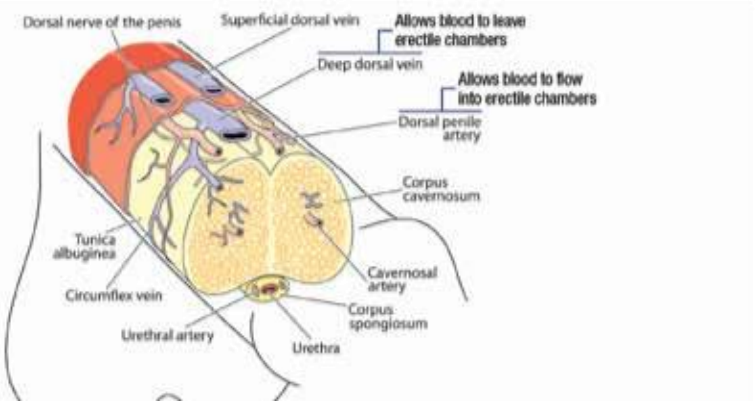
Here, erections are positioned as rooted in the body, which is distinct from other aspects of sexuality such as interest and desire. This contrast shores up a biomedical construction of erections and facilitates a focus on biomedical interventions such as penile rehabilitation.

Excerpt 4:



Non-erectile state: contracted smooth muscle allows less space for blood flow into sinusoids; Erectile state: relaxed smooth muscle allows more room for blood flow into sinusoids (Prostate Cancer Online Patient Publication)

Excerpt 5:



(Prostate Cancer Online Patient Publication)

Patient materials occasionally include diagrams to illustrate the biomedical processes of erections. These diagrams further secure a mechanical/biomedical construction of erections. Arrows in one penile diagram point to the dorsal nerve, the corpus spongiosum, and the tunica albuginea, among other things, and another diagram provides a compare/contrast of sinusoid blood vessels and muscle tissue when the penis is erect vs. non-erect. There is no body attached to the penises in either diagram, which erases the man and any subjectivity he might bring to the experience of erections. Men would be hard pressed to locate their sexual hopes, fears, and desires in these diagrams. Similar to other excerpts, these images encourage an observer's stance to be taken with erections. It is as though erections happen to a man's body and he may observe (rather than experience, be in, etc.) the process.

To conclude, erections are squarely situated within physiology and are constructed as a technical production involving various chemicals, mechanical processes and biological systems. Individual subjectivity, emotions, thoughts, and the relational context in which erections take place are all largely sidelined within the dominant construction. This is evident both in text and visual content from online materials.

Discourse 2: Hierarchy of erections. Patient materials construct a hierarchy of erections. There are indicators throughout which establish a clear delineation between desirable and undesirable erections based on a variety of markers. Criteria include a variety of factors, such as what an erection looked like (e.g., curved vs. straight), what an erection felt like (e.g., warm vs. cool in temperature to the touch), an erection's firmness, the triggering precipitant (e.g., artificially induced vs. naturally occurring), and the effort required (e.g., planned and actively produced vs. spontaneous). Furthermore, this system

of valuation is linked to recovery with more desirable erections signifying progress towards healthy and functional sexuality and less desirable erections signifying the incomplete, stalled or unsuccessful recovery.

Excerpt 1:

Erectile dysfunction is a problem because of the fine network of nerves and blood vessels that run along both sides of the prostate. These networks are essential for normal erections (Cancer Information Website)

Excerpt 2:

There is increasing evidence that the artificial induction of erections on a regular basis may hasten the recovery of spontaneous, or natural, erectile function. (Cancer Centre/Hospital Online Patient Education Booklet)

Excerpt 3:

*Using a penis pump might help you regain erectile function after certain procedures. For example, using a penis pump might help restore your ability to get a natural erection after prostate surgery or radiation therapy for prostate cance*r. (Cancer Centre/Hospital Website)

Words such as "normal", "natural", "spontaneous", "rigid" and "durable" used to describe ideal erections. These are the ideal standards for which patients are striving. Many of these ideals are never clearly defined in the patient literature so it is unclear what exactly these descriptors mean in concrete observable terms. For example, does 'natural' mean 'effortless'? Without medication? Without mechanical intervention? Likewise, does 'normal' mean without intervention? Constantly rigid? Waxing and waning in firmness? The assumption is that patients understand what these terms mean

and will know when their erections reach these ideals. The vagueness in these terms is problematic given their position as being prototypical of recovery. Men are to strive for these standards yet they are operationally imprecise. The (supposed) gold standard penis that is not clearly defined leaves the door open to men imagining that they either do or do not measure up.

It is notable that ideal erections are positioned as natural, normal, and spontaneous. These characteristics are unattainable for many men who have undergone prostate cancer treatment. This is especially true if the definition of 'natural' means 'without medical intervention,' and if 'spontaneous' means without pre-planning. Many men who have undergone radiation or surgery for prostate cancer require long-term and/or indefinite use of pro-erectile aids such as penile pumps, pills or injections in order to experience erections. These aids often require some degree of planning (e.g., not eating for a couple of hours, shaving one's pubic hair at the base of the penis, etc.). Thus, ideal erections, as constructed in patient materials, are outside the realms of possibility for many men. Furthermore, this emphasis on the supposed gold standard penis belies the reality that there is great variability in penises and penile responses even in normal (e.g., non-prostate cancer) conditions. Notably, these excerpts promote the myth of perpetually reliable and stable erections in men. The idealized erection is reliably hard, reliably long lasting, and reliably responsive to a man's demands. Research indicates, however, that 'normal' sexual experiences for men, especially as they age, include fluctuations in erections (e.g., Levy, 1994; Masters & Johnson, 1966). In other words, 'normal' for many men includes waxing and waning of penile hardness and responsiveness. The sexual pharmaceutical industry, however, has largely repositioned 'normal' sexual experience as

'pathological' (e.g., Fishman & Mamo, 2001; Mamo & Fishman, 2001; Marshall, 2002, 2009; Marshall & Katz, 2002). According to Marshall (2002), "what the ED 'industry' is really tackling is not so much a medical epidemic, as it is a reorientation of the normative expectations" (p. 138). Medical professionals and male patients come to view men's erections as falling short of the mark. Not only are their variable erections positioned as abnormal, but also unhealthy.

Excerpt 4:

The rehab group took sildenafil or had alprostadil injections three times a week starting no more than four weeks after surgery: 52% reported spontaneous functional erections, compared with 19% of men in the no-rehab group. (Prostate Cancer Online Patient Publication)

Ideal erections are positioned as functional and as being able to accomplish specific tasks. More specifically, their value is based on their ability to facilitate penetrative sexual activity. See for example the prostate cancer online patient publication, which references "spontaneous functional erections" as an ideal outcome in their review of penile rehabilitation clinical trials.

Excerpt 5:

Most men who have these types of surgeries will have some difficulty with erections (called erectile dysfunction or ED). Some men will be able to have erections firm enough for penetration, but probably not as firm as they were before. (Cancer Information Website)

Excerpt 6:

When investigators followed up 18 months later, 52% of the men in the penile rehabilitation group said they could have spontaneous erections firm enough for intercourse (Cancer Information Website)

Excerpt 7:

After nine months, 17% of men who used a device achieved erections sufficient for intercourse (Prostate Cancer Online Patient Publication)

Excerpt 8:

Penis pumps are effective. With practice and correct use, the majority of men can get an erection sufficient for sex. (Cancer Centre/Hospital Website)

Excerpt 9:

Erectile dysfunction (ED) is the inability to achieve an erection or maintain it long enough for sexual intercourse. (Cancer Information Website)

Ideal erections are positioned as firm, and more specifically firm enough for "penetration" and/or "intercourse." For example, privileged erections are, "hard/firm enough for penetration" (Cancer Information Website), "firm enough for intercourse" (Cancer Information Website), "sufficient for intercourse" (Prostate Cancer Online Patient Publication), and "sufficient for sex" (Cancer Centre/Hospital Website). Sufficient for sex presumably means sufficient for penile-vaginal penetration. Penile prostheses are positioned as a viable treatment option for men. This is further evidence of the privileging of dependable and firm erections that respond on demand and that are in a man's complete control. Functionality of the penis is prioritized over and above what pleasures the penis feels.

Excerpt 10:

We know that daily erections are natural and necessary and that without erections atrophy and scarring can develop. Thus, interventions aimed at preserving sexual function must allow regular erections. (Cancer Centre/Hospital Website)

Excerpt 11:

The average healthy man experiences three to five erections during sleep every night, each lasting up to 30 minutes. Most men who have normal nocturnal erections also develop brief erections when they nap during the day. (Cancer Information Website)

Excerpt 12:

The average man experiences three to six erections every night of his life (lasting 10 to 15 minutes at approximately 70% rigidity). (Prostate Cancer Online Patient Publication)

Excerpt 13:

Most studies have suggested using medicine to get an erection hard enough for penetration about 2 to 3 times a week. (Cancer Information Website)

There are also parameters for the ideal frequency of erections – ideal frequency ranges from several times per day to several times per week, and for the duration of erections. Ideal erections last "long enough for sexual intercourse" (Cancer Information Website) but ought not to last too long lest they enter the territory of being "prolonged" and "inappropriate" in length (Cancer Information Website).

Excerpt 14:

Erections usually improve with time, lasting anywhere from 2-3 years or more

after the operation, because some of the traumatized nerve fibers recover slower. Even if both nerves are spared, most men find their erections are less rigid and durable than before surgery. Younger men recover sooner, and those with stronger erections before the operation have a better chance of recovery than if the erections were weak preoperatively. (Cancer Information Website)

Excerpt 15:

Erections recover over the course of 24 months or longer and are, for some men, less rigid and durable. If problems continue, medications and devices can help. Your doctor may also prescribe medications and devices during recovery to help bring back erection function. (Cancer Information Website – Patient Education Brochure)

Excerpt 16:

Nerves in your pelvic area control blood flow to your penis … A severed nerve can lead to weakened erections or the inability to achieve an erection. (Cancer Centre/Hospital Website)

Excerpt 17:

"*Penis may be cool to the touch so not a natural feel" (using vacuum pumps*) (Cancer Information Website)

Messages about ideal erections provide information about what kinds of erections are less desirable. Generally, patient materials construct undesirable erections as "weak" (Cancer Information Website) or "weakened" (Cancer Centre/Hospital Website), "cool to the touch so not a natural feel" (Cancer Information Website), "nonrigid" (Vancouver

Prostate Centre Patient Education Booklet) or "less rigid and durable" (Cancer Information Website).

Semi or non-erect penises are rarely if ever mentioned as part of recovery and any pleasures or possibilities for sexual activity or sexual play linked to soft or semi-soft erections are largely missing from patient materials. Apropos the title of a clinical trial discussed on a cancer centre/hospital's website – "Hard Times" – men who have difficulty experiencing natural, spontaneous, frequent, and firm erections are positioned as being in for arduous challenges.

All in all, patient materials provide indicators of ideal erections and a hierarchy is constructed whereby better erections are ones that are natural, spontaneous, frequent, functional, dependable, and firm. Conversely, problematic erections are constructed as ones that are weak, unreliable, anything other than firm, and that require mechanical and/or biomedical assistance. The characteristics of ideal erections are positioned as markers of physical recovery and sexual health. These constructions mean that a man is unable to be both recovered/sexually healthy and have erections that fall short of the ideals.

Discourse 3: Perilous prostrate penises. Non-erect penises are positioned as being unhealthy and dangerous throughout patient materials. Penises that are left alone, or that are not regularly attended to, touched, stimulated, or made to be erect are positioned as being at risk for a variety of negative outcomes. Erections are positioned as a means to penile and sexual health. Thus, an erectile imperative is conveyed through materials.

Excerpt 1:

Recent research suggests that when the penis is flaccid for long periods of time, and therefore deprived of a lot of oxygen-rich blood, the low oxygen level causes some muscle cells in the columns of erectile tissue (corpora cavernosa) to lose their flexibility and gradually change into something akin to scar tissue. This scar tissue, moreover, seems to interfere with the penis's ability to expand when it's filled with blood. In fact, imaging studies indicate that blood may drain away from the penis rather than fill it. (Cancer Information Website)

Excerpt 2:

Nature's way of protecting erectile tissue

The average man experiences three to six erections every night of his life (lasting 10 to 15 minutes at approximately 70% rigidity). Nocturnal erections serve to protect erectile tissue during periods of sexual abstinence. Regular erections increase the blood flow and oxygen supply to feed the tissues in the erectile chambers … Without a constant supply of oxygen and other nutrients from the blood, scar tissue can develop that can kill smooth muscle cells. Damaged erectile tissue will remain unresponsive to nerve signals even with complete nerve recovery after a prostatectomy, and a man can be left with permanent erectile dysfunction. (Prostate Cancer Online Patient Publication)

As indicated in these and other excerpts, materials convey that if left flaccid for long periods of time following surgery, a man's penis may be "deprived of a lot of oxygen-rich blood" (Cancer Information Website), and thus "may weaken" (Cancer Information Website) and experience "scarring and atrophy" (Cancer Centre/Hospital Website) and "lasting harm" (Prostate Cancer Online Patient Publication), such as

"permanent erectile dysfunction" (Prostate Cancer Online Patient Publication). The ultimate negative outcome presented to patients is the possibility of lasting erectile dysfucntion (a permanently and persistenly nonerect penis). Thus, the danger in non-erect penises is that they may no longer 'work' or become erect without intervention; the fear is that "he will not be able to get an erection naturally" (Cancer Information Website).

Conversely, 'healthy' penises are positioned as being erect. According to a prostate cancer online patient publication, "Nocturnal erections serve to protect erectile tissue during periods of sexual abstinence. Regular erections increase the blood flow and oxygen supply to feed the tissues in the erectile chambers." Erections are constructed as essential to the health of the penis and as a key component of men's sexual health overall. This reinforces an erection-focused approach to sexuality. The emphasis on obtaining erections (in service of a man's sexual health) also legitimizes erection-focused penile rehabilitation. A cancer centre/hospital's online materials state, "Interventions aimed at preserving sexual function must allow regular erections."

Excerpt 3:

*There is a risk of developing curvature of the penis (Peyronie's disease) due to scarring from repeatedly injecting into the same site or from kinking or buckling of the penis while having intercourse without a sufficiently rigid erection. (*Cancer Information Website*)*

After pelvic cancer (e.g., prostate, bladder, rectal) treatment, the normal physiology of penile erections can be altered. Nerve and blood vessel injury or manipulation can impair normal erections, penile oxygenation, and long term penile and sexual health. (Cancer Centre/Hospital Website)

The privileging of erect penises is further reinforced in patient materials through reference to Peyronie's disease – a condition involving curvature of the penis (see Excerpt 3). For example, a cancer centre/hospital website mentions that Peyronie's disease can develop in men who attempt to have intercourse "without a sufficiently rigid erection." The resulting "kinking or buckling of the penis" from trying to penetrate with a semi-erect penis is a pathway to pathology. This is another example of the dangers presented in materials of non-rigid or insufficiently rigid penises. This reinforces the imperative to achieve fully firm erections so that "buckling" or "kinking" does not occur. Rigid erections are positioned as protection from harm for the penis.

Penises that are not erect become marginalized in this construction of penile health and sexual health. Soft or semi-soft penises are equated with risk, danger, and poor long-term health. There is little room for non-erect penises in this construction of erections.

In conclusion, patient materials convey that non-erect penises pose serious risks to a man's penile and sexual health. Thus, erect penises are privileged; great emphasis is places on experiencing regular erections as a means to preserving health and preventing degeneration of sexual function.

Discourse 4: Interrogating synonyms for erectile (dys)function - diminishment, disability, and (false) dichotomy. Myriad words were used interchangeably with erections and erectile dysfunction. For example, the construct of erectile dysfunction is referred to as: "the price a man paid" (Cancer Information Website), "difficulty with erections" (Cancer Information Website), "impaired" (Cancer Information Website), "impotence after treatment" (Cancer Information Website),

"inability to get or maintain an erection sufficient for sex" (Cancer Centre/Hospital Website), "difficulty resuming sex" (Cancer Centre/Hospital Website), "difficulty with sex" (Cancer Centre/Hospital Website), "their erection problem" (Cancer Centre/Hospital Website), "physical side effects" (Cancer Centre/Hospital Website), "sexual health issues" (Cancer Centre/Hospital Website), "changes in sexual and reproductive health" (Cancer Centre/Hospital Website), "penile and erectile difficulties" (Prostate Cancer Online Patient Publication), "the disabilities and consequences as a result of cancer treatment" (Cancer Centre/Hospital Website), "erection problems" (Cancer Information Website), and "sexual function" (Cancer Centre/Hospital Website). Identification and analysis of these 'stand-in' phrases and terms reveals a host of messages and meanings associated with erections. The following questions guided analyses for this subsection: What different terms are used interchangeably with erections and/or erectile dysfunction? What meanings do these alternate terms convey? And in what ways might these meanings shape the ways in which patients think about erections, sexuality, and the sexual changes they are experiencing?

Erectile dysfunction as diminishment and disability. The equation of erectile dysfunction with things like impairment, impotence, and disability conveys that changes in erections signify a variety of losses. These terms also give particular meaning to these changes/losses. Specifically, a man is constructed as being diminished through the changes he experiences in erections. The definition of impotence includes weakness and stresses inabilities. Dictionary synonyms for impotence include: inaptitude, inability, disability, imbecility, incompetence, and incapacity (thesaurus.com). Thus, a man is in a state of loss of ability, function, power, through his experience of changes in erections.

Use of these terms may shape a man's experience of change in erections in particular ways given the host of meanings that they conjure up. Changes in erections are not positioned as neutral or common; the words used to describe sexual changes are not merely descriptive, rather they convey a host of meanings about sexuality, masculinity, power, and ability, and have values embedded within them.

Erections are frequently discursively positioned as an "achievement" (e.g., Cancer Information Website). Men "achieve" or "produce" erections rather than, say, 'experience' them. This language connotes that erections are an achievement attained through effort and agency. Erections are positioned as requiring will and active production and are to be celebrated and praised as a man's accomplishment (e.g., they are an achievement). Conversely, to not "achieve" erections connotes failure, forfeiting accomplishment in this capacity, and loss. Erectile dysfunction becomes a marker of diminishment.

***(False) dichotomy of functional vs. dysfunctional penises*.** Through the various terms used to refer to erections and (dys)function of erections following prostate cancer treatments, erections are positioned as things that either work or don't work. There is a binary that is set up whereby men were presumably on the "erections that work" side of the divide before cancer, and are on the "erections that don't work" side of the divide after cancer. Penile rehabilitation is positioned as a means to walk a bridge back to the side of "erections that work." Thus, there is little room for erections that fall somewhere along the continuum, erections that behave in different ways at different times, erections that are sometimes responsive and sometimes not, erections that are semi-firm or semi-soft. There is little tolerance for erections that are variable. This begs the question, what

exactly does “function” look like? What do working penises act, look, behave like? What is the measuring stick against which penises must be assessed? What are the criteria? And in what ways does this imaginary or possibly illusionary state of “function” impact or shape men’s experiences with their bodies, penises, erections through prostate cancer and survivorship?

The language of function and dysfunction sets up this binary whereby erections/men fall into either one category or the other. For example, a cancer centre/hospital’s materials mention “restoration of the patient’s sexual function” as a goal of penile rehabilitation (see Excerpt 9). Here, erectile dysfunction is positioned as being in opposition to a state of having sexual function. There are two categories and treatment aims to move men from one category to the other. Likewise, another cancer centre/hospital’s website references “recovery of sexual function” in their materials. This suggests a binary between a state of dysfunction with erections and a state of recovery of function. This language constructs changes in erections as a problem and offers only one plausible/desirable/optimal outcome, that of moving towards function and recovery. Given that changes in erections are constructed as dysfunction, it is inevitable that men ought to work hard to move away from that state. There is little room for alternative positions, for viewing oneself as having function and being functional and having sexual health even in the face of sexual changes.

To conclude, the plethora of terms used interchangeably for erectile dysfunction in online patient materials reveals various meanings and value. In particular, erectile dysfunction is positioned as a state of diminishment and disability in men with prostate cancer. Given that erections are discursively constructed as “achievements” and as

markers of potency, dysfunction is associated with failure and loss of power and status. In addition, erections are positioned as being either functional or dysfunctional. This dichotomy leaves little room for erections that fall somewhere in the middle. It also places a value judgment upon erections that don't work "properly" even as properly is rarely operationally defined. This dichotomy positions most men with prostate cancer as dysfunctional and leaves little room for them to be positioned as sexually whole in the face of sexual changes following their cancer treatment.

Analyses: Patients & Partnerships

Online patient materials were coded for content that related to the discursive construction of penile rehabilitation patients, for the partners of men with prostate cancer, and for relationships. Analysis of material related to patients was guided by the following questions: In what ways are patients being positioned in patient materials? What are the qualities, actions, and attitudes of ideal patients? Conversely, what are the qualities, actions, and attitudes of problematic patients?

Analysis of material related to partners and relationships was guided by the following questions: In what ways are partners and relationships being described in patient materials? What are the qualities, actions, and attitudes of ideal partners/relationships? Conversely, what are the qualities, actions, and attitudes of problematic partners/relationships? What role are partners positioned as playing in the rehabilitation process? What messages are conveyed about the relational context of penile rehabilitation and prostate cancer? In addition to a careful reading of patient material for data that referred or related to partners and relationships, data were scrutinized for the

following search terms: partner, wife, husband, spouse, girlfriend, boyfriend, lover, her, she, couple, and relationship.

The following three discourses emerged:

(1) The Proactive and Persevering Patient: Ideal patients are constructed as proactive and persevering; they are dedicated stewards of their recovery.

(2) The Informed Patient (via Expert Consultation): Ideal patients are constructed as active consumers of medical knowledge related to their recovery.

(3) Prototypical Patients and Partnerships: Parameters for 'normal' and ideal patients are provided; prototypes included minimal markers of diversity. These markers map onto parameters for 'normal' relationships, which are overwhelmingly depicted as heterosexual and homogenous. Visual data include minimal markers of diversity whereas textual data includes some more diverse relationship representations.

The Partner's Rehab Role: Invisible, Incidental and Integral: Depictions of the involvement of partners in penile rehabilitation range from nonexistent to integral.

Discourse 1: The proactive and persevering patient. The ideal patient is constructed as sharing many attributes with the successful neoliberal citizen, who is positioned as being autonomous, entrepreneurial, responsible, self-disciplining, and perpetually engaged in self-improvement through consultation with experts. Likewise, the ideal penile rehabilitation patient is constructed as a unique and agentic individual who acts as a responsible and engaged steward of his health, sexuality, and especially his erections. Good patients are constructed as being proactive, motivated, hardworking,

dedicated, informed, and actively engaged in the penile rehabilitation process. In addition, they rely on the specialized knowledge of medical experts to determine how to manage their recovery and wellness. This poses an interesting dichotomy that men must navigate. They are called to be both expert abiding but also supremely self-driven.

For example, a cancer centre/hospital's Patient Education Booklet states that recovery depends upon "the patient and his partner's education … and their dedication to the rehabilitation process." The message being conveyed is that patients (and often their partners) ought to work hard in order to achieve and secure recovery. The mantra is 'work hard to get hard.' That is, the application of dedication, active engagement in the process, hard work, and informing oneself along the way are the pathway to recovery (a.k.a. reliable, firm erections).

The 'use it or lose it' mantra appeared in many patient materials. Men are instructed to actively engage with their sexuality and erections or risk losing erectile function – which is often equated with sexual function – permanently. Materials state that "men who are interested in preserving their sexual function" need to act quickly and decisively. Likewise, given the treatment options available, patients are told that there is no reason they can't "resume assisted penetrative sexual activity within six weeks of prostate cancer surgery, if you and your partner are so motivated" (Cancer Centre/Hospital Website). Thus, motivation is the bridge to sexual function and lack of motivation is positioned as the only barrier to recovery.

Excerpt 1:

And these calls are usually a lot about encouragement and just keep with it. I mean, I have targeted some areas that they needed some help with maybe their

technique or whatever. But a lot of it becomes sort of an encouragement thing just to stay with this. And yes this is a new reality in their lives and how they are going to approach their relationship with their partners or whatever, but it's a lot about encouragement and staying power and just keeping with it. (Cancer Centre/Hospital Website)

Excerpt 2:

The good news is that today there are many different treatments for ED that can help most men get their erections back. It might take some time, but if you are willing to try the different options, you'll most likely find one that will work. (Cancer Information Website)

Materials emphasize the importance of persisting with penile rehabilitation protocols even when patients experience difficulties. Dedication and "just keeping with it" (Cancer Centre/Hospital Website) are emphasized. For example, a cancer information website communicates to patients that, "it might take some time, but if you are willing to try the different options, you'll most likely find one that will work." The flip side of this pro-motivation message is that patients, who do not promptly and assiduously practice penile rehabilitation, do not care about their erections or their 'sex lives.' Successful recovery is paired with motivation – patients who 'want it' badly enough and who work hard enough will achieve success. The onus is placed on the patient. Quoting Hippocrates, a cancer information website states, "That which is used develops; that which is not used wastes away."

Excerpt 3:

Article heading: Prostate Knowledge: Empowering you to take charge of your prostate health (Cancer Information Website)

Excerpt 4:

If you have sexual or reproductive health concerns related to cancer treatment, take action. Speak with someone on your medical team who can refer you to the Male Sexual Reproductive Medicine Program. You can also contact us directly at 646-422-4359. (Cancer Centre/Hospital Website)

Excerpt 5:

Mulhall, John P. Saving your sex life: A guide for men with prostate cancer. Hilton Publishing Company, 2008. (Prostate Cancer Online Patient Publication)

Patients are advised to empower themselves and take charge, to "please ask" (Cancer Centre/Hospital Website), to take action (Cancer Centre/Hospital Website), and to adopt an active and empowered stance. One site recommends that patients consult a book called "saving your sex life" (Prostate Cancer Online Patient Publication). Agency is encouraged and promoted. Thus, patients who adopt alternative approaches or strategies are constructed as not caring about sexuality, or not caring about erections. There is little room for patients who are confused or conflicted, or for whom an aggressive approach to treatment does not fit. In simple terms active is good and ambivalent is bad. Also, men are presumed to be motivated to *want* to change their bodies, sexual health, and sexual abilities. The assumption is that men are waiting for expert others to come along with the expertise and answers that men have been eagerly awaiting.

Discourse 2: The informed patient (via expert consultation). In accordance with successful neoliberal citizens, patients are encouraged to become "informed" via expert consultation (e.g., see Excerpt 9).

Excerpt 6:

The best patient is an informed patient. Key to the success of the program is your understanding of the rehab program. We recommend that both you and your partner meet with one of our sexual medicine experts (your rehab 'coaches') prior to prostate surgery. (Cancer Centre/Hospital Website)

Excerpt 7:

Article headline: "*What You Should Know About Surgery for Prostate Cancer*"

(Cancer Information Website – Patient Education Brochure)

"The best patient is an informed patient," and "the key to the success of the program is your understanding of the rehab program," states a cancer centre/hospital's online material. Patients are urged to be in the know about their bodies, erections, side effects, and treatments. Patients are encouraged to find out "what you should know" (Cancer Information Website – Patient Education Brochure) and continually add to their "understanding" (Cancer Centre/Hospital Website) of their health, sexuality, cancer treatments, erections, and path to recovery.

Excerpt 8:

What you can do to regain sexual function

Find out as much as you can about what's impeding your sexual function. This may help you feel more in control of the situation and help guide you to treatment options.

(Cancer Centre/Hospital Website)

Excerpt 9:

Request a consultation with a post-prostatectomy sexual rehabilitation specialist

You may also request a consultation by phone by calling [phone number].

(Cancer Centre/Hospital Website)

Excerpt 10:

Consultation before action

As always, these products shouldn't be used without first consulting your doctor. It's important to have a good understanding of your own state of health as well as how these treatments work in order to find the best combination for you. Ask your doctor what approach to penile rehabilitation he/she prescribes. Your local pharmacist can also be a valuable resource for information and support. (Prostate Cancer Online Patient Publication)

Excerpt 11:

Prostate cancer patients and their partners may need to make sexual adjustments as a result of the treatment effects … For these reasons we provide an educational forum to help men and their partners learn about the strategies used to manage sexual side effects, and to ask questions. Our Sexual Health Clinician—a Rehabilitation Nurse specializing in sexual health and chronic illness – presents this 90 minute session which is designed to:

- *Add to one's current understanding of sexual health and sexuality*
- *Inform you about the possible sexual changes caused by prostate cancer treatments*

- *Introduce penile rehabilitation*
- *Begin to review the efficacy, pros and cons of various management options for sexual changes.*

We encourage you (alone or with a partner) to attend this session. Being proactive before and after prostate cancer treatments will help optimize your sexual function and partner intimacy.

(Cancer Centre/Hospital's Online Flyer about a Prostate Cancer Supportive Care Program)

The pathway to becoming a well-informed patient is through expert consultation. Consulting with a team of prostate and sexual health experts and expert sources of information is positioned as a way to "feel more in control" and to make more informed decisions about the recovery process (Cancer Centre/Hospital Website). For example, patients are advised to "request a consultation" with a "specialist" (Cancer Centre/Hospital Website), to speak with their "doctor" or "local pharmacist" (Prostate Cancer Online Patient Publication) and to otherwise arm themselves with information as they navigate this process of recovery. The information that patients "should know" (Cancer Information Website – Patient Education Brochure) is in the hands of medical experts and patients are supposed to tap these expert sources in order to find out how to navigate recovery. Consulting with experts and actively seeking out information is positioned as evidence that the patient cares to "optimize" his "sexual function and partner intimacy" (Cancer Centre/Hospital Website).

Conversely, not seeking out information and expert consultation is a sign of not caring. Not consulting is conflated with not caring. Patients who are not able, for

whatever reason, or those who do not wish to consult with a variety of sexual health and medical experts are positioned as problematic and at risk of various negative sexual health outcomes that they might otherwise avoid. Inactive patients, and those who do not team up with expert sources of knowledge, risk having an unhealthy sex life and one that is rife with permanent problems. The patient who is uninformed and who does not inform himself of what he "should know" (Cancer Information Website), or who does not avail himself of expert sources of information, is problematic.

Discourse 3: Prototypical patients & partnerships. Text and visual materials were analyzed for messages about patients in order to answer the following question: What possibilities for identity exist for patients (e.g., with respect to age, ethnocultural background, sexual and gender identity, class, weight, physical ability, etc.)? Results indicate that patient representations contain some diversity but tend to coalesce into a few patient prototypes.

In addition, text and visual material was analyzed for messages about partners and relationships in order to answer the following question: What parameters are presented for 'normal'/'healthy' relationships within penile rehabilitation (e.g., with respect to age, ethnocultural background, sexual and gender identity, class, weight, physical ability, etc.)? The findings are similar to the ways in which individual patients are depicted in that visual depictions construct relationships in narrow and delimited ways with minimal representations of diversity. Textual materials provide somewhat greater variability in representations of relationships.

Excerpt 1:

(Cancer Centre/Hospital Website)

Excerpt 2:

Cancer Centre/Hospital patient, [patient name] talks about why he chose to have open prostate surgery, the recovery process and the importance of post-care rehabilitation after prostate cancer surgery. (video link)

(Cancer Centre/Hospital Website)

Excerpt 3:

(Cancer Information Website)

Excerpt 4:

(Cancer Centre/Hospital Website)

Excerpt 5:

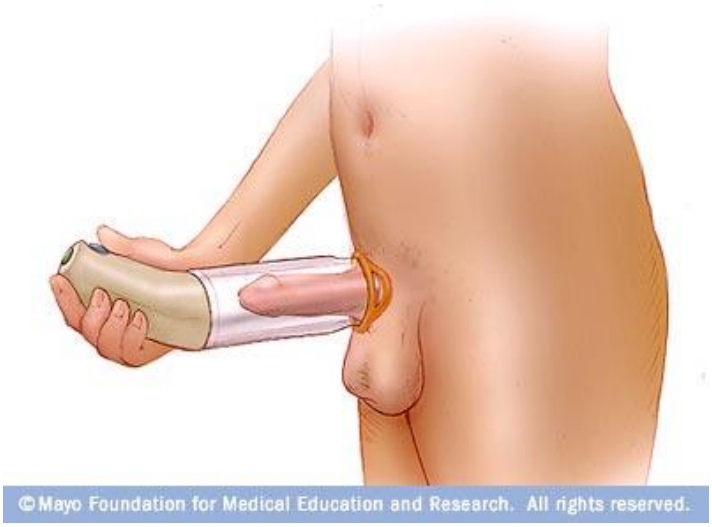
(Prostate Cancer Online Patient Publication)

Visual images construct patients as heterosexual, middle class, able-bodied, slim, educated and/or of professional status, and almost always often Caucasian. In addition, patients' genitals are carefully groomed and decapillated (e.g., all pubic hair has been removed). For example, a cancer centre/hospital's website includes an image of a Caucasian, middle-aged patient dressed in a business suit. Another photographic image depicts a Caucasian, (presumably) heterosexual couple. They carry markers of socioeconomic privilege, for example, they both have straight, white teeth, are in collared dress shirts, and are well groomed (e.g., she is wearing elegant make-up and has a chic hair style; he is clean shaven and is wearing contemporary eyeglasses). There is some age diversity depicted in images with couples ranging from being relatively youthful to one

couple in their senior years. Ethnocultural diversity is lacking with the exception of one image that depicts a man and woman of unknown but likely non-Caucasian ethnocultural background. Notably, this website's focus is on urological concerns generally and does not focus exclusively on prostate cancer. This could account for the younger age of the couple.

There are no depictions of individuals with physical disabilities, people of lower socioeconomic status, larger bodies, or individuals who do not confirm to traditional gendered presentations (e.g., men with short hair, women with longer hair; women with makeup, etc.)

Excerpt 5:

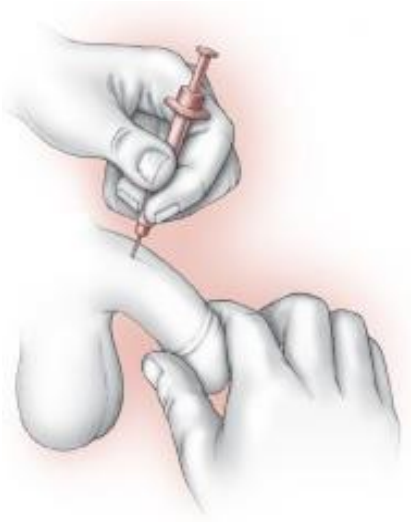


Battery-powered penis pump for erectile dysfunction

(Cancer Centre/Hospital Website)

Excerpt 6:

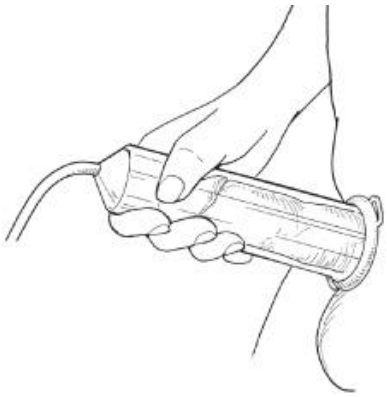
Figure 1: Injection therapy



(Cancer Information Website)

Excerpt 7:

Figure 2: Vacuum device



(Cancer Information Website)

Illustrated diagrams provide fewer details than photographic images; however; all diagrams construct patients as Caucasian. Across patient materials, myriad markers of diversity are missing, including ethnocultural, class, body size and shape, and physical (dis)ability. The markers of 'normal' patients, as established in online patient materials, exclude a great many axes of diversity and representations.

With few exceptions, materials overall construct patients into narrow prototypes. The typical patient is depicted as Caucasian, heterosexual, able-bodied, of secure socioeconomic status, slim, and as following traditional gender scripts for self-presentation (e.g., hair, clothing, grooming).

The few visual images provided in online patient materials (see Excerpts 1, 3, 4, 5,) construct prostate cancer couples as dyadic, heterosexual, of similar age, of similar ethnocultural background (most often Caucasian), middle class, slim, able-bodied, and attractive. Thus, these couples are relatively privileged and homogenous in their visual depictions. There is a notable lack of diversity presented in couples. For example, there are no images of same sex couples, or of couples of notably disparate ages, or different ethnocultural backgrounds. And there is a lack of diversity of alternative configurations of relationships (e.g., non-dyadic formations).

Excerpt 8:

But along with that it's really nice if you can find someone who also works with a psychologist or other mental health professional and bring your partner into the whole process. Don't leave her out of it if you are in a committed relationship.

(Cancer Centre/Hospital Website)

These findings are concordant with analyses of text material. Relationships are predominantly constructed as heterosexual. For example, a cancer centre/hospital's website tells men, "don't leave *her* out of it" (emphasis added). The partner is presumed to be a "she." Numerous references to penile-vaginal sex permeate patient material. Terms such as "sexual intercourse" (Cancer Centre/Hospital Website), "intercourse" (e.g., Cancer Centre/Hospital Online Patient Education Booklet) "erections for

intercourse" (Cancer Centre/Hospital Website), "erections sufficient for intercourse" (e.g., Prostate Cancer Online Patient Publication, Cancer Information Website), and "erections firm enough for intercourse" (Cancer Information Website), all reinforce dominant constructions of couples as male-female.

In addition, committed and stable relationships are privileged. For example, a cancer centre/hospital's online materials urge male patients to involve their partners "if you are in a *committed* relationship" (emphasis added). This suggests that only committed partners are relevant to penile rehab as opposed to dating relationships, sexual but non-romantic partners, or other kinds of partnerships. These constructions make invisible the many partnership that are new, evolving, diverse, and in any way divergent from dominant depictions. For example, casual or multiple partner configurations are largely absent. These constructions effectively reinforce dominant discourses of committed relationships as being the most valued and other configurations being peripheral, or inconsequential to the prostate cancer experience.

***(Limited) diverse relationship representations*.** Analyses reveal that textual data contains some alternatives to dominant constructions of relationships as heterosexual, dyadic, committed, and spousal.

Excerpt 1:

Use of a penis pump requires patience and understanding from both you and your partner. (Cancer Centre/Hospital Website)

Excerpt 2:

Our rehab plan helps maintain sexual satisfaction and overall quality of life for you and your partner as you head into prostate cancer survivorship. (Cancer Centre/Hospital Website)

Excerpt 3:

Your partner can offer vital support as you recover from cancer treatment. She or he might also have ideas on how to help you regain your sexual function. (Cancer Centre/Hospital Website)

A number of sources use terms like "partner" as opposed to girlfriend, wife or spouse. This opens up the possibilities for legitimate partnerships as including same-sex and/or non-married couples. Likewise, many materials use the term "relationship" as opposed to "marriage," which provides some space and flexibility for diversity in couples. A single source made explicit reference to male partners of men with prostate cancer. Notably, use of the term 'partner' does not always represent a more expansive notion of partnership and there are far more references to mainstream couple formations (e.g., images, references to spouses and female partners) than there are to alternative relationship formations. While use of the term 'partner' in materials is more inclusive, its pairing with images of male/female couples and the emphasis on intercourse suggests that the term refers more to non-spouse heterosexual couples than to non-heterosexual-couples.

Excerpt 4:

Penile Prosthesis Disadvantages: may be embarrassing with new partner (Cancer Information Website)

Excerpt 5:

… you need to look at the emotions and the relationship or the dating issues as well as fixing the physical problem and the sexual communication issues. (Cancer Centre/Hospital Website)

Excerpt 6:

We use this information to develop a personalized treatment plan to help you manage the effects of cancer on your sexual health. Our strategies include: … suggestions to enhance communication and intimacy with current or future partners (Cancer Centre/Hospital Website)

Excerpt 7:

Are your erections better when you relax, when you stimulate your own penis, or when you unexpectedly see someone attractive? If you have a few partners, are your erections better with one of them than with the others? (Cancer Information Website)

In addition, some sources reference relationships that may be new or evolving or multiple. For example, a cancer information website mentions that there may be some embarrassment in using a penile prosthesis with a "new partner," and a cancer centre/hospital's online materials include a comment about addressing "dating issues" in sexual recovery and rehabilitation. Another cancer centre/hospital's website references future partners. Also, a cancer information website mentions that men may have "a few partners" and that it may be helpful to compare erections with different partners when trying to figure out what kinds of experiences and sensations contribute to maximum arousal. These textual examples provide discursive spaces that legitimize partnerships that fall outside of traditional configurations. They are, however, greatly superseded by

references to heterosexual, monogamous, dyadic, married, and/or committed relationships.

Discursive strategy 4 - The partner's rehab role: Invisible, incidental and integral. Analysis of data for messages about partners reveals great variability in how partners and relationships are positioned in relation to penile rehabilitation (e.g., the contribution of partners, the role of partners, etc.). Several of the materials that were analyzed make no reference at all to partners. Other materials make minimal reference to partners and position partners as having a peripheral role in the process. Still others position the partner and the couple relationship as being indispensable in the penile rehabilitation recovery process.

***Partners as invisible*.** Four sources do not reference partners or relationships at all in online material either through images or text. In these cases the relationship context is positioned as inconsequential. De-emphasizing partners in many online materials is striking given the probable impact on partners from penile rehabilitation protocols. For example, many protocols prescribe medically induced erections several times a week and make reference to regular sexual activity, intercourse, and penetration. Thus penile rehabilitation interventions have dyadic implications whether or not partners are explicitly incorporated into treatment.

***Partners as incidental*.** Several sources reference partners in an auxiliary way. It is often acknowledged that partners are part of the context of sexual changes and their role is acknowledged in several places. This ranges from scant references to more frequent mention of partners throughout materials. For example, one source includes an image of a couple lying down side-by-side and staring up, but does not reference partners

or the relationship context in any of the text material (Prostate Cancer Online Patient Publication). In this source, partners are positioned as background context versus central to penile rehabilitation.

Excerpt 1:

(Prostate Cancer Online Patient Publication)

Excerpt 2:

[A penile implant] may be embarrassing with new partner (Cancer Information Website)

Excerpt 3:

Some men say that a dry ejaculation feels no different and, often, their partners don't notice or don't mind the difference. (Cancer Centre/Hospital Website).

Excerpt 4:

We welcome input and assistance from the patients' partner in order to help maximize rehabilitation success. (Cancer Centre/Hospital Website)

The reference to partners in many materials is their possible reaction to sexual changes. For example, a cancer information website indicates that use of a penile implant "may be embarrassing with [a] new partner." Another source references partners'

reactions to dry ejaculation, which occurs following radical prostatectomy. Material conveys that partners often "don't notice or don't mind the difference" (Cancer Centre/Hospital Website). The only mention to partners on one cancer information website is in reference to men's possible urine leakage during orgasm following prostate cancer treatment. The site reassures readers that "this fluid is not harmful to you or your partner." No other mention of partners is made.

Partners as integral. In some materials, the relationship between the patient and his partner(s) is constructed as being integral to recovery and as a core component of the penile rehabilitation process. As part of this more central positioning, partners are encouraged to become treatment allies in penile rehabilitation. For example, they are encouraged to "help maximize success" for their partners (Cancer Centre/Hospital Website), and to become informed and active participants in the process and bring motivation to their role in rehab (Cancer Centre/Hospital Website). The ideal partner is thus positioned as a willing, accommodating, and resourceful ally in the process.

Excerpt 5:

Talk with your partner. Let your partner know what works best for you. Be honest about your concerns and feelings. If you're silent about what you're experiencing, your partner may feel rejected. Your partner can offer vital support as you recover from cancer treatment. She or he might also have ideas on how to help you regain your sexual function. (Cancer Centre/Hospital Website)

Excerpt 6:

The successful recovery of erectile function is highly dependent on the patient and his partner's education about treatment-related sexual problems and their

dedication to the rehabilitation process. Open sexual communication between partners is essential. (Cancer Centre/Hospital Online Patient Education Booklet)

The cancer centres/hospitals in Excerpts 5 and 6 emphasize the central importance of partners in penile rehabilitation. These excerpts reference honesty, sharing feelings, and mention that partners may have insights that are valuable for the sexual recovery process. Partners are mentioned as being valuable, and reference is made to partners having their own needs and concerns, thus they are positioned as more than peripheral and as more than facilitators or coaches or rehab.

The cancer centre/hospital's materials from Excerpt 6 state that recovery "is highly dependent on the patient and his partner's education about treatment-related sexual problems and their dedication to the rehabilitation process." They state, "open sexual communication between partners is essential." This source positions treatment as involving both men and their partners: both are said to be impacted by sexual changes, both may need "to make sexual adjustments," and both are encouraged to learn new strategies to cope through joint attendance at information and counseling sessions. Thus partners are woven into this centre's conceptualization of rehabilitation and their approach to care based on analysis of online materials.

Excerpt 7:

… bring your partner into the whole process. Don't leave her out of it if you are in a committed relationship.

(Cancer Centre/Hospital Website)

Excerpt 8:

Well, some of the videos are men interviewing actual patients who agreed to do that, you know, to benefit others. And some are actually vignettes with actors that we created with UT TV who did a fabulous job. And they show kind of the coping issues that people go through. One is a younger man, and one is a younger man [sic]. *They talk about dating, and they talk about communicating with your partner and the impact on relationships. And I think what is unique about our website is not only is all the information accurate because it was all vetted by [Cancer Centre/Hospital], and not everything on the Internet by any means is accurate. But also it has not only the medical things but the counseling things. So it actually has self-help exercises that couples can do together or a man can do if his thoughts are very negative and he wants to kind of motivate himself and change his thinking. And it, you know, really integrates the emotional the physical not just one or the other. And it has a lot of parts for partners. So partners want to help a man improve his sex life and also want their point of view to be part of the equation. Have some place to go.* (Cancer Centre/Hospital Website)

Excerpt 9:

Definitely. As I said, men tend to be very technically oriented. Just fix the physical problem and everything will be OK. And we know now from many years of research that that is often not true. That you need to look at the emotions and the relationship or the dating issues as well as fixing the physical problem and the sexual communication issues. (Cancer Centre/Hospital Website)

The cancer centre/hospital's website materials in Excerpts 9 and 10 also position the relationship as being at the core of recovery. Materials state: "bring your partner into

the whole process. Don't leave her out of it if you are in a committed relationship." Supposedly sexual or romantic partners who are not sufficiently committed are not to be incorporated into recovery, although this is not explained. These excerpts construct recovery as a partnered process involving "counseling for couples," and strategies that address "the relationship or the dating issues" and "sexual communication issues." The partner's perspectives are positioned as being valuable and important. Thus, partners are not just positioned as being willing and accommodating coaches for men but as having their own "point of view" that is incorporated into recovery as "part of the equation."

Excerpt 10:

Some men may also experience a loss of sexual confidence after cancer and its treatment. Restoring this self-assurance is a complex process that involves not only the patient, but his partner as well. (Cancer Centre/Hospital Website)

The cancer centre/hospital's website in except 10 reads that the process of men regaining sexual confidence following prostate cancer treatment "is a complex process that involves not only the patient, but his partner as well." Here too we see that interventions are aimed at the couple and the couple relationship is positioned as integral to recovery rather than peripheral.

Excerpt 11:

A man who is married or in a committed relationship should include his partner in any decision about implants. Your partner needs to understand the procedure and have a chance to discuss any fears or questions with you and the doctor. (Cancer Information Website)

The cancer information website in Excerpt 11 stresses that men ought to speak openly with their partners about the decision to get a penile implant. They position this treatment as something that will impact both members of the couple and that is about more than the penis/erections. They focus on the context of the erections by stating, "Having a penile implant can't solve any other problems … it can't turn a poor sexual relationship into a great one." This level of involvement and consideration of the partner and attention to the system level was not common across materials, which tended to emphasize the individual patient.

Discussion

This study positions penile rehabilitation as a technology of sexuality (e.g., Potts, 2002) in that it functions as a vehicle that contains and conveys messages about sexuality. In line with Foucault's (1988) concept of technologies of the self, technologies of sexuality provide means for individual subjects to perform particular actions upon themselves and to transform themselves from dysfunctional, ill, unhealthy, and abnormal into functional, well, healthy, normal, and increasingly 'perfect' states of being. Technologies of sexuality, like technologies of the self, provide templates for 'successful,' 'normal,' and 'healthy' states of being as well as means of achieving these ideals. This study analyzed online patient materials about penile rehabilitation by examining the ways in which these programs are explained and presented to patients (e.g., the rationale provided) and by identifying discourses of sexuality, gender, and intimate relationships embedded within textual and visual content.

Analyses revealed a number of discourses and discursive strategies related to penile rehabilitation, erections, sexuality, patients, and partners. The discussion section

will address these findings by first discussing the ways in which penile rehabilitation is positioned in patient materials and the ways in which it accomplishes 'legitimization' as an intervention. Next, a discussion of the construction of the 'ideal penile rehabilitation patient" will be presented by drawing upon concepts like neoliberalism, which refers to a sociocultural, political and economic climate in which things like privatization, deregulation, individual freedom, autonomy, and responsibility are emphasized (Gill, 2008, 2009), and the responsibilization of health. Finally, discussion of key discourses of sexuality and gender conveyed through patient materials will be presented, including the ways in which these discourses reinforce the rehabilitation imperative.

Alliance with science: Positioning penile rehab as a medical imperative. Analyses explored the way in which penile rehabilitation is positioned and legitimized in patient materials. Findings reveal that penile rehabilitation is closely aligned with scientific empiricism. Erections and erectile difficulties are framed in biomedical and mechanical terms, and so too are the solutions to sexual difficulties. Penile rehabilitation is presented as scientific, straightforward, and corporeal (e.g., as acting on and fixing the body). The optimal corrective solution is presented as a combination of consultation with biomedical (s)experts, consumption of literature on the science of penile rehabilitation in order to make the most informed biomedical treatment choices, and enrollment in aggressive and intensive penile intervention protocols.

Penile rehabilitation accomplishes 'legitimization' through its intimate association with science and biotechnology in patient materials. Detailed explanations of treatment options (e.g., oral medications, penile suppositories, penile injections, penile pumps, and penile prostheses) emphasize scientific explanations and diagrammatic illustrations. In

addition, selective citation of empirical evidence is sprinkled throughout. For example, clinical trial outcomes are described in some materials including details about study design, and detailed statistics about results. In other cases, the existence of supporting 'scientific evidence' for penile rehabilitation is vaguely referenced as though the existence of some supporting data 'out there' is sufficient rationale to engage in treatment. Outcomes are described in objective terms (e.g., a penis that gets enough blood flow to facilitate intercourse). Notably, disconfirming empirical data and scientific debates and uncertainties about penile rehabilitation are excluded from most patient materials. The dominant message conveyed is that science has provided a successful biomedical cure for what is positioned as a biomedical problem.

Furthermore, penile rehabilitation is legitimized as an intervention through its reliance on biomedical (s)experts. Patient materials emphasize the importance of expert consultants (e.g., sexual medicine experts, pharmacists, doctors, etc.) to guide patients through the process of recovery and to help people navigate the pathway from illness to wellness, from broken to whole, and from dysfunctional to functional. Experts are positioned as the gateway to recovery in that they understand the complex nature of both the problem and the remedy.

Reliance on experts is achieved through a discourse of use-it-or-lose it. Patient materials convey that there is a narrow window of opportunity within which to achieve recovery. While patient materials are inconsistent on the specific window of opportunity, a sense of urgency is conveyed about there being a finite period of time during which penile rehabilitation will work. If patients fail to administer adequate and appropriate treatment to their penis during this window, they risk permanent penile damage and a life

of dysfunctional erections. Thus, patients are instructed that they don't have the luxury of time to 'wait and see,' they must consult with experts who will direct them to the appropriate interventions.

This alliance between sexuality, sexual problems (e.g., erectile dysfunction), and science as a solution (e.g., penile rehabilitation) is strategic, as not all discourses in society have equal power. Some discourses are afforded greater power and privilege and are positioned as being more truthful and valid than others, especially those with institutional ties (e.g., to law, education, science, medicine; Weedon, 1987). Biomedical and scientific discourse is especially privileged (Oudshoorn, 1994). Thus, it is strategic to be aligned with science. Problems and interventions that are aligned with biomedicine are afforded greater privilege, legitimacy, and status.

In their deconstruction of discourses of 'evidence-based health science,' Holmes, Murray, Perron, and Rail (2006) outline the great privilege and regulatory power that is afforded to evidence-based health science. Its legitimacy is not questioned and its positioning as the best – and often only – means to the truth both marginalizes and delegitimizes other ways of producing health science knowledge. Thus, alliance with biomedicine and scientific 'evidence' is a legitimizing strategy and particular deployment of power.

Sexology, or the science of sex, is afforded privileged status in making claims about the 'truth' about sex, and is a powerful institutional force in the regulation of sexuality today (Potts, 2002). "Through its explicit links to a strictly scientific or biomedical paradigm, this branch of sexology claims to know the origins of normal and abnormal, healthy and unhealthy sexuality, and develop appropriate treatments or 'cures'

for those who may stray from the norm" (p. 15). The power afforded to sexology and its status as a "particularly influential 'technology of sexuality' derives from its connection with the dominant discourses of science and medicine" (Potts, 2002, p. 18).

Penile rehabilitation materials position this treatment as biomedical and scientific. This strategy both legitimizes penile rehabilitation as a valid medical treatment for erectile dysfunction, and reinforces biomedicine and science as key authorities on the body sexuality and health. This is not to say that patients won't or don't experience physiological change from penile rehabilitation, or that there are not physiological consequences should patients choose not to engage in penile rehabilitation following surgery. However, this study wishes to highlight the discursive strategies used to convey information about penile rehabilitation to patients and to interrogate the meanings given to functional vs. dysfunctional penises, sexuality, normality, erections, etcetera.

Proactive, persevering, and proficient: Constructing the ideal penile rehabilitation patient in a neoliberal health care context. The way in which an intervention is constructed also implies a corresponding patient. The two constructs refer to and rely upon each other. Analysis of materials for the construction of penile rehabilitation also identified the ways in which the ideal penile rehabilitation patient is positioned, and their various attributes and actions. Analyses reveal that ideal patients are positioned as dedicated stewards of their (penile) recovery. They are proactive, persevering, and informed with sophisticated medical knowledge and understanding of their recovery and of their role in treatment. This knowledge is obtained via consultation with expert clinicians. Thus, the ideal patient is entrepreneurial and enterprising. They are responsible for their health and for their recovery. They are invested in the betterment of

the self via active engagement in their health care. The ideal patient is engaged in a perpetual retooling of themselves for optimal health, functioning, and sexual performance.

Links can be made between the positioning of the 'ideal' penile rehabilitation patient and the rise of the 'expert,' 'informed,' and 'active' patient in health care more broadly (e.g., Brown & Baker, 2012; Fox, Ward & O'Rourke, 2005; Horrocks & Johnson, 2012; Rogers, 2009). Threads of individualism, neoliberalism, and responsibilization converge upon the present day health care patient and produce a subject who has unlimited choices for self-production and authentication, who is capable of self-regulation and reconfiguration such that their conduct is conducive to the needs of the free market, and who is responsible for managing their health (Brown & Baker, 2012). It is a modern requirement that people today are active participants and actors in their health care (Brown & Baker, 2012).

Brown and Baker (2012) have documented a shift towards the "interiorization of health" with increasing emphasis on the individual "as an actor in the rituals of heath and a guardian of his or her own destiny in the health sphere" (p. 39). Health has increasingly become a property, accomplishment, and responsibility of individuals. Patients must be constantly vigilant as new information emerges about how they can best achieve good health. Responsibilized patients are able to self-govern in pro-health ways once given adequate knowledge and instruction. So long as expert health authorities provide information, people then become responsible for acquiring, understanding, interpreting, and implementing the information and in managing their health.

This interiorization and responsibilization of health means that:

> "people … see themselves as if they were a project upon which they can work … The tendency to see health in terms of arrangements of the mental architecture encourages a degree of self-scrutiny where health practices and beliefs are concerned and an implication that the responsible citizen will constantly adjust themselves in the light of new information as it is available." (Brown & Baker, 2012, p. 42)

The good patient is capable of grasping the importance of actively managing their health and of consuming and interpreting the knowledge and instructions on how best to accomplish this. "The entrepreneurial citizen in neoliberal healthcare regimes is possessed of certain mental capacities – grasping the importance of taking responsibility for their health" (Brown & Baker, 2012, p. 61). Failure to achieve or maintain good health is positioned as a problem with the patient rather than the treatment or treatment providers.

The existence of penile rehabilitation websites as a source of information for the prostate cancer patient can be seen as facilitating the 'informed patient' subject position. This is the fuel for the responsibilization of recovery. Men are given the necessary tools and information with the assumption that they will be able to use this information. This also reinforces the idea that failure to seek penile rehabilitation treatment is the fault of the individual man. His (potentially permanent) penile pathology is his problem and the consequence of improperly managing his health. Conversely, if he opts into this form of surveillance medicine, he will be provided with expert consultants to teach him how to properly self-monitor and to become a good steward of his penile health. In this way, penile rehabilitation is positioned as an imperative.

In a study analyzing the construction of the patient in outpatient genitourinary medicine clinics, Pryce (2000) found that patients are socialized into self-surveillance and self-monitoring of their sexual health through engagement with clinics and staff. The patient is positioned as 'active' and engaged in a process of subjectification via constant self-scrutiny, self-monitoring, and 'confession' of the intimate details of their bodies and selves in order to obtain good health. Pryce (2000) explores the idea of disciplinary power that is at play in the clinic, which is positioned as an example of "surveillance medicine." This clinic facilitates construction of the 'neoliberal patient' who is socialized into a practice of self-surveillance. The responsibility of the man's (sexual) health is placed in his hands; it becomes his responsibility to monitor his body and mind for signs of pathology and markers of recovery. These observations are consistent with the findings from the present study, which found that patient materials promoted an entrepreneurial approach to recovery.

The entrepreneurial subject is prominent in penile rehabilitation patient materials. This ideal patient is knowledgeable, enterprising, informed, and actively engaged in their recovery. They are aware of the importance of being active participants in their recovery and of seeking out sources of information. The entrepreneurial/neoliberal penile rehabilitation patient knows that they must be patient and diligent as they care for their penile health and wait for signs of improvement. They must take steps to protect and preserve their health. The 'work' they are doing is essential; it is not optional – rather, it is an obligation for men who wish to protect and preserve their sexuality and penile health. The good patient is persevering and sticks to their pro-health program. Failure to adequately self-monitor and take appropriate pro-health action is associated with negative

consequences in patient materials. The warnings of permanent penile flaccidity is analogous to the use of cautionary tales and inspirational stories in women's magazines (Roy, 2008), which reinforced readers for taking charge of their health and placed blame on readers for potential breakdowns in their health.

Penile rehabilitation can be seen as an extension of 'surveillance medicine' – a form of medicine that emphasizes self-monitoring, self-management, identification of risk factors *by patients*, and individual responsibility for one's health (Armstrong, 1995). Patients are socialized into a mode of self-surveillance: they are to watch for the slightest signs of recovery or lack of recovery. Good patients are those who engage in self-scrutiny and who carefully and faithfully monitor the penis and engage in intervention. If patients fail to engage actively in treatment, they risk terrible repercussions. If they fail to protect and preserve the penis while it lays temporarily dormant following surgery, they are told that their penis will remain permanently inert, dead, unmoving, and unresponsive. Thus, the responsible patient will engage in treatment and will take up the task of self-surveillance and self-monitoring for signs of blood flow.

Medicalization and healthicization of sexuality. Sexuality is positioned as a health and medical matter through patient materials. Erections are likewise constructed as health and medical concerns. The physiological dangers of flaccid penises are emphasized, as are the risks of missing the narrow window of therapeutic recovery. Overall, the physiology and functionality of erections are emphasized over multiple possible meanings and subjective experiences of erections.

Medicalization is "a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (Conrad, 1992, p.

209). It represents an expansion of the medical domain into other areas of life, for example, sexuality. One of the key markers of medicalization is the delineation of behaviours, experiences, and other measurable phenomenon into categories of good vs. bad, or healthy vs. sick (Bradley & Fine, 2009). This dichotomization is necessary in order to identify what or who needs 'treatment' and what exactly 'recovery' constitutes. Medicine thus becomes "an institution of social control" (Conrad, 1992, p. 210) with the power to establish and disseminate definitions of (ab)normality, (dys)functionality, health, and illness.

Healthicization is a concept closely related to medicalization and refers to the expansion and increasing role of health promotion in regulating ideas about health and illness in people's lives (Conrad, 1992). Whereas medicalization focuses on biomedical causes and solutions for health problems, healthicization emphasizes lifestyle causes and solutions.

There has been extensive writing on the current dominant framing of sexuality as a health matter (e.g., Giami, 2002; Hart & Wellings, 2002). Although sexuality as a public health concern extends far back in history (e.g., Foucault, 1978), 'sexual health' was initially developed as a concept by the World Health Organization 40 years ago and has become increasingly important as a cultural concept since then (Giami, 2002). The current dominant cultural position is "that health is the natural discursive home for sex" (Segal, 2012, p. 375).

Penile rehabilitation patient materials contained numerous examples of the medicalization and healthicization of sexuality. There was repeated pairing of 'sexual' and 'medicine' as well as 'sexual' and 'health.' These terms were often used

interchangeably within websites. Patients were encouraged to consult with a "sexual medicine" expert, "male sexual health specialists," a "sexual health counselor," or "sexual health clinician," and to visit "sexual medicine clinics" to resolve their "sexual health" matters. Penile rehabilitation programs were housed in "sexual and reproductive medicine clinics," conveying that problems with the penis are health and medical matters. Clinics assured patients that they would screen for "risk factors for sexual health problems," and "develop a personalized treatment plan." Sexuality is positioned as belonging to medical clinics and health care specialists rather that to men and their partners. The discursive framing of sex emphasized medicine and health.

Medicalization and healthicization of erections. Erections have undergone a similar process of increasing medicalization and healthicization. While 'impotence' was once considered a normal part of the aging process, this shifted alongside the emergence of discourses of "successful aging" and the imperative to be active, healthy, and perpetually sexual as seniors (e.g., Fishman, 2010). Thus, impotence became a condition to be treated, largely via psychological intervention. In the 1980s and 1990s, another shift occurred whereby erections came to be viewed as pathology with primarily organic etiologies. This coincided with the rise in urology as a medical sub-specialty, and with the advent and widespread circulation of increasing numbers of biomedical treatments for erectile difficulties such as injections and oral medications (Fishman, 2010). Injections solidified a biomedical view of erections and an emphasis on the mechanics of erections. The introduction of Viagra in 1998 was also key in "solidifying (erectile dysfunction's) conceptualization as an organic condition controllable through pharmacologic means" (Fishman, 2010, p. 293). Emphasis was placed on things like blood flow, nitric oxide,

penile arteries, and vascularization (Fishman, 2010). Difficulties with erections were thus rooted in bodily malfunction and breakdown of natural processes. Difficulties with erections were turned into "erectile dysfunction," a distinct medical condition with its own emerging science and set of interventions.

> "With continued focus on the physiology of the penis, attention shifted to studying its function as an organ in much the same way that a medical researcher might study the kidney or the heart; it became devoid of most of the remnants of the psychological components of erections." (Fishman, 2010, p. 300)

Erections now exist in a biomedical and health context. They are largely viewed as biomedical phenomena, and are treated as such. Patient materials largely position erections as medical and health matters. Explanations of the physiology, biochemistry, and mechanics of erections are illustrated in patient materials, thus establishing the construction of erections as technical and biomedical productions rooted in the body. Materials refer to nitric oxide, neurotransmitters, cavernous arteries, erectile chambers, arterial cells, and descriptions of blood flow and traumatized nerve bundles to explain the processes involved in erections. The importance of a regular supply of oxygen via freshly flowing blood to the penis is emphasized in descriptions of penile rehabilitation. Erections are broken down into sequential physiological steps and processes. Potential mechanical issues (e.g., unresponsive nerves, venous leakage) are discussed in medical terms and biomedical solutions are offered to address these breakdowns.

> "Modern technology seems determined … to keep alive the hope that a perfectible biology is just around the corner. The complex ritual and devices attached to the penis in the examining room by white-coated technicians transform sexuality as

> they reduce it to neurology and blood flow. The spotlight directed on 'the erection' within current medical practices isolates and diminished the man even as it offers succor for his insecurity and loss of self-esteem." (Tiefer, 1994, p. 373)

Penile rehabilitation patient materials contained numerous examples of the medicalization and healthicization of erections. Furthermore, erections are positioned in patient materials as key to sexual and penile *health*. Materials stated that erections are "necessary." The healthy man is said to have regular erections (e.g., "daily," "five erections during sleep every night," "three to sex erections every night," etc.). The many perils of prostrate (non-erect) penises are emphasized. Materials also position erections as health and medical matters by emphasizing the need to engage in penile rehabilitation quickly, lest they miss the narrow window of opportunity within which they can achieve recovery. Prolonged absence of erections is linked to "atrophy and scarring," "scar tissue" that "can kill smooth muscle cells," "damaged erectile tissue" that will be "unresponsive to nerve signals," and "permanent erectile dysfunction." Erections are a requirement of sexual health. They are not elective experiences rather health imperatives.

When something has been medicalized, the behaviour or 'problem' becomes reframed as a medical condition. This then both mandates and licenses medical professionals to establish and deliver treatment (Conrad, 1992, referencing Conrad, 1975). Thus, when a phenomenon or experience becomes medicalized, medicine is positioned as the proper and ideal solution, as is the case for erectile difficulties in patient materials. Erectile difficulties are positioned as a medical crisis rather than a social or emotional problem. Thus, medical treatment is necessary in order to restore the patient to good health and to circumvent a long-term health crisis/condition.

In her analysis of patient literature on penile implants, Tiefer (1986) notes that a biomedical frame for sexuality compels a biomedical solution. “When biomedicine, health, and physiology are considered the appropriate sexual discourse, scientists and health care providers are the appropriate authorities” (Tiefer, 1986, p. 585).

Patient materials likewise convey a need for expert professionals to navigate the complex science of sexuality and erections. Patients are instructed to “talk to your doctor,” “discuss treatment options such as medications, implants or devices,” and to consult with “sexual medicine experts,” “experts,” and/or “your local pharmacist.” The knowledge and expertise needed to remedy the situation is owned by and located within expert medical professionals. They are positioned as guides to get patients through the maze of sexual difficulty to sexual wellness and functionality.

Sexual difficulties are positioned as biomedical problems and a set of biomedical interventions are offered to patients as solutions. These solutions include a complement of treatments ranging from orally ingested pills to penile suppositories, injections, pumps and implants.

Dichotomy of (dys)functional bodies & (dys)functional penises. A medical or health model of sexuality views sex through a lens of health and disease (Tiefer, 2002). Ideas of ‘natural’ sexuality become used in discourses surrounding sexuality to reinforce and reify certain behaviours, functions, and capacities. Anything that deviates is labeled ‘unnatural’ or ‘unhealthy.’ Emphasis is placed on identifying standards of normalcy and functionality so that people can be assessed, diagnosed, and repaired. A medicalizing frame thus facilitates “the standardization of sexuality” (Cacchioni & Tiefer, 2012). The

focus of standardization is often on genitals (e.g., penises), which Cacchioni and Tiefer (2012) refer to as "the genitalization of sexuality."

Inherent in a biomedical model of sexuality and of a pharmaceutically driven approach to erections is the assumption that soft penises are a problem and need treatment and fixing (Kleinplatz, 2004). Such a mindset conveys the message that "soft penises are necessarily problematic and require treatment … [and] that penises ought to be hard whenever sexual opportunities present themselves" (p. 219). There is little if any space for a variety of kinds of penile responses and erections. This places emphasis on the performance of the penis rather than the pleasures of the penis or the sexual satisfaction of the person that may or may not coincide with penile tumescence.

Penile rehabilitation materials reinforce a false dichotomization of penises into functional/dysfunctional and good/bad categories. Erections are positioned as either working or not working. This binary is frequently referenced, but never clearly operationalized. A functional and 'working' penis presumably means that it can adequately penetrate a vagina upon demand. Penises that are soft or semi-soft or variably hard and soft are positioned as unacceptable and dysfunctional. Analysis of words used to refer to changes in erections reveal that erectile difficulties are equated with things like impairment, impotence, disability, and diminishment in men. Erections that do not meet standards of 'functionality' are positioned as lack of achievement, loss of power, and loss of function. Terms used to describe changes in erections are overwhelmingly negative and convey a sense of lack and loss. This study does not dispute that men experience high levels of distress about changes in their sexual functioning; rather, it wishes to highlight that the ways in which sexual functioning is positioned in materials (and more broadly in

society) is tied to this distress. In other words, patient materials convey messages, meanings, and judgments about sex that likely contribute to the ways in which patients experience sexual changes. For example, the discursive framing of sex as being about functionality, and the ways in which loss of 'function' are framed in patient materials, likely make it difficult for men to adopt robust and satisfactory sexual subjectivities in the face of sexual changes.

The biomedical framing of sexuality also establishes a clear hierarchy of erections and provides criteria for ideal/normal/healthy erections, which are generally positioned as "natural," "spontaneous," "functional," and "firm enough for intercourse." Patient materials do not clearly operationalize these descriptors and it is assumed that people are able to clearly identify natural/spontaneous/firm/functional erections and know when erections do and do not measure up to these criteria. Tiefer (1994) notes that while erections have been widely medicalized, there is a notable lack of definitions and norms for erections in medical literature. "The assumption that everyone knows what a normal erection is central to the universalization and reification that supports both medicalization and phallocentrism" (p. 365). Tiefer argues for the "multiple meanings of erections" (1994, p. 372), rather than for a single meaning of 'good,' 'normal,' 'ideal,' or 'healthy' erections. While analysis of penile rehabilitation materials likewise did not provide clear definitions or norms for what idealized erections look like (beyond the vague descriptors), penises that fail to measure up to these markers of desirability are positioned as problematic and pathological and in need to intervention.

Erasure of the (inter)subjective context of sexuality. A 'medical model' of sexuality emphasizes physiology, biochemisty, disease, and dysfunction, minimizing the

relational context in which difficulties occur (Bradley & Fine, 2009), as well as things like communication, compatibility, creativity, tenderness, technique, knowledge, and subjective experience (Tiefer, 2012). Good sex is predicated upon an individual's functional bodily systems and capacities within a medical and health framing of sexuality. This decontextualization of experiences and problems from their social context is a consequence of medicalization (Conrad, 1992). As sexual 'problems' become medicalized, they also become individualized. This effectively erases the social and collective context of problems and the potential for social or collective solutions (Conrad, 1992). The more medicalized a problem becomes, the less we pay attention to the social context in which a problem emerges and exists.

Analysis of patient materials for penile rehabilitation finds that the relational and interpersonal context of sexuality and erections is minimized. Much greater emphasis is placed on the individual man's physiological functioning. Materials largely position the genesis of erections as being in the man's nerves and neurotransmitters as opposed to his mind. Solutions are largely device-based rather than being rooted in the whole person or relational context. A man's nerves become stimulated rather than the man. His erections are linked to physiological processes rather than psychological, emotional or subjective mechanisms. The context in which sexuality occurs and in which erections are experienced is largely missing. The relationship context is mentioned peripherally in some materials, and select sites emphasize the importance of communication with one's partner. However, relative greater importance is placed on getting the man's body back to a state of functionality.

In her research on the positioning of female partners in Viagra literature, Tiefer (1994) notes that partners' experiences are ignored. When they are referenced, it is to prop up a phallocentric view of sexuality (e.g., erections are positioned as necessary for female partner's desires and needs for vaginal penetrative sex). "Women occupy an essential place in the discourse (the need for vaginal 'penetration' being the justification for the entire enterprise), but women are only present in terms of universalized vaginal needs; their actual desires opinions are (conveniently) invisible, suppressed, neglected, denied" (p. 374).

The experiences, desires, fears, wants, needs, and hopes of female partners are largely missing from accounts of Viagra and erectile treatment research. This finding is largely consistent with analysis of patient materials on penile rehabilitation. There are notable exceptions to the invisibility of female partners in penile rehabilitation materials. In some cases the treatment is positioned as dyadic and the relational context is emphasized. Partners are said to offer "vital support" and "ideas on how to help you regain your sexual function," and men are instructed that including their partner is important to their successful recovery. However, the actual experiences and perspectives of female partners are largely absent. The main message is that pro-erectile treatment, which is positioned as universally positive for the male partner, is likewise beneficial to the female partner. Emphasis is places on intercourse and on removing barriers to intercourse. Thus, the assumption is that female partners desire frequent and long-lasting intercourse and will be willing, active, and supportive participants in the process.

Reification of the intercourse imperative. A diagnosis of sexual or erectile dysfunction reflects, reinforces, and depends upon dominant discourses of sexuality and

sociocultural expectations of what the body or body parts (i.e., the penis) ought to be able to *do*. If a penis *ought* to become firm enough for vaginal penetration upon demand and to remain perpetually firm throughout a sexual encounter, then failure to do so is positioned as dysfunctional. If, however, the requirement of a penis is that it feel pleasure and can do so through a variety of possible sexual practices (e.g., manual touching, oral sex, etc.), which are compatible with the waxing and waning of penile firmness, then a penis that is not perpetually hard is not dysfunctional.

In her interrogation of gendered constructions of sexuality in the "Viagra Age," Marshall (2002) asks, "what is the 'function' that 'sexual dysfunction' threatens? While simply, it is penile-vaginal intercourse in the marital (or at least stable heterosexual) unit. The 'function' is 'successful' intercourse, which is 'functional' for the couple, which is 'functional' for society" (p. 134). She adds, "this understanding of sexual 'function'… operates through an increasing valorization of, and eroticization of, marital intercourse" (p. 134). The concept and diagnostic category of erectile dysfunction is thus intimately connected to a particular construction of sexuality – one that privileges intercourse (Potts, 2000). The medicalization of sexuality "reifies erections" (Tiefer, 1994, p. 372), and reinforces a heternormative view of sex, one that reinforces that intercourse represents 'healthy' and 'normal' sexual practice (Potts, 2000). If healthy and normal sexuality is intercourse, then anything that gets in the way of that sexual practice (e.g., erectile dysfunction) is positioned as problematic.

Penile rehabilitation patient materials dichotomize penises into categories of useful/functional and useless/dysfunctional. Penises that do not get hard on demand are positioned as problematic. Dysfunctional penises are ones that are unable to perform or

participate in penetrative sex. Thus the very definition of erectile dysfunction reifies the coital imperative. Men with erectile difficulties are constructed as diminished and disabled lovers because of the inability to perform the core sexual practice of intercourse. Patient materials reinforce the 'function' of erections and idealize erections that 'function' on command. Emphasis is on objective and measureable criteria for erections (e.g., what they look like, how long they last, what they can *do*) rather than on subjective experience (e.g., what pleasures the man feels through or with his penis). Thus, the ability to engage in intercourse is positioned as more important than the ability to experience sexual pleasure.

The pairing of erections with male sexuality and the coital imperative are not 'givens,' but rather the result of "phallocentric imperatives … that are reproduced and reinforced in a variety of discursive fields (e.g., medicine, sexology, psychiatry, pornography, popular culture, and the media)" (Potts, 2000, p. 88).

The coital or intercourse imperative is strongly reinforced through penile rehabilitation patient materials. Sex is often equated with penile-vaginal penetration. Terms like "normal sexual function" and "having sex" are used to refer to penile-vaginal penetration. In her analysis of discourse surrounding erectile dysfunction, Kleinplatz (2004) states, "erectile dysfunction is seen as an obstacle to *sex*, rather than merely an obstacle to sexual intercourse" (p. 224). This is frequently reinforced in penile rehabilitation materials where the assumption is made that men do not and can not be sexual in the absence of an erection. The purpose of sex is positioned as intercourse; this is 'normal' and 'healthy' sexual practice. Thus, sex is both erection-focused and erection-

dependent. Erections are positioned as a necessity for sexual activity, sexual pleasure, and sexual satisfaction.

Analysis of 65 sex advice books (Barker, Gill & Harvey, in press) identified three dominant assumptions: the sexual imperative (e.g., that healthy relationships contain sex and that healthy individuals engage in sex), relationship normativity (e.g., narrow definitions and depictions of healthy relationships), and the coital imperative (e.g., equating 'sex' with foreplay → penile-vaginal penetration → orgasm). Sexual 'problems' are generally framed as things that disrupt these "normativities" and books offer up solutions that are tailored to reinstating 'healthy' relationships and 'normal' sex.

Analysis of Pfizer's US Viagra promotional materials likewise reinforces the coital imperative (Mamo & Fishman, 2001). The most desirable sexual practice is positioned as penetration and/or intercourse. The privileging of intercourse in Viagra ads, sex advise books, and penile rehabilitation materials marginalizes other kinds of sexual practices and restricts the possibilities for pleasure, play, exploration, and satisfaction. In the context of sex advice books, Barker et al. (in press) state:

> "The 'solutions' proposed in the books generally limit themselves to varying, or 'spicing up', the normative sexual script in ways which erase the diversity of erotic possibilities and individualise [sic] what could be more accurately conceptualised [sic] as social struggles." (in press)

In the context of prostate cancer, men face the need to adapt to physical, emotional, and psychological changes. They would be well served by the expansion and proliferation of discourses of sexuality and increased possibilities for pleasure and sexual practice, rather than reinforcement of narrow normativities.

Room for resistance: Alternative approaches to sexuality. Critical voices and alternative discourses appear in the midst of dominant medicalized and healthisized discourses of sex. In these instances of resistance, sex is positioned as expanding beyond a man's genitals and as involving both his broader physical body as well as his emotional and psychological spheres. Attention is paid to the sociocultural embeddedness of sexuality. In these cases, sexual dysfunction is positioned as one of many possible impacts of prostate cancer treatment, in contrast to the nearly exclusive focus on this in many patient materials. Some materials emphasize that addressing sexual problems is not just about taking a pill or injection and producing an erection, but that it is about addressing the emotional fall out and relationship dynamics (e.g., "dating issues," "sexual communication issues," etc.) in which these changes occur. It was acknowledged in one source that producing erections "can't solve any other problems" like lack of sexual desire, or relationship discord. In other words, "It can't turn a poor sexual relationship into a great one." The presence of an erection is decoupled from subjective sexual desire and a hard penis is not assumed to represent that a man is "truly excited" about sex. Furthermore, the idea that manliness depends upon erections is challenged. A good lover comes to mean a myriad of things, which may or may not include having 'functional' erections.

Notably, the World Health Organization's (WHO) definition of sexual health is expansive and offers resistance to dominant medial discourses of sexuality (WHO, 2015). It states in part that sexual health is "a state of physical, emotional, mental and social well-being in relation to sexuality" (p. 1). The WHO's definition establishes that sexual health is not merely the absence of disease or dysfunction but also encompasses "the

possibility of having pleasurable and safe sexual experiences" (p. 1). While this non-medical approach to sexuality has "largely been ignored in medical and sexological contexts" (Tiefer, 2012, p. 312), it nonetheless provides space for resistance and alternative readings of sexuality.

Potts (2000) likewise calls for expansion and proliferation of alternative discourses of sex and for a broader and more expansive approach to erections and male sexuality. She calls for the introduction of multiple meanings and forms for the penis – for "diversity of penile physicalities" (p. 100) – so that there are greater possibilities for sexual practices and pleasures associated with the penis.

> "These male bodies might become differently inscribed, coded for holistic pleasures, for jouissance beyond the phallus/penis. They might enjoy a variety of penile styles: flaccid, erect, and semiflaccid/semierect. Male eroticism would incorporate different sensations connected with the diversity of the penis, as well as, and significantly, the exploration and enticement or other erotogenized regions of the male body in pleasure." (Potts, 2000, p. 100)

These critical voices, and those that appear in penile rehabilitation materials, offer resistance to discourses of sex, of the coital/intercourse imperative, and the primacy of the hard penis. They offer possibilities for people to deconstruct the meanings behind dominant sexual practices and beliefs. They provide the possibility for people to disentangle concepts that are repeatedly coupled together in dominant cultural discourses (e.g., sex/intercourse, desire/erection, erection/sex, erection/orgasm, masculinity/erection, etc.). In addition, they draw attention to the limitations of dominant discourses and create

spaces for alternatives when men's bodies and life experiences preclude them from fitting into/measuring up to the rules and standards embedded within dominant discourses.

Study II: Discourse Analysis of Interviews with Men with Prostate Cancer and Female Partners of Men with Prostate Cancer

Overview

This study involved discourse analysis of in-depth semi-structured interviews with 10 individual men who had been diagnosed with prostate cancer, 5 individual female partners of men who had been diagnosed with prostate cancer, and 9 couples where the male partner had been diagnosed with prostate cancer. Participants were asked nine questions, tapping into different domains of life affected by prostate cancer and penile rehabilitation (e.g., individual sexuality, sexual intimacy in their relationship, relationship functioning, sense of masculinity/femininity, experiences with penile rehabilitation). Participants also completed a brief demographic questionnaire that included questions about cancer diagnosis, treatments, and penile rehabilitation experiences. This study examined the ways in which participants make sense of penile rehabilitation, as well as the ways in which they construct sexuality, erections, gender, and relationships, through interviews. The aims of the study were to identify the social norms (i.e., discourses) participants adopt and/or resist when speaking about penile rehabilitation, prostate cancer side effects, sex, gender, and their relationship, and to make connections between these norms and broader collective meaning systems. Guiding questions included the following: In what ways are participants constructing their experiences with and understanding of penile rehabilitation? What messages about 'healthy' and 'normal' sexuality are being conveyed through interviews? In what ways are erections being positioned and what meanings are attributed to erections in the context of a dyadic

relationship? And, what messages about successful and competent gender role performance are conveyed through transcript materials?

What follows is a review of the method (e.g., materials, recruitment, participants, procedure, and data analytic approach), a presentation of the analyses, and a discussion. The analysis section focuses on findings from the interview data; references to past research are largely saved for the discussion section.

Method

Materials. A semi-structured interview guide was generated for the study and three adapted versions were then generated (see Appendix A for interview schedule for individual male participants, see Appendix B for interview schedule for individual female participants, see Appendix C for interview schedule for couples). Questions were based upon major themes identified in the literature as well as the clinical experiences of the principal investigator working in the field of prostate cancer at a major cancer hospital. As indicated earlier, nine core questions were included in each of the three interview guides. Examples of questions include: *How has your relationship been impacted by your cancer diagnosis and treatments? What impact has your cancer treatment had on the sexual part of your relationship? Has being treated for prostate cancer had any impact on your sense of masculinity/being a man or femininity/being a woman?* And, *Tell me about your experiences with penile rehabilitation.* Various prompts were also identified for each core question in order to expand upon and facilitate greater clarity and understanding of participants' initial responses. A demographic questionnaire, which was completed by all participants, included questions about age, education, cultural background, household income, living situation, children, marital status (see Appendices

D, E, F, G for questionnaires). The questionnaires also included questions about prostate cancer (e.g., date of diagnosis, date and type of treatments received, etc.), and penile rehabilitation (e.g., date and type of treatments received).

Recruitment. In accordance with Ryerson University's REB approval for this study, recruitment was primarily done through prostate cancer support groups across Canada. Leaders for various prostate cancer support groups, who had their contact information posted online, were contacted via email or phone and given information about the study. Group leaders who expressed interest were asked to pass information about the study on to their group members. This was done in a variety of ways: through email, via newsletters, and by oral announcement at group meetings. In addition, the principal investigator was invited to attend some group meetings in person to give a brief presentation about the study and provide printed informational materials. Participants who were interested contacted the study directly via email or phone.

Participants. Eligibility requirements for the study included: being 18 years of age or older, identifying as male or female, having been diagnosed with prostate cancer or being the female partner of a man diagnosed with prostate cancer, having received penile rehabilitation or being the partner of a man who received penile rehabilitation, and speaking English. A total of 36 individuals were screened for participation in the study. Of these individuals, 33 people were eligible and agreed to participate. Two people decided that they were not interested in participating in the study and a third person was found to be ineligible due to their recent widower status. People had the option of participating individually or as part of a couple. A total of 14 women and 19 men living in Canada participated for a total of 24 interviews (See Table 1 for detailed aggregate

participant demographic information; see Table 2 for aggregate participant information related to prostate cancer diagnosis and treatment; see Table 3 for basic demographic information based on participant ID). The mean age for women was 60.5 years and the mean age for men was 65.3 years. Most participants had children (90.9%) and were married (84.8%). The mean length of relationship was 31.9 years. Participants self-identified a variety of cultural backgrounds (e.g., "Germanic," "Russian Mennonite," "Canadian," "British-Anglo-Saxon," etc.) that all fell into the broader category of "Caucasian." In general, participants were highly educated (81.9% had completed at least some college or university studies) and were in the middle-high income bracket (60% had an annual household income of $60,000 or more).

Men had been diagnosed with prostate cancer an average of 7.5 years ago and had a mean age of 58 at the time of their diagnosis. Couples had been together an average of 27.1 years at the time of the man's prostate cancer diagnosis. The most common treatment was radical prostatectomy (91.7%) followed by hormone therapy (25%), radiation therapy (25%), active surveillance (16.7.8%), and transurethral resection of the prostate (TURP; 4.2%). About half the men (45.8%) had undergone more than one kind of treatment for prostate cancer. Men had undergone a variety of penile and/or sexual rehabilitation treatments with the most common being oral medications (100%), the vacuum pump (41.7%), penile injections (37.5%), and self-stimulation (29.2%).

Table 1

Aggregate Participant Demographic Information

Demographic Variable	Categories	Results
Gender	Male	19 (58%)
	Female	14 (42%)
Age	All participants (years)	*M* = 63.3; Range = 49 – 76
	Female participants (years)	*M* = 60.5; Range = 49 – 75
	Male participants (years)	*M* = 65.3; Range = 56 – 76
Cultural Background	Caucasian	33 (100%)
Religious*	Yes	17 (51.5%)
	No	16 (48.5%)
Education	Some high school	3 (9.1%)
	Completed high school	3 (9.1%)
	Some college or university	9 (27.3%)
	Completed college or university	10 (30.3%)
	Some postgraduate studies	2 (6.1%)
	Completed postgraduate studies	6 (18.2%)
Income	Less than $19,000	1 (3%)
	$20,000 – $39,000	4 (12.1%)
	$40,000 – $59,000	3 (9.1%)
	$60,000 – $79,000	4 (12.1%)
	$80,000 – $99,000	3 (9.1%)
	More than $100,000	8 (24.2%)
	Declined to answer	2 (6.1%)
Children	Yes	30 (90.9%)
	No	3 (9.1%)
Relationship	Years together	*M* = 31.9; Range = 0.3 – 57
	Years married (for the 21 participants who were married)	*M* = 32.2; Range = 4 – 54

*Participants self-identified as religious (“yes”) or not religious (“no”)

Table 2.

Aggregate Participant Information Related to Prostate Cancer Diagnosis and Treatment

Variable	Categories	Results
PC Diagnosis	Years Since PC Diagnosis	*M* = 7.5; Range = 1 – 16
	Age of Man at PC Diagnosis (years)	*M* = 58.0; Range = 51 – 69
	Relationship Length at Time of PC Diagnosis (years)	*M* = 26.1; Range = 1 – 44
PC Treatments Received*	Radical prostatectomy	22 (91.7%)
	Hormone therapy	6 (25.0%)
	Radiation	6 (25%)
	Active surveillance	4 (16.7)
	TURP	1 (4.2%)
Sexual/Penile Rehabilitation Received**	Oral pills	24 (100%)
	Penile pump	10 (41.7%)
	Penile injections	9 (37.5%)
	Self-stimulation	7 (29.2%)
	Physiotherapy	2 (8.3%)
	Penile ring	1 (4.2%)
	Supplements	1 (4.2%)
	MUSE***	1 (4.2%)

*N = 24 for this question because it only relates to male participants. The percentages add up to more than 100% because 11 (45.8%) male participants received more than 1 type of treatment.

**N = 24 for this question because it only relates to male participants. The percentages add up to more than 100% because many participants received/tried more than 1 type of rehabilitation treatment.

*** MUSE is a pro-erectile suppository medication. It comes in the form of a tiny pellet that is inserted into the urinary opening at the tip of the penis. The active ingredient, alprostadil, opens blood vessels and increases blood flow to the penis.

Table 3

Basic Participant Demographic Information by Study ID

Study ID	Gender	Interview format	Age	Duration of relationship	Years since PC diagnosis of male partner	PC treatments received by male partner	Sexual/penile rehab treatments received by male partner
F01	Female	Individual	70	52	10	Radiation, Hormone therapy	Pills, Injection, Pump
F02-C*	Female	Individual	53	25	2	RP**	Pills, Injection, Pump
F03-C	Female	Individual	56	34	10	RP	Pills
F04-C	Female	Individual	61	36	9	RP, Active surveillance	Pills
F05-C	Female	Individual	75	37	13	RP	Pills, Self-Stimulation
M01-C	Male	Individual	62	23	2	RP	Pills, Injection, Pump
M02	Male	Individual	70	50	16	RP, Radiation, Active surveillance	Pills, Injection
M03-C	Male	Individual	68	34	6	RP, TURP	Pills
M04	Male	Individual	76	57	14	RP	Pills, Injection, Pump

M05	Male	Individual	60	41	5	RP	Pills
M06-C	Male	Individual	60	35	8	RP, Hormone therapy, Active surveillance	Pills
M07	Male	Individual	56	28	3	RP	Pills, Injection
M08	Male	Individual	65	0.58	11	RP, Radiation, Hormone Therapy	Pills, Penile ring
M09-C	Male	Individual	65	38	13	RP, Active surveillance	Pills, Self-stimulation
M10	Male	Individual	65	40	8	Radiation, Hormone therapy, Active surveillance	Pills, Pump
CA01 CB01	Male Female	Couple Couple	68 67	51.5	6	RP, Hormone therapy	Pills, Injection
CA02 CB02	Male Female	Couple Couple	69 62	41	12	RP, Radiation	Pills, Injection, Self-stimulation
CA03 CB03	Male Female	Couple Couple	63 49	17	12	RP	Pills, MUSE
CA04 CB04	Male Female	Couple Couple	63 59	42	2	RP	Pills, Self-stimulation

CA05 CB05	Male Female	Couple Couple	65 60	30	5	RP	Pills, Pump, Physiotherapy
CA06 CB06	Male Female	Couple Couple	66 54	0.33	1	RP	Pills, Pump, Supplements
CA07 CB07	Male Female	Couple Couple	57 53	29.5	1	RP	Pills, Self- stimulation, Pump, Physiotherapy
CA08 CB08	Male Female	Couple Couple	69 62	18	6	RP, Radiation, Hormone therapy	Pills, Self- stimulation, Pump
CA09 CB09	Male Female	Couple Couple	74 66	5	5	RP	Pills, Injection, Self-stimulation, Pump

* -C = An individually-interviewed participant whose partner was also individually interviewed in the study

**RP = Radical prostatectomy

Procedure. Individuals who expressed interest in the study by either emailing or calling were guided through a brief screening phone call in order to determine eligibility. Those who were eligible were given more detailed information about the study. Individuals who were still interested in participating were given the option of being interviewed on their own, or of being interviewed as a couple. In four (16.7%) cases both members of a couple participated in the study but opted to be interviewed individually. Participants were also given the option of three interview formats. Most interviews took place by phone (n = 13), followed by video conferencing/Skype (n = 9), and in-person (n = 2). At the scheduled time of the interview, participants were guided through an informed consent procedure. Those who gave consent then completed the brief demographic questionnaire. For participants who were not interviewed in person, the interviewer asked the demographic survey questions and recorded participants' responses. Participants were then interviewed with interviews typically lasting between 1 to 1.5 hours. Participants were given a $15 honorarium per person for their participation.

Data analytic approach. The 24 interviews were transcribed verbatim (with identifying information removed) and then uploaded to NVivo, a qualitative data analysis computer software program. Consistent with Study I, data were analyzed using a feminist poststructuralist discourse analytic approach. Transcripts were coded by hand using NVivo's colour-coding functions. Coding was initially done according to major thematic categories (e.g., interview material that related to the discursive construction of penile rehabilitation, sexuality, erections, gender, and relationships). The text for each larger theme was then analyzed in finer detail for identification of discourses. Transcripts were

read multiple times in their entirety in order to contextualize individually coded excerpts within participants' larger narratives.

Analysis of interview transcripts focused on identifying the ways in which sex, erections, gender, relationships, recovery, and penile rehabilitation were represented. Discursive patterns of meaning were identified, including contradictions in meaning that related to these key topics of interest. In addition, analysis established the various subject positions (e.g., the kinds of selves) made available to participants and constructed by participants, and the ways in which they adopted or resisted these positions through interview dialogue. Analyses are organized according to the following four subsections: 1) Penile Rehabilitation, 2) Sexuality and Relationships, 3) Erections, and 4) Gender. Please see Figure 2 for a summary of the analytic findings for Study II.

Figure 2. Study II Analytic Findings

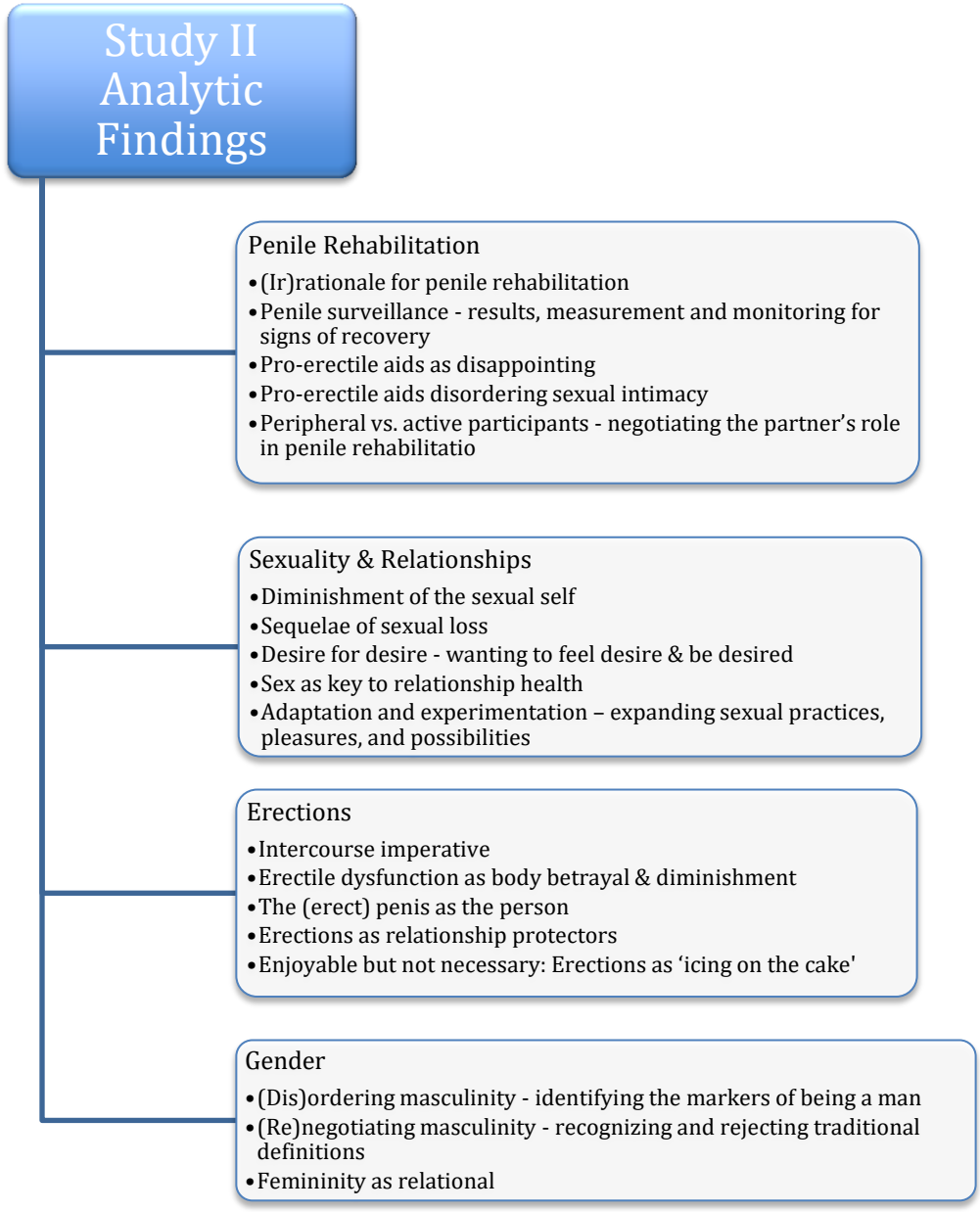


Figure 2. The analytic findings for Study II are organized by content theme and then by discourse.

Analyses: Penile Rehabilitation

Interview Excerpt Legend:
I: indicates interviewer is speaking
MP: indicates the male partner is speaking (as part of a couple interview)
FP: indicates the female partner is speaking (as part of a couple interview)
P: indicates the participant is speaking (in an individual interview, could be male or female)
MP#: indicates that the excerpt came from an individual male partner interview
FP#: indicates that the excerpt came from an individual female partner interview
C0#: indicates that the excerpt came from a couple interview

Interview transcripts were coded for material that related to penile rehabilitation. Analysis of the coded excerpts was then guided by the following question: In what ways are participants constructing their experiences with and understanding of penile rehabilitation? Analyses revealed the following five discourses:

(1) **(Ir)rationale for Penile Rehabilitation:** Participants generally position themselves as having been insufficiently informed about penile rehabilitation by medical care providers in the past. Based on their accumulated knowledge of penile rehabilitation, they currently position this intervention as essential for recovery. They draw upon biomedical discourses when establishing penile rehabilitation as therapeutic.

(2) **Penile Surveillance – Measuring and Monitoring Signs of Recovery:** Participants discuss ongoing observation of the penis for signs of change and recovery. Surveillance emphasizes signs of increased blood flow and recovery of nerve function. Recovery is positioned as observable and quantifiable and as being located in the penis.

(3) **Pro-Erectile Aids as Disappointing:** When discussing their experiences using pro-erectile interventions, participants position treatments as disappointing. Not

only do pro-erectile treatments result in myriad unpleasant side effects, the desired outcome (e.g., an erection) often does not occur. Treatments are positioned as failing to provide the professed benefit of sexual betterment.

(4) **Pro-Erectile Aids Disordering Sexual Intimacy:** Participants position pro-erectile treatments as being disruptive to 'authentic' and 'normal' sexual intimacy. While they offer the allure of sexual normalcy, participants frame these treatments as disordering the 'natural' flow of sexually intimate experiences.

(5) **Peripheral vs. active participants – negotiating the partner's role in penile rehabilitation.** Participants position partners' role in penile rehabilitation in various ways ranging from peripheral to integral. Tension is present in accounts between the different perspectives on and options for partners' ideal role.

Discourse 1: (Ir)rationale for penile rehabilitation. Most participants position themselves as having been given inadequate instruction about penile rehabilitation in the immediate aftermath of their treatments. In the present, they frame penile rehabilitation as beneficial and adopt the view that it is a medical imperative. They adopt the subject position of 'informed patient' in interviews. However, they position themselves as having been disadvantaged by their initial ignorance and by the failures of their medical care providers to educate them about this treatment in the past.

***A prescription as a stand in for rationale*.**

Couple 1:

MP: Honestly, there was not a whole lot of discussion. I just told [the doctor] that I think I needed something because the doctor that did the surgery – he told me that he would preserve the nerves.

FP: Yeah, exactly.

MP: Like, the nerves for the – so I could still have sexual activity. He did state that I would have internal orgasms. It wouldn't be external and I agreed to all of that but when it came down to the reality – to even having an erection – it seemed almost impossible, so that's when the GP recommended trying the daily dose of Cialis and just build up to it. And see if it would help.

I: So he explained that you would start low and try to build up to a higher dose was that it? Or build up to –

MP: Yeah, I don't know what the eventuality would have been but with the daily dosage it wouldn't last long, simply because I started to have side effects that were not pleasant so we stopped it.

Individual Female Partner 3:

I: How did the family doctor explain the use of Viagra or why it might be helpful?

P: I don't think she was that helpful actually. It was [my husband] who went in to see if that was a possibility and I think she said that, according to [my husband], "It probably won't work," or "It won't make a huge difference" but, you know – "Go for it." And yeah, and I can't remember what instructions that he had. But I think they were more kind of side effects. Basically zero rehab, zero, zero rehab.

Participants position themselves as being ill-informed about rehabilitation when interacting with their doctors. Pro-erectile medications stand in for absent explanations and discussions. Participants talk about being given prescriptions and about being informed of the side effects of medications; however, they construct these interactions as lacking key contextual information, such as why or how medication will rehabilitate

them, and what exactly is being rehabilitated. The male participant in C03 articulates that he requested a remedy from his doctor following surgery in order to rehabilitate his nerves. Cialis is provided as a solution to his "impossible" erections; however, the particulars of its rehabilitative effects are not well understood. The participant constructs medication as a way to "build up" to something important – presumably an erection and/or intercourse – during recovery. For F03, knowing about the side effects of medication and having instructions on how to take pills does not amount to penile or sexual rehabilitation. A package of pills is not a plan of action. Doctors are positioned as being in possession of knowledge that they opt not to share with patients. While medical providers are generous in doling out medical goods, they are less forthcoming with justifications, clarifications, and open discussions.

Individual Male Partner 4:

I: *So who introduced [sexual or penile rehabilitation] to you, or how did you learn about this?*

P: I don't know. I think it was myself. Certainly the medical profession didn't say, "Oh, and by the way if you're having difficulties here's what I would recommend you do." They're careful not to recommend anything in my case, I think.

I: Like, when you took you took pills it was a few years after surgery – I'm just curious about what led to that. How did you find out that was an option?

P: I think that I'd be leaving something out if I didn't say that after the surgery one's first thought would be, "Okay, when can I regain the sort of thing."

…

I: So I was curious about who prescribed Viagra for you.

P: My doctor, my urologist.

I: Okay, your urologist. And so when they prescribed it how did they explain your use of it following all of your treatments?

P: I don't think he did. I think he just assumed I'm a big boy I should know, I think. I'm not sure but I don't recall instructions as to how to use [it].

M04 positions himself as the initiator of discussion with his doctor about penile rehabilitation. Though he was provided with a prescription for pro-erectile medication in the hopes that he would "regain" something not articulated but presumably important to him (e.g., erectile capacity), he was not provided with a rationale or set of instructions for using this medication following prostate cancer treatment. The patient infers that he should know how to use it. A knowledgeable adult male (e.g., a "big boy") ought to possess the knowledge on how to take Viagra. Access to Viagra is supposedly sufficient for rehabilitation.

Individual Male Partner 1:

P: There was a lot of things that weren't explained to me … we talked about that quite often in our support group – that doctors don't have the time or they don't have the resources to talk to you about sexual activity because we're not being informed on what to do and how to do it and how to get back up on our feet. It's just kind of like, "We'll operate on ya and if you can urinate properly without wetting yourself and you don't have to get up 3 or 4 times a night." Well, I guess that's all that they are instructed to do and it's unfortunate. I know I'm not the only patient in the world but [they] have much more people than just me to look

after, and you know it's just that I have never got an answer for that.

The absence of adequate information signals a lack of resources. He positions himself as having been let down by his care providers when it came to needing help with penile and/or sexual rehabilitation. An abstract busy system is the culprit, rather than a specific health care provider. In searching for an answer for sub-optimal information provision, he is left with few viable targets: they don't have the time, they don't have the resources, they have been instructed to offer limited care, they *care about* patients but have too many patients to *care for*.

Feeling 'let down' by medical experts. Many participants report having been insufficiently informed and supported by medical providers with respect to penile rehabilitation, which they say resulted in lost opportunities for intervention. Patients position this as problematic in the context of more recent understandings they have come to about the importance of aggressive and early intervention. Thus, participants reproduce the perspective that there is a narrow window of opportunity within which to rehabilitate, and they position themselves as having missed this window. Several men described being 'let down' by their medical care providers and upset that they weren't better informed about penile rehabilitation options in the immediate aftermath of treatment. Some of these men initially tried and quickly gave up on pro-erectile treatments but said that had they been informed about the principles and process of rehabilitation, they would have persevered with treatment. Thus, they frame penile rehabilitation as important, effective, and time-limited, and position themselves as having missed out. This facilitates the subject position of responsible patient. The failure is located within the medical system as

opposed to within the patient, thus any problems with long-term recovery are attributable to inadequate patient education rather than irresponsible self-care and governance.

One male partner was prescribed pro-erectile medication soon after surgery but stopped taking it after two attempts (C02). The man says that his surgeon "never really explained" at the beginning what the purpose of Viagra was in terms of rehabilitation. The couple position themselves as having been uninformed about the healing properties of Viagra and about the rationale or purpose of penile rehabilitation. The male partner frames his surgeon as "very open" in that he explained the various interventions available to the couple after surgery; however, this openness was not coupled with adequate discussion about the purposes of Viagra. Viagra was understood to be a means to an erection and to sex by the male partner rather than a facilitator of long-term functional recovery. Markers of successful Viagra use were thought to include immediate signs of penile response, "if there were any results to show." The male partner feels that "there was a miscommunication because he was just trying to get my blood vessels working again and I didn't find that out until much later and had already discontinued the use of it, so that was really bad." The female partner positions herself and her partner as being unaware of the need "to stimulate the blood." The benefits of Viagra are positioned as potent even when undetectable and these participants express that their doctor did not convey information about the invisible therapeutic effects of pro-erectile medication.

Another couple (C03) likewise positions Viagra initially as a sexual aid (e.g., to facilitate intercourse) rather than as a rehabilitation tool after cancer treatment, which they attribute to the approach of their doctor and to the lack of information provided about rehabilitation. "He didn't talk a lot about that [rehabilitation]. He didn't give a lot of

options," the male partner recalls. The female partner concurs, "No, he said 'when you're ready to start let me know and I can prescribe Viagra'." "Ready to start" is understood to mean 'ready to have penetrative sex' by the couple. They position themselves as having been put at a disadvantage because of the lack of information. "I only discovered after we had given it up for a long time that sometimes people use it as a therapy – as a rehabilitation therapy – on a regular basis, I didn't realize that," the male partner says.

Couple 4:

MP: I'm much more aware of my understanding – like, let's say [a year] post prostate – because I have gone deeper into the research. We watched one webinar by a woman who is a certified urology nurse … and she talked about how for a lot of their patients, post catheter, right away it's about penile stimulation, oral medication – and how important that can be, you know, to get some function back quicker. My reaction to that was "Jeez, I wish someone had told us that a year ago" …

FP: Well, I don't think it's very well explained by the surgeon. I learned far more from that webinar. I don't think surgeons are comfortable talking about sexuality.

I: And in your experiences what gave you that impression?

FP: How quick the conversation goes. I got better information from my gynecologist.

Timing is positioned as crucial in recovery by this couple and they express that time was needlessly wasted because of the discomfort of their surgeon in discussing sex. They position themselves as behind the recovery curve because of the year spent without proper knowledge about the benefits of penile stimulation and oral medication. Getting

"some function back" – presumably getting erections back – is linked to effortful and diligent engagement in penile rehabilitation. They position themselves as having been let down by their prostate cancer medical providers because they did not get information about rehabilitation, and therefore as having been disadvantaged.

M04 also positions himself as having been disadvantaged by his medical team because he was not given information about penile rehabilitation soon enough. He constructs his approach to recovery as 'wait and see.' "I just didn't want to hurt the process that I had been through, so I waited and I waited and I waited," he says. Having waited patiently for two years, he now positions himself as having lost the window of opportunity for recovery. He positions recovery as an active process and constructs his passive approach as flawed. He says that he "waited too long for things to happen," not knowing that he was supposed to *make* things happen. He positions penile rehabilitation as key to recovery of erections and to the maintenance of sex in his relationship; however, he expresses that he was not given information about this crucial treatment.

Female partners also position themselves as being poorly informed about and supported through sexual rehabilitation, and as being let down by medical providers. When they expressed concerns about sexual intimacy to doctors, some partners felt positioned as problematic and selfish because of their desire to talk about sexuality in the context of cancer.

One female partner (F01) positions herself and her partner as active agents seeking help with sexuality in the absence of useful support or information from the oncologist or urologist. "It was like all the way along we were trying to find people who could help," she says. She felt that they were positioned as needing less support with sexual concerns

because of their age. "'Well you know it shouldn't really be a problem because you're both in your 60s,'" she says, recounting the urologist's response to her sexual questions and concerns. She felt designated by the medical provider as someone who should not care about sexual intimacy and sexual rehabilitation in the context of cancer. While penile rehabilitation is positioned as essential to recovery in prostate cancer medical literature, this female partner feels that her sexual concerns were positioned as peripheral in the real-world clinical setting.

Individual Female Partner 3:

P: After the surgery – I don't remember – right, in the hospital after the surgery when the surgeon told me, "Yeah, he's come out of the surgery" and I think – no, I asked him about "So what's the sexual functioning, you know, what's the sexual functioning going to be?" And I was told – and I remember this was kind of similar to what I think you said in a previous conversation – "We got all the cancer." ... And I kinda thought "Oh, okay I'm being selfish, the selfish horny wife," so I kind of back pedaled and said, "yeah, I'm very grateful – thank you for getting all the cancer." [I'm] clearly not going to be able to have a conversation with him around that piece. So, yeah ... typical kind of assertive category, kind of the cold – and the facts ... no rehab.

This female partner expresses that her interest in sexual side effects and her efforts to engage the surgeon in a discussion about sexuality were positioned as problematic. She is framed as "the selfish horny wife." Her efforts to "back pedal" in the conversation with her surgeon indicate she struggled to resist this subject position. She positions herself as

having been let down by the doctor, who she positions as providing cold hard facts, but no rehabilitation or real dialogue about sex.

In contrast, a minority of participants position themselves as satisfied with the support they received from their doctors. For example, one man frames his urologist as an effective source of information about penile rehabilitation (C07), and a female participant mentions how grateful she was to finally locate a doctor who was both able to talk about pro-erectile aids and also the "emotional stuff," including "the angst" that she was feeling and the "mystification" that her husband was experiencing (F01). While satisfaction is present in some accounts, the majority of participants position their sexual rehabilitation as incomplete and insufficient.

***Employing biomedical rationale*.** When participants were informed about penile rehabilitation, either through their doctor or other sources, the paradigm adopted was largely biomedical. The main purpose of rehabilitation is positioned as getting regular blood flow to the penis and stimulating nerves. Doing these things as early as possible is understood by participants to be paramount. Participants take up this biomedical discourse and reproduce it in their interviews.

Individual Male Partner 2:

P: Really, the way that it was explained was just to help you. Your body's gone through some trauma and we want to get the blood flowing back in that area and you're going to need some help as far as doing that, just to get it flowing, and this is one of the best vehicles to do it in – so why don't we do that and come back in a couple of weeks and let me know how it's working?

M02 positions recovery as being about blood flow, and penile rehabilitation as having the tools to achieve this goal. He describes a video on sexual recovery and prostate cancer and recalls the key message: "they want to get blood flowing back into the area, to get it going." In addition, the video conveys, "that, from a rehabilitation point of view, you've got a window of so much time to get the muscles growing there and to get the blood flowing, and if you don't maximize that time then going forward after that, the performance issue is dramatically down." Cancer treatment is likened to trauma to the body and to the groin area in particular, and rehabilitation is described as facilitating healing. If recovery does not occur right away in the form of pro-erectile medications, the trauma is positioned as having permanent effects.

M07 likewise espouses the view the penile rehabilitation via oral medication ought to occur "right away," stemming from conversations with his doctor. He was told "studies show that that there was a better chance of getting back to normal – or as close to normal as possible – if you, if you started this right away." Taking up this biomedical discourse, the participant decided to take the pills. He likens his penile rehabilitation to fitness training and physiotherapy, and engages in diligent and disciplined administration of treatment in order to regain normalcy and erectile function.

Approaching penile rehabilitation like physiotherapy appears in several accounts, and the analogy of 'working out' and physically working oneself back to wellness seems useful and compelling to some participants. M02 refers to "the muscles" that you need to get "growing there" and M01 mentions "the muscles" and the parts that have been 'torn." The male participant in C04 refers to "penis memory," which can be likened to muscle

memory. The goal of penile rehabilitation is positioned as regaining (penile) function and (penile) form after physical trauma. One's (penile) fitness is emphasized in recovery.

M01's rationale for using the penile pump is: "You use it because it betters the muscles and your torn, you know – your cut parts, and it helps blood circulation." He expresses that he uses it twice a day to improve his erectile functioning, much like working out and strength training. While somewhat unsure of the exact therapeutic effects, this participant adopts a physiotherapy rationale whereby repetition and persistence are expected to pay off. And while the pump has not helped him with sexual activity ("It wasn't doing what I planned on using it for"), he continues to use it in the hopes that it will help with "getting back into shape and helping with the blood circulation."

Couple 4:

I: You talked about this book being very helpful, what do you wish you had known beforehand that you had learned afterwards through this book?

MP: Well – and not only that book, some of the webinars and people we had contacted after – some of the importance of masturbation as quickly after surgery as possible – quickly after the catheter is out as possible – and earlier start with oral medication might have been more helpful at that point. A lot of them talked about the loss of penis memory and that you wanted to get that back as quickly as you can. So it was just things like that.

Akin to a physiotherapy patient not being prescribed proper exercises and stretches, the male participant in C04 positions himself as not being informed about daily

masturbation, oral medication, and other core penile rehabilitation practices. He constructs recovery as an active and physical process requiring early engagement.

Couple 5:

MP: So… because I'm a techy freak, I was on the internet reading about this, reading about that and you know what was working for some guys – trying to separate the nonsense from the real because … from the point of achieving an erection or the size of your erection – they are very hard to separate – and there's a lot of misinformation about that aspect … And basically I found a couple of studies that showed that Cialis and a pump were good because they got your blood flowing. And that's the key ingredient of this, don't let the blood pool and go stale.

Like many others, the male participant in this couple interview positions blood flow as key to penile rehabilitation. He adopts the subject position of avid consumer of scientific literature and frames himself as taking an active approach to his recovery. His rehabilitation practices were chosen to maximize circulation of blood and he positions this as being based on solid empirical data. Stale or pooled blood in the body is positioned as dangerous. Inactivity (e.g., pooling of blood, stationary bodies or body parts) is positioned as bad and conversely, activity (e.g., circulation of blood, movement of the (penis) body), is positioned as therapeutic. This participant adopts the subject position of active, engaged, and responsible patient, doing everything he can to ensure recovery. This corresponds to the way in which he positions the path to recovery as a physically demanding process.

The male participant in C07 also emphasizes the importance of a regular supply of blood to the penis. While he expresses dissatisfaction with the effects of pro-erectile medication (e.g., he wasn't getting an erection), he has persisted because his doctor told the couple "it keeps blood circulation happening so it's important" (female partner). Thus, blood flow is taken up as rationale for engaging in pro-erectile interventions, and oral medication comes to make sense as a daily practice even in the absence of observable improvements or benefits.

Discourse 2: Penile Surveillance – Measuring and Monitoring Signs of Recovery. Participants position penile surveillance as part of the recovery process and of penile rehabilitation. For some participants, this involves monitoring the penis for changes in form and function. For other participants, this involves close observation of the penis for small signs of animation and increased blood flow. Measurements are characterized either as signs of improvement or stalled progress.

Couple 2:

MP: Oh, I didn't really see any results till … it was about a year.

FP: A good year.

I: And results meaning you started getting a partial erection?

FP: Yeah!

MP: And, I mean, and little signs would be encouraging and believe me they were little …

FP: So up to that we tried – we kept still trying to do vaginal sex, like, but then we would do oral, we would do body [stimulation] – we would do trying anything.

…

FP: But having said that, there were certain things we had to do routine because that was much as we could do – some of the real experimental stuff – because [Male Partner] only had a certain certain strength in his penis that you know –

…

FP: It wouldn't, you know, it wouldn't accommodate you know other positions or whatever–

…

FP: Positions that we would have had normally. And he had lost quite a bit of growth or girth.

MP: Yeah, I'd say.

FP: Quite a bit of length.

MP: I'd say 25 to 30 percent maybe even 40.

Results (e.g., partial erections) are identified as markers of recovery. Blood flow to the penis is a "sign" that healing is happening and that normalcy is returning. This couple positions the penis as having changed both in form (e.g., lost length and girth) and function (e.g., limited tumescence) and they adopt increased blood flow as a measure of progress. These markers of recovery matter in that they make possible sexual practices that were formerly enjoyed (e.g., vaginal sex). As the penis recovers some of the attributes of its former self, so too does this couple's sexual intimacy.

Couple 6:

MP: I want to be able to just be fulfilling as ever type of thing and, I mean, the sexual part isn't all of the relationship by any means … in that I'm not ever going to let it be … to that point where that's all it is. It would be nice just to be able to

be comfortable with it and be back to my regular old self type of thing with it, but the way it's been looking and everything else, and the problems that I've had, and I just don't think it's ever going to happen to tell you the truth.

FP: We had a little success there the other night, a little bit of growth.

MP: But you know I'm just going to keep on pushing – that's all there is to it.

FP: You know, like, we like – he had a partial erection the other night … like it was a little.

This male partner expresses that he would like to "be back to my regular old self type of thing" with his erections. He positions sex without erections as missing as an essential aspect of himself. He articulates that his current erections do not reflect the true 'him' as a sexual partner. The male partner expresses some discouragement at the lack of signs of recovery in his penis as he engages in monitoring and waits for signs of encouragement. Progress is positioned as quantifiable and linear. More blood flow means progress is occurring. His partner positions a recent partial erection as success and as something to be celebrated whereas the male participant discounts this as a marker of anything significant. A partial or half erection signifies incomplete healing and fractional fulfillment for him. He positions himself as needing to "keep on pushing" towards recovery. By his measure, progress is not happening quickly enough. He positions recovery as being about hard work and dogged determination.

Couple 7:

FP: Well in this case you're told your odds are 50/50 and it might take 3 years even in the 50/50.

I: 50/50 of whether you can have an erection ever again in your life?

FP: Yeah, yeah.

MP: Well, without injections or a penile implant or something like that.

FP: Right.

…

MP: That's what the doctor says. … He said, "I think it's important that you know that this could take up to three years for you to get function back if you do."… But he said, "You know it can be any percentage of function along the way." And what they determine as a success by the way … is the ability to achieve intercourse or to sustain intercourse. That's what they call success. … So if – sometimes you'll see if you get a bit of increased blood flow, you can actually – and [Female Partner] has said it lately a couple of times – you'll see the that there is a thickening. So you'll see that happen and think "oh boy, this is good it – maybe something is going to happen" and you know, but in terms of actual erection nothing happens.

FP: Right, but I still see it as a good sign.

MP: Yeah, and – of course.

FP: It's moving in the right direction.

Both partners in this couple interview draw upon statistics when discussing recovery and put their odds of return of unaided erections at 50/50. The male partner positions himself as having been well-informed about what recovery might look like and the "slim chance" of full recovery. He and his wife jointly monitor the penis for signs of return of function and position recovery as something that can be measured and observed. Recovery is anchored to the physical body and to penile tumescence. Increased blood

flow and thickening of the penis are positioned as markers of healing and as stepping stones along the pathway to full and functional erections. Success is equated with erections that can be used to both initiate and sustain intercourse. The male partner waits and watches for "something" to "happen"; this "something" is presumably an erection. Recovery is constructed alternately as watching and waiting for something to happen, and as actively working to make something happen. Despite his efforts (e.g., daily medication, diligent monitoring), the male partner positions himself as falling short of the ultimate marker of success (e.g., intercourse). His partner, however, positions them as "moving in the right direction."

Individual Female Partner 4:

P: So it was over a year ago, I said, "Oh, you know, we're experimenting because I want to know that he still has erectile function, you know I worry so I touch him and you know." It's shorter and it's kind of bent. So it's not the same as it used to be.

…

P: Nobody tells you about this.

I: It's getting used to a new penis.

P: And we talk about it, and we look at it, and we say you know – it's, you know. And he explained, I guess with the surgery some of the connections – I don't know which one the urethra or whatever – you've got to join them so it actually –

I: Pulls back.

P: Sort of shrinks a little bit. So, I mean other than that – so, it's not as hard as it used to be. And it's hard for him to sustain an erection. It will come and go.

Whereas before he was sort of like, you know, "I'm in the mood – let's get it on and I need an orgasm," now he doesn't.

…

I: Oh, interesting. Okay. So how have the changes in his penis … impacted sexual intimacy for both of – or for you?

P: Well, this has been a while actually. Initially afterwards, we would sort of experiment a bit because we wanted to make sure that he hadn't lost it completely.

…

P: The erection is definitely not what it used to be it's got, you know, it's a little bendy. I play with it like, you know … it's almost like we're experimenting, we just play, we touch each other and then that's the end of that and then we go about our day.

This female partner positions her partner's penis as changed since treatment; it looks different and functions and acts differently. The penis is positioned as a person and as having an identity complete with patterns of behaviour and preferences. The penis is constructed as a knowable entity that she was once intimately acquainted with. She positions recovery in part as becoming reacquainted with her husband's penis so that it becomes recognizable and intelligible to her. Through experimentation, observation, and monitoring, the female partner is sussing out the new features and attributes of the penis. Sexual play and penile attention are about more than reestablishing connection; they are about measuring physiological recovery. As the penis is tended to, touched, and played with, its responses are carefully observed for signs of "function," and to see if everything

has been "lost" or not. Observations are thus positioned as providing meaningful data on penile improvement.

Individual Female Partner 3:

P: *And no matter what you do … it's not going to be what it was before. So … I think [Male Partner's] not that keen on trying something that's really painful and I don't blame him. And I'm not too sure that this is actually going to do anything significant, so he was willing to try the Viagra but we were both kind of scrutinizing, kind of saying this – we didn't quite bring out the little tape measure but you know, it was like, "Is this really different? No!" [laughs]*

Viagra is positioned as having the potential to transform the impaired penis into a larger, active, responsive, healthy organ. This female partner and her husband closely observe the penis for signs of change, which do not appear. The female partner positions Viagra as having failed to deliver any detectable enhancements. Markers of change and effectiveness are thus positioned as physical and observable.

Discourse 3: Pro-erectile aids as disappointing. Men and their partners position penile rehabilitation interventions as disappointing because of unwanted side effects, dose calibration issues, and the failure of treatments to live up to expectations.

***Unwanted side effects: Promises vs. practices*.** Many participants spoke about aversive side effects to medications, which were positioned as either unpleasant or intolerable especially when the desired effect (i.e., an erection) was notably absent. For example, one participant (the male partner in C07) describes eagerly waiting two hours for the pro-erectile effects of Viagra to kick in, only to end up with heartburn, backache, nasal congestion, trouble breathing, and no erection. Another man took Viagra with

modest hopes that it would produce a slight erection: “even if it only got an inch long, that would been – even that would have been something,” he says (M03). The end result was “a massive headache about 4 or 5 hours later,” and no erection. M04 tried Viagra twice, hoping to see the beginnings of an erection. He didn’t notice any change in his penis but got unpleasant side effects such as “projected little rings around the lights” and a plugged nose. Medications often fail to live up to their promises in that they do not produce reliable erections or facilitate ‘normal’ sexual encounters. The lingering presence of uncomfortable and/or embarrassing side effects enhances participants’ disappointment and highlights their ‘impairments.’

Unlike other treatments, injections reliably induce blood flow to the penis. Despite the established clinical efficacy, participants position these treatments as complicated and compromising. For example, a number of participants talked about the initial psychological barrier of putting a needle into their penis, and others talked about the challenges in sorting out dosage for injections.

Couple 2:

FP: He had erections with the needle but he wouldn’t inject himself.

MP: Oh that, now that, the injections – on the plus side wonderful erections, just like beautiful!

I: Yeah, they work!

MP: But on the negative side –

FP: He couldn’t do it to himself.

MP: I couldn’t do it to myself.

FP: And I was – I could do it.

MP: And I wanted her to do it. It seemed very clumsy.

Couple 7:

MP: [My urologist has] been trying to – the last couple of conversations that we had he has been talking, I think he's trying to ease me into the potential for injection … But I don't know if I'm there yet.

…

MP: Sticking a needle in your, you know, in your male part. Yeah, that's the hesitation … there's two things and the one is – I mean I don't think anybody wants to stick a needle in that.

FP: Or anywhere really.

MP: Well anywhere but there particularly. You know unless you – I don't know – unless you're some kind of a–

FP: Have 18 tequilas first.

While injections offer the promise of erections, they are also pose challenges to men. In order to achieve penile engorgement, the "male part" – the essence of the man – needs to be penetrated by a needle; the 'prick' needs to be pricked. And as the male participant in C07 says, "I don't think anybody wants to stick a needle in that." Likewise, M04 states, "The idea of taking a needle and sticking it in 'you know who' is not something that thrills the hell out of a guy." This is echoed by M05 who says, "No way on this earth am I … sticking a needle into that. It's just not going to occur." *That* object, the uncooperative penis, is the reason participants are considering injections, yet the cost of

achieving an erection (poking and prodding and penetrating *that*) is positioned as ultimately being too high for some participants.

In addition, injections are problematic in that some men require help from their partners to complete the procedure, as is the case with the male partner in C02. This couple acknowledges that while injections produce what the male partner positions as "wonderful erections, just like beautiful," injections are ultimately not satisfying for this couple because the male partner "couldn't do it himself" (female partner) and "it seemed very clumsy" (male partner), having his wife do it for him. According to the female partner, the male partner is "squeamish" about the procedure, and administration of the drug made it ultimately undesirable to him. Injections are associated with vulnerability. They expose men to penetration, pain, fear, and the need for help. In this way they disrupt the performance of masculine mastery, courage, control, and sexual infallibility.

Medical and patient literature depict injections as offering reliable, long-lasting, and hard erections and, thus, as a solution to sexual disruption caused by prostate cancer treatment. However, several participants position injections as barriers to sexual intimacy because of dose calibration issues.

Individual Male Partner 7:

P: With injections you've really got to find your dose. You can't overdose so that you could end up in trouble, and I haven't really done that. But the last 3 times that I've injected, well 3 or 4 times it might have been, … it was sort of the same dosage but the erection sticks around. You know … if the erection lasts more than 4 hours contact the physicians. Well some of these lasted close to 4 and a couple lasted more and I did go to the emergency room in the hospital one morning after,

you know, it still hadn't dissipated. And the last 3 times I have had to actually have a cold shower afterwards and go walking for an hour so … my wife does not like the fact that I'm out walking at 2 o'clock in the morning.

…

P: Yeah, I mean that's kind of a turn-off. It's a safety turn-off. It makes it more trouble than it's worth kind of thing.

Injections introduce unwanted stressors to sexual intimacy (e.g., cold showers and long solo walks in the middle of the night after having sex, the possibility of having to go to the emergency room, medical risk, etc.). Erections, which are generally desirable events, become a problem. Injections can create a problematically erect penis and men talk about having to monitor for signs of trouble. Injections introduce uncertainty and undesirable risk. The erection must be carefully managed and monitored, which takes away from pleasure and play. The erection must first be coaxed into existence at great psychological cost to some participants. Next, its duration must be carefully timed so that it lasts long enough (for sexual satisfaction) but not so long that it causes medical complications. Finally, in some cases, the erection must be induced to dissipate using unpleasant interventions.

In an individual male interview, M01 describes injections as unreliable – if he injects too much then he ends up in the emergency department and if he injects too little he doesn't get an erection. For example, he has had 6-hour erections and ended up in the emergency department, but he's also had the opposite: "So last time … I didn't give myself enough so when my wife and I were ready to have relations, I wasn't able to get an erection." He positions this as stressful because "you don't know how you're going to

make out. You're going to have an erection but for how long?" In a separate individual interview, his wife reiterates these challenges: "Either he gives himself too much … and then he's panicked and like 'I got to go to the hospital' … or he doesn't give himself enough which – okay so there's an opportunity lost," she says. Both partners position injections as problematic and as unreliable sexual supports.

Failing to deliver the desired erection or experience. Participants position pro-erectile medications as disappointing. While aids offer the possibility of erections and – by association – sexual normality, continuance, and/or resurgence, they frequently fail to deliver an erection or an experience that is satisfying to participants. One couple (C03) initially views pro-erectile medication as exciting and full of promise but later as useless. Upon receiving a prescription at the male partner's 6-month surgery follow-up appointment, "We just couldn't wait to get home to try it out," the female partner says. Careful preparation and administration resulted in failed hopes. "It just, it just wasn't effective, it wasn't – it didn't work the way we thought it would," the male partner says.

Another couple positions the penile pump as full of possibility for penile transformation (C06). The male partner says, "It seemed … at the very first day … it seemed like it was going to start to do the trick and everything else," but "then it just all of the sudden quit." This pump now sits "in the box." The male partner says, "I really should try it again," but he has not. The initial hope that this device would "do the trick and everything else," resulted in disappointment and frustration. The pump offers the allure of a functioning penis, and "everything else" that is associated with that; however; the reality is more complicated and less promising.

Likewise, the male partner in C07 described his initial hope that the pump would be a successful bridge to recovery, which was followed by disappointment. “The challenge with it is … you’re probably lulled into this … you put this pump on and you use it and all of the sudden you have this – what looks like success. And then you release the pump and the success is gone as quickly as you push the button.” While the visual changes in his penis were encouraging (blood engorgement), the illusion of normalcy and recovery was shattered when he took the pump off and the blood drained out of his penis. The possibility of success quickly turns into failure. Participants’ hopes for reinstatement of wholeness are deflated along with their erections.

Couple 7:

MP: There’s probably more jokes about [Viagra] than there are jokes about anything else in the world. And every guy I know talks about it jokingly and they talk about trying it. … So yeah, I think you have this false expectation that it’s a miracle drug. That you pop this stuff in and the next thing you know it’s off to the races … I had this false expectation that it was just going to be a miracle drug. I was going to pop one of these and one hour later we’re off to the races and nothing, and you know two hours later – nothing. And then all of the sudden I started to have heartburn and back ache and I had this incredible nasal congestion, I could barely breathe. Then I pop open the pamphlet that comes with it and I start to read it and I was having all of the top side effects, and most people get one of them and I was getting, sort of, three of the big ones. So I was really deflated after, you know, trying it. So I thought, “Well okay, we’ll give it a shot again” so, you know, we tried it again and we tried it again and each time the

symptoms kind of got worse – it got to the point where the back ache was so bad with it that I couldn't sleep at night. … And again at the end of the day the whole result in terms of sexual function wasn't there, there was nothing. So I was really disheartened and I didn't even want to try anything else. I just said to [my wife] "I'm done. You know, it's expensive, it's stupid, you know – it doesn't work. I just don't want to do this."

Couple 5

MP: *I experimented a bit with penis things and what they do for you and … they weren't very comfortable, they were very invasive, and they didn't last long enough for me to masturbate the way I used to. So … one failed thing after another.*

The male participant in C07 positions Viagra as a cultural icon with a reputation for enhancing sexual prowess and proficiency. Elsewhere in the interview this participant reproduced some of Viagra's mythical tales (e.g., the main fear a man should have when taking Viagra is that his erection will last too long). In describing his up close and personal encounters with Viagra, he positions the drug as failing to live up to its legendary status. Instead of sending him "off to the races," it left him "deflated" and "disheartened." Viagra becomes a sexual extinguisher rather than a sexual enhancer. Participants describe various tools and pro-erectile interventions as invasive, uncomfortable, and disappointing. They fail to deliver on multiple fronts – they don't deliver the desired blood flow and they impede sexual pleasure and practice.

There were some rare cases where participants described satisfactory experiences with penile rehabilitation. One female partner (F05) said that Cialis "really saved our

necks." A prescription for Cialis was the answer to their SOS for help and the medication delivered on its promise to help maintain erections. This participant described the aftermath of treatment as " kind of great recovery, you know it felt like a successful mission." They had the tools they needed for their "mission." Successful sex (e.g., sex that involved an erection) was made possible with the help of pro-erectile medication. Cialis was a potent prop for the sexual confidence of a male participant (M06) who had an individual interview. These expressions of satisfaction were rare with most participants characterizing their experiences with pro-erectile interventions as frustrating, disappointing, and short-lived.

Discourse 4: Pro-erectile aids disordering sexual intimacy. Participants depict their experiences of incorporating pro-erectile treatments into sexuality and sexual intimacy as troubled. The interventions are described as artificial and mechanical. Even when erections are 'successfully' produced using these aids, the erections are often unsatisfactory because they are no longer rooted in sexual desire. The disconnection between producing an erection and subjective sexual desire is disruptive to many participants' sexuality. Pro-erectile aids also disrupt 'normal' and 'natural' sexual flow for couples. Interventions threaten spontaneity and interrupt the preferred unfolding of sexual episodes. Finally, participants talk about the challenges of incorporating decidedly nonsexual and unsexy behaviours (e.g., injecting ones penis, taking a pill) into sex. Pro-erectile aids are positioned as detracting from the eroticism and intimacy of sex.

***Divorcing erections from desire & disrupting sexual flow*.** Erections are interpreted as a sign that a man is aroused and attracted to his partner and that a partner is arousing and desirable. Participants frame them as a marker of something 'normal' and

'healthy' that emerges between two people who share erotic love. If a pill is taken to help produce an erection then the symbolic meaning of erection-as-a-sign-of-love/lust falls apart. Erections are no longer an indicator of love, arousal, desire, romance, and healthy relationship functioning, but become a tool for sexual activity. Their role as an often-faulty tool ultimately disappoints men and their partners. What is gained by producing an erection is surpassed by what is lost through the means of production. In addition, pro-erectile interventions are positioned as disrupting sexual process and flow, and as detracting from sex.

Couple 7:

MP: The other part of it for me is that it becomes so mechanical. It's "okay it's time. We're going to do the deed, so let's get the needle out and I'll meet you upstairs in half an hour – I'm going to do an injection." You know, and that takes something away from it for me, you know. We used to cuddle and nuzzle and fool around and we'd get what we wanted, and now I'm sticking a needle in myself to make it happen and it just, it just – that's a huge hurdle for me.

I: So the pill is something different.

MP: You pop it and … you can take it 30 hours before you use it or something like that. It lasts for a long period of time. So you take it and you forget about it and then you just go on with … you know, and then the result comes from the normal way of having the result come. … From regular … from manual stimulation. … The great thing is you can take the pill, you can go and have dinner and a couple glasses of wine and come back – and you can have the, you know, have your evening the normal way.

…

MP: The needle is so darn mechanical.

…

MP: It's just so planned and you know, we'll get out the spreadsheet and see what time of week it is and "yep, tonight's the night so let's get the needle out."

FP: Yeah, he did have a problem with that when I wanted to be pregnant too.

…

FP: Yeah, he'd be like, "Well, this is really mechanical, like, it's not really about fooling around anymore."

…

I: So, it's this idea of – it's not to do with the prostate cancer or the needle even necessarily only. It's to do with spontaneity and it being just, to you – the word you had used a couple times – just a normal, natural–

MP: Yeah!

I: Occurrence.

MP: A normal, natural occurrence and spontaneity again like I said … I think that's a perfect word. It's any time … and the great relationship that we've had that way, it's always been spontaneous, it's always been whenever and wherever we decided that it's just time and the kids weren't here. And now it's just so planned, it just goes against who we are and against who I am to do that. Right, that I think I have this fear that the act of injecting myself is actually going to stop me from wanting to perform the act, you know to be intimate after because I've had to go through that process.

The male participant in C07 positions injections as "so darn mechanical" and as disrupting sexual spontaneity. Sexual activity is disrupted by a clinical procedure (injection), which is undesirable. The pill is positioned as superior to injections because they facilitate sex that more closely approximates sex pre prostate cancer surgery. He wants the pro-erectile interventions to fade into the background and for sex to unfold as it used to. He wants his erections to seem like they are being produced from "cuddl[ing] and nuzzl[ing] and fooling around" with his wife. He doesn't want to be faced with the reality that his erections are being produced, at least in part, by medication. The more visible the interventions become and the more localized they are to the penis, the less acceptable they are to this man. 'Normal' is important to this male participant and 'normal' sex is constructed as not requiring (obvious) intervention. There is a script for what are deemed acceptable pro-erectile strategies, which include things like touching, cuddling, sharing wine and dinner, and fooling around. Other kinds of pro-erectile strategies, like injections, are unacceptable. Pills are tolerable because they can be taken and forgotten, thus they sustain the illusion that the erection resulted from 'normal' sexual play with one's partner.

There is a valuation of spontaneity and an ideal that good sex 'just happens' without planning or forethought. Planned sex goes "against who we are" the male partner says. Sex is supposed to emerge spontaneously and ought not to require planning or intervention. Effortless sex is privileged and pro-erectile medication is a threat to effortless, unplanned, spontaneous sex. Planned sex is associated with desire and pleasure deficits and pro-erectile interventions are paired with the unsexy rituals and constraints of pregnancy planning. When things that are marked as non-sexual (e.g., procreation, proper administration of pro-erectile medication) are added to the sexual routine, it crowds out

desire and the way sex is 'supposed' to be for this participant. While the male partner emphasizes that sex for them has "always been … whenever and wherever we decided that it's just time," this is contradicted by the female partner's account of them having "made time" for sex throughout their nearly three decades together. The female partner says, "Honestly, we had a great sex life. We made time for each other even though we had three kids, even though we had crazy jobs, yeah." There is a disconnect between the male partner's perspective that sex 'just happened' for them and the female partner's perspective that they 'made sex happen' by having "made time" for it. Nonetheless, the male partner constructs this couple's sexual intimacy as having relied on passion and impulse historically, and he positions pro-erectile medication as disrupting this narrative.

M04 also equates spontaneous sex with ideal sex in an individual interview. The penile pump was "intolerably successful," in that "it was deemed to be too artificial," both in terms of "the reaction of the pump and the preparation necessary." His penis became "more swollen than it was stimulated" and sex was not "as spontaneous as normal sex would have been." He discontinued using the pump. 'Normal' sexual flow is disrupted by the operations required to produce an erect penis. Thus, an erection is insufficient for the experience of sexual normalcy. The way in which an erection is produced is paramount; it must feel "normal" in order to be acceptable. Penile rehabilitation interventions, which offer the promise of normalcy and redress, most often fail to satisfy.

Individual Male Partner 5:

P: *I still don't find that it's romantic to take the drugs and have a sexual relationship. The impromptu-ness of the experiences [get's] shelved a little bit because I have to take a pill.*

Individual Male Partner 7:

P: The erection is different and of course how I get it is different … I'm getting some natural ones now if I wake up but they don't stick around too long. So I mean that's encouraging, that natural ones are coming, but there's a loss of spontaneity when you have to pop a pill three hours before or inject 20 minutes before.

…

P: Well, I mean spontaneity is spontaneity. Before we might be in bed and then it just kind of happens, but now we actually have to, you know, the preparation would be part of our, you know, you brush your teeth you do this, do that, you know – part of the whole ritual beforehand. It's just not, you know, when you're planning for it – just does not seem to be as, it's not the same.

Pro-erectile interventions represent diminished romance and sexual insufficiency. In an individual interview, M05 expresses wanting "to do this myself without the assistance of drugs." Doing it 'on his own' is more romantic and intimate. Drugs introduce an undesirable 'other' into the sexual encounter whereas drug-free sex is sealed off to anyone or anything but him and his partner. M07 explains that medications detract from the possibility of 'anytime, anywhere' sex. Sex is "not the same" now because it is effortful. Sex after treatment for prostate cancer cannot "just kind of happen." Notably, this participant privileges 'naturally' unfolding and spontaneous sex, even though sex used to include particular kinds of preparation. A distinction is made between acceptable body preparations for sex (e.g., brushing teeth) and unacceptable ones (e.g., injecting the penis).

The female partner in C03 positions treatments as "too artificial" and "mechanical." This construction results in "put[ting] more pressure on each other to perform" (female partner in C03). Medication takes "away from the sex act" rather than adding to it. This couple describes enjoying spontaneously unfolding sex ("surprise nookie type thing" that "just happens") previously, and medication gets in the way of a 'natural' unfolding of sexual intimacy. Medication disrupts their sexual script of spontaneity. In addition to pro-erectile medication, this couple tried the penile pump. The male partner positions the pump as disappointing: "the way it works it … doesn't bring on a natural erection … it's just swelling … It was uncomfortable and distracting and … it wasn't firm and it didn't work the way … it was just such a big distraction." This couple notes that having an engorged penis is not the same thing as having an erection. An erection has a host of associated meanings for this couple that include things like pleasure, desire, lust, intimacy, spontaneity, and possibility. Blood flow lacks the discursive power to elicit this desired web of meanings; rather, it conjures up loss and lack. The context in which the erection emerges is positioned as important to the unfolding of sexual pleasure, excitement, and intimacy.

Couple 2:

MP: It was alright – I mean once you get over that–

FP: Knowing someone's putting a needle in your–

MP: Then your erection comes, but then, you know … it's–

FP: It's not spontaneous and it's not–

…

FP: Well, we got through it. I–

MP: Yeah.

FP: He wasn't going to waste this opportunity of having an erection so–

I: Yeah.

FP: We got through it but it was never–

MP: Well, it felt synthetic.

FP: Yeah! That's a good point.

MP: Like it didn't–

I: Like, the actual erection or the experience?

FP: The whole thing.

MP: The fact that it was erect, it was good, and when I looked at it I thought, "Wow, that's the old me," but it didn't feel like it was me, it felt–

FP: Yeah, it was really.

MP: It's synthetic.

…

MP: Well, it felt somewhat artificial but almost like it was a dildo or something, but it wasn't really me …

…

FP: I was willing to have smaller erections and maybe less stimulation for me but a different – but a better, closer relationship …

…

FP: It was us, it was just us. It wasn't having to rely on, you know, medication and

stuff. I think from my point of view that's how I looked at it – it was just us getting back to our relationship.

This couple juxtaposes the apparent success of the injections in producing erections with the ultimate failure of injections to enhance sexual intimacy. While the erections are described as something to marvel at, they are problematically "synthetic." While the erection looks like a familiar body part, it is experienced as alien and unrecognizable, and like a plastic sexual toy. While medication 'works' for this male participant's penis in that it generates blood flow, it does not 'work' for the couple. Medication creates a barrier between the partners. Stopping medication is experienced as a way to draw closer as sexual partners: "it was us, it was just us. It wasn't having to rely on you know medication and stuff. I think from my point of view that's how I looked at it – it was just us getting back to our relationship" (female partner). The sense of alienation that this man associates with his "beautiful" erections reveals that just having erections is not enough. The erections have to feel like they both belong to and 'are' the man and that they are generated by the couple ("just us"). Part of the pleasure and valuation of erections is rooted in beliefs about how they are generated and attribution of whom they belong to.

One man surmises that his partner has a negative response to injections because "she may be feeling that, you know, just desire itself isn't doing it," and injections are needed for an erection (M07). He adds, "It could be that she's feeling that she doesn't have what, you know, what's needed anymore." When the emergence of an erection cannot be solely attributed to the sexual connection between partners or to the man's desire for his partner, it is positioned as problematic. It no longer has the power to signify

or communicate a state of desire and wanting; it is no longer anchored in the love and lust in the relationship; rather, it comes to signify artificiality and the absence of desire.

Individual Female Partner 3:

P: One of the videos that we watched was an urologist giving a presentation to a prostate group … And he basically said what he would recommend is for couples before the surgery to start playing around with sexual expressions that didn't involve the erect penis. … Just so that you can kind of expand your repertoire and so it doesn't become so focused on the, you know, 'sex equals the erect penis.' And then he said afterwards, what he noticed was that, like, with the man, you know, the prosthetic devices – often couples who try it for a while and then it wasn't successful. And he said what would happen is that the man would go off and you know get himself ready.

I: Like use an injection or something.

P: An injection or vacuum pump. You know, go through all this effort and pain – you know, kind of labour intensive – and then kind of spread almost like a peacock with the erect penis and then the wife would be going "did I ask for this? What makes you think I'm interested in sex now?"

Pro-erectile aids are potentially problematic for this female participant. Sexual preparation is a dyadic experience that partners ideally engage in together, as opposed to a set of solo machinations that a man engages in to produce an erection. Presentation of a mechanically or medically induced erection is thus an unappealing invitation to sex. This participant highlights how divorcing the production of erections from a couple's sexual desire can lead to miscommunication between partners about desire and interest in sex.

***Unsexy acts during sex*.** There is tension between the starkly unsexy actions involved in administering pro-erectile interventions and what participants define as acceptable and/or desirable behaviours involved in the unfolding of sexually intimate encounters. Pills, needles, pumps, pain, and planning are antithetical to sexual intimacy, thus pro-erectile interventions are situated outside of 'normal' sexual behaviours and activities, and as disruptive to traditional sexual scripts.

Couple 2

FP: *It was so hard to get back in the mood after you just injected your husband in the penis*.

Couple 3

FP: *[The pump] just looked so uncomfortable … like, sex shouldn't be like that.*

Individual Male 1

P: *I did it for a while, when I was trying to get her interested in the pump … the nurse that advised me that – tried to make it like a toy that would help our relationship be a little bit better … like a little toy right… like, make it fun. I mean sex is supposed to be fun … When it stops being fun, it stops being sexy sex as far as I'm concerned. I mean, it's not something that you have to do – it's something that you want to do, so.*

…

P: … I think she just didn't want to get involved in giving me a needle into my penis I guess… she has no intentions on taking part in anything to do with it. She just tells me to go and inject myself and that's all there is to it. I'm on my own.

Individual Female 2

P: *Now it's like "well okay, if I'm going to give myself a needle, you've got to go have a shower and everybody's got to be clean and" … are you fricken kidding me? We're not doing surgery here … It's like we don't want to get dirty. It's like we can't do this … no spontaneity..*

While some prostate cancer resources advise couples to try to incorporate pro-erectile aids into sex, participants position this as problematic. They describe the method of administration as unsexy and as detracting from sexual passion. They find pro-erectile interventions antithetical to sexual passion and pleasure.

Sex with pro-erectile aids is also clinical and sterile; it lacks the fecund, messy, and lush qualities of 'normal' sex. One female partner in an individual interview describes physical intimacy as surgical rather than sexual when using injections. Elsewhere in her interview she defines good sex as being able to wake up, roll over and 'go to it' without having to plan and prepare. Sex with injections lacks grit and she misses being able to "get dirty" with her husband. Injections get in the way of how she wants sex to unfold, which 'should' be unfettered by the procedures of penile rehabilitation.

She and her partner have conflicting accounts of incorporating penile rehabilitation into sex. He states that he wants her to inject him as part of their sexual practice and to playfully explore pro-erectile treatments. He describes her as not being interested in participating and as abandoning him to deal with this on his own. In her own individual interview, the female partner associates injections with pressure for her to perform. The subject position of nurse/wife is unappealing to her because of the risks associated with failing to perform perfectly. "If I gave him too much and he ends up in the hospital, it's my fault. If I give him too little and it's not going to work, I didn't do it

right. There is this blame game," she says. As a way of resisting this subject position and the risks that she perceives to be associated with it, she designates penile rehabilitation as 'his' job and adopts a "hands off" role in penile rehabilitation.

Earlier in the interview, this female partner expresses longing for increased sexual intimacy in the relationship. She longs for her husband to regain his sexual power, prowess, and passion. She imagines saying to him "go take a shot and get in here and fucking fuck me." Thus, she wants to heighten the sexuality in the relationship and misses a raw sexual energy and intimacy that she describes them as once having; however, she also admits to adopting a passive sexual role in relation to her desire for change. There is tension between these two states of sexual longing and passive retreat. Positioning her role in rehab as "hands off" relieves her of the power, responsibility, and burden of transforming both the penis and their sexual intimacy. She no longer holds the power of the penis in her hands and thus cannot be blamed for erectile or sexual failures. "Not my job. I don't have nothing to do with that. You want it, you go figure it out," she says.

Discourse 5: Peripheral vs. active participants – negotiating the partner's role in penile rehabilitation. Analysis of interview transcripts reveals that partners play wide-ranging roles in penile rehabilitation, from peripheral to integral. There is tension in these accounts between one-person (male centered) and two-person (couple focused) models of penile rehabilitation. Sometimes, the conflict is located between members of the couple who have differing perspectives on the role of their partner in rehabilitation, and other times the conflict is located between the couple and their health care providers. For example, some female participants express wanting take a more active role in rehabilitation but frame health care providers are putting up barriers to their involvement.

***Partners as peripheral*.** Partners are often positioned as peripheral actors in penile rehabilitation, and sexual recovery is constructed as a solo endeavour. Some female partners assert that they believe themselves to be important to the process but describe facing barriers integrating into penile rehabilitation. They describe their experiences as dissatisfying and marginalizing. In addition, some male participants describe their partners as playing insubstantial roles but position this as a choice made by their partners, who are uninterested and/or unsupportive. There were some exceptions where participants frame a male-focused approach to penile rehabilitation as satisfying and appropriate.

Couple 2:

I: How did you conceive of your role in [Male Partner's] sexual rehabilitation?

FP: I don't think I did at the time. I think I went into it a little blind. [Male Partner] was getting all this info – I mean, I went to all the meetings with him, I went to ninety percent of his doctor's appointments with him. So I knew what was going on, but I didn't know what I could do other than just be supportive. And then it was afterwards, when we got the tape and we got a couple of books … I think I went through a phase where "okay, everybody is thinking about how [Male Partner] is doing. I'm not sure if anyone's thinking how [I'm] doing." And so as far as rehabilitation, I don't think I had the information I needed … So it was almost like a self initia– a self thing I had to work that through. I don't think that was a big part of the rehabilitation. It wasn't really "how is the wife going to be involved in this," it was "how is the guy" … I think that was an issue – that it wasn't really "you're going to play a big role in this and you two being together and–." I think it was "we have to get this guy back into, you know, functioning.

MP: It was more emphasis on the guy.

FP: Yeah, so as far as that goes I think … that is an area I think could always be improved on, 'cause I don't think people stop to think that it's two ways, that it's two people involved in this.

Couple 4:

FP: It was talked about, the central role of the partner but, like, the internet stuff, some of it talks about it but not in – I didn't find helpful – ways. Like I had to start to think "okay, like, what can we do?" Like, I felt like we were inventing the wheel a little bit. And I think there has to be some information out there that can be easier to get than what we've, what I've found. Maybe I just wasn't looking in the right space – places.

In the interview with C02, the female partner says she felt extraneous during rehabilitation. The experiences, needs, and perspectives of partners were overlooked and insufficiently integrated into the process. She articulates a difference between being physically present (e.g., at appointments) and being integrated into prostate cancer services. Being allowed to attend a doctor's appointment or support group is not synonymous with being incorporated into care in a meaningful way and she describes penile rehabilitation as containing numerous barriers to partners. Likewise, the female partner in C04 had to unnecessarily 'reinvent the wheel' when trying to integrate herself into her partner's penile rehabilitation.

Penile rehabilitation is largely oriented to men and focused on getting men back to a recovered state of functioning, rather than being about helping couples or partners cope with change. The female partner in C02 says elsewhere in the interview, "It wasn't really

‘You’re going to play a big role in this and you two being together and.’ I think it was ‘We have to get this guy back into, you know, functioning.’” In that sense, she feels peripheral to her partner’s recovery but resists this marginalization as it contradicts her view that her role and needs are integral to successful recovery and adaptation. She positions her own recovery as important to the process of rehabilitation. In addition, she resists the position that successful recovery is about achieving ‘working’ erections. For her, recovery is a dyadic process where both partners’ needs and desires are taken into account.

Individual Male Partner 1:

I: I’m curious too about what it’s like for you and [Spouse] to navigate all these different treatments, so the injections and the Viagra and the pump, what’s that been like for the two of you?

P: She’s not involved in it. … She’s left it up to me. She isn’t interested, doesn’t seem to be interested, she just lost her interest completely and probably more frustrated that I’ve asked her to come to my support group with me. She was good up until I started my support group and she has never been so – I don’t kind of, I don’t push the gauntlet.

Individual Female Partner 2

P: *He does what he wants, when he wants, where he wants, and how he wants. Let’s make no mistake about that. So with … rehabilitation if this is supposed to be something that’s done by the two of us, then the appointments need to be made by the two of us … My schedule’s never come into this. He just books things when*

he wants to book them. And then I'm inconsiderate because I don't go to these appointments with him … he just wants me to jump through hoops to get there.

In an individual interview (where both partners participated separately), M01 positions his wife as being uninterested in participating in penile rehabilitation. By his account, he is engaging in efforts to include her in the sexual and emotional domains of recovery (e.g., trying pro-erectile treatments, attending his support group), which are not working out as he had hoped. He describes his partner as both disengaged and also negatively reactive to his requests for increased engagement. He adopts battle language (e.g., pushing the gauntlet); the requests he makes of his wife are a bid to combat.

In her own individual interview, this man's wife constructs an account whereby she has been made to prove her commitment through various challenges and tests set up by her partner. She expresses that she cares greatly about sexual recovery and intimacy in the relationship. Thus, there are contradictions in their individual accounts of her interest in participating in rehabilitation. She views herself as having tried to become involved but as being unappreciated and shut out of the process. She characterizes her partner's approach as self-centered. She resists being positioned as someone who has to constantly prove her love and devotion, and articulates and disputes the perspective that she doesn't care. She wants to participate on equal terms.

Individual Male Partner 4:

I: What role, if any, did your wife play in you seeking this information out or trying these different options out?

P: She didn't encourage it but I didn't ask her either. You're the man – help yourself. If you have a problem, try to resolve it. But I didn't ask her.

Here, penile rehabilitation is a man's job and a man's problem. The wife's uninvolved stance is attributed to this perspective. Elsewhere in his interview, this participant describes feeling alone and abandoned by his wife with respect to sexual rehabilitation and unable to either articulate this to his wife or express his desire for a more communal approach. Despite the misgivings he has about his solitary experience, a one-person model of recovery is reinforced in his account.

Individual Male Partner 7:

P: I wouldn't say she has a role in it. … She went to the … second appointment I had with my surgeon, the first one – when he told me I had prostate cancer – he said, "Here's some information. Read up on it, make another appointment in two weeks, come back with your wife." Well, she came back, she heard all the questions but, other than that, it's pretty much like every appointment has been on my own. I'm responsible – I feel I'm responsible to educate myself and make sure that I'm, you know, taking and doing what I need to get rehabilitated.

I: Gotcha. So, like, when you meet with your urologists around the injections, that's something that you would do on your own.

…

P: Yeah, I did ask her if she was interested in going to one of those and she didn't think she needed to go. And you know what? I don't really think she needed to go either. She – I thought maybe she would just like to hear about it but no, I mean, I have to be responsible for, you know, knowing what the dosages are and doing the injections.

This male participant appoints his wife with a minor role in his penile rehabilitation. While she attended appointments, rehabilitation is primarily his responsibility and is something he is content to take the lead on. He does not describe his wife as unsupportive or uninterested and this perspective is associated with his approach to penile rehabilitation, which is as a largely individual (male) responsibility. He readily takes up the subject position of responsible and active male patient, which contributes to acceptance of his partner's minimal involvement.

***Partners as active participants*.** A number of participants position themselves as adopting a two-person approach to penile rehabilitation, with the role of partners varying from minor to more significant. For these participants, penile rehabilitation is "a partnership … something that we need to work on together" (F04).

Individual Female Partner 5:

P: He took the lead and I sort of just, you know – what we do, or how we do, you know, and that kind of thing. So at the moment we would talk about it, but there was communication going on, but as far as, you know, "We need to go find something now," I mean that's a different thing than what went on. That to me – I didn't have that sense, "Oh, we should go, we'd better go find out about this, or we need help with this." ... It felt like he was doing what he needed to be doing and that we were going forward, and that if we had questions we had people we could ask. The Cialis really helped.

This female partner designates herself a supportive partner in penile rehabilitation and describes her role as secondary to her husband's leading role. Leadership is a flexible and transferable role in the relationship. Penile rehabilitation is an area in their shared life

where it is normal and acceptable for the male partner to take the lead. This female partner defends her less active approach, and resists being positioned as a partner who does not care: “Had there been any question about his safety or life or that kind of thing, I would’ve looked into that,” she says. She adds that she took a less active role because she felt her partner was able to handle this and she didn’t want to tell him what to do. She positions their roles as partners as flexible and complimentary.

The female partner in C07 adopts the subject position of ‘supportive rehabilitation coach.’ For example, when her partner was “deflated” from a negative response to Viagra, she adopted the role of seeking out more information, consulting with a variety of people and encouraging her husband to try more options. “I just kind of have to be coaching because, you know, you have to understand [his] state of mind at the time, he was already deflated but who wants to have regrets?” She positions herself as key to her partner’s engagement in recovery, and as both a motivator and driver of rehabilitation. As he steps back, she steps up to take the lead and keep hope alive for recovery. “To me, if there’s a 50/50 chance, it’s still a 50/50 chance, and if you’re not doing anything to encourage it then it may never happen,” she says.

F01 describes herself as the catalyst for penile rehabilitation with her husband. He is ill-suited to that job given his lack of interest in sex from hormone treatment, and his lack of energy. She readily adopts the subject position of penile rehabilitation leader in the relationship: “I have the energy and I have the motivation,” she says.

Individual Male Partner 2:

I: What was [your wife’s] role in the rehabilitation process?

P: She was my sex partner … I would explain to her, I would go out and get the

information, and then I would come back and explain to her. We both know that the Cialis is not working – what I'm going to try tomorrow night is something else.

…

P: As far as doing the injections, I do that separately on my own. Part of it is just practical because I go downstairs to the fridge, and get it. So it's not part of showmanship … and also, I guess I would find that I'm more comfortable doing it on my own because I'm experimenting. I don't know exactly what to do. I've never given myself a needle before. So I'd rather relax just with myself and do it. … What it would really come down to is a discussion about it or else saying, "You know what? I'm not comfortable with the type of erections I'm getting now. I'm going to go back to the urologist and have a chat about it. I just want to make you're aware." Then when I've come back she'd say, "Well, you know, what did you learn from [the doctor]?" And then that would carry on.

The female partner plays an important and adjuvant role. There is clear demarcation between his role and her role in that he seeks information, meets with medical providers, and brings knowledge back home to his wife. Elsewhere, this participant spoke about traditional gender roles and socialization, such as the hunter (for men) and gatherer (for women) roles. Here, he is the hunter of knowledge and treatment tools. He acquires mastery of the tools and then shares his 'spoils' with his wife through discussion and experimentation. The partner is essential to the process in that she is the sexual partner and the supportive other with whom the patient can practice and play with his new tools and knowledge.

When talking about penile rehabilitation, participants generally describe having been improperly and insufficiently informed. They express that they have been 'let down' by care providers and have missed the opportunity to benefit from this intervention. They utilize biomedical terms and concepts to explain the benefits of penile rehabilitation and to express the importance of early intervention. Participants talk about monitoring the penis for signs of recovery with an emphasis on watching for increased blood flow. Most participants had tried various pro-erectile aids as part of recovery. While these tools offer the promise of normalcy, these aids are positioned as dissatisfying and disappointing. Participants also position pro-erectile aids as disrupting the 'natural' flow of sexual intimacy in the relationship. Finally, there are variable roles for partners in penile rehabilitation, ranging from peripheral to integral.

Analyses: Sexuality & Relationships

Interview transcripts were coded for material that related to sexuality and relationships. Analysis of the coded material was guided by the following questions: How is sexuality being constructed through interview data? What messages about 'healthy' and 'normal' sexuality and sexual intimacy are being conveyed? What role is sexuality positioned as playing in intimate relationships? Analyses revealed the following four discourses:

(1) **Diminishment of the Sexual Self:** Predominantly, male participants position themselves as being diminished lovers who were incapable of doing their 'job.' Incontinence is talked about as a particularly potent impediment to sexual competence and confidence.

(2) **Sequelae of Sexual Loss:** Participants frame sex as important to the well-being of their relationship, and loss of sexual intimacy in the relationship is linked to a number of other associated losses (e.g., in physical affection, emotional closeness, communication, etc.).

(3) **Desire for Desire – Wanting to Feel Desire & Be Desired** Participants speak about changes in sexual desire as a result of prostate cancer. Sexual desire is important to the relationship and to sexual intimacy. They express a desire to feel more desire and to be able to elicit desire in their partners. They want to be both desiring and desired.

(4) **Sex as Key to Relationship Health:** Sex is positioned as essential to strong and healthy relationships. Sex facilitates a number of pro-relationship functions such as closeness, warmth, and patience.

(5) **Adaptation & Experimentation**: **Expanding Sexual Practices, Pleasures, and Possibilities:** Participants describe sex after prostate cancer as expanded and enhanced. The possibilities for pleasure are multiplied as couples are forced to experiment with news ways of connecting with and pleasuring each other. Female partners in particular are described as benefitting from changes in sexual intimacy, as their enjoyment of sex takes on greater importance in the aftermath of prostate cancer treatment.

Discourse 1: Diminishment of the sexual self. Men with prostate cancer-related side effects position themselves as sexually diminished. They adopt terminology of "failing" at sex (C02, C06), having a sexual "handicap" (M01), and being "incapable of having a satisfactory relationship with a partner" (M04) and "diminished" (M07). Incontinence is a

particularly pernicious side effect of prostate cancer with "devastating" impacts on men's sexual subjectivities. With a few exceptions, prostate cancer has a dampening effect on the passion and pluck of men's sexual selves.

Individual Male Partner 1:

P: Well, I used to be an athlete. I used to be good at what I did, so that gives you an idea about my sexual relationships. [They] were always second to none and, I mean, I thought that I performed great, and once I was diagnosed with prostate cancer and I went for surgery, I probably went from a 10 to a probably minus 1 …

P: I had little injuries before that to hold me down, and the older you get, you don't play the sports you use to – I mean your body tells you when to shut down – but, I mean, sexually, I thought that I had another 20 years left in me, but it kind of turns about face when you get diagnosed. They start taking things out your body that affect your performance. There's not much you can do.

…

P: I wanna stop thinking that this whole process made me imbalanced, made me like – gave me a handicap and it's just not a good feeling.

Individual Male Partner 5

P: It was taken for granted before … sexual performance was taken for granted. A fit healthy guy 10 years ago and never second guessed, 5 years ago, 5 and a half years ago, 4 and a half years ago – completely dysfunctional.

Individual Male Partner 7:

P: I feel, I feel like I'm not playing with a full set of equipment but it's still there.

You know, so.

…

P: When I was on vacation … I fell and I landed on my shoulder and I think I got a rotator cuff issue because I can't move my arm without a lot of pain and I'm diminished right now. First when I'm driving and I feel the same way with sex.

Participants adopt various metaphors and analogies when constructing their experiences with sexual side effects. In an individual interview, a male participant (M01) adopts the subject position of injured athlete when describing the impact of prostate cancer on his sexuality. Positioning himself as someone who is used to performing at a high level, he can no longer achieve a '10-out-of-10' performance score. His sexual subjectivity has been 'handicapped' and he is both diminished and "imbalanced." Likewise, M05 describes having reduced performance, which is associated with a range of emotional experiences such as "insecurity" and "embarrassment." He also designates himself as dysfunctional following surgery and resists this subject position by throwing himself into recovery activities, like an athlete going through physiotherapy. Gaining function back comes to represent a regaining of self-esteem. He equates himself with an athlete lacking essential equipment – or rather, playing with a faulty set of equipment – and thus being unable to perform at a high level in various domains of life, including sexuality. His subjectivity is that of a "diminished" man, which is reinforced for him through various embodied experiences (e.g., a rotator cuff injury, changes in his body's sexual response). Faced with what he positions as limitations on his body (e.g., "I'm not capable of doing something like I was able to do it before"), he retreats from sexual

intimacy. He attributes the loss of sexual intimacy in his relationship with reduced sexual prowess, self-confidence, and self-esteem.

Individual Male Partner 2:

P: We all go through emotional peaks and valleys and when you're not happy with yourself, then the circle is not being completed as far as feeling good about yourself overall, and therefore you feel disconnected. So that will for sure from time to time have an effect of pulling back and pulling away, because I guess what it comes down to [is] starting something and not being able to complete it.

…

P: And I think that would be pretty close to the core of where it's coming from. I don't want to get cranked up and I don't want to start something that I can't finish.

This individual male participant also articulates a position of sexual retreat when faced with a sexual subjectivity that is diminished. Sex has an identifiable finish line and starting the race is risky if a man can't complete it. He is a lover who can't take sex where it supposed to go (e.g., "it's going nowhere"). It is safer to not to initiate sexual intimacy and to not "stir" up desires that he can't 'properly' satisfy.

Couple 7:

MP: Sometimes we could – you know, tonight we could have a great time and everything could work out really well, and we could end up with the result that we were looking for, and there would be lots of pleasure from it and so on. We could try the same time next week – and I don't know what it is and I assume it's a side effect of the disease, that [Female Partner] could stand on her head and it just wouldn't work, you know, we wouldn't get to where we wanted to get …. And not

because the two of us weren't trying – and I'm talking about from my perspective, not from hers, because she'll spend a lot of time trying to make me feel great and it may just not work. And, you know, she may end up giving up, and those are the tough nights where she feels terrible because she tried everything and I feel like "What the heck's wrong with me?"

FP: And I say to him–

MP: "Why isn't this working?" …

FP: It doesn't always happen for me.

…

MP: Well, guys aren't used to that 'cause it always happens for guys.

In this couple interview, the male partner designates his body as unreliable. His body varies in its responses to physical and mental sexual stimulation from day to day, which is positioned as upsetting and unacceptable. Sexual response for a man should be dependable, knowable, and controllable, according to this participant. While sexual satisfaction (presumably equated here with orgasm) "doesn't always happen" for the female partner, it "always happens for guys." A capricious sexual body is feminizing and this participant struggles with the implications of an unpredictable sexual subjectivity.

A number of female participants contested a sexually disabled or diminished view of their partners. For example, while her partner views himself as diminished, damaged and "failing," the female participant in C06 frames him differently: "I really don't think women see them as being any less," she says, adding, "You know, he's still going to be my partner." While she notes that her partner thinks "he's let himself down or he's done whatever. I know he's never let me down."

Incontinence. Incontinence is an especially difficult barrier to overcome when trying to reestablish and rehabilitate sexual intimacy. Participants describe it as abnormal, embarrassing, and distressing. It is particularly debilitating because it signifies that men are out of control of their bodies. Their bodily systems are failing to regulate – there is too little blood flow and too much urine flow to and through the penis. Men resist an infantilizing and emasculating sexual subjectivity as they learn how to manage and attend to the limitations of a post prostate cancer bladder.

Individual Male Partner 1:

P: Well, there's other things that go on about sexual activity after prostate cancer too, because you've got to worry about your leakage right? …

…

P: That [incontinence] bothers me! That bothers me mentally.

…

P: Well, I worry about that [incontinence] happening.

…

P: Yeah! And that turns me off too, because I wouldn't like it [incontinence] happening to me. I mean–

…

P: It's not a normal procedure, and I know there's nothing normal about prostate cancer but, like, it's just something hard to digest.

…

P: And it doesn't happen all the time. You don't know when it's going to happen. You try to urinate as much as you can before you perform, but there's always that chance of drippage, right?

Couple 7:

MP: I have a very distinct memory of the first time we were going to try Viagra and I leaked all over the bed. It was just humiliating, absolutely humiliating and that was the end of the night for us, well for me it was – [Female Partner] was great with it.

FP: I wasn't humiliated, I wasn't–

MP: But–

FP: I just felt sad that he was upset.

MP: …So not only do you have this ED problem but … the very first time you're going to try to be intimate, you're peeing all over the place and you can't stop it, you know?

Incontinence is abnormal and bothersome. M01 can't count on his bladder and the unpredictability of (in)continence is "hard to digest." This dampens his sexual passion and erects a barrier to sexual intimacy. Likewise, incontinence is humiliating to the male partner in C07. Elsewhere in his interview, he describes the loss of bladder control as worse than loss of control of his erections. When trying to explain this to a surprised pelvic floor physiotherapist, he recalls saying, "Wait till you're trying to be intimate and you pee all over the bed." Being unable to control or stop himself from "peeing all over the place" in the context of a sexual experience forecloses the possibility for sexual intimacy. The presence of urine ends the sexual encounter. While his partner categorizes

incontinence as inconsequential – "It's just pee, I don't care" – he and many other male participants do not share this perspective.

The male partner in C05 says, "Well, if I suddenly squirt at the wrong time it's going to ruin the mood." He and a number of other men approach incontinence as something to judiciously prevent, strategically manage, and work hard to overcome. For example, C05 adopts proactivity and aggressive intervention. He is engaged in pelvic floor physiotherapy and does kegel exercises religiously. He resists the subject position of incontinent patient by exercising as much control as he can. He approaches continence as something that is within his control and as something that can be achieved through diligent practice.

Like the male partner in C05, participants adopt various strategies to minimize the impact of incontinence on their sexual subjectivities. M03, M08, and M01 speak about emptying their bladder as much as possible before becoming sexually intimate. Men position this as a helpful but ultimately imperfect coping strategy. While voiding "as completely as I can" helps, leakage still occurs (M01).

Incontinence is triggered by sexual stimulation, which men position as "not very nice at all," because, "one doesn't want to pee on their partner" (M03). Sexual attention and penile stimulation, which were once desirable, come to signify potential embarrassment. Experiences that were once characterized by pleasure and positivity are tainted. "Whereas you may – in the past, you would have had an orgasm – here, you are having a little burst of urine," says M08. Likewise, the male partner in C02 reports incontinence during and after orgasm. The pairing of orgasm and leakage is upsetting: "It really bothered me how much," he says. What used to be a carefully timed and controlled

burst of semen at orgasm is replaced by an uncontrolled and unwanted stream of urine. Ejaculate – a marker of potency, virility, and masculinity – is replaced by "pee" – a sign of weakness, sterility, and vulnerability.

Incontinence disrupts sexual flow and pleasure. M04 recalls being sexually intimate after surgery and "having to stop three times during the attempt to empty the condom." He positions his incontinence as the key factor in the loss of sexual intimacy in his marriage: "[My wife] made it clear in that, that – because of the incontinence – that [sex] wasn't, it wasn't a subject that she cared to discuss … [her] fear … of the incontinence just really turned her off about the whole subject," he says. Incontinence forecloses access to the subject positions of desirable and functional lover. M04 associates incontinence with being "incapable of having a satisfactory relationship with a partner … peeing all over the place isn't necessarily a precursor to the beginning of a good sexual relationship."

Individual Male Partner 6:

P: Well, I mean I guess it typically – we haven't really had sex in bed because of the incontinence issue, right? … Typically, people have sex in bed. And … it's not particularly something we can do.

…

P: It's a little torturous I guess you'd have to say, right? It's a bit of a source of disconnect in terms of, you know – like, there's one ailment after surgery that doesn't work, you know, you can't have a feasible erection – but then there's a whole other. What happens then? … And it's just new territory, it really is.

The location where incontinence occurs is important. Incontinence has cost him, and other participants, access to normal 'bedroom' sex. While certain fluids (e.g., semen) may have been acceptable in the bedroom, leaking urine is not. Sex is 'disconnected' from former familiar anchors (e.g., being in the bedroom and having an erection). Incontinence is an added loss for this participant, compounding the difficulties adjusting to erectile changes. He is in "new territory," both psychologically but also physically (e.g., not in the bedroom). Elsewhere in his interview, this participant mentions that he and his wife have sex in the shower as a precaution against incontinence. Leakage in the bathroom is deemed more tolerable than in the bedroom. However, being restricted to having sex in the shower is unsatisfactory for him because he can't also have sex in the bedroom. Sex in the shower, which has the potential to be a marker of an exciting and creative sexual relationship (e.g., a sign of many different places where sex can happen), instead signifies constraint (e.g., a sign of the most important place where sex cannot happen). Sex in the shower comes to be associated with a lack of control and autonomy, and a limiting of choices.

In an individual interview (where her partner, M06, also participated as an individual), F04 provides her own perspective on moving sex into the shower after an incontinence accident. "In the back of my head it was like, 'I can't do this in bed,' and I still feel this way now … You know, my concern is in the bed – because he leaks urine … Like, it absolutely does not bother me in the least in the shower but in the bed, yes," she says. This change is thought to be a loss for her partner, who she says misses having sex in the bedroom.

***Positive coping with incontinence*.** While incontinence is an especially challenging side effect to navigate in the context of sexuality, some participants' narratives contained instances of creativity, acceptance, and humour.

Couple 2:

FP: *Yeah, I think if I was really upset about it, I'd have to get past it, like – I'm thinking, "This is urine," 'cause all of a sudden, I'd feel it was hot, then – and, you know, right after an orgasm I say to him, "I am very wet," and he says, "Yeah, I know. I realize that now." We just had to get past it.*

The female partner in C02 describes urine as 'no big deal.' Incontinence is something "we just had to get past" and she situates herself in the narrative as an accepting and accommodating partner. Being "hot" and "very wet" in the context of sex are typically markers of passionate sexual play and signs of pleasure. Here, they are potential barriers to sexual intimacy and something to "get past." Urine has the potential to disrupt sexual intimacy, but this partner positions it as a shared challenge. Together, they have reconfigured some of the negative meanings associated with incontinence. For example, to minimize accidents, the male partner tries "to void as much as I can before intercourse," he says. Because of their open bathroom door policy as a couple, the male partner's pre-intercourse urination has become a signal for sex. "So I mean, you know, he's sitting on the toilet saying, 'I'm trying to drain it. I'm trying to drain it. I'm trying to drain it.' I'm there thinking, 'Now we're going to have sex' [laughs]," the female partner says.

Couple 3:

MP: *If I can possibly put it this way, it was a normal part of the recuperation. I was told this was going to happen – "You're going to be wearing depends or whatever for a certain amount of time." So we just accepted that that's what's going to happen and if a little accident happens here and there, then that's the way it is.*

…

FP: *Yeah, I knew that he would leak a little bit at times and that's what it was – and it's nothing to worry about. We can get back to what we're doing.*

Couple 6:

FP: There's been bladder issues where at times he couldn't even throw a ball … you know, without peeing and he may say, "I'm so embarrassed" and I would say, "Well great, we'll age together. 'Cause, I mean, I'm peeing out – "There's a clean up in aisle six at the grocery store!"

…

FP: He threw a snowball at me the other night and had to run for the bathroom fast – and I just chuckled the whole time.

For some couples, like C03, incontinence is an expected and normal part of prostate cancer recovery and of aging more generally. C03 expresses that adopting this perspective set them up well to cope and minimizes the perceived impacts on sexual intimacy. Incontinence is inevitable and "the way it is." To fight against this side effect is to fight against the body's recovery process. They adopt acceptance and grace as strategies. They situate incontinence within a natural aging process and position it as

something that happens to many people eventually: “It’s all part of it … that’s life,” says the male partner.

The female partner in C06 likewise positions incontinence as a normal and natural part of aging. To live long enough is to experience incontinence, according to her account. She sees incontinence as a shared experience that facilitates closeness in the relationship: “Well great, we’ll age together.” Incontinence is something to laugh and commiserate about conjointly, rather than a burden to be endured privately. She describes their relationship as lighthearted and flirtatious, and adopts the subject position of cheerful, frisky, and playful partner in the face of this side effect. She produces the following narrative of discovering her partner’s incontinence pads for the first time: “We were … in bed and I put my hand down there to kind of start something and I went ‘Oh!’ Like, “I’ve never dated someone wearing a pad before” [laughs] … It just caught me off guard. It didn’t really freak me out or anything but, yeah, it threw me for a second.” For this participant, incontinence is associated with momentary readjustment and then continuance of closeness and affection.

Discourse 2: Sequelae of sexual loss. Participants attribute a number of associated casualties to the loss or reduction of sexual intimacy in their relationships. Sex plays a key role in the relationship, and facilitates a number of pro-relationship experiences, behaviours, and feelings. Thus, participants couple the cessation of sex with the reduction of a number of other behaviours and experiences such as non-sexual physical closeness (e.g., holding hands, cuddling, hugging), intimate conversations, and a general sense of adhesion in the relationship. These losses, or many “deaths” (F01), are experienced as painful aftershocks in the prostate cancer experience.

Individual Female Partner 1:

P: For me, it's really hard that my husband doesn't see me the same way that he used to see me. And I don't mean externally … we love each other deeply but you lose, I guess it's the intimacy – although intimacy is not just sex, you know, it isn't just intercourse. Intimacy is way bigger than that. And I think what I've lost, it's the hunter and the hunted, right?

…

P: We shared the bed before. For numerous reasons we don't. One, because I snore. Two, because post treatment I was up quite a bit in the night and so we were just constantly disturbing each other. And I talked to my doctor about that and she said, "Have you thought of having a separate bedroom?" And I thought, "I can't do this – we have already lost so much." … But inevitably we had to because just neither of us were sleeping. … It's funny, I was talking to somebody about it recently because they have just got separate bedrooms and she said, "How did that feel to you? And I said, "It felt like another death." You know it seems like honestly stripping away of what you had. And little by little there's a little strip here and a little strip there … Even 10 years later, I mean it can evoke a lot of strong emotion in me. Just the whole, the whole process and what I feel we've lost.

This female partner describes the many losses and "deaths" she experiences as a result of prostate cancer treatment. Her husband is currently receiving hormone therapy, which is charged with eliminating his interest in sex. The loss of sex is linked to a number of other intimate losses. Sleeping in separate bedrooms is experienced as "another death."

Closeness in the relationship is predicated, at least in part, upon physical togetherness, and challenges with sexual intimacy – compounded by separate sleeping quarters – threatens this partner's sense of unity with her husband. She adopts the position of grieving spouse, lamenting the various ways in which she and her husband once enjoyed a playful and robust sense of sexual desire, attraction, and closeness.

Individual Female Partner 2:

P: Sex is more than an act in bed. Sex is, you know, it's the cuddling afterwards it's the talk afterwards, it's the – you know what I mean? It's the communication afterwards. It's the place where discussions happened and sometimes major things got decided in a household. We don't have that anymore.

…

P: Because, as you've pointed out, it's so much more than just an act. It's the intimacy. It's the – you know. We used to walk down the street. We used to hold hands and giggle. You lose that. You lose the intimacy, not just in the bedroom but you lose it outside of the bedroom too … When I lost my mum – my mum passed … and we didn't have the intimacy, the closeness that, that I think should have been there.

F02 frames her marriage as containing a growing void that sexual intimacy used to fill. Loss of sex is associated with the loss of many other desirable relationship activities like cuddling, open communication and closeness, and collective decision-making. Elsewhere in her individual interview, this female partner situates her partner on the far side of a growing chasm between them and attributes this distance to his ongoing evasion and retreat from physical intimacy. She blames her husband for the changes in their

closeness and positions herself as frustrated throughout her interview. This allows her to avoid a hurt, rejected, and resigned subject position. For example, she describes him pulling away when she embraces him and says she is "so sick and tired of him pulling away from me." In addition, this female partner positions her husband as "more like my brother than my husband and my lover … it's more like we're in a friendship relationship now than we're in a marriage relationship." Sex organizes relationship taxonomies. Without sex and the accompanying practices, her marriage is not recognizable and cannot be differentiated from other familiar bonds and alliances. She resists the subject position of desire-less, non-sexual wife by emphasizing her appetite for sex and desire for her husband. She imagines saying to him, "Go take a shot [penile injection] and get in here and fucking fuck me."

Couple 1:

MP: We don't have the physical intimacy and I think that that's a big part of any kind of a relationship. We both miss that and I think, you know, it does impact us to some degree for sure.

…

FP: I feel the same as [Male Partner]. It does affect that closeness to a point because like I said, that was – a big part of your closeness was the sexual aspect and it does affect it to a point.

While this couple is situated as close and loving and as sharing many interests, pleasures, and joys in life, they express that they have lost significant closeness now that they are no longer sexually intimate. The male partner is undergoing hormone therapy and this is inculpated for his lost interest in and desire for sex. Later in the interview, the male

partner describes them as less physically close now that they are not as sexually close. For example, he says, "When we went to bed we cuddled – [we] don't even do that anymore. We kind of like have our own side of the bed and that's it." He contextualizes their current physical detachment within a remembered past when they would draw together like magnets in bed.

Individual Male Partner 4:

P: There is none. We just learned to live without it. Well, I shouldn't say learn because I'm very frustrated because there is no intimacy whatsoever. There is no touching and I'm a touchy kind of a guy. I like to touch her, squeeze her ear, pat her on the bum or something and we haven't done any of that for over two years now because I don't sense that she relates to it at all. Very frustrating.

…

P: I'm trying to think whether or not she was the initiator of it? I'm having a tough time answering yes to this but, well, there was a time in our lives where she would come over to my side of the bed and bring her pillow and we would just lay there before we got up in the morning. That was kind of nice. But that doesn't happen anymore.

This individual male participant describes a growing separation and disengagement in his marriage, which he associates with the cessation of sex. Sex provided "a necessary adhesive" in the relationship that is dissolving. The relationship lacks warmth and closeness in the absence of sexual intimacy and he juxtaposes his dissatisfaction and longing for closeness with his wife's disinterest in physical or sexual affection. Elsewhere in his interview he says he wishes she would express a need for "at

least cuddling … [but] that doesn't appear to be there." He describes his wife and him as being physically estranged and she is ascribed an otherness since prostate cancer treatment and the cessation of sexual intimacy. He supposes that she does not *relate* to physical touch from him anymore, and that his attempts to touch her would be unwelcome. He is tentative and uncertain around his wife; formerly familiar behaviours like a pat on the bum or squeeze of the ear are suppressed in the present. These hesitations and gaps in communication threaten the integrity of the relationship.

Discourse 3: Desire for desire – wanting to feel desire & be desired.

Participants articulate a desire for desire. Sexual desire is described as a reciprocal feedback loop between partners. It is a relational construct that is either increased or depleted depending on feedback from one's partner. Thus, participants become both desired and desiring subjects within the relationship context. Participants on hormone therapy contextualize their loss of sexual desire in biomedical terms; treatment is charged with wiping out their sexual appetite and they express wanting to re-experience sexual hunger. Likewise, a number of female participants are specified as lacking desire because of menopause. In addition, low or no desire in female partners is identified as a 'roadblock' for 'healthy' and 'normal' sexual expression in relationships.

***The desire to feel desire*.**

Couple 1:

MP: Well, I think the big part of it is the treatment itself really impacted me physically, simply because the treatment they'd given me destroys testosterone.

…

MP: So in that respect it's like taking the gasoline out of the gas tank.

…

MP: It was pretty quick. It wasn't – like, after the operation, there was a time of physical healing and then after that there was an attempt to try to regain some of that sexual activity. … it was pretty quick, I mean it just faded. It impacted even the way I feel about sex, like I don't have the normal desire that a man does.

…

MP: It's getting to the point where I don't even think about it and even if I do, it means nothing. Like I don't have any feelings for it. … Well, I remember when I was sexually active, when I thought about sex it affected me. Today if I think about sex, it has no meaning to me. I don't feel anything.

I: Interesting. And when you say you don't feel anything, do you mean in your body? Do you mean also emotionally?

MP: Both.

…

FP: I don't even really have the desire anymore because once I just accepted that we can't have it, I don't think about it.

Hormone therapy has starved this male partner's sexual desire to death. There is no fuel to turn over the engine of his sexual interest or passion. When called upon to rev up, the engine of his desire is nonresponsive. Sex has come to mean "nothing," in that his body-engine does not respond to sexual cues. The subject positions of sexual man and lover are no longer available to him. He articulates that a 'normal' male sexual subjectivity is likewise inaccessible to him ("I don't have the normal desire that a man does"). There are tensions in the female partner's account of the loss of sexual intimacy in

the marriage. She positions herself as having accepted the changes and as having adapted to them both physically and mentally (e.g., "I don't even really have the desire anymore because once I just accepted that we can't have it, I don't think about it"). Elsewhere in her interview she states that she has come to "accept it and deal with it," yet she also frames the changes as "difficult at first" and as requiring her to alter/down-regulate her own sexual subjectivity. She has calibrated her level of sexual desire to match her husband's and positions this as an adaptive response to the impact of hormone therapy on her partner and relationship. Her desire is yoked to her partner's desire, and their mutual downshifting of desire mitigates conflict around discrepancies in sexual needs and wants.

Several participants designate menopause as the cause of reduced or lost sexual desire in female partners. This is distressing to both female partners experiencing the loss of desire and to male partners witnessing the loss of desire in their partners.

Couple 4:

FP: Nothing is working right now and that's because of the surgery. But to be honest and fair, since menopause, my sexuality is gone down the tubes so I'm not bothered by it. He's probably more bothered than I am.

…

MP: I'm bothered but more for the emotional side of it than the pure physical.

…

MP: When we're sexually active, the act of pleasing [Female Partner] was actually more important to me than my physical satisfaction. So that part of it is gone away.

…

I: Do you ever have sex and just please [Female Partner] now that the erections – right now – are not possible? Is that something that you guys ever do or have talked about doing?

MP: Well we've talked about it but … her libido is so close to zero.

FP: He's offered but I've never taken him up on it.

…

FP: He's always been that way so, you know, he didn't really need to tell me, because I knew that that's how it would be. But I said, "You don't have to offer because you know it's not bothering me," and I think that bothers him that it's not bothering me.

…

MP: It bothers me that pre-menopause, our sexuality was pretty good and she would initiate it and I would initiate it, and it bothers me that something that gave her so much pleasure before the menopause has no interest at the moment.

…

MP: But I – because of her lack of libido then it's–

FP: Awful, so much – like, there's a time when you thought, "I would never, ever not want sex" you know?

MP: I just find it very, to me, difficult to understand her lack of desire for something she really enjoyed previously. And I can't fathom that, but I can accept it.

The female partner expresses minimal interest in sex, which both members of the couple attribute to the onset of menopause. Sexuality has "gone down the tubes" (female

partner) since menopause. Desire is appetitive and her once robust sexual hunger has been suppressed. Menopause is targeted with holding her sexuality hostage but also with disrupting his sexuality. His wife's sexual indifference is bothersome to the male partner because it disrupts his ability to adopt the subject position of generous and skilled sexual partner. He previously enjoyed providing sexual pleasure to his wife; his pleasure came from eliciting her pleasure. His sexual satisfaction is framed as being as equally elusive as her sexual desire. This is a difficult change for him to understand. Rationally he *gets* it – he tells himself that menopause is the culprit for her loss of desire – but on the other hand, he cannot *know it* or *understand it* more fully. It is "difficult to understand" and he "can't fathom" her lack of interest in sex.

Individual Female Partner 5:

P: My major concern is "Oh, the desire is gone. Where, how am I going to get that back if I can't take the hormones?"

…

P: So if anybody needs help, it's me – yeah.

This female partner expresses concern about her own drop in sexual desire, which she links to menopause and hormone changes. She desires to desire again and her drop in sexual desire is a "major concern" and more of a problem for sexual intimacy in her marriage than the side effects of surgery. She says she "needs help"; however, she is unsure how to fix what is positioned as a biological problem because she can't take hormones. She worries about her present state of desire and wonders, "how am I going to get that back?"

Individual Male Partner 6:

P: I think there's been a drop in libido right? I think the Avodart, taking that, it's one of the side effects. … I think that, you know, the libido from my wife's side of things, like menopause, has a definite effect.

…

P: You could almost get used to not doing it as much as doing it.

Individual Male Partner 7:

P: I think she feels a little bit guilty that her desire is diminished because one, you know, the stage of her life right now and two, because I think she feels like she should give more.

These male participants express desire for their female partners to experience increased sexual desire. Both men position menopause as a roadblock to sexual intimacy in their relationships. Menopause is designated with having "a definite effect" on "libido" (M06). This "stage" is seen as responsible for diminishment of sexual desire and declining sexual intimacy. Menopause impedes the subject position of giving and engaged lover in women. Women's inability to adopt a desiring sexual subjectivity is associated with guilt.

***The desire to elicit desire*.** Participants prize being able to elicit a state of desire in their partner. Being appraised as sexually desirable is seen as an important component of 'healthy' and 'normal' sexuality.

Individual Female Partner 1:

P: For me, it's really hard that my husband doesn't see me the same way that he used to see me. And I don't mean externally … we love each other deeply but you

lose, I guess it's the intimacy – although intimacy is not just sex, you know, it isn't just intercourse. Intimacy is way bigger than that. And I think what I've lost, it's the hunter and the hunted, right?

…

P: I mean, I could walk naked through the room and it was like, "Ho hum." I found that really devastating … It was huge for me. We'd always enjoyed a wonderful intimacy in our marriage and so to lose that, that was really traumatic, really quite devastating.

This female partner articulates a profound sense of loss in the context of her husband's loss of interest in sex. The ability to elicit desire in him was a source of pleasure, play, and validation that she valued. Sexual desire is experienced as an individual and isolated rather than entangled and dyadic state of being. The subject position of desirable woman/sexual prey is no longer accessible to her now that the subject position of sexual hunter has been eliminated for her husband. Elsewhere in the interview, this participant describes these changes as "a death" for her. Being able to evoke sexual desire in her partner is an anchor for her own sexual subjectivity. His non-response initially made her ask herself, "Like, is there something lacking in me now that I can't turn him on … does it have anything to do with me, am I less sexy?" she says.

Individual Female Partner 4:

P: I need conformation, affirmation that I am still desirable. So I guess with the lack of libido, with the pair of us, that I'm not getting that feeling, that sense … we

could be brother and sister living in the same house. You know, we're very close – we can talk about anything – but there's that lacking that really, you know, that connection that we used to have when we were first lovers. I miss it, I really do miss it.

…

P: And I think maybe the hormones don't work the way they did when you're younger. And you don't look the way that you did when you were younger, but I think your mind still remembers how it felt. That hasn't gone – I still have a vivid imagination, memory, you know, and I think, I think about things all the time and I think that's, you know, that part has not switched off.

…

I: And when you say you remember how it felt, do you mean sexual intimacy? Is that what you're talking about?

P: I just – the whole thing when you're in love and everything is just–

I: Desire and tingles and–

P: The tingles – I miss the tingles. Yeah, just that, you know, electricity that you feel and, you know, I miss that, yeah for sure.

F04 likewise constructs a narrative of loss; she misses feeling desired and wanted by her husband. She says, "I think I wanted to feel wanted. That to me was more important, that he wanted me. And I guess now the difference is I don't feel wanted." She finds her husband as physically attractive and sexually desirable, and as able to elicit sexual desire in her. His lack of interest in sex is experienced as a reflection of her sexual shortcomings. Her inability to elicit his sexual desire disrupts her identity as a desirable

sexual subject. Elsewhere in the interview, she describes a history of sexual intimacy in her marriage where sexual pleasure was not abundant for her and she had sex more to accommodate her partner's needs and to enhance the relationship. Yet, she also constructs a past that contained "tingles" of desire, sexual "electricity," and being "in love." The memory of these embodied experiences of love and sexuality haunt her in the present. And while she finds her husband sexually desirable and expresses that she desires sexual intimacy with him, she finds herself avoiding sex. More than wanting to have sex, she wants to feel wanted and wants to feel the ecstasy of being in love.

In a couple interview, C02 likewise attributes changes in the male partner's erections (difficulty getting them) with the female partner's belief that she was less sexually desirable to her partner: "After a while she took the lack of an erection as disinterest," the male partner says. The male partner's inability to get erections was interpreted as failure of his wife's ability to 'turn him on.' The female partner says that she would have to remind herself, "This is the surgery. This isn't you. This is the surgery," to reduce the negative impact on her sexual confidence. Desire is an interaction between the two partners with each having a job to do – either to elicit desire or to reflect back another's desirability. Validation, reinforcement, and communication are key for this couple to navigate disruptions in their sexual intimacy, and to minimize the negative impacts on sexual desire.

Couple 3:

FP: Trying to get him through the surgery – that took a couple of months, and then we were looking at a doctor's visit some time next January, February and

we'd say to the doctor, "We'd like to try sex now because we've kind of been fooling around like, in like, heavy petting and all that kind of stuff' you know? And [Male Partner] I think just wanted to keep me feeling like I was still wanted as a woman too. 'Cause you know you're dealing with that too, you know? You [don't] want to be turned off to sex attraction like, "I'm not interested in this anymore" or, you know, "This is off the table," but you still want to keep it in the background, but "We'll get at it when we can" type thing.

MP: That was difficult for [Female Partner] because like she was saying earlier, we don't know how – if you put a little pressure on, maybe it's too much pressure and if you say "Well, that's okay we won't bother with that now," maybe I'll take it the wrong way and feel like she's not interested in me anymore. So it's a very–

FP: Delicate balance.

MP: A very delicate balance.

…

FP: *Yeah, like even when he was having his recovery time from the surgery, he made sure that I still felt desired. He would do things for me, you know, manually or whatever, and just touch me and make me feel that, you know, I was still the most important thing in his life in many ways.*

Sexual intimacy is a "delicate balance" between not putting too much pressure on one's partner to have sex and indicating too little interest in sex and thus making one's partner feel undesired. The female partner notes that her husband "just wanted to keep me feeling like I was still wanted as a woman too." And her partner notes that too little expression of sexual desire risked making him feel "like she's not interested in me

anymore." They frame mutual expressions of wanting and desiring as important aspects of their relationship during recovery from surgery. The female partner notes that her husband "made sure that I still felt desired."

Individual Male Partner 6:

P: From my wife's point, I believe it's related to the desire to feel desirable. Not so much sexual craving and I suppose I felt a little bit, I felt – I guess my sexual drive is based on a reciprocal situation, so it's really complicated.

I: So she felt that you didn't desire her?

P: I think so, yeah.

I: And that was hard on her?

P: Mhhm, yeah.

I: And that was hard on you? That being hard on her was hard on you as well.

P: Yep, yep, yep.

…

P: Well, I think she was aware of – at the time, and sexual frequency, and desire and therefore, you know, I guess she sort of deduced that it was because I didn't desire her, I didn't find her sexually attractive and that's why it declined.

…

P: I think that's one of the things that has an impact for sure, because I said before that she desires the closeness and feels the lack of desirability, but the actual sexual attraction seems to be not there as much.

…

I: I want to repeat it to make sure that I understand it. You feel that your wife

misses the closeness, and misses the feeling of being desired–

P: Yes, yes.

I: But that she does not desire you–

P: In a sexual way.

I: In a sexual way. Yeah, she desires emotional closeness, she loves you. But you're not feeling sexually desired by her.

P: Yeah. Because I try to do things that would evoke a response and when I don't get a response I, you know, because both – my sexuality is based on getting the feeling that you are stimulating the other person you know? So–

I: Right, I mean you used the word reciprocal.

…

P: Like, I'm sexually stimulating my wife, that feedback is something that I might desire you know? So, like, when it doesn't happen, there's a bit of a disconnect there you know.

This male participant anchors sexual desire in the relational context. Desire is a reciprocal and dynamic construct; his desire dependent upon his wife's desire and vice versa. The slight drop in his desire following hormone therapy is attributed with a reduction in his wife's desire – the explanation is that she felt less desirable, which then impacted and further reduced his own desire – he felt that he was upsetting his wife. "I guess my sexual drive is based on a reciprocal situation so it's really complicated," he says. There is a "disconnect" in the sensitive feedback loop and desire is not receiving sufficient input or energy. This participant's attempts to sexually stimulate his wife are not resulting in the desired response. While she desires emotional closeness, he wants her

to desire him, and he wants to be able to stimulate her sexual desire for him. In this and other accounts, the specifics of desire matter.

Discourse 4: Sex as key to relationship health. Sex is positioned as being key to a healthy and functioning relationship. It performs important pro-relationship functions such as providing cohesiveness, emotional intimacy, "warmness" (FP1), and "closeness" (FP1). Sexual intimacy provides suppleness and resilience to relationships. In addition, sex is a bridge between partners' physical and emotional selves. They are able to come together physically and psychically through sex.

Couple 4:

FP: I think I'm much more conscious of not letting that part of our lives slip. Like I think that before the diagnosis, we could take sex for granted. Now I think we're much more intentional about being together and having a satisfying experience.

I: And why is that so important to you?

FP: Because I think that it develops a really strong relationship.

MP: And it's always been part of it.

…

FP: I think we have a really strong relationship. And sexuality has always been an important part of it, but there's this deeper emotional stuff that I don't know if I've got words for that … when I get in touch with it, it matters. We don't – this sounds funny in a way – but like, you know, we can reflect after about how good that is and still remember, like even a day later we will still refer back to that, so like the connectedness – and I think that matters to us. It does matter to us.

Individual Female Partner 1:

P: There's something about having sex. And every time we have sex I realize – I didn't know where you were coming from religiously, but the bible talks about one flesh that, you know, a man and a woman will come together and will become of one flesh, and to me there's a warmness that happens and a closeness that happens when we've had sex and it lingers. Okay? Just like right at the moment, it lingers, for me anyway. But I think for both of us – and I think we've commented on this – it just, it is that warmness, I mean you feel more of a warmness and a closeness. So I'm not willing to give that up at this point in time.

…

P: … that feeling of warmness that you gain through that intimacy it's, for me, pretty huge. Sometimes when you kind of feel like you're drifting apart, just to be like that is fantastic.

Sex is a conduit to a deep reservoir of emotional connection that eludes precise verbal articulation and that infuses the relationship with strength. Sex provides lingering pro-relationship benefits such as warmth and closeness and facilitates a coming together between partners where two separate bodies become one communal body. This generates a warmth and closeness that can't be approximated in any other way. Sex is also specified as an anchor that fastens partners to each other. When partners begin drifting away from each other, sex bridges this gap. The positive relational aftereffects and affects linger long after the act of having sex has ended. Partners are able to talk about, refer to, and enjoy the residual derivatives.

Couple 7:

MP: There is this fear that your spouse is going to pull away from you because you're not going to be able to be a participant in the relationship. And this one here never did – ever.

…

MP: … we had such a really good intimate life. I mean, you know, we just really did enjoy each other's company. And we bought a hot tub because it was a fun place to be, and we went on great little romantic trips together, and we did all this stuff. It was just such an important part of our life together – I just thought, "Holy, it's over."

Individual Male Partner 4:

P: Let me just babble on here about why it is important. Well first of all, a couple are brought together not because so much one opens the door for the other, but because there is a significant level of anticipation of sex and the subsequent gratification that it brings. And as you go on, it's not a new thing anymore, it's a thing that just, like, you have to have three meals a day – this is probably the worst analogy I could make – but it is just an expected part of an ongoing healthy relationship, and when that seems to wane, so does the strength of the relationship between the two – at least in my mind. Maybe not in hers, because she's busy doing so many other things. I've reached retirement and I have some volunteer things too, but I certainly have time to think about that subject, and in order to further progress in our relationship that way requires other things. But I don't do other things if I don't sense that there is a need on her part. As a result, the whole relationship seems to be missing something that I think is a necessary adhesive to

a strong relationship. Our relationship … is just that we said we would live together and so we're doing it – she does the laundry and I do the vacuuming.

Sex is a requirement for participation in a relationship and a sexually functional body is necessary for a functioning relationship. Sex is the adhesive that holds the relationship together and keeps partners connected. Without sexual intimacy, partners may pull away or not be drawn together. Sex is appointed with the task of bringing two people together in a mutually gratifying and bonding activity. Numerous couple activities and experiences are marked as revolving around sex for these two male participants (e.g., using a hot tub, romantic getaways, doing "other things"). Without sexual intimacy, relationships are subject to weakening. M04 expresses that his marriage has lost an important ingredient. His relationship is framed as an agreement between two people who have decided to "live together" and share the daily tasks of living together. The pragmatics and logistics of their lives (e.g., "she does the laundry and I do the vacuuming") binds them together even as they have lost some other essential "adhesive" that sexual intimacy used to provide. Thus, sex is an important marker of romantic/marriage partnerships. Without sex, a couple becomes indistinguishable from housemates, siblings, or close friends.

Individual Female Partner 4:

P: I don't know, it's part of the aging process but both of us are less interested, both of us have other focuses. And, you know, I watched programs on TV and there was one, and it's really had the biggest impact on me… they send couples or they told couples they couldn't have sex. I think the period was for a month, no touching, no kissing, and they studied the impact this had on the relationship and

then they put them in a hotel for a night and, you know, studied the results of the relationship … How it had changed and what happened to these people, and I will never forget it because it really had a terrible, negative impact on the couples. They were irritable … the tolerance – it was just, you should look into it… I don't know how old it was, but it's always been in the back of my head, that sometimes I blame – maybe the relationship is not as good as it could be because we don't have that intimacy. If it's been 6 months can you imagine, you know. It's obviously not healthy.

…

P: I think our roles are reversed there – totally – because for me, I would maybe guess I would have three, four orgasms in a year – over 35 years that's not a lot. So mostly, it was just the closeness more than anything else. And it's not that [Male Partner] never asked because I'd go "No. No. No. I'm, you know, I'm not, I'm good. I'm good as long as you're happy and we're close," you know. I like the connection, the closeness, and I think I wanted to feel wanted.

Sex is an emotional emollient in the relationship and is important for a working partnership. Sex brings "closeness" and "intimacy" to this female participant's marriage. The benefits of sex are emotional and relational rather than physical (e.g., orgasms, sexual pleasure) for her. A relationship with minimal sex is positioned as deficient and vulnerable to disruption and decay (e.g., poor health). Drawing upon a television show in which couples were forbidden to have any physical/sexual touch for a month and demonstrated negative relationship effects, this female partner diagnoses her relationship as "obviously not healthy" because she and her husband have not had sex in 6 months.

Regular dosing of sexual intimacy is thus seen as protective and required for a well-functioning marriage. There is no space here for healthy, functioning, and intimate relationships that are sexless or sex-light. Sex is non-negotiable for a sound relationship.

Discourse 5: Adaptation and experimentation – expanding sexual practices, pleasures, and possibilities. A number of participants talk about the sexual adaptation that prostate cancer necessitates. They position the post-treatment period as a time of experimentation as they explore new ways of connecting, eliciting arousal, and of giving and receiving sexual pleasure. Many participants position the 'new sexual normal' as enhanced, expanded, and superior to the past. They report discovering new things about their bodies and about each other. A number of female participants, in particular, are positioned as more sexually satisfied in the present than they were pre prostate cancer. This is associated with the increased sexual attentiveness paid to them by their male partners.

***Expansion of couples' sexual repertoires*.** Rather than positioning themselves as sexually diminished, a number of participants classify their sexual intimacy as enhanced, enriched, and expanded following prostate cancer. Change in sexual function is earmarked as the instigator of frank dialogue about sex, and exploration of new ways to feel pleasure and reach orgasm. These participants characterize the post-treatment phase as one of sexual learning and growth; the pathways to sexual pleasure and satisfaction are multiplied rather than reduced.

In their couple interview, both partners of C02 describe experimenting and trying to adapt their sexual intimacy when erections and intercourse were disrupted. Unable to continue with their habitual ways of having sex, the female partner says, "*we kept still*

trying to do vaginal sex, like, but then we would do oral, we would do body [stimulation] we would do trying anything." The expanded repertoire of "oral" sex and "body stimulation" is described as getting "back to some of the original stuff" that the couple enjoyed when they were first married and "did lots of different things." The post-treatment phase is likened to the experimental sexual stage early in the relationship when lots of things are possible. Prostate cancer is the instigator of this recent period of sexual enterprise. By disrupting the sexual status quo, prostate cancer opens the door for new and different forms of sexual expression. Prostate cancer made them "realize that we could go back to doing a bunch of different things … I guess we experimented quite a bit then," she says. Expansion of sexual practices and forms of pleasure is made possible by the disruption of cancer. Cancer made them "realize" that sex was open for (re)negotiation. As part of their exploration, the couple discovered that a man can have an orgasm without an erection. The male partner says, "I didn't think it was possible … that was big news for me, so I thought' 'Okay, so life's not completely over'." In this couple's narrative, prostate cancer creates possibilities for new discoveries and capabilities. The discovery that orgasms, ejaculation, and erections – while often co-occurring – are not co-dependent is surprising to several other participants. For example, the female partner in C07 states, "I didn't even know that you could actually have an orgasm without having ejaculation or, like, [an] … erection."

Couple 3:

FP: … we found when we took the pressure off ourselves and just lie in bed and play with each other, and just talk and – yeah, and almost like you're young again,

you're teenagers again, experimenting – these worked really well.

…

MP: I think that was probably the biggest discovery. The thing that led to success long term was the realization that sex can take many forms, you know, and we were still having sex even without an erection.

FP: Like even with the usual – yeah.

MP: It was an amazing realization.

This couple characterizes the post-treatment period as a time of sexual discovery and growth. Sex is framed as playful and unthreatening. They are thus able to adopt subject positions of sexual playmates, like "teenagers again, experimenting." They are liberated from the pressure to perform as sexual partners, and sex is dissociated from any one particular form. The destabilization that prostate cancer brings to sexual intimacy is attributed with the expansion of possible ways to have satisfying sex. The couple positions their new sexual norm as having additional pathways to pleasure and play; they characterize themselves as sexually enhanced rather than sexually diminished.

Couple 4:

MP: I would say that the intimacy is a lot deeper.

FP: And I would say I agree. Like, it's different. It's richer in some ways. It takes more time.

MP: Which is fine.

FP: Which is good, but sometimes when you would like something more quicker or less involved, I miss that but, like, because we've had to talk about it in such detail, I think we're communicating better about what each of us needs.

…

FP: I think we have added more mood like music or massage or–

MP: Candles.

FP: We spend more time setting it up as opposed to before so that the, I guess, the signals or the signs are a little bit different.

…

FP: Like the massage oil is very sensual, like the smell, so, like, using all the sense differently than what we did before.

While this couple describes having a broad and experimental approach to sex in the past (e.g., they emphasized "foreplay" and prioritized both partners' pleasure), they characterize their current sexual intimacy as enhanced and deeper. Sex takes more time and requires greater engagement and communication. This is framed as largely positive and as adding greater depth and richness to the relationship. However, there is some tension in the account. The loss of quick, easy, and "less involved" sex is noted. At the same time, the current sexual practices are positioned as elaborate and enhanced. There is greater sensual and emotional engagement.

M05 likewise classifies sex as more intimate following prostate cancer. There is more "intimacy involved in the act of making love now," he says. He describes bringing greater sensitivity to sexual intimacy than he did in the past because of an overhaul in his broader approach to life. He also assesses himself and his wife to be better communicators about sex. For example, they now discuss sexual preferences, "whereas prior to that, I think the talking was, well, it was limited at best." Prostate cancer gives participants permission to talk about sex and to renegotiate sexual practices. The destabilization in

sexual routines that prostate cancer causes creates possibilities for sex that is more enjoyable, flexible, and personalized for partners.

M03 classifies his sexual intimacy as having enhanced sexual communication, playfulness, and experimentation in the aftermath of prostate cancer treatment because of the need to adapt to sex without erections. He describes pleasuring his wife using sexual toys and "a lot of … caressing and kissing," which he frames as arousing and enjoyable for him. "It works very well and it's a closeness that I didn't think we would have, but it certainly is there," he says.

Prioritizing female partners' pleasure. A number of participants articulate a shift in the way that female pleasure is positioned in the relationship following prostate cancer treatment. Specifically, the pleasure of female partners is ascribed greater importance and receives consideration. While sex before prostate cancer is characterized as prioritizing and privileging male desires and satisfaction, it is presently described as more reciprocal. Some female partners adopt more satisfied sexual subjectivities in light of these described changes.

Individual Female Partner 4:

P: This is a big difference. Before his needs were always more important.

…

P: And he was always focused on his own pleasure and I think that's the biggest difference.

…

P: … he would just want intercourse.

…

P: That was the be all and end all for [Male Partner]. That was his intention. If we kiss that was the next step and I'm very slow to get interested. I like kissing but I don't like kissing and then fondling straight after … because it's like, "I know what you're doing. I know that's what you want. So you think that if you touch me that I'm going to be interested." And it would have the opposite effect.

…

P: However, if I touch him he goes, "Oh, that feels really good,' and he's like, "Oh, yes!" And I've said to him "Just don't go there first." Like, if I have to teach him after 35 years "You think maybe that that's not the way I get turned on?" But the thing is he just wanted to do the job. He had a job to do and that was to have an orgasm. So, you know, get the wife interested and, you know, away we go. And I would definitely say that's not his objective anymore. I think his objective now is to make me feel good.

She aligns her husband currently with the subject position of generous and attentive lover, whereas he is characterized previously as being more selfish, systematic, predictable, and insensitive to her sexual cues and requests. Her pleasure and sexual satisfaction have taken on greater importance in the relationship; they are desirable goals for her husband. Her husband's sexual strategy has changed. Instead of adopting a predictable step-by-step approach to "get the wife interested" in sex and then "do the job" (e.g., have an orgasm), he has gone 'off script' and now emphasizes what she enjoys. The disturbance that prostate cancer has caused to this couple's normal sexual routine has made it possible to rewrite their sexual practices and goals.

Individual Male Partner 8:

P: Vastly, tremendously different. I didn't realize perhaps how I was sexually dysfunctional, perhaps in some ways in my marriage, or had fallen into a pattern of sexual activity – which I think sometimes happens in marriages after a long number of years. So when your marriage ends and you start another relationship, you approach it in a different or a new way, and I started to approach it more as affection and less as needing or wanting to have sexual intercourse. So having some level of sexual activity but focused entirely on my partner and not upon me. So what I started to do was to have vicarious pleasure, in that focusing on the other person rather than worrying about what I would receive. So often, I would not receive much direct sexual contact at all but use sexual activity for the other person.

…

P: But they enjoy, they enjoy the sexual activity more than in the past. And I think probably, the experience in the past would be – what a lot of women might say is that sex is often focused on the man, and that the man is anxious to achieve orgasm and after that, his interest is gone. So you know, with a lot of sexuality, my demographic is male centered, not female centered, male centered.

This participant has made a significant shift in his approach to sex from pre- to post-treatment. He characterizes himself as having being focused on his own pleasure and desires in the past and on falling into rigid sexual patterns, what he typifies as a "male centered" and "dysfunctional" approach to sex. He aligns himself in the present with a sexual subjectivity that is partner focused and affection oriented. Elsewhere in the interview, he frames erections and penetration as "way overrated" and maintains that

pleasurable, enjoyable, and satisfying sex can be had from shifting focus from a penetration to pleasure imperative.

Couple 2:

FP: I'll take this one. It might be awkward, but I think as far as me having – sexual satisfaction has increased because [Male Partner] has paid more attention to other ways of him having, how do I word that, like – so now we will have, you know, we'll have vaginal intercourse, we'll have oral sex, we'll have different versions that I'm getting more pleasure out of it because it's more of a, would you say that? It's more a–

MP: Yeah, it's–

FP: It's more of a combined thing we have–

MP: Yeah.

FP: We have to get to this together. It's not just [Male Partner] having an orgasm.

MP: Yeah, I think–

FP: Which for most of our marriage life, that's what it was about.

…

FP: Which didn't bother me, but that's what it was.

MP: By stimulating her I'm finding out, I'm getting more aroused and so we're having more pleasurable sex.

FP: Which, years ago, that wouldn't have really been the big thing on his mind, because he was already aroused. Whereas now, he needs to make those two work together.

I: Gotcha.

FP: So if he stimulates me more, which makes me feel better–

I: You're getting more aroused by it.

FP: He's also getting a better arousal state.

MP: It's a win-win.

FP: So it's a win-win.

The sexual satisfaction for the female partner has increased since her husband's prostate cancer treatment. She explains that her partner pays more attention to her preferences and reactions, and describes sex as having expanded beyond penile-vaginal penetration to include other kinds of behaviours that are pleasurable for her. The expanded sexual repertoire prioritizes ways of having sex that are more mutually arousing and sex is "more of a combined thing." Sex after prostate cancer treatment privileges mutual satisfaction. Sex cannot continue according to old markers of success (e.g., male orgasm and/or ejaculation) and normality (e.g., penile-vaginal intercourse until the male has an orgasm and/or ejaculates), thus couples must renegotiate sexual intimacy. For this couple, successful sex is more dyadic. Sex is something they do together; it is "a lot more of a two way thing." Her partner's pleasure is now yoked to her pleasure whereas they were disconnected in the past. The disruption of prostate cancer has legitimized and necessitated the female partner's sexual pleasure. Were it not for prostate cancer, this couple supposes they would have "carried on the same way" (female partner).

Sex is the most common topic of discussion during interviews. Male participants position themselves as being sexually diminished due to the side effects of treatment, even when their partners do not endorse this perspective. Incontinence and erectile

difficulties are core challenges to a man's sense of sexual competence. For couples that experience reduction or loss of sexual intimacy, there is an associated series of other losses such as reduced emotional closeness, and less physical affection. Sex is thus identified as being key to a number of relationship enhancing behaviours and practices, and as being important for overall relationship health. Participants ascribe high value to feeling sexual desire and being sexually desired by their partner, and specify a number of barriers to sexual subjectivities that are desiring and/or desired. Finally, a number of participants frame sex following prostate cancer treatment as better than before prostate cancer. The necessity to adapt, explore, and communicate more openly about sex is associated with expanded possibilities for sexual pleasure and play. The sexual needs of some female partners are ascribed with greater importance in the aftermath of prostate cancer, and female sexual satisfaction is enhanced for some participants due to changes in couples' sexual practices.

Analyses: Erections

Interview transcripts were coded for material that related to erections. Analysis of the coded excerpts was guided by the following questions: What messages about erections are being conveyed through transcript material? In what ways are erections being positioned? What meanings are attributed to erections in the context of a dyadic relationship? The following five discourses emerged:

(1) **Intercourse Imperative:** Penile-vaginal penetration is 'real'/'normal' sex and other ways of being sexual are marginalized. Erections are thus designated as essential to sexual intimacy, and gaining access to sex is predicated upon having a 'working' penis.

(2) **Erectile Dysfunction as Body Betrayal and Diminishment:** Male participants classify the changes in their erections as a marker of disability and diminishment. The subject position of effective lover is inaccessible to them in the context of erectile 'dysfunction.'

(3) **The (Erect) Penis as the Person:** A synecdochal relationship is established between men and their penises and/or erections. Erections are key for personhood and at times men use first-person pronouns (e.g., 'me,' 'I') when referring to their penis.

(4) **Erections as Relationship Protectors:** Erections are important to the health and well-being of a couple's sexual intimacy and relationship. Erections are communicators of sexual desire and arousal, and a (necessary) tool to sexually satisfy one's partner.

(5) **Enjoyable but Not Necessary: Erections as 'Icing on the Cake':** Some participants identify erections as a welcome component to sexual intimacy but as nonessential for sexual satisfaction. Sex for these participants is framed as having expanded to incorporate myriad ways to give and receive pleasure that do not require an erect penis.

Discourse 1: Intercourse imperative – sex = intercourse. Participants equate penile-vaginal penetration with 'normal' sex. Intercourse is legitimized and privileged over other ways of being sexual or having sex, and other sexual acts and expressions are depreciated. In addition, erections are framed as providing access to 'real'/'normal'/'valid' sex. When erections are present, sex (i.e., intercourse) is possible. For example, one couple (C03) refers to intercourse as "regular sex" and as having sex

"the good old fashion way" while discussing their recovery arc. "We were back to having regular sex by June," says the female partner. During an evening of experimentation, "one thing leads to another and all of the sudden, like I said, we were having intercourse. It just happened! Like, the first night that it happened, that it was actual intercourse with an erection and it was back to, you know, what we had had once before." Here, "regular sex" is synonymous with intercourse and thus requires an erection. Penetrative sex is emphasized as a marker of recovery and wholeness. It signifies being back to where one was in the "good old" (pre prostate cancer) days. There is tension in this couple's construction of sex in that they frame erections and intercourse as both central to and nonessential for sexual intimacy at various points in their interview. Elsewhere, while discussing non-erection based sexual experimentation, the female partner states, "You can have sex in so many ways, you know," and the male partner states, "Your partner is so much more than an erection."

Individual Female Partner 3:

P: And I think, too, when you're talking about, kind of, sex being over – I think that that was … a big change too. So … you know, after the part where the smoke clears … And when I was approaching kind of "So how are we going to do this?", my sense is [Male Partner] experienced that as [a] kind of sense of pressure. So that I wanted to have sex but he wouldn't be able to, that he wouldn't be able to have sex. And he didn't want to be in a spot where would he disappoint me, or just be confronted with his own sense of failure and not being able to have sex, or just the loss of not being able to have sex – and I can't imagine what the losses would be like for him.

Erections and penetration are key to sexual intimacy for this female participant and her partner. She recalls worrying that her partner would feel pressure to have sex when "he wouldn't be able to have sex" and that he would be faced with a personal sense of "failure" for "not being able to have sex." "Being able to have sex" is equated with having an erection and engaging in intercourse. While this couple subsequently adopted a creative and expansive approach to sexual adaptation, "sex" is still used as a verbal stand-in for penetration and intercourse.

Individual Female Partner 4:

P: I think when he first got diagnosed, we thought, "We better, you know, carry on like rabbits and make the most of it." We used to joke about it – "Let's get it, fit it all in, you never know." And so that sort of "Let's make the effort, you know" ...

...

P: Yes! That's exactly it – seize the day!

This female partner expressed fears about her husband becoming "incontinent and impotent" when he was first diagnosed. Here, she refers to erections as precious and not to be wasted due to their scarcity. Erections are designated as being central to sex; they are a symbol of normality and functionality. Like engaging in a pre-diet decadence, erections are a treat to savour and maximally enjoy before they are (potentially) cut off.

Individual Male Partner 4:

P: We're pretty traditional in that case, before the surgery – well, I guess even after the surgery other than on the odd occasion my wife would manipulate me, but because of the surgery, it was an extended process that she didn't have the

strength to carry on for a long period of time … The penetration method, I guess, has always been the adopted, accepted goal completion and fulfillment of the act.

Erections are a key part of the mechanics of sexual intimacy for this individual male participant and his ex-wife. Erections and penetration provided access to "fulfillment" and "goal completion"; they were a means to performing "the act." Sex temporarily expanded to include other practices (e.g., some touching and manipulation of the penis); however this was short-lived. Foreplay activities did not successfully supplant intercourse. Sex is framed in mechanical, bodily, and achievement-oriented language. The "act" is something that was done with particular body parts, to accomplish a particular goal. Emotional connection and the *intimacy* of sexual intimacy seems missing from this account.

Individual Male Partner 8:

P: I think one positive experience changed it for me – that I realized that, and I knew this, that human sexuality is far more than sexual intercourse. And what I found with the prostate cancer support group and the speakers – and again, I think it has to do with social acceptability – most of the discussion, probably 95 percent of the discussion, is all about erections. And maybe even using some sexual toys but very little discussion just about what is human sexuality and what does it comprise and what does intimacy really mean? Does intimacy mean sexual intercourse? And in our society, it seems to be that's the kind of definition that people hang on to. And even the medical or the related, you know, the psychologists or whatever it is, tend to focus on that. And usually in the context of having a partner, whereas not everyone has a partner. And so there was no

discussion about "Well how do you introduce this topic to someone you're dating? Do you introduce it? How do you deal with the awkwardness or the embarrassment? How do you bring – introduce that into the, into the discussion?" Because it's pretty difficult. In the sack you say to them, "Well I'm really glad to date you, I'd love to have sex with you, however I have prostate cancer – I may not be able to get an erection, I may not be able to sustain an erection." And suddenly, you know, they're walking out the door.

The conflation of intercourse with sex is reinforced in multiple domains, including medicine and psychology. This participant resists the dominant 'intercourse = sex' discourse, while struggling with its power and prevalence. He positions sexual intimacy as expansive and broad, encompassing far more than penile-vaginal intercourse, yet also designates intercourse as a core expectation for engaging in sexual intimacy. He resists the subject position of deficient lover, yet also describes himself as being at a disadvantage in the dating world.

For this participant and others, the loss of erections comes to mean a lacking and loss of a core part of sexuality. Mostly male participants associate the absence of erections with incomplete sex. In the absence of erections, sex cannot unfold the way it is 'supposed to' and cannot be completed.

The male partner in C06 identifies the loss of erections as "aggravating" and disruptive to being able to feel or be fulfilled. Erections are a means to sexual fulfillment through intercourse. The participant struggles to articulate why erections are so important to him: "I'm just trying to put it into what it is. I think it's a very nice feeling between a man and a woman, and to not have that anymore, it – I don't know – it, I, to me – I just

kind of feel like I've let myself down type of thing. Like I just – I really don't know how to describe it to you, I really don't." In this narrative, erections provide fulfilling sex; through penetration, this participant can have fulfillment of pleasure and access activities that are required for proper sexual intimacy (e.g., pleasure, "a very nice feeling," fulfillment). Erections allow him to "complete the act" (female partner). Sex without erections is marked as incomplete and deficient.

Erections = passport to sexual intimacy. Sex is predicated upon the presence of erections for many participants. Erections are thus the gateway to sexual intimacy with one's partner. For example, in a couple where the male partner is on hormone therapy, has lost sexual desire, and is no longer able to have erections, the female partner states that sex is "impossible" for her and her husband (C01). When asked what makes sex "impossible" for them, the male partner responds by saying, "I can't have an erection. Simple," and that hormone therapy destroyed the "capability" to have an erection. Sex for this couple is predicated upon the male partner having erections. When hormone therapy knocked out his desire and ability to have erection, sex became "impossible."

Couple 5:

FP: … the way I figure, the way you're working at all, of all of these things – using the pump, doing your exercises, doing everything that you need to do, that, that eventually, if you manage to get an erection, then you will be able to have sex again.

…

FP: But in the meantime, it's not bothering me. It's not like I'm going to get mad at him because he can't have sex. You know, so there's no pressure … I mean

should he be able to get an erection and us have sex then, you know, I'll go back to the lubricants that the doctor suggested, so. But in the meantime, if he can't get an erection then, you know, it's no problem for me, it's not going to bother me. I'm not going to be on to him or anything like that so. Right?

Sex requires an erection for the female partner in this couple interview and she pairs the return of erections with the return of sexual activity. She adds that she is not bothered by the lack of erections and lack of sex; she isn't "going to get mad at him because he can't have sex," she says, reinforcing the construction of sex as synonymous with intercourse. The female partner adds that if her husband were to "be able to get an erection," that would mean they could "have sex" again, and she would "go back to the lubricants." She positions herself as a willing participant in intercourse, should her husband gain the capacity for erections, even in the absence of her own sexual desire. However, in the absence of erections, she is content to not have sex and declines her husband's suggestions of sexual experimentation beyond penetration. It is permissible to decline to participate in sexual activity so long as erections are absent; however, the presence of erections compel the female partner to take up the subject position of sexual partner.

F02 attributes the loss of sexual intimacy in her marriage to changes in her partner's erections. "Everything is off the table," she says, as a result of erectile changes. "Go back 20 years … sex didn't just mean intercourse, you know. But no, because that's what he's lacking or can't do, then that's what it means to him." She imagines that sex is equated with intercourse for her husband and she positions herself as being let down by him. In her narrative, her partner is withholding sexual intimacy by refusing to participate

in creative sexual play and expression. “We have had some creativity. We have had some giggles,” she says. She adopts the subject position of willing partner who wants to “figure something else out,” and to “make out,” have oral sex, and play around with toys, handcuffs, etc. like they used to. However, her partner is designated as unwilling and/or unable to adapt to the changes. Erections are the route to sex and the access has been cut off with no tenable detour.

Discourse 2: Erectile dysfunction as body betrayal & diminishment. Many male participants identify changes in erections as a sign of diminishment and disability. Their frame themselves as having been betrayed by their bodies and assess themselves to be depreciated as lovers and men.

Couple 7:

MP: That’s ‘cause in fact, when I found out the results of some of that stuff, I sat down with [Female Partner] one night and I said, “This is going to be life-changing” – you know, it just hit me like a ton of bricks – I said, “This is going to be life-changing. This is not a minor surgery at all … It’s not just cancer – they’re going to take a leg off.”

Individual Male Partner 8:

P: I don’t know if it’s self-esteem so much [as] demasculization changing your mindset. I think it would be like somebody who had an amputation. It’s like that. You miss your hand, you know, I mean it used to be there, and it was a part of you. And sometimes that hand would touch your face and you’d say, “Oh, there you are. Oh, okay, yeah – I see you, I feel you.” And another time, you might wake up

with an erection beside your partner or just have an erection and you'd say, "Oh yeah, there you are. Okay, yeah – you're part of me, I know who you are." So when that's not there, you don't miss it, but it's not a part of you anymore. Do you understand what I mean?

I: Mhhm.

P: I guess you do miss it, but you eventually kind of, you know – I think a person with an amputation, eventually, they aren't aware that they don't have a leg or a hand unless someone calls attention to it, right? Unless they really are in a situation where they need it, and so in sexuality maybe you think, "Oh, now I'm in a sexual relationship I need this erection in order to have–"

I: I see. I see.

P: "To have sex."

The loss of erections is equated with amputation of a limb. And like an amputee whose body modification is more or less salient depending on the context, this individual male participant experiences varying awareness of his own 'impediment.' While he doesn't notice the loss of erections all of the time, he is reminded of his altered corporeality in the context of specific triggers (e.g., when there is "need" for the penis to perform). Loss of erections represents the loss of a fully functioning and whole self. When he hears people say things like "Oh, it's no big deal, don't worry about it, erections are overrated, sex is overrated, no big deal," he disagrees. "It is a big deal," he says. Elsewhere in his interview, the male partner in C07 likens engaging in sexual intimacy without erections to trying to do a job without working tools: "I mean, you know, one of the tools that's required for, you know, what we understand to be acceptable sexual

relations is no longer there. … You have this body part that just kind of lays there." He describes his body as nonresponsive and his penis as uncooperative. His penis just "lays there" during sex when, in the past, it was an active and core component of sexual intimacy. He adopts a sexual subjectivity that is "deflated."

In a couple interview, the female partner likens the loss of erections in her husband with loss of function that people who are suddenly "paralyzed" or who become "quadriplegic" experience (C01). Adopting this frame allows her to accept the loss of sexual intimacy in her marriage following prostate cancer treatment. She views her husband as someone who has been suddenly disabled and who is incapable of having sex. This allows her to adopt the subject position of understanding wife who accepts the loss of sexual intimacy that this 'disability' has brought to the relationship.

Individual Male Partner 1:

P: Well, I can't be good at what I do anymore so, I mean, of course it's gonna mess up your head. You always worry that you're not going to perform to the best of your abilities, because your body tells you you can't do that anymore. I can't keep an erection properly to have any kind of activity for any amount of time.

I: And what do you mean by properly? It may seem like an odd question but I am curious, like–

P: Well, I always thought sex should be done properly. It's not like 'jump on and jump off' type of thing. It's an activity and it's something that you both share together, it's – and once you can't share what you want to and the other party that you're sharing it with doesn't get the satisfaction, you're not doing your job anymore. And that would affect I think any male into not being able, not having

the interest that you had before.

…

P: Well, I find that I have, I don't know – in my mind I'm trying to get my mind back into shape. I mean, it's been through a heck of a lot and it controls what you do with your body. To be able to have your brain and your penis on the same page I guess is everything. It's starting to turn the pages and it's starting to get to where I want to get and hopefully in another short time, I'll be where I want to be – but so far it hasn't been that way.

Sexual intimacy is described in competitive and evaluative terms. This participant positions himself as injured and/or handicapped, and unable to perform the task of sex to his full capacity. He thus adopts the subject position of disabled lover, who is unable to provide satisfaction to his partner. This deficiency is "mess[ing]" with his head because he can't "perform to the best of [his] abilities." His body, which was in peak physically shape in the past, no longer cooperates with him. He is not able to have sex "properly" because he can't keep an erection long enough so that sex can be "done properly." Erections are key to sex for him and his unreliable erections are a barrier to sex. The problem is described as a disconnection between his brain and his body; should he get the two "on the same page" he is certain that his penis will perform.

Individual Male Partner 2:

P: In looking at it initially – before I had the radiation – as far as being able to get erections etc. with the help of the pills etc., really wasn't a big deal, as far as doing that. After the radiation, which you'll be aware of, that makes it even harder to get an erection. The other thing being, I'm obviously aging through that period,

which again impacts on it, alright? The other thing that happens as you get older, you put on a bit of weight, so that works against it as well. So those are 3 factors that you deal with and yes, it does take away some of your maleness because you've got a history of, say in my case, of close to 60 years of being a man, and therefore being able to perform and being able to feel that you can when you want to. And that's taken away from you …

I: So by that you mean, like, you could count on your body, count on erections, like it was just – you had confidence that that would work as you wanted it to?

P: Correct. As normal as breathing does right now – you don't have to think about it, you know you're going to be able to breathe right now, and therefore the other impulses that will come along, which have just been natural for you all the way along, are suddenly not an option.

Changes in erections strike at the core of a man's trust in his body and embodied masculine identity. Feeling like a man is closely linked to the regular experience of erections and a series of changes – which include aging, weight gain, and prostate cancer treatment – erode the (male) body's ability to produce erections and likewise a man's access to a masculine subjectivity. This participant likens being able to count on his erections to being able to breathe. Just like a person doesn't need to think about breathing or consciously command his lungs to expand, a man does not need to think about or will into being his erections. Prostate cancer treatment disrupts the 'natural' flow and reliability of a core bodily experience (i.e., erections). This disruption produces a deficient body that is unable to perform masculinity.

Individual Male Partner 8:

P: And for some of the dating that I did, I did not – and I used Plenty Of Fish the website – I didn't disclose that I had prostate cancer. And they were simply dates – they didn't involve sexual activity. I just wasn't comfortable with that because I was embarrassed and knew that I would not be able to perform sexually the way that I would have done most of my life. So it was the limp dick in the corner.

The flaccid penis comes to represent embarrassment, inability to perform, and shame for this participant. Lack of penile blood flow on command transforms him into "the limp dick in the corner." This participant sees himself as being less desirable of a partner to potential dates because of changes in his erections. His ability to enact dating activities, including non-sexual courting, is threatened by the changes in his erections.

Discourse 3: The (erect) penis as the person. There is close pairing of the (erect) penis and the man. Men refer to their penis and themselves interchangeably as if one is a discursive stand-in for the other. Erections and the penis are core to personhood.

Couple 2:

FP: Right after the surgery was very interesting, I think, because neither of us knew quite how to react with each other, I don't think. [Male Partner] was mostly, from my perspective, he was very anxious about whether he could ever have an erection, on whether he could ever have an orgasm.

MP: And I think you were, you were eager to see if you could get me back.

FP: Yeah, but I was also really scared, yeah.

MP: She got, I think you got hurt and worried because things weren't–

FP: They weren't the same you know.

MP: I wasn't reacting to anything she did.

I: Like you weren't getting an erection or you weren't even interested?

MP: Nothing. Nothing.

FP: He was interested.

MP: Oh, I was interested.

I: You were interested, like, mentally?

MP: Oh yeah, I was interested. I was eager to get an orgasm but I could not get any erection at all.

…

MP: The fact that it was erect, it was good, and when I looked at it I thought, "Wow, that's the old me," but it didn't feel like it was me, it felt–

FP: Yeah, it was really.

MP: It's synthetic.

I: I'm so interested in that. So it – when you say it didn't feel like 'me' what did you mean by that?

MP: Well, it felt somewhat artificial but almost like it was a dildo or something, but it wasn't really me.

Erections are synonymous with the male self. 'Me' comes to be a stand in for the participant's penis, erections, and whole person. The centrality of the penis to personhood is evident in the choice of words. The male partner equates his erections with himself (e.g., "you were eager to see if you could get *me* back" [male partner]). When referring to his wife's efforts to stimulate his penis to produce an erection, he frames his penis as a separate and autonomous being: "*I* wasn't reacting to anything she did," he says. While his person-self is interested in having sex, his penis-self is non-responsive. 'I' comes to

refer to both the man and the penis; they are one and the same. In this interview, the female partner likewise moves between referring to him-the-man and him-the-penis. She expresses concern about being able to get *him* back. Return of erections is likened to the return of her husband as his recovered self.

Notably, not all erections are framed as 'me' or 'I,' and the synechdochal relationship is dependent upon the means by which the erection is produced. An erection produced via injection is framed as foreign, other, and *not me* by this couple; such an erection fails to represent authentic identity.

Individual Male Partner 4:

P: Mind you, the fact that it would require either an injection or the continued use of the pump – those two are always a factor as well. The idea of taking a needle and sticking it in 'you know who' is not something that thrills the hell out of a guy.

This male partner positions his penis as a person (e.g., "you know who") while describing how unappealing penile injections sounds to him. The penis has an identity and is granted personhood.

Individual Male Partner 8:

P: Well, you're demasculated [sic], right? I mean if you do hormone therapy, for example, they call it chemical castration – and so as soon as you put the word castration into your mind, the connotation of that word is extremely strong. … It's a part of who you are, each part of your body is part of your self-image, and marketing and advertising and media in general right, it's … "Male power is erection." And … there's a lot of esteem issues with penis size, for example. So

there's just that kind of – you lose an important part of who you are. When you look at Maslow's hierarchy of needs, you know, it's right down there as one of your basic needs, right?

Erections are "part of who you are." Losing erections is framed as "los[ing] an important part of who you are." This male participant equates loss of erections with the loss of a basic human need for survival, like shelter or food and water. Erections are intimately connected to personhood and survival, like basic human reflexes.

Couple 6:

MP: I want to be able to just be fulfilling as ever type of thing and, I mean, the sexual part isn't all of the relationship by any means … in that I'm not ever going to let it be … to that point where that's all it is. It would be nice just to be able to be comfortable with it and be back to my regular old self type of thing with it, but the way it's been looking and everything else, and the problems that I've had, and I just don't think it's ever going to happen to tell you the truth.

"You" stands in for you-the-man and you-the-penis in this couple interview, and the male partner links changes in erections to changes in the self. "My regular old self" is aligned with both his penis-self and his person-self. His old self is a penis/man that worked properly, that ejaculated, that felt fulfilled, and that was comfortable.

Discourse 4: Erections as relationship protectors. Erections function as relationship protectors because of their ability to signify sexual desire and thus interest in one's partner. Male participants also designate erections as key to preserving sexual intimacy in their relationships. Erections stand in for the ability to pleasure one's partner,

and are thus important for good sex. Erections are framed as serving important pro-relationship functions.

Couple 2:

FP: I just thought that was going to affect our relationship, then I thought, well, I was kind of–

MP: Useless.

FP: Not useless but less desirable, less used, less of a partner … Well, feeling that I wasn't part of his whole sexuality anymore. Before, you know, I mean, he would get an erection first thing or we would talk or he'd be stimulated. But now, even though he said he was interested, I didn't see any physical you know. I didn't see that – which sounds so kind of crude – but you didn't see a physical erection.

I: Yeah, yeah.

MP: So she took the – after a while she took the lack of an erection as disinterest.

FP: Yeah, that he wasn't–

…

I: I'm not turned on by you. I'm not interested.

FP: Yeah, yeah!

MP: Whereas in the meantime, I'm just trying to get an erection any way.

Erections speak for the man and to the woman; they indicate her desirability and usefulness in male sexuality, and signify his interest and arousal. The loss of erections is framed as a loss of sexual communication between partners. The female participant is unable to decipher her partner's desire or pleasure. What was once communicated via the

body must now be articulated through words, lest each partner come to faulty and hurtful conclusions (e.g., “I’m not turned on by you”).

Couple 2:

FP: So up to that we tried – we kept still trying to do vaginal sex, like, but then we would do oral, we would do body [stimulation] – we would do trying anything.

I: So you were trying all kinds of ways–

FP: All kinds of things, just to see if we could bring back something that would be the two of us together as opposed to [Male Partner] having an orgasm and me just saying, “Oh, that’s nice” – you know, that sort of thing.

Sex without erections is framed as less interactive, less intimate, and more solitary – like being engaged in parallel processes. Sex is more like the male partner “having an orgasm and me just saying, ‘Oh, that’s nice,’” as opposed to a shared activity. In their narrative, the couple describes experimenting with different sexual practices “to see if we could bring back something that would be the two of us together.” Erections are designated with the task of turning sex into a shared and intimate experience. They are a conduit to intimacy and to a shared sexuality. The following participant adopts a bridge metaphor to explain sex with erectile difficulties for men:

Individual Male Partner 2:

P: So then, all of the other stuff beforehand that flows along naturally and then, you know, you’ve gotta cross this river but the bridge has just been blown up.

…

P: How are you going to get across? Cause there’s not [a] bridge there, but there’s been a bridge there for the last 60 years. And the river that you’re trying

to cross is flowing at about 100 miles an hour, so you can't wade across it, you can't swim across it. And you don't have a lot of options because planes weren't invented, ships weren't invented. And the river is a mile wide so you can't throw a rope across it. So then you really hit on the core – so, for you or your partner, you can't make them happy. And I'm not saying that the only way that somebody can be happy is by having sex. I'm not saying that's the only way, but there is a time over months or weeks duration that it will come to that. In other words, you can have time together physically without it being, you know, direct sex and that's all very satisfying but then you'll come to a certain point where "Boom! Let's complete it." And you can't do that.

He likens sex without erections to the task of crossing a raging river without a bridge or a safe and reliable means of transportation to the other side. Getting to the other shore of the river is equated with sexually satisfying your partner and having/completing sex. Loss of erections is likened to a bridge being blown up. This act of war and destruction wreaks havoc on sex, the man, and the relationship. Loss of erections is a barrier to one's partner's pleasure and to mutual sexual satisfaction. While spending non-sexual time together with a partner is designated as satisfying and positive, completing the journey to the other side (e.g., having sex) is the ultimate and most desirable destination.

Couple 7:

MP: Well, I did because we had such a really good intimate life. I mean, you know, we just really did enjoy each other's company, and we bought a hot tub because it was a fun place to be, and we went on great little romantic trips together, and we did all this stuff. It was just such an important part of our life

together – I just thought, "Holy, it's over."

I: Can I clarify, by it – sex, you mean sex?

MP: Yeah, yeah.

I: [It] was an important part of your life.

MP: Yep, yep

…

MP: For both of us. And I just thought, "It's over for me, and you too, right?

Surgery is a threat to sexual intimacy in this male participant's relationship and to the relationship more broadly. Erections are the cornerstone to sexual intimacy in his marriage and are linked to numerous other fun and pleasurable activities (e.g., romantic trips, hot tub hangouts). He associates the loss of erections with the cessation of sex and these other shared pleasurable pastimes. Notably, the male partner locates erections at the centre of sex for both him and his partner – "it's over for me, and you too, right?" – while his partner adopts a difference stance. Relationship health and sexual intimacy are not dependent upon erections in her narrative, although she articulates a sense of sadness that erections are so important for her partner and that changes in erections have come to take on such significance for him. She states, "it makes me sad that it's changed for [my partner]. It makes me sad that, you know, for a man the erection is so important."

Individual Male Partner 3:

P: … so one morning there was the hint of a small erection and I thought,

"Hmmm, maybe. Maybe!

I: Did you feel, not – no pun intended – did you feel excited about that, when there was that hint of an erection? Did you feel emotionally elated at all? …

P: No, but it would have – it would have been nice to be able to stimulate ones partner with one's own tool instead of a toy, and that's where I was going with it. Not that I would have an orgasm or anything, but I could then help her a lot.

Individual Male Partner 7:

P: Well, I think it's similar but I mean, like I told you, I'm, it's – even with the aids I'm not getting the, I'm, it's not the same erection that it was. So it's, I mean, staying penetrated is a lot harder.

….

P: … and I really feel that she's not getting anything out of it.

I: When you say that, what do you mean by that?

P: Well, I mean, I don't think – there's not a lot of penetration.

I: … you're thinking she's not as sexually satisfied or not getting as much pleasure.

P: Yeah.

Erections are a means to pleasure one's partner. Without erections, the pathway to providing sexual satisfaction is inaccessible. Desire for an erection for these participants is linked to their desire to pleasure their wives, rather than to their own physical pleasure or desire for orgasm. While it would presumably be possible for M03 to pleasure his wife using various other means and tools (e.g., other body parts, sexual accessories, etc.) an erect penis is given privileged status as the ultimate provider of sexual stimulation; the penis is "one's own tool" and thus second to none. The way in which pleasure is provided comes to matter. Without an erect penis, he is unable to provide the ultimate "help" to his

sexual partner. Sex without a lot of penetration is framed as lacking for female partners. Getting something out of sex is predicated upon firm and durable erections.

Individual Female Partner 3:

P: I think, more recently, having – being able to at least voice and kind of say out loud that we both miss the, we miss his penis. We both miss the thrusting part and that being attached to him so that we both miss that. … this is the big elephant in the room and we're both missing it, missing the erect penis. And yeah I guess … kind of celebrating our successes … might make it a little bit easier. Kind of, yeah, we know how to do this and, yeah, but I can kind of say I still miss his penis. All these other things are good but I miss [his penis].

…

P: I use a dilator so I can kind of – thinking about the thrusting kind of approximated that, I get that, so, but … I guess it's the fact that it's not attached to him and it's, I guess, in the way that we have sex, I control the dildo so that piece well, and that [yeah, if I'm talking about it], that might be another [thing], kind of upping the ante because I have control of that too. It's that it's attached to him, that he is being sexually aroused as well. It's the dance about the sexual arousal being, kind of, being a little off and a little on with the two people. And then there's also a piece about us being joined or fused, kind of emotionally fused in our, in some way, and I think there's just something about that emotional fusion of just – kind of that craving of, kind of, wanting to crawl inside of him that, kind of, connection I miss. So, and that can't be approximated in any other way. So I think,

yeah, there's something about the, there's an emotional intimacy connected with the typical connection and I think that's what I miss.

Erections and penile-vaginal penetration are specified as fulfilling core longings and relationship needs in this account. The pre-treatment penis is missed and mourned for the myriad experiences and activities it facilitated. Erections are linked to feeling emotionally and physically fused. This participant identifies intercourse with feeling "enveloped," to a sense of "union," "fusion," and to "being cared for, taken care of." The penis facilitates connection that "can't be approximated in any other way" in this account. In addition, erections make possible a "dance" of mutual sexual arousal and pleasure between partners. While this participant receives sexual pleasure from her partner (e.g., through his hands and various sexual toys), this is less desirable than intercourse because his body (his penis) is not being stimulated and pleasured through this act. The mutual pleasure that penile-vaginal penetration provided is important and deeply missed.

Discourse 5: Enjoyable but not necessary: Erections as 'icing on the cake.'

Some participants frame erections as an enjoyable and desirable but not necessary component of sexual intimacy. While erections are likened to "icing on the cake" (C06), they are not required components of pleasurable and satisfying sex for these couples. Rather, moving beyond erection-focused sex is attributed with expanding sexual satisfaction.

Couple 6:

FP: Because we never met until after he had the surgery, of course … so I guess this impacted us, because usually when you have a relationship, I mean, the physical part is a huge part of it as well. But being a menopausal woman, it really

hasn't bothered me a whole lot. You know, I like more of the physical contact, the hugs, the kisses – that kind of thing. I'm loving our relationship that we are developing, and that would just be sort of the icing on the cake if it comes back. But if it doesn't, on my part, it's not going to have an impact on this relationship.

This couple met after the male partner had had a radical prostatectomy, so they have been dealing with the sexual side effects of prostate cancer treatment since the beginning. Erections are part of, but not required for, sexual intimacy for the female partner. She notes that they are both "wide open to using different methods and trying different things." Thus, physical closeness and sexual connection are not predicated upon the presence of erections. Erections are "icing on the cake"; it would be deliciously sweet if they were to return, but physical pleasure and connection are present and abundant even in their absence. The bread and butter of their "physical encounters [and] sexual encounters," are intact, and she describes herself as sexually pleasured and satisfied.

Individual Male Partner 8:

P: Just that I have a level of comfort that I've never had before, and having said to, you know, upon the first intimacy, you know, you say – I don't know why, but your tendency is to apologize. You know, "I'm sorry, please don't take my lack of response as a lack of interest or attraction" and then to have it said back to you, "You know, I'm really happy just the way it is – it's really wonderful, it's just fine. I'm really comfortable with it, don't worry about it."

I: Wow.

P: But they enjoy, they enjoy the sexual activity more than in the past. And I think probably, the experience in the past would be – what a lot of women might say is

that sex is often focused on the man, and that the man is anxious to achieve orgasm and after that, his interest is gone.

…

P: … I didn't have the openness and the reciprocation that I experience today. Yeah.

In his interview, this participant identifies the dominant discourse of erection-focused male sexuality and describes his ability to function outside of this discursive frame, as a man with erectile difficulties. He is able to resist a deficient and apologetic sexual subjectivity and take up the subject position of confident and capable lover in the context of his current relationship, in part because his partner's sexual satisfaction is enhanced by the absence of intercourse. She is described as enjoying erection-less sex with him far more than she enjoyed erection-focused sex with past partners. She is sexually satisfied not in spite of but because of the de-emphasis on erections. This awareness is sexually liberating to him. While he has used injections in the past and has tried pro-erectile medications, he is currently using neither. He says, "I came to the conclusion that it really isn't that important … you don't need to walk around with an erection to feel … that you're on top of things. Bad pun!"

Couple 3:

MP: I think that was probably the biggest discovery. The thing that led to success long term was the realization that sex can take many forms, you know, and we were still having sex even without an erection.

…

FP: It was the end result that you can still have intimacy, you can still have this.

And that's why when we went to that conference years later that – when that person, that woman said, "Oh, if there's no sex, you know, it's over." And I'm like, "My goodness, you can have sex in so many ways," you know?

MP: Your partner is so much more than an erection.

FP: Yeah! There's just so many ways that you can do and be with each other, and just have fun, you know?

Sex is not predicated upon the presence of erections for this couple and they have discovered that "you can have sex in so many ways." Sexual play and pleasure may include penetration but there are myriad ways to have sex, connect, play, "be with each other," "just have fun," and "have intimacy."

Overall, erections represent the cornerstone of sexuality and healthy, pleasurable, and functional sexual intimacy. Intercourse is privileged as 'normal' sex while other sexual acts are classified as 'extras' or temporary alternatives. A synecdochal relationship between men and their penis is evident in some interviews, with participants adopting personal pronouns when discussing their erections and penises. Erections are identified as central to being a good lover, and as key to being able to please one's partner. Some participants adopt an alternative orientation to erections, by positioning them as a welcome but not necessary component of good sex.

Analyses: Gender

Interview transcripts were coded for material that related to gender. Excerpts were then analyzed using the following guiding questions: In what ways are participants constructing masculinity, and conversely, femininity? What messages about 'normal,'

'successful,' and competent gender-role performance are conveyed through transcript material? Analyses revealed the presence of the following three discourses:

(1) **(Dis)Ordering Masculinity: Identifying the Markers of Being a Man**. Participants identify various indicators of masculinity and frame prostate cancer as a threat to male participants' identities as men.

(2) **(Re)Negotiating Masculinity: Recognizing and Rejecting Traditional Definitions.** A number of participants simultaneously endorse and reject traditional definitions of masculinity. While referring to what typically 'makes a man,' they espouse alternative formulations. Thus, participants are able to position themselves or their partners as successfully performing masculinity even in the face of significant threats to this construct (e.g., in the face of erectile difficulties and incontinence).

(3) **Femininity as Relational.** Femininity is designated as a relational construct embedded within a heterosexual matrix. Womanhood is both reinforced and undermined through interactions with male partners.

Discourse 1: (Dis)ordering masculinity – identifying the markers of being a man. Participants articulate various markers of masculinity and identify the ways in which prostate cancer treatment disrupts a secure sense of manhood. Testosterone, strength, and erections exemplify masculinity. On the other hand, erectile dysfunction, physical changes to the penis, and incontinence complicate and disrupt masculine identity.

Body shame. Unwelcome changes in the body are threats to men's sense of masculinity. Loss of physical strength and stamina, scarring and deformation of the penis, loss of muscle mass, and incontinence are experienced as shameful and emasculating

Couple 1:

MP: Well, I don't know. That – the whole thing. That, the psychological part of it that I can't seem to grasp, it has a lot to do with my feeling, lack of feeling a man. I don't have the, you know, without the testosterone, like I said, it not only affects your sexual life it affects your thinking too.

…

MP: Well, you just don't feel like a man. You just don't feel like you're able to fulfill or … carry out your activities fully, so it has a psychological effect on you, kinda, you know, turns you off, so to speak.

I: And when you say you can't, you know, complete your activities, do you mean like having sex or do you mean beyond that? Just to make sure I'm understanding you.

MP: I [am] like a wet rag. I don't have energy to perform any of the tasks. Like, if I work, I sweat profusely and I get tired very easily.

I: Ahhh, I see. So it's a sense of not being able to do things you use to be able to do, well beyond sex.

MP: Yeah, not even close. I – even mentally if I want to read something, I seem to exhaust even mentally very quickly.

I: So it sounds pretty all-encompassing, the side effects.

MP: It is.

…

MP: Well I just don't, physically I know that I'm certainly not as manly as I used to be. I used to be quite muscular and [in] physically good shape and now I've

turned pretty much into a pudge ball. No stamina and, you know, it's just the feeling that you have about that condition – kind of deflating.

…

MP: … I mean a man is meant to perform his duties and to have a strong body – stronger than a woman – and, you know, carry out the function of life normally, but I don't feel I can do that anymore.

Testosterone promotes "feel[ing] like a man" for this participant. He blames the lack of testosterone for myriad changes to his body, mind, and relationship. And these are all tied to the erosion of masculinity. Reduced sexual desire, loss of muscle mass, increased sweating, difficulties concentrating, and less physical stamina stand for reduced manhood. Masculinity involves fulfilling tasks, carrying out duties, and adopting certain relational roles. Without testosterone, the participant likens himself to "a wet rag," both literally (he sweats profusely when doing things that used to come easily to him, and his penis does not get hard) and metaphorically (he lacks vigor as a person). The subject position of man is inaccessible to this participant.

Individual Male Partner 5:

P: Oh yeah, for a couple of years I never – for 2 years, maybe 3 years – I never undressed in the gym. I showered at home because of the scar. Now I could care less but, again, there was that as well.

…

P: Yes. It struck to the core. It sort of, I mean, I'm – I don't know what a typical male is and I certainly don't know what a typical me is – but I know the fact that I have a very strong perspective of wanting to do it myself, not washing my nununu

thing in public, not wanting to show weakness in any form, being stubborn to a fault. I'm told that this surgically induced symptom threatened all of that and shook all of that … the thing is that when I was diagnosed, I was relatively active… I, 5 years ago, I was doing a lot of running, I was doing cardio performance, I was running half marathons as best as I could … and so whenever I got into the issue of the surgery and carrying the bag, the – what do you call it? – the catheter–

…

P: Yeah, I mean that 2 weeks or whatever that was, that was my lowest physical point, in the fact that one week, I was able to go out and run for two hours and come back, you know, irrespective of the temperature feeling great. Two weeks later I couldn't walk to the end of the road.

This participant adopts the subject position of athlete in peak shape. Being able to demonstrate physical infallibility (e.g., running for 2 hours) is closely tied to this participants' masculine subjectivity. The immediate aftermath of treatment is identified as his "lowest physical point." Physical markers of vulnerability (e.g., physical scars, reduced stamina, a catheter bag) are marked as shameful and embarrassing, and disrupt his ability to enact masculinity.

Individual Female Partner 3:

P: *But he also talks about going into … men's changing room in the swimming pool. And he's kind of confronted with, I guess, the lack of knowledge or the discrimination, you know. As a woman, I go into the changing room, there are separate stalls with doors on them, and there are also stalls with little containers*

for tampons and pads. There's nothing like that in the men's washroom. In the men's changing room, it's all open. And he wants to, he has to go into the toilet area, so all that stuff about changing and what have you, I just get kind of confronted with the, I guess, kind of the stigma, and that he gets confronted with it all the time. So I think it's more of being sad for him about the losses and being confronted with that all the time. So I think that's maybe, that's kind of part of it, and when I'm kind of feeling sorry for myself, "Oh yeah, this is an inconvenience for me," I think, "Yeah, you have no idea what the losses are like for him really, and what that means to be a man." He's a big guy – he's 5'11" and like 230 pounds – so to have this really small penis that you can't kind of see, and then you go swimming and there's shrinkage already – yeah, I kind of think I've got no idea really. So yeah, I think that's kind of how that changes things. I guess more of a, I guess, respect for him and that he still kind of puts himself out there, as well as the sadness, I guess, and thinking I've got nothing to complain about. Yeah.

This female participant adopts an empathic stance when imagining her partner's experience revealing his post prostate cancer body in public spaces. Men's change rooms are "all open" in contrast with women's change rooms, thus he has nowhere to hide. His body is all in the open as are the visible markers of prostate cancer treatment (e.g., incontinence pads, scars and physical changes to the penis from surgery) unless he covers them up. It is the experience of other men witnessing her partner's body that is specified as particularly difficult. In that moment, he is "confronted with" his loss. In a separate interview, the male partner frames all-male public change rooms as challenging spaces to occupy. Male bodies (and thus markers of masculinity) are on display, and enacting

masculinity involves public display of one's body. He is cut off from participating in this homosocial and masculine practice because of the changes in his body: "Going to the gym is a bit of a problem because I sure as heck don't want to show anybody what's, what remains [of my penis], which is nothing. So that, and yet I can't go in women's change rooms. So that's a bit of a problem … all the other males have decent tools and I would be embarrassed if I didn't have a towel around me, or I sometimes use the handicapped change room so then I can close that off and be by myself." He is relegated to the private "handicapped change room" in order to pass under the radar of other male eyes and possible evaluators. There are challenges in enacting both the private and public aspects of his identity as a man, given the changes in his body.

Couple 2:

MP: I sit down like a girl. I never go to a urinal because I'm never sure how much is still in there, so I make sure I'm as empty as possible.

Urinating exemplifies masculine subjectivity in many interviews. The position in which a man urinates as well as his control over urination are designated as important. Standing up to urinate is a marker of masculinity, as is urinating in front of other possible (male) observers. This male participant sits down "like a girl." In addition, urinating in private (e.g., in a closed stall) is marked as feminine and shameful. It stands for the need to hide something from others, and a failure to be a man in this moment. A man who is able to perform public and stand-up urination has nothing to hide, and participation in this masculine ritual reinforces self-identity. Enacting 'up' functions is key for masculinity – men *stand up* to pee and *get it up* for sex. Standing up to pee for this participant means he can stand up and be counted as a man. This shared demonstration of masculinity has been

disrupted for this participant. The struggle to function as a man in public (e.g., to urinate in a public washroom) is layered on top of his private struggle to function and feel like a man. A number of other participants spoke about changes in urinary function and the ways in which incontinence negatively impacted their sense of masculinity:

Couple 7:

MP: I have a very distinct memory of the first time we were going to try Viagra and I leaked all over the bed. It was humiliating, absolutely humiliating and… that was the end of the night for us, well for me it was – [Female Partner] was great with it.

…

MP: So not only do you have this ED problem but, you know, you're deciding that – the very first time you're going to try to be intimate, you're peeing all over the place and you can't stop it, you know?

MP: It's interesting because, I mean, you know, the ED is certainly something that – at 57 years of age – you never thought you would lose that, the ability to have that. But I really, in terms of masculinity, I would have to say that the bigger issue – because that's a very, it's a very private thing, it's a very, you know, people don't necessarily know about that – and I've been in situations where I've had to leave a party because my pants were wet or … [Female Partner] and I go places and we carry a backpack with us, and she brings extra stuff with us in the backpack in case of an accident.

…

MP: … I've actually had to leave a – more than once – leave a party at my sister

in-law's house with very wet pants and, you know, and come home hoping that nobody saw them or, you know. To me, I mean that's where you feel just absolutely emasculated – where that sort of thing happens. Guys don't, and generally – I talk about this all the time – guys think incontinence is a female problem, that women have that problem as they age, or women have it as a result of pregnancy, or – because they don't hear about guys having that problem. And one of the reasons they don't hear about it is because they don't talk about it, and all you have to do is walk into a pharmacy and you'll see aisles full of men's incontinence products, but I walked down those aisles for 57 years and I never noticed one because guys just don't think that happens to them.

Incontinence is "very emasculating," even more so than erectile difficulties and loss of ejaculation. Incontinence in the context of sexual intimacy is particularly humiliating. Sex is an activity in which masculinity is performed and reinforced. Thus, to experience a markedly emasculating event (i.e., incontinence) during sexual intimacy is especially devastating. Incontinence is designated as a "female problem" that comes with age. "Guys" are not supposed to have this "wet pants" problem. So the impact of having incontinence is both emasculating and feminizing for this participant.

Individual Female Partner 4:

P: I think the biggest concern was the incontinence. That was, that was really devastating for [Male Partner], so that's all he was worried about afterwards.

…

P: And, you know, my concern is in the bed – because he leaks urine … Like, it absolutely does not bother me in the least in the shower but in the bed, yes. I guess

because he had a big accident in the bed when he was recovering, and he had the catheter, and it was very disturbing for him – and it was disturbing for me. Like, I felt really bad for him because I think he was embarrassed. It was pretty bad…

P: And then, when he did have an accident in the bed, it's not that he was less desirable, and even when he wore the adult diapers – I think, I think he was self-conscious. And I would say, "I'm going to get you the nice ones, the sexy ones, you know, there's new ones out. Here, model them for me," you know, and I think just to try and "It's okay, I still love you, you're still a man, I still find you very manly, you haven't lost any of that for me." Because I think, for him, … it wasn't very masculine to wear diapers.

I: Do you think that he feels less masculine now than he used to?

P: We talked about this yesterday and no, no. I guess when he has the occasional … incontinence with sneezing, exerting himself and I say, "You know what we've been doing? That, all the time." And I've been to bed with diapers and all kinds of things, you know, with having periods, and I never felt any less desirable to him. And I guess he's – I'm lucky that he was never repulsed, you know, when I was lactating and menstruating, like, he was, you know, he wasn't in the least sort of avoiding me at the time. And I certainly didn't ignore him either, you know, I would snuggle him and, you know – there was there was no difference there.

This female partner explains that incontinence has not made her husband any less desirable to her. She states she still loves him, he's "still a man," and she finds him "very manly" even wearing adult diapers. Incontinence is a non-issue when it comes to his

identity as a man in her eyes, and she likens his incontinence to menstruation and lactation – experiences that involved wearing pads to control leaking bodily fluids, that did not hinder sexual intimacy in the relationship. She describes her husband as just as manly as before, and reports that her husband, likewise, denies feeling less masculine now than he did in the past. Yet, she states that incontinence has been "really devastating," "very disturbing," and embarrassing for her partner, and that it has made him feel both self-conscious and less masculine. There is discrepancy between what the female partner observes in her husband and what he reports. While he maintains that he is not bothered, her observations indicate that his masculine identity and pride have been deeply wounded by incontinence.

***Erections as essential to manhood*.** Erections are part of 'a man's job' and a core marker of masculinity. Difficulty or complete inability to obtain an erection represents a threat to one's identity as a man and symbolizes a loss of phallic power.

> Individual Male Partner 8:
>
> *P: Well, you're demasculated [sic], right? I mean if you do hormone therapy, for example, they call it chemical castration – and so as soon as you put the word castration into your mind, the connotation of that word is extremely strong. And so … my friends who have female friends who have breast cancer, for example, will talk about how they felt they lost a part of their femininity. And so it's a part of who you are, each part of your body is part of your self-image, and marketing and advertising and media in general right it's … "Male power is erection." And*

… there's a lot of esteem issues with penis size, for example. So there's just that kind of – you lose an important part of who you are. When you look as Maslow's hierarchy of needs, you know, it's right down there as one of your basic needs, right?

Losing the ability to have erections stands for losing "a part of who you are." Male power is symbolized by erections in broader cultural contexts, so erectile dysfunction is constructed as a loss of power that was once easily and 'naturally' accessible. Erectile function is placed at the base of man's survival needs alongside food, water, and shelter. In addition, loss of erections is likened to amputation of the phallus. While the penis is still present, access to phallic power has been cut off.

Couple 6:

FP: When we have had our intimate encounters, I am very much satisfied – he makes sure of that – but, at the same time, it's not all that important to me, and I don't see him as being less of a man because he can't do that part of it. But to the men, they feel like … they are less of a man. With not being able to use it …

…

MP: … I think a man really puts a lot of onus on that part of his life and, that, and … and once it's just taken away from you so suddenly, that type of thing, I think that's the worst part about it, it just kind of hits you real quick and–

FP: I think it's drilled into them, the generations of men, you know, and it's like the father and they all talk and sit around and, you know, as young men they are always having these conversations, and there's just so much emphasis put on that. And you know I'm sure as young men if they say, "Oh, I haven't been able to get it

up," or "Oh, jeez, I've never slept with anybody" – oh, the other guys are going to go, "'Ha-ha-ha," you know? ... Like, if a guy has six women, it's like "Hurray! Way to go, you're the man!" But if a woman has six men, they're sluts. It's really a double standard. So women could go through the same type of private surgery, whether it's sort of a cervical, ovarian, or having their breasts removed, and we can come out the other side still feeling like a woman. Where men, when they go through the surgery, I'm finding – and this is all just new to me too so maybe I'm off base, maybe I'm out of whack – but they seem to feel, like I said, he's let himself down or he's done whatever. I know he's never let me down and that has nothing to do with that part of him.

Being able to experience erections similar to pre-treatment is key to retaining a sense of masculinity for the male participant in this couple interview. This participant struggles to maintain access to a male sexual subjectivity in the face of sexual changes. If male prowess is predicated upon penile activity, then a man with erectile difficulty cannot enact masculinity. This is the dilemma constructed by the female partner. While she does not view her partner as "less of a man" she understands his position in the context of dominant discourses of male sexuality, which emphasize erectile function. A distinction is made between actions that make her partner a good lover, and actions that allow him to enact masculinity. They are specified as being different for her but one and the same for him. He is unable to self-identify as a successful and competent male lover because he cannot perform certain sexual practices. Even though the female partner adopts a satisfied sexual subjectivity, the male partner cannot take pleasure in or ownership of her satisfaction.

Individual Male Partner 2:

P: … you've got a history of, say in my case, of close to 60 years of being a man and therefore being able to perform, and being able to feel that you can when you want to. And that's taken away from you.

…

P: So therefore, your being as a person is now being compromised – and this is the first time in your life that that has happened. So you've got 50 or 60 years of history under your belt of thinking the opposite way, and suddenly somebody has come along with a carpet and pulled it right out from underneath your feet.

…

P: It's the erections, that's number one. And then what goes along with that after. If I can't perform with an erection – that's a very critical part of maleness, of doing that. And part of what it means is therefore my partner will think less of me because I can't satisfy them.

…

I: And where does that pairing come from? Being a man means having a dependable erection, 'cause I get that and I'm thinking, "Who decided that?"

P: Adam. It literally goes back that far … I'm trying to be direct here. Going back in history, basically what it was is, the men were the hunters and would go out and kill the beast or defend the house, the village whatever – that was their prime job to do that. For the women, it was looking after the children and the meals. Again, I'm not trying to be smart on the – but that's where it was based, and therefore what it meant, and just the way that men are built is physically stronger than

females, and therefore what it meant is for men to be more of the aggressive person from a lovemaking point of view, and for the females to be a submissive in relation. So that's just been born down over the years in doing that.

A man's sense of self faces a critical threat through prostate cancer. A series of side effects all combine to "take away some of your maleness." Maleness is thus anchored in being able to "perform and being able to feel that you can [perform] when you want to." Male gender enactment is specified as performative and there are visual markers of performance (e.g., an erection) that signify success – "And that's taken away from you." This participant situates erections at the core of masculinity for many men and draws links between this core capacity and other components of masculine gender expression. Men are framed as naturally more aggressive, active, and sexually pursuant. Associations are made between men's physical strength, their role as sexual pursuer/aggressor, and emphasis on erections and penetration. These gendered attributes are linked to men's historically assigned tasks of hunter and defender. The narrative is that men as far back as Adam have performed maleness in a particular way (e.g., through penetrative sex) and prostate cancer disrupts this ancestral/evolutionary training.

In an individual interview, M04 attributes intercourse with providing validation. Intercourse is a marker that his female partner accepts him as a man. Sexual intimacy is designated as providing both sexual fulfillment but also "fulfillment of the macho desire of the male." The act of penile-vaginal penetration comes to signify and reaffirm masculinity. This participant also associates aggression and sexual pursuit with maleness. In this way, erectile capacity enables men to embody masculine sexuality, and erectile difficulties are framed as disrupting men's ability to be sexual aggressors and pursuers.

Men are rendered unable to "just flip the switch … and forget about it." Rather, they are left with a loss of capacity, a loss of ability to perform masculinity, and a loss of validation. "We feel the need to be concerned about it, be obsessed about it," he says, adding, "It's ego debilitating."

Other men construct similar accounts of masculinity and erections. M05 associates changes in erections with embarrassment and threats to his "pride," "self-esteem," and "manliness." He talked about having to "wrestle with all of that myself" as he navigated the impact to his sense of masculinity. M07 frames changes in his erections as resulting in a sense of diminishment in him as a man. Being able to have erections like "before surgery" is linked to "what a man should be able to do." He states, "I feel a little bit diminished right now" as an individual. Notably, having access to penile rehabilitation aids like injections does not protect this participant from a diminished male sexual subjectivity. He says, "I can't come to the table and do what I'm supposed to be doing as a man."

Discourse 2: (Re)negotiating masculinity – recognizing and rejecting traditional definitions. A number of men and their partners espouse alternative definitions of masculinity, which are not predicated upon 'working' erections, sexual function, or continence. These participants position themselves and/or their male partners as being 'outside of' and 'not buying into' traditional definitions of masculinity. These men are able to maintain a sense of maleness in the face of treatment side effects that would otherwise threaten their masculine identities. However, there are contradictions present in participants' attempts to renegotiate definitions of masculinity. To identify as a non-traditional man still involves reference to and entanglements with traditional markers

of maleness. Masculinity appears as a slippery construct that many participants actively struggle with in interviews. And while participants articulate different definitions of masculinity, most participants designate it as important.

Couple 7:

MP: I don't define masculinity that way. If someone was to say, "What masculinity is to you? [sic]", I wouldn't say that it's the ability to have an erection or not to pee your pants. That's not the answer that I would give you … I think it's the ability to provide for your family, and the ability to, you know, be a – certainly from a guy's perspective – to be a strong leader, and a good support, and to, and all of those important things – to, you know, and to bring the male perspective to things and, you know, I wouldn't even go there at first. So if you were to ask me to define it, I wouldn't say that it's defined by my ability to have sex or not. I do think if you asked me this question 20 years ago, and I had the disease – and not many people at that age do, although there are a few – I might add the ability to father a child, which I couldn't do.

…

MP: Yeah, I mean I can't do that now because you're impotent …

FP: Do you think maybe loss of control may be the biggest factor? You don't have control over those two things and there's, like, it's out of your hands.

MP: Yeah, I mean, yeah – I would agree with that. I mean, again, there's an important element of masculinity as it's a strength and a control and you're–

FP: You're in charge.

MP: You're in charge of yourself, kind of, guy in charge of yourself and there to

[be] the pillar of strength for your family and all that sort of stuff. And yeah, it does kind of, I guess, when you lose control in those areas, you feel like, yeah, you've lost a, you've lost a little bit of that strength.

In this couple interview, the male partner alternatively adopts and rejects traditional markers of manhood. He separates urinary continence and erectile function from the definition masculinity (e.g., "I don't define masculinity that way"; "I wouldn't even go there at first"). He ascribes alternative characteristics with masculinity, such as being an emotional and financial support to one's family, being a strong leader, and bringing "the male perspective" to things. These abilities are not predicated upon urinary or sexual function and they thus allow this participant to resist a subject position of deficient male. However, there is evidence that he is struggling to maintain a secure masculine subjectivity. In this same excerpt, the participant frames strength and control as important components of masculinity, and positions loss of bladder control as a loss of strength and control. In addition, earlier in the interview, he positions himself as "just absolutely emasculated" as a result of incontinence, and frames incontinence as a typically female problem. Defining masculinity is an iterative, complex, and at times contradictory process for the following couple as well:

Couple 2:

MP: I'm not a 'man's man' to tell you the truth, I'm really not a 'man's man' and I don't really have many man friends. So my sense of being a man is probably somewhat not normal so … I just think I'm a bit oddball in that category, so I have my own sense of who I am and who I am sexually, but I don't really equate that to being an average guy … yeah, so I, you know, I don't hang out with 'men's men'

types of guys, soooooo–

FP: But I wonder if that has – would have a negative impact if you did?

MP: Yeah, maybe.

FP: If you were one of the guys and went out drinking and everything, and all these sudden you were having these sexual issues, would that come back to you? Would you mentally think that more so?

MP: I don't know.

…

I: So for you, what I'm hearing is that there was there wasn't a threat to your sense of being a man or sense of self, because that wasn't being a macho man with–

MP: No. No. No. No.

…

MP: I would say who–

…

MP: Who I am as me but–

…

MP: I've always had a huge inferiority complex cause I'm not a 'man's man.' So that's another issue really, as far as I am who I know I am, yeah, I mean I wanted the erection for me. But not 'cause I want to be a big macho man.

…

FP: … [Male Partner's] sexuality was a huge part of who he is, but not in respect to who he is as a man.

This participant identifies his "sense of being a man" as "not normal" in that he is not a "man's man" and doesn't associate much with other men, especially traditionally masculine men. His lack of identification with markers of 'machoness' and hegemonic masculinity afford him protection from prostate cancer side effects. His sense of masculinity is not threatened by the changes in his erections because his sense of masculinity is not predicated upon having erections that function in a particular way. In addition, because he does not hang out with "men's men," his wife suggests that his masculinity may be protected because he isn't faced with having to have "crude" conversations about sex and erections over drinks. However, his sense of self and "who I am as me" is closely tied to his sexuality and to his erections, and this stable selfhood has been threatened by changes in his erection. His erections are important "for me. But not 'cause I want to be a big macho man." As such, changes in his erections threaten his sense of personhood but leave his sense of masculine identity unaffected.

The male partner in C03 states that he has come through prostate cancer treatment with his sense of masculinity intact. He espouses a confident and secure sense of masculinity, predicated upon having a clear understanding of what "makes a man." For him, this is about being "a good husband, a good father and … a good lover," and not about his job, or about being a "strong, masculine man at work" who can "take charge." This participant describes having "strength inside of me," which protects his sense of himself as a man. This means that "other people's [opinions] … don't really matter that much." However, there is contradiction within his account. He states that his wife makes him feel like "top man in the world." This reinforcement from his wife is framed as key to securing his sense of manhood. Thus, while his definition of masculinity is different from

the norm, and while he positions himself as not being "overly concerned" about masculinity, there is evidence that his identity as a man does indeed matter.

The male partner in C04 likewise works creatively with the definition of masculinity. He emphasizes his identification with and embodiment of more feminine and relational traits. He references his daughters' affectionate teasing: "Dad, you're such a girl!" He presents his sense of himself as a man as being based on fluid and flexible expression of gendered characteristics, and being rooted in and shored up through family relationships. He frames more traditional or "neanderthal" men as being more vulnerable to and disadvantaged by prostate cancer side effects. He classifies them as being more likely to suffer. The act of distinguishing himself as 'other' and more evolved than traditionally masculine men protects his sense of self as a man.

Couple 5:

I: Okay, so [Male Partner] given that, given where you guys are at – what's been the impact on your sexual self-esteem? Your sexual self-confidence?

MP: Nothing.

I: Nothing.

FP: He's always been very confident, like, nothing, nothing bothers him, like, you know.

MP: It doesn't bother me for an extended period of time. I may lose an hour of sleep thinking about it but I can compartmentalize very well.

FP: But you don't take it as–

MP: No. No, I–

FP: You know, anything about your masculinity.

MP: I'm very comfortable as me as a man, me as a sexual being or, you know, whatever … My masculinity probably would be affected more by – I'm very athletic, so I'm still going cycling, I'm a ski patroller, etcetera, etcetera, etcetera – if that was taken away from me, I'd be more bothered by that than the sex being taken away from me. … Yeah, it's more – the biggest thing I espouse is protectiveness and protecting them and caring for them. That means more to me than all of the other trappings of masculinity …

…

MP: Well, like, you know, being able to grow a mustache or a beard, being physically you know, "Roar! I'm a big, strong hulking man" – oh, give me a break.

I: Right. Right.

MP: You know, I reject this, and I've rejected this from a very young age – the concept of you have to act a certain way because you are a man or a woman. You know I got rid of that thing in high school.

This participant describes being liberated back "in high school" from the traditional "trappings of masculinity that society has hoisted at us." He rejects that men and women are supposed to act in particular gender-specific ways, and maintains that this has acted as a buffer for him during his prostate cancer journey. Were his physical strength negatively impacted, then his sense of self as a man would be threatened. Thus, physical strength is more central to masculine identity than sexual function. This

participant yokes his masculinity to fitness, and to being able to protect and care for his family. Given that these abilities have remained intact through his prostate cancer experience, his sense of masculinity has likewise remained intact. While he does not pair his sense of masculinity with the ability to have erections, he has gone to great lengths to rehabilitate his erections and continence. For example, he has gone to see a pelvic floor physiotherapist, does kegel exercises daily to improve continence, continues to use the penile pump every few days to improve blood flow, and takes regular doses of pro-erectile medication. He has read up on clinical trials to determine the best course of action for rehabilitation and has ordered special rehabilitation tools online. These actions suggest that erections and continence are deeply important to this participant, even if they are not framed as important to his sense of male identity.

Individual Male Partner 2:

I: In your case, did you feel a sense of threat to your masculinity or what it was to be a man? What was your, kind of, trajectory in figuring that out?

P: To some extent, to a small extent – I would put it maybe around a 10% or something like that, 10 or 15 %.

I: So not a huge threat?

P: No. Because even from a sexual point of view, I don't put myself first … I put my partner first. So, and that's not necessarily normal I don't think. So more so, where my emphasis would be is not being able to traditionally satisfy my partner in the way that [I've] always been able to.

I: … Often men say, "My role was to pursue and sometimes that gets turned upside down with prostate cancer and treatments," and I'm wondering if you

noticed that in your own experience or if you've found that in talking to men. That the female partners feel like they now have to do the pursuing, sexually?

P: No, and that's something that we've talked over as a couple … you know, "Tonight, or this week, would you like to be more the pursuer?" and she says, "No," and "Thank you very much, I'm not comfortable with that. I love it where you are." And I said, "Well, you know, I don't want you to feel like it's same old same old, that it's always me coming at you."

…

P: And so in our situation, that would be the case, and I would think generally that's the case – if you have the woman doing that, that's taking away a further notch of a guy being a male. Because through history and training and psychology ecetera, he's most of the time … the pursuer.

This participant indicates that most men rely on erections to shore up their masculinity; however, he differentiates himself from them. He associates the side effects of treatment with a fractional impact on his sense of masculinity. He identifies himself as a man who prioritizes emotional intimacy and his partner's sexual pleasure over his own sexual performance. These are factors that he maintains control over even when experiencing erectile difficulties. Thus, his approach to sexuality and masculinity are framed as adaptive for him. He does, however, identify traditional gender roles in the sexual patterns within his relationship. Men are classified as pursuers and women as being pursued. These complementary gendered preferences are espoused and enacted in his marriage, and this supports his identity as a man. To disrupt these roles would be "taking

away a further notch of a guy being male." While this participant adopts a definition of masculinity that emphasizes non-traditional male attributes, the definition is still entangled with some of the trappings of traditional masculinity.

Discourse 3: Femininity as relational. Femininity is framed in relational terms. Feminine subjectivity is both threatened and reinforced through interactions with others. For example, some participants designate femininity as being bolstered through their ability to elicit male desire and through their role as a caregiver. Alternatively, some participants position themselves as less feminine in the absence of indicators that they are sexually desirable and desired by their partners. These interpersonal experiences are inextricably linked to femininity.

Couple 1:

I: … something that we're also curious about in our research is trying to understand if this experience has an impact on the female partner's sense of what it means to be a woman, and your sense of femininity, and I'm wondering if there's been any impact on that for you?

FP: Not really. No, that doesn't really it doesn't affect me like that. I don't feel any less a woman because of it. We still enjoy, you know, the things that we can enjoy. We enjoy, you know, going out on trips together. We enjoy eating out, you know, different things like – but as far as being a woman, no, that doesn't impact me at all.

MP: Trouble is she's still a good lookin' woman.

The female partner maintains access to the subject position of woman through her marriage. She locates her sense of femininity squarely in the context of the day-to-

day activities of her relationship, such as sharing mutually enjoyable activities. The ongoing companionship in the relationship is sufficient validation of her femininity. This couple does not engage in sexual intimacy – this is not one of "the things" that they "can enjoy." Thus, the wife's attractive physical qualities are framed as "trouble." The male partner identifies a physical element to her femininity that is "trouble[ing]" to him given the absence of sex in the relationship.

Couple 3:

FP: Maybe that was the forefront, that role was the forefront, and I pushed other things behind? Because I just want to focus on him and maybe that's the personality that I have. But I just really want to focus in on him and make sure I wasn't losing any little gestures or clues or anything that was given, that I was doing too little, or not enough, or too much, or that type of thing – and trying to be all encompassing. And it wasn't, like, exhausting or anything – it was what I needed to do. You know, for him and maybe I got a lot out of that as well, you know, maybe that type of thing. Maybe that's what got me through it. But it's – I don't know, I seem, like, the femininity grew at that point, because I was his woman looking after him and, you know, we just went from there type of thing. I feel really strong as a woman, and I feel stronger as a woman, maybe because of our experiences together, maybe life experiences … I feel great in my femininity.

Being a woman is closely paired with the act of caring for 'her man' for this female participant. Growing confidence as a caregiver and a sense of purpose during the process of her partner's recovery is attributed with enhancing her sense of femininity.

Being able to 'do' woman in particular ways (e.g., focusing on her partner) facilitates her access to female subjectivity; it has also strengthens her identity as "his woman." Femininity is a relational experience – feeling like *a woman* is intimately connected to feeling like "*his woman*."

In another couple interview (C05), the female participant frames herself as having a secure sense of femininity. She attributes this to an atypical identity as a woman – she identifies as more practical (masculine) than emotional (feminine). In her husband's words, "you rejected all gender rules … you didn't believe you had to act a certain way because you were a woman." The female partner says, "No, I didn't follow the same rules." Incorporating more 'masculine' personality characteristics into her definition of woman provides her with a buffer from potential threats to her identity posed by prostate cancer. In addition, her partner's regular expressions of sexual desire for her, and his offers to pleasure her sexually, act as additional buffers against possible threats to her feminine subjectivity. Her desirability is validation of her femininity.

Individual Female Partner 1:

I: What impact on your sense of being a woman or your sense of femininity, if any, has this journey had?

P: I think initially it was pretty huge because you question why it's happening. Does it have anything to do with me? Am I less sexy? You know, everything has to do with gravity right? So you have nice, nice breasts and they were, you know – there's a joke, a funny joke: an 80-year-old woman went to a doctor and she said, "Can you tell me where my heart is?" And he said, "Your heart is way down where your nipples are." Have you heard this?

I: No, but I can see where it's going.

P: So she wanted to commit suicide, so she went home and she shot herself in the knee. I'm not quite there, but aging is not kind at times and I'm very conscious, like, I like to keep my weight under control. I still feel very feminine but at that point in time, that many years ago, it was really hard. I think that had everything to do with "Oh, why bother going and getting sexy night wear because, you know, like who cares?" and I went through, you know, sort of a period of depression, sort of anger, depression, you know, just like "Why didn't they tell us?", "Why isn't there help?", and you know this whole kind of thing. And so, yeah, I think we hug and kiss a lot, and my husband fondles me a lot, and smacks me on the bum a lot and so, you know, in that sense, I still feel very much like a woman and his woman.

This participant associates femininity with youthfulness and sexual desirability. While her perceived youthfulness has declined, she maintains access to female subjectivity through her relationship and in particular through the desire she elicits in her partner. Her partner has undergone hormone therapy treatment, which resulted in significant reductions in his sexual desire. His lack of desire has at times disrupted her sense of femininity and her enactment of femininity (e.g., wearing of lingerie). She has adapted to the decline in her partner's sexual desire and has been able to maintain access to the subject position of woman through gestures of physical affection. The hugs, kisses, and "smacks … on the bum" are markers that she is still "a woman," and furthermore that she is still "his woman." A woman is most fully a woman when she is associated with and

claimed as someone's. Female subjectivity is reinforced by a person's connection to and alliance with another.

Individual Female Partner 2:

P: The other thing is, I'm still very active. I work full time – you wouldn't know it now, but I do. I work full time. I sit on board. I do community work. I raise funds for various organizations. I am busy. I have people flirting with me all the time. Not to take it to another level, not to do anything inappropriate. Do you understand what I mean?

I: Yeah. Yeah.

P: Like are you married?

I: I am.

P: Okay, so I'm sure that sometime you've been, say, walking into Ryerson and somebody, give or take your age or whatever, has said, "Oooh, cute shoes there!"

…

P: Somebody has acknowledged, without being overly offensive or whatever, that you know what? You're still cute you've still got something. I mean, I've walked into a room where – and I'm not a little person I'm, you know. I'm, I have extra cellulite where I'm not supposed to!

…

P: So, you know what? I've walked into a room where I've had both men and woman walk up to me and say, "Oh, girly – you look hot tonight!' and I say, "Thank you." I acknowledge the compliment because sometimes, I've worked very hard to make myself feel better that day. And sometimes, you know what? I've

walked into a room and it's just a smile, a glow, an interpretation of how I'm feeling that day. So I think there's more ways and I think really, in life, unless you've been extremely sheltered, you have not relied just on your partner, your spouse, to give you those signals.

This female participant's femininity is not yoked solely to her husband's expressions of desire; rather, it is supported by expressions of desire from myriad sources, and by instances of flirtation in her daily life. There is minimal sexual intimacy in her marriage, yet she maintains a subject position of sexually desirable and attractive woman. Markers of her womanhood abound in the world outside of her home and it is these signifiers of her desirability that form the core of her female identity. She differentiates herself from other women who rely exclusively on their male partners for their female identity. Her female subjectivity is positioned as more robust given the diversified nature of possible sources of feedback and reinforcement.

Conversely, in another individual interview, F04 states emphatically, "I do not feel feminine at all!" She links this to her aging body. She says, "I don't like what I look at in the mirror," and framed herself as "overweight," "wrinkly," and "going grey." Femininity is rooted in physical attractiveness and body regulation. Female subjectivity takes effort and energy. She questions whether she should "make en effort" and "walk around in high heels" to regain a female subjectivity. But, she notes, "It's just not me." She describes herself as a gardener and an outdoorswoman, and likes comfortable clothes that keep her warm. She labels these preferences as antithetical to femininity. To just be "me" is to not be feminine for this participant. Femininity is a performance that emphasizes allure and requires skill.

Likewise, F05 describes an insecure sense of femininity due to struggles with body image and weight: “It was always more my weight, the stuff that women usually worry about, how you know – looks and that kind of thing … I never had challenges with the sexual side of it.” Femininity for her has more to do with being able to control her weight and body shape than with prostate cancer. Womanhood is associated with a particular silhouette. How closely she approximates that imagined silhouette determines her access to female subjectivity. She notes that in the present, “I’m better looking now than I think I was when I was younger, somehow I’m happier and I, we, and I’m a little more satisfied with my weight.” This increased positive self-appraisal is associated with a more secure sense of femininity.

Participants construct masculinity and femininity in particular ways. Masculinity has a number of key markers, such as strength, vigor, functional erections, and bladder control. Threats to masculine identity are thus anything that disrupt these signs of masculine performance, such as erectile dysfunction, incontinence, weakness, physical scarring, and vulnerability. A number of participants espouse alternative definitions of masculinity, which do not rely on more traditional roles and functions. This serves to protect men from the threats to male identity that prostate cancer treatment presents. It proves to be difficult for participants to entirely disengage from and do away with traditional masculinity. While masculinity is largely linked to individual performance, femininity is constructed as relational. Womanhood is associated with interactions with one’s partner and/or others. The relational context provides both affirmation of and threats to participants’ sense of femininity.

Discussion

This study examined discursive strategies used by men and women, individually and together, to describe penile rehabilitation, sexuality, relationships, erections, and gender. Possibilities for subjecthood (e.g., subject positions) were identified in relation to identified discourses. That is, within a given discourse or network of meanings related to a topic, the following questions were explored: what resources are available for describing experience, and what possibilities for being are precluded? The ways in which participants reference, take up, and resist discourses were explored. Contradictions and tensions within and between participant accounts were noted alongside the presence of multiple, often competing discourses.

Analyses were organized in accordance with the following sections: Penile Rehabilitation, Sexuality and Relationships, Erections, and Gender. The discussion section will focus on three key, overarching themes, which connect all analytic subsections. First, participants' endorsement of penile rehabilitation as a medical imperative – with the power to bestow healing and normalcy for those who take a serious, informed, and committed approach to recovery – is discussed. Second, a consideration of the ways in which prostate cancer is framed as a disruption to gender and sexual performance, while at the same time reinforcing dominant constructions of (normal) gender and (healthy) sexuality, is addressed. Third, participants' positioning of penile rehabilitation and pro-erectile aids as ultimately inadequate and disappointing is summarized, with a focus on the failure to address core injuries (e.g., disruptions to one's sense of self as a gendered, sexual, and partnered person) inflicted by prostate cancer.

Penile rehabilitation as a medical imperative and the subjectification of expert patients. Participants frame penile rehabilitation as a necessary and effective medical intervention that offers the promise of recovery. Many participants position themselves as having missed out on the benefits of penile rehabilitation, and in discussing their disappointment about being insufficiently informed by their medical providers, they (re)establish penile rehabilitation as an incontrovertible and necessary treatment.

Participants apply neoliberal and responsibilizing discourses to their participation in penile rehabilitation. While many frame themselves as having being let down by care providers, they take up an active and responsible patient subject position in the present as a means of maximizing successful recovery. Recovery is approached as an achievement that depends upon dedication, hard work, and resource gathering. In this way, participants adopt the 'expert patient' subject position, whereby they take on increasing responsibility for the self and for management and monitoring of their health conditions.

Recent emergence of the 'expert patient' construct is an extension and convergence of discourses of neoliberalism, healthism, and responsibilization (e.g., Fox et al., 2005; Horrocks & Johnson, 2012). Analysis of U.K. government policies on 'expert patient' initiatives reveals that the ideal expert patient is responsible, self-managing, empowered, autonomous, and knowledgeable (Rogers, 2009). 'Expert patient' discourses construct patients who are 'individualized' and "positioned as responsible for self-management of health and well-being" (Horrocks & Johnson, 2012, p. 9), embedding patients in a matrix of responsibility and self-surveillance (Gastaldo, 1997). Participants in the present study adopt the role of expert patients as they take on the responsibility to both self-govern and report to expert others (e.g., sexual medicine experts) details of their

recovery. Participants thus endorse an individualized approach to recovery that is consistent with neoliberalism, and adopt responsibilizing and entrepreneurial discourses in the management of their side effects.

Injured athlete metaphors are present in participants' accounts. In these cases, participants compare recovery from prostate cancer treatment to sports injury rehabilitation and cite dedicated effort, careful monitoring of progress, and expert assistance as key components of healing. Participants also adopt self-improvement discourses when talking about recovery. Penile rehabilitation is likened to working out, as participants talk about building muscles back, getting fresh blood flowing through the body and penis, and improving penis memory and function. Men refer to themselves as having a handicap and as being diminished. In response, they endorse the need to keep pushing and working hard at recovery. They adopt the perspective that degree of penile recovery is aligned with degree of personal effort.

These findings are consistent with broader sociocultural messages about health identified in popular cultural texts. For example, in an analysis of the construction of health in popular Canadian woman's magazines, Roy (2008) found dominant discourses of healthism and neoliberalism, and reinforcement of the neoliberal patient was prevalent. Health was positioned both as a moral imperative and as an individual(ized) obligation. Responsibility for health was "not only something that can be chosen, but also something that *should* be chosen" (p. 473). Thus, healthism is closely paired with the subject position of the entrepreneurial patient, who actively takes up the responsibility and obligation for their good health by performing perpetual actions on their bodies. Additionally, patients come to rely on expert knowledge in order to retool themselves so

that they can perform their designated role as an active, responsible, neoliberal patient. Roy (2008) writes, “In the case of healthist discourse, technologies of disciplinary power create the rational, health-seeking, entrepreneurial subject” (p. 466).

Many participants in the present study adopt an entrepreneurial stance to their recovery in that they research, seek out, and solicit treatment and resources. This responsibility/obligation is welcomed by some participants and resisted by others. For example, some participants willingly take on the role of reading clinical trials, researching possible innovations in penile rehabilitation, and recruiting a set of experts to support their recovery. Others express frustration at the lack of readily available resources for recovery and the amount of responsibility placed upon patients to navigate this challenging and confusing life experience.

Medicalizing discourses of sexuality are also prominent in participants’ accounts. Recovery is largely framed in medical terms, with emphasis placed on observable, biological, and penis-centered markers (e.g., increased blood flow to the penis, nerve stimulation, increased sensation in the penis). Participants position sexual recovery as empirically detectable and measurable through surveillance of the penis and of the body. In line with a biomedical frame of reference, there are markers of normalcy (e.g., erections that occur on demand, that last long enough, and are firm enough for intercourse), for which participants are striving.

The repositioning of sexuality as a health and medical concern more broadly conveys the idea that there are ahistorical, amoral, empirical, and objective bodily ‘truths’ that constitute ‘normal’ sexuality, and obscures the idea that sexuality, health, and medicine are infused with culturally and historically contextual meaning, values, and

assumptions (Sandfort & Ehrhardt, 2004). This supports an approach to sexuality that is based on distinctions of 'normal' vs. 'abnormal.' Participants largely adopt the view that there are normative and universal standards against which the body and the penis can be measured. Failure to meet those standards is positioned as a problem with and in the body that is best resolved through biomedical intervention (e.g., penile rehabilitation).

Prostate cancer disrupts gender performativity and sexual performance. Most male participants frame prostate cancer as a disruption to their gendered sense of self. Judith Butler's (1990) 'heterosexual matrix' is a useful framework for understanding participants' difficulties. The heterosexual matrix is a system of sex, gender, and sexuality in which male bodies are assumed to adopt masculine gender identities and be sexually attracted to women, and in which female bodies are assumed to adopt feminine gender identities and be sexually attracted to men. Participants' gendered subjectivities become dislocated within this organizational system and they are left disoriented and dis-identified.

Prostate cancer disrupts men's abilities to perform the activities or embody traits that demonstrate maleness, masculinity, and sexual attraction to women. Reduced testosterone and strength, incontinence, as well as changes in body composition, genitalia, and erections are posed as barriers to enacting and exhibiting maleness for many participants. They are unable to *perform* their gender, which results in a crisis in which they are unrecognizable as men. Notably, feminine identity for female participants is not ascribed the same level of damage or fragility post prostate cancer as masculine identity for male participants. While some position their sense of womanhood as unsettled – an unsettling of feminine identity that is associated with feeling less desired by their male

partners, and as designating themselves as being unable to elicit desire in their partners – many female participants frame their gendered sense of self as securely intact.

Butler (1990) frames gender as performativity, such that gender is an act of doing rather than a result of being. Gender is an "effect" generated through a "*stylized repetition of acts"* (Butler, 1990, p. 191, italics in original). Similarly, Lazar (2007) positions gender as an accomplishment, such that masculinity and femininity are designated as "produced identities" (p. 150) rather than natural essences. In the present study, male participants identify markers of being a man, such as having a particular kind of erectile functioning (e.g., the penis gets hard upon demand, as hard as men want, for as long as men want), continence (e.g., control over bodily fluids), and strength and vigour. Prostate cancer disturbs men's ability to enact these markers of maleness and as such, men express a sense of dislocation and disruption to self/gender identity. An identity crisis is created for participants through their inability to *do* masculinity; they lose access to their masculine subjectivity and sense of self as men.

This crisis of gender identity is consistent with the findings of other studies on the subjective experience of men with prostate cancer (e.g., Bokhour et al., 2001; Bokhour et al., 2007; Fan et al., 2012; Heyman & Rosner, 1996; Fergus et al., 2002; Gray et al., 2002; Klaeson et al., 2012, 2013; Lavery & Clarke, 1999; Oliffe, 2005, 2006). The side effects of prostate cancer treatment, such as erectile difficulties, incontinence, and body changes, have been described by men as infantilizing (e.g., Fan et al., 2012). Men have characterized their experiences as disruptive and threatening to a secure sense of self and masculinity (e.g., Bokhour et al., 2001; Bokhour et al., 2007; Fan et al., 2012; Fergus et al., 2002; Gray et al., 2002; Klaeson et al., 2012, 2013; Lavery & Clarke, 1999; Oliffe,

2005). They have articulated a deep sense of loss to their sense of male personhood (e.g., Harden et al., 2002), and a loss of manhood (e.g., Heyman & Rosner, 1996; Oliffe, 2005). They have reported feeling diminished as men and losing defining features of manhood (e.g., Bokhour et al., 2001). Male participants have described prostate cancer as triggering identity struggles, as emasculating (e.g., Fergus et al., 2002), and as leaving them feeling invisible and worthless as men (e.g., Oliffe, 2005).

Qualitative research is largely consistent in reporting profound disruption to men's sense of masculinity. The threat that prostate cancer poses to masculine subjectivity reveals the fragility of gender and masculinity as constructs. Without the "various acts of gender" (Butler, 1990, p. 190), such as erections, penetrative sex, continence, strength, muscularity, etc., masculine gender identity is destabilized and called into question. Men in the present study are unable to *do* particular gendered things or enact particular gendered roles. Because "gender is always a doing" (Butler, 1990, p. 34), without the ability to *do* the *doing*, gender falls apart as a stable and essential part of self-identity, and participants struggle to (re)define themselves as gendered persons.

***Sexual disruption*.** Participants frame prostate cancer as disordering the sexual status quo. Changes in erections are ascribed blame for much of the sexual disruption by male participants, many of whom designate themselves as sexually diminished and incapable of doing their job as lovers. They adopt sexually handicapped subjectivities and position themselves as out of control of key bodily functions (e.g., erections, continence). This sense of body betrayal and diminishment precludes access to subject positions of competent, confident, and capable lovers and instigates a crisis in men's sense of self. For men in the study, 'healthy,' 'normal' sexuality is closely paired with erections, and loss of

erections comes to represent a loss of one's male/sexual self. In the words of Potts (2002), "The absence of – or difficulty in 'achieving' and 'maintaining' – a robust 'hard on' in appropriate circumstances thus presents as a disastrous affliction in the male, an abnormality, a failure to stand up and be counted as a 'real' man" (p. 138).

Participants in the present study frame incontinence as a particularly devastating side effect of prostate cancer. Some participants identify incontinence as more distressing and life changing than erectile difficulties. With few exceptions, men paired the loss of continence with reduced sexual confidence, loss of masculinity, feminization, humiliation and shame, distress, and less frequent and less satisfying sexual intimacy. They talk about struggling to adapt to changes in this bodily function (e.g., using pads, frequent bathroom visits, carrying extra clothes) and their efforts to find solutions (e.g., kegel exercises, consulting experts). Participants lament the ways in which incontinence impacts their sexuality psychologically (e.g., feeling less sexually confident), interpersonally (e.g., having to address it with their partner), and behaviourally (e.g., not being able to have sex in the bed).

These findings are consistent with the results of other studies, with men reporting feeling physically and sexually diminished from prostate cancer treatment side effects, resulting in negative impacts on their sexuality (e.g., Arrington, 2003; Bokhour et al., 2001; Hanly et al., 2014; Harden et al., 2002; Klaeson et al., 2012, 2013; Oliffe, 2005, 2006). For example, men report that treatment side effects: lead to changes in sexuality and to an associated deep loss to their marriage (Harden et al., 2002); pose a threat to sexuality and sexual intimacy with others (Klaeson et al., 2012, 2013); and negatively impact their sexual performance, relationships with women, and experiences of sexual

fantasizing (Bokhour et al., 2001). In addition, prostate cancer has been identified as a pivotal point of change in men's approach to sexuality and to their sex lives (e.g., Arrington, 2003; Klaeson et al., 2013).

Other studies have also identified incontinence as a distressing, if not *the most* distressing, side effect of prostate cancer for men (e.g., De Sousa et al., 2012; Fan et al., 2012; Fergus et al., 2002; Gray et al., 2002; Hanly et al., 2014; Klaeson et al., 2013; Walsh & Hegarty, 2010). Like participants in the present study, men have positioned incontinence as a significant barrier to masculine identity, self-esteem, and sexual intimacy – and as a significant disruption to daily life (e.g., Fan et al., 2012; Gray et al., 2002; Klaeson et al., 2013). A review paper on men's experiences with incontinence following prostate cancer surgery (Fan et al., 2012) identified many struggles similar to those reported by men in the present study. For example, participants have reported limiting social engagements, limiting fluid intake, worrying about emitting odours, being concerned about pads being visible, and feeling stress about locating washrooms in public spaces. Overall, incontinence has far reaching negative impacts on men's daily lives, sense of self, and sexuality.

Prostate cancer has been linked to the decline or end of sex altogether, with studies citing erectile dysfunction; pain; changes in penis size, ejaculation, orgasm, and desire; difficulties communicating with partners; and feelings of inadequacy and embarrassment with reduction and/or cessation of sex (e.g., Arrington, 2003; Hanly et al., 2014; Klaeson et al., 2012, 2013). For example, a number of participants in Hanly et al.'s (2014) study indicated that they stopped all sexual activity and related this to the challenges they were facing with various treatment-related side effects such as erectile

dysfunction, pain, and changes in penis size. Participants reported negative changes in self-perception and self-esteem. They reported feeling inadequate and embarrassed. Notably, the men in the study who stopped all sexual activity in the face of erectile dysfunction also equated sex with intercourse. Likewise, participants in Arrington's (2003) study who defined 'natural' sex as unaided intercourse were more likely to cease all sexual intimacy in the face of erectile dysfunction.

Female participants likewise describe sexual disruption. Some interpret their partners' reduction in sexual interest as an indicator that they are less desirable. Some female participants describe missing being sexually pursued/hunted, and they mourn the loss of being a subject of desire. Female participants frame themselves as less relevant or important in sexual intimacy. For many, arousal is no longer a joint project or the result of sexual interplay; rather, arousal – marked by the sign of an erection – is attributable to medical and/or mechanical intervention. Thus, these 'unnatural' erections fail to signify women's desirability or proficiency as sexual partners. Many female partners are faced with the task of redefining themselves as sexual partners and reorienting themselves to new markers of successful sexual intimacy. They can no longer rely on spontaneous erections, nor can they rely on their partners' sexual passion or interest to signify their desirability. Some participants become unmoored and struggle to find their bearings in the new sexual reality.

Other studies have reported that female partners shoulder a significant burden in the aftermath of prostate cancer diagnosis and treatment (e.g., Couper et al., 2006; Fergus, 2011; Gray et al., 2000; Gray et al., 2002; Maliski et al., 2001; Sanders et al., 2006). They focus on their partner's emotional and physical needs, often at the expense of attending to

their own. Studies have found that they struggle to cope with the sexual side effects (e.g., erectile difficulty and incontinence), and with losses in sexual and emotional intimacy in the relationship (e.g., Ka‘opua et al., 2007; Wootten et al., 2014).

The intercourse imperative is frequently referenced in participants’ responses in the current study. Intercourse is positioned as the most ‘normal,’ fulfilling, and preferred sexual activity. In some cases, sex is used synonymously with intercourse, such that this one sexual activity comes to dominate and supersede all other possible sexual expressions and acts. Penile-vaginal penetration is thus privileged in participants’ accounts. Erections are often positioned as necessary for sexual intimacy, male sexual satisfaction, and partner satisfaction. Erections and intercourse take on many important meanings for participants.

In their analysis of how people talk about and make sense of intercourse, and the various social meanings that they ascribe to it, Gavey et al. (1999) draw attention to the ways in which (heterosexual) intercourse is constructed and to the “silent imperatives” (p. 63) that govern sexual behavior and choices. The researchers conclude, “Intercourse is a powerful signifier for a range of relationship qualities and emotions (such as love). Intercourse *means* things” (p. 49). Participants in their study positioned intercourse as natural, normal, and pre-cultural. Intercourse was positioned as a non-optional sexual practice in heterosexual sex and as being beyond questioning, scrutiny, or judgment, unlike other sexual acts or desires. There was no need to justify or explain intercourse and many participants struggled to explain why they engaged in intercourse, or to imagine heterosex that did not include intercourse. The researchers note that the intercourse imperative reinforces the primacy of the penis and the need for erections. Their work

draws attention to the social constructedness and context of these associations and to the various sociocultural meanings that become attached to sexual practices like intercourse, which are often obscured by dominant medicalized discourses of sexuality.

Cultural emphasis on working bodies, operative penises, and functional erections is connected to the ways in which men and their partners experience prostate cancer. In other words, there are intimate connections between the broader cultural context (e.g., dominant discourses of sex), the sexual meanings endorsed and taken up by participants, and the crisis posed by prostate cancer. The "coitus-centered model of sex" (Tiefer, 2004, p. 128), which likens penile-vaginal penetration with "real sex" (Tiefer, 2004, p. 128), is evident in participants' accounts, and heightens couples' vulnerability to the impact of prostate cancer. Given that sex is predicated upon the presence of erections, loss of erections is framed as a threat to sexual intimacy, and relationship stability and durability.

Many participants position sex as a compulsory activity for robust relationships – sexual intimacy fosters 'healthy' connection. Thus, reduction in the intensity or frequency of lovemaking is associated with myriad anxieties and fears about the health of the relationship. Complications in sexual mechanics, and erectile difficulties more specifically, are linked to breakdowns in sexual communication, to reduced sexual intimacy overall, and to subsequent losses in relationship cohesion and closeness (e.g., less hand holding, cuddling, intimate sharing, etc.). Participants frame sex as key to relationship health and robustness. For most participants in the study, healthy relationships are characterized by the presence of sex. Thus, participants are largely unable to conceive of sex-less (and often intercourse-less) relationships as healthy, normal, or secure. This is not surprising given the strong cultural imperative of sexuality

in relationships and more broadly (e.g., Emens, 2014; Gupta, 2015). "The societal message is that you *have* to be sexual, you have to *want* to be sexual, you have to be *good* at being sexual, and you have to be *normally* sexual" (Tiefer, 2004, p. 140, italics in original). Participants in the present study who do not fit these cultural standards are vulnerable to distress, self-doubt, and worry.

Expansion of sexual pleasures and gender possibilities. A number of participants resist hegemonic masculinity and work out alternative masculine subjectivities that do not rely on traditional markers of maleness, such as erectile functioning, penetrative sex, physical strength, etc. These participants are able to access and enact the subject position of 'man' while simultaneously experiencing prostate cancer side effects. In addition, a number of participants position prostate cancer as a catalyst for positive sexual change, in that the definition and practice of sex is expanded. The possibilities for what counts as 'sex' are extended beyond penile-vaginal penetration, and there are increased options for both bodily and psychological sexual pleasures. For some participants, erections are welcomed as sexual bonuses, but are not required. As such, there is a shift in sexual practices and a change in what comes to counts as successful sex. In addition, the satisfaction and pleasure of female partners is ascribed greater importance in the aftermath of prostate cancer, by some participants. A common link between couples that were able to expand their sexual practices was adaptability and flexibility. The ability to reimagine and reconfigure sexuality individually and together seemed to facilitate change and adaptation. In addition, a number of the participants who spoke about expanding sexual practices and pleasures also spoke about renegotiating

definitions of masculinity. It is possible that the capacity to resist dominant gender imperatives is associated with the ability to resist dominant sex imperatives.

This resistance to dominant discourses of sexuality appears in other prostate cancer studies. A number of participants in Arrington's (2003) study positioned prostate cancer as an opportunity to explore and expand on the ways in which they engaged in partnered sex, and on the ways in which they experienced sexual pleasure. Creativity and adaptation featured heavily in these accounts. Some participants in Oliffe's (2005) study likewise articulated a process of redefinition and expansion of sex in the aftermath of prostate cancer. Intercourse as the core sexual activity was dethroned and other sexual practices became legitimate and competing alternatives. Notably, some men came to accept and make space for a variety of types of erections during sex, thus expanding the definition of acceptable and sexy penile states.

In their discourse analytic study of the ways in which heterosexual men and women make sense of intercourse, McPhillips, Braun, and Gavey (2001) noted instances of resistance to the coital imperative, despite its prevalence and dominance in participants' talk. While the coital imperative was identified as a dominant theme, "many … participants were able to imagine the possibility of sex without intercourse" (p. 239). They noted that some participants had negotiated "sexual relationships that did not always or usually involve intercourse as part of heterosexual sex" (p. 239). These instances are evidence of active resistance to dominant cultural imperatives and "normative heterosexual practice" (p. 239).

Studies on the experiences of men and their partners using Viagra reveal other instances of resistance to dominant narratives of sexuality, and the ways in which

difficulties with erections can be opportunities for expansion rather than restriction of sexual pleasure and possibility. In their study on men who use Viagra and female partners, Potts, Grace, Gavey, and Vares (2004) explored the ways in which participants challenged the idea that erectile dysfunction was a marker of abnormality or dysfunction and, rather, framed it as a natural and acceptable part of aging and/or illness. And while some participants framed erectile dysfunction as devastating (e.g., as losing one's masculinity), others expressed positive outcomes associated with "decentering of the erect penis from sex" (p. 497) such as having an impetus for experimenting with other ways to be sexual and to experience pleasure. The expansion of sexual possibilities and practices was associated with an enhanced sense of masculinity for some male participants. The authors challenge the position that 'functional' erections are a requirement for healthy sexual relationships.

In a similar study, Potts, Grace, Vares, and Gavey (2006), explored men's counter-narratives to erectile dysfunction, male sexuality, and aging through interviews with 33 men who had experienced erectile difficulties and who had tried Viagra. Several participants resisted the dominant sexual decline narratives (e.g., sex gets worse as you age) and expressed that sex in later years offered unique opportunities to explore different kinds of sex, and to experience enhanced pleasure and satisfaction. Many men noted the ways in which sex had improved with age, even in the presence of erectile difficulties. Sex changed from being efficient/driven, self- and genitally focused, and goal oriented (e.g., focus on penetration and orgasm) to being more focused on their partner's experience or mutual satisfaction, relaxed and "langorious" (p. 319) in pacing, and about multiple kinds of bodily pleasures.

Also, while many participants in Potts' (2004) study on Viagra use adopted the coital imperative (e.g., they reported that it was hard to imagine sex without erections and penetration), some participants resisted this position. One participant said that sex had improved for him in the presence of erectile difficulty because he was forced to "focus now on different modes of pleasure" (p. 29). One female participant in the study likewise expressed that sex had improved for her because she and her partner had explored more diverse forms of sexual pleasure and open communication. Other couples in the study spoke about their hopes for expanded sexual expression and erotic connection.

When what comes to count as a sexual body, a penis, an act, etc. is both challenged and expanded, then greater access to sexual subjectivity may be possible. People may be more readily able to conceive of themselves as sexual subjects from a variety of different physical and psychological states. For example, some participants in the present study are able to redefine themselves as lovers and sexual beings in the face of erectile changes. Their sexual subjectivities are not predicated upon a 'working penis.' It is possible that the collateral damage of treatment side effects may be lessened through this and other kinds of resistance.

'Functional' penises and 'workable' sex fall short. Patient literature frames pro-erectile aids as primary and effective solutions to the crisis posed by sexual side effects in men with prostate cancer. However, analysis of interviews revealed a contradiction between the promises of these aids and participants' experiences of them as largely insufficient, disappointing, and disruptive. Pro-erectile aids and the biomedical or mechanical production of erections do not protect men and women from the identity and relationship crises posed by prostate cancer.

A medicalized view on sexuality means that things like feelings, fantasies, pleasure, desires, fears, hopes, etc. are minimized. When the crisis for men with prostate cancer is approached as a crisis of a (malfunctioning) penis, resulting solutions focus on fixing the penis, and on developing and administering treatments that produce erections. 'Successful' interventions are defined as ones that reliably produce firm erections.

> Whether by behavioral exercises, later followed by penile implants, suction and constriction devices, intracavernosal injections, and MUSE pellets inserted into the urethral opening or magic blue pills, the aim is to turn his penis into a rigid thrusting machine capable of producing erections on demand. For the most part, these treatment methods ignore the persons or couples involved and focus primarily on their genitals." (Kleinplatz, 2004, p. 225)

This approach to sexuality obscures the broader context in which the penis and erections are situated, neglecting the possibility that pro-erectile solutions may not solve the crisis for men or their partners, and may in fact be additionally disruptive to partners or to the relationship as a whole – as indicated by participants in the present study. Their accounts include many instances of resistance to the hydraulic model of male sexuality, and highlight the social, psychological, and interpersonal facets of erections. Problems with erections are not merely biomedical issues; rather, for most participants in the study, problems with erections are framed as psychological, interpersonal, and relationship challenges. Participants often identify pro-erectile 'solutions' as unacceptable, unsexy, artificial, disordering, painful, and unreliable, among other characterizations. Treatments often fall short of the promised effects, both in terms of producing erections, and in terms of facilitating sexual intimacy.

Participants in the present study position pro-erectile interventions as an unwanted third in their sexual relationship. The treatments are difficult to integrate into sexual intimacy due to their artificial and mechanical nature. Some female partners resist the role of sexual technician, and the clinical tasks involved in producing an erection. The necessary preparations, sterility, and clinical precision required for proper administration of treatments are incompatible with passion, pleasure, and desire for many. Men likewise report that proper administration of interventions detracts from sex. Treatments often have unreliable results, and even when they 'work,' they disappoint. The promised result is a let down. Participants stress that a penis that is swollen with blood is not the same thing as an erection.

***Desire disrupted*.** One of the key early marketing strategies for pro-erectile medications employed by pharmaceutical companies was to position these drugs as relationship preservers and saviours (e.g., Lowe, 2004; Mamo & Fishman, 2001; Vares & Braun, 2006). Lowe (2004) refers to this marketing strategy as the 'Romance Drug Viagra' construct. Advertisements convey promises that drugs like Viagra will reinvigorate the romance and sexual intimacy in relationships, bring partners closer together, and save ailing marriages. Similarly, in their analysis of advertising and promotional documents for two sexual disorder treatments (Viagra and Eros), Mamo and Fishman (2001) note that Viagra is framed as a "relational and coupled technology" (p. 185). Its benefits are touted as being for the relationship rather than for the individual man. Promotional materials convey that "Viagra 'fixes' erections and relationships too!'" (p. 186).

Participants in the present study challenge these alluring promotional promises. Their accounts position injections and other pro-erectile aids as poor protection from feelings of sexual and gendered deficiency and defectiveness. For many participants, pro-erectile aids do not protect the relationship from sexual disruption; rather, they contribute to conflict. Interview accounts convey that obtaining an erection is not the only thing that matters; the way in which an erection is produced has great bearing on one's sense of (male) sexual adequacy as well on one's sense of (female) sexual desirability. Erections are a marker of desire; they communicate to participants that a man is *desiring* and that his partner is *desirable*. Thus, mechanical or pharmacological production of erections comes to represent an absence of desire in men for their female partners and the undesirability of these female partners. This is consistent with Potts's (2002) contention that "The erect penis signifies desire for her; failure of this organ to elevate and rigidify is a demonstration of her lost ability to attract his desire. …The erect penis stands (up) for her desirability" (p. 144).

Pro-erectile aids disrupt a meaning system of desirability and desire. For example, injections become disconnected from the subjective experience of sexual desire and come to incorrectly mark the arc of sexual intimacy. For a number of pro-erectile aids (e.g., injections, the vacuum/penile pump, MUSE, etc.), the penis does not require subjective desire to become firm, nor does it soften as desire wanes. Erections are anchored to dose and time rather than to desire and orgasm. Erections don't map onto the 'normal' unfolding of sex for participants and this disconnect is disruptive and disturbing. Pro-erectile aids don't address issues of desire in relationships and can disturb the ways in which couples read each other's desire.

Some participants code oral medications differently than injections or penile pumps. Oral pills generally require stimulation (either psychological or physical) in order to induce blood flow to the penis. Thus, one's partner still has a potentially active role in the genesis of the erection, and resulting erections are ascribed a greater 'we-ness' than other treatments. Erections supported by pills can be (at least partially) claimed by the couple and retain a link to love and lust, desire and desirability. However, for other participants, even oral medications prove to be too disruptive to their narratives of love, desire, and sex. Pills introduce artificiality to sex and their presence broadcasts an uncomfortable and unacceptable reality: that erections are the product of pharmacology rather than sexual feelings or fantasy. In exploring the impacts of Viagra on couples' experiences, Tiefer (2004) writes:

> "In the worse-case scenario, Viagra could cause both men and women to feel resentful and less erotic – women, because the drug eliminates their sense of desirability and sexual efficacy; men, because the pill is just further proof that they are less potent and less masculine than they used to be." (p. 109)

Some male participants in Potts' (2005) study on men and their partners' experiences with Viagra expressed discontent and discomfort with Viagra-induced erections, similar to participants in the present study. They made distinctions between erections that came from themselves (desirable, ideal) and erections that were produced by medication (less desirable, devalued, "false" [p. 11], "robotic" [p. 13], and "plastic" [p. 13]). Thus, for some participants, Viagra introduced an unacceptable element of artificiality and 'not-me-ness' to sex. She notes that "one man who was unhappy about requiring assistance now to obtain an erection, described his 'original' erection, prior to

Viagra use, as more authentic, and likened using Viagra for sex to using an aid for hearing" (p. 11). Some participants also positioned Viagra as a threat and disruption to spontaneous and unplanned sex. For these participants, Viagra was framed as a barrier to sexual flow rather than a facilitator.

Likewise, participants in numerous studies on men with prostate cancer and their female partners have reported dissatisfaction with pro-erectile aids due to the lack of spontaneity (e.g., Fergus et al., 2002; Klaeson et al., 2013; Lavery & Clarke, 1999; Oliffe, 2005). In addition, sex with pro-erectile aids was described as unnatural (Klaeson et al., 2013), artificial (Oliffe, 2005), mechanical (Fergus et al., 2002; Oliffe, 2005), and effortful and awkward (Fergus et al., 2002). Participants in published studies report that pro-erectile aids did not deliver the promised solutions to prostate cancer side effects, and these accounts challenge the position that erectile difficulty is a physical problem that is easily fixed by biomedical intervention. Participants in the present study also identify pro-erectile medications as disruptive to sexual flow and spontaneity. 'Normal,' 'healthy' sex is framed as spontaneous, effortless, and naturally unfolding, whereas effortful sex is framed as foreign, unromantic, unsexy, and clinical. Pro-erectile aids disrupt spontaneous, 'natural,' and unplanned moments of passion.

Joint Discussion

Study I involved a discourse analysis of online prostate cancer patient materials about penile and/or sexual rehabilitation, and Study II involved a discourse analysis of interviews with individual men with prostate cancer, individual female partners of men with prostate cancer, and male/female couples where the male partner has been diagnosed with prostate cancer. This discussion will draw links between the two studies and identify some key discursive similarities and differences between them. Of note, this study does not deny that participants experience significant distress related to prostate cancer side effects. Nor does this study deny the threat to sense of self, grief, loss, or relationship crises described by many participants. Rather, this study seeks to emphasize links between (1) the ways in which sexuality and gender are framed in society, (2) the associated ways in which sexuality and gender are positioned within patient materials, and (3) the crisis posed by prostate cancer to men and their partners. This study demonstrates that dominant meaning systems surrounding gender and sexuality in the broader cultural context are reproduced within prostate cancer patient literature. In addition, this study proposes that propagation of these sex/gender meaning systems shapes the ways in which men and their partners comes to experience, interpret, and respond to the physical, emotional, and relational impacts of prostate cancer.

Expert and Entrepreneurial Patients

Both Study I and Study II convey the message that one's health and recovery is largely an individual responsibility. Ideal patients are framed as entrepreneurial, responsible, and informed in Study I. Materials employ a 'use it or lose it' discourse whereby there is a narrow window of opportunity within which men can benefit from

penile rehabilitation. If they fail to do any number of things (e.g., avail themselves of key recovery knowledge, recruit a team of medical experts, acquire the tools for rehabilitation, etc.) within a short period of time, they are told that they risk permanent penile damage. Patients are incited to be proactive, persevering, and informed. Many participants adopt and reproduce these responsibilizing discourses in Study II. Health and recovery are largely framed as active, and as things you *do.* Patients earn their good health and achieve wellness by constructing and executing a recovery plan. Participants are instructed to (in Study I) and come to (in Study II) accept responsibility for their recovery and engage in self-surveillance. In Foucault's words, prostate cancer patients are subjected to 'the clinical gaze' (Foucault, 1973) and also direct this gaze upon themselves, through focus on the penis and through scrutiny of physical signs of penile recovery. They are incited to self-monitor for signs of pathology/improvement and to collaborate with and confess all details to medical experts as they work towards wellness. Many participants in Study II engage in increased bodily surveillance both externally (e.g., via doctors, medical experts, urologists, sexual health clinics) and internally (e.g., via self-regulation, self-assessment, self-discipline, etc.; Hart & Wellings, 2002). Some participants in Study II express discontent in shouldering the responsibility of recovery; however, most come to accept it – along with the resulting self-blame when recovery does not unfold as hoped.

Medicalization/Healthicisation of Sexuality

Online patient information sources largely situate sexuality within the realm of health and medicine, so that changes in erections are positioned as medical issues best resolved using the expertise and interventions of medical experts. The findings from Study II, however, challenge a purely biomedical or health-focused approach to erectile

changes. While most participants take up and reproduce a discourse of 'penile rehabilitation as a medical imperative' in their talk, many resist a purely medical approach to their sexual problems and to sexuality in general.

These findings can be contextualized within the broader repositioning of sexuality within the medical/health domain. In a study on the sexualization of cancer patients, Segal (2012) documents the ways in which sex has come to be positioned as a key marker of health. In a cultural context in which 'good sex' has come to be equated with 'good health' (p. 370), the (re)ignition of one's sex life has become a key marker of recovery for cancer patients, and a way of establishing one's re-emergence as a 'healthy' person. On top of the pressures to be happy, funny, and to look good, cancer patients must now also "be sexy and, indeed, if at all possible, to have sex … especially … penetrative, vaginal, heterosex" (p. 375). Having (penetrative) sex has become an "obligation for healthy subjects" (p. 370). She links this imperative to the larger "cooptation of sex by the discourses and the institutions of health and health promotion" (p. 371).

Comprehensive accounts have been written about the gradual and increasing medicalization of sexuality more broadly (e.g., Bass, 2001; Bradley & Fine, 2009; Fishman, 2010; Marshall, 2002, 2009; Sandfort & Ehrhardt, 2004; Tiefer, 1994, 2002, 2004, 2012), and a review of this is beyond the scope of this discussion section. Significant markers of this process include: increasing attempts to standardize and 'physiologize' human sexuality, the expansion of urology as a medical specialty, increasing research into biomedical treatments for erectile difficulties, and the introduction and widespread dissemination of Viagra and other sexual pharmaceuticals in the late 1990s (e.g., Fishman, 2010; Potts, 2002; Tiefer, 2002, 2004). The establishment

of models of sexuality and sexual 'function,' such as Masters and Johnson's 'human sexual response cycle' (Masters & Johnson, 1966), set the standard for function and dysfunction, normal and abnormal. Analysis of the 'sexual dysfunctions' listed in key diagnostic texts reveals that 'dysfunctions' are intimately tied to penile/vaginal intercourse (Barker, 2011). "From this, we can see that 'normal' sex is often viewed as requiring enough, but not too much, sexual desire, and that it is necessary, when applied to heterosexual people, for men to be erect and to penetrate women vaginally, for women to be penetrated, and for both to orgasm" (Richards & Barker, 2013, p. 149).

Medical models provide universalized norms against which all human bodies can be – and are – compared. These norms "provide a context whereby we not only understand our bodies, but *experience* them – as sick or healthy, functional or dysfunctional" (Marshall, 2002, p. 135, italics in original). Such medical models of human sexuality presuppose that there is an "objectively knowable, universal body governed by laws and processes that work independently of social life and culture (for example, penises are the same, whether attached to men in Siberia or Sumatra)" (p. Tiefer, 2002, p. 25). The close pairing of sexuality, medicine, and health means that "sexual problems and their solutions are conceived in biomedical terms, eclipsing the fact that sexuality is a social practice, occurring in specific sociohistorical contexts" (Sandfort & Ehrhardt, 2004, p. 184). Participants in Study II emphasize the sociocultural, interpersonal, and intrapersonal context for erections and sexual experience. The biomedical production of a firm penis does not resolve sexual difficulties for many participants. Correcting faulty mechanisms in the body does not protect participants from injury to their sense of self or to their relationship. This discrepancy between online

patient materials and participants' interviews is notable, as medical solutions fail to fully address the complex experiences and challenges faced by many participants. For these participants, penile rehabilitation is not, in the end, relational rehabilitation.

There are also parallels between the responsibilizing discourses (e.g., you should be taking care of and constantly bettering, transforming, and/or upgrading yourself, your sexual capacities, your body, etc.) embedded in penile rehabilitation materials, and broader cultural discourses of responsiblization, self-management, and self-discipline when it comes to sexuality (e.g., Gill, 2009; Harvey & Gill, 2011a, 2011b; Taylor, 2008). Direct-to-consumer advertising of pro-erectile medications, such as Viagra, positions medication users as responsible (e.g. they are taking responsible action to protect their erections, their sexual health, and their relationships; Mamo & Fishman, 2001). However, access to this subject position assumes a high level of health literacy and financial resources. Patients with money and health knowledge possess the resources needed to access care/recovery. Those lacking resources (e.g., to pay for medications, to access specialists, to interpret what is happening in their bodies, to understand penile rehabilitation interventions, etc.) may not. Yet the onus is placed upon the individual patient. Participants in Study II adopt responsibilizing discourses. They largely accept responsibility for the recovery process, even as they express frustration at the lack of information and guidance provided to them. Difficulties in recovery are often interpreted as personal failure rather than as shortcomings in the medical system.

Narrowly Defined (Normal) Gender and (Healthy) Sexuality

Online patient materials from Study I largely present and reinforce narrowly defined views of masculinity/femininity and (hetero)sexuality. Online patient materials

largely position masculinity and femininity as complementary and distinct opposites. Couples depicted in visual images are male/female dyads and partners are typically referred to as female, if gendered pronouns are used. Men are physically holding, embracing, or carrying their female partners in images; thus, they are in physically dominant positions. Conversely, women are being embraced, supported, held, or carried by their male partners, and are typically in more submissive or receptive positions. Grooming and clothing also highlight gender binaries. Men have short hair vs. women's long hair, and women have more ornamentation (e.g., makeup, jewelry, frilly collars) than men (e.g., glasses). Many participants in Study II also position gender as a binary system. Many participants associate masculinity with physical strength, muscle mass, stamina, and control over bodily functions (e.g., continence, erectile functioning) and frame incontinence, physical weakness, physical changes to the penis, and erectile difficulties as threats to masculinity. Men report struggling greatly with the effects of incontinence on their sense of self as men and on their sexual self-confidence. Urinary leakage is framed as incompatible with a secure sexual subjectivity and with being a 'successful' man. The effects of and strategies to cope with incontinence (e.g., wearing pads, frequent trips to the washroom, using private bathroom stalls vs. communal urinals, sitting down vs. standing up to urinate, etc.) serve as markers of reduced masculinity for many men. Likewise, sexual adjustments to accommodate incontinence (e.g., no longer having sex in bed) are distressing reminders of physical diminishment for many men.

Femininity is positioned as relational. Female participants come to understand and experience their womanhood through interactions with and in contrast to their male

partners. Thus, threats to masculinity (and associated behavioural and psychological changes in men) come to be experienced as threats to femininity for some participants.

Study II similarly echoes Study I's specific depictions of 'normal,' 'healthy' (hetero)sexuality. Materials in Study I emphasize heterosexual partnerships and intercourse, privileging erection-focused sexual practices. Other sexual possibilities are minimized through this singular presentation of 'normal,' 'healthy,' and 'acceptable' sexuality. The biomedical solutions offered to men in Study I typically reinforce dominant definitions of masculinity and sexuality, rather than exploring, questioning, or resisting them. Closely associated with this presentation of sexuality is the assumption that fixing or reinstating erections is the optimal outcome for men and their female partners. Various biomedical interventions are presented as curative and/or assistive options. Emphasis is placed upon workable bodies and penises.

Participants in Study II also take up and reproduce constricted definitions of normal (hetero)sex; many of them prop up the coital imperative in their responses. Erections are often framed as essential for sexual intimacy and sexual subjectivity for both men and women. A narrow range of sexual practices – typically centered on erections and/or the penis – are considered, normalized, and adopted by most participants. Many participants largely struggle to disentangle sex from erections and to imagine satisfying, exciting, pleasurable sex that does not include an erection.

The coital imperative is reinforced in patient materials in Study I as well as in sources of sexual advice giving more broadly. Sources of expert sexual advice, such as sex self-help books, bolster the primacy of penile-vaginal penetration, (e.g.,

Barker, Gill, & Harvey, in press; Tyler, 2008) such that "penis-in-vagina (PIV) sex is clearly assumed to constitute 'proper' sex. Other forms of sex are generally relegated to 'foreplay' or a chapter on 'spicy sex' towards the end of the book" (Attwood, Barker, Boynton, & Hancock, 2015, p. 530).

According to Potts (2002), by focusing on fixing men's erections, we reinforce definitions of masculinity that are dependent upon potency and erectile functioning; we engage in the "reification of the erection in constructions of male sexual health" (p. 142). We also reinforce a singular definition of sexuality and delimit the possibilities for sexual pleasure and sexual practice, as 'successful' treatments for erectile dysfunction results in the restoration of erections and "phallic manhood" (Potts, 2000, p. 94). Where we could be deconstructing and *re*constructing male sexuality and possibilities for connection, sex, and pleasure, we risk reinforcing the status quo.

Materials in Study I largely reinforce the gender and sexual status quo by constructing and reinforcing a number of pairings (e.g., intercourse = sex, erections = masculinity), and Study II participant accounts demonstrate some of the implications of these pairings. When (hetero)sex and successful gender are predicated upon the man having a working penis, sexual changes pose significant disruption to one's sense of self, and to both sexual and relationship well-being. In addition, interviews point to the limitations of an erection-focused approach to sexual rehabilitation. While many participants locate erections at the core of both sexuality and masculine identity, they also express dissatisfaction with medically produced erections. Even when pro-erectile treatments produce objectively 'beautiful' erections, the treatments fail to fully satisfy many participants. Tensions appear in participant accounts between their strong desire for

return to ‘normal’ sexual functioning and their recognition of the insufficiency of technical functionality of the penis for satisfying sex.

The medical establishment has constructed a view of male sexuality that emphasizes “workable sex,” according to Bass (2001, p. 338). Workable sex involves body parts that ‘function’ well enough to facilitate intercourse. Bass labels the field of biotechnology research into sexual ‘disorders’ and ‘dysfunctions’ as “the sexual performance perfection industry” (p. 337), and argues that the targets emphasized in biotechnology are more about performance and achievement and less about pleasure and intimacy. He and others argue that the definition of ‘good’ sex adopted by many sexual medicine experts and the pharmaceutical industry tends to reinforce ideas of ‘function’ predicated upon erections that are suitably hard, last a suitable length of time, and lead to vaginal penetration and orgasm. Penises are assessed for functionality and pathology based on shifting biomedical/pharmaceutical criteria. The advent of ever-new technologies of sexuality and pro-erectile interventions establish and reinforce standards of penile functionality. A functional penis is able to do/perform/achieve certain things. Functionality and wholeness are rooted in what the penis can do rather than what the penis or body can experience, feel, appreciate, or enjoy.

Despite the emphasis on functional penises that appears in Study I and that is echoed within many accounts in Study II, there are many instances of resistance to dominant discourses of sexuality. Critical and alternative discourses appear in online patient materials in Study I. In these cases, sex is connected to a man’s emotional, psychological, and relational well-being, rather than being rooted in his genitals. Some of these materials also state that while pills, injections, and other pro-erectile interventions

can produce erections, they are insufficient ingredients for good sex (e.g., they do not replace sexual desire, good sexual communication, etc.). A number of participants in Study II actively resist dominant discourses of sex and gender. A number of male participants discuss a process of redefinition and renegotiation of manhood. These participants espouse definitions of masculinity that are decoupled from erectile functioning and the ability to engage in intercourse. Likewise, they talk about expanding their sexual repertoire so that they come to engage in a wider range of sexual practices and enjoy an expanded range of sexual pleasures. The possibilities of sex have increased rather than diminished for some couples in the face of the sexual side effects from prostate cancer. These examples of resistance and creativity suggest that by working against "the restriction of male sexual expression to penile tumescence" (Potts, 2000, p. 89) and "by relinquishing the penis's executive position in sex" (Potts, 2002, 134), the possibilities for sexual pleasure are magnified.

Broadly, this dissertation explored the ways in which dominant discourses of sex and gender frame the prostate cancer experience for men and their female partners. The two related studies explored links between messages about sex and gender embedded within prostate cancer patient materials and messages reproduced in interviews with men, women, and couples coping with prostate cancer. Key findings include positioning penile rehabilitation as a medical imperative, and adoption of neoliberal and entrepreneurial language to frame the ideal patient. Medicalized and healthisized discourses dominate content related to sexuality. In addition, the largely heteronormative framing of sexuality privileges intercourse over all other sexual practices – valorizing reliable, persistently hard, and predictable erections. Patient materials and participant interviews endorse the

close pairing of masculinity and control over bodily functions (e.g., erections, continence), such that loss of continence and erectile difficulties signal reduced manhood. Gender is framed as a binary and essential quality, with masculinity and femininity possessing clear markers. Finally, there are instances of resistance in both studies (although more so in Study II) to these dominant meaning systems. In particular, a number of participants challenge hegemonic masculinity and endorse alternative, adaptable definitions of masculinity, and several participants expand the boundaries of healthy and normal sexuality to include a wider range of sexual practices and pleasures.

Reflexivity

Reflexivity is widely accepted as a core component of doing qualitative research (e.g., Dowling, 2006; Willig, 2001). The concept has variable operational definitions and practices; there are multiple ways of 'doing' reflexivity (e.g., Dowling, 2006). *Personal reflexivity* commonly involves reflecting on the ways in which the researcher's beliefs, opinions, preoccupations, and assumptions influence the research process (Dowling, 2006). On a personal note, my paternal uncle is a prostate cancer survivor who has been open about his survivorship experiences and challenges and my father was diagnosed with prostate cancer during the course of my doctoral studies. Also, the two years that I spent working and training in a prostate cancer centre and sexual rehabilitation clinic informed the development of this dissertation. I attended an intensive sex therapy training program at the University of Guelph during my graduate studies and one of my core instructors was Dr. Peggy Kleinplatz. In addition, I have been a research assistant and/or graduate student in a critical, feminist, sexuality research laboratory for the past 8 years. Finally, I

am someone who is preoccupied with questions of identity and possibilities of being when it comes to gender, sexuality, and relationships.

Beyond personal reflexivity, *epistemological reflexivity* involves reflecting on how knowledge has been generated in the study (e.g., how was the research question both defined and limited what can be found or concluded? What assumptions about the world and about knowledge are made during the course of the research project? etc.; Dowling, 2006; Willig, 2001). Engaging in epistemological reflexivity requires us to "begin to 'crack the codes' within our discipline, to consider together the invisible assumptions that pervade everyday theorising [*sic*] and practice" (Kinsella & Whiteford, 2009, p. 251). It involves piercing the 'cloud of givenness' (Greene, 1995) and making these assumptions explicit. The personal and professional training experiences outlined earlier gave me a strong critical and feminist-informed foundation from which to approach human experience and sexuality. They informed the theoretical and epistemological foundations of this dissertation and thus directly shaped the possibilities of knowledge production. For example, it was assumed that the participants and I co-constructed the data – responses were not taken as windows into the truth of participants' experience, rather it was assumed that many factors shaped responses (e.g., the questions, the context of the interviews, the language used, the relationship established between the interviewees and interviewers, etc.). It was also assumed that participants were actively *doing* things with their participation and were engaged in identity work when constructing their responses. Epistemological assumptions of the project have been outlined in greater detail earlier (see Theoretical and Epistemological Perspective section on p. 40).

Implications and Suggestions

This study positions patient materials as a technology of sex. In other words, patient materials are a vehicle for messages about sexuality and sexual health, gendered bodies and practices, and relationship conduct. They convey information on how one can transform oneself into a 'functional,' 'normal,' 'healthy,' and 'acceptable' sexual subject. Medical literature is a privileged technology of sex because science/empiricism is afforded greater 'truth' and 'validity' status relative to other sources of information. Thus, information from hospitals and research institutions are ascribed greater relative trust and are accorded greater deference. I contend that this greater relative power and trust comes with considerable responsibility to be mindful of the choices being made when generating and disseminating knowledge about sexuality, gender, and health. I suggest that clinicians and authors of patient education materials should adopt a practice of reflexivity. I am referring to Marcus' (1995) definition of reflexivity whereby one adopts "a self-conscious account and meditation upon the conditions of knowledge production as it is being produced" (p. 108). Individuals who are exercising power (e.g., by producing patient texts, by adopting the subject position of clinician/doctor/expert) ought to adopt a self-consciousness about the biases, assumptions, 'truths,' and meaning and knowledge systems that they bring to these clinical activities. I recommend that a practice of reflexivity include exploration and identification of normative assumptions and beliefs held by clinicians and those responsible for communication with patients (e.g., in person, in pamphlets, online, etc.) in the following areas:

- The patient (e.g., assumptions about the patient's sexual identity, ethnicity, cultural background, age, socioeconomic status, physical ability, literacy, etc.).

- The nature and configuration of the patient's relationship(s) (e.g., assumptions about the duration, level of commitment, number of partners involved, preferences for involvement, etc.).
- Sex and sexuality (e.g., normative messages about what counts as 'sex,' what physical abilities and capacities are required for sex, what is considered 'normal,' 'healthy,' 'natural' sexual expression, etc.).
- Gender (e.g., messages about the genesis, stability, and 'normal' expression of gender, what gender-appropriate sexual performance looks like, etc.).

Choices are being made about how to frame and present constructs of sex and gender, whether or not these choices are apparent or acknowledged. Thus, I recommend explicit acknowledgement that these clinicians and clinical sources do not merely *describe* things as they are – rather, they actively *shape and constitute* what is legitimized as knowledge and truth. In other words, I recommend that authors of patient communications come to acknowledge that they have a privileged ability to exercise norm-shaping power. They are uniquely positioned to both restrict and expand normative discourses.

My recommendation, based on the results of these studies, is that patient communications include a greater number of discourses so that patients have access to a greater variety of subject positions and more possibilities for resistance. Patient communications could serve a fuller range of patients by expanding the possibilities of normal sexuality and successful gender expression. I echo advice offered to care providers by Richards and Barker (2013):

> "It may well be helpful to normalise the diversity of styles of sex and relationship that are possible with clients, for example by describing different options that people

choose … It is important both to broaden out all the possibilities that exist within 'normal' as well as exploring why being 'normal' is valued so highly." (p. 159)

Richards and Barker (2013) also advise:

"It may well be helpful to normalise the diversity of ways of being masculine or feminine that are possible with clients, for example by describing different options that people choose appropriately to their context." (p. 70)

In line with this, I recommend that patient materials position sex as a broader construct that may or may not include penile-vaginal intercourse, that may or may not include a man and a woman, that may or may not take place in the context of a long-term committed relationship between two people, etc.

Specifically, I recommend that patient materials emphasize an approach to sexuality that (1) expands beyond the physical body and (2) focuses on broad bodily pleasure rather than narrow bodily function. I suggest that fantasy, imagination and the myriad pleasures of the mind should be emphasized in patient materials as a way to explore and expand one's sexuality. I also recommend that patient materials focus on bodily/physical pleasure quite broadly rather than focus on penile function. This approach to sexuality would have the potential to *increase* access to both experiencing and facilitating pleasure and is a contrast to traditional materials. Much could be learned from kink communities and from those who adopt alternative sexual practices.

Materials could also convey that flexibility facilitates adaptation and sexual satisfaction. A common finding both in the present project and other research is that couples that are able to disentangle sexual intimacy from penile-vaginal intercourse seem better equipped to maintain sexual pleasure and play. The cultivation of creativity is an

important function that patient materials can perform. The ability to play in a new way both with the body and with meaning systems is a key capacity for couples.

Materials might also convey the important of acceptance – acceptance that the post prostate cancer-treatment body is not the same as the pre prostate cancer-treatment body. If materials emphasize and prioritize the importance of obtaining pre-cancer functioning (often at high emotional and financial cost), men and partners are set up for failure should the man's body not achieve this standard of recovery. Materials ought to convey information about how to have the best possible life, sex, relationship, etc. given the body that one has at this particular point in time. In other words, materials ought to convey that phenomenal sex and relationship satisfaction are not dependent upon a narrow definition of physical function.

I hope that communications with patients can serve to enhance their ability to question, challenge, and work with and/or against dominant discourses and give then a delicious sense of freedom and possibility. For example, if patient materials resist the intercourse imperative discourse, then a man may retain easier access to a sexual subjectivity in the face of erectile dysfunction. If 'sex' is defined as including an expansive range of sexual practices and forms of pleasure, then loss of erections may limit but not eliminate his sexual possibilities.

To be clear, patient materials will not, nor should they, become value-free or discourse-less. Rather, I suggest that these materials come to contain a greater variety of discourses and provide expanded possibilities for being (e.g., being a man, being a sexual person) in the context of prostate cancer. In a sexuality and gender guidebook for mental health professionals, Richards and Barker (2013) advise the following:

> Professionals should be cautious in uncritically accepting the versions of sex suggested by these [DSM sexual dysfunction] categories as the normal/only ways of having sex, and may benefit from considering other possibilities within it… and outside of heteronormative sex… This is not to say that heteronormative sex may not be quite the right things for a particular client, but rather that it should be considered choice, rather than an unconsidered one which causes enough distress to bring them to a professional." (p. 149)

This would give patients access to an expanded set of subject positions and possibilities for viewing themselves. My hope is that patient materials and care providers might present a greater variety of narratives and possibilities for recovery. If men had access to a wider variety of recovery stories conveying multiple kinds of sex, physical capacities, relationship configurations, and masculinities, then recovery from prostate cancer might open up, rather than restrict, possibilities for pleasure and identity. If they are presented with more diverse representations of what 'recovery' looks like and how to access 'recovery,' they might find it easier to position themselves as 'recovering' and/or 'recovered.' The following include some examples of what this might mean:

- A man without erectile capacity could experience himself and be seen as being sexually recovered and whole.
- A man with erection changes could position himself and be seen as actively engaged in sexual recovery whether or not he is using pro-erectile interventions.

Limitations & Future Directions

A core limitation of the study is the relatively homogenous sample. Participants are of similar ethnicity (all participants are Caucasian), are relatively well-educated, financially privileged, older, and in long-term committed relationships. Participants share a similar cultural context, and as such, the study is missing men and partners who might adopt alternative discourses of sexuality or have alternative framings of masculinity and femininity based on their backgrounds. As indicated in Study I, patient materials assume a relatively high level of literacy and many patients actively consumed medical literature. Thus, patients who struggle to read and understand medical content would quite possibly have a different experience.

Most participants are of similar age (mean age of participants = 63.3 years old, age range from 49 – 76 years), with the overall sample lacking younger men and partners. Almost all prostate cancer couples' research has been done with participants who are developmentally relatively mature (e.g. Fergus, 2011; Manne, Babb, Pinover, Horwitz, & Ebbert, 2004). This has important implications for study outcomes. Many studies mention that a couple's longevity and unique history together serve as a buffer against the significant challenges, conflicts, and distress they face during diagnosis, treatment, and survivorship (e.g., Fergus, 2011). In addition, research suggests that younger men fare worse than older men when it comes to depression (Pirl & Mello, 2002; Weber et al., 2004) anxiety (e.g., Schröder, 2010), and negative reactions to diagnosis (e.g., Manne et al., 2004). And this also seems to be the case for younger partners. Couples with partners younger than 65 years old have been found to be at greater risk for a variety of negative outcomes when compared to couples with partners in the age range of 65-74 years

(Manne et al., 2004). All in all, younger couples seem to be more vulnerable to distress related to prostate cancer (e.g., Harden, 2005). Thus, the present study findings are limited by the missing accounts of younger couples. Future directions include a study exploring the accounts of younger partners of men with prostate cancer, to address this gap in the literature.

With some exceptions, most participants were in long-term, stable, committed relationships. Thus, there was a lack of diversity of relationship formations and durations. This likely impacted the results of the study. Newer couples might face different and possibly greater struggles coping with prostate cancer, as they lack a history of successfully navigating hardship together. Inclusion criteria included male-female couples, thus the study lacks diversity in relationship configurations. The decision to only include heterosexual couples in this initial project was based on a desire to focus on how couples negotiate, navigate, and construct male/masculine and female/feminine roles. An assumption was made that the male/female binary (e.g., positioning maleness and femaleness as distinct opposites) would be more pronounced in male/female partnerships than in same-sex partnerships.

In addition, much of the prostate cancer patient literature is oriented towards heterosexual men (e.g., Blank, 2005; Filiault, 2008), thus an assumption was made that these couples would likely interact with patient materials differently than same-sex couples. Specifically, heterosexual couples may be more likely to take messaging in patient materials as prescriptive and relevant to them. They may be more vulnerable to normative discourses embedded in patient materials. In contrast, the inclusion of same-sex couples would permit an exploration of possibly alternative ways of navigating dominant

discourses of sex and gender in the context of prostate cancer. In particular, the relative invisibility of same-sex couples in prostate cancer literature would lead to other questions. For example, does their invisibility offer greater or less opportunity for resistance?

Recruitment was done primarily through prostate cancer support groups. This was purposeful, based on the assumption that men willing to speak/share in a support group context would be more likely to engage in an interview study. However, this choice also biased the sample. Participants in the study are socially connected, relatively articulate, and have likely thought and talked a lot about their experiences with prostate cancer.

Many participants indicated explicitly that they chose to participate in the study in order to help others. They expressed that they wished to tell their stories so that others would be more informed and feel less isolated and alone. This undoubtedly impacted the ways in which they framed their responses to questions.

This is not a unique limitation to the present study as samples are always self-selected; participants often decide to participate in research because they want to convey something about their experience. Participants are actively *doing* something through their decision to participate in a study, rather than merely *revealing* some underlying objective truth to investigators. Thus, a personal narrative can be thought of as something that participants *do,* rather than something that they *possess* or *have,* in the context of a research study (Diamond, 2006; Fivush, 2000). In her paper on autobiographical narrative research, Diamond (2006) states that while "all memories are dynamic and situationally influenced (Davies and Harre, 1990; Schacter, 1996; Conway and Pleydell-Pearce 2000), autobiographical memories are particularly sensitive to an individual's present goals, self-perceptions, and interpersonal contexts (pp. 477-478, citing McAdams, 1993; Kihlstrom,

1996; Conway & Pleydell-Pearce, 2000; Fivush, 2000; Tversky & Marsh, 2000; Pasupathi, 2001; Marsh & Tversky, 2004). In a review of research on the social and co-construction of the personal past in conversation, Pasupathi (2001) states that people have various goals in mind when they construct a narrative of their past, and that these goals are linked to the particular moment in time when the telling/narrating takes place. The goals may determine which events are inserted into the narrative vs. omitted, and may impact the ways in which the events are recalled. Narrative reconstruction is thus subject to the goals, perceptions, and reflections of participants (Diamond, 2006; Pasupathi, 2001), and the accounts collected and analyzed in the present study are undoubtedly no exception to this.

Future directions include a study that conducts interviews with clinicians and other professionals working in the field of prostate cancer (e.g., those working in penile rehabilitation clinics, those offering services more broadly to men with prostate cancer and their partners, those authoring patient materials, etc.). I would like to pick up on the themes that emerged in this dissertation project (e.g., discourses about sex, gender, relationships, etc.) and to explore similarities and/or differences in the discourses adopted in interviews. It would be interesting to explore the subject positions adopted and/or resisted by these professionals (e.g., benign helper? conveyer of objective truth? norm shaper? etc.).

Finally, Study I included analysis of a subset of online patient materials about penile and/or sexual rehabilitation. It would be useful to expand this analysis to include a greater variety of technologies of sex. For example, a next study could involve discourse analysis of messages about sex and gender embedded in popular books about prostate

cancer and sexuality, such as *Saving Your Sex Life: A Guide for Men with Prostate Cancer* (Mulhall, 2010). Sexual improvement shows, sexuality researchers, spokespersons and experts, sex therapies, and self-help manuals all exert great power in establishing and reinforcing sexual norms (e.g., Attwood, Barker, Boynton, & Hancock, 2015; Barker, Gill, & Harvey, in press; Gill, 2009; Harvey & Gill, 2011a, 2011b;Tiefer, 2004). In their analysis of sex media advice-giving, Attwood, Barker, Boynton, and Hancock (2015) write that advice "is frequently dependent on a dysfunction/disorder-based understanding of sex and on assumptions of mononormativity and heteronormativity. It often presents male and female sexuality as radically different, addresses women as responsible for maintaining good sexual relationships with their partners and constructs its audiences as responsible for maintaining 'great' or 'hot' sex in their relationships" (Attwood et al., 2015, p. 532). 'Sexpert' sources mediate sexuality; one comes to understand, experience, and relate to one's sexuality through sources of sexual expertise. It is thus important to analyze expert sources for meaning systems because of their power to shape, restrict, and expand sexual subjectivities, possibilities, experiences, and desires.

Appendix A

Individual Interview Questions – Male Partner

The purpose of this interview is to explore the ways in which being treated for prostate cancer may alter a man's sense of self-identity and sexuality. In particular we will be exploring how men make sense their sexual and relationship experiences in the period of time following their treatments, and what their experiences are like being part of penile rehabilitation.

Domain #1: Navigating changes in the relationship

1. How has your relationship been impacted by your cancer diagnosis and treatments?
Probes:
-Closeness in the relationship
-Roles in the relationship

2. What has this (these changes) been like for you?

Domain #2: Navigating sexual changes in the relationship

3. What impact has your cancer treatments had on the sexual part of your relationship?
Probes:
-Any impact on your sexual connection?
-Changes in frequency of sex?
-Changes in sexual desire/interest?
-You/partner withdrawing sexually?
-Do you talk about sex more/differently?
-Do you approach sex differently?
-Impact of other side-effects on sexual intimacy (e.g., bowel problems, urinary incontinence)

4. What has this (these changes) been like for you?

5. What, if any, impact has your cancer treatments had on your sexuality?
Probes:
-Any impact on your sexual desire?
-Any impact on your sexual pleasure?
-Any impact on your sexual self-esteem or sexual confidence?
-Any impact on your experience of feeling desired/wanted by your partner?

Domain #3: Sense of masculinity

6. Has being treated for prostate cancer had any impact on your sense of masculinity?/being a man?

Domain 4: Penile Rehabilitation Experiences

7. Tell me about how you were first introduced to penile or sexual rehabilitation.
Probes:
-Who introduced them? (oncologist? Surgeon? GP? Book? Online?)
-How was it explained? (what rationale was given for penile rehabilitation?)
-Why did you/your partner decide to participate in penile rehabilitation? (If they stopped, inquire about why they stopped)
-How was your role/participation explained (if at all)?

8. What is your partner's role in your sexual recovery/penile rehabilitation?

9. Tell me about your experiences with penile rehabilitation
Probes:
-What has it been like for you?

Appendix B

Individual Interview Questions – Female Partner

The purpose of this interview is to explore the ways in which being with a partner treated for prostate cancer may alter a women's sense of self-identity and sexuality. In particular we will be exploring how women make sense their sexual and relationship experiences in the period of time following their partner's treatments, and what their experiences are like being part of penile rehabilitation.

Domain #1: Navigating changes in the relationship

1. How has your relationship been impacted by your partner's cancer diagnosis and treatments?
Probes:
-Closeness in the relationship
-Roles in the relationship

2. What has this (these changes) been like for you?

Domain #2: Navigating sexual changes in the relationship

3. What impact has your partner's cancer treatments had on the sexual part of your relationship?
Probes:
-Any impact on your sexual connection?
-Changes in frequency of sex?
-Changes in sexual desire/interest?
-Partner withdrawing sexually?
-Do you talk about sex more/differently?
-Do you approach sex differently?
-Impact of other side-effects on sexual intimacy (e.g., bowel problems, urinary incontinence)

4. What has this (these changes) been like for you?

5. What, if any, impact has your partner's cancer treatments had on your sexuality?
Probes:
-Any impact on your sexual desire?
-Any impact on your sexual pleasure?
-Any impact on your sexual self-esteem or sexual confidence?
-Any impact on your experience of feeling desired/wanted by your partner?

Domain #3: Sense of femininity

6. Has being with a man treated for prostate cancer had any impact on your sense of femininity/being a woman?

Domain 4: Penile Rehabilitation Experiences

7. Tell me about how you were first introduced to penile or sexual rehabilitation.
Probes:
-Who introduced them? (oncologist? Surgeon? GP? Book? Online?)
-How was it explained? (what rationale was given for penile rehabilitation?)
-Why did you/your partner decide to participate in penile rehabilitation? (If they stopped, inquire about why they stopped)
-How was your role/participation explained (if at all)?

8. What is your role in your partner's sexual recovery/penile rehabilitation?

9. Tell me about your experiences with penile rehabilitation
Probes:
-What has it been like for you?

Appendix C

Couple Interview Schedule

The purpose of this interview is to explore the ways in which being treated for prostate cancer may impact a couple, and in particular both women's and men's sense of self-identity and sexuality. In particular we will be exploring how couples make sense their sexual and relationship experiences following prostate cancer treatment and their experiences with penile rehabilitation.

Domain #1: Navigating changes in the relationship

1. How has your relationship been impacted by your the cancer diagnosis and treatments?
Probes:
-Closeness in the relationship
-Roles in the relationship

2. What has this (these changes) been like for you?

Domain #2: Navigating sexual changes in the relationship

3. What impact have the prostate cancer treatments had on the sexual intimacy in your relationship?
Probes:
-Any impact on your sexual connection?
-Changes in frequency of sex?
-Changes in sexual desire/interest?
-Partner withdrawing sexually?
-Do you talk about sex more/differently?
-Do you approach sex differently?
-Impact of other side-effects on sexual intimacy (e.g., bowel problems, urinary incontinence)

4. What has this (these changes) been like for you?

5. What, if any, impact have the prostate cancer treatments had on your individual experiences of sexuality / senses of selves as sexual beings?
Probes:
-Any impact on your sexual desire?
-Any impact on your sexual pleasure?
-Any impact on your sexual self-esteem or sexual confidence?
-Any impact on your experience of feeling desired/wanted by your partner?

Domain #3: Sense of femininity/masculinity

6a. (For female partner) Has being with a man treated for prostate cancer had any impact on your sense of femininity/being a woman?
6b. (For male partner) Has being treated for prostate cancer had any impact on your sense of masculinity/being a man?

Domain 4: Penile Rehabilitation Experiences

7. Tell me about how you were first introduced to penile or sexual rehabilitation.
Probes:
-Who introduced them? (oncologist? Surgeon? GP? Book? Online?)
-How was it explained? (what rationale was given for penile rehabilitation?)
-Why did you/your partner decide to participate in penile rehabilitation? (If they stopped, inquire about why they stopped)
-How was your role/participation explained (if at all)?

8. How do you think about/what are each of your roles in sexual recovery/penile rehabilitation?

9. Tell me about your experiences with penile rehabilitation
Probes:
-What has it been like for you?

Appendix D

Questionnaire: Couple (Male Partner)

Section 1: Demographic Questions

1. How old are you? _____

2. What is your cultural background? _____

3. Are you religious? If so, what is your religion? _____

4. What is the highest level of education that you obtained? (please circle)

No High School	Completed College or University
Some High School	Some Postgraduate Studies
Completed High School	Completed Postgraduate Degree
Some College or University	

5. What is your annual household income range? (please circle)

Less than $19,000

$20,000 - $39,999

$40,000 - $59,999

$60,000 - $79,999

$80,000 - $99,999

More than $100,000

Section II: Questions about Your Relationship

9. How long have you been with your partner? _____

10. Are you and your partner currently (please circle one):

Married

Co-habiting/Common-law

Dating but not living together

Other (please specify)

Section III: Questions about your Prostate Cancer

11. When were you diagnosed with prostate cancer?

12. How old were you when you were diagnosed with prostate cancer?

13. How old was your partner when you were diagnosed with prostate cancer?

14. How long had you and your partner been together when you were diagnosed with prostate cancer?

15. What treatments have you received for prostate cancer? (please indicate which treatments, and when)

Type of Treatment	Date Started	Date Ended (if complete)
Radical Prostatectomy		
Radiation Therapy		
Hormone Therapy		
Other (please specify):		

Section IV: Questions about your Penile/Sexual Rehabilitation Treatments

****Feel free to consult with your partner when answering questions from this section**

16. What kind of penile/sexual rehabilitation treatments have you received since being treated for prostate cancer? (please indicate which treatments, and when they occurred)

☐**Oral Pills:** I partner was given and/or prescribed oral medications (e.g. Viagra, Cialis, Staxyn, Levitra)

Approximately when did this treatment first occur? _____

Approximately how many times have you used this treatment since then? _____

If this treatment is ongoing, approximately how often do you take these oral medications? _____

☐**Injections:** I was prescribed penile injections

Approximately when did this treatment first occur? _____

Approximately how many times have you used this treatment since then? _____

If this treatment is ongoing, approximately how often do you use it? _____

☐**MUSE:** I was prescribed penile suppositories (e.g., MUSE) to insert in the tip of the penis

Approximately when did this treatment first occur? _____

Approximately how many times have you used this treatment since then? _____

If this treatment is ongoing, how often do you use it? _____

☐**Self-Stimulation**: I was instructed to self-stimulate on a regular basis

Approximately when did you first start using this treatment? _____

Approximately how many times have you used this treatment since then? _____

If this treatment is ongoing, how often do you use it? _____

☐**Vacuum Pump**: I was prescribed/obtained a penile vacuum pump

Approximately when did you first start using this treatment? _____

Approximately how many times have you used this treatment since then? _____

If this treatment is ongoing, how often do you use it? _____

☐**Other (Please specify):** _____

Approximately when did you first start using this treatment? _____

Approximately how many times have you used this treatment since then? _____

If this treatment is ongoing, how often do you use it? _____

Appendix E

Questionnaire: Couple (Female Partner)

Section 1: Demographic Questions

1. How old are you? _____

2. What is your cultural background? _____

3. Are you religious? If so, what is your religion? _____

4. What is the highest level of education that you obtained? (please circle)

No High School	Completed College or University
Some High School	Some Postgraduate Studies
Completed High School	Completed Postgraduate Degree
Some College or University	

5. What is your annual household income range? (please circle)

Less than $19,000

$20,000 - $39,999

$40,000 - $59,999

$60,000 - $79,999

$80,000 - $99,999

More than $100,000

6. Who do you live with? _____

_____

7. Do you have children? If so, what are their ages? _____

Section II: Questions about Your Relationship

8. How long have you been with your partner? _____

9. Are you and your partner currently (please circle one):

Married

Co-habiting/Common-law

Dating but not living together

Other (please specify)

Appendix F

Questionnaire: Individual (Male Partner)

Section 1: Demographic Questions

1. How old are you? _____

2. What is your cultural background? _____

3. Are you religious? If so, what is your religion? _____

4. What is the highest level of education that you obtained? (please circle)

No High School	Completed College or University
Some High School	Some Postgraduate Studies
Completed High School	Completed Postgraduate Degree
Some College or University	

5. What is your annual household income range? (please circle)

Less than $19,000

$20,000 - $39,999

$40,000 - $59,999

$60,000 - $79,999

$80,000 - $99,999

More than $100,000

6. Who do you live with? _____
_____

7. Do you have children? If so, what are their ages? _____
_____

Section II: Questions about Your Relationship

8. How old is your partner? _____

9. How long have you been with your partner? _____

10. Are you and your partner currently (please circle one):

Married

Co-habiting/Common-law

Dating but not living together

Other (please specify)

Section III: Questions about your Prostate Cancer

11. When were you diagnosed with prostate cancer? _____

12. How old were you when you were diagnosed with prostate cancer? _____

13. How old was your partner when you were diagnosed with prostate cancer? ___

14. How long had you and your partner been together when you were diagnosed with prostate cancer? _____

15. What treatments have you received for prostate cancer? (please indicate which treatments, and when)

Type of Treatment	Date Started	Date Ended (if complete)
Radical Prostatectomy		
Radiation Therapy		
Hormone Therapy		
Other (please specify):		

Section IV: Questions about your Penile/Sexual Rehabilitation Treatments

16. What kind of penile/sexual rehabilitation treatments have you received since being treated for prostate cancer? (please indicate which treatments, and when they occurred).

☐**Oral Pills:** I partner was given and/or prescribed oral medications (e.g. Viagra, Cialis, Staxyn, Levitra)

When did this treatment first occur? _____

How many times have you used this treatment since then? _____

If this treatment ongoing, how often do you take these oral medications?

_____

☐**Injections:** I was prescribed penile injections

When did this treatment first occur? _____

Wow many times have you used this treatment since then? _____

If this treatment is ongoing, how often do you use it? _____

☐**MUSE:** I was prescribed penile suppositories (e.g., MUSE) to insert in the tip of the penis

When did this treatment first occur? _____

Wow many times have you used this treatment since then? _____

If this treatment is ongoing, how often do you use it? _____

☐**Self-Stimulation**: I was instructed to self-stimulate on a regular basis

When did this treatment first occur? _____

Wow many times have you used this treatment since then? _____

If this treatment is ongoing, how often do you use it? _____

☐**Vacuum Pump**: I was prescribed/obtained a penile vacuum pump

When did this treatment first occur? _____

Wow many times have you used this treatment since then? _____

If this treatment is ongoing, how often do you use it? _____

☐**Other (Please specify):** _____

When did this treatment first occur? _____

Wow many times have you used this treatment since then? _____

If this treatment is ongoing, how often do you use it? _____

Appendix G

Questionnaire: Individual (Female Partner)

Section 1: Demographic Questions

1. How old are you? _____

2. What is your cultural background? _____

3. Are you religious? If so, what is your religion? _____

4. What is the highest level of education that you obtained? (please circle)

No High School	Completed College or University
Some High School	Some Postgraduate Studies
Completed High School	Completed Postgraduate Degree
Some College or University	

5. What is your annual household income range? (please circle)

Less than $19,000

$20,000 - $39,999

$40,000 - $59,999

$60,000 - $79,999

$80,000 - $99,999

More than $100,000

6. Who do you live with? _____
_____

7. Do you have children? If so, what are their ages? _____
_____

Section II: Questions about Your Relationship

8. How old is your partner? _____

9. How long have you been with your partner? _____

10. Are you and your partner currently (please circle one):

Married

Co-habiting/Common-law

Dating but not living together

Other (please specify)

Section III: Questions about your Partner's Cancer

11. When was your partner diagnosed with prostate cancer? _____

12. How old were you when your partner was diagnosed with prostate cancer? _____

13. How old was your partner when he was diagnosed with prostate cancer? _____

14. How long had you and your partner been together when he was diagnosed with prostate cancer?

15. What treatments has your partner received for prostate cancer? (please indicate which treatments, and when)

Type of Treatment	Date Started	Date Ended (if complete)
Radical Prostatectomy		
Radiation Therapy		
Hormone Therapy		
Other (please specify):		

Section IV: Questions about Penile/Sexual Rehabilitation:

16. Based on what you know, what kind of penile/sexual rehabilitation treatments has your partner received since being treated for prostate cancer? (please indicate which treatments, and when they occurred)

☐**Oral Pills:** My partner was given and/or prescribed oral medications (e.g. Viagra, Cialis, Staxyn, Levitra)

When did this treatment first occur? _____

How many times has your partner used this treatment since then? _____

If this treatment is ongoing, how often does your partner use this treatment?_____

☐**Injections:** My partner was prescribed penile injections

When did this treatment first occur? _____

How many times has your partner used this treatment since then? _____

If this treatment is ongoing, how often does your partner use this treatment?_____

☐**MUSE:** My partner was prescribed penile suppositories to insert in the tip of the penis (e.g. MUSE)

When did this treatment first occur? _____

How many times has your partner used this treatment since then? _____

If this treatment is ongoing, how often does your partner use this treatment?_____

☐**Self-Stimulation**: My partner was instructed to self-stimulate on a regular basis

When did this treatment first occur? _____

How many times has your partner used this treatment since then? _____

If this treatment is ongoing, how often does your partner use this treatment?_____

☐**Vacuum Pump**: My partner was prescribed/obtained a penile vacuum pump

When did this treatment first occur? _____

How many times has your partner used this treatment since then? _____

If this treatment is ongoing, how often does your partner use this treatment?_____

☐**Other (Please specify):**

When did this treatment first occur? _____

How many times has your partner used this treatment since then? _____

If this treatment is ongoing, how often does your partner use this treatment?_____

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