Redefining masculinity – Men’s repair work in the aftermath of prostate cancer treatment

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Treatments for prostate cancer have many potential side effects such as a loss of erection, weaker orgasms, and incontinence. These are all bodily changes that may challenge dominant masculine ideals. In this article, I use Persson’s repair work to describe how men tackle these side effects, and I describe the trouble their repair work elicits in terms of masculinity. I analyse interviews with eleven Swedish men, all treated for prostate cancer, and show that such work is done in three ways. Bodily repair work elicits the work men do to restore bodily functions, often through medical technologies. Relational repair work describes how relations with (potential) others shape men’s bodily and sexual concerns, and the ways relations redefine such concerns. Age marking as repair emphasises how age is used in the redefinitions of norms about masculinities and aging bodies, both in relation to oneself and others. The analysis highlights how men’s repair work is multifaceted, and is performed against the backdrop of dominant discourses on masculinity, medicine and old age. The analysis of such repair work is valuable to research on how masculinity is constructed in the light of treatment side effects and older age.

Prostate cancer and masculinity

Any changes in the prostate, benign or malignant, may cause urination problems. For many men, such problems will be among the most common symptoms of prostate-related disease, including prostate cancer (Sieve, 2019). However, in Sweden and many other western countries, increasing numbers of men are being diagnosed with ‘asymptomatic’ cancer. This is mainly due to an increase in the use of tests of prostate-specific antigen (PSA) level as part of routine health check-ups. This enables many cancers to be found and treated, even before the first symptoms arise (Bratt et al., 2010). The most common forms of treatment for invasive prostate cancer include surgery and radiation. While completely different from a medical point of view, the side effects from these two treatments overlap to a certain extent, and include incontinence, a loss of erection and a weaker orgasm (Albaugh, Sufrin, Lapin, Petkewicz, & Tenfelde, 2017). These effects challenge men’s ability to control body fluids and to have penetrative and
ejaculatory sex. The way in which bodily performance connects to contemporary western hegemonic masculinity (Connell, 1995) suggests that ‘leaky’ and ‘impotent’ bodies can be a threat to men’s masculine self (Oliffe, 2005).

Most studies on prostate cancer, sexuality and masculinity have been carried out studying older, often white, heterosexual men (Broom, 2004; Chapple & Ziebland, 2002; Oliffe, 2005, 2006). In recent years, however, a focus on gay men and younger men has increased (Danemalm Jägervall, Brüggemann, & Johnson, 2019; Fillault, Drummond, & Smith, 2008; Matheson et al., 2017). Although studies may differ with regard to sexual identity and sexual practice, a central theme has been erectile problems and their impact on sexuality. Klaeson, Sandell, and Berterö (2012) described the essential meaning of the impact of prostate cancer on sexuality as ‘losing the elixir of life’ (p. 1190), which consists in part of threats to manhood. Related to this, erectile problems are a main cause of significant emotional distress in prostate cancer patients (Maharaj & Kazanjian, 2019).

Studies have focused on how masculinity is maintained or redefined in relation to prostate cancer treatment. Oliffe (2005) was among the first to highlight how heterosexual men actively redefine sexuality and masculinity in the light of treatment side effects. He focussed on erectile problems, and argued that it is not possible to know how men will respond to potency-related side-effects. He emphasised diversity and complexity in his informants’ accounts: most men used medication and tried to regain their erectile function, striving for a sense of sexual ‘normality’. Others had explored new ways of sexuality and intimacy. Ussher, Rose, and Perz (2017) found similar patterns in their study on how gay men make sense of sexuality, in particular in relation to aging, after prostate cancer treatment. They identified three subject positions. The first, mastering youth, emphasises regaining erectile function or emphasises sexual activity and attractiveness in other ways. The second, the lonely old recluse, are those who go into social isolation and position themselves as a ‘tragic old man’. The third, accepting embodied aging, renegotiates intimacy and accepts changing bodily functions as an effect of aging processes. Maliski, Rivera, Connor, Lopez, and Litwin (2008) studied Latino and African-American men, and also highlighted processes of normalisation and renegotiation. They emphasise the importance of cultural sensitivity in understanding masculinity and sexuality.

New subject positions and processes in which masculinity and sexuality are redefined are not unique to those with the side effects of prostate cancer treatment or as part of aging processes. They are seen in a range of diagnoses and treatments. A recent study among men with breast cancer showed that they felt compelled to rethink what makes a man a man, and how they were rather suddenly confronted with living at the margins of a culture dominated by hegemonic masculine ideals (Thompson & Haydock, 2020). This study emphasised not only the relationship between bodily changes and masculinity, but also how the gendered status of the disease mattered to the way in which the men reformulated ideas of masculinity (breast cancer being seen as a ‘feminine’ disease). Even diseases with less obvious gendered characteristics may evoke similar threats to masculinity. One example is rheumatoid arthritis, where threats to identity stem from changes in bodily abilities (Flurey et al., 2018), which highlights the complexity of the relationships between illness and masculinity.

The current article contributes to research on illness and masculinity in general and the realm of prostate cancer in particular. It does so by introducing the concept of repair work (Persson, 2012) to the field of health sociology, and uses this concept to
study how men tackle treatment side effects, and the problems that their repair work elicits. The analysis views repair work as more than ‘fixing what has broken’ and teases out diversities in the ways men redefine masculinities.

**Theoretical context**

This article starts from the assumption that gender and masculinity are socially constructed categories and arrangements (West & Zimmerman, 1987). Social construction does not imply that bodies are mere objects of social practices – they are generative of such practices (Connell & Messerschmidt, 2005). Thus, material bodies are very much part of what masculinity comes to be and how it transforms. The same applies to sexuality, which creates normative ideas about the male body and its abilities (Mamo & Fishman, 2001; Oliffe, 2005). Another assumption on which this article builds is that a plurality of masculinities exists. This idea has gained increased attention through the work of Connell (1995) and is used in a wide range of disciplines. A core idea behind this plurality is that a non-essentialist understanding of masculinity is needed to make sense of the multiplicity of norms, relationships and hierarchies that various social sciences have studied (Connell & Messerschmidt, 2005). Connell originally identified hegemonic, complicit, subordinate, and marginalised masculinities, and viewed these as relational and hierarchical (Connell, 1995). Hegemonic masculinity is the dominant configuration in a given time and setting, in its relationship to femininity, and in its relationship to other masculinities. A recent development in masculinity theory is the engagement with feminist theory on care and relationality, and the related development of caring masculinities (Elliott, 2016). These masculinities are relevant in European settings (Elliott, 2016), and in the Nordic countries in particular (Nissen, 2017). Caring masculinities can be described as ‘a refiguring of masculine identities away from values of domination and aggression and toward values of interdependence and care’ (Elliott, 2016, p. 256), or a ‘caring for and about and taking care of individual bodies and selves, both one’s own and those of others’ (Nissen, 2017, p. 555, original emphases). It is implied that traditional hegemonic masculine practices, such as risk-taking behaviour, do not respect or take care of bodies and selves, but are of a destructive character (Schrock & Schwalbe, 2009). However, as Nissen also notes, some risk-taking practices can care for bodies and selves, which demonstrates the complexity of practices and the co-construction of various masculinities (Connell, 1995).

I use and refine the concept of repair work (Persson, 2012) as an analytical tool to learn more about the construction of masculinity, in particular in relation to prostate cancer. Persson took the concept of repair work from ethnomethodology into her ethnographic research in an armed forces unit ‘in order to understand how individuals in a particular social context attend to “trouble” that disturbs their established ways of doing gender’ (Persson, 2012, p. 138). This concept, Persson states, can help us understand repair practices as part of how gender is done, and help us identify what is threatened and at stake. Connecting this to work on masculinities, repair work is either in line with traditional, hegemonic masculine ideals (Connell & Messerschmidt, 2005), or rejects or reformulates them (Gerschick & Miller, 1994). So, rather than claiming that repair work is always in line with only one type of masculinity, I will show how repair work can consist of a broad repertoire, attending to different masculinities.
For a nuanced view on the concept, I turn to work from cultural theory that has unpacked different conceptualisations of repair. Sennett (2018) identified three forms of repair when applied to the reparation of objects. Restoration is a closed form of repair, meaning that the materials of the object are used to rewind the object back to its original state, with the same form and function. Remediation also aims to preserve the form and function of an object, but with slight improvements. Reconfiguration is more open, and alters the form and function of an object, turning it into something different. McLaren (2018) adds reconciliation as a form of repair of ‘broken’ relationships, and this widens the idea of what the objects of repair can be. Graham and Thrift (2007) suggested that repair is vital to maintain stable infrastructures and technologies. They argue that disruptions and breakdowns are part of these infrastructures and networks, and show how such disruptions produce learning, adaptation, and innovative solutions. In the context of gender repair work, the construction of masculinities may come to the forefront during disruptions, such as sudden bodily changes and the adaptations and redefinitions that follow.

Interviewing men treated for prostate cancer

The material used in the current article consists of a series of interviews I conducted during the autumn and winter of 2016–2017 with men who had been treated for prostate cancer. After the project had been approved by the regional ethical review board in Linköping, Sweden (no. 2016/167-31), a few prostate cancer patient organisations in Sweden emailed invitations to participate in an interview with me to their members. Men who accepted received more information about the study and were given the opportunity to suggest a date and place for the interview. Most of the interviews took place in the men’s home, others at their workplace or in a library room. The men signed an informed consent letter and were informed about confidentiality at the start of the interview, and informed that the interview would be recorded and transcribed. The interviews lasted between 45 and 75 min.

Ten men agreed to participate in an interview by replying to the invitation, and one additional participant was contacted through a snowball technique (Table 1). All the men were white, Swedish-speaking, middle-to-upper class (as determined by their profession and other class indicators such as their homes), and in relatively good physical shape. All but one were without metastatic cancer (the exception being Participant 9, who stated that he had skeletal metastasis, without giving further details). I, the interviewer, am also a white Swedish-speaking, heterosexual, middle-class man, but younger than the participants; I was in my mid-thirties at the time of data collection. In the interviews I drew on my earlier experience of doing qualitative research on sensitive issues related to health and medicine.

The interviews were semi-structured and followed an interview guide that was essentially chronologically structured. It started with personal background, and progressed through the time of diagnosis, the period between diagnosis and treatment, and finally to treatment and the subsequent period. For each of these periods, questions were asked about their lives during that time, with a specific focus on bodily and sexual changes, or the anticipation of such changes. The transcribed interviews were analysed using a theoretical thematic analysis (Braun & Clarke, 2006, 2014). Such an analysis,
in contrast to a more inductive data-driven approach, is ‘driven by the researcher’s theoretical or analytic interest in the area’ (Braun & Clarke, 2006, p. 84). I started by writing extensive memos, and then performed an initial manual coding of the material, in which I identified and coded excerpts that were relevant to the overall research topic of masculinity and prostate cancer treatment. In the next stage, going from codes to themes, I used thematic maps (Braun & Clarke, 2006), which help to tease out relationships between codes and themes, and relationships between themes. At this stage, the analysis was more explicitly connected to the study’s theoretical backdrop on repair work. I passed several times back and forth between codes, memos, theory, and potential themes. In the final stage, the three themes that had been identified were refined and thereafter labelled: bodily repair work, relational repair work, and age marking as repair. The three themes were present in all interviews.

**Bodily repair work**

All men were in some way concerned with their bodily changes, mainly their loss of erection or their urinary incontinence. For one participant, the idea of losing his erection was likened to a life-ending experience. About his first radiation session he said: ‘It was tough, really tough. No, I didn’t want to do it. I was like, someone being on death row walking to the electric chair. That’s how it felt.’ (P1). Others expressed similar concerns, identifying their loss of erection as now only being ‘half-human’ (P2), while another participant referred to memories of his last sexual intercourse with his wife before the operation, ‘when I still was manly’ (P11). Incontinence was described as shameful and as bringing the risk of ‘smelling old man’, a disparaging Swedish expression that may relate to urine smells. The body, however, was not only framed as a problematic site: it was also deployed as part of men’s repair work.
Five participants were particularly concerned with the period between their cancer diagnosis and the treatment, and anticipated potential trouble that the treatments may cause. These concerns translated into a very deliberate engagement with treatment choices or learning about expected bodily changes. In this way, they turned some side effects into effects they had chosen to undergo, after becoming well-informed—a kind of damage control. They not only talked to medical experts, but also studied literature and talked to other men (sometimes strangers) to learn more about the pros and cons of different options. One man (P1) had intense pre-treatment worries about his new partner’s future sex life, and feared that he would be unable to perform penetrative sex. His worries were as much about caring for his own future abilities, as about her future sex life. Another man (P8) translated these anticipations into a ‘gambling procedure’ when he was discussing surgery with his physician.

Then I said: “Well, this is a no-brainer, of course I’ll take the riskier option, if it means I can keep the function and there’s a treatment afterwards. […] I mean, 10% or 20%, I have at least 80% on my side”. I also thought: “This is an early stage, so I am gambling a bit”, I did. But I thought it was obvious. (P8)

This can easily be understood as repair in line with traditional masculine norms of risk-taking and control. There is, however, also a dimension of careful contemplation of bodily pleasures and the relationships that are at stake, and viewing suggested invasive medical treatments in a broader picture of what and whom the man cares for: a caring endeavour and part of enforcing a caring masculinity (Nissen, 2017).

After the treatment period, practices to restore bodily functions were a dominant form of repair work. The men mobilised various medical technologies, mainly injections (such as Caverject) and pills (such as Viagra), in their repair work. First, they used these technologies to restore their pre-treatment bodies. They accepted that medications did not make their bodies similar to they had been pre-treatment, but they restored a bodily function that gives access to certain sexual practices: to obtain an erection and penetrate. For most men, using medication was a primary strategy in the period after their treatment (although not immediately after treatment), while it was an important strategy at the time of the interview for only a few. Second, the men believed that the existence of medication itself took care of potential trouble, even though the men did not choose to use them. For one married participant, the availability of medication made the thought of becoming alone much less of a threat.

How would it be if I met a new woman? […] Should I tell her at once or just see what happens? Now I don’t intend to get a new woman, I am happy as it is and you also get lazy, but the thought has been there and still is. What would happen? And then I really think it is nice to know that there are medications, that I can get an erection, and that I can have intercourse. (P4)

The availability of medical technologies enabled the men to choose whether to strive after certain bodily abilities, and provided the men with an instant repair kit. The availability of erectile medication gave the men some control; they could choose to decline certain dominant heterosexual practices without having to reject them (Eck, 2014).

For one man in particular, bodily restoration was not intrinsic to pills or injections, but to ways he himself worked with his body. He and his wife had very little sexual intimacy, and no penetrative sex, but he still worked actively to ‘train’ his erection.
The thing that affected me quite a lot, was what a counsellor, a woman, told me: “You have to keep going, you need to try to get orgasms”. [...] In the back of my head I thought: “Of course me and my wife will get a normal sex life eventually”. That hasn’t happened yet, but I had that wish. So that’s why I did that, because she said: “If you stop doing that, it can hurt you in the long run, then it’s more difficult.” (P2)

This practice fits well with this participant’s overall ambiguity about sexuality: on the one hand he was trying to frame it as trivial in his current life, while on the other hand giving it a very prominent place in his, and any man’s, life overall. The ‘keep going’ strategy for him served the same function as the injections and pills for some others: it allowed him to start reconfiguring sexuality while staying in control of his body and keeping the door open to certain hegemonic sexual and masculine ideals. This is not isolated from counselling and medical discourses, at least in Sweden, which emphasise ‘penile rehabilitation’ and the reconciliation of caring relationships and intimacy at the same time.

Actively restoring bodily functions, either through medication or training, can be seen as repair work to regain or maintain normative masculine bodily functions. But there are also aspects of a caring masculinity, a caring for the self and others in the light of post-treatment suffering. About using erectile injections, one participant said:

This woman at the hospital taught me exactly how to use it, so it feels really natural to me. But the lady I am dating is a bit more bothered. She wondered: “Can you take this as often as you want”? You can’t, not more than three times a week, and I haven’t used it more than once a week. But she’s fine without it actually. So it’s not that I use it every time we have sex, no. And it [sex] works fine anyway. (P6)

Much of the bodily repair work described above has a clear relational dimension to it: bodily functions were tuned and tweaked to fit practices that involve others or potential others. The following section highlights men’s relational repair work.

**Relational repair work**

Which troubles the men identified depended strongly on whether they had an intimate partner or not. Only one of the participants was single at the time of his treatment. His wife left him at the time of his diagnosis and he remained single. For him, the ten years since the diagnosis had been a great struggle; he had a strong wish to be together with someone, but described his loss of erection as preventing him from finding a new partner. He had thought about this every single day for many years. He described his thoughts about meeting women and talking about situations that could lead to intimacy:

You don’t even want to open up for such a situation. Because, that’s going nowhere, it feels like. The ultimate thing is to have intercourse. That’s how I see it. Both having a good time. Of course you can do that in different ways. But, for example, when you’re at a party or something, it happens that you meet a woman and get in touch. And suddenly you think, “Hold on ... let’s not go further than this.” (P3)

At the time of the interview he had given up the search for a new partner and believed that he would never have any further sexual contacts with others. He was open to the idea of other, less normative, types of sexual contact, but was not acting on this, and it was not mobilised as part of any repair work. He was absorbed by his bodily failures which led him to be somewhat socially isolated, despite trying to get round the impasse he was
experiencing. This highlights how destructive gendered bodily and sexual norms can be when repair work does not suffice. This man’s story also shines light on the way in which two other participants engaged with the matter of disclosing that they had difficulties in obtaining an erection and performing penetrative sex. These men expressed a need, or even an obligation, to disclose aspects of their body to a potential new partner. Fear of disclosure is a common theme in studies of single men who have been treated for prostate cancer (Matheson et al., 2017), and illustrates a broader theme of ‘coming out’ about one’s sexuality or ‘atypical’ body (Guntram & Zeiler, 2016).

Three men had rather recently met another woman at the time of the interviews. One of them (P6) is of particular interest here, as his story shows how repair work is contingent and relational, rather than a fixed individual strategy that a man employs. This man had lived almost all of his post-treatment life with his wife, with whom he had been together for over thirty years, until her death a year before the interview. He had been together with another woman during a six-month period immediately preceding the interview. He had started using Caverject injections while his wife was still alive, but they stopped having sex, ‘at least penetrative sex’, soon after. He emphasised that their life together worked anyway. With his new partner, sexuality has acquired a new meaning and a different status. His relationship with the new partner made him change from reconfiguring his identity and what sexuality is about, to restoring it.

It was at the annual check-up that [a hospital nurse] contacted me. And she asked me: “How are you doing, with your erection and so on?” […] And then she said: “Well, we are going to test this one [Caverject]”. I replied: “No, I am a widower now”, but she countered: “No, but you are still going to do this.” (P6)

This anecdote shows how the reasoning of the participant shifted; the nurse opened a door for him to get together with a new partner, while he was thinking that he would live the rest of his life alone. The nurse-patient repair work intrinsically linked a potential partner with the need for erection and medication, just as the men’s fear of disclosure seemed to signal.

A common repair practice used by men living with a partner was that the couple accepted the man’s bodily changes and redefined the relationship. While others have described acceptance mainly in terms of re-negotiations of intimacy (Oliffe, 2006; Ussher et al., 2017), the men in the current study constructed acceptance rather through an emphasis on the couple recognising that certain sexual practices now belonged to the past. Acceptance within couples was further emphasised through the men’s concerns with their partner’s genital issues:

No, we did not have sexual intercourse [after radiation], there were other things instead. […] But then she has had genital complaints too, so that contributes to her being less interested too [laughs]. So she says that she does not miss it either, so we are pretty happy the two of us. (P7)

The emphasis on a partner’s genital issues, expressed by four men, functioned as a way of reconciliation – potential friction in their relationship had been dissolved by aligning their bodies. As the two bodies gradually lost the ability to (enjoy) coital sexuality, the men were able to reconfigure what their relationship with their partner was about. The quotation given above puts the partner’s expressed or imagined will and needs in
focus. Likewise, other men stated that their partners did not ‘demand’ an erection, and thereby their bodies were no longer ‘failing’. The attention to their partners in these stories demonstrates a mixture of traditional and caring masculinities; although the men attend to their partner’s wishes and bodily conditions, they also put a focus onto getting out of trouble.

A great deal of repair work was also done in relation to other men. The infrastructure of patient organisations, through which these men had been included in the study, serves an important function. In patient organisation meetings, the cancer-treated body becomes a new normal; the unique individual body becomes part of a variation of cancer-treated bodies, and sexual problems become one of many issues in life.

Not many people show up, ten at the most, once a month we meet. It’s at a cafe here in the centre of town and we talk for an hour, an hour-and-a-half. We drink coffee and talk about the disease and football, it doesn’t matter. (P9)

This participant also described that having found new erectile medication is discussed in the same way as a football match is discussed. The openness about sexuality and sexual problems performs a resistance to hegemonic ideals, a caring for each other. Penetrative sex is seen as just one of many things men can do in life, creating a forum in which traditional ideals of masculinity are confirmed and contested at the same time.

**Age marking as repair**

Age-related repair work was a dominant theme throughout the interviews. Much of what the men described is what Coupland, Coupland, Giles, and Henwood (1991) call *age marking* or the way in which age is discursively used in identity work. Working with and around age as part of the men’s repair arose in all interviews, and was related to many of the practices described concerning bodily or relational repair work. One participant suggested that questions of sexuality and identity are especially important for younger men.

It may have been a big thing for me, it’s not that big for all men, especially not if you’ve been married for forty years and are seventy years old, sexuality has disappeared a long time ago, or you haven’t had any sexuality. I notice this in these [patient organisation discussion] groups, it doesn’t mean too much. But it does to us who are younger, also young at heart, which you can also be at age seventy or seventy-five. (P1)

By describing himself as *young*, this participant included himself in a younger age group, and drew a contrast with older men. While he described himself in the interviews as a ‘sexual creature’ and positioned himself as a person for whom sex is a really big thing, he associated sexuality to his relatively younger age, and pointed out that he had not *yet* reached an age that would make it appropriate to give up (penetrative) sexuality. Later in the quotation, however, he moved away from age as important *per se* and talked about being ‘young at heart’. He thereby made a discursive association between being young and being sexually active, which created the backdrop for his bodily and relational repair work. The oldest participant in the study, in contrast, accepted that his bodily changes did not allow for sexuality in the same way, and he instead emphasised and cared about other bodily abilities. When asked what came instead of penetrative sex, he answered:
We were outdoor people, so that’s what we continued doing. In any case we could still do our mountain hikes fifteen years after [my treatment] at least. We didn’t stop until, well I was eighty-plus, my wife may have stopped a bit earlier. So I can’t complain about my condition. (P10)

Contrary to this repair work that aligns well with ideas of ‘healthy’ or ‘successful’ aging, stretching ideals of sexual activity and physical fitness into higher ages (Spector-Mersel, 2006; Calasanti, 2016), age marking was also used to normalise bodily changes.

Sexuality may just have been slackened anyway, and maybe it’s just because of age, I don’t know. […] So things may not have been so much different if nothing had happened. It’s possible that the same things could have happened to us, at least the same stepping-down. (P5)

Old age is here used as a way out of trouble: less sexual lust, erectile problems and less sexual engagement are considered normal (see also Maliski et al., 2008). The bodily changes that occur after cancer and its treatment are no longer positioned as individual failures, but rather as variations of the older male body: ‘I thought nature can have its effect, actually. I don’t know, those who haven’t suffered from cancer, they may also have problems with erectile function. They must have that at such an old age’ (P10).

This repair work rejects certain bodily and sexual ideals and emphasises an older body – a body that is not directly referred to with pride, or as a new ideal, but rather as a state in which everyone, sooner or later, will end up – cancer treatment just accelerated the process (Maliski et al., 2008). In a way, the men use their aging process to frame their individual bodily failures as part of a collective set of failures. They thus permit themselves to settle down and accept that they lie outside of the boundaries that hegemonic scripts construct (Spector-Mersel, 2006).

**Concluding discussion**

The men’s stories in the current study are in line with those told by men in other studies, and highlight the bodily and relational invasiveness of the side effects of treatments for prostate cancer. This and previous studies have shown that the men tell stories in which erectile problems play a large part (Chapple & Ziebland, 2002; Maliski et al., 2008; Oliver, 2005). The strategies used by the men in the current study to tackle these side effects and to repair masculinity also partly echo strategies identified in previous studies. There are traces of Oliver’s (2005) analysis on striving for sexual normality, the normalising strategies described by Maliski et al. (2008), and the various subject positions relative to the aging body highlighted by Ussher et al. (2017). The current study uses the concept of repair work (Persson, 2012), and contributes to the field by showing how repair is done relative to three different areas: the body; relationships; age. The theoretical approach taken also adds to knowledge by further illuminating the complex, multifaceted repair work undertaken by men, and how it relates to masculinity.

Much of the men’s bodily repair work identified in the current study corresponds with dominant discourses around masculinity and medicine. These dominant discourses centre mainly on bodily restoration, e.g. aiming to regain erectile function, as a self-evident way of repairing masculinity and sexuality. An emphasis on bodily restoration, with the introduction of Viagra, has also led to erectile ‘dysfunction’ (Katz & Marshall,
becoming a condition that the individual patient can treat, rather than the relational challenge it used to be (Johnson & Åsberg, 2012). This development fits the dominance of biomedical approaches to rehabilitation, in which patients are defined in physical, biological, and mechanical terms (McPherson, Gibson, & Leplège, 2015), rather than in relational or emotional terms (Nissen, 2017). Even though couples counselling and sexual counselling are gradually becoming part of rehabilitation practices (Katz, 2016), penile rehabilitation is still dominant. This restoration strategy was also dominant in the bodily repair work described in this study. It appeared when the men talked about the use of erectile medication, and surfaced as a norm when they described the way in which they had reasoned that medication was something they had decided not to use, or could use if it were to become ‘necessary’. Bodily restoration was, however, given equal prominence in their descriptions of relational repair work, in the ways that erectile medication could open doors to new intimate and sexual relations, and how they adapted their use of medication to the needs of an intimate partner. So even though the men in the current study clearly used language that fits dominant discourses, using repair work and multiple masculinities as a lens, we see more nuanced pictures of the ways in which they dealt with side effects. Particular attention to the relational dimensions to illness and coping (cf. de Boer, Zeiler, & Slatman, 2019) may deepen our understanding of the construction of caring masculinities (Nissen, 2017).

As with bodily and relational dimensions, complex repair work could be seen also in the ways that age was used. Here the men simultaneously adhered to and made efforts to distance themselves from dominant discourses on sexuality, masculinity and old age. However, both age-related repair strategies boil down to a reinforcement of hegemonic ‘successful’ aging discourses (Calasanti, 2016). Either the men emphasised the importance of sexual or physical activity, which fits well with successful aging discourses (and is reinforced by erectile medication, see Katz & Marshall, 2004), or declared themselves to be part of the community of older men, who have ‘stepped down’ and for whom ‘nature has had its effect’. But being older, or having an older body, is not something that the men referred to as a valuable alternative, but rather as a sort of failure. They tended to downplay this by emphasising the failures of others, such as their partners or other men. And while this fulfils a need for normalisation and acceptance for these men, positioning the older, cancer-treated body as a failure does, in fact, reinforce very specific ways of aging successfully (Calasanti, 2016). Intrinsic to this dynamic are the ideas that ‘respectable models of later life’s masculinity are not available’ and ‘it [is] culturally unfeasible to be both a ‘true’ man and an old person’ (Spector-Mersel, 2006, p. 78). The current study provides some insight into the consequences of such narrow hegemonic scripts, and has offered insights into where and how men redefine and repair their bodies and (sexual) relationships in ways that can contribute to a broader range of respectable aging – ways that do not necessarily build on hegemonic ideas of activity and function (Spector-Mersel, 2006; Lamb, 2014).

The spectrum of repair practices highlighted in the current study, as with agency more generally, relates closely to the social position adopted by the participants, and the relational and physical resources they have available. In that respect, the current study is limited in its rather small, and more importantly, narrow sample. The men in the current study were all white, heterosexual, and middle-to-upper class. Most men were in reasonably good physical shape and lived without metastatic cancers. This means
that during the period of diagnosis and treatment they had considerable resources available, which could help them to stay within hegemonic boundaries, while at the same time being under more pressure to do so. For these ‘normative’ men, the cancer treatment may have caused even more abrupt and distinct collisions and tensions (see also Calasanti, 2016). While a narrow sample may have given depth and consistency to the analysis, it must be assumed that men in other positions will perform repair work differently, with different resources at hand. Men in other positions will also relate to different normative ideals. This is supported by research that shows how differently gay and bisexual men, working class men, and men from minority populations experience post-treatment concerns (Danemalm Jägervall et al., 2019; Fry, 2017; Ussher, Perz, & Rosser, 2018). The participants were recruited to the present study through prostate cancer patient organisations, which says something about the status and homogeneity of the members of such organisations. Therefore, questions must also be raised about the situation for non-white and non-heterosexual men, and how they can engage in repair work that involves other prostate cancer patients (Capistrant et al., 2016; Danemalm Jägervall et al., 2019). Consequently, there are several reasons to engage in future research on repair work in more diverse and less privileged populations. Doing so will increase health sociological understandings of the constructions of masculinity in the light of prostate cancer treatment, old age, and sexuality.

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