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(Dis)embodying gender and sexuality in testicular cancer

Maria Gurevich[a,*], Scott Bishop[b], Jo Bower[c], Monika Malka[d], Joyce Nyhof-Young[e]

[a] *Department of Psychology, Ryerson University and Psychosocial Oncology and Palliative Care Program, Princess Margaret Hospital, University Health Network, 350 Victoria Street, Toronto, Ont., Canada M5B 2K3*

[b] *Psychological Trauma Program, Centre for Addiction and Mental Health, and Department of Psychiatry, University of Toronto, Canada*

[c] *Communications and Psychology Research Consulting, Canada*

[d] *Circle of Care and Jewish Hospice Programs, Canada*

[e] *Department of Radiation Oncology, University of Toronto, Princess Margaret Hospital, University Health Network, Canada*

Abstract

Testicular cancer is the most common cancer in men aged 15–34. Although post-treatment prognosis is generally very good, the impact on sexuality, gender identity and fertility is amplified in this age group. A Canadian study of men with testicular cancer explores how men (re)consider questions of sexuality and gender post diagnosis and treatment. Semi-structured interviews with 40 men were analyzed using thematic decomposition, an analytic technique that combines discursive approaches with thematic analysis. The theoretical framework that guides this work relies on material discursive approaches. From an analytic stance, this perspective is concerned with a focus on the ways in which both subjectivity and the body are experienced and constituted in language. In particular, we are concerned with how these men interpret the (altered) male body as a locus of gender signification and gender disruption. Men in this study construct testicular cancer as alternately inhibiting and enhancing masculinity and sexuality. Disruption interpolates with potentiality. A discourse of *precarious masculinity* predominates these accounts, wherein the link between anatomy and masculinity is simultaneously asserted and disavowed. Constructions of anatomical essentialism (i.e., testicular integrity is equated with masculinity) are juxtaposed against construals of anatomical superfluousness (i.e., other sites of sexuality and male identity are emphasized as being more central).

Keywords: Testicular cancer; Discourse; Embodiment; Masculinity; Sexuality

Introduction

Although testicular cancers account for only 1–2 percent of all cancers in men, it is the most common cancer found in men aged 15–34 with a 10% increase in age adjusted incidence in the last 30 years (Buetow, 1995). While generally associated with a good prognosis, with 5 year survival rates approaching 90% or higher (Nikzas, Champion, & Fox, 1990), testicular cancers occur at a point in a man's life when the impact on sexuality, identity and fertility may be significant. In contrast to other cancers, the psychosocial impact of testicular malignancies has received relatively little attention. It is only within the last decade that there have been any significant attempts to investigate the impact of testicular cancer on quality of life and psychosocial functioning (e.g., Heidenreich & Hofmann, 1999; Fossa, Dahl, & Haaland, 1999). Although survival might be associated with less distress overall, concerns related to sexual and reproductive functioning may contribute to feelings of inadequacy, hopelessness and depression.

In fact, there is evidence that perceived attractiveness, retaining fertility, having children, and living with a

*Corresponding author. Tel.: +1-4169-79-5000x7570; fax: +1-416-979-5273.

E-mail address: mgurevic@ryerson.ca (M. Gurevich).

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partner are among the most important predictors of good health-related quality of life for men 3–13 years post treatment (Rudberg, Nilsson, & Wikblad, 2000). This is significant given that 15–30% of men experience long-term disruptions in sexual functioning (Hartmann et al., 1999; Heidenreich & Hofmann, 1999; Kuczyk, Machtens, Bokemeyer, Schultheiss, & Jonas, 2000; see also Gotay & Muraoka, 1998) and sexual functioning is compromised in a significant proportion of men in the first 2 years following treatment (Nazareth, Lewin, & King, 2001). Significantly, this literature is framed within the medicalized discourse of 'sexual dysfunction,' focusing on performance impairment, such as reduced ejaculatory capacity and erectile potential, impaired fertility and, to a lesser extent, decreases in sexual desire. The men we interviewed draw on this discourse of dysfunction to both (re)instantiate and interrogate prescribed masculinity. Only a handful of studies (e.g., Brodsky, 1999; Gascoigne, Mason, & Roberts, 1999; Inger, Larsson, & Eriksson, 2000; Sanden, Linell, Starkhammar, & Larsson, 2001) have used qualitative approaches to explore how men experience testicular cancer. The predominant focus here is on diagnostic and treatment issues, rather than the ways in which having testicular cancer alters men's sense of self as sexual and gendered beings. Notably, a recent qualitative study found that concerns about masculine identity and sexual performance acted as barriers to seeking early diagnosis in response to testicular symptoms (Gascoigne et al., 1999). This confirms other research showing that greater endorsement of a traditional male gender role is associated with less favourable intentions to perform TSE (testicular self-exams) (Morman, 2000). This centrality of testicles in the coherence of male (sexual) identity is exemplified by other research. For example, losing a testicle to cancer has been rated as the second most humiliating experience by college-age men, second only to being unable to maintain an erection during sex (Morman, 2000).[1] Similarly, an analysis of media representations of testicular cancer (1980–1994) has also shown that the 'machismo discourse' is central in these descriptions and sexual attractiveness and desirability is linked to testicular integrity (Clarke & Robinson, 1999).

Theoretical framework

The theoretical framework that guides this work relies on material discursive approaches. Material-discursive approaches acknowledge that physical embodiment is inseparable from beliefs, perceptions and interpretations regarding physical conditions (Yardley, 1999). In recognising the 'intrinsically embodied' nature of all human experience (Sampson, 1998), such frameworks emphasize equally both the socio-historical forces that impinge upon the body and the role of bodies in expressing, producing and contesting social norms. Accordingly, our talk *about* the body cannot be disconnected from the way we talk *through* the body because we are "socialized into both a linguistic and bodily community of practices" (Sampson, 1998, p. 38). In acknowledging the reciprocal and contiguous relationships between materiality and physicality, material-discursive perspectives "can embrace the physical side of existence in a non-realist manner, thus side-stepping some of the unwarranted or exaggerated distinctions between the subjective and objective, mental and physical, mind and body" (Yardley, 1999, pp. 37–38), and, in so doing, expose the 'flimsy division' between the material and the representational (Joffe, 1997). Theoretical formulations of embodiment can best be understood as positioning the body "as a recursive process of inscription and projection" (Frank, 1998, p. 209). In other words, our relationships and responses to bodies (our own and others) are mediated by numerous culturally and historically shifting axes of social relations and meanings, including gender, race/ethnicity, (dis)ability, age, class, etc. Importantly, "the body is always more than these meanings, [as it] projects its realities onto social spaces. The process is recursive: the body organizes the culture and society that inscribe this same body with meaning" (Frank, 1998, p. 209).

Embodiment theory provides a theoretical and analytic framework for exploring the ways in which certain socio-historical and culturally specific discursive practices 'converge upon the body' (Malson, 1998) to regulate, constitute and make (un)intelligible bodies and subjectivities. Discourse is used here in a Foucauldian sense; that is, it refers not only to language (i.e., speech, text, signs), but to social practices that "systematically form the objects of which they speak" (Foucault, 1972, p. 49). These 'objects' include experiences, events, concepts, individuals, identities, and bodies (Prior, 1989). Because discourses are 'more than signs,' "they are irreducible to language" (Foucault, 1972, p. 49). That is, rather than merely reflecting or representing meaning, discourses exert 'real' effects by designating and regulating norms of behavior (Walkerdine, 1986). Accordingly, as social practices, discourses are not merely shaped by linguistic norms (Malson, 1998). Discursive practices are realized under "[historically] specific conditions of possibility" that regulate what can be designated as 'reality' or 'truth' (Walkerdine, 1986, p. 64). This is not a negation of an extra-discursive reality, but rather a critique of the primacy of the real relative to the discursive. Perceptions, interpretations, descriptions

[1] The third highest rated humiliating experience is being teased about penis size. The remaining rankings, in order of descending 'humiliation valence,' are as follows: having a rectal exam; being diagnosed as sterile; being left by a romantic partner; being seen naked by male friends (Morman, 2000).

and understandings are reciprocally implicated in the production of 'real' physicality. Therefore, language is not viewed as simply descriptive of real phenomena but rather as constitutive of (what we come to think of or can imagine as) reality (Weedon, 1987; Parker, 1990). Likewise, the material discursive approach, far from negating the material texture of life with illness, permits health psychologists to disentangle and "to comprehend the material force and substantive implications of our conceptualizations and discussions of health and illness" (Yardley, 1999, p. 44). Thus, this conceptualization emphasizes the "textuality of being" (Stenner & Eccleston, 1994) as much as the (more apparent) textuality of discourse. From an analytic stance, this perspective is concerned with a focus on the ways in which subject positions, subjectivities and bodies are experienced and constituted in language.

'Subjectivity' refers to "individuality and self awareness—the condition of being a subject" (Henriques, Hollway, Urwin, Venn, & Walkerdine, 1984, p. 3). It encompasses thoughts, emotions, identities and ways of understanding the self, all of which are "the results of a practice of production which is at once material, discursive and complex, always inscribed in relation to other practices of production of discourse" (Henriques et al., 1984, p. 106). In this way, discourses produce subjects and subjectivities that are not only rendered intelligible, visible and recognizable to others, but they also constitute how individuals construct meaningful selves (Bower, 1999).

Importantly, discourses are simultaneously constitutive of both power and resistance. For Foucault, "discourse transmits and produces power; it reinforces it, but also undermines it and exposes it, renders it fragile and makes it possible to thwart it (Foucault, 1978, p. 101). Discourses operate dialogically rather than in isolation, because they are always part of a "system of reference, which includes other discourses, other texts and other practices" (Foucault, 1972, p. 23). Therefore, discourses are always simultaneously reiterated and resisted as 'reverse discourses' emerge in contestatory response to dominant knowledge forms. In other words, the operation of the power/knowledge configuration engenders "reality, domains of objects, rituals of truth" and, thus, also individual subjectivities (Foucault, 1995, p. 194). Thus, within the dichotomous discourse of gender, supported by the biological discourse of sex (Fausto-Sterling, 1993; Kitzinger, 1999), the possibilities for embodying gendered and sexualized subjectivities are at once delimited and potentiated (via reverse discourses) by regulatory norms.

In summary, it is because of its attention to the constitutive power of discourses in producing, destabilising and regulating subjects, subjectivities and (even what we typically think of as primarily material) bodies, that a Foucauldian formulation of discourse is adopted within the present material discursive analysis of how men with testicular cancer (re)construct masculinity and sexuality following diagnosis and treatment. In particular, we are concerned with how they construct the (altered) male body as locus of gender signification and gender disruption. Because in the final analysis, "nothing is more material, physical, corporeal than the exercise of power" (Foucault, 1980, pp. 57–58), the body is a central site for contestations of ideology.

Method

Procedure

Semi-structured audiotaped interviews were conducted with 40 men diagnosed with testicular cancer. All participants were recruited through a testicular cancer clinic at a university-affiliated tertiary-care cancer center (Princess Margaret Hospital; PMH). Ethical approval for the research was granted by the PMH Research Ethics Board, and informed consent was obtained prior to the conduct of all interviews.

Socio-demographic and medical characteristics are described in Table 1. Briefly, the average age of participants was 36; just over half were in a partnered relationship; two thirds had attained a secondary

Table 1
Socio-demographic and medical characteristics

Age M (SD) (R = 17−62)	36.03 (10.35)
Partner status n (%)	
Single	16 (40%)
Partnered	22 (55%)
Divorced/separated	2 (5%)
Education n (%)	
Primary	6 (32.5%)
Secondary	26 (65%)
Employment n (%)	
Full time	32 (80%)
Student	6 (15%)
Disability	2 (5%)
Months since diagnosis M (SD) (R = 1−228)	49.5 (59.92)
Type of orchiectomy n (%)	
Unilateral	30 (75%)
Bilateral	10 (25%)
Disease type at diagnosis n (%)	
Local	8 (20%)
Regional	12 (30%)
Distant	7 (17.5%)
Regional and distant	7 (17.5%)

educational level; and 80% were employed fulltime. The men predominantly identified as heterosexual, with the exception of one man who identified as gay; 12 men did not specify their sexual orientation. The group was relatively heterogeneous in terms of illness characteristics. Patients were near various important illness milestones (e.g., immediately post-orchiectomy; prior to and during adjuvant treatments—chemotherapy, radiotherapy, or surgery; post-treatments periods of 3, 6 and 12 months; and those on surveillance and long-term follow-up). The average time since diagnosis was 49.5 months. Seventy five percent of men had a unilateral orchiectomy.

All interviews were conducted at the hospital by one of two female and two male interviewers and lasted between 45 and 90 min. The transcripts did not vary as a function of the gender of the interviewer. A brief questionnaire was also administered to gather socio-demographic and medical information. The interview schedule, which was piloted on five participants, was sufficiently broad to facilitate an unfolding of individual stories, but was guided by the following focal question: How has the experience of testicular cancer affected your sexuality? The prompts pertained to relationships, sexual functioning, performance, desire, and fertility. The interviews were transcribed verbatim, using standard grammatical convention to enhance readability and clarity; speech features such as intonations or pauses were not highlighted (see Malson, 1998).

Analysis

Thematic decomposition (Stenner, 1993; Woollett, Marshall, & Stenner, 1998) was adopted to explicate the dominant themes. This analytic technique combines discursive approaches with thematic analysis, and it is situated within a broader discursive approach (Potter & Wetherell, 1987), which is informed by the notion that meanings are socially constituted through discourse (Burr, 1995; Burman & Parker, 1993; Parker, 1992).

The term 'theme' here refers to coherent patterns identified in participants' accounts (both within and across transcripts) (Stenner, 1993). Discourse, as described earlier, is defined in the Foucauldian sense, as not only referring to language, as in the "general domain of all statements," but also to regulated social practices (Foucault, 1972, p. 80). As Prior (1989) notes, "[objects, events and experiences] are not referents about which there are discourses but [are rather] objects constructed by discourse" (p. 3). In this sense, discourses are fundamentally productive of realities (e.g., objects, social institutions, individual subjectivities and 'subjects') and they have a material dimension; they constitute objects, subjects, and individual and social realities in particular ways (Bower, Gurevich, & Mathieson, 2002). For example, arguably gender norms regulate the 'discursive field' within which (healthy and ill) masculinity and sexuality are currently constructed. Therefore, men with testicular cancer constitute their specific (sexualized and gendered) diagnostic and treatment realties within, and against, this discursive backdrop. "Thus, although participants echo similar 'themes,' these can be understood as being negotiated within a broader 'discursive field,' which both produces individual and social meanings and relays meaning through culture" (Bower et al., 2002, p. 30).

Results and discussion

Men in this study construct testicular cancer as alternately inhibiting and enhancing masculinity and sexuality. Disruption interpolates with potentiality. A discourse of *precarious masculinity* predominates these accounts, wherein the link between anatomy and masculinity is simultaneously invoked and disconnected. Constructions of anatomical essentialism (i.e., testicular integrity is equated with masculinity) are juxtaposed against construals of anatomical superfluousness (i.e., other sites of sexuality and male identity are emphasized as being more central).

Displaying a 'dysappearing' anatomy/masculinity

The body is not only the encasement for our corporeal, psychological and social identities, but as a 'medium of display' it transmits expressions of our identifications, resistances, and transformations (Radley, 1998). Accordingly, embodiment is not only an inevitable 'ground of being' but it also situates us fundamentally "in relation to each other in our mutual visibility" (Radley, 1998, p. 15). This ineluctable conspicuousness can be welcome and facilitative (e.g., when we want to convey particular social stances) or undesirable and restrictive (e.g., when we want to conceal). Concealment becomes particularly problematic when we are at our most bare, both literally and as symbols of cultural signification. As this participant says

> It took me a long time to change in front of other guys. I would have been uncomfortable the first year doing that [going to the gym]. I went to a urinal once and somebody came in and I had to go in to one of the stalls, I was self conscious about it. (Interviewee #20)

This concern about others' (possibly pejorative) construals of this refigured 'display' is reiterated in a variety of self-regulating activities. The men talk a lot about monitoring their descriptions and disclosures:

> It's just that as a guy you don't usually talk about things like that. Other guys don't want to hear it, so

you think, and they don't want to be picturing that in their head either, right? (Interviewee #26)

I usually said germ cell because I don't like saying testicular cancer. Especially because of where it's going to spread and everybody's going to think you have one nut… . I wouldn't want the whole world knowing that I had one nut. (Interviewee #32)

I wanted to tell people I had cancer but I was kind of sketchy about telling them what kind it was. I didn't know what kind of reaction it would be. Like I told lots of people and I did get different reactions from people. Some people were like, oh, a testicle. (Interviewee #42)

Because the physical and psychosocial anchors of 'embodied display' (Radley, 1998) are inseparable, concealment about physicality is conflated with self containment in other domains:

It feels like I have to hide a lot of myself I guess. Try not to really expose too much of what's going on. In a way it's kind of embarrassing to talk about. … The fact, that at my age I have cancer and especially, testicular cancer. (Interviewee #21)

In hiding the site of the cancer, the men attempt to dislocate the testicular from the masculine, while simultaneously reproducing this link. For instance, when the above participant is asked if the 'especially testicular cancer' makes him feel like less of a man, he replies equivocally:

Maybe a little… because as long as I don't share it with too many people then it will be ok, I assume. (Interviewee #21)

Thus, retaining one's hold on masculinity is predicated on concealing the source of its '*dysappearance*' (Leder, 1990). Leder's notion of a 'dysappearing' body refers to the conspicuousness of one's body during illness. That is, appearance by virtue of dysfunction, disability or disruption. Our bodies are usually 'absent' (Leder, 1990) in the sense of being taken for granted unless something such as pain, illness or intrusion calls attention to them.[2] They are also in a state of, more or less, dormant (dis)connection from our sense of selves, our lives, in a state of 'hibernating' embodiment. As Miles (1994) notes, "in health and ordinary circumstances, psyche and body seem to maintain a tenuous connection at best; one's body comes to be noticed only when it 'acts up'" (p. 54). However, in (transient or persistent) illness we are perceptibly propelled into 'inescapable embodiment' (Toombs, 1992). For these men, their anatomy, and by association, their masculinity, *dysappears* with the excision of one or both testicles. That is, both become both more salient and less fixed:

When I first got diagnosed he [doctor] was talking about removal. His point of view was to remove, right? Yeah, but what are you going to remove? I mean what's going to replace it? (Interviewee #1)

The doctor put a prosthetic in so it didn't look as you know, just one testicle. I worried about that at first… well, just not being normal. Like having something removed from your body. All of a sudden you're not like the guy next to you… .The look of it definitely bothered me a little bit… Just because, it didn't look right. I wasn't normal. (Interviewee #8)

What is being removed is not only an anatomical structure but a signifier of masculinity and normalcy. Removal and replacement vie for position here: as the marker of masculinity is detached, the men contemplate both a physical (i.e., prosthetics) and psychological replacement (e.g., alternate meanings of masculinity).

The anatomical configuration of the body is arguably under the greatest scrutiny within the 'fields of visibility' (Foucault, 1995) that construct and constrain possible sexed (and gendered) subject positions and subjectivities. The binary discourses of sex and gender delimit the possibilities of intelligible identities, wherein the only 'bodies that matter' are those that conform to specific, ostensibly 'natural,' physical and sociocultural contours (Butler, 1990). Not surprisingly, then, even when the functional aspects of their sexuality are intact, the men in this study frame their physicality as being somewhat incomplete or deficient. As this participant says

I still feel handicapped in a way. Even though I still have my functionality, it's just, it's not there. (Interviewee #21)

The "it" that is no longer there is not just an absence of an (arguably in this case superfluous) anatomical structure, but an absence of a physical and symbolic marker of masculinity. As the anatomical is disrupted, the girders of a thinkable masculinity become unhinged, rendering their bodies and identities 'abject,' that is, outside of the grid of the acceptable, the imaginable (Butler, 1991).

[2] We are also arguably living in period of heightened bodily fixation, as exemplified by a proliferation of discourses on physical fitness, 'cosmetic' plastic surgery and body adornment (e.g., body piercing, tattooing), wherein "the project of the self becomes the project of the body…the ultimate DIY [do it yourself] project "(Chrysanthou, 2002, p. 471). These modifiable, 'flexible' bodies (Davis, 1995; Martin, 1994) are deemed superior bodies within this corporeal cult. However, the ultimate goal here is the attainment of (ostensibly) flawless, enduring bodies. The ill body, situated as it is outside the cultural limits of perfection and permanence, calls attention to itself on very different terms. Therefore, no matter what level of preoccupation may exist prior to illness, bodily awareness is accentuated and refigured following diagnosis and treatment.

Rupturing sexuality/fertility

The men also constructed their sexuality as fractured. The focus here was on performative failures, existent or anticipated, as well as on diminished desire or pleasure:

> It was pretty devastating. To be 19 and to be told you will never have a normal sex life again… . That was really difficult to deal with, that was the worst part of it… . Sex is not as good now as it was then, that's definite, I miss ejaculating. There's no doubt about that. (Interviewee #29)

> I had…limited. I wasn't able to maintain an erection. (Interviewee #3)

> Did I have any worries about it? … Well sure because I had one testicle. Am I going to be able to perform like I used to? (Interviewee #8)

Normalcy in the sexual realm is equated here with unaltered performance. While diminution in the enactment of sexual activity can (and does) cause varying degrees of interpersonal distress, it also has a particular cultural valence in the context of late modernity, which has prescribed a mechanized and flawless vision of the body (Seidler, 1997).

This conception of the body prizes efficiency, regulation and perfection and suggests that 'hardware (or software) failures' can and must be fixed. In the realm of sexuality, "the sexual self-help genre" (Potts, 1998, p. 153), underpinned by the wider, ubiquitous self-help regimes, offers an inexhaustible supply of marketed (hetero)sexuality (Hawkes, 1996). This self-help doctrine functions as 'disciplinary' regulation (Foucault, 1995) in producing self-monitoring and self-treating subjects. Specifically, the sexual toolbox, comprised as it is of mechanical devices, sexual therapists, and how-to text and visual manuals (Potts, 1998), is aimed at fixing and perfecting what is also paradoxically commonly referred to as a 'natural activity.' This commodification of sexual competence leaves little room for 'underachievers.' Therefore, in the context of testicular cancer treatments and their (both temporary and permanent) consequences (e.g., orchiectomies, radiation) this physical and symbolic excision of markers of masculinity pose a dilemma for identity as a 'real man,' as well as a thoroughly (post)modern man.

Sexual virility, potency and undeterred/unencumbered performance are 'requirements of the male role' (Tiefer, 1987). As Romeo, Wanlass, and Arenas (1993) assert, a man's ability to achieve an erection is seen as central indicator of his masculinity. Relatedly, losing a testicle, in conjunction with disruptions in sexual performance or reproductive potential can have a deleterious impact on one's sense of masculine identity (Tiefer, 1987). Fertility issues are indeed prominent in these men's accounts, with masculine identity as centrally connected:

> You can still make love and maintain that whole aspect and part of your life, but are you good enough because you can't have children? And this and that… . I think that's going to affect you once you go out and you want to find a mate, right?… it, it kind of eats at that insecurity. (Interviewee #2M)

The adequacy, as a sexual and romantic partner is predicated here on the possibility of (in)fertility. Within "culturally intelligible grids of an idealized and compulsory heterosexuality," reproductive ability is positioned as integral to the stabilizing of gender identity (Butler, 1990, p. 135). So, although the ability to perform sexually is intact, the possibility of reproductive 'failure' is framed as a failure of achieving a normatively coherent (heterosexual) masculine identity; questions concerning being 'good enough when finding a mate' remain. The 'sanctity' of sperm within this linkage is directly addressed by some of the men:

> I think they're [sperm] pretty sacred for a guy. (Interviewee #32)

> Am I ever going to get to have kids or what am I going to be able to do… . I put sperm in a sperm bank… . So I had to make some serious decision about saving my sperm in the sperm bank. (Interviewee #24)

Sometime the links to masculinity are more oblique:

> I've always wanted to have kids when I got older so I would be disappointed if that had happened. I mean there are always ways around it, adoption, artificial insemination, all that other stuff, even though I wouldn't like to take that route, if I had to, it's a possibility but I would be very disappointed. (Interviewee #22)

> Everybody tells us like there's adoption and there's artificial insemination, blah, blah, blah. But it's not the same, to us… . You have to borrow someone else's [sperm]… . And that's what we were concerned with. I think the most that we were kind of upset about was that. (Interviewee #34)

'Borrowing' another man's sperm is positioned as a decidedly less preferred 'route.' In relying on other sources of insemination, the men risk becoming not only 'paternity deficient' but also the recipients of a kind of 'hand-me-down masculinity.' The primacy of biological paternity underscores the cultural imperative to 'naturalize' gender identity (Butler, 1990). In other words, although there are multiple ways to become a parent, the hierarchy of adequacy and desirability reveals what is considered a 'natural' route to both paternity and

masculinity. Indeed, the most 'persuasive' argument that is typically provided for asserting the 'naturalness' of binary gender roles as rooted in biological sex is that 'women can bear children and men can produce sperm.' Not surprisingly, then, questions about the viability of sperm production incite questions about the viability of masculinity.

(Dis)embodying a precarious masculinity

The disrupted sexuality discussed above relates specifically to a 'precarious masculinity' discourse, which predominates in these interviews. And this hinges on anticipated public perceptions as much as on concerns about (more private) performative failures:

> Am I ever going to get an erection? A lot of fears were around my manhood, so a couple of times I couldn't get a hard on… . Now I have dry ejaculations. Does that make me less of a man? (Interviewee #24)

> Once you lose that, geez. It would make you feel less of a man. You know what they say, lose the family jewels, you lose those and…? (Interviewee #1)

> Well, it's somewhat a hit on the manhood, sure… . I'd need 100,000 people and toes and fingers to count the number of people that ask me if I can still have sex because I lost a testicle. That was one of the first questions out of people's mouths, you know, can you still do it? Uh, yeah! You know, obviously it's a very important thing. That would be pretty devastating, if I lost another one. The manhood issue I think is the big thing, a lot of people don't, you know, it's an important part for men, for some people it's a real concern. (Interviewee #20)

The men simultaneously implicate and disconnect their anatomy in the construction of masculinity; this is indeed a *dis*/embodiment. In this sense, they are "working with bodily contradictions as sites of creative genesis" (Bayer & Ror Malone, 1998, p. 115). The tension here is between the direct link of anatomy to manhood, which is simultaneously reified and unsettled. These men use these embodied constructions to interrogate the cultural imperative that equates unaltered anatomical efficiency with masculinity. In fact, they (sometimes explicitly) ask the question: "Does this make me less of a man?"

In negotiating this discourse of 'precarious masculinity,' they rely on constructions of anatomical superfluousness, juxtaposed against construals of more central sites of gender identity and sexual pleasure:

> Yeah, it [manhood] has nothing to do with down there. That little part down there is not as important as they make it out to be. (Interviewee #20)

> It is not what's inside your pants that makes you a man…and I didn't bother having the prosthetic put in because it is not really necessary… . I think if my whole identity had just been in one little testicle I would have been crushed. But there is a lot more to a human being than just that. (Interviewee #11)

> Mentally and emotionally I feel like a better man than I've ever been and it's not just about a testicle it's about who you are. People, men and women have male and female characteristics to differing degrees and if you want to label something as being a sort of a female characteristic or male, because of what you do. I mean some people think that being open is sort of a, is more of a female characteristic, or whatever you're going to say. But, I think that I'm every bit the man that I ever was. I feel… not having a testicle doesn't affect that for me. (Interviewee #4M)

By negating the relevance "one little testicle" or "that little part down there" for masculinity and sexuality, they divest the testicles of their symbolic power as conduits of masculinity. In so doing, their embodiment is projected as a "stubborn refusal at universalization" (Stam, 1998, p. 9). Gender identification is broadened to incorporate dimensions that extend beyond the anatomical. Moreover, the anchors of 'personhood' are also extended beyond gender here. The invocations of "human being", "whole identity" and "differing degrees" of maleness and femaleness work to subvert a discourse of seamless gender bifurcation. In as much as the unmarked male body sustains the illusion of natural, ahistorical maleness, the obverse is also true. The altered male body disrupts the myth of foundational gender categories and exposes their fictive nature. However, the preoccupation with the significance of the testicular to the masculine is always already present, even in the negation of the link. Notably, losing both testicles is positioned as being the ultimate break with the masculine:

> I guess what does it mean not to have a testicle. It's kind of what most men do have and [I wondered about] how well I would do at it… . But I feel as much a man…being a man is so much more than just having testicles and how they affect you. I don't know how it would be different if I had lost another one. I mean that's really a worry, but they say that doesn't tend to happen. But I have heard of cases where that happens and other people take testosterone injections to just, to retain some of their more characteristics that are kind of higher level [secondary sexual characteristics]. (Interviewee #4M)

In defying the image of emasculation, they construct their sexuality and masculinity as accentuated rather than hampered:

> Oh, yeah, being manly, I don't feel less of a man, at all. If so, I feel more of one now because ever since that, I think I've had sex more after that, after all the surgery and after everything than I did before and everything's been the same… . I'm capable of being just as good as I was before because I'm better now with experience…It's like people that say you're less of a man or whatever, they don't have any idea of what they're talking about. You're actually more of a man because of the experience you went through and you survived… . I feel like more of a man now. (Interviewee #26)

> I have a strong or stronger sexual, kind of ability than I have in the past and I'm not affected at all. I guess I just feel that our relationship has progressed now, just being married as long as we have and I just feel really comfortable in our relationship now-…overall I would say that our sex life is better than it's ever been, from a sort of sharing and sort of, I don't really know how to put it, but just from being sort of more in unison than we have been. (Interviewee #4M)

Notably, the discursive trope of the deficient castrated man is simultaneously punctuated AND countered by an emergent 'resistant discourse' (Foucault, 1980) of (hyper)masculinity and (hyper)sexuality or even (hyper)humanity. These men feel at once less *and* more masculine! Hyper-masculinity and hyper-sexuality are both impelled by corporeal and cultural undermining of what it means to inhabit a male body and male subjectivity in our culture:

> My own insecurity [about] basically being castrated. I mean, you know, like, for lack of a better word it was all about loss of manhood. You kind of have to look beyond that stage…I found that half the battle has been a mental battle to overcome it. You're not turning into some freak of nature because basically you're being castrated and there is life beyond…in the scope of how big our life is and how sophisticated a human being is, this is peanuts, this is nothing. Be happy you've got your health, you know. (Interviewee #2M)

This reverse discourse also functions to dissolve the demarcation between the healthy and ill (male) body. Because the prognosis is excellent for this type of cancer, relative to many others, the emphasis on global health is predominant. As one participant said: "*sexual pleasure with my spouse and fertility… those are big things, they're not greater than life*" (Interviewee 4M). In many ways, these men do not view themselves as (former or current) cancer patients, but rather as people who have had a 'bout' of cancer that has been (or is imminently to be) 'cured.'

Conclusion

This study found that constructions of masculine identity figure centrally in the experience of testicular cancer. While the men simultaneously assert and disavow understandings of masculinity as situated within testicular integrity, the routes to readings of masculinity inevitably pass through anatomy. This parallels a recent qualitative study on testicular cancer that found that definitions of masculinity were strongly linked to sexual performance abilities and the appearance of 'normal' genitals (Gascoigne et al., 1999).

According to Butler (1990) gender identity is always a masquerade. That is, the notion of a real, essential masculinity and femininity is illusory and is sustained rather effortfully by repeated 'performative' means, where 'performative' refers to constructions of meanings:

> In what sense, then, is gender an act? As in other ritual social dramas, the action of gender requires a performance that is *repeated*. This repetition is at once a re-enactment and re-experiencing of a set of meanings already socially established; and it is the mundane and ritualized form of their legitimation…[Moreover] the performance is effected with the strategic aim of maintaining gender within its binary frame (Butler, 1990, p. 140):

Whether one endorses or dismisses this post-structuralist thesis of gender, few would dispute the contention that "gender is a performance with clearly punitive consequences. Discrete genders are part of what 'humanizes' individuals within contemporary culture; indeed we regularly punish those that fail to do their gender right" (Butler, 1990, p. 139). Examples of the punitive effects of deviations from gender-role proscriptions can be found in all arenas, from physical appearance to behavior, from emotional to cognitive expression. What is particularly relevant in the present context, is that bodies, as much as subjectivities, are inscribed with gender signification in ways that render certain bodies more or less 'intelligible' within the regulatory matrices of masculinity and femininity (Butler, 1993). Thus, anatomically intact bodies are designated as anatomically and socio-culturally 'correct' bodies. And likewise, anatomical 'deviations', even if unavoidable (e.g., resulting from life-threatening disease) risk repudiation. Therefore, testicular cancer cannot be experienced *without* invocations of gender-role definitions, whether culturally sanctioned readings are adopted or transcended.

Within the terms of late modernity, masculinity in particular can not be taken for granted but must ceaselessly be re-asserted and re-inscribed (Seidler, 1997). As traditional sources of male identity affirma-

tion become undermined, it becomes increasingly difficult to locate relevant anchors for *the* masculine. There are a number of contributing factors here, including: restructuring of late industrial capitalist society in ways that provide fewer opportunities for constructions of traditional masculinities (and femininities). At the same time, "in the industrialized Western world, individuals no longer find support, sustenance and meaning from the public symbols of institutional roles, but retreat instead into the 'private' worlds of sex and relationships for life-enhancing meanings" (Kitzinger, 1994, p. 194). Alongside this shift from the 'social' to 'privatized' selves, noted in all aspects of our lives (e.g., death attitudes, construction of the psychological subject), sexuality and sexual activity has achieved primacy in definitions of identity (Kitzinger, 1994). Therefore, disruptions in sexual identity, physicality or performance also carry the weight of potentially unhinging other markers of identity.

At the same time, because the body has become "the material infrastructure of personhood and social identity" (Turner, 1994, p. 28), the body can now 'imagine' being both more and less than its signification. As a signifying medium, the body decidedly

> Incarnates reigning inscriptions, for example, gender. [However], just as clearly, the body may well be that temporal or signifying interstice that intimates a beyond to any signifying system (Stockton, 1992). But whatever it is, the body is never as univocal as psychology and the western epistemologies it recapitulates would have it (Bayer & Ror Malone, 1998, p. 115).

The men in this study seek to defy emasculating readings of testicular cancer, while at the same time punctuating this configuration in the negation. These testimonials attest to the simultaneous impermanence and inexorability of the body as a site for social categorization, including both adherence to and defiance of social/cultural imperatives. These men reiterate the link between anatomy and masculinity while simultaneously disavowing its ineluctability. In so doing, they confirm that although embodiment is both symbolic and material (Merleau-Ponty, 1962), "representation and the body collaborate by undermining one another" (Bayer & Ror Malone, 1998, p. 114). So, although 'testicular integrity' may signify masculinity and virility, the absence of this anatomical structure emasculates this configuration, in both its gendered and mitigating sense. In other words, for these men, testicular excision represents both a loss of masculinity and an escape from the rigidity of what it means to be a man. There are no resolutions here, but rather productive questioning about what it means to embody maleness, to enact a male identity and sexuality.

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