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Restoration of Satisfying Sex for a Castrated Cancer Patient with Complete Impotence: A Case Study

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We present a first-hand account of a fully impotent, testosterone-suppressed prostate cancer patient who has satisfying, multiorgasmic sex using a strap-on dildo. We use his narrative to examine dildos as an alternative to erectile dysfunction treatments for men, such as this patient, who find selective inhibitors of PDE-5 ineffective and surgical intervention unacceptable. We explore what conditions allowed this man to progress from suspicious distrust of the dildo to full acceptance. In terms of making a dildo acceptable to other patients, we contrast offering it to them as a penile prosthesis in a formal medical setting versus treating it as a toy in fantasy sex play. Last, we present a neurobiological hypothesis involving sensory integration to help explain why sex with the strap-on dildo can be satisfying to a male.

We report a simple, noninvasive strategy for reestablishing orgasmic sex without erections, based on the experiences of one prostate cancer patient, and consider the implications of his experience for other patients and their partners. The patient was diagnosed with prostate cancer 6 years earlier

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and had both a radical prostatectomy and salvage radiotherapy. He is now in his late 50s, currently free of cancer symptoms but impotent from the cancer treatments. He is on androgen deprivation therapy, via the LH-RH agonist Lupron (leuprolide acetate), which suppresses the testosterone that stimulates prostate cancer cell growth. This has reduced his testosterone to castration levels, as confirmed by regular blood tests. He no longer has erections and has a reduced libido, both typical effects of his treatment. We have worked with the patient to construct the narrative and analysis presented here and have his approval for the final version. However, he wishes to remain anonymous.

Most treatments of erectile dysfunction (ED) focus narrowly on restoring erectile function and coitus rather than on improving sexual satisfaction within relationships. Here, we suggest the use of a strap-on dildo as a medically noninvasive sexual alternative. Dildo sex allows full body contact and natural, familiar movement patterns, combined with effective genital stimulation. Moreover, it offers a security of sexual performance to the wearer without the problematic intensification of the coital imperative implicit with the use of pharmaceutical or surgical therapies for ED. We explore the idea that dildo use can make sex a lower stress, more playful and collaborative process.

Surveys and interviews with partially or fully impotent prostate cancer patients repeatedly reveal great psychological distress associated with the loss of sexual capability (Althof, 2002; Brucker & Cella, 2003; Clark et al., 2003; Cooperberg et al., 2003; Dahn et al., 2004; Fergus, Grey, & Fitch, 2002; Gray et al., 2002; Navon & Morag, 2004; Pirl, Siegel, Goode, & Smith, 2002; Schover et al., 2004; plus older studies cited therein). Before cancer treatment, patients are reassured by health professionals that there are interventions to help if treatments cause impotence. But these interventions are only effective for a fraction of patients (Schover et al., 2002). Patients on antiandrogen therapy are particularly unlikely to find the common medical interventions helpful. The patient discussed here has found a way to circumvent these problems.

HIS STORY

Neither Viagra nor a vacuum erection device worked for me. I am loath to inject drugs into my penis or have a surgically implanted penile prosthesis, the remaining medical options for treating ED. Not surprisingly, like so many other cancer patients sexually incapacitated by modern medicine, I was clinically depressed within a few months of starting hormonal therapy.

This situation began to change when a close lesbian friend, who was aware of my cancer treatments and the sexual dysfunction they had caused, refused to accept my giving up on life. She told me that she uses a strap-on dildo. She claimed that she got genuine sexual satisfaction from this and

thought I could too. I was very skeptical. A dildo is not innervated, and I imagined that sex performed with such an appliance would be wholly contrived and not a sensual act at all. My friend persisted in encouraging me, arguing that sexual satisfaction is as much in the brain as in the groin.

It took me more than a year to act on her suggestion. I was embarrassed to go into a sex shop to buy a dildo. I had never used sex toys. I was afraid that I would feel foolish and humiliated by using a strap-on penis. To do so meant facing fully, frontally (so to speak), the functional failure of my own flaccid phallus. Despite my reservations, I eventually agreed to experiment with a strap-on dildo. My expectations, though, were muted. At most, I thought I might be able to please my partner. But I honestly did not envision recreating a fully satisfying sexual experience.

My lesbian friend took the initiative to get me going on this project. She fabricated a harness that was customized to fit me and took me shopping for a dildo, which she insisted I consider "a toy." I don't think I could have even walked into the sex shop without her. I was worried that I might be identified and mocked by someone who knew me. In the store I debated buying a dildo that looked relatively natural or one that was beyond the realm of real anatomy. I finally selected one that was similar in size, shape, and angle to my erect penis before cancer treatments, to the best of my recollection. It is made of silicone, which makes it durable, appropriately stiff, yet still flexible, like a natural erect penis. Beyond that, the dildo that I bought bears little resemblance to a human penis. Granted, it has an expanded "head," like the real glans penis but a uniformly smooth shaft, with none of the irregular surface texture caused by real-life veins. And it is purple! Clearly, it does not constitute a realistic bio-mimetic prosthesis. I knew then that I could not seriously think of this piece of purple plastic as a medical appliance. This was important in my reconceptualizing the situation. Whatever I was going to do with the dildo was not in anyway a "cure" for ED nor was it meant to restore my masculine sense of sexuality. If this was going to work, it was because it was something completely different. I had to stop thinking about this clinically and accept the idea that I was heading into the theater of the absurd, and I was going to play the part of a lesbian!

Before this purchase, I discussed extensively with my partner whether she was willing to have sex with me wearing a strap-on dildo. She was at first hesitant but ultimately supportive of the exploration. We have now used the dildo many times. It caught me by total surprise how natural intercourse felt with this strap-on device. I discovered that my hip movements with the dildo on were the same as during normal intercourse. Our body contact and embrace was full and natural, as well. The first time that we used the dildo, my partner reached down and held my penis in her hand. She had coated her hand with the same lubricant used to coat the dildo and stimulated my penis in synchrony with my pelvic movements. There was little sensory difference between this act and intercourse—my penis was not in her vagina but it

did not know that. It was in a wet, warm place being firmly mechanically stimulated. My hindbrain took over, and I carried the act through to orgasm, to the sexual satisfaction of both my partner *and* myself.

My partner had not discussed with me her plan to hold my glans penis, so I was totally surprised by that action. I had not expected to achieve an orgasm and was astonished that it happened. At first I, thought it was the novelty of her holding my penis that brought me to climax. I thus feared that being aware, and then self-conscious, of this activity would defeat its effectiveness. This, however, has not been the case. If anything, sexual satisfaction has become easier, because both of us have come to accept the dildo as part of our sex play. Each time we use it, it becomes further imbued with the knowledge of the previous sexual satisfaction it has provided. It is thus now both a normal and at the same time erotic part of our lives.

We have both been able to have orgasms many times using the dildo. The knowledge that it will never become flaccid means that my having an orgasm need not prohibit further penetrative sex. The dildo gives me the sexual capacity to serve my partner more reliably than I might have been able to achieve as a potent male (with or without Viagra). Significantly, my partner claims that she could not previously have an orgasm simply by penile penetration. However, with the dildo, I am able to continue pelvic thrusts long and hard enough that she now regularly achieves an orgasm in the missionary position. We have also used the dildo with me lying on my back and my partner sitting on it, so she has control of the movement. This was sexually pleasurable for her, although I have not achieved an orgasm in this position.

When I had a prostate gland, sexual arousal that did not lead to ejaculation was frustrating, and I found it incomprehensible when a woman claimed she had pleasure from sexual stimulation yet had not had an orgasm. After my prostate was removed, I discovered that I too could have incremental pleasure from sexual stimulation and enjoy sex without orgasms. I can also have multiple orgasms! Without a prostate gland, my orgasms are less anatomically focused, radiating across my pelvis. They are of variable intensity but sometimes massively cathartic. When I have multiple orgasms, they are usually 2 or 3 within one minute or 2. I find it easiest to achieve orgasms when my partner wants me to, especially in the context of mutually satisfying dildo intercourse, but far more difficult on my own.

I am fascinated by the eroticism that has developed between my partner, myself, and our dildo. For example, one morning, after having sex the night before, I went to the bathroom and found the dildo sitting upright on the counter-top wearing one of my favorite neckties. My partner had decided to personify and personalize it. I interpreted this as a signal to me that the dildo pleased her and did so because of its association with me.

On another occasion, I was waiting for my partner's arrival and decided to put on the harness and dildo ahead of time. I covered myself and the

dildo with a bathrobe, but there was no mistaking the fact that when I looked down there was sticking out what looked like a large firm erection. For a brief instant, it brought back my fear that wearing a dildo would force me to confront in a demoralizing fashion my own failed phallus, my mutilated masculinity.

But that was not at all what I felt. Instead, I felt joyfully empowered. My thoughts went to a glib one-liner from my lesbian friend: "A dyke with a dildo can outlast a male anytime." I realized that that was equally true for a prostate cancer patient with a dildo, and I almost started laughing. I was playing a role and doing it better than I ever could before I became impotent. I had acquired a performance capability that surpassed "male" and I was thoroughly enjoying the "play" part of sex.

When I reported this experience to my lesbian friend, she suggested that my partner and I explore oral sex with the dildo. Once again, my first thought was, "That's absurd." But since everything else she suggested had worked better than I could have imagined, my partner and I took on the challenge. Simply stated, there has now been enough acceptance of the dildo as a sexual object—and transference from "object" to "organ"—that the visual image of my partner mouthing the dildo was indeed highly erotic in the context of our sex play. On another occasion, in order to tease me, my partner started playing with the dildo in a flirtatious fashion outside of the bedroom. I found the activity erotic and sufficiently distracting that I had to ask her to stop so that I could concentrate on what I was doing.

DISCUSSION

On the Psychological Context of Dildo Refusal and Dildo Use: Changes Over a 5-year Period

We believe several factors may have contributed to this man's initial refusal to try a strap-on dildo and his later acceptance and enthusiasm. First, his relationship with the lesbian friend who suggested that he try the strap-on is pivotal. He has been close to this woman for 16 years, and he considers her a role model. Over the years, she has shared a great deal of personal information with him about her nonerection–dependent sexual practices and experiences.

Despite her recommendation and his high regard for her, he was unwilling initially to try the dildo alternative. Key obstacles to him were the unnatural appearance of the dildo and the fact that it was not innervated. He felt that he would not be able to identify with this inanimate object; it would not "be him." At one point, he expressed mild interest in the possibility of a personalized prothesis cast from a mold of his own erect penis. But his impotence and aversion to injecting drugs into his penis to achieve an erection precluded that possibility. At that time, he had a normal libido,

despite his lack of erections. Hormonally, he was, and perceived himself to be, fully male. He was frustrated with his sexual limitations but not depressed or despairing. This is the period during which he tried Viagra and a vacuum suction device.

When he began Lupron treatments, his attitude changed. He gave up even the idea of sexuality and felt life was not worth living. After a few months on Lupron, the turning point came when his lesbian friend finally convinced him that his sexuality need not be testosterone dependent. He let go of trying to regain what he had been before and embarked on a path to create a new personal and sexual identity. The acceptance that he had somehow fundamentally changed, on Lupron, allowed him to be more open to a process of experimentation to find out who he could be, sexually, in this new state.

As well as the continued support of his lesbian friend, a second pivotal factor was a new sexual relationship. His partner is a woman with whom he had been friends for many years. They had spoken at length about his cancer treatments and their effects on him over the years, and she had been understanding and supportive. When she got involved with him, she knew his condition and wanted to work with him to see what kind of sexuality they could create together. Thus, although she was initially hesitant about the dildo, she was fundamentally open to alternative sexual practices and to a process of mutual discovery. Her support, openness, and active participation in the process have been critical to the development of his new sexual practice.

Who Owns that Phallus?

A key component to the sexual satisfaction that this patient has achieved is that he and his partner are working together. Her acceptance of the dildo matches if not exceeds his, and his satisfaction is enhanced by the equality that the partners achieve in their sex play. For dildo sex to be effective, it likely requires, at least initially, a cooperative "suspension of disbelief" and a willingness in both partners to play along with the game in order to begin creating the positive experiences that will become self-reinforcing. Such cooperation within a couple appears essential for a strap-on dildo to work as well as it has for this man and his partner. Although this patient acquired the dildo on his own, by the end of his narrative, he considers the dildo to belong to both him and his partner. This joint ownership is quite unlike a penis, which may act like it "has a mind of its own" (Friedman, 2001) but is clearly the sole property of the man of whose body it is a part. A dildo is quite different. Since it is detachable, a woman can take possession of it. She can share a sense of potency that was previously solely the man's. This seems to have happened in this case, where it works to the satisfaction of both partners.

Is It a Medical Prosthesis or a Sex Toy?

A strap-on dildo is simple, inexpensive, and noninvasive. Yet this patient, who was clearly quite distressed about his lost sexuality, was initially very resistant to experimenting with such a device. This suggests that, although some impotent men may be inspired to try dildo sex, others–probably many others–may resist exploring this alternative.

The success in medical treatment of ED suggests that some patients may be willing to consider dildo sex if it is prescribed by their physicians. Gray and Klotz (2004) discuss this approach. For instance, a doctor could prescribe a "belted prosthetic phallus" for his impotent patients and then refer them to a sexuality clinic in a medical setting for instruction on how to use the appliance. Although such medicalization of sexuality is problematic, it may nevertheless be the most acceptable route for some couples.

For other patients, such as the man described here, a dildo may be more effective if viewed not as a medical treatment for ED but as a sexual alternative or enhancement. For him, the dildo worked because "it was something completely different," a *toy* with which he and his partner *played*. In order for him to achieve sexual satisfaction, he "had to stop thinking about this clinically and accept the idea that [he] was heading into the theater of the absurd." It worked not because it was a medically prescribed treatment for his disability but because it was a sex toy.

If other patients can profit from the experience of this man, careful consideration must be given to the subtleties of how to introduce dildo sex to patients. Some patients may find a "belted prosthetic phallus" acceptable and a dildo not. For others, like this patient, it may be best to take sexuality completely away from the medical arena of impotence, dysfunction, and "treatment" for sexual failure and move it into the realm of play, communication, and a collaborative project with a partner. Toys have long been a part of human play and human communication.

Is It an Acquired Fetish?

This patient rapidly shifted from his initial view of the dildo as a somewhat ridiculous piece of purple plastic to finding it a highly erotic and personal object in association with his partner. From one perspective, one may view this as the development of a fetish. Effectively, the repeated positive experiences that this man and his partner have had with the dildo transformed it in both of their minds into a sexually charged object and created a mutual sense of ownership. This suggests that couples need not approach dildo sex with the idea that it will work for them or any prior sense of eroticism associated with the object. They need only the willingness to try it, to experiment. Any positive reinforcement through sexual satisfaction will increase the effectiveness of the dildo as a sex toy or tool for them in the future.

On the Biomechanics of Copulation and the Dildo Advantage

Although using a strap-on dildo may initially seem a poor match to natural penile copulation, it has several mechanical advantages over treatments that focus on achieving an erection for vaginal penetration. Vacuum devices and many penile implants distend the shaft of the penis but do nothing to stiffen the root of the penis within the body. This leads to a "hinge" effect, where the shaft is stiff, but freely bends at its base. Similarly, drug treatments such as Viagra, unless they are 100% effective, leave the penis only semifirm. These conventional interventions may produce a "stuffable" penis but make it difficult to maintain normal copulatory movements. Coitus is then easily interrupted. This is a common problem with these treatments, which can be extremely frustrating for both the man and his partner (Tomlinson & Wright, 2004).

A dildo completely circumvents this problem. A strap-on dildo can closely match the natural size, shape, stiffness, and angle of a man's erect penis, allowing him to make completely natural hip thrusts. Even though he cannot feel the dildo within his partner, he can move naturally without fear of coming out of the vagina. Our patient credits these movements and associated full body sensations with a critical role in his reestablishment of orgasmic sexuality.

Also, when traditional ED treatments are not completely effective, they fail to provide adequate stimulation to the glans penis during intercourse. Without the penis being fully erect and at the proper angle, pressure on the penis and stimulation to the glans is reduced. Many men after surgery, radiation, and hormonal therapy report that they need *extra* penile stimulation to achieve an orgasm. All current treatments for ED, however, focus on vaginal *penetration* rather than glans *stimulation*. In fairness, these treatments are designed to help the male recover coital capability. However, if they are not fully effective, they cause *less* rather than greater stimulation to the glans. In using a strap-on dildo, the penis is external so it can be stimulated manually, providing more pressure to the glans. It is not obvious to the penis itself where it is (Friedman, 2001). Provided it is in a moist environment and stimulated firmly and rhythmically, the sensation can induce a climax.

Finally, when traditional ED treatments are not perfect, they can undermine a man's confidence in his ability to provide sexual satisfaction to his partner. The acceptance of a dildo circumvents this psychological problem, because both the man and partner can be fully confident that the dildo will remain erect.

Although the sex described here is farther from natural intercourse than that provided by other ED therapies, it offers enhanced penile and vaginal stimulation. Consequently, it may be more sexually satisfying for both partners than what can be achieved with other ED treatments that focus only on penile penetration.

A Neurobiological Hypothesis on Dildo Eroticism

Recently, Ehrsson, Spince, and Passinghan (2004) used functional magnetic resonance imaging (fMRI) to explain the strange "rubber-hand illusion." In this illusion, a person watching a brush stroking an artificial hand, while his or her own hand is out of sight but simultaneously being stroked, develops a sense that the rubber hand is their own. The fMRI established that the illusion happens because of "multisensory integration in the premotor cortex" (Ehrsson et al., 2004, p. 876).

Could a similar illusion apply to the strap-on dildo? Part of the psychological success of the dildo for our patient was how "real" it both felt and looked to him. When it was strapped to his hips by the harness, it rested on his pelvis in the natural position and angle of his own erect penis, before he was impotent. This allowed for full body contact between him and his partner in a completely natural, copulatory posture. Thus this may have provided enough proprioceptive and tactile stimuli to produce sufficient "self-specific intersensory correlations" (Botvinick, 2004) for a sensory illusion, like the rubber-hand illusion, to occur.

During coitus in the missionary position, this man could not see the dildo. Hence, this is not completely analogous to the rubber-hand illusion, which involves integration of visual and tactile stimulation. However, Ehrsson et al. have extended their earlier work on multisensory integration to show that visual input is not essential and that multiple sensory information of a purely tactile nature can induce the same illusion of ownership (Ehrsson et al. 2005). Our patient describes intense erotic sensation from both sexual intercourse in the missionary position with the strap-on dildo and watching his partner performing fellatio on the dildo. Given concurrent manual stimulation to the man's flaccid but out of sight penis, these situations would closely mimic the simultaneous tactile-tacile and visual-tacile input in the rubber-hand illusion.

Of course, it remains to be seen if multisensory integration takes place in the brain to provoke a genuine genital illusion equivalent to the rubber-hand illusion as described by Ehrsson et al. (2004, 2005). Having a man in an fMRI machine wearing a dildo while his partner has the dildo in either her vagina or her mouth and simultaneously strokes his penis, sounds like the ultimate kinky science experiment. Yet there is a serious context for doing such a study. Establishing a solid neuroanatomical basis for a "rubber-penis illusion" may help make a strap-on dildo an acceptable, noninvasive, cost-effective treatment for ED for the 85% of men treated each year for prostate cancer who experience some ED as a result of their treatment (Schover et al., 2002).

CONCLUSION

A strap-on dildo, in conjunction with manual penile stimulation, allowed our fully impotent patient to achieve sexual satisfaction and concurrently satisfy

his partner (Gray & Klotz, 2004). For some impotent patients, this simple noninvasive approach may work better than more established ED treatments. More research is needed to see how effective a dildo is for other patients and, if it is effective, to identify the best way of presenting this option to patients and their partners.

It should be noted that the current cost of one dose of Viagra or similar drugs (e.g, vardenafil, adalafil) is $8–10 US. The cost of a penile implant generally ranges from $12,000 to 25,000 US. The total cost of a good quality, off-the-shelf dildo and harness is less than $200 US.

REFERENCES

Althof, S. E. (2002). Quality of life and erectile dysfunction. *Urology, 59*, 803–810.

Botvinick, M. (2004). Probing the neural basis of body ownership. *Science, 305*, 782–783.

Brucker, P., & Cella, D. (2003). Measuring self-reported sexual function in men with prostate cancer. *Urology, 62*, 596–606.

Cooperberg, M. R., Koppie, T. M., Lubeck, D. P., Ye, J., Grossfeld, G. D., Mehta, S. S., & Carroll, P. R. (2003). How potent is potent? Evaluation of sexual function and bother in men who report potency after treatment for prostate cancer: Data from CaPSURE. *Urology, 61*, 190–196.

Clark, J. A., Inui, T. S., Silliman, R. A., Bokhour, B. G., Krasnow, S. H., Robinson, R. A., Spaulding, M., & Talcott, J. A. (2003). Patients' perceptions of quality of life after treatment for early prostate cancer. *Journal of Clinical Oncology, 21*, 3777–3784.

Dahn, J. R., Penedo, F. J., Gonzalez, J. S., Esquiabro, M., Antoni, M. H., Roos, B. A., & Schneiderman, N. (2004). Sexual functioning and quality of life after prostate cancer treatment: Considering sexual desire. *Urology, 63*, 273–277.

Ehrsson, H. H., Spence, C., & Passingham, R. E. (2004). That's my hand! Activity on the premotor cortex reflects feeling of ownership of a limb. *Science, 305*, 875–877.

Ehrsson, H. H., Holmes, N. P., & Passingham, R. E. (2005). Touching a rubber hand: Feeling of body ownership is associated with activity in multisensory brain areas. *Journal of Neuroscience, 25*, 10564–10573.

Fergus, K. D., Gray, R. E., & Fitch, M. I. (2002). Sexual dysfunction and the preservation of manhood: Experiences of men with prostate cancer. *Journal of Health Psychology, 7*, 303–316.

Friedman, D. M. (2001). *A mind of its own: A cultural history of the penis*. London: Penguin.

Gray, R. E., Fitch, M., Phillips, C., Labrecque, M., Fergus, K., & Klotz, L. (2002). Prostate cancer and erectile dysfunction: Men's experiences. *International Journal of Men's Health, 1*, 5–20.

Gray, R. E., & Klotz, L. (2004). Restoring sexual function in prostate cancer patients: An innovative approach. Canadian *Journal of Urology, 11*, 2285–2289.

Navon, L. L., & Morag, A. (2004). Liminality as biographical disruption: Unclassifiability following hormonal therapy for advance prostate cancer. *Social Science & Medicine, 58*, 2337–2347.

Pirl, W. F., Siegel, G., Goode, M. F., & Smith, M. R. (2002). Depression in men receiving androgen deprivation therapy for prostate cancer: a pilot study. *Psychooncology, 11*, 518–523.

Schover, L. R., Fouladi, R. T., Warneke, C. L., Neese, L., Klein, E. A., Zippe, C., & Kupelian, P. A. (2004). Seeking help for erectile dysfunction after treatment for prostate cancer. *Archives of Sexual Behavior, 33*, 443–454.

Schover, L. R., Fouladi, R. T., Warneke, C. L., Neese, L., Klein, E. A., Zippe, C., & Kupelian, P. A. (2002). The use of treatments for erectile dysfunction among survivors of prostate carcinoma. *Cancer, 95*, 2397–2407.

Tomlinson, J., & Wright, D. (2004). Impact of erectile dysfunction and its subsequent treatment with sildenafil: Qualitative study. *British Medical Journal, 328*, 1037–1040.