

LE Magazine June 2003

## REPORT

One Man's Ten-Year Ordeal  
With Prostate Cancer

It is a rare individual who can so eloquently chronicle a disease that their personal essay becomes a lead editorial in the Journal of the American Medical Association. Such is the case of Professor Harold Harrod, who authored a fascinating description of the emotional and physical challenges he endured after being diagnosed with prostate cancer in 1993.

The educational vividness of this editorial was so exceptional, that Life Extension Foundation purchased the right to re-print it from the American Medical Association. Life Extension felt compelled to memorialize Dr. Harrod's story for the purpose of encouraging greater emphasis on finding a cure for prostate cancer. The reason for this urgency is that microscopic cancer is found in the prostate beginning by age 30 in about 20% of men, and the incidence increases steadily so that by the time a man is 90 years old, he has almost a 100% chance of having cancer in his prostate<sup>1</sup>. While most of these men do not develop clinically significant disease, this high prevalence mandates more aggressive actions be taken to eradicate today's prostate cancer epidemic.

Dr. Harrod's essay makes it empathetically apparent that a perfect life can be turned upside down upon a cancer diagnosis. As is the case with many cancers, the treatments can be as bad as the disease itself. The one advantage with prostate cancer is that it can be detected early enough so that aggressive treatments do not have to ruin one's life. The downside is that so many men will develop it.

People tend to live in a state of denial when it comes to health disasters like cancer...until it strikes them! While 1500 Americans perish from cancer every day, the media and politicians focus on issues that affect relatively few individuals.

The United States was turned upside down by 3000 people who were murdered at the World Trade Center, yet this represents only two days worth of cancer deaths. The government has allocated virtually unlimited resources to preventing future terrorist attacks, while ignoring the 952,000 Americans who have died of cancer since September 11, 2001.

Cancer research has long been economically linked to politics, but there has been no grass roots campaign to educate members of Congress about the need for more research dollars to find a cure for cancer. Life Extension believes that Dr. Harrod's essay may motivate Congressional leaders to prioritize cancer research! Life Extension members are encouraged to photocopy Dr. Harrod's article and send it to their Congressional representative with a request that more monies be allocated to finding a cure for cancer. To find the name and address of your Congressional representative, just call 1-202-225-3121 or go to [www.house.gov](http://www.house.gov). Dr. Harrod's two-page editorial titled An Essay on Desire appears on the next page.

Following his editorial is an article by Stephen B. Strum M.D., a medical oncologist who has focused his practice on prostate cancer for twenty years. His article describes the early diagnosis and prevention of prostate cancer.

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1. Peehl DM. Vitamin D and prostate cancer risk. Eur Urol 1999;35(5-6):392-4.

## REPORT

### A Piece of My Mind An Essay on Desire

Howard L. Harrod, PhD Nashville, Tennessee  
Reprinted from the Journal of the American  
Medical Association (JAMA), Feb 19, 2003.

The fall and winter of 1993 were among the best times of my life. I was 62 years old and working on a book about Native American animal rituals; my wife, Annemarie, was preparing a paper in environmental sociology. Our intellectual lives were full. And since we were living in a remote area near the Canadian border and Glacier National Park, spectacular beauty surrounded us. During the fall, we laid in firewood, took long hikes, and fed our souls on the gorgeous crispness and solitude that fall on the land in anticipation of winter. After the main range of the Rocky Mountains was covered with snow, we spent long evenings reading. During that part of the day not given over to writing and research, we ventured forth on cross-country skis.

We returned to Nashville in December to spend Christmas with our children, grandchildren, and extended families. On the drive back, I experienced an urgency to urinate that would not be denied. Fortunately, a deserted cornfield just off the freeway provided me with sufficient cover and blessed relief. Reassured by previously normal PSA tests, I was certain the possibility of infection was high and made an appointment with a urologist.

Infection was not detected, but my PSA level had risen significantly. My urologist strongly suggested an ultrasound biopsy. The results: a fast-growing, probably very aggressive cancer. I spent much of January anxiously reviewing options, spending as much time as possible in the medical school library at Vanderbilt. Alternatives were murky. I gradually became more deeply aware that significant risks and uncertain benefits accompanied each therapy and that alternate paths were contested.

After reviewing research, further consultation with my physicians, long conversations with my wife, and listening to my own body, we decided that surgery was the best option for me at that time. So in early 1994 I entered Vanderbilt Medical Center and underwent surgery for the removal of my prostate. The cancer had spread to my lymph nodes but, thankfully, had not metastasized to my bones.

Hormone therapy was the recommended course of treatment, so I began monthly injections of Lupron. Every month upon entering the Vanderbilt clinic, a flood of memories swept over me as I relived aspects of the operation and despaired of what had happened to me. Finally, after a year of treatment, I decided to give up my testicles.

After the orchiectomy I was still physically able to do almost all that I wanted. But I was impotent, and despite considering all the possibilities, from penile implants to pumps, I remained in a state of despair. As a consequence of trying to sort out this complex emotional tangle, I gradually became aware of how deep my gender socialization had been. Not only had I a sense of having been mutilated, I had also lost the very capacities that were symbolically associated with manhood in American society. I no longer had a prostate, I was incapable of an erection, and I had no testicles. More fundamentally, I had lost the capacity to experience desire.

The sudden loss of libido produced forms of suffering I had not anticipated. The initial forms were stimulated by my context: I taught at a university each day; on campus and elsewhere, I encountered young people caught in the throes of raging hormones. Because I had lost the capacity to experience desire did not mean that I was not tormented by memories of desire. Surrounded by the presence of youthful Eros, expressed in forms of touching or longing looks, I began to feel a crushing weight of loss. Why was this happening? After all, mine was a mature sexuality fully integrated, I thought, into my personality.

But such experiences continued and they produced increased suffering. The sight of young males walking across the campus tormented me. I began to envy their capacities and, most fundamentally, their possession of what I had lost. I hated these feelings; and sometimes I hated myself for having them. But they were difficult to suppress, and they continued to break into ugly blooms in my experience. As I endured the suffering produced by unwanted fantasies, I finally began to see what was producing them. Like a range of mountains that appears in the distance, those structures of meaning that had formed the capacities for my erotic responses came gradually into focus.

When these meanings became clearer, I confronted an idea that I had read about in literature by feminist scholars: male sexuality was excessively genital in its focus. Confronting this idea at a deep emotional level was shattering; and allowing it to have an affective impact on my experience began to deconstruct my previously taken-for-granted expressions of erotic pleasure. As a consequence of my male socialization, how restricted these "pleasures" now appeared, and, more painfully, I began to sense how

much I had missed.

All of this was not new to my wife. She had been saying many of these things for years, but I was not listening. The loss of capacities, body parts, and what I thought of as my essential maleness was less important to her than the intimacy that accompanied other forms of reciprocal communication: touching, holding, sharing feelings, and being deeply present to one another. As a consequence of these insights, a surprising disgust arose in me, and now I began to hate my previous sexual responses: how insensitive, narrow, and compulsive they had been. And, in a phrase that seemed to summarize all that I was feeling, how goatish!

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What I had not yet realized was the deeper significance of testosterone deprivation. It was clear that this manipulation of my body had probably postponed my death, and for that I was grateful. While I did not fully grasp what it would mean to live in a male body without potency, I had not begun to contemplate the meaning of continuing to live without the experience of desire. Desires are always directed toward a subject or an object, and erotic desires are no different. But when desire is radically extinguished, then the way it had been shaped as well as the objects and subjects of its focus still remained as memories. Without the urgency of desire, these memories stood out in ways that were both painful and instructive.

Male socialization had taught me to imagine the female body in a certain manner, to focus my erotic attention on particular body parts, to objectify and depersonalize these body parts, and to understand sexual pleasure as focused almost entirely on orgasm. These structures of the embodied imagination had shaped my experience of desire. The practices, language, and example of other males in my environment powerfully enforced them. I had been so deeply formed by that world that there was virtually no transcendence of it in my experience. Again, I was plunged into despair and, finally, into hatred of the structure of desire that was still alive in my memory and projected in my imagination.

I still struggle with these issues, but at least some feelings of acceptance and consent to my condition are beginning to be stronger than the more negative and destructive responses. At the same time, I am increasingly aware of several things that I consider invaluable. I have learned, first, that women are embodied in much more complicated ways than I had ever imagined. Second, relationships between men and women are complicated—inevitably so—by Eros. But for me, there is a sense of transcendence and peace in being able to experience persons as the complex beings they are without being so completely captured by the undercurrent of desire. Third, there is richness and creative playfulness in human relationships that is distorted by patterns of male socialization. Fourth, the terrain of manhood is much richer and fuller of possibilities than I had ever imagined.

I have survived and, in many ways, flourished for almost 10 years. Six of these years have been characterized by excellent quality of life on many levels. But there have been other losses and some deepened suffering connected with aggressive treatment. In the fall of 2000, for example, when I was again on leave in Montana, I experienced kidney failure as a consequence of lymph node swelling that blocked my ureters. I now have two nephrostomy tubes that require care but that are partially internal so that I urinate “normally.” It became clear, however, that if my quality of life were to be sustained I would have to undergo further treatment.

After consultation with my oncologist, I endured 6 months of chemotherapy with Taxol, which gave me about 4 additional months of satisfactory quality of life. Then in the spring of 2002, I was diagnosed with cancer progression in my right femur and some involvement in my left hip. I underwent surgery and a pin was placed from the top of my femur to my knee. My left hip was radiated at the same time. My recovery was successful, and I went from a wheelchair to a walker to a cane and then to full mobility.

With the blessings of my surgeon and my oncologist, my wife and I left in July 2002 for another research trip to Montana. But after less than 2 weeks I lost bladder control as well as my ability to walk. An MRI revealed serious spinal cord compression, and we were immediately flown back to Nashville where I endured another surgery to decompress the spinal cord. This surgery was apparently successful and I am now proceeding from the wheelchair to the walker; my hope is for full mobility.

These surgeries were defined as “palliative,” but the last one had real authority. The pain was significant, and recovery has been slower than I would like. My condition is different now, and the sense of loss has a different quality and weight. I clearly anticipate the loss of my world. But I am not simply contemplating this possibility; it is a powerful sensibility that arises within me daily. Nurtured by a supportive network of friends, family, and groups like Gilda’s Club and Alive Hospice in Nashville, I feel a strange peace descend on me. My life seems to have come full circle as meaning folds back upon itself and deepens in a manner that makes more and more sense.

Certainly my experience will not characterize all who read this description. In part, the quality of my experience is dependent on having had sufficient time to assimilate the meaning of what has happened to me. First I lost desire. Now I am gradually losing my body, and I will soon lose my life, my wife, my family, my friends, and the whole beautiful world. I hope that other readers in my situation will have sufficient time to integrate their experiences as I have, and I hope these reflections are helpful for their respective

journeys.

Editor's Note: Professor Harrod died February 3, 2003.

To read a retrospective analysis of Dr. Harrod's journey with prostate cancer log on to [www.lefprostate.org](http://www.lefprostate.org). This analysis has been written by Stephen B. Strum, M.D., a medical oncology specialist in prostate cancer. His goal in writing this is to familiarize the reader with important biologic concepts relating to the diagnosis, evaluation and treatment of this disease. Dr. Strum believes it is crucial to familiarize Foundation members with prostate cancer about more comprehensive treatment choices. This detailed review is by no means a criticism of Dr. Harrod or his physicians.

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