Health services should consider the masculine representation of disease that underlies men’s health behaviors. This study presents a transcultural view of Prostate Cancer (PC) among Canadian men of European descent. Nine men who were enrolled in a PC support group in Southeastern Ontario comprised the sample. Data were collected through interviews, genograms and ecomaps. The contrasting-ideas method guided analysis and interpretation of the findings. Healthcare providers must assist men to understand that an immediate investment of time is imperative to adequately decode and understand medical information, consider available therapies, and reflect on the potential outcome of their decisions.

Keywords: prostate cancer, masculinity, transcultural representation

Beliefs about the origins and natural course of cancer vary among cultures and influence individuals’ attitudes about prevention, screening, and management programs.
(Dein, 2004; DiMatteo, 2003; Lodge, 2001). In the context of modern medical care, individuals who live with cancer are expected to participate in medical decisions, give informed consent, and modify habits of life to transcend their limitations (Anonymous, 2004a). Prevention and illness management are assumed to be among these tasks and responsibilities. Such an active attitude is expected of all Canadians (Carlier & Cognet, 2005). Healthcare policies are based on a contractual model of health prevention (Dozon, 2001) where the consumer plays the role of sentinel in his or her own health and learning (Kelly, 1999). However, an “untiring warrior” attitude is not universal among individuals with cancer, because the experience of cancer may be complicated by confusion, stereotypes, and stigma. Public discourse about positive thinking and success, and persistent war-metaphor medical language (Penson, Schapira, Daniels, Chabner, & Lynch, 2004) may justify either hope for a cancer cure or pessimism about the future (Anonymous, 2004a).

Among men who have survived cancers specific to males, reconstructed identity involves a new concept of a healthy life, and new roles and relationships that transcend all the limitations of cancer (Evans, Butler, Etowa, Crawley, Rayson, & Bell, 2005; Little, Paul, Jordens, & Sayers, 2002). More information is needed about what men who have undergone treatment for prostate cancer (PC) think about PC as a result of their experience of the disease given their ethnocultural heritage (Lees & Papadopoulos, 2000).

The Phenomenon

In a previous study with 15 French-speaking, Canadian men (self-identified as Canadian born or immigrant from France, Italy or Algeria), Zanchetta (2002) described distinct representations of PC. The cultural value the men attributed to virility strongly biased their representations of PC. These interpretations opened the door to reflection about possible shared interpretations of PC among men from other ethnocultural backgrounds. In this study, expressions of affiliation with ethnocultural groups by the participants were accepted as a form of self-identification (Bradby, 2003; Cuche, 1996).1 We conceptualized elements of representation of PC that could be repeatedly identified among various ethnocultural groups, indicating that these traits are multicultural.

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1 We adopted a constructivist perspective of culture as a dynamic, relational and situational object. Since Barth’s work (1969), many consider expressions of ethnocultural affiliation to result from an identity negotiation between unequal social groups. Culture is assumed to be more a consequence or implication of the reproduction of boundaries between ethnic groups than part of their definition. To recognize, affirm or claim an ethnocultural identity involves interactions between groups and how they differentiate themselves (Cuche, 1996). In this study, the participants fluidly affiliated themselves with one ethnocultural group or another by referring to their own life history; for example, as a son of immigrant parents, having lived in Canada or elsewhere.
Research on men’s health frequently overlooks the sociocultural and psychological effects of illness (Papadopoulos & Lees, 2004), in particular how men in different cultures develop representations of diseases based on their social milieus and popular education. We do not know whether men from different cultures share a core representation of PC. However, we assume that such a core representation would redefine men’s identities, their ways of handling health challenges and their ways of using health services. A transcultural representation of PC may be linked to the male social roles determined by power, authority, domination, strength, and virility (Gray, Fitch, Fergus, Mykhalovskiy, & Church, 2002; Kiss & Meryn, 2001). This study looked at similarities across ethnocultural backgrounds to delineate a core, transcultural representation of PC, one that could be incorporated in new health-promotion educational initiatives aimed at transforming the experiences of men with such stigmatized chronic disease.

Aims of the Study

This exploratory pilot study aimed (1) to identify the experiences of men with PC from different ethnocultural backgrounds, including their essential thoughts related to learning the medical diagnosis, telling their family about the diagnosis, facing moments of frustration, and reassessing life priorities, (2) to describe major representations of PC as they relate to the aforementioned thoughts, (3) to specify the essential similarities among representations of PC, and (4) to assess the existence of hints of a core transcultural representation of PC.

Review of the Literature

Scientific advances in medical research and cultural understanding of cancer inform the social representation of the disease. This can vary depending on where one lives and one’s social, cultural, economic and political world. Cancer is variously believed to be an abnormal growth of cells, a death sentence (Anonymous, 2004a), a punishment for sin (Anonymous, 2004b), a consumptive disease (Saillant, 1990; Skott, 2002), a result of genetic heritage (Stancey, 1997), and a result of exposure to environmental risks and problems of the modern world (Stancey). It is variously believed to lead to intractable pain, mutilating surgery and nauseating chemotherapy (Mahon & Casperson, 1997) as well as incorporating crises, battles and resistance (Justman, 2003), inevitable fear, dread and suffering, and heroic transcendence (Flanagan & Holmes, 2000).

Across cultures, the literature documents different perceptions of cancer. For instance, to some Native Americans, cancer is believed to be hosted by a weakened body. Some Africans tend to acknowledge cancer only when it is in the terminal stage. Egyptians generally are more likely to restrain themselves from showing anger or even complaining due to fear of divine wrath. Some Indians perceive cancer pain as a natural life event (Navon, 1999). In Latin Americans some perceive cancer as synonymous with death, extreme suffering and disfigurement (Granda-Cameron, 1999).
The availability of good medical care generates hopes of remission and cure. Cancer is also perceived differently by men and women. In general, men exhibit quiet control of a chaotic situation and women make sacrifices to endure their cancers (Justman, 2003). Masculine cancers, particularly PC, remind men of their vulnerability, force them to reconsider their social roles, and disrupt their traditional view of masculinity (Gray, Fitch, Fergus, Mykhalovskiy, & Church, 2002; Oliffe, 2005, 2006a). Their self-image is significantly affected (Broom, 2004; Chapple & Ziebland, 2002; Dahn et al., 2004) because men are forced to recreate their masculine identity (Kelly, 2004; Stansbury, Mathewson-Chapman, & Grant, 2003). The social stigma of PC associated with impaired sexuality (Kunkel, Bakker, Myers, Oyesanmi, & Gomelle, 2000) leads many men to join other men in fighting against labelling (Davison, Pennebaker, & Dickerson, 2000).

PC is seen in terms of the disease itself, men’s bodies, masculinity and sexuality. Misconceptions, lack of information about PC, and threatening messages in health education materials about the need for early detection reduce men’s willingness to seek medical help (Clarke, 1999).

Men’s health behaviours are also linked to their views of their own bodies and thus their social and individual identities. Such identities incorporate ideas about masculinity, including invulnerability, taking risks, hiding feelings, having a strong, well-built body, silently enduring life’s misfortunes, and not complaining about disease (Arber, 2004; Drummond, 2003). In American society, force, strength, rigidity and endurance are important components of masculinity (Addis & Mahalik, 2003; Courtenay, 2003; Sabo, 1999) that reinforce the status quo by encouraging power, independence, and self-reliance (Gordon, 1995). In Canadian society, both traditional views of masculinity and men’s desire to control their life situations influence men’s health behaviours (Tudiver & Talbot, 1999).

Within a traditional view of the masculinity, health and self-care are not seen as important. Men are believed to be strong; thus they do not need healthcare and can even avoid self-care. A man must not allow any health care professionals to touch his genitalia or anus, touching that might violate his heterosexuality (Braz, 2005). The aforementioned conceptions may explain why men tend to delay the search for medical help, stretching their bodies to their limits of endurance, perceive health services to be for women, children and older ill individuals, do not discuss their gender-related worries with their physicians, and do not value health-promotion educational campaigns (de Keijzer, 2003; Schraiber, Gomes, & Couto, 2005). Neglect of men’s health, inequity in healthcare services and reinforcement of prejudices toward men are evident (de Keijzer). Health services operate for only a few hours outside of business hours, forcing men to seek healthcare in hospital emergency rooms. There is an unequal allocation of financial resources to men’s and women’s health programs as well as a lack of health-promotion and early-detection programs for men.

Although extensive, the available literature on PC focuses on decision-making about treatment, quality of life associated with treatment consequences and complications, and male sexual failure after treatment. Results of the recent studies reveal some
ethnocultural aspects of PC. These studies explore the access of minorities to healthcare and health-education initiatives, their participation in screening programs and clinical trials, and preferences for sources of PC-related information. The most common ideas about PC among PC-diagnosed men as well as healthy women and men corroborate the need for further investigation into the triad ethnicity/culture/PC.

Regarding knowledge of PC, results of a survey conducted with a subsample composed of 700 healthy and PC-diagnosed men in France, Italy, Germany, Spain, Sweden and UK revealed that 86% of the men cited urinary problems as being the main indicator of PC. Only 1% of participants knew that PC could be asymptomatic, and 73% stated that age was the major risk factor (Schulman, Kirby, & Fitzpatrick, 2003). Since PC is believed to be transmitted only by men, European-American, African-American and Mexican-American men believed that PC inheritance is possible from only one’s father’s relatives. They did not understand that women could inherit PC genes and then transmit them to their sons (Plaetke, Thompson, Sarosdy, Harris, Troyer, & Arar, 2002).

Studies of PC screening document that, even in popular African-American men’s and general magazines, information about PC and its screening remains partial, incomplete and biased (Katz et al., 2004). In fact, Hispanic men were less likely to have PSA tests than non-Hispanic Caucasians, non-Hispanic Blacks and men from other ethnic and racial groups (Finney Rutten, Meissner, Breen, Vermon, & Rimer, 2004). Caucasian men tend to have less knowledge of the limitations and benefits of PC screening than did African-American men (Weinrich et al., 2004). Healthy Caucasian, African-American, Asian-Pacific Islander and Hispanic men decide to go for PC screening based on how they perceive the test will affect their current health status (Liberatore et al., 2003). Healthy African-American, Caucasian and Hispanic men prefer to know their screening results and tend not to take any chances if PC is identified. Since PC arouses feelings of fear and anxiety related to death, these men believe that screening tests will reduce uncertainty and increase vigilance about PC development (McFall & Hamm, 2002). The motivation for screening healthy African-American and Hispanic (predominantly of Mexican descent) men was high, because to them PC means a death sentence, fear and despair (Meade, Calvo, Rivera, & Baer, 2003). Such cultural beliefs seem to underlie men’s health practices and, ultimately, their efforts to acquire credible and useful PC-related information in order to remove uncertainty (Zanchetta, 2002, 2005).

Opposite findings were reported among highly educated African-American men, who considered PC-screening procedures neither uncomfortable, painful nor embarrassing (Clarke-Tasker & Dutta, 2005). Anglo-Australian men rationalize the benefits of screening through a transrectal, ultrasound biopsy, seeing it as a safe way to detect PC (Oliffe, 2004). A large survey of 528 men identified as African-American, English-speaking Caribbean, Haitian-American and African explored knowledge about methods of PC screening. The results show neither a significant difference in PC knowledge among the ethnic subsamples nor a significant correlation of PC knowledge with level of education (Magnus, 2004).
Lack of suspicion of PC or even susceptibility to PC was reported among Anglo-Australian men of Welsh, English, and Irish backgrounds (Oliffe, 2006b), French-Canadians, French and Algerian immigrant men (Zanchetta, Perreault, Kaszap, & Viens, 2007), as well as African-American men with master’s degrees (Clarke-Tasker & Dutta, 2005). Indeed, lack of PC knowledge seems to be a long-lasting problem, as reported by 500 Caucasian-American men who primarily wanted to know the symptoms of PC recurrence, the causes of PC, and lifestyle changes that can modify the clinical evolution of PC (Boberg et al., 2003).

Regarding PC treatment, data from the United States National Cancer Institute Clinical Trial Cooperation Group reveal that Hispanic, Asian-Pacific Islander and American Indian-Alaskan Native men were underrepresented in PC clinical trials conducted from 2000 to 2002 (Murthy, Krumholz, & Gross, 2004). Racial or ethnic characteristics do not fully explain the differences in care among African-Americans and Hispanics at the beginning of PC; namely, monitoring symptoms and waiting for change before taking action (Shaves et al., 2004). Race does not seem to play any role in the differing outcomes of similar treatment provided to African-American and Caucasian men (Peters & Armstrong, 2005).

The literature also indicates that ideas and thoughts about PC strongly influence men’s attitudes throughout their illness. French-Canadians and immigrant men from Italy, France and Algeria disclosed two time-framed ideas about PC. First, PC meant suffering and death, based on their childhood memories of PC endured by their fathers and grandfathers; or, second, PC was seen as an innocuous disease. These men had bad memories of fathers and grandfathers suffering, but because they had not encountered such serious cases of PC in their own adulthoods, they believed that PC no longer causes illness nor pain (Zanchetta, 2002, 2004; Zanchetta, Perreault, Kaszap, & Viens, 2007). Similarly, in another study, African-American, Filipino, Chinese and Caucasian men perceived PC as a life-threatening disease causing suffering and death (Maliski, Connor, Fink, & Litwin, 2006). Using PC case studies, Papadopoulos and Lees (2004) described men’s reactions to PC diagnosis. A Greek Cypriot man reported feeling fearful, upset and unwell; a Jamaican man reported numbness, shock and surprise. The words study participants used to describe PC were “dangerous,” “mysterious,” “torturous,” “a snake-like disease” (Greek Cypriot), “sinful,” “a bad disease” (Jamaican), and “a life-threatening disease” (Caucasian English). Oliffe (2004) reported similar emotional reactions toward PC diagnosis among Anglo-Australian men, even though they reacted rationally while undergoing screening tests. Conversely, Caucasian-American men who participated in a PC lifestyle-moderation clinical trial reported less dramatic emotional reactions related to the idea that PC is natural and not “a problem” (Kronenwetter et al., 2005).

Recent studies indicate that representations of PC are closely tied to ideas about masculinity. Even in the earlier phases of PC, men face obstacles determined by such ideas. Beliefs about men’s tolerance and denial of pain among Anglo-Australians were evidenced by physicians’ decisions to proceed with transrectal, ultrasound prostate biopsy without local anaesthesia and by men’s tolerant silence during their exams (Oliffe, 2004). Men who undergo PC treatment very much want to enhance their phys-
ical and mental health in order to avoid post-treatment consequences. The driving goal is to increase their chance of survival and to preserve physical and mental energy to enhance their recovery and future well-being, rather than to resume active, penetrative sex (Broom, 2004—Australian men; Oliffe, 2006a—Australian-born men of Welsh, English and Irish backgrounds; Arrington, 2003—American men). Even with lack of awareness about the side effects of androgen-deprivation therapy and prostatectomy, Anglo-Australian men transcended functional limitations and developed strategies for rebuilding their masculine self-images as well as their sexual and intimate lives (Oliffe, 2006a, 2005).

More negative PC-treatment experiences were documented by Navon and Morag (2003a, 2003b, 2003c), who studied Israeli men who underwent androgen-deprivation therapy. Changes in their bodies and their level of energy significantly affected their partner’s acceptance of the men’s changed bodies. These factors, as well as their masculine roles within the family, were affected by the men’s new self-perceptions of their masculinity after the therapy. Probably, Israeli ethnocultural beliefs (as exemplified by the beliefs of the participants’ wives about male bodies, social roles, attitudes toward life events, responses to emotions, and disclosure of personal experiences) accounted for these men’s more negative interpersonal experiences with PC treatment.

Study of PC in terms of cultural diversity remains limited (Dunn & Dyck, 2000; Lees & Papadopoulos, 2000). Several knowledge gaps exist regarding the experience of living with PC in multicultural societies. Questions that emerge from the literature analysis in the present study include but are not limited to:

What ideas regarding PC do men share?
Do men share only a core set of ideas regarding PC?
Do men share similar ideas regarding their illness only at certain times during the course of their illness?
At what point in their experiences do these ideas evolve and other solidify?
What causes men to make change their ideas regarding PC?

Theoretical Framework

Le noyau de la représentation sociale (Core of Social Representation) theory (Abric, 2001; Flament, 1994) framed this study. A social representation is a way of knowing and a way of social thinking, both of which include common sense. It is related to communication, understanding of lived experiences, and mastering one’s social, ideological and material environment (Jodelet, 1999). The theory is grounded in cultural values. The core of a representation is stable. It does not change, regardless of new experiences or knowledge, but it can generate or change the meaning and the value of a given social representation. The core representation organizes the links between elements of the social representation. These elements are most likely to be modified by one’s interpretation of the outcome of new experiences and learning within the social world. The elements comprising a social representation also depend on the interface be-
between the core concepts and the reality out of which the social representation originates (Abric, 2001).

Research Questions

Given our theoretical framework and literature analysis, we were led to ask the following research questions:

1. What ideas regarding PC occur across subsamples of men from different ethnocultural backgrounds and emerge from the men’s experience with the four phases of PC experience?
2. To what extent do similarities exist between these groups of ideas regarding PC?
3. How do these ideas delineate hints of a core, transcultural representation of PC?

Method

The qualitative design of this descriptive, exploratory pilot study required a methodology that would (1) allow a logical framework to emerge from the participants’ input and reveal a hypothetical representation of PC and (2) permit the researchers to detect links between the framework, ethnocultural values and beliefs, and identify the noncentral elements of the representation. In the preliminary, conceptual phase of this pilot study, we pondered the major methodological challenges of exploring hints of a transcultural representation of PC:

1. How could we choose meaningful, evocative words that would reflect the experiential perspectives of the participants?
2. How could we determine from the interviews which elements were core and which were noncentral, and which schemas related to the representation of PC?
3. How could we create an organizing image with which the participants could identify themselves as individuals and acknowledge the feelings associated with their lived experiences with PC?
4. How could we conceive strategies to analyse and combine the gathered findings?

The methodology we devised privileged theoretical and methodological approaches that allowed researchers and participants creativity, originality and freedom in the process of assembling, verbalizing, classifying and analyzing ideas.

To address the first and second methodological challenges mentioned, we applied Guimelli’s method (1993, 2001) of using evocative words to provoke the verbalization of elements that might be at the core of a social representation. The third methodological challenge led us to use a synthesis image to allow more intuitive communication, as well as encourage participants to organize their own ideas and establish links among
evoked ideas about PC. This synthesis image also helped the researchers in their analysis, since it produced both an organizational structure and a hierarchy of ideas provided by the participants. The image also produced preliminary clues about the analytical dimensions that should be explored in depth. The fourth methodological challenge required us to find analytical strategies to reduce the participants’ narratives to simple words and phrases. We decided that Guimelli’s method of contrasting ideas would be sufficient to attain enough internal coherence and cohesiveness to support a grounded formulation of the representation of PC. Aiming to maintain this rigour, the first author obtained technical advice from Professor Juliet Corbin, who examined and corroborated the authors’ plan of analysis (personal communication, April, 2003).

Collaboration with the Kingston PC Support Group

The principal investigator (PI) presented a preliminary plan for the study at a PC support group (PCSG) meeting in Kingston, Ontario, Canada. After the PI answered attendees’ questions, she and the PCSG chairman informally agreed to collaborate. The PI obtained approval from the Queen’s University Research Ethics Board.

For two months, three volunteers helped the PI create the initial interview guide. These volunteers reviewed 156 evocative words extracted from descriptions of 15 French-speaking Canadian men’s experiences with PC from a previous study (Zanchetta, 2002). These words were grouped into the following nine categories: attitudes, behaviors, expectations, feelings, knowledge, personal experiences, PC, reactions to PC, and social experiences with PC. The participants were each given a form displaying nine rows (one for each category of evocative words) and two columns labelled “Agree” and “Disagree”. The volunteers were asked to check either “Agree” or “Disagree” for each row, based on how they themselves had experienced PC or based on the experience of other men diagnosed with PC. The volunteers agreed with 90% of the 156 words and nine categories. The three volunteers suggested that the ideas expressed by these evocative words varied according to which of the four phases of PC experience (as the volunteers named them) any man was in: (a) learning the medical diagnosis; (b) telling their family about the diagnosis; (c) facing moments of frustration; and (d) reassessing life priorities. Later, the researchers refined and then clustered the confirmed words into 40 evocative words and 13 evocative phrases (see Tables 1 and 2).

We used these confirmed evocative words and phrases to create the 14 questions in the interview guide in five different formats: semi-open, open, multiple-choice, sentences to complete, and words to indicate. We also used a diagram to be completed. Finally, we used three projective techniques: word association, sentence completion and the Thematic Apperception Test (Lilienfeld, Wood, & Garb, 2000). These techniques are usually used to assess similar constructs by assuming that respondents cannot easily verbalize their attitudes, motivations and ideas, and need cues to help them express opinions and beliefs. Inferences about their answers emerged from analysis of the responses through the inductive hypothetic-deductive process (Lilienfeld, Wood, & Garb, 2000). More detailed information regarding the creation and development of the orig-
inal interview guide has been published elsewhere (Zanchetta, Cognet, Xenocostas, & Aoki, 2005).

Participants

In this study, the prospective participants were men who had received a diagnosis of localized PC and had undergone at least one treatment modality up to five years earlier. The selection criteria included (a) effective oral communication in English, (b) no reports of hearing, vocal, or visual impairment, and (c) no reports of drug treatment for psychosis. The identification of prospective participants involved mailing to all 120 PCSG members a stamped, self-addressed envelope containing a presentation letter.

Table 1

Evocative Words

| 2. Anger   | 17. Information | 32. Treatment |
| 11. Family | 26. Resignation | |
| 12. Fatality | 27. Result | |
| 13. Fear   | 28. Sexuality | |
| 15. Help   | 30. Surprise | |

Table 2

Evocative Phrases

- Best feelings
- Best moments
- Capacity to make decisions
- Cultural values
- Disease confirmation
- End of the treatment
- Health professionals
- Most difficult moments
- Personal strength
- Prostate cancer
- Spiritual life
- State of mind
- Way of responding to difficult situation
and an invitation to volunteer, along with a demographic and ethnocultural background questionnaire. Data on ethnocultural background were collected to allow the PI to create groups for internal comparison (Creswell, 1998).

**Data Collection Methods**

Out of 120 letters mailed, 9 were returned (7.5%), and all of the men satisfied the inclusion criteria. They comprised the final sample. Once the prospective participants were identified, the research assistant (a third-year, undergraduate, male nursing student) introduced the men to the study by ways of a telephone call to them. When potential participants expressed interest, an interview was arranged at each participant’s convenience. The research assistant conducted the interviews. A short introductory text and the informed consent form were read jointly by the interviewee and interviewer before the form was signed. All participants were informed of their right to interrupt their interview without explanation and their right to refuse to answer any questions. All participation was voluntary and unpaid. All participants were offered and accepted $20 CDN as compensation for personal expenses.

An English teacher revised all forms used in the study for clarity. Interviews (on average lasting 72 minutes) were audiotaped, transcribed, and coded using Atlas ti 4.2 qualitative software (Muhr & Scientific Software Development®, 1997). Only the interviewer and the first author had access to the raw material. Each interview included structured questions to explore the interviewee’s health history, family experiences with PC, and cultural and educational influences on his thinking about PC. Each interviewee was asked to complete 15-short sentences in three different ways in order to communicate his current thoughts relating to life and health after finishing PC treatment (e.g., “My disease is ….”; “My worries are ….”; “My best feelings are ….”). The interview guide required the participant to react to 16 words that might evoke recall of his most important ideas regarding PC. An open-ended question asked the participant to give the five words that, to him, best described PC. A closing question aimed to synthesize each interviewee’s ideas regarding PC and the importance he attributed to the disease. This closing question aimed to document a synthesis of the participant’s ideas about PC, as well as to identify the core and non-central elements in the participant’s representation of PC, and the organization of those elements.

The last question presented an image of a tree (see Figure 1) developed by the first and second authors. The participant was asked to respond to the following statement: “Now, imagine a tree. PC is the root. Complete the tree trunk with the most important idea you had after the disease happened in your life. Organize the four branches representing the precise moments of your experience, completing each one with five leaves and writing all the ideas you remember during these moments.”

Interviews also included the drawing of genograms and social network ecomaps. This simultaneous construction of genograms and ecomaps with each participant allowed the identification of complementary new information regarding health and illness-related events in the participant’s life. McGoldrick and Gerson (1985, p. 1) defined
a genogram as “a format for drawing a family tree that records information about family members and their relationships over at least three generations.” Genograms evolved from simple representations of demographic information and intergenerational patterns to an expanded format that covers family resources and critical junctures that systematically map family structure, relationships, and functioning across generations within a given environment (DeMaria, Weeks, & Hof, 1999; Herth, 1996).

Based on Family Systems Theory (Bowen, 1978) and Bertalanffy’s General Systems Theory (Puskar & Nerone, 1996), a genogram explains the multiple forces that tai-
lor the way a family system functions. It has key symbols to represent gender, marital bonds, children, and the nature and intensity of the relationships among individuals (McGoldrick & Gerson, 1985) as well as the name, profession, health status, birth date, cause and date of death, position within the family of each family member, as well as the number of individuals in each household including the presence of extended family members (De Maria, Weeks, & Hof, 1999).

We also gathered data for this study through ecomaps. The ecomap (or ecological map) was developed to depict a family’s or individual’s experience within an environment or domain. The map may display features of an extended family, healthcare, school, or work, as well as supportive resources in the family’s or individual’s social environment. More recently, ecomaps have evolved to include social supports (Hodge, 2000). Ecomaps are often linked to genograms and are used to construct a wider vision of the family’s or individual’s way of handling experiences within their present environment. They are “an ecological metaphor” (Dobson, 1989) that displays situations, strengths, conflicts and stressors, as well as sources of nourishment, stimulation and support. They also rely on a systemic overview of well-being. Their primary value is visual impact (Wright & Leahey, 2005). The usual way of constructing an ecomap is by starting with a circle and then connecting elements of the external environment to the circle with lines. The thickness of the lines varies with the intensity, importance or strength of the connections represented. Arrows are added to the lines to show the flow of energy, time, or resources (Dobson, 1989).

Method of Data Analysis and Verification

Manual content analysis (Bardin, 1997) was applied to answers in less-than-complete sentences. The analysis explored semantic proximity, units of meaning, internal structure and dichotomy, and conceptual categorization. To interpret the data, the PI contrasted clusters of thoughts and grouped them into conceptual categories of ideas within polarized (positive, neutral and negative) perspectives of meanings, as recommended by Guimelli (2001).

The final interpretation of the findings was confirmed by three volunteers in individual meetings with the first author. These volunteers examined the researchers’ interpretations (which they had summarized in key points), definitions, descriptive sentences, and diagrams displaying the descriptors of the PC representation. These meetings were also audiotape recorded and transcribed, and their contents were analyzed and compared with the preliminary interpretation.

Finally, three months after the data collection, the results were presented to 37 attendees at a meeting of the PCSG (including group members, their wives, fiancées or daughters). Various contacts in the field and PCSG-member checks also supported the validity of the researchers’ interpretations of the findings in terms of grounded knowledge (Creswell, 1998) and the study’s catalytic validity (Lincoln & Guba, 1999; Altheide & Johnson 1998).
Description and Analysis of the Findings

This section divides the findings into two separate sets. The first is a set of descriptive findings gathered from the part of the interview that collected data on the participant’s experiences as framed by his ethnocultural and familial backgrounds. The second set of findings was gathered from projective techniques that revealed a hierarchy of ideas, thoughts and perceptions rooted in the participant’s illness trajectory.

We first describe the sample, then discusses the overall themes of the findings: participants’ health history; influence of cultural and familial values; family members as health educators; support received to live with PC; evolutionary ways of understanding PC; ideas related to life and health after finishing PC treatment; and ideas recalled through evocative words. The section ends with an empirical description of PC and the roots of its social representation.

Descriptive Findings: The Sample

To ensure anonymity and confidentiality, only self-reported ethnocultural identities are used to describe the participants. Participants were drawn from a small urban population whose cultural heritage is Irish, Scottish and English. Nine men, age 64 to 80, eight married and one single, participated in this study. Their reported schooling ranged from 13 to 21 years. They were mainly English-speakers. Two spoke and read another language (French or German). Participants’ past occupations were teacher, manager, engineer, veterinarian, and chemist. They had a mean of six years of experience with PC and were at a mean of three years post-treatment: surgery \( n = 4 \), hormone therapy \( n = 3 \) and radiation therapy \( n = 2 \). With the exception of one participant, an immigrant from Ireland, all of the participants were Canadian-born with immigrant parents. Information related to the participants’ ethnocultural affiliation was extracted from their responses to the mail-in survey sheet, which asked about ethnic or cultural affiliation, country of birth, as well as the mother’s and father’s country of birth. The participants identified themselves as Anglo-Saxon, Anglo-Canadian, Canadian, Anglo-Saxon and Irish, Scottish-Canadian, Caucasian (2 participants), German, Irish and English, and Swiss-American.

These ethnocultural identities were based on the participant’s parents’ countries of birth (Canada, England, Germany, Ireland, Scotland, Switzerland, or United States). Although there was some apparent homogeneity in ethnocultural identity, in order to avoid misinterpretation based on the identities’ apparent nearness and to prevent the loss of meaning participants attributed to their ethnocultural identities (Bradby, 2003), we did not attempt to cluster the identities. All of the data reported in this study is presented using the self-reported ethnocultural identities described above.

Health History

Participants rated their current health status as relatively good \( n = 1 \), good \( n = 5 \), very good \( n = 1 \) and excellent \( n = 2 \). Five participants reported cases of cancer among their parents or siblings. Only three participants (Irish, Anglo-Saxon and Cau-
casian) reported family cases of PC. All participants except the Anglo-Canadian man reported fear as their first feeling immediately after the diagnosis of PC.

I’m fairly old and I guess I read enough. It is one thing that men get as they get older. I didn’t feel it was the kiss of death or anything. (Anglo-Canadian)

Dreadful. Very, very, uh … a very traumatic experience. So much so that I couldn’t wait to get out of the doctor’s office. When you first hear that you have cancer, I think it’s the worst thing that probably ever happened to me. (Anglo-Saxon and Irish)

After being diagnosed, two participants sought out a friend to talk about the experience (Anglo-Canadian, English-Scottish Canadian) or shared information with other men about early detection (Anglo-Canadian, Caucasian). Participants with family histories of PC actively sought information from newspapers, magazines, PCSG’s in the province or outside Ontario, or the Internet and spoke with other men about their experiences with PC. They also discussed technical procedures related to PC control and treatment with their physicians.

Overall, PC was perceived as a natural consequence of aging (Anglo-Canadian, Caucasian) with impact on sexual life and physical strength (Canadian, Anglo-Saxon and Irish). One of the Caucasian participants revealed that more serious to him than losing erectile function was losing sexual drive. Loss of libido seemed to affect his masculine self-image more than impotence. He felt inferior about his masculinity, frustrated, and perturbed.

I was completely incontinent for about two and a half years before there was an improvement. So that was a frustration and somewhat limiting in activities. Certainly sexuality, that’s bothered me. I guess in the last 4 to 5 years it hasn’t really affected my life too much. (English-Canadian)

**Influence of Cultural and Familial Values**

Seven of the nine participants (Caucasians, Swiss American, Anglo-Canadian, German, Irish and English-Canadian) denied that their ethnic background exerted any influence on their attitudes toward PC. Only the Irish participant decided to break the typical silence in his culture regarding disease and suffering. According to him, such silence was expected of men rather than facing the cultural stigma of virility loss. Contrary to other participants, for him sexual impotence had more impact than loss of sexual drive.
I would think it had an influence because the Irish are classically fairly tight-mouthed about disease. They don’t go around and talk a lot about their diseases. You grin, bear it, and get on with life. (Irish)

Moreover, the cancer drove this participant to become a listener and to create a new process of consensual decision-making within his family. This action challenged the traditional dominant role of a man in the Irish family.

So, I think it influenced me in one way: I sort of got on with my life … but, I talked about it. I talked about it openly, which is different … and that’s something which is actually almost a reaction to my cultural background. (Irish)

**Family Members as Health Educators**

For all participants, the role of the family in shaping ideas related to health and disease was evident. In all cases, mothers played a crucial role in teaching health promotion, which in turn colored the participants’ views about healthy living. Mothers’ teaching covered appropriate diet and the need for physical exercise (Anglo-Saxon, Canadian, Anglo-Saxon and Irish), as well as preventive health behaviour and self-care (Anglo-Saxon, English-Scottish Canadian, Caucasian).

So we were always encouraged to eat oranges for vitamin C and bananas were good for you. And we were always encouraged to eat cereal ... that type of cereal so your bowels would move properly, and those types of thing. (Anglo-Saxon)

Moreover, the Swiss-American participant’s father, who was a pharmacist, encouraged his son’s interest in alternative medicine and reading about diseases on websites oriented to professionals.

I did go to the doctor. I did also do a lot of reading in regards to naturopathic alternatives and became interested in that. And just read up on disease and was aware through the media also, and Health Canada, as to what there was out there and what you should avoid—what trans fats were and all that sort of stuff. (Swiss-American)

Participants who read a lot at home as children demonstrated interest in learning about alternative medicine and general health topics (Irish, Anglo-Saxon). This happened mainly in families where fathers were physicians or pharmacists (English-Scottish Canadian, Caucasian, and Swiss-American). As one participant said, “I’ve always been interested in health matters. I suppose I got that from my father being a pharmacist” (Caucasian). A family history of cancer also provoked interest in learning about cancer genetics (Swiss-American). Overall, familial influences were evident in formal
teaching or values of health-professional fathers, informal teaching of health promotion and disease prevention by mothers, and help-seeking behaviours of participants due to family histories of cancer.

**Support in Living with PC**

During interviews, participants drew schematic ecomaps that showed networks of social support, sources of motivation or resources they used to live with PC. According to the Swiss-American, Anglo-Canadian and Irish participants, wives gave the most important support. The other six participants indicated a variety of support sources, including the PCSG, oncologists, music, reading, nurses, family, and sports. Only the Canadian, Anglo-Saxon and Irish participants rated the PCSG as their most important source. Less important sources of support were friends, manual work, travel, positive mood, health professionals, arts, dancing, a clergyperson, a positive outlook, hobbies, researchers, reading about PC, church, fitness, learning languages and co-workers. Only the Anglo-Saxon participant mentioned the Internet as a less important source of support. He related one disadvantage of browsing websites for PC-related information:

> The weekend of the diagnosis, I went on the Internet and I had a panic attack. I phoned my doctor…. He said, “For goodness sake, don’t go on the Internet, especially at midnight on a Sunday night. There’s nobody around to help you.”

This participant revealed how, in these websites, messages about PC were mixed with other kinds of unwanted information. For instance, he faced a “blasting” of junk email messages claiming that a large penis and sexual potency are required for an active sexual life.

> I get spams four times a day: if I want to lengthen my penis, super Viagra. I’m thinking, why am I getting this for? So, that shows how prevalent the idea of having to be sexually intact and you don’t have that anymore with the prostate situation.

**Evolutionary Ways of Understanding PC**

All of the participants’ experiences of PC began with a lack of knowledge about the disease and no concern about vulnerability to PC. The men reported surprise and even astonishment even at having PC and difficulty in recognizing the actual signs of the disease or treatment-related consequences. Their ideas about PC were grounded in three broad perspectives.

**PC as a biological entity.** Feelings about PC emerged while waiting for diagnosis confirmation and after treatment completion. Participants recalled feeling apprehensive, hopeful, anxious, full of dread at times, aware that their lives might be ending, and
fearful about the possibility of malignancy. Their major concern was what would happen after they had received the test results. Negative feelings intensified while they waited to undergo biopsy; however, they also recalled feeling glad to be alive and that their physician had decided to test for PC. Such optimism was possible, since they perceived PC as a non-lethal condition and its treatment consequences as minimal.

Later concerns were the limited availability of early-detection tests and the improvement of clinical follow-up measures. All participants said that a kind of battle exists between men and woman over which cancer has priority: breast or prostate. The participants’ goal is to get more funding for PC detection programs, advocate changes in screening programs and increase treatment availability. Participants believed that the titration level of prostate-specific antigens is a monitoring tool for assessing treatment effectiveness and thus survival prognosis. They also believed that panic after diagnosis could be prevented by a wider sharing of information about PC, mainly by family physicians. After treatment, they acknowledged the lack of major complications and wondered whether their cancers would become resistant to PC treatment eventually. In reflecting on their initial responses to diagnosis, participants realized how “quickly” and “naïvely” they had made pre-treatment decisions, due to lack of information and having to patiently wait to have their “damage” repaired (their words).

And you become—I don’t know if the word is naïve—so I chose to have radiation. And I was so dumb; I never asked the doctor . . . I discovered the information after I took radiation. (English-Scottish Canadian)

Wanting to quickly ensure their survival and wanting to have a normal life justified such past actions. Having a choice among therapies seemed to have generated a belief that time would not be wasted. Knowing about other treatment options and trusting that they would receive good care reassured participants that they could be cured.

PC as a turmoil of ideas, worries and doubts. When participant had to make choices in dealing with the disease, major doubts surfaced. Because participants had no prior knowledge of PC, the phases of the illness and of treatment results and their side effects, these choices evoked fear (Anglo-Saxon, Anglo-Canadian, Canadian, Anglo-Saxon and Irish, Irish, and Caucasian).

Initially you wonder: Is it positive, or is it negative, of course. And then, of course, how severe is it? Then, how long am I gonna have to wait before I can get treatment? (Caucasian)

Participants wanted a second medical opinion but could not get one due to limited access to specialists in the Ontario healthcare system (Anglo-Saxon and Irish). The resulting lack of knowledge and limited understanding of clinical conditions led to feelings of anger and frustration (English-Scottish Canadian, Swiss-American), as well as perceived loss of control and lack of support (Irish). Participants worried about their
families’ well-being and financial stability should they die (Caucasian), the non-existence of a cure for PC, and the proximity of death (Swiss-American, German, Irish and English).

**PC as individual and collective responsibility.** After treatment, participants learned that PC affected their sexual and social lives, and they developed a commitment to other men’s health.

I would be taking treatment for it. I tried to influence my sons, once they got to be 50, to start to have their prostate checked when they go for their medical. And they are heeding my advice so far. (Anglo-Saxon, Irish)

Realizing that PC had negatively changed their masculine image and identity (Anglo-Saxon, Swiss-American), participants felt panic and lost self-confidence (Canadian, Anglo-Saxon and Irish). They berated the practice among most physicians of referring their clients to PCSGs after the first PC treatment intervention (Canadian, Anglo-Saxon and Irish). Participants stated that this referral process is unsatisfactory. Because physicians usually collect information from their clients through questioning and verbal reports, according to the Scottish-Canadian participant, physicians often miss significant information from older men. He suggested that, due to clients’ memory impairments, physicians should ask them to complete personal health logs. He was the only participant to advocate that men should have at least three months to decide about treatments.

PC was a catalyst for addressing worries and redefining future life plans. Indeed, participants’ most recent decisions related to learning how to live normally with sexual impotence (Anglo-Saxon, Caucasian); advising brothers, sons and nephews to be tested (Anglo-Saxon, English-Scottish Canadian, Canadian, Anglo-Saxon and Irish); undergoing periodic medical follow-up, keeping physically active, avoiding thinking about PC and developing more emotional control (Canadian, Anglo-Saxon and Irish); and making lifestyle changes such as working out, thinking positively, a healthy diet, practising meditation and prayer (English-Scottish Canadian and Swiss-American).

**Ideas Revealing New Conceptions of Life and Health after Treatment**

Analysis of the interview findings revealed recurrent, similar themes among participants’ thoughts. Their sense of personal strength directly related to how much they loved life and how much they wanted to live longer. For four participants, their newly positive attitude resulted from accepting the natural aging process and its concomitant reduction in physical ability. All the participants responded to stressful situations using their inner strength. Later, some of the men also searched for information about treatment effectiveness. Judicious thinking, objectivity and self-criticism describe their personal styles in confronting stressful situations and making decisions. To maintain mental control and a positive state of mind, the men balanced inner calm and hope with
endurance and acceptance. Spiritual practices such as prayer and meditation promoted stability, acceptance and satisfaction with their lives. Having slightly modified their lifestyles, they now felt joyful and happy. A sense of normalcy, energy and a positive mood accounted for their sense of wellbeing.

Once participants overcame unpredictability about the progression of their cancers, they saw the PC as under control. In fact, they now trusted their understanding of PC and the best ways to live with it. Some of their expectations included enjoying the present, being cured, living optimistically, and having a long, normal life. They expected to benefit from any medical discoveries of PC treatments and to continue drawing on their spiritual strength. In the near future, they all expected to have more time to enjoy family and friends, offer financial security to their families, and receive medical treatment capable of prolonging life. In the distant future, one participant hoped to die in his own bed, one wanted to remain in the company of his spouse in their home, and one decided he did not want to be moved to a seniors’ residence. These expectations coexist with frustration about the current lack of a cure for cancer:

That I was going to die and that there’s no cure yet. I’m kind of frustrated that, with the millions and I’m sure billions of dollars that have been poured into cancer research, that no cure has yet been found. (English)

One question in the interview guide asked participants about their “best moments” after the end of treatment. These included being with friends, relatives, family and people (n = 6); being in touch with nature and being alone (n = 3); making love and ejaculating (n = 2). Awareness of being alive was a common best moment. It is noteworthy that “being with male friends” was more often reported as a best moment than “being with my wife.” This shows that being able to maintain recreational and leisure activities with other men reinforced participants’ self-image as healthy, able, functional men. In contrast, when the cancer progressed or they encountered unbearable challenges, the men shared these moments with their wives. Eight participants reached a balance among the multiple spheres of their lives as spiritual men, as social men, as intimate partners, and as family members.

To conclude, all participants were able to sustain hope in the present as well as in their near and distant futures. Eight felt normal and their energy sustained a positive state of mind and active decision-making ability. Living their best moments with friends and their own inner strength smoothed the way during hard times. They felt cured while knowing that their cancers could recur. When men felt negative, this was accounted for by impaired virility and physical concerns after treatment.

Ideas from the Illness-Trajectory Phases

Thoughts Produced by Evocative Words

Content analysis of the thoughts recalled during interviews (see Table 3) revealed seven conceptual themes. These themes can be used to build an understanding of PC
based on cultural values. They account for the extensive help that participants received through multiple relationships and communication with family members and health professionals. For all, learning about PC was the turning point. After that they could decode and understand complex information and then apply it to their lives. Uncertainty remained, however, about genetic susceptibility to PC and probabilities of a cure. Participants organized such knowledge according to what they already knew and what they might learn in the future. Moreover, genetic susceptibility was corroborated by the participants’ beliefs about a triad of violation, masculine malediction ($n = 3$) and predestined disease ($n = 3$). These thoughts paint a picture of PC as inevitable for ageing men. Participants acknowledged that PC would significantly alter their sexual health and virility while they struggled to stabilize their health and improve their quality of life.

Men Describe PC and Its Conceptual Dimensions

The central findings of this study are grounded in the responses evoked by the question that asked participants to list the five words that they felt best described their thoughts regarding PC. Figure 2 shows the descriptors of PC developed by the researchers to capture the many responses that emerged. Within each descriptor are the most frequently evoked responses. Neither the interview question format nor the type of responses allowed for demonstrating how the descriptors interact. The authors used these descriptors to formulate the following conceptual definition of PC, as described by the participants based on PC’s effect on their lives: “PC provokes damaging consequences and generates painful feelings. Despite being a simple, uncontrolled biological process, it leads to several masculine losses that may nonetheless co-exist with a hopeful, positive vision of life.”

This definition combines all the damaging consequences, painful feelings, losses, and absence of control of which participants were aware. Conversely, all of the participants perceived PC as a non-threatening disease that also evoked positive feelings. Other than that, participants’ reactions to PC were a mix of positive and negative, because while the disease caused damage it was possible to survive it and regain a healthy life.

It should be noted that, due to physical fatigue, two of the nine participants stopped their interviews before completing the interview process. Of the seven who completed it, only four positioned the following ideas in the trunk of the “evocative tree”: What happens next?, fear, death, and PC as a potential killer. Again, negative ideas coincided with difficult times at the beginning of the participants’ experiences of PC. Only seven out of the nine participants filled in all of the tree’s leaves. Table 4 presents the ideas associated with the four “branches” or phases of PC experience. The labels positive (+), neutral (n), and negative (-) refer to the orientation of meanings, as interpreted by the researchers.

The tree diagrams produced in the interviews point out the multiple origins of the participants’ representation of PC. Throughout the four phases of PC, the participants’
## Table 3
*Evocative Words and Demonstrated Thoughts*

<table>
<thead>
<tr>
<th>Conceptual themes</th>
<th>Evocative words and demonstrated thoughts</th>
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| **Structure**     | - *Cultural values*: family, self-knowledge, provoking interference, and preserving masculine identity  
                     - *Help*: acknowledgement, religious beliefs, medical beliefs, social network, PCSG, expected cure |
| **Learning process** | - *Understanding*: ability, insufficient information, need, problem resolution, motivation, quality, reading  
                           - *Information*: decisions, insufficient information, learning, need, quality, reading, searching  
                           - *Knowledge*: decisions, help, insufficient information, medical knowledge, power, quality |
| **Past vs. future** | - *Probability*: cure, elimination of the tumour, generality (any man could have the same cancer), genetics, growth of the tumour |
| **Inevitable reality** | - *Needs*: absence of resources emotional needs, friends, medical support, wife’s understanding  
                           - *Prostate cancer*: changes, cure, deserved punishment, disease, inevitability, male curse, need for research |
| **Lived experience** | - *Relationships*: acceptance, friendships, continuation of contacts importance of other people, openness, scarcity of contacts, received support  
                           - *Support*: extensive (varied contacts in many aspects of life), medical, spiritual, quality, PCSG, wife  
                           - *Treatment*: changes, cure, help, novelty, option, possibility, radiation, security |
| **Facilitation**   | - *Communication*: channels, essential, help, physician-patient relationship, questioning  
                           - *Family*: disease history, effect, importance, support  
                           - *Health professionals*: expectations, helpful/expert, quality, variety of feelings and reactions, urologists, oncologists, researchers. |
| **Acknowledged**   | - *Health*: damage, diminution, future needs, quality, consequences stability  
                           - *Results*: more participation in own medical care after PC treatment, cure, elimination, loss of virility, monitoring prostate-specific antigen (PSA) levels, surprise  
                           - *Sexuality*: acceptance, compensation, continuance, damage, impact  
                           - *Virility*: absence, at-risk, changes, devalued, ending, loss |
Figure 2. Descriptors of prostate cancer.

PC leads to losses
- Sexual potency
- Sexual desire
- Libido
- Functional erection
- Ejaculation

PC generates painful feelings
- Resignation
- Frustration
- Fear
- Indignation
- Shock
- Concerns about sufferings

PC provokes damaging consequences
- Annoyance
- Multiple destruction and limitations
- mutilation of sexual life
- Lifestyle changes after treatment
- Incontinence

PC originates from
- An out-of-control biological process
- Aging
- Invasion of the body by a potential killer
- Violation of the body
- Disorganized cell growth

PC is not the end of the world
- Major beliefs:
- Best cancer to have
- Not the main cause of men’s death
thoughts about PC fluctuated. Their thoughts centred on the issues of knowledge, action, certainty, normalcy, power, control, time and predictability. These issues formed the conceptual dimensions of their representation of the experience of PC. Table 5 maps these dimensions according to each phase of participants’ experiences with PC.

Table 4
Participants Thoughts as Synthesized in a Tree of Ideas

Branches (phases), followed by ideas in the leaves.

1: Learning medical diagnosis
   (+) acceptance, confrontation, cure ratio, hope, knowledge gathering, wish for information
   (n) disease inevitability, opportunity to care for oneself, surprise, treatment modalities
   (-) aggressiveness, increase in antigen levels, bad news, confusion, devastation, disaster, ignorance, loss of control, powerlessness, probability of disease progression, preparation for the worst, suspicion of abnormality, uncomfortable technical procedures, urgency to visit an urologist, wrong diagnosis

2: Telling family about the diagnosis
   (+) advising other relatives to be tested, certainty regarding help, courage, hope for a cure, careful choice of words, wife’s support
   (n) telling wife, telling children, telling siblings
   (-) concerns about the children, difficulty in accepting diagnosis, effect on one’s body, emotions, fears, temporarily hiding the news, way to tell

3: Facing moments of frustration
   (+) advice, hope, need for action plan, search for help, support
   (n) time to reflect
   (-) daily treatment, depression, fear, impatience, incurable disease, medical delay, missed early diagnosis

4: Reassessing life priorities
   (+) twinning the future with today, awareness of not being invincible, being closer to wife, being positive, having a normal life, enjoying the present, favorable treatment, future needs, importance of life, making lifestyle changes, reassurance regarding wife’s future well-being, receiving help, spiritual searching
   (n) buying a cemetery plot
   (-) concerns about sons’ health and their lack of knowledge about PC
Action + Time \((n = 4)\) were the most frequently reported pair of dimensions. Knowledge + Predictability were the next most frequently reported pair \((n = 3)\), followed by Certainty + Normalcy \((n = 2)\) and Power + Control \((n = 2)\). These dimensions applied to all participants. Their ways of living with PC were rooted in normalcy, strength and energy gained by establishing bonds with other men, and through their social networks and satisfying social lives. These dimensions secured for them a public image as healthy men. They constantly tried to repair problems with their sexual health and family life after the PC diagnosis. Time was another concern—time to deal with past health conditions, expectations in the present, and the length of time remaining to survive. Most of the participants felt they had to use the time available to them quickly and efficiently.

Time as a core variable directs us to consider the need for more dialogue between health professionals and men about time management during their experience of PC. Our findings suggest that, when men invest time in learning about PC, they deal more effectively with the disease. This investment of time may result in a greater sense of control over life choices and a greater degree of sense of normalcy.

. . . if I’ve got 5% chance of living 10 years, or a 50% chance, that’s the sort of information I would like to hear…. It’s important that you know the worst, because you do have to make plans with the rest of your life. (German, Irish, English)
The pair of dimensions Action + Time disclose a perspective opposite to the current paradigm of men’s health education, particularly for men who live with PC. Currently, health education focuses on anatomy, available screening and diagnostic procedures, therapies, and knowledge of rates of success for various procedures. Communicating the need for investment of time to seek information must become central to delivering health information to men with PC. Men need time to adequately understand medical information, and explore alternative treatments and their consequences.

In this study, the results of the analysis allowed identification of some core and non-central elements of a representation of PC, as expressed through evocative words. These words may be incorporated into educational initiatives aimed at assisting men who face new exigencies and responsibilities related to PC and its repercussions on their masculinity. It will also be possible to use meaningful words expressing the non-central elements of the PC representation to create for men a new language that resonates better with their lives and to help them meet their need to understand PC-related information.

Eight months after the initial interviews, the volunteers’ assessments corroborated this interpretation, as illustrated in the following statements:

I would only add that PC represents a disease that asks for urgent and effective use of available time and depends, I would add, and depends on current medical treatment and research. (Volunteer #1)

I think it’s something that, the tendency is—perhaps it’s a male thing—you can procrastinate and do it another day, it will go away, but it doesn’t … and you’re trying to decide what to do, and you’re waiting to find out what’s going to happen. It seems like time is standing still and sometimes it seems like time is flying. (Volunteer #2)

Discussion and Implications

The concept of self-affiliation with ethnocultural groups guided identification of the participants, data collection and analysis of the findings. Given similarities among some participants’ demographic information, such similarities did not undermine this study’s intention to explore each man’s frame of mind and to create a PC representation based on each man’s personal life and illness history. The aim of our study was to explore PC from the viewpoint of each cultural group. Cultural affiliation was not seen as related primarily to currently being a member of a social group (the PCSG), but instead understood as a synergy between participants’ past and present socialization experiences. Seldom do men enrolled in these groups take into consideration their ethnocultural identities, as the first author has anecdotally observed over the last seven years in her contact with five Canadian PCSGs in the provinces of Quebec and Ontario. For example, in the meeting at which she presented the proposal for this study, numerous male attendees expressed their surprise when peers revealed their ethnocultural affiliations: “Are you kidding? We all have the same skin colour!”
Culture is seen as a matter of common sense by epidemiologists or clinicians when they talk about the health of their foreign-born clientele (Cognet, 2005a, 2005b). Most of the time, culture is imprecisely defined, especially when individuals from different cultures talk about their health (Cognet, 2005a, 2005b; Fassin, 1997, 2001; Ho, 2004; Roy, 2003, 2004). Participants in this study defined their ethnicity and culture imprecisely (Cuche, 1996), using indicators such as geographic location and their family’s general characteristics and values (Bradby, 2003; Shilton, 1999). Given the imprecision, we cannot systematically categorize information from participants’ self-identification while preserving the meaning attributed by participants to their ethnocultural identities (Bradby, 2003).

Because participants for this study were recruited solely from among men enrolled in a PCSG located in a small city in South-eastern Ontario, the sample is mainly Caucasian and well-educated. Anecdotal reports gathered during the first author’s conversations with men enrolled in PCSGs indicate that less literate Canadian men and foreign-born Canadian men are less likely to participate in PCSGs. The low response among prospective participants (nine of 120) corroborates the difficulty cited in the literature of recruiting men to studies of sensitive issues (Laws & Drummond, 2002).

All the participants in the present study denied that their ethnocultural background or family influenced their ideas about PC. However, data collected in the study showed the influence of all participants’ mothers (who were in charge of health education and promotion within their families) on participants’ health behaviours. The study also revealed a new perspective: the influence of fathers’ in health-related professions on children’s inquisitive minds. This influence, we assume, motivated participants to seek information about themselves, their environments and others when they faced uncertainty (Sorrentino & Roney, 2000).

Feelings of uncertainty about a future with PC were present both in participants’ daily experiences and in their informal learning. Despite their uncertain futures, as they gradually learned informally about PC, men were able to change their perception of the disease. In this study, participants destroyed the myth of PC as a family secret (Arrington, 2003; Jakobsson, Hallberg, & Lovén, 1997). Participants talked openly with other men, disclosing their intimate thoughts and fears about PC. Individually, all participants built strategies to deal with medical controversies about PC, treatment-related complications, inconsistent advice about seeking second opinions, and lack of consensus among physicians regarding clinical follow-up (O’Rourke, 2001).

Despite the considerable number of studies conducted with African-American men, few studies have explored the beliefs of other ethnic groups (Lees & Papadopoulos, 2000) in PC-treatment decision-making and self-management. Nevertheless, Evans et al. (2005) revealed that perceptions of masculinity among male African-Canadians led them to avoid early screening procedures that can detect PC. Only men who lacked knowledge about PC and those with low education levels verbalized dissatisfaction with treatments that resulted in a compromised quality of life (Hu, Saigal, & Litwin, 2003). Otherwise, the influence of ethnocultural beliefs has been documented only with regard to men’s decisions to join screening programs (Bennett et al., 1998; Tingen et al., 1998).
Oliffe (2005; 2006a) and Broom (2004) illustrated how cultural codes of masculinity among Australian men influenced their attitudes toward PC-treatment decision-making and self-management. Maliski et al. (2006) suggested the formation of ethnic-specific PC support groups to enable men from minority groups to disclose their thoughts and experiences with PC only to other men from the same group. The four authors of the study also alerted readers to the existence of ethnic preferences for and differing use of informal sources of PC-related information.

In a study with French-speaking Canadian men (both native born and immigrant), PC was seen as less lethal than other cancers that study participants assumed naturally often occur in older men (Zanchetta, 2002). Monitoring the titration of prostate-specific antigens was also believed to improve survival rates. One of the differences between the French speakers in the 2002 study and the English speakers in the present study was their views about PC. French speakers tended to have a more fatalistic view of PC, as well as partial knowledge and greater misunderstanding about the disease, mainly due to the reported more limited access to popular and medical literature written in French. The findings of the present study corroborate the existing literature indicating the threat to masculinity as an important feature of the representation of PC.

When deciding on treatments, all participants reported feeling frustrated, powerless, and vulnerable (Fan, 2002; O’Rourke & Germino, 1998), as well as fearful of impotence and impaired masculinity (Broom, 2004; Moore & Estey, 1999). All described struggling to choose the best treatment for themselves, the one that would yield the least pain, urinary incontinence, and compromised virility (Burke, Lowrance, & Perczek, 2003), as well as the least risk and loss (Brett, 1998). Oliffe (2006b) and Kronenwetter et al. (2005) identified the same urgency to act after receiving the PC diagnosis. The ability of older adults to develop accommodation strategies for neutralizing problems (Harden, 2005) may account for such an attitude.

The post-treatment period affected participants’ sense of masculinity. As previously described, participants faced some loss of libido (Arrington, 2003) and poor sexual performance (Clark, Rieker, Propert, & Talcott 1999; Talcott et al., 1998). They no longer saw their bodies as perfect, strong, unbreakable machines (Addis & Mahalik, 2003). The findings of the present study also corroborate the literature on men’s awareness of the altered performance of their bodies that affects their social identities (Detrez, 2002). Little et al., (2002) argue that PC survivors often decide to fight against the stigma of being unnatural and unhealthy (Arrington, 2003; Chapple & Ziebland, 2002). Our results showed that all the participants transcended their initial perception of PC as a source of mental pain and loss. They overcame their own physical, spiritual, and emotional limits. As described by Maliski, Heilemann, and McCorkle (2002), participants learned how to transform a life-threatening situation into coexistence with a “good and non-lethal” cancer. There were many examples among the participants of active decision-making in reaction to PC and overt demonstration of their belief that the disease demanded urgent, effective decisions.

Conclusions

This pilot study produced hints of an initial transcultural representation of PC and some ethnocultural particularities among men from a small city in South-eastern On-
tario, Canada who were of Irish, Scottish and English backgrounds. The results of this study also confirm the ability of the initial interview guide we developed to provoke participants to verbalize their views of PC and thus allow the generation of expressive words. The study results also confirm the appropriateness of the analytical strategies we applied to deal with complex, intertwined ideas. This study went beyond mere description of experiences, responding to some recent claims that socially and culturally grounded inquiry should be changed in order to advance knowledge of men’s health experiences particularly with PC (Oliffe & Bottorf, 2006).

The key finding of this study is that PC requires efficient time management and decision-making throughout its stages (action through time). This representation of PC seems to be based on participants’ perceptions of their health before the PC diagnosis and on how they believe, according to their ethnocultural background, men should react to disease. The main thoughts that framed participants’ representation of health grew from health education by parents. As adults, when men received the diagnosis of PC, their representation of health was affected by stigmas about loss of virility and libido; however, they were determined to transcend such stigmas. Through bonding with other men, networking, and struggling to survive, they refined their representation of PC.

Is the representation of PC presented in this paper exclusive to men of Irish, Scottish and English backgrounds, or does it describe a masculine way of behaving and thinking across all cultures? Further studies need to explore this question, as well as representations of other male cancers. Future research could involve men with no affiliation with PCSGs, younger men, men of varying socioeconomic status and education levels, as well as men who live in rural or isolated communities. The study could be replicated in less developed or developing countries, where more traditional ideas of masculinity interact with inadequate policies to promote men’s health. Other areas of inquiry could include how the representation of PC is affected by access to Web-based information, and by social interaction about PC among men who self-identify as homosexual or bisexual and those who have undergone a male-to-female gender-reassignment surgery.

Finally, a larger study with a substantial sample of men from different ethnocultural backgrounds would be useful in assessing the revised version of the interview guide, its usefulness, acceptability, and comprehensiveness, as well as its ability to capture men’s thoughts on the PC experience. In accordance with the scientific paradigm of qualitative inquiry, such an effort to improve the revised interview guide’s utility would have to be conducted as a co-creative collaboration among researchers, interviewers, and interviewees.

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