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Phenomenological Approach toward Understanding the Experience of Men Living with Breast Cancer

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Abstract

Background: Men account for approximately 1% of the total population of breast cancer. Men are generally diagnosed at much later stages of breast cancer than women. Evidence shows the earlier breast cancer is detected, the better the outcome.

Objective: The aim of this study is to describe the meanings of men living with breast cancer.

Method: Descriptive phenomenology was the research design used. An international sample of 10 men participated in this study. Men were asked, "Please describe for me all your experience living with breast cancer. Please describe all your thoughts, feelings, and perceptions that you wish to share. Any examples of points you are making will be very helpful to describe the lives of men living with breast cancer. Colaizzi's method for data analysis was used to analyze the stories of the 10 men.

Results: Data analysis yielded 80 significant statements and 4 themes: (a) Resilience, (b) Advocacy, (c) Pain, and, (d) Masculinity

Discussion: Although a small number of men have breast cancer compared to the number of women with breast cancer, men have poorer outcomes and survival rates. The impact of men's experience with breast cancer was the motivation for their passion with advocacy and education. Resilience, advocacy, pain, and masculinity were noted to be challenges and successes for men living with breast cancer.
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

Phenomenological Approach toward Understanding the Experience
of Men Living With Breast Cancer

Lisa Nemchek

B.S., University of Phoenix, 2010
M.S., University of Connecticut, 2018

A Dissertation
Submitted in Partial Fulfillment of
the requirement for the
degree of
Doctor of Philosophy
at the
University of Connecticut
2020
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

Approval Page

Doctor of Philosophy Dissertation

Phenomenological Approach toward Understanding the Experience of Men Living With Breast Cancer

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University of Connecticut
2020
Acknowledgments

An understanding heart is everything in a teacher, and cannot be esteemed highly enough. One looks back with appreciation to the brilliant teachers, but with gratitude to those who touched our human feeling. The curriculum is so much necessary raw material, but warmth is the vital element for the growing plant and for the soul of the child. (Jung).

I felt like a young child when I entered the University of Connecticut, everything seemed so new and exciting. Everyday, with every class, my head exploded with new ideas, new knowledge, and new language. While I felt like a child with all this new information, I also felt secure I would be successful because of the educators that touched my life.

I’m so grateful to and need to mention a few of these very special teachers about which Jung spoke in the quote above.

Thank you to my major advisor, Dr. Michelle Judge, for your support and guidance. There were times when I thought I’d never finish this program but your belief in me and passion for my dissertation topic were an integral part in my completion.

Dr. Carol Polifroni showed authentic and sincere care to me. By always telling the truth, I knew I could trust her. I am in awe of her knowledge and admire the way she shares it with clarity and poise. Dr. Polifroni is an example of professional authenticity. I appreciate all she has done for me. There are not enough pages or words to express my gratitude to this very special educator.
I am honored that Dr. Cheryl Beck took the time to support me during my years in coursework and with my dissertation. Dr. Beck’s direction, guidance, and kindness were immeasurable. I appreciate your pushing me during the dissertation process to ensure my study was accurate and appropriately followed the chosen methodology. Because of your support and advice, I am very proud of my study.

Thank you to the Peggy Miller, Director and to the Male Breast Cancer Coalition. Peggy’s approval and direction enabled me to obtain volunteers for my study. Peggy's support and guidance have provided educational insights and hope for all men living with breast cancer.

I am honored the courageous men in the study shared their stories with me. I hope I was able to clearly express their experiences. These men took the time in their battle with breast cancer to tell their stories in the hope male breast cancer education will be enhanced to fit men’s specific needs.

Last but not least, I want to thank my family for their belief in me. Without their support I would not have completed this program. Thank you to my daughter Sara who transcribed the interviews as well as proof read my work. Thank you to my nephew David who supported me through years of statistics. Thank you to my brother-in-law Dan who supported my goal to go to the University of Connecticut. Finally, thank you to my husband Ed, for your encouragement and love.
# THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

## Table of Contents

Chapter 1  Introduction ..............................................................................................................1
- Overview of Breast Cancer ..................................................................................................1
- Table/Breast Cancer Stages Table 1 ..................................................................................2
- Male Breast Cancer .........................................................................................................3
- Theoretical Framework ......................................................................................................3
- Overview of Dissertation Chapters ..................................................................................4

Chapter 2  Male Breast Cancer: Examining Gender Disparity in Diagnosis and Treatment ....7
- Methods ..........................................................................................................................8
  - Search Strategy and Operation Process ..........................................................................8
  - Quality Appraisal ..........................................................................................................12
- Results ............................................................................................................................13
  - Selected Studies ..........................................................................................................14
- Discussion .......................................................................................................................20
- Limitations ......................................................................................................................21
- Conclusion .......................................................................................................................21

Chapter 3  Riding the Train Until We Reach the End: Men and Metastatic Cancer ..........23
- Why Descriptive Phenomenology? ....................................................................................24
- Evolution of Study ..........................................................................................................24
- Literature Search .............................................................................................................25
- Rigor ...............................................................................................................................26
- Method ............................................................................................................................27
  - Sample ..........................................................................................................................27
  - Procedure .....................................................................................................................27
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

Data Analysis ..............................................................................................................................................28
Strengths and Limitations..........................................................................................................................30
Results ..........................................................................................................................................................31
Theme #1: No Time to Dwell on the Aches and Pains ..............................................................................30
Theme #2: Being Afraid and Feeling Fortunate at the Same Time ............................................................31
Theme #3: Do Whatever It Takes ................................................................................................................33
Theme #4: Laugh, Laugh, Laugh? ................................................................................................................34
Fundamental Structure ...............................................................................................................................35
Discussion .....................................................................................................................................................35
Implications for Clinical Practice ................................................................................................................35
Suggestions for Future Research ................................................................................................................36
Chapter 4 Men and Cancer: A Meta-Synthesis ..........................................................................................37
Literature Review ..........................................................................................................................................37
Metasynthesis ................................................................................................................................................39
Research Design ..........................................................................................................................................39
Sample .........................................................................................................................................................40
Data Analysis ..............................................................................................................................................45
Results .........................................................................................................................................................45
Overarching Theme 1: Go With the Flow .................................................................................................47
Overarching Theme 2: Play the Hand I’m Dealt ....................................................................................48
Overarching Theme 3: Cover Up the Suffering .......................................................................................49
Discussion ....................................................................................................................................................50
Chapter 5 A Phenomenological Approach Toward Understanding the Experience of Men Living
With Breast Cancer ........................................................................................................................................53
Background ....................................................................................................................................................54
# THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>55</td>
</tr>
<tr>
<td>Literature Review</td>
<td>55</td>
</tr>
<tr>
<td>Philosophical Underpinnings</td>
<td>58</td>
</tr>
<tr>
<td>Research Question</td>
<td>61</td>
</tr>
<tr>
<td>Research Design</td>
<td>61</td>
</tr>
<tr>
<td>Method</td>
<td>61</td>
</tr>
<tr>
<td>Sample</td>
<td>61</td>
</tr>
<tr>
<td>Sample Criteria</td>
<td>62</td>
</tr>
<tr>
<td>Data Collection</td>
<td>62</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>63</td>
</tr>
<tr>
<td>Results</td>
<td>64</td>
</tr>
<tr>
<td>Theme 1: Resilience - The Tool Box</td>
<td>64</td>
</tr>
<tr>
<td>Theme 2: Advocacy - Lighthouse on a Foggy Shore</td>
<td>67</td>
</tr>
<tr>
<td>Theme 3: Putting My Affairs in Order - Pain and Anger</td>
<td>68</td>
</tr>
<tr>
<td>Theme 4: Masculinity - Getting Knifed</td>
<td>70</td>
</tr>
<tr>
<td>Discussion</td>
<td>71</td>
</tr>
<tr>
<td>Strategies for Healthcare Professionals</td>
<td>71</td>
</tr>
<tr>
<td>Suggestions for Future Research</td>
<td>72</td>
</tr>
<tr>
<td>Chapter 6 Conclusion</td>
<td>74</td>
</tr>
<tr>
<td>References</td>
<td>76</td>
</tr>
</tbody>
</table>
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

Table of Figures

Figure 1. Literature search................................................................. 10

Figure 2. Incident by cancer type in 2015 (ACS, 2015)................................. 40

Figure 3. Key metaphors derived from the studies........................................ 51
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

List of Tables

Table 1  Breast Cancer Stages ................................................................. 2

Table 2  Characteristics of Selected Studies ........................................ 11

Table 3  CASP Ratings for Selected Studies ........................................ 13

Table 4  Methodological Characteristics ............................................. 41

Table 5  Demographic Characteristics .................................................. 44

Table 6  Noblit and Hare Data Analysis ............................................... 45

Table 7  Key Metaphors ...................................................................... 46

Table 8  Bracketing Journal Example: Men Living With Breast Cancer .......... 59
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

Chapter 1

Introduction

Cancer occurs as a result of mutations in the genes responsible for regulating the growth of cells. Normally, the cells in our bodies replace themselves through cell growth; however, over time, mutations can “turn on” certain genes and “turn off” others in a cell. That changed cell gains the ability to divide without control or order, producing identical cells and forming a tumor (ACS, 2019).

Overview of Breast Cancer

Breast cancer is a malignant tumor that develops from cells in the breast. It generally begins in the cells of the lobules or ducts; over time, cancer cells can invade nearby healthy breast tissue and invade the lymph nodes. Once cancer cells spread to the lymph nodes, they have a direct link into other parts of the body. Clinicians use breast cancer stages to describe the extent to which cancer cells have spread beyond the original tumor; other characteristics of the cancer (such as size and hormone involvement) also determine the stage. It is important to determine the breast cancer stage because treatment plans and survival rates vary across stages. Survival rates reflect the percentage of people with the same type and stage of cancer who are still alive a certain amount of time (usually five years) after diagnosis. Clinicians measure breast cancer stage through biopsy of the affected area and the corresponding biopsy report, and they classify breast cancer stages using two major methods. The first method includes five main breast cancer stages, ranging in severity from 0 to IV (ACS, 2019). Table 1 summarizes these stages (breastcancer.org).
## THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

### Table 1

**Breast Cancer Stages**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Breast Tumor Size and Spread</th>
<th>Lymph Node Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No invasion to other parts of body</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IA</td>
<td>Up to 2 cm; not spread outside breast</td>
<td>Not involved</td>
</tr>
<tr>
<td>IB</td>
<td>No tumor or tumor up to 2 cm</td>
<td>Small groups of cancer cells (0.2–2 mm in size) in lymph nodes</td>
</tr>
<tr>
<td>II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IIA</td>
<td>No tumor</td>
<td>Cancer (&gt; 2 mm) in 1–3 axillary lymph nodes or in lymph nodes near the breastbone</td>
</tr>
<tr>
<td></td>
<td>Up to 2 cm</td>
<td>Spread to axillary lymph nodes</td>
</tr>
<tr>
<td></td>
<td>2–5 cm</td>
<td>Not spread to axillary lymph nodes</td>
</tr>
<tr>
<td>IIB</td>
<td>2–5 cm</td>
<td>Small groups of cancer cells (0.2–2 mm) in lymph nodes OR spread to 1–3 axillary lymph nodes or to lymph nodes near breastbone</td>
</tr>
<tr>
<td></td>
<td>&gt; 5 cm</td>
<td>Not spread to axillary lymph nodes</td>
</tr>
<tr>
<td>III</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IIIA</td>
<td>No tumor in breast or tumor may be any size</td>
<td>Cancer in 4–9 axillary lymph nodes or in lymph nodes near breastbone</td>
</tr>
<tr>
<td></td>
<td>&gt; 5 cm</td>
<td>Small groups of cancer cells (0.2–2 mm) in lymph nodes OR spread to 1–3 axillary lymph nodes or to lymph nodes near breastbone</td>
</tr>
<tr>
<td>IIIB</td>
<td>May be any size; spread to chest wall and/or skin of the breast and caused swelling or an ulcer</td>
<td>May spread to up to 9 axillary lymph nodes OR to lymph nodes near breastbone</td>
</tr>
<tr>
<td>IIIC</td>
<td>May be no sign of cancer in breast or may be a tumor of any size</td>
<td>Spread to 10+ axillary lymph nodes OR to lymph nodes above or below collarbone OR to axillary lymph nodes or lymph nodes near breastbone</td>
</tr>
<tr>
<td>IV</td>
<td>Spread beyond breast to other organs, such as lungs, distant lymph nodes, skin, bones, liver, or brain</td>
<td>Spread beyond nearby lymph nodes</td>
</tr>
</tbody>
</table>

*Note. Axillary lymph nodes are those found under the arm. Stage information taken from breastcancer.org.*
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

The second method, developed by researchers at the National Cancer Institute (NCI), classifies cancers as localized, regional, or distant (NIH, 2019). NCI researchers derived these classifications from the Surveillance, Epidemiology, and End Results (SEER) program data. In the localized stage, there is no sign that the cancer has spread outside of the breast. In the regional stage, the cancer has spread outside the breast to nearby structures or lymph nodes. Lastly, in the distant stage, the cancer has spread to distant parts of the body such as the lungs, liver, or bone.

**Male Breast Cancer**

Men constitute about one percent of the total population of breast cancer cases in the United States (ACS, 2019). Survival rates for men with breast cancer are the same as women at the same stage (ASCO, 2018); however, men are generally diagnosed at later stages than women, and thus have poorer survival rates overall (ASCO, 2018). This gender disparity may be due to lack of knowledge about breast cancer. Some studies have found that men are not aware that they can get breast cancer (Macdonald et al., 2006, Nemchek, 2019). Healthcare professionals’ lack of specific knowledge about breast cancer genetics (Al-Haddad, 2010); may also contribute to this disparity. The current research on male breast cancer is insufficient (Al-Haddad, 2010); although studies suggest potential reasons for the disparity, these reasons lack empirical support. Further research is necessary to provide tools for healthcare professionals to close this gender gap.

**Philosophical Underpining**

The philosophy of *transcendental phenomenology* guided the work presented in this dissertation. Edmund Husserl (1930) first presented this model in his book *Ideas*, describing it as a new (at the time) science of essences (or a descriptive science of experience).
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

Transcendental phenomenology is based on the idea that every mental experience focuses (in its own unique way) on an object that may or may not exist. Because Husserl intended transcendental phenomenology to be a pure science without facts, empirical data or any reference to factual reality (i.e., focusing on the nature of existence and not the nature of knowledge), it includes the process of stripping empirical knowledge and factual references to get to the pure science of essences.

Transcendental phenomenology requires researchers to go through the process of bracketing prior to collecting data. Through bracketing, researchers identify their current beliefs and biases so that they can exclude them from the study. Beck and Watson (2012) provide a moving example of research using bracketing. In their study on the lived experience of childbirth after a previous traumatic birth, they used bracketing to prevent their biases and presuppositions from affecting the study. Because they went through the process of bracketing, they were able to analyze their participants’ statements and capture the essences of childbirth without empirical facts, data, or biases. This work used a similar process of bracketing.

Overview of Dissertation Chapters

My personal breast cancer diagnosis, along with my male cousin’s diagnosis, motivated this dissertation. Although my cousin and I had the same type of breast cancer at the same time, our experiences were vastly different. For example, I was initially diagnosed at stage IIA, whereas he was initially diagnosed at stage IV. We also experienced differences in treatment and prognosis. Research supports the idea that prognosis tracks closely with stage at diagnosis—the earlier the diagnosis of breast cancer, the better the outcome (ACS, 2019). However, what remains an open question is why men generally receive breast cancer diagnoses at later stages than women.
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

This dissertation comprises four chapters, with each chapter presenting an original study on men with cancer. Chapter 2 presents an integrative review of the current literature on the gender disparity in initial breast cancer diagnosis (Nemchek, 2018). This chapter describes possible reasons for this disparity and also proposes nursing interventions to address and correct the disparity. Proposed interventions include creating a comfortable environment for men to share their feelings, providing male-specific education on breast cancer risks, symptoms, and treatment, and co-opting educational tools typically used to support women. This chapter concludes that male breast cancer is under-researched and includes a call for further work to both improve outcomes and decrease the gender disparity in breast cancer detection.

Chapter 3 presents a phenomenological pilot study on men living with different types of metastatic cancer (Nemchek, 2016). The aim of this study was to identify key information to support the development of targeted learning tools for men through analyzing interviews with men with cancer. When asked to describe their experiences as men living with cancer, the participants specifically described their appreciation for their families and friends and the importance of authentic care from clinicians. From this data, strategies were proposed to support families, including promoting comfort, respecting the patient’s wishes, and providing a calm environment. This study concluded that men have different needs than women when living with breast cancer.

Chapter 4 presents a meta-synthesis of nine qualitative studies on men living with cancer (Nemchek, 2018). This study synthesizes the current nursing research on male breast cancer, including both psychological and other social science disciplines, and aims to provide new insights, inform practice, and identify new research directions supporting men. Very few nursing studies on male breast cancer exist; however, the study results highlight that men with breast
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

cancer especially need information regarding their disease and a supportive and personal relationship with their physicians. Furthermore, additional research is necessary to identify targeted educational and emotional support tools for use by health care professionals. Together, Chapters 2–4 provide an integrative resource for clinicians to better understand issues facing men with breast cancer, the challenges of men living with metastatic cancer, and the current state of literature on male breast cancer.

Chapter 5 addresses a critical issue in the current literature on male breast cancer: the gender gap between men and women with breast cancer at time of initial diagnosis (Nemchek, 2019). Women are generally diagnosed at early stages (0 and I); whereas men are diagnosed at later stages (III and IV). This gender gap may arise from men’s lack of awareness and recognition of symptoms (Macdonald, Macleod, Campbell, Weller, & Mitchell, 2006). The main goal of this study was to identify challenges and barriers to care, as well as to explore the tools men use to improve their quality of life. It is critical that clinicians address the gender gap because it can result in poorer prognosis, more difficult treatments, and more expensive treatments for men (Giordano, 2005). Diagnosis at early stages can lead to a cure; whereas diagnosis at later stages is often incurable and terminal. Through interviews with men living with breast cancer, overarching themes were identified and significant statements illustrating the essence of their experiences. This study provides information supporting the development of tools to decrease the gender gap at time of initial diagnosis, including specific education for men, authentic care, and advocacy. Using these tools, clinicians may be able to close the gender gap at time of initial breast cancer diagnosis.
Chapter 2
Male Breast Cancer: Examining Gender Disparity in Diagnosis and Treatment

About 2,550 men will be diagnosed with breast cancer in 2018, and about 480 men will die from the disease that same year (American Cancer Society [ACS], 2018). Although men account for less than 1% of breast cancer cases in the United States, they are more likely than women to be diagnosed with advanced stage breast cancer (ACS, 2017b). Breast cancer that is found early, and that is small and has not yet spread, is typically easier to treat successfully than breast cancer discovered at a later stage (ACS, 2017a). In addition, a diagnosis of advanced stage breast cancer may warrant more intense and aggressive treatment, as well as an increase in expense for treatment (Ottini et al., 2010). Overall, the mortality rates for men and women diagnosed with breast cancer are similar, but men are generally diagnosed at a later stage than women, and, consequently, they often live for a shorter length of time after being diagnosed (American Society of Clinical Oncology [ASCO], 2018).

In addition, the rate of breast cancer diagnosis in men has increased, jumping 26% from 1973–1998 (Rudlowski, 2008), and racial disparities among men diagnosed with breast cancer exist. Black men have the highest incidence rates of breast cancer, with 2.7 of every 100,000 men being diagnosed with the disease, followed by white men, with an incidence rate of 1.9 of every 100,000 men (ASCO, 2018). Although male breast cancer cases constitute about 1% of the total population of patients with breast cancer, men face a significant risk because they are generally diagnosed at a later stage than women. Education for the general population and healthcare professionals, coupled with early detection and treatment plans targeted toward men, may decrease the gender disparity in breast cancer (Al-Haddad, 2010). This integrative review will examine research from 2000–2016 on male breast cancer that examines the gender
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

disparity that exists at the time of initial detection (i.e., men are generally diagnosed with breast cancer at a later stage than women), as well as possible reasons for this disparity and interventions to minimize this disparity.

Methods

Search Strategy and Operation Process

PubMed, PsycINFO®, CINAHL®, and Sociological Abstracts were searched for literature published from 2000–2016 using the following keywords: male, breast cancer, and staging. Studies were included in the review if they were peer-reviewed and met the following criteria:

- Involved male patients with breast cancer aged older than 18 years
- Noted possible reasons for the gender disparity in breast cancer (either based on data or not)
- Suggested nursing interventions (either based on data or not)
- Were written in English

Studies were excluded if they addressed the racial disparity in breast cancer, included information on the transgender community, were written prior to 2000, and/or focused on female breast cancer. Database searches resulted in 3,845 nonduplicate hits (see Figure 1). Overall, 12 studies were selected for final inclusion (see Table 2).
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

Records identified through database search (N = 42,394)
- PubMed (n = 41,830)
- CINAHL® (n = 67)
- Sociological Abstracts (n = 25)

Records after duplicates removed (n = 3,845)

Full-text articles retrieved after screening based on title and abstract (n = 37)

Full-text articles excluded (N = 11)
- Redundant information (n = 6)
- About racial disparity (n = 2)
- About transgender community (n = 2)
- About female breast cancer (n = 1)

Full-text articles assessed for eligibility (n = 26)

Full-text articles included after eligibility assessment (n = 11)

Additional articles included after backward and forward citation search (n = 1)

Total articles included (N = 12)
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

Figure 1. Literature search.
THE EXPERIENCE OF MEN LIVING WITH BREAST CANCER

Table 2

*Characteristics of Selected Studies*

<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Sample</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al-Haddad (2010)</td>
<td>Canada</td>
<td>1 man with breast cancer</td>
<td>Education and early detection may help to decrease the gender disparity.</td>
</tr>
<tr>
<td>Anderson et al. (2010)</td>
<td>United States</td>
<td>161 men with breast cancer</td>
<td>Nurses may help to educate and support men with breast cancer.</td>
</tr>
<tr>
<td>Iredale et al. (2007)</td>
<td>United Kingdom</td>
<td>186 surveys</td>
<td>Men need specific and gender-neutral breast cancer information.</td>
</tr>
<tr>
<td>Mattarella (2010a)</td>
<td>United States</td>
<td>–</td>
<td>Risk factors for male breast cancer were identified.</td>
</tr>
<tr>
<td>Mouchawar et al. (2001)</td>
<td>United States</td>
<td>400 family practitioners</td>
<td>Physicians lack knowledge regarding hereditary breast cancer and male breast cancer.</td>
</tr>
<tr>
<td>Nahleh &amp; Girnius (2006)</td>
<td>United States</td>
<td>Surveillance, Epidemiology, and End Results Program data from 1973–1998</td>
<td>Genetic mutations and their effects on male breast cancer were identified.</td>
</tr>
<tr>
<td>Peate (2001)</td>
<td>United Kingdom</td>
<td>–</td>
<td>Nurses may act as advocates for male breast cancer.</td>
</tr>
<tr>
<td>Ruckart et al. (2015)</td>
<td>United States</td>
<td>71 men with breast cancer and 373 controls</td>
<td>The effect of the environment on male breast cancer incidence was identified.</td>
</tr>
<tr>
<td>Tawil et al. (2012)</td>
<td>Lebanon</td>
<td>47 men with breast cancer</td>
<td>In Lebanon, the incidence of male breast cancer is higher than it is in the West, and men diagnosed with breast cancer present at a younger age.</td>
</tr>
<tr>
<td>Thomas (2010)</td>
<td>United States</td>
<td>28 men</td>
<td>80% of men were not aware that they could get breast cancer.</td>
</tr>
<tr>
<td>Villeneuve et al. (2010)</td>
<td>8 European</td>
<td>104 men with breast cancer and 1,901 controls</td>
<td>Environmental and occupational risk factors were identified.</td>
</tr>
</tbody>
</table>
Whittemore and Knafl’s (2005) integrative review method was chosen because of the paucity of research and the need to include multiple methodologies (quantitative and qualitative), as well as the method’s focus on evidence-based practice.

Quality Appraisal

The Critical Appraisal Skills Programme (CASP) method was used to evaluate the quality of the studies used for this integrative review (Nadelson & Nadelson, 2014). CASP checklists, specific to each study type, were used to evaluate each of the 12 studies selected for inclusion in this integrative review (9 cohort studies, 2 case control studies, 1 qualitative study). Each study was evaluated for validity, results, and practical nursing interventions (see Table 3).
Table 3

*CASP Ratings for Selected Studies*

<table>
<thead>
<tr>
<th>Study</th>
<th>Study type</th>
<th>CASP checklist type</th>
<th>Quality rating&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al-Haddad (2010)</td>
<td>Qualitative</td>
<td>Qualitative</td>
<td>4 of 8</td>
</tr>
<tr>
<td>Anderson et al. (2010)</td>
<td>Quantitative</td>
<td>Cohort</td>
<td>9 of 11</td>
</tr>
<tr>
<td>Iredale et al. (2007)</td>
<td>Mixed methods (sequential)</td>
<td>Cohort</td>
<td>8 of 11</td>
</tr>
<tr>
<td>Mattarella (2010a)</td>
<td>Review</td>
<td>Cohort</td>
<td>7 of 11</td>
</tr>
<tr>
<td>Mouchawar et al. (2001)</td>
<td>Quantitative</td>
<td>Cohort</td>
<td>8 of 11</td>
</tr>
<tr>
<td>Nahleh &amp; Girnius (2006)</td>
<td>Review</td>
<td>Cohort</td>
<td>8 of 11</td>
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<sup>Note</sup>. A higher ratio of “yes” responses indicates greater reliability of the study. CASP = Critical Appraisal Skills Programme.

<sup>a</sup>Questions were answered with “yes,” “no,” or “cannot tell.” The ratio indicates the number of yes responses and the total number of questions.

**Results**

The studies selected for inclusion in this integrative review (N = 12) addressed the rarity of male breast cancer, the gender disparity in breast cancer, possible reasons for the gender disparity, the paucity of research on male breast cancer, and potential interventions to decrease the gender disparity. All 12 studies suggested that advanced stage breast cancer detection was the norm for men.
Selected Studies

**Qualitative study.** Al-Haddad (2010) found that because of later breast cancer detection, men often present with larger tumor size and at an older age than women. According to this case study, which compared the treatments of a man and a woman with breast cancer, men also have a lower survival rate than women as a result. In addition, men require more invasive and longer treatment regimens. Al-Haddad (2010) suggested that late detection in men can be traced to the societal identification of breast cancer as a woman’s disease and to the denial of men that breast cancer is a possibility for them as well. The feminization of breast cancer may be the reason that men wait until visible signs appear (e.g., inverted nipple, noticeable lump on the breast). The patient in this case study had an inverted nipple and thought it was normal; he did not know that men could be diagnosed with breast cancer and did not mention anything to his doctor until nipple discharge appeared. Al-Haddad (2010) noted that nurses should promote breast health, educate men about breast cancer risk factors, and advocate for early detection and prevention; according to the study, additional research is needed to develop specific interventions for men with breast cancer.

**Cohort studies.** A quantitative study by Anderson, Jatoi, Tse, and Rosenberg (2010) compared male breast cancer to late-onset female breast cancer (i.e., male breast cancer) is often diagnosed at a later stage than female breast cancer) and noted that progress made in terms of survival rates has been much more significant among women than among men. Using Surveillance, Epidemiology, and End Results (SEER) Program data from 1976–1985 and from 1996–2005, Anderson et al. (2010) showed that breast cancer deaths for men declined 28% and 42% for women. Although breast cancer survival rates have improved for both sexes, the progress made for men lags behind the progress made for women. Anderson et al. (2010)
suggested that late-onset breast cancers in both men and women may be related to environmental and/or nonhormonal risk factors, including diet and obesity.

In a review, Nahleh and Girnius (2006) showed that the incidence of male breast cancer is rising, but the mortality rate is unchanged. Although male breast cancer cases are increasing in the United States, rising 26% from 1973–1998, the number of U.S. cases is still significantly lower than the number of cases elsewhere, such as sub-Saharan Africa, where the incidence rate of male breast cancer is about 15%; only about 1% of the entire U.S. population of patients with breast cancer is male. The authors suggest that these trends may be attributable to a lack of awareness about male breast cancer because of its rarity or about treatment options. Nahleh and Girnius (2006) examined three genetic mutations that, although rare, are associated with male breast cancer: founder effect, in which interbreeding over several generations can cause rare mutations; hamartoma, a benign tumor that grows because of the faulty development of an organ; and Cowden syndrome, which involves abnormal tissue growth. Hormonal research could lead to improved understanding and new opportunities for treatment that would yield better outcomes for men who are currently treated in the same ways as women with breast cancer (Nahleh & Girnius, 2006).

Rudlowski (2008), in a review, noted that no randomized clinical studies have information on the optimal diagnostics and treatments for male breast cancer, in part because it represents such a small percentage of breast cancers. Lack of awareness about male breast cancer, as well as gender-specific variations in breast cancer (i.e., physiologic differences between men and women, including hormonal differences), were identified as the reasons for late detection and poor prognosis of male breast cancer. No interventions were identified, except for the need for more research.
In a quantitative study, Tawil et al. (2012) examined the clinical and immunohistochemical differences between male breast cancer and female breast cancer. This study aimed to describe male breast cancer cases in Lebanon and compare these cases with those in the male breast cancer literature to determine if geographical differences exist. Forty-seven male breast cancer cases were retrospectively reviewed. The median age of patients was 62 years, and the median tumor size was 2.2 cm. Histologically, 36 patients had been diagnosed with ordinary infiltrating ductal carcinoma, 5 had adenocarcinoma not otherwise specified, 3 had infiltrating pleomorphic lobular carcinoma, 1 had mucinous carcinoma, 1 had pure ductal carcinoma in situ, and 1 had fibrosarcoma. In contrast, of the female patients, 85 had been diagnosed with infiltrating ductal carcinoma, 12 had infiltrating lobular carcinoma, 1 had mucinous carcinoma, 1 had papillary carcinoma, and 1 had colloid carcinoma. The male patients were older and had higher hormone receptor and lower HER2/neu expression than the female patients. Although these results are typical for a Caucasian population, some differences exist in terms of breast cancer in Lebanon versus the West. For instance, the median age of male breast cancer diagnosis in Lebanon is 62 years, compared to 67 years in the West. In addition, the incidence of infiltrating lobular carcinoma is higher in Lebanon than in the West, and the higher occurrence of axillary node involvement in Lebanon may signify the existence of a biologically different and more aggressive male breast cancer in Lebanese men.

In another quantitative study, Mouchawar, Klein, and Mullineaux (2001), looked at breast cancer information needs using a random sample of 400 family physicians in Colorado. Based on survey results, these physicians lacked knowledge regarding hereditary breast cancer, including the increased risk for disease among men with the BRCA2 mutation. Although all the physicians in this study reported taking a family history as part of their regular practice, the
majority said they had not referred any male patients with a family history of breast cancer for BRCA1 or BRCA2 testing. All physicians taking part in the study reported an interest in learning more about hereditary breast cancer. The authors recommended that outreach efforts focused on cancer genetics and aimed at primary care physicians in the United States take place.

In a qualitative study, Thomas (2010) explored the awareness and knowledge of male breast cancer among English-speaking men, with the goal of obtaining information that could be used to direct clinical practice and the development of gender-specific educational interventions. Twenty-eight men, all of whom had at least one maternal blood relative with breast cancer, were interviewed. A majority of these participants were not aware that men could get breast cancer, and although all the participants were at higher risk for breast cancer, given their positive family history, all reported that their providers had never discussed the disease with them. Most participants could not identify any signs of breast cancer, aside from a lump in the breast. Almost half of the participants voiced concerns that a diagnosis of breast cancer would cause them to question their masculinity. Participants also suggested ways that men, as well as healthcare professionals and the lay public, could be better made aware of and educated about their risk for this disease, emphasizing the need for the development of evidence-based, gender-specific health promotion and disease prevention interventions for men.

Mattarella (2010a), in a review, presented possible reasons why male breast cancer research is rare, suggesting that the public and healthcare professionals lack awareness about the disease. Similarly, Pituskin, Williams, Au, and Martin-McDonald (2007) found that just 2 of 20 men interviewed knew that men could develop breast cancer; in addition, men usually wait about 19 months after signs of breast cancer appear before seeing their physician. Pituskin et al. (2007) noted that interventions to minimize the gender disparity in breast cancer include involving male
patients with breast cancer in more research, developing practical resources specific to men at high risk for breast cancer, being sensitive to the psychological issues men face when dealing with breast cancer, and using gender-neutral language.

Iredale, Williams, Brain, France, and Gray (2007) used a cross-sectional survey and interviews to collect demographic, psychological, and clinical data among men in the United Kingdom with breast cancer, intending to identify the information needs specific to male breast cancer and what men need for improved care. Overall, in this sequential mixed-methods study, 161 surveys were returned and 30 men were interviewed. Results from both indicate that these men feel that they did not receive enough information about breast cancer, that the information they did receive is directed toward women, that verbal information is more helpful than written information, and that gender-specific information is needed.

In a review, Peate (2001) examined nursing interventions for men who may feel isolated because of their disease; these interventions would empower them with education about breast cancer and allow them to become more involved in their care. These interventions targeted factors known to affect men’s health, such as health-damaging behaviors, and centered on preventive programs. Collaboration among various entities (e.g., physicians, community healthcare programs, and social support groups) to address specific issues concerning men’s health was also noted, as was the promotion of health-related activities (e.g., exercise programs) among the local male population at risk for breast cancer. The author stated that age, sexual orientation, socioeconomic status, physical ability, and ethnicity must be considered when targeting men at risk for breast cancer. In addition, verbal information specifically directed toward men is helpful, as are written materials (e.g., leaflets and booklets) if written for men.
**Case control studies.** In addition to genetic and hormonal differences between men and women, there may also be a difference in environmental vulnerability in terms of breast cancer. Villeneuve et al. (2010), in a quantitative study, examined 104 men with breast cancer and 1,901 controls in eight European countries, finding that endocrine disrupters, including alkylphenolic compounds, may play a role in the incidence of male breast cancer. Occupational exposures were assessed on a case-by-case basis; an increase in male breast cancer incidence was noted among motor vehicle mechanics, forestry and logging workers, furniture manufacturers, painters, and paper makers. Endocrine disrupters may be environmental carcinogens, and Villeneuve et al. (2010) noted that education may help to decrease the gender disparity in breast cancer. However, this study was conducted in Europe, and the compounds used in the occupations examined may not be the same as those used in the United States.

Ruckart, Bove, Shanley, and Maslia (2015), in another quantitative study, evaluated associations between exposure to contaminated residential drinking water and male breast cancer from 1960–1980, prompted by the identification of a high incidence of male breast cancer at the Marine base in Camp Lejeune, North Carolina. The study consisted of 71 men with breast cancer and 373 controls. After adjusting for age at diagnosis, race, and service in Vietnam, the odds ratio (OR) for each Marine stationed at Camp Lejeune was 1.14 (95% confidence interval [CI] [0.65, 1.97]). Adjusted OR for high residential cumulative exposures to tetrachloroethylene (PCE), t-1,2-dichloroethylene (DCE), and vinyl chloride, which were found in the drinking water, were 1.2 (95% CI [0.16, 5.89]); 1.5 (95% CI [0.3, 6.11]); and 1.19 (95% CI [0.16, 5.89]). However, these results were based on more than one case in the high cumulative exposure categories (a group exposed to high levels of affected water for the longest time compared to Marines exposed to lower levels of affected water for a shorter period of time). Male Marines
with breast cancer stationed at Camp Lejeune with a high cumulative exposure to trichloroethylene (TCE), PCE, DCE, and vinyl chloride were associated with earlier age at onset for male breast cancer (Ruckart et al., 2015). Results from this study suggest possible associations between male breast cancer and being stationed at Camp Lejeune and having cumulative exposure to TCE, PCE, DCE, and vinyl chloride. However, this study was limited by small numbers of cases in the high cumulative exposure categories. In addition, this study did not evaluate the impact of TCE, PCE, DCE, and vinyl chloride on the women also stationed at Camp Lejeune, who were also exposed to the contaminated drinking water.

Although Villeneuve et al. (2010) and Ruckart et al. (2015) identified chemicals that may be linked to a higher incidence of male breast cancer among men who have been exposed to them, the inclusion of women and genetics may have been useful. Neither study identified whether the men had any risk factors for breast cancer, including genetic risk factors, and neither study compared women and the impact of the chemicals on their health.

**Discussion**

Male breast cancer is often treated similarly to female breast cancer, with treatment being dependent on disease stage (ACS, 2018). In primary care, healthcare professionals have the responsibility to know and make available all current information on male breast cancer; in addition, men should be educated about breast cancer with tools and techniques that are targeted to their needs (Iredale et al., 2007).

A diagnosis of breast cancer is upsetting, particularly for a man who may view breast cancer as a woman’s disease and may feel less masculine as a result. Being sensitive to the psychological issues men with breast cancer face and establishing a caring environment will support and enhance education and treatment. Men with breast cancer found nurses to be the
most helpful and supportive healthcare professionals (Iredale et al., 2007). More research is needed to support nurses in their development of educational techniques specific to men regarding risk factors for breast cancer, as well as early detection and care. Nurses can play an integral part in decreasing the gender disparity that exists within breast cancer by raising awareness of the disease and its effect on men, such as by teaching all patients about male breast cancer. Risk factors for the disease should be promoted, breast examinations should be included in assessments of all men at risk for the disease, and the community should be educated about the disease during health fairs and other events.

The main objective of this review was to examine the current research on male breast cancer staging, with additional goals of identifying reasons for the later-stage diagnosis of most men with breast cancer and determining interventions to target the gender disparity existing within breast cancer. There is a paucity of research about male breast cancer, including the risks for male breast cancer, the experience of the patient, and appropriate interventions. More research on a host of related topics is necessary.

**Limitations**

This review is limited in scope, with a focus on reasons for the gender disparity in breast cancer. Because no studies examined specific nursing interventions and only suggested them, it is unclear which interventions would be most beneficial. In addition, because studies were evaluated with varying quality, findings from studies should be interpreted with caution.

**Conclusion**

Breast cancer affects women and men, but men are at a disadvantage because studies indicate that they usually present at a later stage than women, and this negatively affects their treatment and prognosis. Nurses have an opportunity to lead the charge in decreasing the gender
disparity through education and the creation of a comfortable environment for men to express their feelings (Al-Haddad, 2010).

Current techniques used to educate women with breast cancer can also be used in educating men with the disease, as long as the information provided targets men (Al-Haddad, 2010). Additional techniques, such as counseling, humor, spirituality, guided imagery, and mind diversion activities, may also benefit men with breast cancer (Sadruddin, Jan, Jabbar, Nanji, & Tharani, 2017). Modifying nursing practice to incorporate the techniques described in this article is a first and important step in ensuring that men understand that they can get breast cancer, know the risk factors for breast cancer, and are aware of when to advocate for themselves.
Chapter 3

Riding the Train Until We Reach the End: Men and Metastatic Cancer

The phenomenon of interest for this study is men and their experience living with metastatic cancer. The men in this study had different types of cancer but each cancer was metastasized. The aim of this pilot study is to understand what it is like to live with metastatic cancer as men.

Studies have shown there are gender differences regarding learning issues related to managing health, pain, and “health talk.” In the book *Women’s Ways of Knowing: The Development of Self, Voice, and Mind* (Belenky, Clinchy, Goldberger, & Tarule, 1986), the author states that men and women have different ways of knowing. Men are more authoritative while women tend to adhere to authority. Men question authority while women generally acquiesce. While the information in this study is older due to the lack of qualitative research regarding men and metastatic cancer and may not reflect the current specific differences between men and women, current data referenced shows men and women remain different regarding health care concerns. This pilot study shows how men live with metastatic cancer.

It is imperative for all primary care and oncology health care professionals to know how men experience living with metastatic cancer to shape and direct care to target men. Caring for men and women should not be the same process for both but should include unique caring techniques specific to men’s needs. For example, men’s breast cancer may physiologically different from women’s breast cancer and men’s emotional needs also may differ (Mattarella, 2010b). Men are usually diagnosed at later stages than women that could lead to a worse prognosis (Ottini, 2009). Listening to men’s experiences may demonstrate a difference in the way they physiologically, psychologically, and emotionally live with cancer. By hearing men’s
experiences and developing common themes, health care professionals will have a clearer picture of the way men live with metastatic cancer providing insight on how health care professionals can better support men in a way to achieve the best patient outcomes.

**Why Descriptive Phenomenology?**

Descriptive phenomenology is a qualitative approach to study a phenomenon, a human experience. Transcendental phenomenology was the term Husserl used to describe the new science of essences, a new descriptive science of experience without any philosophical theory (Husserl, 1930). Transcendental phenomenology was to be a pure science without facts, empirical data, or any reference to factual reality. Topics appropriate to descriptive phenomenology include experience of domestic violence and living with chronic pain (Polit & Beck, 2017). The phenomenon of men living with metastatic cancer is an organic choice for a descriptive phenomenological approach. This study is a descriptive phenomenological approach using Colaizzi’s (1978) method for data analysis.

**Evolution of Study**

Bracketing or reduction is an important component of descriptive phenomenology. Bracketing guides the researcher to identify their current beliefs and biases, so they do not influence outcomes of the study. According to Husserl, “Reduction begins with a philosophical époché or bracketing; no item from any philosophical theory or doctrine can be imported into phenomenology; one must simply abjure all invocation of traditional philosophical idea or concept from whatever source” (Husserl, 1930, p. 18). Documenting such beliefs and biases before conducting the study in a journal is considered one important way to ensure the researcher’s beliefs and suppositions on the topic do not impact the study. An example is of a researcher studying male commercial sex workers (Abalos, 2011). Preconceived beliefs and
biases were written down in a journal in an attempt to acknowledge beliefs and suspend them so as to not impact the study.

Colaizzi (1978) wrote that without some personal interest on the part of the researcher, the study may never be initiated or completed. My experiences as a wife, mother of a son, and a nurse tells me that men know and cope differently than women regarding illness. Also, my experience as a metastatic breast cancer patient and a member of a support group, that includes both men and women with cancer has led to a perception that men are more hesitant than women to speak about their feelings. There were more men than women in the support group, but it was my experience that the women spoke more than the men. Women spoke more about their feelings and men focused on their specific health plans and goals. All these feelings and more were documented in a journal in order to keep the essence of the phenomenon free from impacting the study.

**Literature Search**

Peer reviewed literature search for qualitative studies using the words, “men and metastatic cancer” was performed. Searches in CINAHL, PubMed, Psychology and Behavioral Sciences Collection, and ProQuest Dissertations and Theses for the years 2015 to 2019 were completed. Three qualitative studies in CINAHL were identified regarding men and metastatic cancer, two regarding prostate cancer and one about small cell lung cancer. A case study from the United Kingdom reviewed the impact of prescriptive authority using a multidisciplinary approach including prostate cancer nurse specialists caring for men with prostate cancer. Results emphasized the need for further research (Primeau, Paterson, & Nabi, 2017). The second qualitative study explored the experiences of patients with metastatic prostate cancer and their caregivers using a structured interview process with 33 patients and caregivers. Results
demonstrate care can be improved using a holistic approach when developing nursing care plans for men with metastatic prostate cancer (Paterson, Alashkham, Windsor, & Nabi, 2016). The third qualitative study in CINAHL is a case study of a 63-year-old man with small cell lung cancer who chose comfort care. This study identified use of the CARES tool to prevent and relieve symptoms when caring for patients who choose comfort care. The CARES tool is an acronym for comfort, airway, restlessness, emotional support, and self-care (Paterson, & Nabi, 2017). A PubMed search revealed hundreds of articles on men and cancer, mostly concerning prostate cancer and mostly quantitative in nature. The small amount of qualitative studies concerned specific ethnicities (Wenger, 2013). Review in Psychology and Behavioral Sciences Collection showed 84 studies regarding cancer, mostly quantitative in method and mostly about women. The ProQuest Dissertations and Theses search revealed 12 studies, mostly about women and cancer and mostly quantitative in method. Based on the above results, the literature search was an important process as it identified a gap in research and knowledge regarding men and metastatic cancer.

**Rigor**

Criteria used to demonstrate validity and rigor for this study were member checks and peer debriefings. Member checks were performed after transcription was complete to give the participants an opportunity to add or delete anything from their interview and after the study was completed. Peer debriefings were conducted by reviewing the 40 significant statements and four clusters of themes with three peers. Review included discussion of statements and appropriate placement of themes with peers from a cohort in a PhD program.
Method

Edmund Husserl developed phenomenology as a new science to explore the lived experience of phenomenon. Phenomenology is based on the idea that every mental experience is directed in its own unique way at an object that may or may not exist. Phenomenology included the process of stripping empirical knowledge and factual references to get the pure science of essences. Phenomenology is one of a science of essential being, concerned with essences and not facts (Husserl, 1930). Descriptive phenomenology was chosen as a method to reveal the essence of the experience of men living with metastatic cancer. Colaizzi’s (1978) method for analyzing phenomenological data was chosen.

Sample

The research question is, "what is it like to be a man living with metastatic cancer." A purposive sample of three men was chosen for this study, men who were at the end stage of their diseases. The mean age of men at the time of the study was 71 (range 65-77), all had end stage cancer, and all were enthusiastic about telling their stories. The three men were from the northeast. All three men described themselves as hard workers. All but one was no longer working at the time of the study. Data was maintained and stored according to established institutional guidelines for handling research data. Confidentiality process was shared with participants.

Procedure

After the decision to study this topic was determined and approved by the institution's review board, three men were identified after request for participants was sent to peers of my cohort in the PhD program and to acquaintances. After introducing the study verbally over the
telephone and obtaining informed consent, face to face interviews were arranged. Two interviews were completed in restaurants, and one in the participant’s home. Each participant signed two consent forms, one for the participant and one for the researcher’s records. The initial interview took between 23-52 minutes. Each interview was audiotaped. During the audiotaped interview, each participant was asked the same statement, “Please describe for me what it is like to be a man living with metastatic cancer. Please share your thoughts, feelings, and any examples as you can.” Participants were given their transcript to review for any additions or deletions. One participant had requested a change regarding a name, 1 participant stated he had no changes to offer, and the third participant expired before a request for additions or deletions could be requested.

**Data Analysis**

Through interviews, four theme clusters emerged that reflected the 40 significant statements. Specific examples were chosen to best reflect each theme and to capture the essence of the phenomenon. An analogy of this study is the artichoke. Removing each artichoke leaf to get to the heart can be likened to the interview process and the thematic development. The taste of the artichoke heart is the essence of the phenomenon. The artichoke heart might taste differently to each person; thus, the meanings and outcomes of this study may be different for each reader, depending on their beliefs and experiences. Colaizzi’s method of data analysis was used for this study. This 7-step method includes the researcher returning to the participants for confirmation and comments of their stories. Colaizzi’s 7-step method includes:
1. Participants descriptions are called protocols. All protocols should be read in order to have full understanding. All interviews are transcribed and re-read to the participants to allow any and deletions or additions.

2. Extracting significant statements specific to the phenomenon is conducted by reading interviews multiple times. All significant statements were highlighted, extracted, and added to index cards.

3. Meanings specific to the significant statement were formulated. These meanings were written on the back of each index card.

4. Clusters of themes were categorized based upon formulated meanings. Index cards were grouped based on meanings.

5. Exhaustive descriptions were developed to integrate thematic findings based on the phenomenon.

6. Discrepancies identified by validating the exhaustive descriptions with a set of participants to include, but not limited to, the co-principal investigator and committee member(s). This was done to determine if descriptions adequately depict their experiences. This was accomplished by sending transcripts to each participant for any additions or deletions.

7. Have the participants read the findings and ask if anything was omitted or if there was something they would like to add and incorporate into the final description. After receiving modifications to the transcript, changes were incorporated in the descriptions.

After reading and re reading each interview, a total of 40 significant statements were identified, highlighted, cut, and taped to index cards. On the back of each index card, meanings were assigned and documented for each significant statement to ensure the exact words of the
participant were used. Staying true to the exact words of the participant was paramount in determining the meaning of each statement.

**Strengths and Limitations**

Feasibility and value of any study are determined by identifying the strengths and limitations. Strengths for this study include its low, cost e.g., audio recorder ($50), transcription ($100), and travel cost to New Jersey ($50). The other two important strengths are the results themselves and the attention that the study brings to a topic that could change healthcare practice for healthcare professionals caring for men with cancer. Several limitations of the study exist. Because this was a pilot study, the sample was too small to identify commonalities among men living with metastatic cancer. Data saturation was not achieved due to the death of one of the participants. The researcher was unable to review the transcription and to obtain any additions or deletions. The researcher was inexperienced with descriptive phenomenological method. This study was the first qualitative study for the researcher. Participants appeared reticent to share their feelings. While participants were able to tell the specifics of their story in chronological order, they appeared uncomfortable when asked to describe their feelings. This discomfort was evidenced by their body language and repetition of words. Discomfort with the interview process was mitigated by ensuring confidentiality, having the participant choose the location of the interview, and sharing pastries and coffee brought by the researcher.
Results

Four cluster of themes were revealed from the 40 significant statements: no time to dwell on aches and pains; being afraid and feeling fortunate at the same time; do whatever it takes, and, laugh, laugh, laugh?

Theme #1: No Time to Dwell on the Aches and Pains

Men living with metastatic cancer found keeping busy helped cope with the physical and emotional discomfort of cancer. Two of the three participants were not currently working. Of the two not working, one kept busy around the house and the other stated he does not think about cancer until the day before or after treatment. The one participant that was working at the time of the interview stated that he has worked 12 hours a day, seven days a week. Participant stated he sometimes gets “disgusted,” but if he is working he does not have time to feel this way. He feels work is a good remedy for him, “You know I work 11-12 hours a day, seven days a week, so I really don’t have time to really think about cancer.” The same participant stated, I don’t even have time to dwell on my problems and even the aches and pains. Sometimes I feel a pain or something and if I’m moving around and working that sort of not disappears but it’s not in the forefront.

Another participant likened living with metastatic cancer as being a policeman. You never know what is going to happen. For example, whenever a new medication is added to his regimen, he wonders what it will do to him. This participant stated, “Ok, if that’s what has to be done from the medicine if necessary and I’ll continue on. So, I just kinda take it, go ahead and give me your best shot.”
Another participant stated that one day he would like to go back to work. But does not need work to keep his mind off cancer. The participant stated he never thinks about cancer until the day before his treatment and the day after. The participant stated, “It probably doesn’t sound feasible but we don’t think about it, we just go on with our lives and that’s the way I live.”

**Theme #2: Being Afraid and Feeling Fortunate at the Same Time**

All three participants frequently stated how although afraid of the unknown, they were very fortunate and sincerely appreciated their strong support systems. All three participants voiced concern over one day being incapacitated, frustrated at not being able to do the things they were once able to do, yet fortunate to have people who love and support them. One participant stated it was difficult to see his brother mow his lawn. This difficulty prompted him to sell their home and move to a condominium. The same participant stated there are days when all he can do is brush his teeth and go back to bed. This was very difficult for him, as he was once a very active athlete. Another participant said he was afraid of the unknown, "The unknown is the worst part. Each time I have a scan I’m afraid the results are going to show that it has spread or that it has grown significantly or that I’m going to require some treatment or that’s no more treatment. That’s a fear that’s always in the back of my mind."

The third participant stated, “My feeling is not even how long I have to live but how incapacitated I’d be, or would it change my life a lot and I didn’t want that. I didn’t want to be in bed forever.” This man also said, "I feel sorry for the young people that have cancer and I start feeling their pains and stuff. I feel myself kinda lucky because I feel like I look a little better than they do you know, they’re skin and bones and pale as ghosts and stuff. It bothers me for them.
Feeling fortunate was a common theme for all three participants. All three voiced appreciation for their families, for their doctors, and for their current state of health. One participant said he apologized to his wife for putting her through the cancer journey. The man described he told his wife, “We are going through this together. Yeah, I get the physical part you’re in the emotional part and you’re an emotional person, more so than me.” Another participant said he would not want to live without his family, “I’m a very fortunate man. I always say that. I have three beautiful kids, I have a wife that put up with me for 43 years. As I say, I’ve been blessed.”

One participant said he is afraid and fortunate at the same time, "I read some of these drugs, the side effects and I say oh my God and then I see people in the cancer ward, you know the treatment center with the oxygen coming in the wheelchair and they’re in there you know. They bring a case full of food and drinks and they’re in there for the day. Thank God I’m in and out within a couple of hours.

One participant said the doctors and nurses at the treatment center made him feel comfortable, "I love my doctor, she cares, she understands and truthfully, I know she loves me and I know that I’m an exception because I think when she walks in to see me and she sees how well I am and how happy I am, I think I make her day. I know it makes her day because she tells me all the time. That’s what it is, I’m very fortunate."

**Theme #3: Do Whatever It Takes**

Despite stating fear of the unknown, all three participants stated their plan was to do whatever was needed to maintain their current state of health. Trying to find normalcy in an abnormal situation, doing what the doctors told them to do, and trying to cope with issues that
were out of their control was their way of coping with metastatic cancer. One participant said, “I look at every day as a new day and not worry about things I can’t control.”

Feeling “normal” was important to the participants. One man said, “If everyone acts normal, then you know your family can cope with the situation and then I can cope with the situation too. So, everybody should act normal this way you feel normal.”

Fighting metastatic cancer was important to one participant, "I’m 72 years old. I’ve had a tremendous life. I’ll deal with it and sure to hell will fight like hell to do whatever I have to do. I have too many things I want to do and see for the rest of my life."

Prognosis was another significant statement especially when other people would inquire about their health and what the doctor said about their life expectancy. To illuminate this statement, one man replied when asked by others about his prognosis, "I say I really don’t want to know. I said I go for my treatments. If it works, it works and if it doesn’t work it doesn’t work. I don’t want to know how many years I got. You know, who cares?"

Theme #4: Laugh, Laugh, Laugh?

Each participant gave examples of humor, situations they found funny in their cancer journey. Each interview included much laughter and a strong sense of humor was found in all three participants.

For example, one participant said at his first appointment both the doctor and the nurse thought his wife was the patient because she was so visibly upset. He stated his wife was not happy about being mistaken as the patient, but he thought it was very funny. During this point in the interview, the participant laughed heartily.

Another participant started the interview with a story he found to be very funny. He said he went to the first appointment alone despite his family’s misgivings. He went into the doctor’s
office in the hospital and looked around and saw all these pregnant women. When he told the office receptionist he was there to see the doctor, everyone in the office laughed. Appears there were two doctors in the hospital with the same name, one an oncologist and the other a gynecologist. When he told his wife the story she was angry and told him he needed to have someone with him for every doctor and treatment appointment. The participant found the story to be very funny, especially his wife’s response.

**Fundamental Structure**

The essence of the phenomenon of men living with metastatic cancer is a normal life interspersed with cancer and cancer treatments. Trying to live a normal life while also doing whatever treatment was needed to treat their cancer was a common theme. Feeling fortunate, fearful of the unknown, and doing the needful is how these men live with metastatic cancer. As one participant said, "I’m encouraged by the doctors telling me that I’m going to be in his office when I’m 80. He’s not quitting, I’m not quitting. Ok, I’ll ride the train until we reach the end, let’s see what we can do."

All three participants were appreciative of their family support, one man telling his wife, “We’re in this together.” All three men were proud of being hard working, all viewed living with metastatic cancer as a journey, and all had a strong sense of humor.

**Discussion**

**Implications for Clinical Practice**

Family, caregivers, and their support were extremely valuable to these participants. Appreciation for their healthcare providers was made evident. Men stated feeling fortunate to have their family by their side, one man telling his wife “we are in this together.” They also expressed appreciation for their doctors and nurses, one man even felt loved by his doctor.
Showing the patient and families/caregivers genuine care made them feel fortunate in a fearful situation. Strategies to support families include: promoting comfort, respecting the patient’s wishes, providing a calm environment, managing care mutually, and reprioritizing plans mutually as needed (Ipa, Warunee, & Nitaya, 2017).

**Suggestions for Future Research**

The opportunity to explore this participant in depth would necessitate interviewing a much larger cohort. By interviewing more participants, more themes may emerge, and perhaps more coping mechanisms may be identified. A mixed method approach that includes a quality of health survey along with interviews could identify specific emotional and educational needs that nurses can use to develop targeted tools for men living with cancer. Another suggestion for further research is using the grounded theory method to explore how men cope with metastatic cancer that includes a larger population of men over a longer period of time. The literature search for this study demonstrated a paucity of research on this participant, and as is apparent from the results, that more research is needed. Information resulting from further research may motivate different styles of healthcare delivery specific to men, improve healthcare outcomes, and make the experience as comfortable as possible for men and their caregivers.
Chapter 4

Men and Cancer: A Meta-Synthesis

Fear, humor, lack of control; these are just some of the many emotions expressed by men living with cancer (Nemchek, 2014). Identifying these emotions is a challenge as men are less likely and more reluctant to seek support. This topic is important because there is evidence that men show poorer psychological adaptation to cancer than women (Love, Thompson, & Knapp, 2014). According to the ACS, there will be over 800,000 new male cancer cases in 2015. How can we, healthcare professionals and caring people, support men who are living with cancer? As such we would want to support men in reaching their optimal physical and psychological state of health while living with cancer. The intent of this study was to conduct a metasynthesis with a focus on the emotions and feelings of men living with cancer as well as strategies to support men to share their emotions. Nine qualitative studies were chosen to demonstrate the feelings of men living with cancer and two mixed method studies were included to access existing evidence supportive of the development of interventions for healthcare professionals to use to foster communication.

Literature Review

The intent of this metasynthesis was to demonstrate what living with cancer is like for men. By learning and appreciating the different experiences for men living with cancer, healthcare professionals can modify and enhance current practice. Modifying practice may improve support and assist men to optimize cancer related outcomes. One common theme surrounding men and cancer was their inability to share their feelings. Men stated that their feelings were not as important as the cancer treatment and that they were uncomfortable sharing their feelings (McCaughan et al., 2007). Furthermore, men expressed that they were not offered
the appropriate venue to share their feelings (Hagen, Grant-Kalischuk, & Sanders, 2007). A metasynthesis is a way to inform and to direct future research (Paterson, Thorne, Canam, & Jillings, 2001).

The literature search revealed two quantitative articles about enhancing communication with men about their feelings. These two studies were not used in the synthesis due to being quantitative in nature. However, these two studies are reviewed here for important background information. The first quantitative article, “A Brief Self-Administered Psychological Intervention to Improve Well-Being in Patients with Cancer: Results from a Feasibility Study” (Ramachandra, Booth, Pieters, Vrotsou, & Huppert, 2009), used seven different instruments to determine which one would adequately measure anxiety, depression, well-being, and quality of life with men in the easiest and most cost-effective manner. Results showed statistical improvement in quality of life using the WHO Quality of Life Scale (WHOQOL-BREF). This instrument could be one tool for health professionals’ use for men initially and concurrently during their cancer care to increase emotional communication. Using WHO Quality of Life Scale to identify the degree of anxiety, depression, wellbeing, and quality of life and to develop interventions to support men to reach their optimal state of health, may be an option for men who are reticent to share their feelings. The other quantitative study, “Confiding in Crisis: Gender Differences in Pattern of Confiding Among Cancer Patients,” noted that appropriate support has been shown to reduce risk of depression but that there are gender differences in emotional support technique. (Harrison, Maguire, & Pitceathly, 1995). A checklist was used for their participants that compared male and female patients according to their degree of confiding. Thirty nine percent of men compared to 33% of women reported little to no confiding while 45%
of men reported having one confidant compared to only twenty five percent of women only having one confidant.

**Metasynthesis**

According to Paterson & Thorne (2001) Metasynthesis was a method of reflecting on the processes and perspectives of a body of research to determine what we know and do not know about the phenomenon under study, as well as to suggest future direction for researchers, theoreticians and clinicians.

The goal of this metasynthesis was to take a deep exploration into the existing literature to identify new information and to further clarify how it feels to be a man living with cancer. There are three types of metasynthesis; integrating results from multiple analytic approaches included in one researcher’s program of study, synthesizing results across studies conducted by various researchers on a similar topic and integrating qualitative results from cases across various studies (Paterson, 2013). The intent of this study was to synthesize studies from various researchers in the nursing, psychological and social studies disciplines to provide new insights to inform practice and to identify new research directions supporting men living with cancer.

**Research Design**

The research question is, what is it the experience of men living with metastatic cancer? This metasynthesis is a process that includes reviewing studies to form an interpretation and involves critical reviews of these men’s stories to identify overarching themes and metaphors. This also involves an inductive process of analyzing and comparing studies against each other to compare the work of the researchers with the goal of identifying new information (Noblit & Hare, 1988). This metasynthesis includes nine different qualitative studies regarding men living with different types of cancer. Figure 2 illustrates the types of male cancer for 2016 (ACS,
2016). All nine studies reviewed were used based on relevance and timelines and were published between 2003 and 2014.

![Figure 2](image)

**Figure 2.** Incident by cancer type in 2015 (ACS, 2015).

**Sample**

All nine qualitative studies are outlined in Tables 4 and 5. The first study, “The Lived Experience of Men with Advanced Cancer in Relation to Their Perceptions of Masculinity: A Qualitative Phenomenological Study,” focused on men and their perceptions regarding masculinity while living with cancer (Stapleton & Pattison, 2015). The second study, “The Need to be Superman: The Psychological Support Challenges of Young Men Affected by Cancer,” also involved men’s perceptions of masculinity and the need to be strong without support from others (Love et al., 2014). The third study, “Information-Seeking Behavior of Men Newly Diagnosed with Cancer: A Qualitative Study” (McCaughan et al., 2007), reinforced the challenges demonstrated in the other studies that men have with asking and obtaining
information regarding their treatment, care, and prognosis. The fourth study, “The Lived Experience of Men Diagnosed with Prostate Cancer,” was chosen because the themes identified are common to all men with cancer. These themes included bearing the diagnosis of cancer and feeling comfort in the presence of others (Krumwiede & Krumwiede 2012). The fifth study, “Quality of Life While Dying: A Qualitative Study of Terminally Ill Older Men” (Vig & Pearlman, 2003), was chosen because the sample included older men and the focus was on dying. In this study, older men with cancer and heart disease were studied. All men were terminally ill and their experiences living with a terminal illness were common to the phenomenon under study. The sixth study chosen was, “Disappearing Floors and Second Chances: Men’s Journeys of Prostate Cancer” (Hagen et al., 2007). This study is about men and challenges in asking for information regarding their treatment and care. The seventh study, “‘The Only Way I Know How to Live is to Work’: A Qualitative Study of Work Following Treatment for Prostate Cancer” (Grunfeld, Drudge-Coates, Rixon, Eaton, & Cooper, 2013), was chosen as it focuses on men living with cancer in relation to their work. The eighth study chosen, “Riding the Train Until We Reach the End: Men and Metastatic Cancer,” is an unpublished qualitative review of men living with cancer and was chosen because of its detailed stories about men living with cancer (Nemchek, 2014). The ninth and last study, “The Supportive Care Needs of Men with Advanced Prostate Cancer” (Carter, Bryant-Lukosisus, DiCenso, Blythe, & Neville, 2011), also focuses on men and their challenges with expressing their care and information needs. All nine studies have many characteristics in common including, but not limited, to feelings of men living with cancer and their common challenges and barriers to living their optimal state of health. Table 4 is an outline of the methodological characteristics of the studies and Table 5 is a demographic outline of all nine studies.
### Table 4

**Methodological Characteristics**

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Qualitative research design</th>
<th>Data analysis</th>
<th>Sampling type</th>
<th>Data collection method</th>
<th>Discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>McCaughan et al. (2006)</td>
<td>Qualitative</td>
<td>Miles &amp; Huberman (1994)</td>
<td>Purposive</td>
<td>In depth interviews</td>
<td>Nursing</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Methodology</td>
<td>Sample Description</td>
<td>Data Collection</td>
<td>Discipline</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------</td>
<td>---------------</td>
<td>--------------------</td>
<td>-----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Nemchek (2014)</td>
<td>Descriptive</td>
<td>Convenience Interviews</td>
<td>Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carter et al. (2011)</td>
<td>Descriptive</td>
<td>Purposive Focus groups</td>
<td>Nursing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5

Demographic Characteristics

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample size</th>
<th>Age range</th>
<th>Diagnosis</th>
<th>Setting</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stapleton &amp; Pattison (2015)</td>
<td>8</td>
<td>26–68</td>
<td>Multiple types of cancer</td>
<td>Palliative care unit</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>Love et al. (2014)</td>
<td>On-line = 3000; Focus groups = 6; Interviews = 4</td>
<td>21–36</td>
<td>Multiple types of cancer</td>
<td>On-line, telephonic interviews, focus groups in conference rooms of support cancer centers</td>
<td>United States</td>
</tr>
<tr>
<td>McCaughan et al. (2006)</td>
<td>13</td>
<td>Various</td>
<td>Multiple types of cancer</td>
<td>Oncology clinic</td>
<td>Ireland</td>
</tr>
<tr>
<td>Krumwiede &amp; Krumwiede (2012)</td>
<td>10</td>
<td>62–70</td>
<td>Prostate cancer</td>
<td>Community</td>
<td>United States</td>
</tr>
<tr>
<td>Vig &amp; Pearlman (2003)</td>
<td>26</td>
<td>70–71 (mean)</td>
<td>Terminal heart disease or cancer</td>
<td>Outpatient clinics</td>
<td>United States</td>
</tr>
<tr>
<td>Hagen et al. (2007)</td>
<td>15</td>
<td>49–80</td>
<td>Prostate cancer</td>
<td>Home</td>
<td>Canada</td>
</tr>
<tr>
<td>Grunfeld et al. (2013)</td>
<td>50</td>
<td>18–65</td>
<td>Prostate cancer</td>
<td>Private room or outpatient clinic</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>Nemchek (2014)</td>
<td>3</td>
<td>65–77</td>
<td>Multiple types of cancer</td>
<td>Home</td>
<td>United States</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Setting</td>
<td>Diagnosis</td>
<td>Setting Type</td>
<td>Country</td>
</tr>
<tr>
<td>-------</td>
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<td>---------</td>
<td>-----------</td>
<td>--------------</td>
<td>---------</td>
</tr>
<tr>
<td>Carter et al. (2011)</td>
<td>17</td>
<td>Various</td>
<td>Prostate cancer</td>
<td>Outpatient clinics</td>
<td>Canada</td>
</tr>
</tbody>
</table>
Data Analysis

A systematic and concrete process to synthesize these studies and identify overarching themes and metaphors was used. The process chosen was Noblit and Hare’s (1988) seven phases process approach (Table 6). The seven phases are designed to help the researcher to systematically review the studies and for the reader to see the phenomenon in terms of others’ perspectives. Hopefully, the reader will also take from these perspectives new information and learning regarding their own views and understanding of what it is like for men living with cancer.

Table 6

Noblit and Hare Data Analysis

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify an intellectual interest, one that is important enough for this synthesis effort</td>
</tr>
<tr>
<td>2</td>
<td>Develop a list of studies to be reviewed that are pertinent to the phenomenon and parsing through the studies to decide which ones to use</td>
</tr>
<tr>
<td>3</td>
<td>Become very familiar with chosen studies to know the details that can be highlighted to enhance the phenomenon</td>
</tr>
<tr>
<td>4</td>
<td>Identify how each study is related to the other by creating a list of metaphors or phrases used in each account and how they relate to each other</td>
</tr>
<tr>
<td>5</td>
<td>Translate the studies into one another</td>
</tr>
<tr>
<td>6</td>
<td>Synthesize the translations</td>
</tr>
<tr>
<td>7</td>
<td>Express the synthesis</td>
</tr>
</tbody>
</table>

Results

Key metaphors from each study were grouped into three overarching themes including: (1) go with the flow; (2) play the hand I’m dealt; and (3) cover up the suffering (Table 7). Under
the theme “go with the flow” are key metaphors, such as fear, humor, support, adapting to change, work as a couple, rationalization, and riding the train. Included in the second overarching theme of “play the hand I’m dealt” are the key metaphors, of coping, work, and disclosing cancer at the workplace. The third overarching theme of “cover up the suffering” includes such key metaphors as loss of control, unmet needs, lack of support from physicians, fear of being helpless, and not wanting sympathy.

Table 7

*Key Metaphors*

<table>
<thead>
<tr>
<th>Study</th>
<th>Go with the flow</th>
<th>Play the hand I’m dealt</th>
<th>Cover up the suffering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stapleton &amp; Pattison (2015)</td>
<td>Adapting to change</td>
<td></td>
<td>Importance of manhood</td>
</tr>
<tr>
<td>Love et al. (2014)</td>
<td>Work together as a couple</td>
<td></td>
<td>Cover up the suffering</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Too proud for therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Chin up buck</td>
</tr>
<tr>
<td>McCaughan et al. (2006)</td>
<td>Hate the smell of the place</td>
<td>Need to get back to work</td>
<td>Awkward talking to a doctor</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>about feelings</td>
</tr>
<tr>
<td>Krumwiede &amp; Krumwiede (2012)</td>
<td>Unwavering support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vig &amp; Pearlman (2003)</td>
<td>Rationalization</td>
<td>Family support</td>
<td>Fear of being incapacitated</td>
</tr>
<tr>
<td></td>
<td>Spirituality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hagen et al. (2007)</td>
<td>Humor</td>
<td></td>
<td>Lack of support from physicians</td>
</tr>
<tr>
<td>Grunfeld et al. (2013)</td>
<td>Hate cancer but not afraid of it</td>
<td>Disclosing cancer at the workplace</td>
<td>Do not want people to feel sorry for me</td>
</tr>
</tbody>
</table>
The following paragraphs describe the overarching themes along with key metaphors with significant statements by the men interviewed that will bring their challenges to life. While most of the studies overlap with overarching themes and key metaphors, the significant statements, and the studies from which they were taken are reviewed.

**Overarching Theme 1: Go With the Flow**

Under Go with the Flow and its key metaphor of rationalization, humor, and support were common and consistent in many studies. For example, in the study regarding terminally ill older men, one man stated, “I’ve lived a full life, you know. And I think I’ve done about everything I wanted to do, been everywhere I wanted to go” (Vig & Pearlman, 2003, p. 1597). Another man stated, “It’s just one of those things in life that occur. I didn’t think I would ever have cancer. But I don’t think it changed my outlook on life noticeably” (Vig & Pearlman, 2003, p. 1598).

There were many examples of humor in most of the articles. For example, one man with prostate cancer stated, "I couldn’t go to a department store and go Christmas shopping. My daughter and I tried to go to a department store. Like, they give you certain pads you have to wear, or like a big diaper. It was very embarrassing. By the time I got to my car, to the store, and back to the car again, they were leaking. [pause] I won’t tell you too much about that aspect of it” (Hagen et al., 2007, p. 210).
Another man stated he was now “99% potty trained” to deal with his urinary incontinence (Hagen et al., 2007, p. 210). One man said his family had misgivings about him going to the doctor for the first time alone. The doctor’s office was in the local hospital. When he went into the office he looked around and saw all these pregnant women. When he told the receptionist he was here to see the doctor everyone laughed. Apparently, there are two doctors with the same last name; one an oncologist and the other a gynecologist. When he left the office, he told his wife what he did, and she yelled at him saying this is why he needs someone to go with him to every appointment (Nemchek, 2014). Unwavering support from family and friends was another common metaphor. One man stated, “My wife was very supportive. She believed that I made the right choice even though there was a risk of sexual activity loss and I was concerned about incontinence” (Krumwiede & Krumwiede, 2012, p. 448). Another gentleman said, “We have a lot of church friends, and we feel that prayer has helped us an awfully lot. I don’t think I could have got through without the support of our church friends” (Vig & Pearlman, 2003, p. 1599).

Living with a terminal illness includes incontinence, uncertainty, and constant reassessment of the value of life. Participants valued humor and family support in coping and managing their disease.

**Overarching Theme 2: Play the Hand I’m Dealt**

Living with cancer may not be about fighting the disease as much as learning to accept it. Unexpected consequences of cancer necessitate learning to acknowledge and accept difficult changes in a new lifestyle. For some men, their professional life and work are important. Learning to manage and cope with changes can be a challenge. The overarching theme of play the hand I’m dealt has two metaphors that are important to note: work and disclosing cancer in the workplace. Regarding work, one man stated:
The only way I know how to live is if I work and my work is my life. And therefore, when I’m not doing my work my life is obviously, unfortunately not full. My work/life balance is tipped more toward work, than life, I guess. That’s just how it is. (Grunfeld et al., 2013, p. 77).

Accepting that cancer care rather than work is the priority can be a difficult transition. Being perceived differently at work, a place that plays an important role in one’s life, is another challenge with which to cope. One man stated upon returning to work after cancer treatment:

You are thrown back into it and you wonder how you will be received, whether people will say ‘Here he comes, he’s been loafing for three months.’ So they don’t look at you, at what you’ve done and could do. (Grunfeld et al., 2013, p. 78).

Perceptions at work can be important to yearly raises and bonuses, impact on team work, and promotions. Negative judgments regarding workplace perceptions can create a challenge for men. Regarding disclosing cancer in the workplace, many men felt the diagnosis of cancer is perceived to evoke negative feelings, a fear of being stigmatized, and a fear of not being considered for promotions due to cancer. (Grunfeld et al., 2013). For some men, cancer creates a challenge professionally. Dealing with perceived negative perceptions from those they report to and their peers can negatively team outcomes. These perceived negative perceptions are challenges with which men need to cope. Grappling with perceived negative perceptions in the workplace is a harsh reality for men.

**Overarching Theme 3: Cover Up the Suffering**

The third overarching theme of cover up the suffering has many important key metaphors throughout most of the studies reviewed and provide information about next steps. Lack of support from physicians was a surprising and interesting key metaphor. Discomfort with
physicians includes: advocating for more time to discuss their care; asking questions in a way that will yield desired information; and articulating needs. One man stated his feelings on this participant very well when he said, “It’s a bit awkward talking to a doctor about your feelings” (McCaughan et al., 2007, p. 2689). Another gentleman stated, “There is little time to talk about things, I wanted to find out the important information, like, does he think he can treat me and what are the chances of a cure?” (McCaughan et al., 2007, p. 2689). One man clearly stated his disappointment with his physician, “It was like pulling teeth. I had the feeling that the doctor was too busy to sit down and talk to me and granted, they probably are. But then maybe they should have somebody that could sit in for that, maybe a nurse or something and say “Here is what you are confronted with.” (Hagen et al., 2007, p. 209).

Some men admitted that the lack of information was due to their reluctance to ask questions. One man stated, “That was my own fault. I didn’t ask enough questions” (Carter et al., 2011, p. 425), and another stated, “But I didn’t get to the bottom of it. I didn’t ask the questions and it wasn’t volunteered either at that time. I just felt shuttered off to one side” (Carter et al., 2011, p. 425). Not receiving needed information from physicians, not advocating for more time with physicians to get questions answered and feeling unable to articulate needs are challenges for men. These challenges could lead to unhealthy physician/patient relationships and negative health outcomes if not corrected.

Discussion

Men living with cancer are challenged with managing the highs, lows, and changes with their disease. Living with cancer and attempting to maintain normality while being stoic to not show their fear appears to be the norm for men. Presumptions that men do not need or want
emotional support have been shown to be untrue according to the information in the studies presented.

Three key metaphors were derived from the nine studies (Figure 3). All three metaphors describe living with metastatic cancer with adaptation, acceptance, and hiding pain and needs. Going with the flow includes adapting to changes at work, to the treatment environment, and coping with unmet needs. This metaphor also includes using spirituality and humor to support going with the flow.

**Men and Cancer**

- **Go with the Flow**
  - Fear
  - Humor
  - Support
  - Adapting to change Work as a couple
  - Rationalization
  - Riding the train

- **Play the Hand I’m Dealt**
  - Coping
  - Work
  - Disclosing Cancer at the workplace

- **Cover Up the Suffering**
  - Loss of Control
  - Unmet Needs
  - Lack of support from physicians
  - Fear of being helpless
  - Don’t want people to feel sorry for me

*Figure 3.* Key metaphors derived from the studies.
Unexpected and unanticipated consequences of living with cancer are illuminated in the metaphor, Playing the hand I’m dealt. Coping with changes in professional life, including interactions with supervisors and peers presents challenges. Negative perceptions, such as being lazy for taking time off for cancer care and being ineligible for promotion were derived from these studies. This can be difficult for men who need to work and who take pride in their work. Negative impact on raises, bonuses, and promotions, are also challenges for men, even if the impact is only perceived.

Masculinity is an important value for men living with cancer and is illustrated in the metaphor, Covering up the Suffering. Masculinity for these men includes being too proud for therapy, being perceived as masculine, and not wanting people to feel sorry for them. Unfortunately, fear of asking questions exacerbate may exacerbate a sense of helplessness and incapacity.

The paucity of research on male metastatic cancer is evident from the literature search. Describing the experience of male metastatic cancer yielded only nine studies. These studies were all peer reviewed and published between 2000 to 2014, inclusive. Studies included seven qualitative and two mixed method studies. Further research is needed to identify targeted educational tools for health care professionals to care for men living with cancer. Specific educational and emotional support tools that target need to be developed to enhance positive outcomes. The results of this metasynthesis show that men do have unspoken needs. Men want emotional support, although they are reluctant to report problems (Stapleton & Pattison, 2015). Results describe unspoken needs that include information regarding their disease. Having a physician/patient relationship that supports and encourages personal discussions is imperative to improving the lives of men living with cancer.
Chapter 5

A Phenomenological Approach Toward Understanding the Experience of Men Living With Breast Cancer

While deciding on a research project, most begin by asking the “so what” question. This question ensures the topic is relevant, demonstrates the researcher has thoroughly reviewed the literature and considered the implications and ability to apply new or more knowledge to a pertinent topic. Asking and answering this question is an imperative before the start of any research topic.

Currently, there is a gender gap between men and women with breast cancer at time of diagnosis. This gap is key to life expectancy, quality of life, and medical cost. Women are generally diagnosed at early stages 0 and 1 while men are diagnosed at later stages, 3 and 4. Prognosis for men compared with women is worse due to later diagnosis than women (Giordano, 2005). Lack of awareness and lack of recognition of symptoms may be the reason for the gender gap (Macdonald et al., 2006). The outcomes of a diagnosis at these early stages can lead to a cure, treatments that are temporarily difficult but manageable and successful. The outcomes of a diagnosis at later stages are considered incurable and terminal. The treatments at later stages are difficult, ever changing based on the effect of treatment, and costly (ACS, 2019). Most importantly, being diagnosed with a late stage breast cancer is life changing and permanent. Much has been written about women living with breast cancer. This study seeks to illuminate the experience men have living this disease to start to identify reasons men are generally diagnosed at later stages than women to initiate targeted interventions and decrease this gender gap.
The study may promote more questions than it answers however those questions will motivate further research and continue to illuminate the experience of men living with breast cancer.

**Background**

Around the world, male breast cancer comprises about 1% of the total breast cancer population (ACS, 2019). Perhaps because of this small number, there are little research and data about male breast cancer. Also, due to the relatively small population of male breast cancer patients and lack of gender specific research data, men with breast cancer are treated like women (Rudlowski, 2008). For example, after a diagnosis is determined, drug treatment and surgical interventions are decided based on the histologic type of cancer. At this point, men and women with breast cancer are treated the same although one study suggests male breast cancer may be histologically different than women's breast cancer (Tawil et al., 2012).

**Objective**

The intention of this study was to illuminate the challenges, successes, and barriers to care for men with breast cancer. Goals were to educate both health care professionals and the public on the experience of men living with breast cancer. As this is a descriptive phenomenological study, there is no research hypothesis. The aim is to describe the breast cancer experience for men without any preconceived suppositions on the part of the researcher.

**Literature Review**

A review of the literature on the experiences of men living with breast cancer yielded limited research and those found were quantitative in nature and published 10 or more years ago. Studies chosen were <10 years of age and were either qualitative or mixed by way of methodology. Three studies were found that dealt with men’s concerns living with breast cancer.
These studies included men’s concerns, fears, challenges, and coping strategies while navigating the health care system as well as the impact on their families. Additionally, three studies were found that discussed aspects of men living with breast cancer. All 3 articles focus on stigmatization, masculinity, and personal and professional impact of male breast cancer.

Men have specific challenges when living with breast cancer. Three challenges were revealed in a study by the Male Oncology Research and Education (MORE) program in Canada. MORE is an academic program that collects clinical data on men who are at risk for cancer, specifically prostate and breast cancers (Lorentz, Liu, & Vesprini, 2018). Using interpretive phenomenology, in-depth interviews were conducted with a convenience sample of 15 men at risk for breast cancer. Small sample size reflects numbers of men at risk for breast cancer, especially men at risk. Mean age was 55, all were white, all had either BRCA1 or BRCA2 gene mutations; none were under current breast cancer treatment; and, all were recruited through MORE. Three themes emerged from this study:

- **Body Talk.** “Guys don’t have breasts,” was noted as men tend to use gender specific language when talking about their bodies. One man stated if he had breast cancer he would refer to it as “chest” cancer.

- **Changing Awareness of Breasts.** Men distanced themselves from the concept of breasts while reporting thinking about the significance of their chests/breasts with respect to how age and medical conditions can change their appearance.

- **Experiences of Undergoing Mammography.** Men experienced feeling awkward and excluded while waiting in the mammography waiting room and discomfort and pain during the mammography. Study suggested further study to understand the experience of men living with breast cancer to mitigate men’s discomfort and to improve access to care.
The feminization of breast cancer was described in, “Men with a ‘Woman’s Disease’: Stigmatization of Male Breast Cancer Patients - A Mixed Method Analysis” (Midding et al., 2018). Men were recruited from the N-Male project in Germany. N-Male project started in April 2016 and ended in March 2018. The intent of the program was to identify prevention, diagnosis, treatment, rehabilitation, and follow-up care needs for men with breast cancer. Using qualitative interviews (n=27) and quantitative data (n=100), stigmatization and ignorance of male breast cancer were found to occur mostly in cancer care systems and in the workplace. In the workplace, men expressed feeling isolated from peers and from projects. In the healthcare system men expressed feeling unwelcome and awkward as they were intruding into a woman’s area. Feelings of isolation in the workplace from peers and from projects were expressed from men in this study as well. Suggested interventions to mitigate these feelings included education, advocation of MBC, and gender-neutral breast cancer information. Sample size was noted to be a weakness of this study.

The third study focused on the differences between men with breast cancer who live in metropolitan areas versus men who live in nonmetropolitan areas (Klein, Ji, Rea, & Stoodt, 2011). Data from the Surveillance, Epidemiology, and End Results Program of the National Cancer Institute (SEER) from 1988 through 2006 were used. The study noted MBC is about 1% of the total breast cancer population, a small number compared to women with breast cancer. 4,222 men of all racial/ethnic types were studied. There were 3,836 men from metropolitan counties and 384 men from nonmetropolitan counties. Results identified men with breast cancer >80, black, and being divorced as having poorer survival than men who were <80, white, and married. Also, men with breast cancer living in nonmetropolitan counties had poorer survival rates than men in metropolitan counties. Access to care and education were not identified as
significant variables, however improvements in post cancer detection, access to care, and education were suggested.

Across studies, disparity in healthcare delivery and personal and professional emasculation were reported for men who are living with breast cancer or at risk for MBC. All 3 studies identified the need for gender neutral education in healthcare to increase awareness in MBC and to develop environments for men that are conducive to expressing their feelings and supporting their healthcare needs. Access to care between metropolitan and nonmetropolitan counties was also identified as a possible reason for differences in MBC outcomes. Also, all 3 studies identified MBC numbers as a possible weakness of the study due to the sample size.

**Philosophical Underpinnings**

Husserl’s science of transcendental phenomenology was used as a guide to explore and describe the experience of men living with breast cancer. The intention of transcendental phenomenology is to be a pure science, one without facts, empirical data, or any reference to factual reality (Husserl, 1930). The goal of transcendental phenomenology is to explore, to discover and, and to shine a light on the phenomenon (Husserl, 1930). Understanding the lived experience of men with breast cancer is the first step towards gender specific support.

Husserl initially was a mathematician that is evident in the process of bracketing, an important way for the researcher to obtain the purest information by disconnecting from the phenomenon.Bracketing a researcher’s feeling, suppositions, and ideas regarding the phenomenon at hand is an important part of Husserl’s science. Bracketing allows the researcher to examine and separate these feelings, suppositions, and ideas so as to not to color or affect the research. Suppositions, feelings, and ideas regarding male breast cancer were documented in a
journal at the start of this project according to the disconnection framework provided by Husserl (see Table 8).
### Table 8

**Bracketing Journal Example: Men Living With Breast Cancer**

<table>
<thead>
<tr>
<th>Preconceived belief</th>
<th>Metaphor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of knowledge</td>
<td>I believe the many men and women are not aware men can get breast cancer.</td>
</tr>
<tr>
<td>Masculinity</td>
<td>Most men are embarrassed to seek help when they first find a breast lump.</td>
</tr>
<tr>
<td>Stubbornness</td>
<td>I believe men are stubborn. Just like men do not like to ask for directions or follow directions even when they are truly lost, I think men do not like to follow medical advice. For example, before he was diagnosed with bone mets Tony had excruciating back pain. When I, along with many others suggested he go back to his oncologist because the cancer may have spread to his back he refused stating he just had a spasm. When I had severe back pain, I went straight to my oncologist without question.</td>
</tr>
<tr>
<td>Reality</td>
<td>I believe men have a different way of dealing with reality. Up until the day Tony died, he felt he was going to beat cancer and live a long time. He weighed less than 100 lbs., could no longer walk and was in a lot of pain but refused hospice and requested chemo up until he died. When I would talk about what I perceived as &quot;our reality&quot; based on statistics and what my plan for my end of life care was, he told me that by planning my end of life I was being negative and giving up.</td>
</tr>
<tr>
<td>Medical Practice</td>
<td>I believe that men need to be “cared” for in a different way than women. I believe it takes time to establish a caring and trusting relationship with men, more time than it would take to establish with women. I believe new techniques need to be explored to help men seek support and receive care.</td>
</tr>
<tr>
<td>Support</td>
<td>I believe men need as much support as women, but healthcare professionals need to modify I believe men need as much support as women, but healthcare professionals need to modify their practice to enhance a relationship with men.</td>
</tr>
<tr>
<td>Data</td>
<td>I believe that there may be more cases of breast cancer for men, as gender data is usually not documented on breast cancer initial assessments. Speaking with one oncologist, he was not certain if his practice collected gender data. On reviewing the initial patient questionnaire, there is no question regarding gender. Identifying gender is based on the patient’s first name. There are many instances where gender identify cannot be determined by a patient’s first name. For example, a “Pat” could be a man or a woman. Also, at this time there is no specific identification for the transgender identity. For example, there may be women who are now men and men who are now women. Medical treatment includes hormone therapy, which may lead to breast cancer.</td>
</tr>
</tbody>
</table>
Research Question

The research question for this study is, “What is it like for a man who is living with breast cancer?” The intention of this study was to understand what life is like for men living with breast cancer in order to develop targeted educational strategies and emotional counseling techniques to support men and their caregivers.

Research Design

Descriptive phenomenology was the research design for this study. Husserl’s science was an appropriate choice to describe and illuminate the essence of the experience of men living with breast cancer.

Method

Colaizzi’s (1978) method of data analysis was used for this study. This 7-step method includes the researcher returning to the participants for confirmation following completion report and evaluation of their stories.

At the beginning of each of the 10 interviews the researcher obtained demographic data using the Demographic Information Form and consent form (see appendix) recorded electronically.

Sample

A sample size of 10 men living with various stages of breast cancer was interviewed electronically. A sample of approximately 10 participants was deemed to be adequate to reach saturation (Guest, Bunce, & Johnson, 2006). The purposive sample of 10 men who had breast cancer lived in Australia (n=1), and United States (n=9). Mean age of the sample at the time of the study was (55). Nine men were married, 8 men were retired and 2 men were on disability.
Sample Criteria

Adult men (> 21 years old) living with breast cancer who are members of the MBCC were invited to participate. Purposeful sampling was used to identify the investigational population (i.e. men with breast cancer) solely through recruiting in collaboration with MBCC (malebreastcoalition.org). The MBCC is an advocacy group that educates and supports men with breast cancer with over 400 members who are men living with breast cancer. Men living with breast cancer and their caregivers are members of this organization.

Data Collection

After receiving approval by the Institutional Review Board (IRB) at the University of Connecticut, the processes of recruitment and data collection began.

The MBCC posted a notice of the investigation on their website (See appendix). This notice provided an overview of the investigation and details of the investigational population of interest. As a component of this notice, the researcher’s email address was included for individuals who are interested in participating. Additionally, a follow up introductory email was sent to the members using the MBCC listserv from the researcher explaining the project and requesting volunteers.

All volunteers with expressed interest were contacted via e-mail to arrange their investigational meeting and to obtain their address to facilitate the mailing of a hard copy version introductory message and two hard copies of the consent form (see appendix). Participants were instructed to have these consent forms ready for review during the scheduled investigational meeting for use during the video-recorded consent process using Zoom software (Zoom.us). The primary reason for choosing Zoom software was because it enabled face-to-face interviewing and recording of interviews. Use of the Zoom program is particularly useful in this investigation
as Zoom is the mode of communication used regularly by the MBCC members. Video
conference interviews were stored in a password-protected file.

During this video-recorded meeting, potential participants were provided with the study
criteria. During this time, the voluntary nature of participation, freedom to withdraw, and
confidentiality procedures were emphasized. Upon expressed verbal interest in participating, the
researcher reviewed the consent form and asked the participant to sign one copy of the consent
form and mail it to the research team using the self-stamped envelope provided to them in the
packet. Participants were instructed to maintain the second copy of the consent form for their
own records. Screening and the subsequent interview started following the obtainment of a
video-recorded consent and confirmation from the participant that the hard copy of the signed
consent was mailed. Study eligibility was confirmed using the inclusion and exclusion criteria.
Each interview started with: “Please describe all your thoughts, feelings, and perceptions of your
experience that you wish to share. Any examples of points you are making will be very helpful.”

Data Analysis

Colaizzi’s 7-step method of analysis of qualitative data was used for this study (Colaizzi,
1978). Following Colaizzi’s process, the researcher returns to the participants for confirmation
that their story is complete as defined by the participant. Colaizzi’s 7-step method includes:

1. Participants descriptions are called protocols. All were read for full understanding.
2. Extracting significant statements specific to the phenomenon.
3. Formulate meanings specific to the significant statement.
4. Categorize clusters of themes based upon formulated meanings.
5. Develop an exhaustive description integrating thematic findings of the phenomenon.
6. Identify discrepancies through validating the exhaustive description with a set of participants to determine if it adequately depicts their experience. This was accomplished by returning to some of the participants to ask them how the descriptions compare to their experience during a follow-up video conference.

7. Finalize the exhaustive description by incorporating changes suggested by the participant. This was accomplished by reviewing transcripts with each participant during a follow-up Zoom meeting for any additions or deletions.

An important step for this study is #7. Honoring the men and ensuring accuracy by giving them the opportunity to modify their stories was an imperative.

Significant statements were organized in order of the most statements to the least statements to demonstrate significance/importance to the men. The 4 themes were validated by 5 of the men who had participated in the study. Individual meetings occurred using video conferencing. All 5 men agreed that the results should not be changed and did not want to add anything further. All agreed the results captured the essence of the experience of living with male breast cancer.

**Results**

Four themes from 80 significant statements were gleaned from the interviews with the participants. Resilience, advocacy, pain, and masculinity were documented below in order of number of significant statements to note the importance of the theme to the men interviewed.

**Theme 1: Resilience - The Tool Box**

Resilience: “An ability to recover easily from or adjust to misfortune or change” *(Merriam-Webster, 2019)*.

The definition of resilience is accurate for the theme of resilience except for the word
“easily.” The amount and quality of worry expressed in the statements describes real difficulty with adjustment due to fear. One man stated living in the present helped him mitigate worry stating, “I don’t have hope because the future doesn’t exist anymore. What only exists is now and actually that is very freeing. I can control today.” About adjustment to fear, another man stated, “You’re scared they’re gonna um excuse me, they’re gonna find something but if they do, they do, if they don’t, they don’t but I mean if they do I’ll fight it again.” This statement was difficult for this man as it was said with much emotion. Sub themes for resilience included support from family and healthcare professionals, humor, and prior hobbies. These sub themes were the strategies or “tools” men used in their “toolbox” to recover from change, to maintain resilience.

Support from family, caregivers, friends, and healthcare professionals were very important to men for them to remain resilient. One man stated he would not “be here” if it were not for his wife and her support. Another man said his wife suffered as much as he did. One man stated, “She’s a big part of who I am, and I always get a little upset when I talk about her because she had to sacrifice just as much as I did.” Another man noted the positive impact of his elderly mother traveling during a hurricane and a long distance to be with him during his surgery. Another man expressed the positive response he received after posting his diagnosis on social media. This man stated, “I was gonna you know put something on social media, on Facebook and my finger hovered over the button for probably like 10 minutes because I was like not sure what kind of reaction I was gonna get.” This man noted how he received, “nothing but love” from family, friends from high school and from his church. According to this man, “It definitely helped all the support.”

Support from healthcare professionals was also noted as an important tool to recover
from the changes of MBC. One man referred to healthcare professionals as “saints and angels.”

Being remembered by HCPs was also valued as one man stated, “Everybody seemed to remember who we were everywhere we went which was kinda shocking.” Another stated appreciation specifically for the cancer care nurses stating, “The support you got from the doctors and especially the cancer care nurses both male and female was excellent. It really was it was just there’s so much information given to you by the nurses.” One man relayed this experience, "A male nurse who as an Egyptian came in and he said ‘you know Mr. (redacted), if you think you’re gonna have trouble with Taxol you’re gonna have all kinds of trouble,’ he said, ‘but most people do not have that bad a time’ and he said ‘most likely you’re gonna be fine.’ It was all about what you’re thinking and he really calmed me down.

Healthcare professional support was recognized as care, something all the men in the study appreciated, “If I have to go to the emergency room I’ll just wrap myself up and go back up there and sit there lay there and they’ll just give me pain meds and I can make jokes.” Another man said a friend took him to his chemo treatments and stated, “If it’s such a thing as having a good time while you’re getting chemo, that’s what we did.” Another man said, “the girls used to love to see me come in for chemotherapy because I could keep them laughing.” One man said the third day of his first treatment was rough. This man asked, “Is the local funeral parlor in town? I told them ‘call Finch and Finch and go on and get me a room because I’m ready to go.’” Humor was an important tool in the tool box for the men in this study. One man painted his fingernails black. He did this to mitigate the negative reaction his chemotherapy would have with the sun’s rays on his fingernails. He stated the staff at the cancer facility as “fingernails” knew him. A situation that could have been awkward for many resulted in a funny story. One man joined a breast cancer support group where he was the only male. The group had a planned activity as
going topless in the ocean as a fundraiser. The man asked the lead of the group if his participation would be uncomfortable for the other women in the group and if so, he would not participate. The women were comfortable with his being there and as he stated, “And boom, here I was with 10 other women topless in the water.” Reaction from the women made him feel welcome. Humor had the most number of significant statements expressed by participants.

Other tools in the toolbox were singing, fishing, riding their motorcycles, things men had as hobbies prior to their cancer diagnosis. One participant, who is a music teacher, stated he sings in the cancer facility choir. When asked which song he felt described his cancer journey he said songs of hope and perseverance like the song, “Ain’t No Mountain High Enough.” Men interviewed expressed the importance, value, and appreciation of the things they have or use to manage living with breast cancer.

**Theme 2: Advocacy - Lighthouse on a Foggy Shore**

Advocacy took on two forms in this study, mentors and advocacy. Advocacy led to specific suggestions for healthcare professionals and cancer facilities.

The impact mentors had on the men in this study was strong and evident by the number of significant statements (n=21). Lack of information and difficulty finding information on MBC led first to frustration and then to appreciation of mentors and their motivation to support other men. Regarding the difficulty finding Internet information on MBC, one man stated, “I typed in male breast cancer and it said nothing found did you mean mall breast cancer? I’m like what? This search engine is broke.” After one man’s mastectomy he asked a nurse for information on MBC, “and they gave him pamphlets where somebody had got a pen and crossed out women and wrote men on it.” Another man stated lack of information motivated his passion for advocacy, especially when some of the men he encountered were initially diagnosed at later
stages stating, “These men were at a loss right out of the gate because they had no idea about male breast cancer.” Another man commented about the value of his mentor, “and so he’d tell me you know ‘well did they tell you this, did they tell you that?’”

The value and appreciation the men in this study expressed for their mentors as well as lack of information on MBC was key. One man stated he made it a personal mission to raise awareness on MBC. Raising awareness in the form of television interviews, fundraising events, including cancer care breakfasts, local Nascar events, and developing educational pamphlets for teens on MBC and hygiene. One man stated, “I’ll sit and talk to anybody that will listen to me.” This same man stated, “As a matter of fact, I’m going to a local restaurant here in town and wearing my pink tutu and my pink bra to get the awareness out.” One man stated advocacy has been therapeutic saying, “The more I talk about it the more people I meet who are shocked to hear that I’m a breast cancer survivor. I feed off of that and it helps me get the word out.” Another man called MBC a gift stating, “I even called it my gift and people look at me like I’m crazy and say ‘Why do you call it a gift?’ and I’m like I feel like I was given this gift so I can get out and talk about it.”

Lack of MBC information and appreciation of their mentors motivated the men in this study to educate others regarding MBC. Despite initial hesitation and embarrassment, men pushed themselves to speak out in multiple venues.

**Theme 3: Putting My Affairs in Order - Pain and Anger**

Physical and emotional pain and anger were described in this theme. These pains negatively impacted the families and caregivers and exacerbated the patient’s pain. One man stated about his wife’s illness, “It’s been acting up terribly because of all this and she’s in great shape otherwise…but it’s very hard to see her go through her illness because of my illness.”
Another man stated, “kills you physically and mentally and sexually and it um I’m lucky I got a good wife because I can see that type of thing putting a lot of pressure on your wife and relationships.” Family emotional pain was expressed by one man when he said, “I started planning for what it’s gonna be when I’m not here. And initially it was very painful it was very scary it was a lot of crying watching my wife cry and my daughter sob up.” In expressing fear, one man said, “What scares me more and makes me fearful and sad is the slow methodical degradation till I pass and what that looks like and what my loved ones are going to have to deal with as that happens.”

Physical fear was expressed by men when having mammograms as men do not have as much breast tissue as women and some mammographers expressed discomfort when working with men stating, “I’ve never done a mammogram on a man before.” Men stated the pain of a needle biopsy was very difficult with one man stating, "Worst experience I ever had as a man was having a needle stuck into my nipple without anesthesia. I know most doctors have paper table clothes on their exam table well I sweat right through that thing it stuck to my back.” Cognitive decline was also a concern shared by some men. One man had to leave the community theater where he worked both on the stage and back of the stage due to his poor memory stating, “I’m afraid to go back to that because learning lines was difficult for me before you know and I have fear of getting up there and not knowing what to say and if I’ll be able to get around.”

Perceived lack of understanding on the part of health care professionals and health plans were a source of frustration and anger for some men. One man stated his surgeon suggested he use sanitary napkins to absorb the copious amount of drainage he had after his surgical drains were removed. This man stated, "I turned to him at that point and said, ‘How dare you? You do
not even have a clue as to the insensitivity of a man going through this as a male breast cancer patient’ I was aghast, it was an eye opener. Another man stated, “My biggest frustration over the last I’d say 8 months was fighting with insurance companies.”

Fear, physical or emotional, were constants in these men’s lives. Being disabled and the impact on their families was a source of concern for the men in this study.

**Theme 4: Masculinity - Getting Knifed**

Men in the study expressed embarrassment over having MBC initially thinking breast cancer was a woman’s disease. About telling family and friends about his MBC one man stated, “I was extremely, uh, nervous about how their reactions would be you know it’s a woman’s disease and would I you know would they think less of me, am I less of a man because I got this?” Due to embarrassment, men in this study sometimes used euphemisms for MBC. One man, when asked what kind of cancer he had, stated he had “chest cancer.” A Vietnam vet stated the stigma of having MBC was so embarrassing he wore a shirt in pools and at the beach and had difficulty with female relationships stating, “I didn’t have I had very few relationships with females and because of that I didn’t want anybody to see me without a shirt.” This same man also stated, “there were even times when I told them I got knifed, I said they put a knife, somebody put a knife to me well that was true somebody did.” One man discussed women’s perception of masculinity as an issue during his search for support stating, "We don’t have group therapy session like women have that would be very helpful but we’re so few and far between and spread out over the country I can’t go into a group of women and talk about uh my breast cancer number one most of them don’t want me there um number two they’re embarrassed to talk in front of me."

Embarrassment at having a women’s disease motivated men to use other words such as
chest cancer and getting knifed. To some men, these words were more palatable and less embarrassing than male breast cancer. With time, some men in the study were able to tell people they had male breast cancer. With time, some men were able to use their diagnosis to advocate and educate others. As an example, one man stated, “I said, oh my god, I have to tell everybody that will listen to me that men could get breast cancer and I mean that’s my mission now.”

**Discussion**

Themes of resilience, advocacy, pain, and masculinity identified in this study are also reflected in previous research regarding male breast cancer. Becoming awkwardly aware of their breasts and using euphemisms like chest cancer for their breast cancer and feelings of isolation were common concerns. Stigmatization regarding having a “women’s disease” and loss of masculinity were common concerns from men in this study and in other research studies (Midding et al., 2018). Need for male breast cancer education and further research were imperatives voiced by men in this study and echoed by existing research (Midding et al., 2018). One man stated regarding cancer care professionals, “They’re not prepared for men and that’s upsetting because the frequency and treatment we receive is all based on what happened with women.”

**Strategies for Healthcare Professionals**

Evidence is overwhelming that strategies to improve outcomes for men living with breast cancer must include all healthcare professionals. Healthcare professionals play an important role in the way men perceive and manage their breast cancer diagnosis. Information, guidance, continued support, and comfort is key to a positive breast cancer experience for men.

Information that is specific to men is needed. Cancer care facilities, surgeon’s offices, radiology centers, and physician’s offices should have MBC information available. For
example, shower cards for men demonstrating breast self-exams, information pamphlets for men on what to expect from surgery and chemotherapy, and information on emotional support for men should be accessible for healthcare practitioners to use when caring for men with MBC. Breast surgeons should have information available to men on obtaining post op surgical equipment such as bras that are made for men. Some sources for this information and equipment are the ACS (www.cancer.org) the Male Breast Cancer Coalition (malebreastcancercoalition.org) and the Susan G Komen Foundation (ww5.komen.org).

Some men mentioned the importance of care they received from healthcare professionals as being very important to their experience. One man stated, “The support you got from the doctors and especially the cancer care nurses both male and female was excellent,” and another man stated, “Just having that feeling that your healthcare providers care means a great deal.”

Men described feeling uncomfortable in this “pink world.” At surgeon’s offices, radiology centers, and cancer care centers, some men felt unwelcome. One man stated how strange he felt going through the women’s dressing room. Another man stated how he felt angry glances from other women when he went for his mammography in a breast cancer clinic. Strategies to make men feel comfortable could be improved with education. Posters that men get breast cancer too, pamphlets that educate the risks for both women and men and supplying large and extra-large blue gowns may educate and mitigate the discomfort for both men and women.

Suggestions for Future Research

Each man in this study as well as previous research reviewed in this study agrees that more information is needed regarding MBC. Research to identify the specific physical and psychological needs of men with breast cancer is imperative. One suggestion is a mixed method study combining a quality of life survey with interviews to identify specific physical and
emotional needs. Another suggestion is a survey for physicians and nurse practitioners to identify gaps in knowledge and possible learning opportunities regarding male breast cancer. Studies identifying the specific histology of male breast cancer and possible targeted treatments are also necessary as male breast cancer may be different physiologically from female breast cancer. Targeted treatment may improve outcomes for these men.
Chapter 6

Conclusion

The goal of this dissertation was to provide insight into the lives of men living with breast cancer. Men living with breast cancer experience unique challenges, barriers to care, and successes. The main reason that their experiences differ from those of men living with other types of cancer appears to be a lack of available education and inadequate support from clinicians. Chapter 2 (Nemchek, 2018) described the gender disparity at time of initial breast cancer diagnosis. Specifically, it discussed how, due to this disparity, men experience more expensive and intense treatments. Chapter 2 also highlighted how the disparity could be the difference between a cure and a terminal diagnosis. Chapter 3 (Nemchek, 2016) was a pilot investigation that explored the experiences of three men living with metastatic cancer and specifically described participants’ value of support, coping mechanisms for emotional and physical pain, and fear. This chapter was related to chapter 5 and precluded the initial framework. Chapter 4 (Nemchek, 2018) presented an integrative review of the current state of literature on male breast cancer and highlighted the paucity of qualitative research on the participant. Chapter 5 illustrated the challenges and barriers men experience living with breast cancer and the results echoed the information of all previous chapters.

Considering chapters 2 through 5, significantly more research is necessary toward the development and care strategies for men living with breast cancer. Specific gender-specific care needs includes shower cards for men demonstrating breast self-exams, information pamphlets for men on what to expect from surgery and chemotherapy, and information on emotional support for men should be accessible for healthcare practitioners to use when caring for men with MBC. Breast surgeons should have information available to men on obtaining post op surgical
equipment such as bras that are made for men. Some sources for this information and equipment are the ACS (www.cancer.org) the Male Breast Cancer Coalition (malebreastcancercoalition.org)
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