Men and masculinity: understanding the challenges for urological cancer

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Stereotypical expectations of male behaviours do not always align with the reality of serious life-threatening illness, particularly urogenital cancer. However, masculine ways of coping can be harnessed to maximise benefit when providing support for men at all stages of the cancer journey.

Change demands adjustments to existing, long-established, cultural norms of attitude, cognition and behaviour. In the 20th century one of the most profound changes in Western culture was the emergence of women’s rights, and the position of women in society. The legislative framework of female emancipation in the 1920s, the contributions women made in two world wars, increased access to higher education and the professions, allied to equal-opportunity legislation, has resulted in a series of challenges to male hegemonies.

Women dominate in medical and legal education, and the image of the ‘alpha female’, who balances motherhood with the demands of working life, has developed.

Equality for women, allied to the reduction of opportunities for physically demanding work for men, has resulted in a ‘crisis in masculinity.’ Wider societal changes also affect healthcare provision, resulting in implications for men’s health. The emerging literature suggests that discussions about changing masculinity,
and the role of men within society, have direct and important implications for urological cancers. What, then, is the nature of these challenges, and how can urology work with the changing nature of masculinity to provide healthcare that is supportive, and appropriate, for men who are living within a more feminised world?

HEGEMONIC MASCULINITY

For thousands of years the most potent symbol of male dominance has been the erect phallus. Visitors to the British Museum, Pompeii or Rome are aware of the totemic significance of the phallus as the exemplar of male power. In modern society, evidence suggests that anxieties abound regarding penile size, with an increase in men seeking help via surgery. The arrival of sildenafil (Viagra) heralded a step change in the quest for potency. Access to easily available pornography has further increased concerns regarding virility because of often unrealistic expectations of what is ‘normal’.

If there is an increased concern about such matters in the healthy population, what, then, are the implications for those men who present with urogenital cancers of the prostate, penis or testes? How do well-established male attitudes and expectations impinge upon adaptation to the aesthetic and functional consequences of the surgical, radiation and hormonal therapies commonly used when treating male urogenital cancer?

Hegemonic masculinity is characterised by images of men as tough, unemotional, physically competent, competitive and aggressive. Central to that image is the ability to defend the vulnerable, and demonstrate virility through the fathering of children. Such images are socialised into male children from birth and are the basis of numerous images in the media and advertising. As a society we ‘know’ what a man is, with well-established, highly stereotyped expectations of male behaviours. How, then, do these dominant images align with the reality of serious life-threatening illness and the challenges of urogenital cancer?

THERAPEUTIC APPROACHES TO UROGENITAL CANCERS AND MASCULINITY

Prostate cancer is the most common male-specific cancer (13 per cent of new cancer cases per annum) in the UK. Testicular cancers account for more than 1 per cent of new male cancer cases, with the rarer penile cancer diagnosed in 400–600 men per annum in the UK. Although differing in aetiology, epidemiology and presentation, there are common aspects shared by all three. Namely, they are unique to men and all ‘attack’ men in the area of the body that is most directly associated with notions of masculinity.

Surgery, radiotherapy and hormonal treatments have sequelae that can affect the way a man’s body looks, feels and functions. Surgery and radiotherapy can result in penile shortening and possible impotence following prostatectomy. Androgen deprivation therapy results in changes to body images such as gynaecomastia and loss of muscle mass allied to greater emotional volatility. Penectomy, either partial or complete, can severely compromise men’s ability to have erections and have profound effects on urinary function. Perhaps for the man with testicular cancer, the implications are least obvious, as erectile and urinary functions are maintained; however, decisions regarding aesthetics and the use of testicular prostheses have to be addressed.

Across diagnoses, life-changing decisions have to be made, with little time to consider the implications of surgery. Following diagnosis, the driver for decision-making can be survival. Many men report that it is only following surgery that the longer-term implications are considered.

As cancer medicine and surgery have improved, different challenges have emerged. In conditions such as prostate cancer, the concepts of cancer chronicity and survivorship have come to the forefront. The stark dichotomy of cancer meaning ‘life or death’ is being eroded to give way to a more nuanced understanding of ‘life with cancer that cannot be cured’, but can be managed. Central to these changes has been the concept of quality of life, which encompasses physical, social, psychological and relational wellbeing.

There is an increasing expectation of a good quality of life following cancer treatment, even when the disease is not eradicated. How, then, does masculinity interact with this expectation, and what are the implications for successful post-treatment rehabilitation for men with urogenital cancers?

MASCULINITY AND CANCER TREATMENT AND SURVIVORSHIP/REHABILITATION

The masculine ideals of strength and resilience can have both positive and negative implications for men with urogenital cancers. Late presentation is commonly understood as being one of the key determinants of poor prognostic outcomes. ‘Soldiering on’ and not giving in to feelings of ill-health tie in with the idealised masculine view of coping, but with potentially highly negative consequences for the late presenter. Being emotionally strong, and not disclosing vulnerability, is another well-established aspect of masculine socialisation.

The exhortation of ‘big boys don’t cry’ is a given, which is highly likely to be a potent factor in the high incidence of male suicides, and the increased incidence of violence and substance abuse in men diagnosed with post-traumatic stress disorder. For men who have supportive relationships, an inability to disclose and confide in others, apart from partners, has been shown to have a detrimental effect on the partner’s mental health as they balance the challenges of supporting their partner while simultaneously grappling with their own grief and anxiety.
Masculinity is developed within cultural norms and expectancies. Although well established, masculine hegemonies are mutable. Male attributes such as stoicism can result in the late presentation of cancers. For many men the spur to report symptoms is the urging of their partners. Masculine ideals of strength and coping can cause conflict when dealing with emotional responses to cancer and its treatment. Partners can experience considerable emotional carer burden when supporting a man with urogenital cancer. Applying feminised approaches to support – such as that seen in breast cancer care – may not be the most appropriate way to provide rehabilitation for men. Accepting and harnessing masculine ways of coping may be a more effective method of providing support. The use of reliable information via the internet can be invaluable in enabling men to access support and is particularly useful for men with rarer cancers. Sharing information with a healthcare practitioner can allow men to disclose fears and concerns in a non-challenging way, which is less threatening to a man’s sense of masculine identity.

Nonetheless the positive aspects of ‘being a man’ can provide benefits for cancer survivorship. Stoicism, and being calm when faced with difficulty, can translate into an acceptance of support and a determination to survive and thrive for the sake of immediate family. Demonstrating courage and compassion for others is seen in becoming an expert patient, or volunteering for charities such as Prostate Cancer UK. It is apparent that masculine ideals do have the potential for great benefit for men with urological cancers if they are harnessed appropriately. The question is how best to achieve these positive ends?

OBSERVATIONS AND RECOMMENDATIONS

Providing a supportive, person-centred environment within which cancer treatment is delivered is well-established best practice. Patients, and to an extent their families, are considered part of the therapeutic team, with joint decision-making the norm. The dominance of breast cancer treatment and support is such that it is often perceived as the ‘gold standard’ against which all other cancer support services are modelled. However, whether this feminised approach to cancer support translates optimally into male survivorship and rehabilitation is questionable. The challenge is to find methods of support that, rather than imposing established more feminised perspectives, acknowledge and embrace masculine approaches to dealing with difficult situations.

Following the initial shock of a cancer diagnosis, two commonly reported responses are loss of control and feelings of isolation. If being powerful and in control are key elements of hegemonic masculinity, admitting to vulnerability and feelings of isolation constitutes a substantial challenge for many men. Although far from a uniquely male response, information seeking is an important method by which control can be re-established by patients. Providing information in a person-centred and comprehensible way, allied to opportunities to discuss options with a person the man respects, can be a powerful way to enable male cancer patients to reassert their masculinity when challenged with a cancer diagnosis and treatment decision-making process. Time with a high-status member of staff can improve feelings of being important and listened to, buffering feelings of vulnerability and passivity – both of which are challenges to masculine ideals.

Similarly, acknowledging the difficulties disclosure of vulnerability poses for masculinity is an important aspect of providing appropriate support. Being vulnerable in front of a male consultant urologist may be too much of a challenge, while weeping with a compassionate clinical nurse specialist may have therapeutic outcomes for many male patients.

In both situations, an increasingly useful source of support can be access to reliable and well-evidenced support on the internet. Organisations such as Macmillan Cancer Care, Orchid, Prostate Cancer UK and HealthTalkOnline can provide men with non-threatening and emotionally safe opportunities to address their informational and emotional needs. Although both men and women have these needs, it may be that the use of technology can be a more acceptable method of providing appropriate support and help for men, allied to excellent face-to-face healthcare provision. Additional benefits can also be accrued for those men with rarer cancers, such as penile cancer, and for those who, because of restricted mobility or geographical access, have increased feelings of isolation.

CONCLUSION

Masculinity and masculine ideals can have advantages and disadvantages for men with urogenital cancers. Providing
appropriate support at all stages of the cancer journey will be greatly enhanced by acknowledging the challenges masculinity presents for practitioners so that we can harness masculine strengths to maximise patient benefit.

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REFERENCES