

Psychology, men and cancer

Peter Branney, Karl Witty and Ian Eardley call for a consideration of masculinity in understanding and treating the disease

A disease of the anatomical or social body, cancer raises fears about the uncontrollable division and multiplication of some abnormality that will lead ultimately to the destruction of those very conditions that make possible our lives. Cancer incidence and mortality rates are higher in men than women, raising questions about the roles for psychologists in relation to gender and cancer. Psychologists are wont to question the division of population level statistics by sex rather than other, such as behavioural, categories. Conceptual distinctions between biological sex and psychosocial gender are taught early in the psychology curriculum, but cancer of the breast questions the easy separation of the biological body and psychosocial society.

questions

What roles can psychologists take in relation to men and cancer?

Is sex a useful category at the population level?

resources

Breast cancer in men:
<http://healthtalkonline.org/peoples-experiences/cancer/breast-cancer-men/topics>
 Penile cancer:
<http://healthtalkonline.org/peoples-experiences/cancer/penile-cancer/topics>

The term cancer has terrifying connotations. It can refer to evil, a social disease or to a collection of over 200 medical pathologies. Under the 1997–2010 Labour administrations, psychologists cautiously welcomed the Department of Health's 2007 Cancer Reform Strategy (Jarrett, 2008). The strategy was unique for devoting a subsection to gender (p.90–91) and highlighting the issue of greater cancer morbidity and mortality in men compared to women. Nevertheless, a key concern for psychologists was that the strategy failed to explicitly identify roles for them. Here, we address the core issue of the relationship between masculinity and cancer and explore what psychology can contribute to the understanding and treatment of cancers specifically across the spectrum of the male population.

Epidemiological arguments

The argument for classifying men with cancer together as a group (White et al., 2009, 2010; Wilkins, 2007) is based on epidemiological, population-level statistics. Broadly, men do appear to be more vulnerable to non-sex-specific cancers. Sex differences in annual standardised rates of cancer registration and deaths attributable to cancer are simple and powerful (e.g. 221 deaths due to cancer for every 100,000 men each year compared with 146 for every 100,000 women: Wilkins, 2007), though questions will inevitably be asked about how such data is conceptualised, collated and used.

Across the world, public health systems for the collection of morbidity and mortality data, such as 'cancer registries' or 'public health observatories', are integrated into civil and health services. For example, the annual reports of mortality in the UK by the Office for National Statistics are a legislative requirement dating back to a 1953 Act of Parliament. There is a format for such public health reports whereby causes of death are routinely reported by age and sex. It is statistics such as these that have prompted the Men's Health Forum's mission to 'tackle the issues and inequalities affecting the health and well-being of *men and boys*' (emphasis added).

Behavioural epidemiology

Whether or not the epidemiological argument for focusing on men and cancer is persuasive, population-level differences call for population-level interventions. Through behavioural epidemiology (Sallis et al., 2000), psychologists have a role in exploring and identifying links between behaviour and cancer and devising interventions to influence those behaviours.

Most notably, there is good evidence to suggest that there are several avoidable factors that can cause cancer, with tobacco use being the most prominent. However, the relationship between tobacco use and



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sex or gender also appears to be important. For example, Martin-Moreno et al. (2008) describe cancer rates of 29–38 per cent in male smokers compared with 2–10 per cent in female smokers. The Tobacco Control Report by the WHO Regional Office for Europe (2007) shows that more men smoke daily than women in 37 countries of Europe with the exception of Iceland and Sweden. Nevertheless, the public health interventions that have been implemented to reduce tobacco use – low-tar and filtered cigarettes, taxation, restrictions on smoking in indoor workplaces, pubs and restaurants, advertising limitations and changes to packaging – have been designed and implemented without any explicit reference to gender.

Tobacco use is a complex set of behaviours that arguably form some of the conditions through which it is possible to be feminine or masculine. Payne's (2001) review of gender and lung cancer, for example, shows sex differences in the depth and rate of inhalation, whether or not tobacco is used as a buffer against negative emotions, to increase positive feelings, or is used in social situations.

Workplace smoking bans are an example of a population-level intervention through which behavioural epidemiology can highlight a complex set of behaviours with sex differences. Employees who go outside to smoke because smoking bans are in place are likely to smoke faster and with a greater depth, and frequency, of inhalation (Payne, 2001). Payne argues therefore that whilst an overall reduction in the incidence of tobacco-related cancers could result from such bans, there would also be a concomitant increase in the severity of those cancers that do occur. Because more women than men work in environments where such bans are in place (Prescott-Clarke & Primates, 1998), we can therefore further argue that women would be more likely than men to benefit from the general reduction in workplace smoking and passive-smoking. Nevertheless, those women that do smoke are therefore also more likely than men to

be disadvantaged by an increase in the severity of tobacco-related cancers.

The sex and gender of breasts

Breasts and breast cancer are surely an example of treating something that is gendered as if it were biologically determined. In Western society, breasts are arguably symbolic of femininity, both in terms of biological sex and psychosocial gender. It is no accident that the UK charity, the Breast Cancer Campaign, promotes Pink Science and that its (non-sex specific) vision to 'cure breast cancer' is explained in a video that starts with the stark fact: '1 in 8 women in the UK will be diagnosed with breast cancer'. Men may know someone with cancer; they may be their son, father, lover, husband, friend; they may even don pink clothing and raise money for breast cancer charity; but they don't get breast cancer, do they?

Anatomically, both men and women have breasts. We could make a distinction between size of breasts between men and women (that men's are too small to be considered breasts), but this would be to ignore the great variation in our bodies. At a young age, there is rarely any difference in breast size between boys and girls. In adulthood, both men and women's breasts vary in size. Breasts in men are sometimes mockingly referred to as 'moobs' (man boobs). Gynaecomastia is the medical term for men's breasts that swell unduly, and some men have surgery to reduce their size (Singleton et al., 2009). Alternatively, we could make a distinction between men and women in terms of the anatomical function to produce breast milk. Yet some men's breasts do produce milk (Singleton et al., 2009) and in women the function is

Experiences of penile cancer

- I 'Because of the surgery what I've had I could never bring myself to say you know asking a lady out simply because I feel like most of my manhood's been taken away like' (Paul, 61 diagnosed 59)
- I 'I don't feel a proper man. I feel... completely emasculated and it's difficult to explain but I still have, a problem wearing jeans. I still have a problem wearing shorts. Because I think that people know' (Mark, 48 diagnosed 46)
- I 'As I say, our sex life is back to something approaching normal or something slightly different and certainly no worse than it was before. Perhaps after nearly thirty years of marriage then perhaps things had got a bit, bit routine, a bit regular, and this has, you know, forced us to spice things up' (Tim, 54 diagnosed 53)
- I 'What's particularly nice is that... you know a lot of people have bothered about me and sent me cards and boxes of chocolates and things like that so that's just great and nice bottles of wine. So that's the upside, you know that people care about you rather than you're just a part of the furniture' (Jordan, 58 diagnosed 57)

largely dormant throughout their life. Breasts are not technically a sex difference, even if they play a considerable role in gender differences.

As for breast cancer, men do in fact get it. Additionally, men can carry the hereditary BRCA gene mutations that increase the risk of breast cancer and, for those diagnosed, recurrence and reduces survival. The Cancer Research UK (CRUK) information web pages have a section on what they term 'male breast cancer', which is listed as a type of breast cancer even though the condition has no sex. Like CRUK, healthtalkonline.org (see box on p.412) had a module on breast cancer that was created from interviews with 53 women about the experiences of their condition. At the launch of a module with interviews of men who had been diagnosed with breast cancer the language changed to 'breast cancer in men' and 'breast cancer in women'. The section title 'What should breast cancer in men be called?' is telling. While some of the men interviewed unthinkingly used 'male breast cancer' others disliked the term and thought people should know that it is the same disease whether in a man or woman. One interviewee, who you can see speaking on the site, had contacted cancer charities and persuaded all but CRUK to stop using 'male breast cancer' (CRUK started using 'breast cancer in men' for the section heading in October 2013 while still using 'male

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breast cancer' within the text of the page).

Reports of the excess incidence of cancer in men that use epidemiological data usually exclude sex-specific cancers, such as cancer of the penis or vulva. It is notable that breast cancer is also usually excluded. Wilkins and his colleagues followed this same approach in the Gender and Access to Health Services study (Wilkins et al., 2008) because the incidence of breast in cancer in women is so great that the aggregate excess incidence of all other cancers in men diminishes. This does raise a question about the utility of clustering all cancers together, when there is such great variation in their incidence, effects and treatments. Yet we could also ask about the utility of dividing epidemiological statistics by sex rather than, for example, behaviour.

Patients' experiences of penile cancer

Like breasts with women, the penis is arguably the key signifier of masculinity;

an anatomical symbol of the wider conditions that make it possible for bodies to be male and masculine. As a rare condition (Branney et al., 2011), those who receive a diagnosis of penile cancer are unlikely to meet anyone who has direct or indirect experience. The primary form of treatment is surgical excision of the tumour and a 1 cm margin of healthy tissue. While some can recover full urological function after a period of rehabilitation, up to two thirds report impaired sexual functioning (Maddinini et al., 2009), such as low confidence in erectile function, an inability to achieve an orgasm, or reduction in sexual activity, desire and/or satisfaction with intercourse.

Consequently, we worked with healthtalkonline.org to create a module on penile cancer as a resource sharing patients' experiences. The primary audience of this site is those affected and their friends and family, although it will also be useful for psychologists. As the healthtalkonline.org research primarily uses video interviews with patients, it

was expected that recruitment would be extremely difficult because men might be reluctant to talk about the dismemberment of their penis. It is standard procedure for clinical trials to close if a specified number of potential participants decide to opt out. Practically and ethically it would make no sense to continually attempt recruitment when too few are interested. In fact, of those clinical penile cancer trials of which we are aware, all have closed early because of insufficient recruitment. Nevertheless, our group found 27 men who were willing to share their experiences of penile cancer and as the site shows, there is a wide variation in experiences (see 'Experiences of penile cancer'; Witty et al., 2013). For example, in one case cancer had a devastating impact on the man's marriage whereas another man actually enjoyed finding new ways of being intimate with his wife.

Psychology as critique

Every day by adorning our bodies in particular ways, ticking male/female on forms and dividing epidemiological statistics into two, we habitually create and recreate both gender and sex. This presents psychologists with a number of potential roles beyond the clinical. Psychologists can continue to explore how gender and sex are constructed in relation to cancer; they can examine and share patients' experiences of cancers that are in some ways marginalised by contemporary understandings of gender and sex; and psychologists can ask critical questions about epidemiology, health care and wider society.

Health talk online

www.healthtalkonline.org is a unique, award-winning website produced by the DIPEX charity; it features video and audio clips from carefully conducted in-depth interviews with people about their experiences of health and illness. Over 75 separate 'modules' covering different conditions or health topics are currently available on the site, including prostate and testicular cancers and the prostate-specific antigen blood test.

Each module is based on a rigorous qualitative research study exploring the experiences of people facing the condition, health or social care issue. Each module presents careful analysis of around 25 of the most important issues identified within these in-depth interviews, illustrated with around 250 video, audio and written extracts from the interviews.

Research for all

healthtalkonline studies uses ethically approved methods developed over many years by the Health Experiences Research Group at the University of Oxford. The penile cancer study was led by researchers at Leeds



Metropolitan University in close collaboration with the Oxford team.

The healthtalkonline modules reflect what is important to people facing different health conditions and also harness the appeal of patients' experiences to impart accurate, useful information to range of users, including the public,

patients and their families, and health and social care professionals. The website has been evaluated with patients and as a teaching resource and is registered with the Information Standard.

Healthtalkonline modules are intended primarily for people who have the condition, but also to educate health and social care professionals. Partners, families and colleagues will also be able to learn about a wide variety of perspectives on the condition.

Applied psychologists are increasingly being encouraged to recommend reliable websites to their clients. Healthtalkonline has a reputation as a site that can be trusted because it is based on rigorous research; it has been widely cited as an example of good health information on the Internet and commended in the national press.



Peter Branney
is in the School of Social, Psychological & Communication Sciences, Leeds Metropolitan University
P.Branney@leedsmet.ac.uk



Karl Witty
is at the Institute of Health & Wellbeing, Leeds Metropolitan University
K.Witty@leedsmet.ac.uk



Ian Eardley
is in the Pyrah Department of Urology, Leeds Teaching Hospitals NHS Trust
ian.eardley@leedsth.nhs.uk