Abstract

Aim
This paper is a report of a study exploring and comparing the experience of men and women with colorectal cancer post diagnosis during surgery.

Background
Men have higher incidence and mortality rates for nearly all cancers. Males frequently use health behaviours that reflect their masculinity. There has been minimal investigation into the influence of gender on the experience of a ‘shared’ cancer.

Methods
From November 2006 to November 2008 a qualitative study was conducted involving 38 individuals (24 men, 14 women) with colorectal cancer. Data were generated using semi-structured interviews at four time points over an 18-month period. This paper reports the participants’ experience at diagnosis and during surgery (time point 1) with the purpose of examining the impact of gender on this experience.

Findings
In general, men appeared more accepting of their diagnosis. The majority of females seemed more emotional and more affected by the physical side effects. However, there was variation within sexes, with some men and women portraying both ‘masculine’ and ‘feminine’ traits. There was also individual variation in relation to context.

Conclusions
It appears that many men may have been experiencing side effects and/or psychological distress that they were reluctant to discuss, particularly as some men portrayed typical ‘masculine’ traits in public, but felt able to open up in private. Nurses should not make assumptions based on the traditional view of masculinity, and should determine how each man wants to deal with their diagnosis and not presume that all men need to ‘open up’ about their illness.

Keywords: Gender, Experience, Colorectal Cancer, Nursing
Summary Statement

What is already known about this topic:

- Men have higher incidence and mortality rates for nearly all forms of cancer.
- Men frequently use health behaviours that reflect their masculinity.
- Colorectal cancer has a physical and psychological impact on an individual. It is not clear how gender affects the experience.

What this paper adds:

- Many men appeared less affected by a cancer diagnosis than their female counterparts.
- How men portray their masculinity differs from individual to individual.
- Some men may ‘downplay’ the impact the disease.

Implications for practice and/or policy:

- Nurses should be aware that not all men conform to the traditional view of masculinity.
- Nurses should not make assumptions based on the traditional view of masculinity.
- Nurses should determine how each man wants to deal with their diagnosis and not presume that all men need to ‘open up’ about their illness.
INTRODUCTION
Men have higher incidence and mortality rates for nearly all forms of cancer than women (White and Cash, 2004). While there may be biological and physiological reasons to account for differences, health behaviours play an important role. Masculinity, as a concept, is crucial to understanding men’s health behaviour (George and Fleming, 2004). Traditionally the terms masculinity and femininity have represented a stable set of gender beliefs that distinguish men from women (Wall and Kristjanson, 2005). Gender has been defined as ‘a set of socially constructed relationships which are produced and reproduced through peoples actions’ (Gerson and Peiss, 1985). Gender is therefore not something we ‘are’, but something we ‘do’ (Moynihan, 1998). Gender consists of multiple forms of masculinities (and femininities) (Connell, 1995). Hegemonic masculinity describes men who demonstrate aggression, strength, self reliance and limit their emotional responses. This is the idealised form of masculinity (Connell, 1995; Wall and Kristjanson, 2005). Men construct and reconstruct their gender identity from context to context (Speer, 2001). It is possible that many men have a public masculinity which conforms to the hegemonic reference point, and a private masculinity. Males frequently use health behaviours to demonstrate their masculinity, for example, the denial of pain or weakness, the appearance of being strong and the refusal of any need for help (Courtenay, 2000). Thus they maintain a socially acceptable masculine appearance of taking illness ‘like a man’ and being able to cope through not expressing any concerns and fears (Moynihan, 1998). It is important to note that there are differences among men. Although men may endorse similar principles, different men may enact these beliefs in different ways (Courtenay, 2000). Some men do not conform to the socially accepted view of masculinity and do adopt healthy behaviours; similarly, women can adopt unhealthy behaviours.

Background
A review of the literature examining masculinity and the cancer experience revealed that the majority focused on male only cancers such as prostate cancer (Kelly, 2009; Arrington 2008; Oliffe, 2006; Broom 2004 and Wall and Kristjanson, 2005). Only one study was found that examined the impact of gender in a ‘shared’ cancer (Emslie et al., 2009). They demonstrated a difference in spousal support between men and women with colorectal cancer (CRC), but they also reported diversity among men and women (Emslie et al., 2009). Examining the
impact of gender on the cancer experience of a shared cancer provides more opportunity to compare and contrast the male and female experience. It is clear from the literature that there are gaps in studies of men with ‘shared’ cancers, for example CRC. CRC is the third most common cancer in the UK and US (National Cancer Institute, 2008; Cancer Research UK, 2009). The occurrence of the disease is related to age, with over 80 percent of first diagnoses occurring in the over sixties. Until the age of fifty, there is no gender difference in CRC incidence and mortality rates, but in later life mortality in males is much greater than in females (National Cancer Institute, 2008; Cancer Research UK, 2009). Data are available on the impact of gender on CRC screening uptake (Wardle et al., 2005), survival rates (McArdle et al., 2003) and tumour location (De Cosse et al., 1993). However, very little information exists on the influence of gender on the experience of CRC (Rozmovits et al., 2004; Schmidt et al., 2005).

There is a need to investigate the similarities and differences in the experience and coping strategies of men and women with cancer over a length of time in order to gain a more meaningful understanding of the cancer experience. The current study was undertaken as part of a larger study focusing on the impact of cancer and its treatment on men.
THE STUDY

Aim
The aim of the study was to explore and compare the experience, and coping behaviour, of men and women with colorectal cancer over an 18-month period, post-diagnosis. This paper reports the participants’ experience at the time of diagnosis and surgery with the distinct purpose of examining the impact of gender on this experience.

Design
A prospective longitudinal descriptive qualitative study (Sandelowski, 2000) exploring and comparing the experience of men and women with CRC was conducted. Participants were interviewed on four separate occasions over an 18-month period; 1) after diagnosis and surgery, 2) on completion of chemotherapy, 3) six months after chemotherapy and 4) twelve months after of chemotherapy. This paper reports the findings from the first interview.

Participants
Men and women aged > 18 years, English speaking, with a first diagnosis of CRC attending the Northern Ireland Cancer Centre, formed the sampling frame. This cancer centre treats all patients from all areas of the country. A purposive sampling method was used. Factors considered were gender, age, newly diagnosed with CRC, treatment to be received, and the presence of a stoma. Recruitment continued until no new themes were emerging from the interviews and data saturation had been reached.

Data collection
Recruitment commenced in November 2006 and ended in June 2007. During this period, 56 individuals were identified as eligible, 38 (24 men and 14 women) agreed to take part. The ratio of male to female of those who declined was the same as the participants: 2 male to 1 female. The main reasons for non-participation were either disinterest in the study or they did not need chemotherapy and therefore did not want to be involved in an 18-month study. Potential participants were identified during their first oncology appointment. If there was an expression of interest, potential participants were approached by the researcher and written informed consent was sought. Process consent was used in the study.
Interviewees were asked to tell their story from the time when they first suspected there was a problem. This provided the opportunity for participants to express unsolicited opinions and describe their own unique experience. During the interview, participants were invited to describe their experience of being diagnosed with CRC and undergoing surgery. Their current strategies for coping with their illness were investigated. Issues raised by the participant were explored using a semi-structured interview technique. Topics covered were the cancer journey, information and support needs, and coping styles. Following preliminary analysis; emergent themes were explored with participants.

All but three interviews were conducted in the participants’ home, the remainder taking place in the individuals’ workplace. Participants were asked to choose the venue for the interview to ensure they felt comfortable and in control of the situation. The interviewees were interviewed alone or with their partner in accordance with their own preference. The inclusion of the participants’ partner provided further insight into how the participant was coping. Each interview lasted approximately 1 hour, were audio-taped and transcribed verbatim by support staff. Each transcript was checked for accuracy by the researcher who had conducted the interview. The interviews were conducted by four members of the research team (3 female, 1 male) who had no connection to the individual’s clinical care.

**Ethical considerations**

Ethical approval was obtained from the Office of Research Ethics Committees (OREC).

All potential participants were given a study information sheet and had the opportunity to ask questions about the study and provided written informed consent. Process consent was used; therefore prior to subsequent interviews the participant was contacted to ensure they still wanted to participate. This was obtained without any coercion and no incentives were offered. Confidentiality was assured and participants advised that the recorded interviews would be deleted following transcription. Data were protected under the provisions of the Data Protection Act (1998).

There was potential for a prolonged discussion on a sensitive topic to cause distress. Participants were told that they could stop the interview at any time and the researcher would terminate the interview if they felt that the participant was becoming distressed. None of the
participants seemed distressed and none asked for the interview to be terminated. After the interviews debriefing and support from the clinical support team were offered to participants, if required.

**Data Analysis**

Data were analysed according to Miles and Huberman’s (1994) techniques of labelling, coding, categorising and theme development. Data collection and analysis were undertaken concurrently; hence analysis began as soon as data became available. Recurrent themes were subjected to close scrutiny in subsequent interviews until the development process reached saturation and the theme could not be developed further. The NVIVO computer package was utilised to help with data management.

**Rigour**

Following transcription, the interviewer reviewed the transcript. Constant comparative techniques were used to ensure all perspectives were represented in the analysis and deviant cases were examined. Other members of the research team continually reviewed a selection of the transcripts and discussed the coding. From this, additional questions were identified for use in subsequent interviews in order to include newly identified areas of importance. Emerging themes were recorded and discussed among the investigators. During these discussions an agreement was reached when all members of the team felt data saturation had been reached.

In many qualitative projects, participants are invited to validate the findings, which they should recognise as an explanation of their own experience. This was not done in the current study as it has been considered unethical to ask individuals with cancer to validate outcomes due to the sensitive nature of their illness (Ramfelt and Lutzen, 2005). However, at different points during the interview, the interviewer summarised the participant’s response to ensure the interviewer’s interpretation was not different to that of the participant.
FINDINGS
Participant demographics are presented in Table 1. Participant ages ranged from 24 years to 78 years with a mean age of 60 years (SD 12.15). Most were married and not working at the time of their diagnosis. Although the participants ranged in age from 24 – 78, most of the respondents were in their sixties. Participants received various combinations of cancer treatment, the most common being surgery followed by adjuvant chemotherapy. The chemotherapy was administered every week for 26 weeks (see Table 2).

The findings are divided into two sections reflective of two points of time within the CRC experience; ‘time of diagnosis’ and ‘time of surgery’. Within ‘time of diagnosis’ we present findings on delaying to seek a diagnosis and the emotional response to this diagnosis. At the ‘time of surgery’ the participants reported experiences of being dependent and having to manage altered bowel habits or a stoma bag.

Each participant was assigned an identification number which was used to code each interview, in combination with either an ‘F’ or ‘M’ indicative of female or male respectively.

Time of diagnosis
Delay in initial presentation
Many male narratives revealed the men were not proactive in presenting to their General Practitioner (GP). Some men discussed how they mentioned their symptoms whilst attending for another medical problem. Many men were experiencing rectal bleeding for months before eventually confiding in their wife. A male respondent describes how it was ultimately his wife who was the driving force behind him presenting to his doctor.

‘She (wife) nearly went spare because I hadn’t told her before. So she insisted that I go to the doctor.’ 046M

Not all men avoided attending their GP. One man went straight to his doctor when he experienced bleeding, despite his wife suggesting he may have been over-reacting.
‘Funny enough the wife said...I don’t think you have anything to worry about.....I said I’ll just go to the doctor and let him check it.’ 052M

There was no evidence of delaying in the female narratives.

**Reaction to the diagnosis**

Many men and women emphasised their shock upon diagnosis. However, some male narratives seemed to suggest that they were unaffected emotionally by their diagnosis. For example, one man when describing his feelings towards his diagnosis discusses how his experience in the Armed Forces influenced his reaction to his diagnosis.

*I’ve probably always been like that, just accept things as they come... I don’t know whether it was my upbringing at home or the life I have led through the forces......I’ve always been like that. Just accept things.* 009M

He also presents very succinctly how society’s perception of how a man should behave, played a part in how he reacted.

*It’s just a macho business probably! There is definitely...men are from Mars and women are from Venus, it’s definitely that! .........If a man shows his feelings he is looked on as a sissy whereas women console each other.* 009M

Such behaviour was not restricted to men only. One woman explained the decision and action she took.

*You know you are going and getting it sorted and that’s it. There is no point in sitting and crying and getting in a state.*’ 008F

However it was more usual for the men in the sample to talk about ‘unemotional’ reactions to the cancer diagnosis than the women.

The majority of women’s narratives suggested that they were emotional about their diagnosis. One female described how she could not stop crying upon being told she had CRC.

*He said it was cancer. I just looked at him. When he went outside the door I cried. I cried and cried for nearly an hour. Then (husband) came up and I cried again.*’ 032F
A few men were also emotional about their diagnosis. One man chose to hide this reaction from his family.

_I have cried when there is nobody about. After they told me and after Mum and Dad left I just broke down really and don’t think I really wanted people to see me like that._ 030M

Interviewer: And do you think it would help you to be more…like you said you cried or you broke down when you are on your own, do you think it would help to…I mean do your parents know that it’s having that sort of an impact on you?

_No I don’t think so._

Interviewer: Do you think it would help if they did or if somebody did or would you just rather not?

_I would just rather not. I would rather let them know that I’m fine about it._

Similarly, another male respondent described how he was emotional in response to his diagnosis, but only in front of his family. In the presence of his doctor, his reaction was more stoical.

_‘So she (doctor) came in and he just said there is a massive growth on your bowel which will require surgery……I said ok, fair enough. So on the way home my wife and I never spoke and then we came in here (house) and both of us broke down’_ 046M

Although this shows that some men do react emotionally to the diagnosis, they try not to show emotions in front of others.

**Time of surgery**

**Being dependent**

A number of male narratives suggested that they may have found the experience of being a patient difficult. They vented this frustration through anger to the medical profession. One man demonstrated this when he was recounting his reaction to the doctor suggesting he have an operation.

_‘He said go for it he says, it’s simple he says. I says you go for it if you’re the big man’_ 059M
Many men described a loss of independence, with other family members having to do household tasks.

‘My biggest problem is that on a Tuesday morning it’s bin morning and I can’t take this out!’ 023M

Similarly, some female respondents emphasised how they too found being dependent at home difficult.

Many of the men found difficulty in accepting assistance from their wives in relation to the management of their stoma bag. One male respondent described how he felt humiliated when he had to rely on help from his wife.

‘she would do it for me. Then I got fed up with that because it does degrade you, it really does. It’s humiliating. So I said to hell with this, I’ll do it myself’ 043M

In contrast, one unusual account from a male participant reveals how he was comfortable with his assistance until he was able to handle the bag himself. When speaking about managing his stoma, he speaks in terms of ‘we’ rather than ‘I’.

‘when I first had the bag we had awful trouble......didn’t we love?’

This approach to managing the stoma bag was reported more by women than men in the sample. For example one female was experiencing difficulty in changing her stoma bag, and she was comfortable with her husband assisting her.

‘It’s (x) my husband who deals with the cleaning of mine. I can't totally see it.........we have even thought it through that if I need to change the bag......my husband will come in (to the disabled toilet) with me’. 047F

Managing altered bowel habits or stoma bag

Following surgery, both men and women who did not require a stoma bag described how they experienced a change in their bowel habits.

‘You still have to go back and forward if you know what I mean.......in fact I’m going more now than I ever did.’ 026M
‘I would go to the toilet four times a day now because I’ve lost the majority of my bowel......I would go to the toilet after every meal.’ 040F

In a number of female narratives it became clear that they found this situation embarrassing. They described how they got embarrassed in public and did not like having to run to the toilet in social situations. In response to this, many female participants stated that they had reduced their social activities. It may be the case that these women felt it was not ‘feminine’ to have bowel problems. From an early age females are taught that bodily functions are something to hide, whereas men are taught that their bodily functions do not need to be hidden (Toner and Ackman, 2000). This may have caused bowel problems to become more of a social embarrassment for women than men. One female highlights this belief well.

‘I’m sure you heard my stomach there. It’s really embarrassing because I don’t like to go out anywhere.....Even going to my friends house......I mean to actually get up and go to their loo......you don’t know if you are going to be sitting up there for 10 minutes or 20 minutes at a time......My best friend......I was in her loo for half an hour......It was just gurgling and gurgling and gurgling and the wind is coming out in gushes. You don’t want people listening to you. It’s really embarrassing......’ 010F

For some female respondents the embarrassment was related to context. These women found it very embarrassing in public, but their attitude changed when they were with their family. One female emphasised how at home she was able to see the humour in the situation.

‘I have terrible flatulence. It’s absolutely terrible......It’s fun in the family now but you have to have a thick skin......’ 040F

This sense of embarrassment was not as apparent in the male narratives. For example, when one man was asked about how he was coping with his altered bowel habits, he responded with:

‘there is nothing really upsetting me at the minute......it doesn’t upset me about going to the toilet if I have to run......’ 024M

The experience of having a stoma bag also lead to feelings of embarrassment and inconvenience and impacted on the social lives of the respondents. Again the female narratives seemed to emphasise greater concerns in relation to adjusting to these experiences than the male accounts. It would appear that at this stage the majority of women coped with a
stoma bag by reducing their social activities. One female account demonstrates how she altered her life until she felt she had gained more control.

‘Well I haven’t been going out……I loved going away for trips and all that has stopped……you are waiting to find confidence in having your colostomy bag’ 032F

This attitude was also noted in some male narratives, but they were atypical cases. One man described his feelings towards the prospect of getting a stoma bag. It is important to note that this was not his reaction to having a stoma bag, following his surgery, his bowel was reconnected and he did not need a stoma. It is impossible to know if his reaction to a stoma would have been the same if he actually had a bag.

‘I think what the big drawback is, is that it’s more embarrassment than anything else. If I have to get a colostomy bag, this will be a big embarrassment too.’ 009M

Another man indicated that he too preferred to stay at home and limit his social activities, similar to the female participants.

‘......but it’s a changed way of life because of the colostomy. I’m happier nearest my own bathroom rather than in strange places......Oh it ruins your life really, to be honest.’ 027M

This depiction was not reflective of the majority of male participants with a stoma bag. A number of male accounts portrayed them as being unaffected psychologically by their colostomy. For example,

‘Again if it’s necessary, it’s necessary. Nowadays it doesn’t change your lifestyle that much....’ 012M

By being prepared and making alterations to their life, they were able to maintain their desired social activities. They described how they carried an emergency kit with them on day trips and familiarised themselves with the location of public conveniences. One man, a keen fisherman, altered his diet and organised the timing of his meals so his bag would not fill when he was out fishing.

‘I’m fishing and all......but I’ve got to time it......I would have at 8am a light breakfast......And I know that overnight I’ve been fasting and I know I can nearly guarantee myself up to 1 or 2 o’clock. OK I’m hungry, but I’m not looking for a toilet...’ 048M
One particular male participant took a very active approach to his stoma bag. He became heavily involved at the planning stages before his surgery, ensuring that the stoma would be placed in a low position to minimise the effect it would have on his life.

‘In my case you have to have a positive attitude and in my case it’s almost like a determination not to beat it but to master it......It also has to suit your body and your lifestyle.......I was thinking ok I want this as low as physically possible’ 052M
DISCUSSION

Limitations of the study
The sample may not be representative of the views of all individuals with CRC attending the Cancer Centre. Due to the nature of the study, many potential participants may not have felt comfortable discussing their experience. In addition, the participants were Caucasians and English speaking, therefore the results cannot be generalised to individuals from other cultures.

Although the participants ranged in age from 24 – 78, most of the respondents were in their sixties and tended to occupy traditional gender roles. A study of younger participants with more varied gender roles might produce different findings.

In some cases the spouse was present during the interview, usually the female spouse of the male patient. Furthermore, all interviews (with the exception of one) were conducted by female researchers. The possibility that this may have enhanced the male patients’ needs to enact their masculinity cannot be ignored. As has been highlighted in the literature, research interviews provide a context for the performance of gender, and may not reflect ‘actual’ gender practices (O’Brien et al., 2007).

Discussion of findings
The purpose of this paper was to examine the similarities and differences in how men and women react to a diagnosis of CRC and undergoing bowel surgery. Generally, a difference was detected. The majority of men seemed more fatalistic towards their cancer diagnosis and presented themselves as being unaffected by surgery. This corroborates previous work by Foley et al. (2006). The female participants appeared to be more open to discussing the emotional aspects of their diagnosis and experienced more of an impact from the physical side effects of the disease and its treatment. However it was not as straightforward as the traditional view of masculinity and femininity being a stable set of attributes that distinguish men from women. There was variation within sexes. It has been suggested that men may adopt masculinity dynamically, in accordance with context (Wall and Kristjanson, 2005). This was illustrated in the current study by the man who chose to hide his emotional response to his diagnosis in the presence of his doctor. In addition Emslie et al. (2009) demonstrated a
difference in men and women with CRC, but they also reported diversity among men and women. The divergent findings in this study provide support for this.

This paper has demonstrated that how men portray their masculinity differs from individual to individual. The majority of men portrayed the ‘typical’ male gender traits. However some men in certain environments revealed more traditionally female traits, for example, emotion and/or dependence. Similarly while the majority of female participants presented themselves as aligning with the traditional views of the female gender, a minority in certain situations presented a more masculine appearance. Figure 1 illustrates how in the acute stage of illness, the majority of men and women react in accordance with traditional gender beliefs. However, in certain situations, for example, at the time of diagnosis, in a certain environment, for example, in private, some men can adopt what has been termed ‘feminine traits’ and vice versa.

The participants found that some aspects of their lives were beyond their control, particularly in relation to bowel and stomal activity. They frequently reported physical effects that led to embarrassment and reluctance to socialise. This appears to be a common feeling in the CRC literature (Rozmovits and Ziebland, 2004; Persson and Hellstrom, 2002; Taylor, 2001). Generally, gender beliefs appeared to influence how they chose to resolve the bowel problems: the majority of female participants seemed to reduce their social activities, whereas the men appeared to maintain their activities by planning ahead and taking action, for example, knowing the location of public conveniences. This problem solving coping is demonstrated in the literature, but the gender influence has not previously been highlighted. It has been reported that the main social concern for individuals with CRC is the location of public toilets (Nikoletti et al., 2008) and individuals frequently restrict themselves to places where toilet facilities were familiar (Wilson et al., 2009). It is important to note the variation that existed within the group, with some men choosing to reduce their social activities.

It would appear that the females were more overtly affected by CRC. However there was evidence that some men tried to hide their emotional reactions. Females with CRC have often been shown to be more emotionally affected and distressed than men (Ernstmann et al., 2009; Hagedoorn et al., 2008; Tuinstra et al., 2004; Northouse et al., 2000). In addition Foley and colleagues (2006) concluded that men more often indicated that CRC had minimal impact on
their lives. This study has added to this knowledge by demonstrating how gender beliefs affect the experience of CRC. The female participants were more affected by the physical side effects than men who appeared accepting of their ‘new normal’. Traditionally women are responsible for juggling multiple roles (mother, partner) and it has been proposed that their sense of identity is affected by a cancer diagnosis and therefore they experience more disruption than their male counterparts. The impact may not be as obvious in men as they do not have the same roles to fulfil in the family (Emslie et al., 2007; Northouse et al., 2000). Another argument is that women are more open about talking about their emotions and are more comfortable than men about discussing their emotional distress (Northouse et al., 2000). It is plausible that both men and women are suffering from the same distress, but men are not willing to share that experience for fear of portraying themselves as less of a man. Women may be more aware of their distress and may be more open in their responses than men (Ernstmann et al., 2009). This avoidance (or blunting) from men, should not necessarily be viewed as a suboptimal coping strategy. It has been demonstrated in the literature that bluters cope well (Miller, 1995). A study examining the influence of correspondence between spouses coping styles revealed that males with cancer who were bluters had a better psychological reaction when their wives were also bluters (Barnoy et al., 2006). Men should therefore be ‘allowed’ to cope in the manner that suits them, and do not necessarily need to ‘open up’. In the current study, there was variation noted between the men, and not all men chose to avoid discussing their illness.

**Conclusions**

Nurses should be aware that how men choose to react to a cancer diagnosis will differ from individual to individual and that not all men will align with the traditional view of masculinity. Many men may tend to minimise the impact of their illness and may be reluctant to discuss problems. However, other males may be comfortable discussing their reaction to their diagnosis, while others may only be comfortable expressing those emotions in private. Nurses need to determine how men wish to deal with their diagnosis and not make assumptions based on traditional gender beliefs. Encouraging men to ‘open up’ about their illness may suit some but not all men. A study which tested the feasibility of an internet based survey completed by patients prior to their consultation relating to their information preferences yielded positive results (Buzaglo et al., 2007). This could be considered for individuals with CRC.
Future research should look to identify the characteristics of those men who chose to avoid discussing their diagnosis and downplay the impact of the disease. It may be possible to identify predictor variables quantitatively, although too much individual variation may exist. It would be interesting to determine whether these men blunt all aspects of their cancer experience, or whether as suggested by Lambert et al (2009), they are guarded information seekers, and only choose to avoid certain aspects of the cancer experience. Research should look to examine if the variability detected exists in younger males, and what impact age has on gender roles.
References


Figure 1 Gender and illness

Context (stage of illness, current environment) ——> Men ——> Male traits ——> Female traits ——> Women ——> Context (stage of illness, current environment)

Beliefs
Table 1 Participant demographics

<table>
<thead>
<tr>
<th></th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number of participants</strong></td>
<td>38</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>60 (12.15)</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>24</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>32</td>
</tr>
<tr>
<td>Single</td>
<td>4</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
</tr>
<tr>
<td><strong>Employment status (at time of diagnosis)</strong></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td>18</td>
</tr>
<tr>
<td>Not working</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 2 Treatment received

<table>
<thead>
<tr>
<th></th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number of participants</strong></td>
<td>38</td>
</tr>
<tr>
<td><strong>Anti-cancer treatment received</strong></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>5</td>
</tr>
<tr>
<td>Surgery + stoma</td>
<td>2</td>
</tr>
<tr>
<td>Surgery + chemotherapy</td>
<td>18</td>
</tr>
<tr>
<td>Surgery + stoma + chemotherapy</td>
<td>7</td>
</tr>
<tr>
<td>Pre-op radiotherapy + surgery</td>
<td>1</td>
</tr>
<tr>
<td>Pre-op radiotherapy + surgery + stoma</td>
<td>3</td>
</tr>
<tr>
<td>Pre-op radiotherapy + surgery + stoma + chemotherapy</td>
<td>2</td>
</tr>
</tbody>
</table>