

Published in final edited form as:

Qual Health Res. 2009 June ; 19(6): 744–754. doi:10.1177/1049732309334737.

Disclosing a Cancer Diagnosis to Friends and Family:

A Gendered Analysis of Young Men's and Women's Experiences

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Abstract

Little is known about how young adults disclose their cancer diagnosis to family and friends, and whether there are similarities or differences between men and women. This article compares young adults' experiences of disclosing a cancer diagnosis, drawing on narrative interviews with 37 respondents aged 18 to 34 years. Most respondents were open about their diagnosis, and there were striking similarities in the difficulties that men and women described and in their desire to protect relatives. However, men made up most of the minority of respondents who were more secretive about their diagnosis. Men also made more explicit connections between their gendered identity and disclosure; worries about being perceived differently by peers resulted in some men hiding their diagnosis and others using humor to pre-empt sympathy. These findings are discussed in the context of gender stereotypes of "expressive" women and "stoical" men.

Keywords

cancer; communication; gender; illness and disease; experiences; young adults

The diagnosis of cancer is traumatic at any age. However, being diagnosed as a young adult is likely to be particularly difficult as it challenges widely held assumptions about youth and health. Although there is a large body of literature about physicians' ethical obligations to disclose information to patients, and some work on family communication about hereditary breast/ovarian cancer, we know comparatively little about how young adults with nonhereditary cancers disclose information to their family and friends. Here, we use the term "disclosure" to refer to the extent to which cancer patients openly discuss with others their diagnosis and thoughts and feelings about their disease (Figueiredo, Fries, & Ingram, 2004; Henderson, Davison, Pennebaker, Gatchel, & Baum, 2002). Existing research on young adults and disclosure emphasizes the importance of viewing cancer within the context of social networks. It suggests that most young adults with cancer think they are supported by relatives, but also perceive family members to be in need of reassurance to help them deal

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with the impact of the diagnosis. Young adults find it difficult if relatives pretend that nothing is wrong, are overprotective, or give unwanted advice (Kameny, 2002; Lynam, 1995). Similarly, young adults find it hard when friends cannot or will not discuss their illness, and they value friends who are able to acknowledge their diagnosis and have some degree of comfort in talking about it (Stewart, 2003).

Many commentators argue that disclosure is important, because talking about cancer helps people reorganize their thoughts and feelings and make sense of their experience (Ballard-Reisch & Letner, 2003; Henderson et al., 2002). Quantitative studies have found that failure to disclose feelings and concerns is associated with low emotional well-being in female patients (Figueiredo et al., 2004), and that good family communication and higher levels of perceived family support are associated with lower psychological distress in both male and female patients (Baider, Ever-Hadani, Goldzweig, Wygoda, & Peretz, 2003; Edwards & Clarke, 2004). However, others have questioned the assumption that disclosure is “good” for cancer patients. Kvale (2007) found that patients in an oncology ward often did not want to discuss their feelings about having cancer with the nurses, and preferred instead to talk about “normal life,” their hobbies, and families. Gray, Fitch, Phillips, Labrecque, and Fergus (2000) argue that “there is no reason to suspect that it is psychologically or socially more adaptive to disclose to family, friends and acquaintances than not to disclose” (p. 280). Similarly, Moynihan (2002) asserts that the importance attached to expressiveness among cancer patients has developed because research focuses on women and so is influenced by assumptions about femininity. This assertion links to wider discussions about gender and cancer.

Although cancer researchers have recognized the importance of biological differences between men and women, much less attention has been paid to gender. Keller and Henrich (1999) argue that “breast-cancer . . . has attracted researchers’ interest, becoming paradigmatic for female cancer, whereas there is little knowledge on ‘typical’ male neoplasms . . . and even less knowledge on gender differences in the many malignancies affecting both men and women” (p. 748). Moynihan (2002) sums it up more succinctly: “Women with cancer are pathologized and medicalized. Men are under-researched” (p. 171). Rather than being guided by good research evidence, it is often assumed that men do not choose to cope through emotional disclosure and are “naturally” stoical and so require less support (Emslie et al., 2007).

It is only relatively recently that there has been interest in making connections between the social construction of masculinity and the experience of having cancer (Broom, 2004; Chapple & Ziebland, 2002; Gordon, 1995; Gray, Fitch, Fergus, Mykhalovskiy, & Church, 2002; Gurevich, Bishop, Bower, Malka, & Nyhof-Young, 2004; Mason & Strauss, 2004; Moynihan, 1998; Navon & Amira, 2003; Oliffe, 2006). These studies reject the notion of men as a homogenous group, and of masculinity as an inbuilt and stable part of male identity. Instead, gender is conceptualized as a dynamic set of socially constructed relationships which are actively constructed and reconstructed over the life course, rather than as a fixed and binary category (West & Zimmerman, 1987). In this article, we draw on Connell’s influential conceptual framework which contrasts a culturally authoritative, or hegemonic, pattern of masculinity with less powerful configurations of gender practice such as subordinated masculinities (e.g., homosexual men) and marginalized masculinities (e.g., working-class men, Black men; Connell, 1995, 1996). Hegemony is about the “winning and holding of power” and having the ability to dictate the terms in which events are understood so that they appear “natural” and “normal” (Donaldson, 1993, p. 643). White, middle-class, heterosexual men set the standard for other men, but whatever the variation in status, “being a man means ‘not being like women’” (Kimmel, 1994, p. 126). Thus, hegemonic masculinity emphasizes strength, stoicism, and emotional control, in direct contrast with

common characterizations of femininity which emphasize vulnerability and emotional expression (Courtenay, 2000; McQueen & Henwood, 2002; Warren, 1983).

Given the power of constructions of hegemonic masculinity, it seems likely that some men with cancer will find disclosure problematic because of the importance of constructing and maintaining a masculine identity in opposition to feminine emotional expression. The qualitative evidence that exists on adult men bears this out. For example, Gurevich and colleagues (2004) found that men regulated their discussions about testicular cancer, as they were aware that “as a guy you don’t usually talk about things like that” (p. 1600). Gray and colleagues (2000) found that most men with prostate cancer tried to avoid disclosing their diagnosis to anyone but their spouse, and others have found that disclosure was limited to men’s immediate families (Boehmer & Clark, 2001; Gordon, 1995; Papadopolos & Lees, 2004). Men were uncomfortable with the idea of needing emotional support and, even with spouses, limited their talk to factual discussions (Boehmer & Clark, 2001; Gray et al., 2000). Men chose not to reveal their diagnosis because of worries about being perceived differently (Gray et al., 2000; Gurevich et al., 2004; Mason & Strauss, 2004), a desire to protect others (Gordon, 1995; Gray et al., 2000; Maliski, Rivera, Connor, Lopez, & Litwin, 2008), and worries about being gossiped about or being the subject of jokes (Mason & Strauss, 2004; Papadopolos & Lees, 2004). However, Gray and colleagues (2000) found that a few men (more likely to be younger and employed) informed friends and coworkers, sometimes to preempt negative assumptions.

To summarize, we know very little about how and why young adults decide whether to disclose their cancer diagnoses to others, and whether there are similarities or differences between men and women’s experience of disclosure. Here, we present data from in-depth interviews with young men and women (aged 18 to 34 years at diagnosis) with a range of cancer diagnoses.

Method

In this article we report a secondary analysis of narrative interviews. These were originally collected for the DIPEX project (now renamed healthtalkonline: www.healthtalkonline.org), which has the purpose of providing widespread access to a range of experiences of health and illness (Herxheimer & Ziebland, 2004). The Web site is unique: each of the 50 modules currently on the site is based on interviews collected and analyzed by experienced qualitative researchers using rigorous methods approved by a United Kingdom multicenter research ethics committee. The Web site features short illustrative extracts of people’s experiences, but the full in-depth interviews from which these are taken are available for secondary analysis (see, for example, Hilton, Hunt, Emslie, Salinas, & Ziebland, 2008; Seale, 2006).

The aims and methods of DIPEX are described in detail elsewhere (Herxheimer & Ziebland, 2004; <http://www.healthtalkonline.org/Research>). For each module, interviews are conducted with a maximum variation sample of 40 to 50 people with experience of a particular health issue. A maximum variation sample is a purposefully selected sample of people who represent a wide range of experiences related to what one is studying (Coyne, 1997). In DIPEX modules, variation is sought in terms of stage of illness, length of time since diagnosis, gender, age, geographical location, occupation and, where possible, ethnicity. Participants are invited to take part through a variety of routes including general practitioners, hospital consultants, specialist nurses, support groups, and word of mouth. Experienced qualitative researchers conduct the narrative interviews. First, participants are asked to tell their story of developing the health condition, with little interruption. Subsequently, the researcher uses questions and prompts to ensure particular issues are

explored. All interviews are audio- and/or video-recorded with the patients' written consent, fully transcribed, and copyrighted to DIPEX for use in research, teaching, and broadcasting. The researchers conduct an initial analysis of the data for each module, write thematic topic summaries for the Web site, produce summary tables of the key features of interviews, and develop articles.

This article is based on a secondary analysis of the full transcripts from a subset of people who were interviewed for six cancer modules. Each respondent was interviewed once between 2000 and 2005. Our aim was to explore how young men and women discussed the experience of disclosing their cancer diagnosis to families, friends, and wider social networks. We analyzed data from all 37 participants (16 men, 21 women) who were aged between 18 and 34 years at diagnosis. Fifteen respondents were aged under 25 years, and the remaining 22 were aged between 26 and 34 years. Most men ($n = 12$) were recruited for the testicular cancer module, and most women were recruited for the cervical, breast, colorectal, or ovarian cancer modules ($n = 8, 4, 3,$ and 2 women, respectively). The remaining respondents were interviewed for the "young people's experiences of having cancer" module, and had been diagnosed with Ewing's Sarcoma, Burkitt's lymphoma, Leukemia ($n = 2$), non-Hodgkin's lymphoma ($n = 3$), or Ganglio neuro-blastoma. Respondents were almost exclusively White British and most ($n = 30$) were in nonmanual jobs or were students. The mean time between diagnosis and interview was 2.4 years (ranging from 0 to 5 years). All 37 respondents had completed active treatment and were in various stages of follow up.

The secondary analysis of qualitative data raises important epistemological issues. First, there has been some debate about whether qualitative data originally collected for one purpose can be used to answer a different question (Heaton, 2004). For example, Mauthner, Parry, and Backett-Milburn (1998) found when they returned to reanalyze their own data after some years had passed that "the data could not supply the answers to questions that had never been raised" (p. 742). However, there was a good "fit" between the research question posed by our secondary analysis and the data. All 37 participants spoke about cancer disclosure to varying degrees and have contributed to this analysis. Most ($n = 34$) were asked questions that prompted reflections on disclosure (e.g., Who did you tell about your diagnosis? How did family and friends react? Was there anyone you couldn't talk to? What support did you receive from family and friends? What impact did the diagnosis have on family and friends?), and the remaining three respondents spontaneously discussed the topic in some detail, making follow-up questions unnecessary. However, it is important to acknowledge that disclosure was unlikely to be discussed in as much depth as it might have been in a primary study that centered on this topic.

Second, there is debate about the extent to which a researcher who has not collected qualitative data can adequately understand its context and meaning. This follows from an epistemological position in which the researcher is regarded as a research instrument who is "part and parcel of the setting, context and culture he or she is trying to understand and represent" (Altheide & Johnson, 1994, p. 486), and findings as "created through the interaction of particular . . . researchers with particular respondents in particular locations and at particular historical junctures" (Mauthner et al., 1998, p. 735). Heaton (2004) argues that this is also an issue for teams of researchers who have to make sense of data collected by other team members and for researchers who have reanalyzed their data after some time has elapsed. Conversely, "distance," rather than very close involvement with qualitative data, can be helpful (Heaton, 2004; Mauthner et al., 1998). In our analysis, we were able to bridge the gap between primary and secondary analysis through discussion of the context of the study and the data collection process because the fourth and fifth authors (AC and SZ) were involved with primary data collection.

All transcripts were read repeatedly and the raw data were recoded thematically by the first author (SH) after extensive discussion of emerging themes in accordance with our focus on gender. All extracts of data relevant to disclosure were reviewed independently by three researchers (the first three authors, SH, CE, and KH) and discussed during team meetings. We used NVivo 2.0 (QSR International, 2002) to facilitate the analysis of themes and systematic comparisons across transcripts. Following the principle of the constant comparative method (Lincoln & Guba, 1985), each transcript was repeatedly compared across and within male and female groups to identify common themes of participants' experiences of disclosure. Particular attention was paid to deviant or contradictory cases. All authors were involved in reading original material, discussing emerging themes, and refining the analysis.

Findings

Telling Loved Ones About the Cancer Diagnosis

Both men and women described telling family and friends about their diagnosis as one of the hardest aspects of having cancer. They spoke of their sorrow when witnessing the pain of loved ones, and their guilt for causing this upset. Respondents delayed telling relatives who lived far away and those they perceived to be vulnerable, such as young children, older family members, and people whose relatives had recently died from cancer. For example, one woman discussed how she carefully organized the circumstances in which her elderly parents would hear about her diagnosis, and a man described how he “managed” information about his testicular cancer to his widowed mother, choosing at first only to tell her that he needed an operation.

A number of studies (Boehmer & Clark, 2001; Gordon, 1995; Gray et al., 2000; Moynihan, 1987) have reported that men with cancer think they need to conceal any distress to protect loved ones. Our study confirmed this finding. For example, one man—in response to a question about family support—stated that he was a “loner” who tended to “bottle things up,” and another discussed how he tried to be the “brave son” and present a stoical facade to his parents. Perhaps more unexpectedly, women also discussed concealing their emotions from relatives to protect them (see also Exley, 1999). Indeed, this theme was as strong in women's narratives as it was in men's. Women described trying to “protect” or “distance” their families from their diagnosis, and several talked explicitly about their efforts to remain upbeat:

I was always very jolly and very strong for everybody else because I didn't want anybody else to worry. . . . I probably kept a lot of it inside even though they were offering support.

I was lying in my bed all piped up . . . and I remember actually sitting laughing with my husband, my mum and my dad. . . . It was much easier for friends and family if I was chatty, yappy, myself . . . and it was much easier for me knowing that I wasn't actually making it difficult for people to approach me.

Most respondents wished to protect their relatives from the impact of their diagnosis, but this process was particularly complicated for the younger respondents, aged under 25 years at diagnosis, the majority of whom lived with their parents or were students who relied on their parents' support. About half of this group learned of their diagnosis while accompanied by their parents, underlining their more dependent status. At a time when their peers were negotiating increased independence, these young adults were particularly conscious of their dependence on their parents; for example, 2 of the younger women commented that, “You're their little girl again” and “I'm her [mum's] baby . . . she's very protective,” and one young man said, “I just wanted to be a kid again . . . just for it all to be alright.”

Gendered Identity and Disclosure of a Cancer Diagnosis

Respondents faced some constraints when considering who to tell about their diagnosis. As discussed above, about half of the younger respondents learned of their cancer diagnosis while accompanied by their parents. In addition, many respondents were aware that people would glean some information about their status because of their changed appearance, particularly their loss of hair. (A separate article, which used the same sample of young adults, focuses on this topic; see Hilton et al., 2008).

There was a broad range of attitudes toward disclosure, from respondents who described themselves as happy to tell anyone, to those who wished to conceal their diagnosis from everyone for as long as possible. Most respondents were relatively open about their diagnosis, but there was diversity among men and among women. Men made up the majority of those who wished to conceal their diagnosis, and were much more likely than women to place these discussions about disclosure in the context of their (gendered) identity. We first describe the majority of respondents who were relatively open about their diagnosis, and then examine the minority who were more secretive.

Respondents who were relatively open about their cancer diagnosis—Most people reported that they told family, close friends, and close work colleagues about their diagnosis, but did not necessarily want it to become common knowledge. The following comments were typical:

I'm not shy about saying it was breast cancer . . . There's nobody that I feel I couldn't [talk] about it to, but . . . I wouldn't choose to talk about it to everyone.

It's not something you want everyone to know about but I told my immediate boss [that I had testicular cancer]. I told a number of my close friends at the office . . . I was fairly up front with people if they asked me about it but I didn't really broadcast it in general.

Others were even more candid about their diagnosis, and linked this frankness with their identity as “honest” and “open” people. These respondents stated that they would tell everyone about their diagnosis to keep them informed and to prevent “whispers” from circulating:

I'm not one to hide things, I'll tell everyone about it [testicular cancer] really, just so they know what's going on.

I told everybody straight away as soon as I knew . . . I didn't want it [cervical cancer] to be a secret . . . I didn't want people not to know and have . . . whispers. I just wanted it all out in the open, it was easier to deal with.

Everyday events could also precipitate decisions about disclosure. One man who had been diagnosed with testicular cancer explained how, because of nerve damage during an operation, he was unable to have children “naturally,” and so had to decide how to answer casual enquiries about parenthood:

[People ask,] “Have you got any kids or are you going to have any kids?” and I say, “Well yes we'd like but this has happened and so it might not be as soon as we'd like.” So I'm quite open who I tell, I mean I'm not ashamed of it.

Similarly, one woman described how her scar provoked questions:

I've always been very honest . . . with people about my illness . . . I do have a big scar . . . even if I'm taking my jumper off, some people go, “Oh, [laughs] what's that?” [laughs], so I've always been quite open about it.

All of the men who were relatively open about their diagnosis had testicular cancer, whereas the women had a variety of cancer diagnoses. Some of the language used by respondents (e.g., “not hide,” “not ashamed,” “whispers”) suggests that their diagnoses could be perceived as something to be ashamed of, or something one might be fearful of disclosing. This was particularly true of the men in this group. The language that the women used suggested that their openness could be a strategy to help them, and sometimes others, cope with their diagnosis. For example, one woman used imagery to suggest that talking to others helped her share the burden, and another woman described how talking made it easier both for other people and for herself:

I really needed to talk about it [I] wasn't carrying it . . . all on my own shoulders it was . . . spreading it out a little bit . . . I found it easier that way.

When I first found out I had cancer, I talked about it all the time, wanting to make it easier for other people I knew if I didn't, they wouldn't come up and see me and they wouldn't know what to talk about . . . so I made the initial move by just constantly talking about it which helped them and probably helped me as well.

It was much more common for men than women to explicitly link the experience of disclosing cancer with their gendered identity. For example, one man implied that he had become a “better” man through the experience, as he was more able to “open up” to people:

I didn't mind people knowing the illness that I had I think from a male point of view it almost makes you a better person because I think men in many respects don't tend to talk to other people openly, other men . . . just talk about the weather or the sport . . . whereas after an illness . . . relationships with your close family and friends become more important in your life. You're less afraid to open up and talk about things.

Other men in this relatively open group also referred to stereotypical notions of women being better than men at talking about their health. One man talked about this at length. On the one hand, he aligned himself with men who would rather talk about cars, bikes, or football than health (“We're just not interested,” “We like to talk about cars”). On the other hand, he made it clear that he was “totally open” about his diagnosis with colleagues:

It's just men talk about other things [than health], we're just not interested [laughs] Women like to talk about things. Men tend to . . . we like to talk about cars or bikes or . . . football, well okay I'm the exception on that I can't stand football but we've got other things to talk about . . . it [health] certainly isn't a particularly macho thing to talk about . . . it isn't a particularly interesting topic of conversation The guys at work know what's happened I found that being totally open about it and just turning the entire episode into one grand joke . . . someone will make a remark which might have a sort of a double entendre . . . and rather than get uptight about it I just crack up [laughs] But having that kind of attitude in there and not being worried about it and not being obsessive about it or having any issues about it, just talking about it openly . . . is by far and away the best way for me . . . of handling it I enjoy a good joke as much as anybody else so hey if I'm the butt of it well what the hell [laughs]!

Robertson (2007) argues that men often have to work hard to manage what he calls the “don't care/should care” dichotomy (“real” men don't care about health, but good citizens should care about their health). The narrative above suggests that this respondent managed to reconcile these seemingly contradictory positions—“real” men don't talk about health vs. personally being open about his diagnosis—through “turning the entire (cancer) episode into one grand joke.” This strategy is consistent with practices around hegemonic masculinity. Indeed, it has been argued that humor plays an important role in “consolidating male peer

group cultures” (Kehily & Nayak, 1997, p. 69), and that men express intimacy covertly through various means such as humor and joking (Olliffe & Thorne, 2007). Chapple and Ziebland (2004), using data from the complete DIPEX testicular cancer module of 45 men (including the 12 young men with testicular cancer in our sample), found that respondents used humor to challenge assumptions about the disease and perceived that jokes made by others helped to dispel tension and reassured them that they were being treated normally. Here we build on their analysis by linking men’s use of humor with their openness about cancer and their gender identity. One man diagnosed with testicular cancer explicitly stated,

I said to my mates, “If you want to sing Hitler songs, if you want to call me Bollockoff it’s entirely up to you, it doesn’t bother me at all.” Because you’ve got to have a sense of humor to get through it . . . it’s built into men that we need to have a laugh about these sort of things.

He then went on to argue that he would much rather be the subject of jokes in the office than be offered sympathy. Men worried that they would be treated with pity by other men, and perceived as a “poor case” or a “charity case.” Taking part in office banter was equated with being treated normally or as “one of the guys,” which was seen as preferable to being treated differently:

Every time I see them [colleagues] they make jokes about it, they laugh about it and that’s how I want them to be . . . I don’t want . . . “Oh, we feel sorry for him” . . . like a charity case. I don’t want to be like that at all, I want them just to treat me normally.

Everyone’s attitude soon changed when I did find out it was cancer. A lot of people that I spoke to looked back and said, “Oh all those jokes, they don’t seem very funny at all now do they?” and I said, “Oh I don’t want you to think that I’m some poor case where you can’t [have] a laugh with me any more.”

Other young men who were open about their diagnosis also suggested that jokes were a way for colleagues to talk about their illness in a nondirect (gender-appropriate) way, and to relieve tension in a potentially embarrassing situation (see also Exley & Letherby, 2001). Thus, even inappropriate jokes and banter from male colleagues could be reframed as a way of caring and showing solidarity:

On returning to work one of my colleagues made . . . a rather insensitive and off-hand comment, but I think that was just a way of . . . trying to bring the fact that I had been off sick with this disease into the open . . . I think he was trying to say that . . . “We don’t need to avoid this issue We all understand.”

I think people generally find it difficult to approach anyone with a disease Jokes are one way to deal with that and to actually raise the topic with someone and to actually show someone that . . . they appreciate what you’re going through.

Respondents who were relatively secretive about their diagnosis—A minority of respondents were relatively secretive about their diagnosis. Most participants in this group were under 25 years of age and most were men. These respondents were very reluctant to reveal their diagnosis to anyone. A recurring theme in this group was the concern to protect loved ones from the knowledge of their diagnosis. A number of men in this group used the term “burden” to describe the knowledge of their diagnosis, and one woman drew on similar imagery (“I didn’t want to sort of put my concerns on their shoulders”).

The only 2 older respondents (aged 25+ years) in this group tried to keep the diagnosis (or details of the seriousness of their diagnosis) from their family, whereas almost all the

younger respondents were concerned about the reaction of friends and colleagues. This latter group viewed having cancer as a direct challenge to their identity as a young person. They feared they might be treated differently, excluded by peers, or stigmatized. For example, one younger woman made it very clear she wanted to continue to be perceived on her own terms rather than having her identity reduced to her cancer status. She also reflected on how her reluctance to divulge her diagnosis to colleagues and friends was not in keeping with her perception of herself as “honest” and “open”:

I didn't tell anyone at work . . . it's all kept very within our family. I . . . didn't want to go back to work and them to look at me in a different way . . . I wanted them to look at me as the girl with pink hair and not the girl that's had cancer at 23 . . . I had this vision that they [friends] would kind of treat me as a cancer patient from now and forever and I couldn't bear that, I just couldn't bear that . . . It's funny how, normally I'm the most honest, open person but I guess when it's your health, it's very personal.

The younger men also expressed fears that they might be excluded or treated differently by peers. Some described how they felt they had to lie to their peers, and others expressed their loathing of divulging their diagnosis:

I absolutely abhorred trying to explain [to friends] . . . because I didn't want any kind of sympathy . . . I just wanted everything to carry on as normal . . . I didn't want to feel excluded . . . just didn't really want anybody to . . . give me any kind of special behavior or attitudes towards, towards me . . . I just wanted them to treat me as they would have normally done.

The only 2 women in this more secretive group had cervical cancer and both referred to the stigma associated with this diagnosis. One woman (who had not disclosed her diagnosis to her immediate family) said that when her husband told other members of her family about her diagnosis, they had found the association between sexual activity and cervical cancer difficult. Similarly, the other woman (who told only her immediate family and boyfriend about her diagnosis) said,

I think my family found that hard because there's almost an insinuation that . . . I must have either started having sexual relations very early or I must have had lots of partners, neither of which were the case . . . That was quite hard, I must admit, most of all because I think my immediate family found it embarrassing . . . if they . . . tell people that I've had cervical cancer, then they might think that that's what their daughter was like.

The most extreme example of this more secretive approach was a young man who was concerned about the effect the news would have on his mother, who suffered from depression and whose husband was overseas. He managed to keep his diagnosis of leukemia a secret from his family, even after being in hospital for 2 weeks, by saying he was staying with a cousin. His family only found out from a friend's mother. He referred explicitly to his gendered identity as a stoical man when explaining his reasons for hiding his diagnosis:

I didn't tell them [family] nothing. I thought to myself if they find out they are going to get more depressed. She's [mother] going to get more stressed out so I didn't say nothing. I usually bottle my feelings . . . I don't tell my best mates anything like that . . . It would have been better if I spoke to someone and told them everything that was going on . . . but I just kept it to myself . . . When I used to see them [friends] I used to have . . . a smile on my face . . . I was cheery . . . I didn't discuss anything with them. I just felt it's a guy thing [laugh]. Guys don't really talk that much about their feelings and that.

The narratives of 2 other men also suggest that their options for discussing cancer were constrained by expectations surrounding age and gender. One described the difficulty of talking to his male friends about cancer:

I never really spoke about it to my parents although they were there for me all the time . . . [so] the only person that I had to talk to was . . . male friends The way that men talk about problems is, “Oh we’ve got a bit of a problem here with my girlfriend,” and a bloke’s solution is, “Oh yeah, yeah well shall we go for a beer then?” . . . Well it’s a bit different when you’re laid up in hospital bed with no hair and you know you don’t want to drink and you can’t drink really anyway. I’m probably not the best talker about emotional things anyway but one thing that would’ve been useful would have been somebody to be able to talk to at the time.

The other man said,

Perhaps I could have asked for a bit more support from the people around me I mean they were . . . there offering it and willing to give it but I was just kind of very blasé and I guess, quite, quite laddish [masculine].

Finally, one man’s fears about people learning of his cancer diagnosis were exacerbated by the fact that he was born with only one testicle. His secrecy about his diagnosis brought other problems, which threatened his identity as a heterosexual man:

I’ve had to lie to all of these people because I don’t want them knowing At the start what I feared most was blokes . . . knowing that I’d had my testicles removed . . . I just wanted to say [to friends], “Look I’ve had a big operation, I’m not out on the pull, I’m not looking for a woman right now.” But because I didn’t want them to know that, I think I got a little bit homophobic.

Discussion

Our findings suggest that there are many similarities in young men’s and women’s experiences of disclosing a cancer diagnosis. Most men and women were relatively open about their illness and had told family, friends, and close colleagues. Both men and women said that telling loved ones about their diagnosis was one of the most difficult aspects of having cancer. They also delayed telling those they perceived to be vulnerable and concealed their emotions from relatives to protect them.

However, there were also gender differences in these accounts. Men made connections between disclosure and their gendered identity in a way that women did not, and men made up most of the minority of respondents who were more secretive about their diagnosis. Men who were relatively secretive about their diagnosis linked this reticence to their identity as stoical men whose options for discussing cancer—or, indeed, health in general—were constrained by gender expectations. Men who were relatively open about their diagnosis often explicitly linked disclosing or discussing cancer with their identity as a man who could “take a joke.” They interpreted the use of humor—even when they were the butt of jokes—to mean that they were still part of male friendship groups, and perceived the alternative as being viewed as a “sad case” who was not “one of the boys.” Humor is one of the ways in which men are positioned within dominant and subordinate groups, so it is perhaps not surprising that many men preferred to be the target of jokes, and have the chance to answer back, rather than be excluded from banter entirely, given the consequences for the construction and consolidation of their gendered identities (Kehily & Nayak, 1997).

Our findings suggest that men who were more secretive and those who were open about their diagnosis shared concerns about being excluded from friendship groups and treated differently by peers. O’Brien, Hart, and Hunt (2007) describe this fear of no longer being

part of the group as “standing out from the herd.” What is interesting in our study is how dominant cultural constructions of masculinity generated different practices; some men responded to this concern by concealing their diagnosis, whereas others tried to pre-empt sympathy by joking about their illness with other men. As Connell and Messerschmidt (2005) argue, it is men’s “practical relationships to . . . models of masculinity, rather than simple reflections of them, that is central to understanding gendered consequences in . . . health . . . (T)here is nothing surprising about the idea of diverse practices being generated from common cultural templates” (p. 841).

In contrast to our study, much of the literature suggests that men avoid disclosing their cancer diagnosis whenever possible. Our findings might differ partly because we deliberately focused on young adults (aged 18 to 34 years), whereas others have sampled men in their 50s and 60s (Boehmer & Clark, 2001; Gray et al., 2002; Gray et al., 2000; Maliski et al., 2008; Papadopolos & Lees, 2004). This emphasizes the importance of more work that explores constructions of masculinity across the lifecourse.

Rather than concluding that all men find disclosure difficult, our findings suggest that some young men can incorporate talking about cancer into their practices of masculinity. However, this process seems to involve discursive work for men that was not evident in women’s narratives, perhaps because it is “common knowledge” that women “can” talk about their health. Those men who were more open about their diagnosis proceeded to demonstrate how they reconciled this “common knowledge” about men and women with their willingness to talk about their own illness, usually through the use of humor. Thus, men used discursive practices to position themselves as being able to talk about cancer in a gender-appropriate way (Robertson, 2007).

Our findings add to the sparse literature on young adults and cancer, and suggest that respondents under 25 years of age in the study experienced particular difficulties. At a time when peers were negotiating life events such as leaving home and establishing careers, they had to accept increasing dependence on their parents (Brown, Pikler, Lavish, Keune, & Hutto, 2008; Lynam, 1995). These younger respondents made up most of the group who were relatively secretive about their diagnosis. They were particularly concerned about protecting loved ones from the “burden” of knowledge of their diagnosis and were worried about the reaction of friends. Thus, these young adults and their families might require extra support from health professionals.

One limitation of our study is that the sample consisted of people who allowed their accounts to be recorded for use on the DIPEX (now healthtalkonline) Web site; it is possible that they found it relatively easy to talk about cancer, and were more open about their cancer diagnosis than others. However, respondents were given the option to conceal their identity on the Web site. In addition, a minority described how they had been relatively secretive about their diagnosis. Second, it could be argued that the men in our sample were particularly unusual; we acknowledge that we are likely to have missed the truly “silent and uncomplaining” men (O’Brien et al., 2007), but it is difficult to see how we could have accessed and interviewed these respondents. Third, it might be difficult to compare “like with like” when examining the experiences of men and women with sex-specific cancers (e.g., comparing testicular and cervical cancer) because different types of cancer have different prognoses and levels of stigma that might influence disclosure. Finally, it is possible that a more socially and ethnically varied sample might have discussed different experiences of disclosing a cancer diagnosis.

Thirty years ago, Sontag argued that the metaphors associated with cancer were themselves harmful: “Many people believe that cancer is a disease of insufficient passion, afflicting

those who are sexually repressed, inhibited, unspontaneous [and] incapable of expressing anger” (Sontag, 1991, p. 22). More recently, Moynihan (2002) suggested that some of these stereotypes linger, as cancer patients are still encouraged to work toward “expressiveness” and “emotionality.” She argued that this places men in a double-bind: those who exhibit stereotypically masculine patterns of response to grief are pathologized as inexpressive, whereas those who try to “grieve well” are regarded with some suspicion, given the assumption that men do not show their emotions. Our findings suggest that there is diversity among men and among women in the way that they respond to and chose to communicate about a cancer diagnosis. Health professionals should be aware of this diversity and be wary of stereotypes about “expressive” women and “stoical” men.

Acknowledgments

Authors’ Note: We warmly thank the men and women who took part in the interviews and the DIPEX research team, particularly Julie Evans, Suman Prinjha, Linda Rozmovits, Maria Salinas, and Francie Smee. Shona Hilton, Kate Hunt, and Carol Emslie are funded by the UK Medical Research Council (WBS U.1300.00.004). Sue Ziebland is funded by the University of Oxford and a Cancer Research UK personal award. The research for these DIPEX cancer modules was funded by Cancer Research UK, the Citrina Foundation, NHS Direct Online, Department of Health, Macmillan Cancer Relief, Wooden Spoon, the NHS Cervical Screening Programme, and the DIPEX charity. We also thank Sally Macintyre and four anonymous referees for very helpful and constructive comments.

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