



An exploration of Francophone and Francophile men's representation of prostate cancer: An ethnographic study

Research Paper

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ABSTRACT

Background. Worldwide, men's health and wellness promotion employ various models and conceptions of masculinity. Masculinities are subjectively experienced and influenced by social differences such as race, class, and sexual orientation. Largely because it threatens men's gender identity and sexuality, prostate cancer is a prominent and sensitive health issue. How men think, speak about, and represent prostate cancer is affected by their cultural, social, moral, and religious values and beliefs. **Methods.** Based on data from a larger ethnographic study, this article reports on Francophone and Francophile immigrant men's experiences and representations of prostate cancer. Data were collected from interviews with 19 men in the cities of Gonesse and Paris, France, using a tool inspired by (core) social representation theory, and submitted to content analysis. **Results.** Similar views between the two groups of men suggest that the representation of prostate cancer prevalent in French society held more sway over the men's attitudes and thoughts than any alternative cultural views from the immigrants' particular ethnic backgrounds. **Conclusions.** The confirmed view of prostate cancer as a disease with neither a positive nor a negative meaning offered opportunities for the men to re-evaluate their lives and plan their future with realistic expectations.

KEYWORDS

Culture; Ethnicity; Ethnography; France; Prostate Cancer

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BACKGROUND

Worldwide, men's health and wellness promotion employ various models (White, 2006) and conceptions of masculinity (Gough, 2013). The way each man lives his own masculinity implies a

multiplicity of masculinities as subjectively experienced (Connell & Messerschmidt, 2005) and influenced by social differences such as race, class, and sexual orientation. Largely because it threatens



men's gender identity and sexuality, prostate cancer (PC) is a prominent and sensitive health issue. How men think, speak about, and represent PC is affected by their cultural, social, moral, and religious values and beliefs (Broom, 2004; Zanchetta et al., 2007a).

Immigrant men's increasing international mobility makes ethno-cultural differences an important factor in dealing with PC issues once the men are in a host society. Like other European countries (Jemal et al., 2014), France's rate of PC is high. In 2011 there were 53,913 new cases, 8,893 estimated deaths, and a total prevalence of 508,699 cases (Institut national du cancer, 2016; 2015). A France-wide survey (Inserm & INCA, 2014) revealed that a considerable proportion of 1,449 men aged 50 or more, who were at least two years post-treatment for PC, reported signs of difficulties: 52.3 percent had reduced sexual relations and 45.3 percent had lowered libido (undisclosed to their healthcare professionals); 26.3 percent reported other post-treatment issues. Only 13.7 percent contacted a patient association over relational or social issues and 3.1 percent consulted a social worker (Inserm & INCA, 2014). Despite the high incidence of PC, there has been little investigation of men's ideas, thoughts, and representations of it within a French multicultural context.

For this study, we explored representations of PC with two samples of men living in France: Francophones and Francophiles. We defined men whose first language was French, whether they were born in France or were immigrants, as Francophone while immigrant men with a different first language were Francophile, that is, non-native speakers of French (Organisation Internationale de la Francophonie [OIF], 2014). Most Francophone immigrants to France come from African Saharan countries and most Francophile immigrants come from other European countries (Portugal, Spain, Italy, United Kingdom, Germany, and Poland) or Asian countries (Vietnam and China) (Institut national de la statistique et des études économiques, 2010).

Native French speakers are distributed worldwide: 53 percent in the African continent, 37 percent in Europe (25 percent of these in a non-Francophone country), 8 percent in North America, and 2 percent in Asia (OIF, 2014). Countries that attract Francophone migrants are interested in international migration and long-term settlement. As a result of

this diversity within French-rooted culture, many host countries may face social and cultural integration challenges with Francophone migrants, including in health services.

We were interested in how cultural views of health and masculinity affect male immigrants' perceptions of PC. Do men from a different ethno-cultural background and with a different first language acquire and share different ideas about PC than survivors who are born in France or native French speakers? Given men's reticence to speak about cancer, particularly PC with its links to sexual impotence and masculinity, we considered it important to encourage men to talk about their experience and express their views.

Vos (2015) argues that healthcare professionals should understand how their cancer patients experience their illness, and that this requires decoding the embedded meaning in all words patients use to reveal their understanding, ideas, feelings, fears, and hopes when living with cancer. In patients' discourse, each word has a hidden meaning that embodies a notion of health-related representations and feelings might be expressed in several different forms (Le Moigne, 2010). In the roller-coaster of emotions that arise from the cancer diagnosis to rehabilitation, patients are expected to become active partners in their care (Henselmans de Haes, & Smets, 2013) and undertake demanding self-management of treatment-related issues (Appleton et al., 2015). This requires good communication so that patients feel comfortable disclosing issues, concerns, and needs (Frenkel et al., 2016). Such disclosures can also help researchers to develop greater understanding of the connections between men's practices and illness representations, and advance gender studies (Welzer-Lang, 2011). Especially for immigrants, open communication also contributes to cultural immersion and the fruitful exchange of ideas (Noels, Kil, & Fang, 2014).

Most recent systematic reviews of qualitative studies (Spendelov et al., 2018) that explore the multiple impacts of PC revealed that it threatens masculine identity independent of men's age, but especially when their virility and an active sexual life are salient (Chambers et al., 2014). Dealing with these vulnerabilities requires men to adapt and restore or



re-create their male identity, develop their mental resilience, and normalize sexual impotence.

To promote men's health in cases of PC, it is imperative to understand that an individual's sense of masculinity is an expression of gender (Robertson, 2007) shaped by his cultural affiliation. This includes the language he uses in daily social interactions, to receive social support, and to develop his level of health literacy and his ability to use health services. Gender influences one's choices and implementation of cultural practices at all stages of life (Buscatto, 2014).

Improved understanding of how PC affects a patient's sense of masculinity within a cultural context will assist healthcare professionals to provide gender- and culturally sensitive treatment and care that promote the health and wellness of all men. Although this study was set in France, the issues are relevant to other countries that host French-speaking men.

This paper is based on analysis of a subset of data from a large ethnographic study. Previous findings have been published on aspects of lived representations of PC and quality of life among patients/survivors as bloggers (Zanchetta et al., 2016), and on clinical representations of PC in the French media (Zanchetta et al., 2018). This paper extends the analysis to focus on the experiences and representations of PC by Francophone and Francophile men living in the cities of Gonesse and Paris, France—two groups that vary in their socioeconomic and cultural profiles. The study design and data analysis involved a cross-cultural validation of a French-language version of a psychological, qualitative projective tool (Zanchetta et al., 2005; Zanchetta et al., 2007a), but an in-depth discussion of the validation process is beyond the scope of this paper.

THEORETICAL FRAMEWORK

Social representation theory, and particularly the core (versus peripheral) elements, (Flament, 1994; Abric, 2001) provided a theoretical framework for this study. A social representation is a way of knowing and a form of social thinking, both of which include common sense. It is related to communication, understanding lived experiences, and mastering one's

cultural, social, ideological, and material environment (Jodelet, 1999). According to Abric (2001), the core of a social representation is stable regardless of new experiences or knowledge, but it can generate or change the meaning and the value of a given social representation. The core of a representation organizes the links between elements of a social representation, which may be modified by one's interpretation of new experiences and learning within the social world. The elements that make up a social representation also depend on the interface between the core concepts and the reality the social representation originates from (Abric, 2001).

We were interested in PC's symbolic value, associations, and how the two groups of men refuted ideas about it through their situated knowledge. We aimed to elicit men's practices and thoughts about PC that were consonant with their idea of its core element of the representation within their cultural group. Such practices and thoughts revealed how they perceived the cancer's impact on their quality of life (Le Moigne, 2010), thus grounding a transcultural representation of PC. A representation that crosses boundaries of ethno-cultural groups while preserving its core element.

Specifically, we aimed to (a) explore a transcultural representation of PC among Francophone and Francophile men; (b) identify the men's thoughts and feelings about the disease experience; (c) analyze any similarities between the groups, and (d) delineate a transcultural representation of PC within a French cultural context. Two research questions guided this study: (a) Which ideas regarding PC are similar among men from different ethno-cultural backgrounds, and emerge at various points or phases of their illness, namely, learning of the medical diagnosis, telling their family about it, facing moments of frustration, and reassessing life priorities? and (b) To what extent do similarities exist between these groups of ideas regarding PC that would suggest a core transcultural representation of PC within a French cultural context?

METHODS

We applied an ethnographic approach to describe and interpret the patterns of values, behaviours, beliefs, and language of a cultural group (Creswell & Creswell, 2018). The study population was men older than 40 years who were enrolled as patients in the



Department of Urology at two study sites (Hôpital Saint Louis-Paris and Centre Hospitalier Emmanuel Rain- Gonesse) and underwent medical treatment for PC and were in distinct phases of their treatment: initial, ongoing, and clinical post-treatment follow-up.

Sampling and Recruitment Strategies

Using multiple cases for contrast-saturation and nonprobability, we used purposeful sampling to identify participants and to solicit in-depth, rich data through face-to-face interviews (Grove Burns, & Gray, 2013). In terms of quota sampling (Wood & Ross-Kerr, 2011) we achieved the expected minimal quota of 10 participants in the Francophone group (final sample, n=15). It is achieved because Pires (1997) recommends having a minimum of three selected participants whose responses are contrasted for each main variable. The sole main variable in this study was the men's linguistic status, which was assumed to be a key factor in their access to information and services, thus shaping their experiences, ideas, and knowledge of PC. Therefore, the necessary minimal was 6 (Francophone and Francophile) participants. The group of four Francophile participants was smaller, but still sufficient for comparative analysis, in conformity with the criteria for internal comparison among participants' prospective empirical traits (Pires, 1997).

Using the medical archives of both hospitals, the first author pre-selected prospective participants with the assistance of medical and administrative staff, identifying them mainly by their backgrounds as French-born or immigrant, with a residence located near the Paris metropolitan area, and by linguistic group (i.e., native, and non-native speakers of French). We mailed study invitation letters to 154 prospective participants (May to June 2013). The participation rate was 9 percent. The first author collected data during July and August 2013.

The inclusion criteria were men who: (a) had received a diagnosis of localized PC; (b) had effective oral communication in French; and (c) were born in France or had immigrated to France more than three years prior. The exclusion criteria were: (a) men who had received a diagnosis of metastatic PC; (b) reports of hearing, vocal, or visual impairment (c) reports of pain and use of pain medication; and (d) reports of drug treatment for psychosis, depression, or any

other major mental conditions. Since we could not access medical documentation, we did not verify clinical variables and instead relied on participants' self-reports. This led to the inclusion of one participant with a metastatic condition. No criteria were used by the first and the second authors to invite volunteers to the verification-of-findings session.

Instrumentation

We used a questionnaire that was inspired by the core of social representation theory and created for a previous study (Zanchetta et al., 2007a). This questionnaire applies techniques of word association, sentence completion, and the Thematic Apperception Test (picture interpretation) (Lilienfeld Wood, & Garb, 2000). Details about the original questionnaire in English are published elsewhere (Zanchetta et al., 2007a). The questionnaire ends with a diagram of a tree, selected to evoke ideas of rigidity, strength, and endurance as suggested by the scientific literature on masculinity (Courtenay, 2003; Arber, 2004), and to elicit from respondents a synthesis image of PC. Such image materializes the most expressive ideas that compose the constructed PC representation. Respondents were asked to use the metaphor of a tree as an organizing image of the elements of PC, as follows:

- * *The roots—associated with PC, the hidden part of the tree.*
- * *The trunk—associated with the meaning of the diagnosis.*
- * *The branches—associated with the major events of the clinical trajectory.*
- * *The leaves—associated with identification of synthesis/ideas.*

The original questionnaire was translated from English to French and revised by a French-born male editor (who lives in Toronto, Canada, but is originally from Paris) to ensure that colloquial words commonly used in Paris and Gonesse were incorporated. The letter of introduction for prospective participants and the consent forms were revised by the same editor for plain language to accommodate individuals with limited written French language skills. These



documents were also reviewed for language appropriateness by psychologists in Paris who are affiliated with a helpline sponsored by the League française contre le cancer and are familiar with how patients typically speak of PC. For examples of questions, see [Table 1](#).

Field Entry and Data Collection

The fieldwork included eight visits to four patients during their pre- or post-prostatectomy hospital stay. Two of the men had clinical-related complications. Men were asked to share their thoughts at various stages of treatment. We interviewed 17 non-hospitalized men who had undergone medical treatment, and two hospitalized men who completed a portion of the questionnaire. In these brief meetings and interviews, we gathered information to identify significant experiences regarding changes in the men's lives caused by PC, specifically, their self-awareness of past health behaviours, their future plans and expectations, their sense of masculinity, and sociocultural representations. The interviews and conversations were audio-recorded. The fourth author transcribed verbatim and coded with support of Atlas ti 7.0.

Data Analysis

We used the content analysis method (Bardin, 1997) on the data to identify the tendency of thoughts and feelings (which the first and fourth authors coded as positive, neutral, and negative), as is recommended for studies exploring social representations (Guimelli, 2001), to categorize the concepts expressed and to explore their semantic proximity, units of meaning, internal structure, and dichotomy. Regarding the data gathered related to the tree diagram and other open-ended questions that were designed to identify key features of the respondents' views of PC representation, both analysts contrasted clusters of thoughts and grouped them into conceptual categories according to their valence (positive, neutral, and negative). The combination of both methods allowed us to assess the internal coherence of the findings, and to extend our understanding of the men's views and ideas.

During analysis of the taped data, the first and fourth authors listened to the audio files several times and the first author recalled her impressions of the

participants, including the intonation of their voices and facial expressions, to ensure consistency in attributing the valence of meanings. Through weekly dialogue, both analysts (in person and virtual contact) reached an interpretative consensus that was corroborated by the second author resulting in a summary diagram to finalize and verify our interpretations.

Verifying the Findings

The verification session was conducted in Paris, May 2015 by the first author with five participant volunteers who constituted a group of natural experts -understood as those who live the phenomenon under investigation (Sandelowski, 1998). We used their comments to assess how meaningful our interpretations of the findings were (Miles et al., 2020). This procedure served as a check by the participants and ensured validity in terms of grounded knowledge (Creswell & Creswell, 2018). The study's validity was strengthened by inviting the natural experts to discuss the interpretations and express any new ideas (Altheide & Johnson, 1998). Verifiers were asked to freely express their thoughts about the diagram synthesis they reviewed. The audio-file of this session was reviewed by the first author, who also discussed the results with the second and third authors to refine final interpretations.

Ethical Considerations

This study was reviewed and approved by Comité d'évaluation éthique de l'Institut national de la santé et de la recherche médicale (CEEI-IRB Inserm-France; Avis #12-083) and Ryerson University Research Ethics Board (Canada; REB 2013-107). Participants provided signed informed consent, copies of which were added to their hospital files in France and offered for their personal files.

RESULTS

The findings are based on the data gathered from: (a) observation and conversations with four Francophone men who were hospitalized during, prior to, or after a prostatectomy, along with two Francophone men with serious clinical conditions who were receiving palliative care, and (b) interviews



with 15 Francophone and four Francophile non-hospitalized men.

Sociodemographic information and particulars regarding social relations and health issues were obtained from the non-hospitalized men only (Tables 2 and 3). Among the Francophone participants, 47 percent were between 71 and 80 years old; 27 percent were 61 to 70 years old; and 20 percent were 51 to 60. Many of the Francophone men had mastered two languages (47%). Two of the four Francophile participants were in their sixties and two were in their seventies. They were multilingual and most spoke three languages (75%). Regarding their health, 84 percent of all participants reported a good or superior status, and 84 percent of them had undergone a prostatectomy.

The data include the men's responses to the structured interview and the dialogue established with participants while they were filling in the questionnaire. To keep the essence of their comments and experience of PC, their original words and short phrases are presented here, translated in English. Not all participants completed the full questionnaire; most of the missing data involved the tree graphic used to recall their thoughts and feelings at specific moments during treatment. Pseudonyms are used to identify participants and to maintain their anonymity ([Table 2](#), [Table 3](#)).

PC-related Ideas that Francophone and Francophile Men Expressed

Despite reports of a generalized silence among men about PC, even cases among their relatives, acquaintances, and friends, all the participants' accounts about PC were comprehensive and addressed more than their sexual life. The exercise of filling in the questionnaire provoked reflections and conversations about men's lack of knowledge about what to expect throughout the course of treatment and related issues of loss or benefit, but the men barely acknowledged the cultural context of their lived experiences with PC. Religion-related narratives were superficial, which suggests religion may not be a highly significant factor in men's experiences, although spirituality was reported to be a main source of comfort. Participants expressed their uneasiness in relation to two confounding concepts: masculinity and virility.

The questionnaire progressively explored current and past ideas about PC at different points, with emphasis on the current rehabilitation phase. The participants were asked to list up to six impacts of PC on their current life. Negative words were used more frequently (n=34; 51%) than those with a positive meaning (n=18; 27%), or a neutral meaning (n=14; 21%). Examples of words or phrases used and their classifications are: *negative* — *mutilation, powerlessness, stressful, fragility, and take my life away*; *positive* — *rebirth, more mature, less obsessed by death, more compassion and humanity, better lifestyle and no complaints, and it could be worse*; and *neutral* — *normal life, follow-up the evolution of the disease, erection, sexuality, and care*. When participants were asked to select from a list of 15 words those closest to their thoughts and feelings regarding PC, they most often chose *surprise, cure, and trust* (n=12), *combat and strength* (n=10), and *fear and energy* (n=8).

While the secondary effects of medical treatments were similar for both samples of participants, the 14 men who had spouses referred to some sort of renegotiation of roles and performance and explained this mainly in terms of age-related functional changes. An equally important issue for the men was urinary incontinence, which affected their self-esteem by causing embarrassment over its visibility (caused by leaking and odours). Despite their compromised sexual life, participants' sense of masculinity remained intact.

The upcoming sections present original accounts from participants that were freely translated from French to English language by the first and fourth authors.

Accounts from Francophone Men

The 15 francophone men differed in birthplaces ([Table 2](#)) and their stories of having PC included references to being uninformed, avoiding discussion of the topic, and facing uncertainties. In the words of a man, we'll call Benoit,

"It is a discussed topic, but I don't know what French people think about it. I don't know why. I have a house in Bretagne and my neighbour has prostate cancer, but why don't we talk about it?"



Even though many of the men had a postsecondary education (only the Tunisian immigrant had little schooling), and had some awareness of PC's prevalence, they were not knowledgeable about it, nor prepared to deal with having the disease:

"At that time, there was an increase of prostate cancer in Guadeloupe. Due to the pesticides, they use in banana plantation — it goes over the bananas, in the soil, in salads, potatoes ... and then everyone has diabetes, the prostate, but not in my family." (Jean-Marie)

"So, I read about it ... I love to read — one wrote that it was a cancer with a slow evolution if we do not touch it. We should not tickle the dragon." (Jean)

Overall, the Francophone group seemed to react well to the uncertainties, difficulties, and unpredictable events of having PC. However, some of their responses indicated that their feelings vacillated over the demands of adapting to their new health status. Some responses suggested a pattern in that they acknowledged the challenging emotional impact but were determined to react and behave as good patients who can take care of themselves and efficiently self-manage their PC-related issues.

"I talked to almost 20 guys. I said to them: 'I have a prostate cancer.' It was like I said, 'I have a throat problem.' To me it was like I had a disease like any other. I think that someday when they recall this, they will be less stressed out ... If we have a positive discourse, they will be positive." (Mustapha)

The Francophone men tended to have negative thoughts and feelings when they were first diagnosed, but these were progressively replaced by more positive reactions once their post-treatment follow-up was initiated.

Although they discussed loss of virility, it was a controversial subject. Some men viewed it as a major threat to masculinity in the context of French culture. One man criticized this common social perception as faulty and limiting:

"It's terrible, but the French man is a macho ... From the moment one touches a part of it [masculinity],

that's a catastrophe ... Yes, it's agreeable but it's not all in life!" (Mustapha)

Another man explained how in Congolese culture male virility is associated with the socio-cultural role of "giving life." Even though this man is a priest (and therefore celibate), he still felt that losing his virility affected his sense of manliness. This is not surprising, given how one medical professional spoke to him about the effects of surgery:

"For us [Congolese people], it is linked to aging. In my country, I barely listened [to the discussion] about the prostate. It's now in the modern times that it develops ... Dr. X who works at a Kenyan medical research centre said, 'We should not operate on you, otherwise you will become a zombie ... because you will lose your virility'." (Abel)

A few men felt that sexual impotence represented the end of their lives (a fatalist response), or that it was an acceptable cost of survival (a resigned response). Other men reacted to impotence more positively, seeing it as an excuse to free themselves from sexual duties or expectations (an opportunistic response), or a time to reassess their priorities and their sexual practice (a creative response). The latter two did not feel diminished as men — they were open to exploring the sensual aspects of sexuality. For instance, six of these men expressed curiosity about sensuality and varied sexual practices, such as how to sexually stimulate a woman without penile penetration. It is noteworthy that they had not raised such intimate questions with their physicians and psychotherapists.

Accounts from Francophile Men

The Francophile men were immigrants ([Table 2](#)) who had lived in France for about 20 years. They expressed predominantly negative thoughts and feelings over the physical, mental, and emotional impacts of their PC, even when they were in an early stage of the disease. When asked to choose words that best matched their ideas and feelings since being diagnosed with PC, the word cure was the top choice. Three of the men chose the words surprise, trust, fight, action, strength, and energy, while two chose sadness and fatality, followed by urgency, learning, and help. Their selection suggested they had a less positive perspective than the Francophone men,



perhaps because they were less prepared to face PC or viewed it more negatively. Only one man chose the word frightening and another one, anger. Strong negative reactions might be related to having a limited understanding of their personal medical condition.

One man's comment revealed a cultural pattern that is no longer part of Western medical practice but still current in some countries—troubling medical diagnoses are shared with family members but not the elderly patient, who is not given much or any explanation of his diagnosis or treatment:

"Almost four years that they did chemotherapy to me. I did not know why. They did not tell me that I had prostate cancer, but they did it every week. They said to my family that I had it, but not to me." (Pedro)

Their lack of knowledge about PC was evident when questioned about media and other informal sources of health information. They denied learning anything about the disease from such sources. They cited their family doctors and cardiologists as the professionals who usually told them about the need for screening by PSA testing and digital rectal examination. Even when adhering to these regimens, one man reported his efforts to shield himself from the talk of other patients, and to select how and what to learn about his own situation with PC:

"It is a quite embarrassing issue ... When I went to radiotherapy I avoided contact with other patients because I [didn't want to hear any] bad information ... What did concern me was my problem, how to treat it in an optimistic manner, even if I am in anguish." (Juan)

Another man said he had received a great deal of information from his urologist, and that this contributed to his positive attitude about having the disease:

"After meeting the doctor, who explained everything to me ... we talked for three hours! He gave me website addresses for more information to read, and some references in the literature. I did study them, and I made my decision for surgical intervention. I talked to my friends and neighbours because they

knew about my uncle's experience of the disease, and this uncle was my father's twin." (Franz)

Yet another man was explicit about accepting his diagnosis and involving his family and friends in making the decision to have medical treatment and face what the future would bring.

"I totally accepted the disease ... that I had a tumour, and then I talked to my children, my friends, my wife ... and after in-depth reflection, because someone told me I should do something ... I couldn't remain with it. We decided that I would do this [the surgery], and I understood the troubles I would have after the surgery." (Ibrahim)

Table 4 shows the dominant valence of PC-related thoughts and feelings at various points during the trajectory and treatment of their disease for both groups of men. The overall trend was more positive among the francophone men than the Francophile men (Table 4).

Lived Representations of Prostate Cancer

Differences in the men's ethno-cultural backgrounds, that is, between the Francophone and Francophile groups, seemed to have little influence on their core of the representation of PC. We asked for men's responses to the tree graphic and other open-ended questions to elicit their core ideas of PC, and to compile a synthesis view of it, grounded in their experiences. The evocative exercise (using the metaphor of a tree, with its roots, trunk, branches, and leaves) characterized their experiences and feelings at specific moments of their PC trajectory (Table 4; Zanchetta et al., 2007a). All the responses were assembled (indicated as ideas), analyzed, and classified in three major categories, as either an action, a condition, or a feeling.

In phase 1, learning about the medical diagnosis of PC, most of the 40 responses (62.5%) reflected a feeling, and were negative, such as *anguish, catastrophe, deception, despair, injustice, and shock*. In phase 2, sharing the diagnosis with family, half of the 16 responses referred to a condition, and were positive, such as *informed to be assured, calm approach, need, generally well accepted, and try to deal together*. When recalling daily frustrations, in phase 3, half of the 28 responses were classified as a



condition, such as *diminished self-esteem, immobile, life change, loss of joy, and urination retraining*. In phase 4, when participants were redefining their life priorities after PC treatment, 13 of the men's 23 responses (56.5%) were positive, such as *life in fullness, restrengthen family ties, resume life, self-care, and travelling*. These answers indicated a mixed scope of classification.

Overall, the findings suggest that the men's construction of a lived representation of PC was influenced by several factors: (a) the type of PC-related information delivered by the urologist; (b) men's direct, passive reaction to PC-related information delivered by urologists; (c) experiences of online information seeking, mainly after treatment; (d) men's discourse about normal life without major pre- and post-treatment disruptions; and (e) the loss of erectile function, which was reported by all the participants and was a major issue.

Among the Francophone men, the most frequently expressed thoughts were a dyad of ideas coded as *surprise-healing*. This suggests that this group tended to adopt a favourable state of mind in reaction to the uncertainties, difficulties, and contingencies of their disease. For the Francophone men, PC represented a disease with no major positive or negative attributes, whose cure is overlaid with life valorization. Despite their awareness of the physical and emotional suffering involved, the men tended to gradually take on a positive perception of their life, merged with an awareness of the need for emotional attachment to their social network and for more realistic future. If frustration seemed to mobilize Francophone men to overcome or adapt to functional change, that did not preclude their putting into practice efforts to renew their life plans and priorities while being realistic about the future ([Table 5](#), [Table 6](#)).

For the Francophile men, ideas of cure led to a positive mental attitude and awareness of their emotional needs. Their representation of PC involves a disease that requires men to prepare themselves psychologically with self-determination and strength to deal with the uncertainty immediately following medical diagnosis. The resulting physical, mental, and emotional impacts generated comparatively more negative thoughts and feelings. This suggests that the Francophile men were less able than the

Francophones to face frustrations and rebuild their plans, focusing on new life priorities.

Extent of Similar Prostate-Cancer-Related Ideas

Both groups of men expressed similar ideas about PC, which reflected the dominant cultural views of PC that the French host society holds—the men's culture of affiliation based on their ethnic background seemed to have little influence. There was a silence among men about PC and men's apparent lack of interest, curiosity, or opportunity to learn about it was identified during the pre- and post-surgery visits with men in their initial phase of treatment. None of them had sought information from any source. Their primary focus was on feeling safer after having had their tumour removed.

Some men described how learning about PC and dealing with the disease and its aftermath was, in fact, an enlightening experience. Information from their urologist demystified the disease and helped the men to understand their situation, face the clinical reality, and strive toward their own rehabilitation. This was a strong contrast to the stories of men who were not informed of their illness or treatment by their doctors.

The concepts of normality and natural aging were frequently implied in the men's discourse. A context of re-establishing normality was evident when they talked about the time "before" (without symptoms) and "after" treatment (resuming a normal life). The men also tended to accept their diminished sexual performance after treatment as a part of "natural change" caused by aging. The advanced age of the participants may have made it easier for them to deal with issues of erectile difficulties than would not be the case for younger men.

Verifying Our Interpretation of Findings

The first author conducted a session with five volunteers (both Francophile and Francophone) among the study participants to test and verify our interpretation of the findings. In a 60-minute session, she presented them with a simple diagram ([Figure 1](#)) that portrays PC as a disease that has neither a positive nor a negative image and offers men opportunities to re-evaluate their priorities and to rebuild their future with some limitations.



The verifiers confirmed our interpretation of the findings, but also commented on healthcare professionals' influential role in framing constructive views of PC by teaching patients about the disease and treatment procedures. Receiving a diagnosis of PC was a significant milestone for the men. Even though it is the practice in France for nurses to be involved when patients are told of their diagnosis (Rannou et al., 2012), no participant mentioned it, not even the verifiers. The men referred to their encounters with physicians and, less often, with radiation-therapy technicians, psychologists, and physiotherapists. These encounters seemed to be the notable players in the initial phases of their representations of PC. Physicians had the most influence, probably because of their early involvement in examination and early detection.

The verifiers confirmed that their initial ignorance about PC changed as they learned a great deal about it from their physician, whose authority and expertise were highly appreciated and missed by most participants. This contrasts with the immigrant men's different experience who reported having had no open dialogue with their physicians. Being fully informed by their physicians was linked to the men's ability to develop a favourable state of mind and help them react constructively to the uncertainties and difficulties they faced. The verifiers corroborated this factor, confirming that educational support is a valuable feature of health care services.

DISCUSSION

Francophone and Francophile men represented PC as a disease with neither a positive nor a negative meaning—one that is treatable and allows hope for recovery. This view contrasts with how Canadian men of Irish, Scottish, and English descent represent PC (Zanchetta et al., 2007a). Canadians represent PC as a disease that had damaging consequences and generated painful feelings. Although a simple, uncontrolled biological process, it caused losses that might nonetheless co-exist with a hopeful, positive vision of life (Zanchetta et al., 2007a). More compatible with the results from our study are those from a study with Canadian Francophone men (born in Canada and immigrants to Canada), who represented the disease as an innocuous entity (Zanchetta et al., 2007b). It appears that similar

representations of PC evolve in French-based cultures in different countries. Still, in all three studies, PC patients adopted a predominantly positive outlook on their lives during the rehabilitation phase. Their representations were influenced by past and current socializations, as well as gendered cultural practices for healthy lifestyles (Buscatto, 2014). How men talk about PC arises from their different experiences, mobility in social spaces, and personal trajectories (Buscatto, 2014).

In Canada, the discourse on PC is highly visible in the media as a matter of public education, social advocacy, debate, and fundraising to promote men's health (Zanchetta et al., 2017). In France, however, the blog posts of PC patients/survivors present an image of survivors as members of a "brotherhood of misery" whose common issue was the absence of sufficient instrumental information about the disease (Zanchetta et al., 2016). The bloggers' views support our findings that stress the importance of full disclosure and provision of extensive information that patients can understand and absorb at appropriate points. This seems to be a key factor in assisting patients to cope with PC and its effects by developing a realistic lived representation.

Research in France has linked a low level of public education about PC with patients' concerns over not having sufficient information or understanding about their past, current, or prospective clinical conditions (Zanchetta et al., 2018). The French media have made much of a lack of clarity on scientific knowledge, largely arising from the influential discourse of three key social actors: public health authorities responsible for public education, general physicians (GPs), who tend to argue against prostate-specific antigen screening in favour of individual medical assessments, and urologists, who perceive themselves to be the most appropriate professionals to inform and educate patients about PC and treatment modalities and assist their decision making (Zanchetta et al., 2018).

Some scholars hypothesize that men's collective silence about PC and the lack of sufficient information and knowledge that bloggers describe are features of the French socio-cultural context. The silence reflects a collective embarrassment linked to modesty about PC and its impacts on critical attributes of masculinity. Furthermore, the apparent lack of scientific clarity



about PC tends to suppress the expression of firm positions as polemical, and therefore, deters men from seeking PC-related information. Since the media channels in France do not disseminate consistent information on the causes, prevention, and treatment of PC, men are unsure about whether or how to act regarding prevention and treatment options (Zanchetta et al., 2018).

For patients and survivors, other forms of silence seem to coincide with the disease's silent and asymptomatic development. Men's implicit acceptance of risk and actual disease may be influenced by their awareness of natural aging, but their desire to maintain a good quality of life should promote efforts to prevent and screen for PC. Any cultural differences between the desires to stay healthy and to remain sexually active (that is, keep one's erectile function) would also be considered as a relevant experiential feature to represent PC.

In thinking about normality, masculinity, and virility, health, and sexual life, men's representation of PC reminds them that sexual activity and sexuality are both societal concepts and social markers (Welzer-Lang, 2008). Verdon (2015) found that although only 32 percent of men in France aged 60 to 69 considered sexuality indispensable to their personal balance. French popular culture considers men's loss of sexuality to imply a harmful rearrangement imposed by the reality of aging. The current hormonal paradigm that defines men by their level of testosterone and hegemonic signs of virility (Carol, 2011) threatens alternate constructions of identity, vitality, and virility.

As in the popular discourse, our data corroborate that PC is widely believed to be a cause of erectile dysfunction, thus diminishing a symbolic representation of men's sexuality and virility. Given that the real, the imaginary, and the symbolic are all structural components of popular discourse about a given matter (Durand, 2012), a cultural representation of PC may bring together societal concepts of sex, health, social markers, and negative consequences (such as loss of erection and libido, among others). By creating situations where men feel comfortable about disclosing their representations, we can sweep aside men's hesitancy about speaking openly about PC. For example, our data revealed that survivors sometimes describe a social "death"

following their cancer diagnosis. This "death" can result from men's loss of ability to meet cultural expectations about masculinity: to partake in reproduction, to be always ready for sex, and to respond logically to their problems.

Against a backdrop of traditional portrayals of men as being strong, authoritative, in control, fighters, and at times, violent, the contemporary concept of male virility is in a state of flux (Courtine, 2011; Verdon 2015). Because it affects an organ associated with a man's sexual and reproductive function and causes sexual impairments, PC paradoxically implies a vulnerability that can threaten and "socially disqualify" a man, meaning his social death (Courtine, 2011). The need for rehabilitation in multiple areas of performance requires men to deal with perceived and actual changes in their bodies' functions and abilities, and to exteriorize their determination toward normalization, role redefinition, and identity reconstruction (Manderson, 2011). Functional and identity rehabilitation were also noted through men's different responses to sexual impotence post-treatment.

Undoubtedly, as more individuals share their experiences and ideas about PC, a critical mass will emerge of diverse disease interpretations and hypotheses. Outcomes may include the adoption of preventive behaviours, and new attributions of values by social groups who are concerned about PC, and who seek occasional or continuous follow-up. Within ethno-cultural communities, men's potential to take charge of their prostate health will ultimately overcome the constraints imposed by their collective fear. Such fear undermines the development of men's proactive health behaviour and limits the scope of awareness about PC risk in certain population groups.

Overcoming silence and fear implies learning about PC and its possible interference in men's life plans (and not uniquely in their sexual life). This would counteract the power of current popular thinking about its causes and consequences. As social actors, men are expected to share information to highlight the beneficial analysis of virility loss versus survival. For example, male cancer survivors in France tend to demonstrate their resilience to life adversities by reinforcing their strength and stoicism (Inserm & Inca, 2014). If the notion of risk were added to ideas of damage and partial benefits, men's discourse about



trusting their urologists could highlight the benefits of focusing on normalization and damage control.

STUDY LIMITATIONS

Two aspects of the study design and context limit the findings' transferability. First, the study's small sample size and exploratory nature allowed only a preliminary, partial understanding of how Francophile immigrant men's ideas of PC interact with the dominant discourse on PC in the host French culture and health system. Second, for ethical reasons, it was very difficult to assess and compare how much appropriate PC-related information the men received (particularly immigrant men with less schooling and using a second language), or whether there was a possible omission of information or understanding. There may be adverse conditions at play that the study was unable to reveal.

Moreover, the study was unsuccessful in attempts to involve the France national PC survivor's association in the study, which may play an important role in shaping men's representation of PC. Another factor in understanding immigrant men's experience and social representation of PC is their length of residence in the host country. The Francophile men in this study were not recent immigrants—their integration into mainstream French culture is likely advanced, and the influence of their native ethnic culture is possibly lessened.

CLINICAL IMPLICATIONS

Our findings on men's ideas about PC of those living in the cities of Paris and Gonesse can be used to contribute to the production of culturally and gender-sensitive educational materials for patients and for public education, as well as in-service initiatives for health and social services providers, at the level of health promotion to complex, tertiary care, as well as rehabilitation.

The variety of words that men used and their valence of meaning (positive, neutral, or negative) to describe their clinical experience of PC support should interest clinicians, particularly in drawing attention to how professional discourse influences the population through media, and how patients react to health providers' discussion about their prostate health. Representation of PC is currently influenced mainly by

urologists, while the clinical experience as lived by the patients completes the mental image of PC that patients build. Clinicians may consider the incorporation of these words in their own spoken and written language used in the assessment interviews, screening tools, evaluation follow-up feedback, etc.

Based on lessons, we learned about men's lived experiences of PC and the meanings they attribute to it in this exploratory study, it was possible to identify some research questions for future investigation into the factors at play in transcultural representations of PC. These questions appear in [Table 7](#).

Since few countries have implemented a men's health policy (Zanchetta et al., 2015) and because PC remains a top health concern for men of all ages, educating the public to be aware of and to adopt proactive prostate health behaviour is a critical priority that must include sensitivity to the cultural context and situation of immigrant men.

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from http://www.recherche-qualitative.qc.ca/documents/files/revue/hors_serie/hors_serie_v2/MZanchetta%20et%20al%20HS2-issn.pdf



Table 1. Sample Questionnaire Questions

| Question | Evocative words and projective answers (in the order presented in the questionnaire) |
|--|---|
| <p>Choose with an « X » all the words that are closest to the ideas and feelings you had since the moment your physician told you you had prostate cancer.</p> | <p>Surprise, sadness, fear, fatality, trust, cure, anger, help, urgency, combat, action, strength, uncertainty, energy, learning</p> |
| <p>Write the most important idea regarding each of the following words that comes to mind when you think about your prostate cancer.</p> | <p>Communication, knowledge, information, sexuality, treatment, probability, results, virility, cultural values, family, health, needs, relationships, comprehension, support, help, prostate disease, society, culture, community, faith, future</p> |
| <p>Complete each sentence using short phrases (maximum of 3 words per line). Choose the words that best describe your daily life regarding the treatment of your prostate cancer.</p> | <p>My lifestyle is...; My state of mind is...; My well-being is...; My spiritual life is...; My main strength is...; My positive feelings are...; My hope is...; My moments of well-being despite the illness are...; My ability of making decision is...; My plans for my future are...; My most difficult moments are...; My virility is...; My concerns are...; My masculinity is...; My reason to survive prostate cancer is...</p> |
| <p>You are invited to create a symbolic image of your experience with prostate cancer and all important ideas you have regarding your life with this disease. Instructions: Imagine a tree. Prostate cancer is the tree root. Write in the square on the tree trunk the most important idea you've had since you were diagnosed.</p> | <p>This tree has 4 branches that represent the important moments for a man living with prostate cancer: 1) the moment of the medical diagnosis confirmation, 2) the moment of announcing to your family that you have prostate cancer, 3) the moment of facing frustrations, and 4) the moment of establishing new life priorities. In each of the 5 leaves on each branch, write all you can remember of your experiences during those moments in your life.</p> |



Table 2. Participants' Socio-demographic Identification

| Participant pseudonym | Age range | Marital status | Country of birth | Countries of previous residence | Number of spoken languages | Years of education | Past occupations | Current occupation |
|-----------------------|-----------|----------------|---------------------|---|----------------------------|--------------------|--|--------------------|
| <i>Francophiles</i> | | | | | | | | |
| Juan | 71-80 | Married | Spain | Algeria, Spain | 2 | 10 | Pharmacy technician | Retired |
| Franz | 61-70 | Married | Sweden | Austria, Sweden | 4 | 16.5 | Lawyer | Retired |
| Pedro | 61-70 | Married | Spain | --- | 3 | 8 | Car builder, stock market | Retired |
| Ibrahim | 71-80 | Married | Algeria | Algeria | 3 | Home-schooled | Train conductor | Retired |
| <i>Francophones</i> | | | | | | | | |
| Mustapha | 71-80 | Married | Algeria | Algeria, French Guyana | 2 | 23 | Administrative clerk | Retired |
| Abel | 61-70 | Single | Congo-Brazzaville | Belgium, Cameroon, Chad, Democratic Republic of Congo, Guinea, Italy, Ivory Coast, Tanzania, Zimbabwe, Zambia | 3 | 29 | Priest | Sabbatical leave |
| Roger | 71-80 | Married | France (Guadeloupe) | --- | 2 | 3 | Illustrator, military, railroad worker | Retired |
| Pierre | 61-70 | Married | France | --- | 1 | 15 | Pharmacy technician, police officer | Retired |



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| | | | | | | | | |
|------------|-------|------------|---------------------|---------------------|---|-------------------------|--|---------------------------------|
| Fortuné | 51-60 | Common-law | Tunisia | Tunisia | 3 | 12 + 1 year home school | Salesperson | Dental prosthetic technician |
| Alain | 71-80 | Married | France | --- | 2 | 15 | Preceptor tax, military, production programmer | Retired |
| Jean | 71-80 | Divorced | France | Belgium, Italy, USA | 3 | 20 | Computer engineer, Security technician | Retired |
| Salim | 51-60 | Separated | Algeria | Algeria | 1 | 12 | --- | Businessman |
| Simon | 71-80 | Married | France | --- | 2 | 18 | Television engineer, military | Retired |
| Benoit | 71-80 | Married | France | --- | 1 | 15 | Administrator | Retired |
| Claude | 51-60 | Married | France | --- | 2 | 20 | --- | Director information technology |
| Jean-Marie | 61-70 | Married | France (Martinique) | France (Martinique) | 3 | 13 | Administrator, military | Retired |
| Patrick | 71-80 | Married | France | --- | 1 | 17 | Industry manager | Retired |
| Ismael | 81-90 | Married | Algeria | Algeria | 2 | 14 | Butcher | Retired |
| Dieudonné | 61-70 | Widower | Congo-Brazzaville | Congo-Brazzaville | 2 | 19 | Architect, TV reporter, high-school teacher | Retired |



Table 3. Family Social and Health Profile

| Participant pseudonym | Family cancer | Family prostate cancer | Year of diagnosis | Underwent treatment | Current self-reported health status |
|-----------------------|---------------|------------------------|-------------------|---------------------|-------------------------------------|
| <i>Francophiles</i> | | | | | |
| Juan | yes | brother | 2010 | PT/RT | Very good |
| Franz | no | --- | 2008 | PT | Good |
| Pedro | no | --- | 1997 | PT | Good |
| Ibrahim | no | --- | 2011 | HT | Overall good |
| <i>Francophones</i> | | | | | |
| Mustapha | no | --- | 2013 | PT | Good |
| Abel | no | --- | 2012 | PT | Not good at all |
| Roger | no | --- | 2011 | RT | Good |
| Pierre | yes | uncle | 2008 | PT | Quite good |
| Fortuné | no | --- | 2008 | PT | Very good |
| Alain | no | --- | 2008 | PT | Very good |
| Jean | no | --- | 2009 | PT | Very good |
| Salim | no | --- | 2008 | PT | Good |
| Simon | no | --- | 2010 | PT | Very good |
| Benoit | no | --- | 2008 | PT/RT/HT | Good |
| Claude | yes | undefined | 2008 | PT | Very good |
| Jean-Marie | no | --- | 2006 | RT | Not good at all |
| Patrick | no | --- | 2010 | PT/RT/CT | Good |
| Ismael | no | --- | 2009 | CT | Not good at all |
| Dieudonné | no | --- | 2004 | PT/RT/CT | Quite good |

Legend:

Chemotherapy: CT

Hormonotherapy: HT

Prostatectomy: PT



Table 4. Trend of Prostate Cancer-related Ideas Expressed at Clinical Phases by Francophile and Francophone Men

| Sample | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Current synthesis idea of prostate cancer |
|-------------------------|--|--|--|--|--|
| Francophile (n=4; 100%) | Balance of positive (n=7; 37%) and negative ideas (n=7; 37%) | Balance of positive (n=8; 40%) and negative ideas (n=8; 40%) | Predominantly negative ideas (n=9; 47%) | Predominantly positive ideas (n=7; 78%) | Predominantly negative ideas (n=2; 50%) |
| Francophone (n=12; 80%) | Predominantly negative ideas (n=31; 61%) | More frequent negative ideas (n=12; 40%) | Predominantly negative ideas (n=22; 76%) | More frequent positive ideas (n=16; 64%) | Balance of positive (n=6; 50%) and negative ideas (n=6; 50%) |

Phase 1: Diagnosis confirmed

Phase 2: Sharing diagnosis with family

Phase 3: Dealing with daily frustrations

Phase 4: Establishing new priorities



Table 5. Francophone Men’s Main Thoughts and Feelings by Clinical Stage, as Synthesized in a Tree of Ideas, by Valence of Meaning*

Main ideas about prostate cancer (the tree trunk)—Balance of ideas between positive: care-related, cure (n=2), life, treat the root, tree of life; and negative: battle, mental illness, paradox, serious, threat, treatment otherwise death

Phase 1. Confirming medical diagnosis—Negative ideas: abnegation, anxiety, brought down, confirm suspicion, confused, laughing-crying, death, dejection, despair (n=2), did not know how to tell my partner, disaster, discouraged, dramatic, end of my activities, fear (n=4), feeling lost, injustice, isolation, life in limbo, no more seeing women, shock, test, thinking about my business, thunder, uncertainties (n=2), worries (n=3).

Phase 2. Sharing diagnosis with family—Negative ideas: crying, difficult (n=2), disaster, dramatic, fear, my wife’s shock, resignation, sadness (n=2), trauma, worries

Phase 3. Facing daily frustrations—Negative ideas: ashamed with women, change of life, decrease in self-esteem, discomfort over not being able to go out with women, end of life as a man, end of normal life, everything is going wrong, fear of frustrating my wife, feeling anxious, frustrated with my elderly mother’s worries, frustrated over need to face mortality, getting used again to urinate, loss of happiness, loss of libido, managing drinking 3L of water daily, no erections, not being able to out with children, not daring too much, sexual frustrations, sick and cannot walk, silence, terrible.

Phase 4. Establishing new life priorities—Positive ideas: adaptation, bonding with children, enjoy (n=2), hope, joy, life goes on, life in abundance, money and my daughter, other projects, see the children grow up, seek solutions, strengthen family ties, strengthen friendships.

*Note: Translated from French to English by the first and fourth authors



Table 6. Francophile Men’s Main Thoughts and Feelings by Clinical Stage, as Synthesized in a Tree of Ideas, by Valence of Meaning*

Major ideas about prostate cancer (the tree trunk) —Negative ideas: death, stop

Phase 1. Confirming medical diagnosis—Balance of ideas between positive: attention, determination, hope, intervention, live for the future, to fight, willpower, and negative: deception, fear (n=3), fragility, lack of courage, lack of spirit, shock, side effects.

Phase 2. Sharing diagnosis with one’s family—Balance of ideas between positive: calm approach, determination, need, to explain, to make sure, try to make it through together, willpower, and negative: fear (n=2), sadness (n=2), crying, shock (n=2), asked if it was false.

Phase 3. Facing daily frustrations—Negative ideas: immobility, fatigue, worry, fear, deception, decrease, depression, fear for my virility, very difficult incontinence.

Phase 4. Establishing new life priorities—Positive ideas: action, cultural activities, hobbies, I know about cancer, look after yourself, need to operate, travelling.

*Note: Translated from French to English by the first and fourth authors



Table 7. Emerging Questions for Future Studies

- Might older men's acceptance of natural aging and death, and their desire to maintain a good quality of life, be factors that influence their lack of interest in seeking out preventive care and prostate cancer screening services?
- Do cultural differences exist regarding men's desire to maintain good health and their concern over sexual performance and erectile capability? If not, is this link influenced only by age?
- Why do men exhibit little interest in learning about prostate cancer and adopting early detection practices, or in participating more actively in self-management?
- What is the connection between men's reluctance to talk about prostate cancer and their collective embarrassment, as well as their limited knowledge of the disease and the lack of clarity about the scientific knowledge held by health authorities, and generalist and specialist physicians?
- Why is prostate cancer not more freely and easily discussed between physicians and patients, or among men?
- What role does modesty play in the silence about prostate cancer (including issues of erections, sexuality, and sensuality) between physicians and patients?

Figure 1. Pictorial Description of Prostate Cancer Representation

