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Because little is known about how low-income Latino and African American men attribute meaning and adapt to prostate cancer treatment–related symptoms relative to masculine identity, in this study we sought to develop a descriptive model of this process. Using qualitative methods, 60 Latino and 35 African American/Black men were interviewed by language- and ethnicity-matched male interviewers using a semistructured guide. Interviews were audiotaped and transcribed verbatim. Spanish transcripts were rigorously translated to produce English transcripts. Analysis using grounded theory techniques found that men constructed masculine identities that were influenced by early experience, challenged by several factors including prostate cancer treatment, and underwent a renegotiation process that resulted in the maintenance of their identity as men. Development and testing of interventions that support this process will facilitate the adaptation process for men in a culturally relevant manner.

Keywords: *African Americans; cancer, psychosocial aspects; coping and adaptation; culture; erectile dysfunction; men's health; Mexican Americans; research, cross-language*

Prostate cancer is the most common new cancer diagnosis in men, and is second only to lung cancer in causing cancer deaths among men in the United States (American Cancer Society [ACS], 2007; Arai et al., 1999). African American/Black men still bear a disproportionate burden, with significantly higher incidence rates for prostate cancer and death than other ethnicities (ACS, 2007). Latino men, too, experience more negative outcomes from prostate cancer (Pendeo, Dahn, Shen, Schneiderman, & Antoni, 2006). Even though their incidence is lower, the death rate from prostate cancer for Latino men has not declined as rapidly as for other ethnic groups (Ashesh et al., 2001).

Incontinence and erectile dysfunction (ED) are potential side effects of most prostate cancer treatments. Both incontinence and ED can occur after surgery or radiation therapy, whereas ED along with loss of libido can occur with hormone therapy. All these might affect a man's quality of life (QOL; Bokhour, Clark, Inui, Silliman, & Talcott, 2001; Litwin, 1999; Litwin, Flanders, et al., 1999; Litwin, Lubeck, et al., 2001; Litwin, Melmed, & Nakazon, 2001; Litwin, Pasta, Yu, Stoddard, & Flanders, 2000; Litwin, Shpall, Dorey, & Nguyen, 1998; Lubeck, Grossfeld, & Peter, 2001). Thus, discussing incontinence and ED is necessary to assist men with prostate cancer to become informed participants in making treatment decisions and managing and coping with these symptoms when they occur. How best to do this for low-income African American/Black and Latino men based on their values is not clear.

Additionally, consideration of issues surrounding incontinence and ED touches at the core of masculine

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identity for many men (Bokhour et al., 2001; Heyman & Rosner, 1996; Schover et al., 2004), particularly as these symptoms threaten the hegemonic or dominant form of socially constructed masculinity (Oliffe, 2006; Wall & Kristjanson, 2005). The dominant Western view of masculinity is one that privileges a phallocentric ideal of male sexuality and promotes characteristics of domination, aggressiveness, competitiveness, physical strength, and control of emotions, which might be interpreted as incompatible with illness (Oliffe, 2006), especially when valued male functions are threatened. The construction of masculinity sets up power structures that are not only dominant over women, but also over men who are considered to display subordinate or marginalized masculinities, including lower socioeconomic and ethnic minority men (Courtenay, 2000). However, because masculine identity is socially constructed in interaction with others, it is constantly being tested and renegotiated within each context (Courtenay, 2000), such that there can be multiple masculinities (Connell, 1995; Emslie, Ridge, Ziebland, & Hunt, 2006; Oliffe, 2005). Although low-income, uninsured Latino and African American men might be considered to be marginalized masculinities in the United States because of socioeconomic and ethnic minority status, the valued characteristics of hegemonic masculinity for these cultures are similar to those for U.S. society (Sobralske, 2006; Torres, Solberg, & Carlstrom, 2002). Consistent with the social construction of masculine identity, Torres and colleagues (2002) described five identity groups of machismo. African American men tend to endorse a traditional Western/U.S. view of masculinity, but have historically found avenues to the enactment of valued masculine roles, particularly those related to economic capacity, thwarted (Levant, Majors, & Kelley, 1998; Palapattu, Kingery, & Ginsburg, 2006). This might increase the importance of sexual prowess for the expression of masculinity (Levant et al., 1998), but might also be related to the finding that African American men, although more distressed than White men about sexual dysfunction, tend to be more open to alternative forms of sexual intimacy (Jenkins, Schover, Fouladi, Warneke, & Neese, 2004).

Previous studies have considered the impact that ED and/or incontinence might have on QOL (Clark, Rieker, Propert, & Talcott, 1999; Kao et al., 2000; Litwin, Lubeck, et al., 2001; Lubeck et al., 2001; McCammon, Kolm, Main, & Schellhammer, 1999; Yarbro & Ferrans, 1998). In general, findings indicate the general quality of life, as measured, was not significantly diminished, even in the presence of these symptoms. Some investigators have speculated that men adapt to these symptoms because of good overall function or because of a determination to live with the symptoms (Eton, Lepore, & Helgeson, 2001; Fowler et al., 1995; Litwin, 1995). Bacon and colleagues (Bacon & Giovannucci, 2002; Bacon, Giovannucci, Testa, & Ichiro, 2001) compared the impact of various localized prostate cancer treatments on general, cancer-specific, and prostate cancer–specific QOL domains. Their findings indicated that there were significant differences in all QOL measures by treatment modality, with the largest differences occurring in sexual, urinary, and bowel symptoms (Bacon et al., 2001), highlighting the importance of these issues for men with prostate cancer. A few studies have qualitatively explored the impact of postprostatectomy incontinence and/or ED on couples (Heyman & Rosner, 1996; Maliski, Heilemann, & McCorkle, 2001; Pickett, Cooley, Patterson, & McCorkle, 1996). These studies revealed strategies used to deal with the symptoms, such as using incontinence aids to control urine leakage, reframing the symptoms within the context of having had their prostate cancer removed, and minimizing the impact of ED in light of their current stage in life. However, participants in these studies were predominantly White, middle- to upper-income, well-educated men. Little is known about the impact of incontinence and ED from prostate cancer treatment on the lives of low-income men of various cultural backgrounds, nor how cultural beliefs surrounding urinary and sexual function and the definitions of masculinity influence the meaning given to these symptoms.

Understanding what these symptoms mean and the processes by which management of and adaptation to them occurs among low-income African American/Black and Latino men is crucial for the development of culturally relevant interventions that address these symptoms in all phases of the disease and treatment process. Therefore, the purpose of this study was to develop a descriptive model of processes used by low-income African American/Black and Latino men to maintain masculine identity with prostate cancer treatment–related symptoms. Reported here are the results from which a model of masculine identity renegotiation was developed as men described living with their treatment-related incontinence and ED.

Methods

A qualitative approach informed the data collection and analysis to capture cultural meanings and the intersection of cultures at the interface of the health care system for the uninsured men and their cultural backgrounds. Grounded theory techniques (Strauss & Corbin, 1998) were used in the analysis to move the interpretation to development of a model based on the meanings as they emerged from the data and the construction of masculinity within the context of having prostate cancer treatment–related erectile dysfunction and/or incontinence.

Participants and Setting

We received Institutional Review Board approval from the University of California, Los Angeles (UCLA) Office for the Protection of Research Subjects. We then recruited men who self-reported as Latino or African American/Black from IMPACT (Improving Access, Counseling, and Treatment for Californians with prostate cancer), a state-funded treatment program that provides free prostate cancer treatment and nurse case management to uninsured, low-income men in California; from a local Veterans Administration Medical Center (VAMC) urology clinic; through advertisements placed in local newspapers targeting African American/Black communities; and through mailings to local prostate cancer support groups. All 60 Latino men and 18 African American/Black men were recruited from IMPACT. Six African American/Black men were recruited from the VAMC and the remaining 11 African American/Black men were recruited through newspaper advertisements and support group mailings. All men recruited into the study had incomes below 300% of the Federal Poverty Level. All of the African American/Black men and 2 of the Latino men spoke English, whereas the remaining 58 of the Latino men preferred Spanish. Ages ranged from 50 to 70+, with 54 of the Latino men and 28 of the African American/Black men under age 65. Men covered by Medicare, federal health insurance for those 65 and older, were not eligible for the IMPACT program.

There were a number of demographic differences among the study participants. Of the 60 Latino men, 59 were born outside of the United States, whereas only 2 of the African American/Black men were born outside the United States. Forty-four of the Latino men had less than a high school education, and 27 of the African American/Black men had a high school education or higher. Another difference was evident in the relationship patterns, with 72% of the Latino men reporting that they were living with a spouse or partner, and 40% of the African American/Black men reporting a similar situation. Another 11% of the Latino men reported that they were in a significant relationship, but not living with the person; this was true for 20% of the African American/Black men. The remaining 17% of Latino and 40% of African American/Black men reported that they did not currently have a significant relationship.

Clinically, there were differences between the Latino and African American/Black men in the type of primary treatment received. Among Latino men, 18% had radiation therapy and 67% had surgery, contrasted with 34% radiation therapy and 46% surgery for African American/Black men. These men had not received any other treatment at the time of the interviews. Hormone therapy rates were similar in pattern, 15% and 17% for Latino and African American/Black men, respectively. These men were receiving hormone ablation therapy at the time of the interviews. For most, this treatment was in response to biochemical recurrence following primary treatment with either radiation therapy or surgery. We do not know about the effects of the primary treatment for these men other than as discussed in the interviews. Almost half (29 Latino and 18 African American/Black) were being treated or had been out of treatment for less than 1 year, whereas 14 Latino and 7 African American/Black had been out of treatment for 1 to 2 years. The remaining 17 Latino and 10 African American/Black men had been out of treatment for over 2 years. All men were experiencing or had experienced ED and/or incontinence

Data Collection

After providing written informed consent, men were scheduled for their initial interviews. They were given a choice of having the interview conducted in person either at UCLA (in a private room), in their home, or by telephone. Telephone was the only option for those living more than 50 miles from UCLA. In-person interviews were conducted with 46 of the Latino men and 24 of the African American/Black men. We saw no evidence of differences in information shared between those interviewed in person versus those interviewed by telephone. The major limitation with telephone interviews was the

absence of visual data; however, interviewers completed a debriefing form following each interview on which they noted their impressions of body language and environment for in-person interviews and voice tone and background noise for telephone interviews. All interviews were conducted in the participant's preferred language by a language- and ethnicity-concordant trained male interviewer using a semi-structured interview guide. The interviews lasted 1 to 2 hr and participants were asked to talk about their treatment and related symptom experiences, starting with learning about having prostate cancer, through treatment, to the present. Men were also asked to talk about learning to be a man, characteristics and behaviors important to being a man, and the impact of prostate cancer treatment–related symptoms on their sense of masculinity. The interview guides used open-ended topical prompts and probes to gain the desired depth of information. Men were contacted for second interviews to clarify or expand on concepts identified in their initial interviews or to confirm emerging themes. All interviews were transcribed verbatim in the language in which the interview was conducted. Spanish-language transcripts underwent a rigorous translation process adapted from Brislin (Brislin, 1980) to produce English transcripts that captured meaning and context for qualitative analysis (Lopez, Figueroa, Connor, Litwin, & Maliski, 2008).

Analysis

The method for this study drew on grounded theory (Strauss & Corbin, 1998) techniques to develop a descriptive model of masculine identity renegotiation in the context of prostate cancer treatment–related incontinence and/or ED. Analysis was undertaken by the first author in collaboration with bicultural study team members and participants. Initially, transcripts were read in their entirety. Next, to open up the data to discover thoughts and ideas that would lead to concepts, close line-by-line coding was conducted. Each line was read and labeled for the major thought or idea expressed. This proceeded with constant comparison of new codes with previous codes. As coding and comparison continued, common characteristics began to emerge that we labeled to become categories. We then returned to the data with questions about the categories to further describe them in terms of properties and dimensions. We also used follow-up interviews to explore categories in which there were gaps in description or understanding. Concurrently with this process, relational statements were suggested and explored in the data relative to the dimensions and properties within and between categories and subcategories. After relationships were confirmed by the team as supported by the data, the process model was developed to describe renegotiation of masculine identity as it emerged from the data. The Principal Investigator and four study staff members independently carried out this interpretive process. Categories and relationships were confirmed by returning to the transcripts and in follow-up interviews with a subsample of the participants. Throughout the analytic process, memos were written on codes and categories as they were developed, decisions about categorization, descriptions of the categories, theoretical hunches and questions, and decisions made about relationships and the model.

Results

The analysis revealed a process by which men experiencing symptoms related to their prostrate cancer treatment renegotiated their sense of masculine identity. This process was influenced by early-life cultural and social factors, as the onset of symptoms such as ED and incontinence challenged masculine identity. The renegotiation process involved normalizing, balancing hopeful waiting with moving on, examining masculine values, and reprioritizing.

Masculine Identity: Multidimensional and Dynamic

Masculine identity as revealed in the stories of the Latino and African American/Black men in this study was multidimensional and dynamic, consistent with a social constructionist framework of gender. The important properties of being a man varied along a dimension of less important to more important as men talked about different situations and stages of life. Major properties that expressed the meaning of becoming and being a man as they emerged from the transcripts were

- Masculine identity as dynamic,
- Enactment and expression of masculinity identity as context dependent, and
- Early life experiences as influential on masculine identity and enactment.

The multidimensional and dynamic nature of masculine identity was demonstrated by the varied properties, as seen in the descriptions men gave of what it

meant to be a man. As one man put it, "To be a man depends on the situation." The essential properties of manhood, as described by the men, encompassed physical, emotional, and relational dimensions, as exemplified by the following quotes:

- "Man works, guides people."
- "To be a man is to be with family, united, and being with the wife. Together."
- "Worked in fields and learned responsibility like men."
- "Man's role at home to set good example to children."
- "Trying to behave the way a man should be. Trying to . . . to carry out with everything that you can within your role as a man, as a father, as a brother, as . . . with the family."
- "Its the man that's the leader, the one in front, the leader of all that."
- "In other words what I believe means to be a man is to love your wife, give her what you can and be a man."
- "Well that's being a man, support his family, having a home and everything . . . to support her and everything that's being a man right? And have one's children and give them the best possible, for me that's being a man."
- "And then a man to me means being responsible and being considerate of others even though you might be physically stronger or you might think been smarter but ah is treating people well. Means that's man to me."
- "To be, to be a man . . . uh . . . well . . . if, if he's thinking within himself, uh . . . thinking whole years to be able to respond in all the ways that God intended for a man. . . . God intends man to have sex."

The importance of physical and relational dimensions varied when the men talked of younger versus older stages of life, different social settings, and whether talking about self or others, highlighting the multidimensional and socially constructed nature of masculinity:

- "Because since I'm an elderly person, an older person is already a person who, one's desire decreases."
- "I think that with the age all men are going to be like this [ED] with no, no, there [are] some that won't but there are a lot that will."
- "I don't talk to friends about the impotence because then they'll laugh at you."
- "Because when you're young none of that matters, you live the moment and you're the macho man. But then when you start to mature it already changes your way of thinking about life."
- "Because when you're with your friends, ay women this and that with your friends, you know one pretends to be a macho man at that moment."

One of the striking differences between the narratives of the African American/Black and Latino men was found in the expression of the definition of being a man. Although there were similarities between the two groups in terms of underlying valued properties of control, independence, and strength as being important, there were differences in enactment of the values. The Latino men talked of enacting their definition by "providing for your family," "taking care of your wife," "working hard," "being dependable," and "protecting others," whereas all except one of the African American/Black men described being a man as "individual," having "no set definition." Common characteristics of manhood were not as readily identified by the African American/Black men, other than becoming an African American/Black man meant "just surviving." Talk of sexual prowess and maintaining a "front" of strong silence and indifference also figured prominently as the African American/Black men talked about the meaning of manhood. Additionally, African American/Black men talked about a connectedness to their community, a brotherhood that was not evident in the narratives of the Latino men.

The exceptions were two Caribbean American/Black men who spent their youth in Jamaica. Similar to the Latino men, they talked about learning to become a man by going to work in the fields at a young age before immigrating to the United States. As one of the men stated, "As a Jamaican man, you just learn to accept." These men described valued masculine characteristics similar to those cited by the Latino men. Conversely, the one Latino man raised in the United States cited youthful experiences that influenced his masculine identity that more closely resembled the stories told by the African American/Black than other Latino men.

Challenges to Masculine Identity

Treatment of prostate cancer and its sequelae presented a number of challenges to beliefs about masculinity held by these men, as revealed in their stories. Major challenges discussed were related to work, control, strength, sexual performance, and independence. Work and the ability to work using physical strength were an integral part of how men in this study viewed themselves as men. Physical strength allowed these men to feel competent in their

daily lives. This was particularly striking in the Latino men's stories. The ability to work was closely tied to the masculine values of protecting and providing for one's family, as well as work being a venue in which physical strength was displayed. Even retired men were quick to talk about the work they had done, its physicality, and how they were good providers for their families. When prostate cancer treatment limited the ability to work, it presented a challenge to men's sense of being a man by limiting the ability to provide for family and to feel strong and independent.

Incontinence proved to be a major barrier to being able to work, because it could become visible and "embarrassing" if not adequately controlled. Incontinence challenged control, often being referred to as "not being able to control my urine." If incontinence became visibly evident, this loss of control became obvious to others. Thus, until this side effect resolved it was a major challenge to activities seen as important to masculinity.

Strength and control were discussed in other contexts as well. In addition to the importance of physical strength, emotional strength emerged as a valued masculine attribute in the narratives of all men. Men talked of needing to control emotions and to be mentally strong so as not to worry others. Although the diagnosis of prostate cancer was often received as a "death sentence," and therefore a significant challenge to control, men expressed wanting to face it "like a man" and to "protect others from their fears." Masculine control for some included "being the boss of the house" or "leading the way," and for others was more related to self-control, particularly of emotional expression. Both incontinence and erectile dysfunction created a sense of diminished control. When talking about incontinence men talked about having to use diapers or "Pampers," and one expressed it as "being like a baby." None used terms related to adult incontinence aids, conveying a sense of infantile dependence.

The sense of male sexual performance was most impacted by ED. However, this was often talked about as the "inability to take care of my wife," "not being able to be united with my wife," and a fear of losing the partner because of the inability to have an erection and "please his partner." Although some men indicated that having ED made them "less of a man" or "incomplete," the sense of loss of the ability to unite with a partner was more prominent throughout the interviews than was the need to prove masculinity through sexual conquest. Men still experiencing incontinence stated that this was the major barrier to sexual relations because the fear of involuntary leakage during sexual activity "made it impossible to even think about sex." Erectile dysfunction was placed within an interactional context and masculinity was challenged by ED in that it limited the means by which a man could interact with and "satisfy" or "meet the needs" of a partner. However, ED could be hidden outside intimate relationships, as demonstrated by men's comments that when they were with their "buddies" they talked as if they were still sexually active. By doing this, men were able to maintain a public masculine image consistent with the image they perceived others to hold.

Men also talked about having other conditions that affected their physical strength, erectile function, and ability to work. This, along with perceptions of an expected decline in sexual activity with aging, led to the start of the renegotiation process for men in this study.

Masculine Identity Renegotiation

The potential threats to masculine identity posed by prostate cancer treatment–related ED and incontinence were experienced within this context of socially constructed masculine identity. The renegotiation process that ensued in response to the challenges included the subcategories of normalizing, balancing waiting hopefully with accepting and moving on, examining values, and shifting priorities. This process emerged within the initial interviews as men reflected back on dealing with prostate cancer–related symptoms and their beliefs about masculinity. Men often framed responses around before or after prostate cancer, and as being younger versus older.

Normalizing. Normalizing was a strategy used by men to explain ED as being normal and thus not detracting from the sense of manhood. This strategy was used by Latino and African American/Black men as they talked about having ED, but not in their talk about incontinence.

Age and comorbidities of self or their partner facilitated normalizing. Erectile dysfunction was framed as being a normal part of getting older. Within the narratives, there appeared seasons of manhood. Young manhood was seen as the time when sexual performance was critical as an enactment of masculinity and for having children. As men aged and children had been produced, this season faded along with the importance of sexual performance. Men stated that "it [ED] would be much worse for younger

men" because sex was more important for younger men. Men in their 50s expressed this as well as men in their 60s and 70s; "younger" was relative to the current age. Men, especially Latino men, said that because "they had already had their children," ED was less of a concern and was expected as they grew older. Other men talked about having lived their lives and having had "plenty of a sex" when they were able. This again placed ED within the context of getting older, and therefore made it less of a threat to masculine identity. The prostate cancer treatment just accelerated this normal and expected part of aging for these men. In one instance the treatment was seen as accelerating aging by ending youth: "The operation ended my young days."

Among men who had comorbidities that had diminished erectile function prior to their prostate cancer treatment, ED was viewed as a gradual transition. As one man put it, "I was already a member of the dead bird club." For these men, ED was already a "normal" part of their lives. Men who had partners with illnesses that made them unavailable sexually expressed similar sentiments. ED was not presented as something that greatly impacted their lives or relationship with their partner.

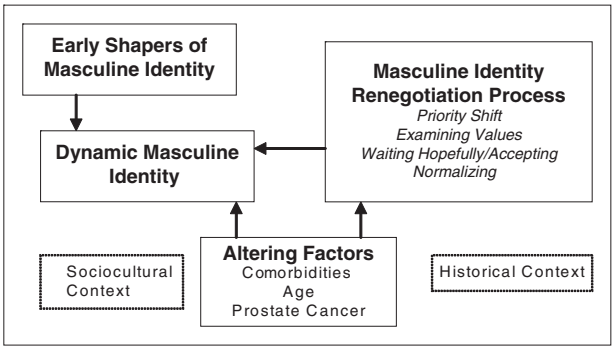
Still others minimized the impact of ED on masculinity by placing it within the context of having had their prostate cancer removed. This functioned similarly to normalizing because it allowed men to talk of ED as a normal or necessary consequence of being freed of cancer. In essence, choosing treatment for prostate cancer was talked about as a choice between "life or sex," and men indicated that their choice was life.

Balancing "waiting hopefully" with "accepting and moving on." Balancing hope with acceptance was a major strategy used to not "give up" on the resolution of treatment side effects, while at the same time accepting the side effects, at least temporarily. This provided the ability to "live with" the symptoms, while maintaining hope for a return to prior normalcy. "Normalcy" in this context was used to mean return to full sexual function, because this was "normal" for a man. One way in which waiting hopefully was accomplished was by moving the time point at which ED should be resolved to a time distant from when they were treated. For example, one man said, "Well, I'm only a year or so after my operation so it [ED] can take up to two years to come back to normal. . . . It will come back." A number of men, particularly Latino men, would qualify this type of expression with "if it's God's will," allowing them to accept while waiting and hoping. A number of men talked of having moved the time frame further into the future if resolution had not occurred by the original target date. They wanted to "give it a little more time."

Latino men and African American/Black men approached hopeful waiting and accepting differently, relative to their acceptance of erectile aids. Many of the Latino men stated that they had been prescribed or given oral medication to assist with erections, but that they had not used it yet. It was something they said they "might try later if it [ED] doesn't get better." "Doctor gave me some samples, but I haven't taken any. . . . Maybe I'll try it sometime." Although Latino men did not directly explain this hesitation, the postponement of using erectile aids might have helped to maintain hope of a return of "natural" function, and delayed the risk of loss of hope if the medication did not work. Also, the sense that sex was less important as men aged or had cancer removed might have lessened the felt need to use aids to perform sexually. The African American/Black men interviewed talked readily about using erectile aids and finding alternate methods of sexual intimacy. The African American/Black expressed hope that "natural" erections would return, but accepted that they currently had ED and were using whatever means at their disposal to maintain sexual relations with their partners. Acceptance and moving on for African American/Black men meant acknowledging ED and using aids and alternative means of intimacy, whereas the Latino men expressed acceptance as acknowledging ED and not having intimate sexual relations. However, more African American/Black men reported not being in a relationship in which they lived with a partner or being in a significant relationship at all, which might have affected their concern.

Examining masculine values. Prostate cancer treatment, comorbidities, and age were factors that stimulated an examination of the meaning of masculine identity properties and the importance of various properties within the men's masculine schema. As men normalized and balanced to integrate prostate cancer treatment–related symptoms into their lives, they examined the values of masculinity that were most important to their own sense of being a man. Men indicated that strength and control meant taking better care of themselves by eating better, exercising, and going to a health care provider more regularly after having prostate cancer. This was seen as a way to be better able to take care of family and to work. In relational terms, men talked about not seeing themselves as dominant over female partners, having respect for others, and being honest and helpful to

Figure 1
Model of Masculine Identity Renegotiation Process



others as increasing in value after having dealt with prostate cancer. Sexual prowess was perceived more as "pleasing" or "taking care" of their partners in ways that did not require erections. This was particularly evident in the interviews of the African American/Black men. Dealing with prostate cancer and its treatment became a new way to demonstrate masculine strength and control.

Men talked about what other men would consider important to being a man. This included the typical view of machismo or macho, but participants typically ended these narratives by saying, "but I'm different." This "being different" was expressed in a number of ways. Strength was redefined as having had cancer, undergoing treatment, and surviving the cancer. Prostate cancer was a challenge that had been overcome. Men expressed that respect of women was valued more over dominance or sexual conquest after their prostate cancer experience. Men indicated that they saw being a good example for children in modeling that respect and providing for the family as more important than macho bravado after prostate cancer than before. From this examination, men shifted priorities—the dimensional position—given to the various properties of masculine identity.

Shifting priorities. Although the values expressed as important to being a man remained the same, the weight given to them was redistributed. The men's priorities shifted from the more physical dimensions of being a man to the more relational dimensions. This was seen as happening concurrently with examining properties, and was signaled by, "but I'm different."

"Being a man is more than having sex" was evident throughout the interviews of the men in this study. This included their expression of increased valuing of the interpersonal aspects of relationships such as talking with their partner, being a good example for their children and spending time with them, and being more health conscious. Strength included surviving and accepting symptoms such as erectile dysfunction as the price paid for survival. Control became the ability to actively decide to "think about more important things," staying positive, "controlling myself," "convincing myself that I don't need it [sex]," and living a "normal life" despite ongoing symptoms. Even deciding whether or not to take oral medications to produce erections can be seen as a way in which some men exerted control. Through this process, as depicted in Figure 1, the men interviewed in this study were able to establish some sense of "still feeling like a man," even with the presence of ED or urinary incontinence.

Outcomes. Men expressed that living with these symptoms was not easy and that there was a sense of struggle and having to work at this process with forward and backward movement. However, work and struggle were expressed by the men as part of being a man. There were several men who had not examined and shifted priorities in their sense of what is important for being a man at the time of their interview. These men spoke of ED as damaging their sense of masculinity, saying that they "felt incomplete" or "less of a man" because of it. These men also equated strength to physical strength and expressed feeling that loss of physical strength contributed to feeling "impotent." They did not talk of views changing from before prostate cancer to after prostate cancer. One of these men stated that he could not relate to women anymore, even in a nonsexual situation, because of the loss of self-confidence he had experienced. Instead of using aging as a way of normalizing ED, this man negatively compared himself to "70- to 80-year-olds who still have kids." This man stated that he had not had children, thereby indicating that erectile function remained an essential property of his sense of masculinity. Men who had children were able to reprioritize by talking about having had their children, providing a sense that the purpose for erectile function, in their view, had been served and future generations created. Several others of this group who were having difficulty talked about not being able to return to work because of urine leakage or inability to lift heavy objects, and instead, did "small jobs around the house" that were identified as "woman's work," expressing a sense of diminished masculine identity.

Men who had examined and reprioritized talked of equality and the equitable distribution of work between

themselves and their partners happening more after their prostate cancer. These men talked about the importance of the support and understanding they had received and were continuing to receive from their partners in moving through the treatment and recovery process. Men said that their wives understood and did not expect or demand sex, and yet treated them "like normal." They stressed the importance of mutual respect and having a relationship that was more than sexual. Even though men respected and valued their partners prior to their prostate cancer, the support and understanding received during their prostate cancer treatment led these men to express increased respect for their partners. The men who talked in this manner also indicated that they had been married for many years. Additionally, many of these men credited their IMPACT program nurse case manager with providing information, referrals, and resources that eased their ability to deal with their prostate cancer and its treatment.

Discussion

These results articulate a process by which low-income Latino and African American/Black men define, face challenges to, and renegotiate masculine identity in the presence of symptoms resulting from prostate cancer treatment. Numerous studies have shown that men's health-related quality of life (HRQOL) returns to pretreatment levels after prostate cancer treatment (Bacon & Giovannucci, 2002; Clark et al., 1999; Krongrad, Litwin, Lai, & Lai, 1998; Litwin, 1994, 1995, 1999; Litwin, McGuigan, Shpall, & Dhanani, 1999; Litwin, Melmed, et al., 2001; Litwin, Nied, & Dhanani, 1998; Penson et al., 1998), but the process of that adaptation has not been clear. Previous studies of IMPACT program enrollees, from which participants for this study were recruited, have demonstrated that although these men start treatment with lower HRQOL, they do recover HRQOL (Brar, Maliski, Kwan, & Litwin, 2005), and the longer they are enrolled in the program, the more quickly their HRQOL recovers (Zavala, Maliski, Kwan, Miller, & Fink, in press). The renegotiation of masculine identity might be a process by which this adaptation occurs, restoring one aspect of HRQOL. However, a connection between masculine identity and HRQOL is yet to be confirmed.

Interestingly, the values cited by the men in this study as core properties of masculinity have been found across cultures and across time (Gilmore, 1990; Mosse, 1996). Mosse traced the history of the masculine stereotype as it endured from ancient Greece through the mid-1990s. He makes the case that the masculine stereotype is socially constructed and has been maintained because of its symbolic function of providing order and progress. The components of this stereotypical masculinity include quiet strength, power, self-control, protectiveness, and stoic bearing of pain (Mosse, 1996). Although the expression of these values varied historically, the values remained steady. Men in our study endorsed these consistent values of masculinity but reconstructed their masculine identities through a social process of renegotiation following treatment for prostate cancer. By doing so, these men might have been able to re-establish a sense of order within their social worlds.

In considering cultural concepts of masculinity, Gilmore (1990) explored manhood and attainment of manhood in aboriginal cultures across the world. He found that with the exception of two cultures, boys became men through rites of passage that included renouncement of dependency on the mother, identifying with the men of the society, demonstration or ability to provide for the community through acts of bravery and hard work, and the ability to unflinchingly endure pain. Within this socially constructed view of masculinity, men were expected to be strong, stoic, and productive both in meeting the needs of the family and in producing a family (Gilmore, 1990). The values of bravery, hard work, enduring pain stoically, and the ability to provide are similar to hegemonic Western views of masculinity including stereotypical Latino machismo and African American/Black masculine identity. In our study, results indicated that Latino and African American/Black men endorsed similar values, but enacted these values somewhat differently within their own sociocultural contexts, and were influenced by early cultural influences, as seen in some of the differences between U.S.- and non-U.S.-born participants.

The renegotiation process is also supported by and extends an anthropological study conducted with primarily White veterans in which investigators found that men coped successfully with symptoms related to prostate cancer by subtly redefining the self through partial transformations of hegemonic masculinity (Stansbury, Matthewson-Chapman, & Grant, 2003). As a dimension of the renegotiation process, normalizing might have been facilitated by the fact that sexual dysfunction was the result of illness, as well as being expected with and attributed to aging. Wall and Kristjanson (2005) found that in reframing masculinity by being able to attribute erectile function

to a body compromised by treatment, negative connotations of erectile dysfunction could be displaced. The men in this study further strengthened this displacement notion by viewing prostate cancer treatment as the only way to live, thereby making it a choice of strength and necessity. O'Brien, Hunt, and Hart (2005) observed that when men survived perceived life-threatening events, including prostate cancer, they seemed to accept that preservation of future health assumed a much higher priority than preservation of masculinity in the traditional sense.

The men who had not examined and reprioritzed were not in a long-term relationship and/or did not have children, which might have influenced the impact of symptoms on their lives. Men who had offspring and a long-term relationship had fulfilled the masculine ideal of producing a family and providing for that family, perhaps mitigating some of the demasculinizing effects of prostate cancer and its treatment. Developmentally, these men had also fulfilled the need for generativity and, in a sense, had achieved immortality through their offspring in the face of mortality brought to the forefront by a diagnosis of cancer. Also, those in long-term relationships had a sense of time and history that fostered the mutual understanding that was important to dealing with the symptoms. Those who did not have a partner or indicated that they had been in their relationship for only a short time expressed more concern about the ability to have sex and the fear that the partner would leave. This interpretation might provide some insight into the findings that men in a public treatment program who were partnered had better HRQOL outcomes (Gore, Krupski, Kwan, Maliski, & Litwin, 2005). Also, it might be that these men had more rigid ideas of masculinity. As noted by Stansbury and colleagues (2003), "individuals with rigid ideas about masculinity suffer greater stresses with illness than are suffered by those who do not hold such views."

These findings and interpretations certainly raise other questions. First, further investigation is needed to discover whether partnership status and length of partnership does impact the process of renegotiating masculinity. Second, it will be important to explore whether renegotiation of masculine identity affects HRQOL. Finally, even though low-income men appeared to move through a renegotiation process, it is unclear whether lack of resources or the type of available resources affect how the renegotiation occurs. Courtenay (2000) contends that in our current health system, lower-status men are subordinated because hegemonic masculinity in the United States is embodied by heterosexual, highly educated men with high incomes. This might place lower-income men of nondominant ethnicities, such as the men in this study, at a distinct disadvantage. For the Latino men, the current sociopolitical discourse on immigration status forms a potentially hostile context within which these men obtain health care and renegotiate their masculine identity.

Conclusion

These findings suggest areas for future intervention development and testing related to renegotiating masculine identity when prostate cancer treatment results in symptoms such as ED and incontinence. By understanding the socially constructed, multidimensional, and dynamic nature of masculine identity, it becomes possible to promote normalizing, balancing, examining, and reprioritzing such that masculine identity is reconstructed. As Oliffe and Thorne (2007) discuss in the findings of their study on Australian and Canadian men, masculinity, and prostate cancer, this can encourage clinicians and researchers to consider "how masculinity might work for, rather than against," men's reconstruction of masculine identity and perhaps help them recover quality of life.

Previously proposed interventions to minimize distress related to prostatectomy-related side effects have included discussion of all potential side effects preoperatively, designation of resources that encourage men to talk about sexuality, and discussion of rehabilitation and altered sexuality (Oliffe, 2005). However, the men in our study do not have access to many of the resources available to men with insurance or in countries with universal health care. Masculinity transformation has been proposed as an intervention for low-income African American/Black men within the context of HIV/AIDS (Whitehead, 1997) and concern over the role of men in contemporary urban problems (Aronson, Whitehead, & Baber, 2003). We propose to use strategies of empowerment to move men away from reputational attributes (i.e., sexual prowess, toughness, physical strength) to more respectability attributes (i.e., strong family provider, economic independence, and higher education; Aronson et al., 2003). Empowerment strategies as described in these studies could be relevant for men similar to the Latino and African American/Black men in our study, and might be a way to encourage examination and reprioritization. Partners, where

available, would be incorporated as a resource in the intervention strategies, and additional resources will need to be developed for unpartnered men. Another approach that bears investigation in our population is narrative intervention similar to that articulated by Bronwynne and colleagues and pilot-tested by Crogan and colleagues among 7 participants (1 man) with cancer (Bronwynne, Crogan, & Bendel, 2008; Crogan, Bronwynne, & Bendel, 2008). Because storytelling allows articulation of a person's identity (perhaps including masculine identity), and promotes finding meaning in the illness experience, it might prove helpful in fostering the renegotiation of masculine identity. Although facilitating this renegotiation process would be helpful for all men with prostate cancer treatment–related symptoms that threaten their sense of masculinity, focusing on men most at risk for distress in this area, such as unpartnered or newly partnered men, might be particularly important.

Finally, as our findings demonstrate, men—even those occupying subordinated positions in American society—use strategies to successfully reconstruct masculinity after prostate cancer treatment. Therefore, it is incumbent on us as clinicians, researchers, and society to explore and provide the resources necessary to foster the positive properties of masculine identity in recovering from prostate cancer treatment and to supplement resources for men at risk for difficulty with the renegotiation process.

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