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ORIGINAL ARTICLE

Men's Lived Experiences with Breast Cancer: The Double Consciousness of Marginal Men

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Abstract

The present study investigated men's experiences with their breast cancer diagnosis and post-mastectomy lives. It is based on the sociological tradition of investigating the "marginal man" who lives in two not merely different but incompatible cultures (e.g., the pink ribbon culture of breast cancer and the everyday ideals of masculinity and the male body). Seventeen mature and aging U.S. men who all lived with a breast cancer diagnosis and treatment, including a mastectomy, were interviewed. The principle finding reveals that they saw themselves as men and remain seen by others in terms of their gender, not their atypical illness. Two meta-themes underlying men's breast cancer stories were identified: body talk and embodiment of their breast. Each of these themes had subthemes. Noticeable was how the historical era when diagnosed and men's aging experiences influenced their illness journey and stories. For all, even the recently diagnosed, their journey was a lonely one. No man had known another man with breast cancer to consult. Only a few men felt their breast cancer was a stigma, and they too did not feel emasculated. Instead, in the process of embodying their breast cancer, they amended their identities and practiced softer, hybrid forms of masculinities.

Keywords Breast cancer · Masculinities · Men's health · Grounded theory coding scheme · Body talk · Embodiment · Marginal man · Double consciousness

The diagnosis of carcinoma in a man's breast is predictably astonishing to the man and his family and peers, principally because public awareness that men have breasts and can get breast cancer is low (Thomas 2010). Although the signs and symptoms of breast cancer in men are similar as in women, including a lump that can be felt, nipple inversion, and nipple discharge, lack of familiarity with male breast cancer (MBC) is not surprising—it is a rare biological entity, accounting for about 1% of new breast cancer cases in the United States annually and less than 1% of all carcinomas in men (National Cancer Institute 2016).

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A paucity of research has examined men's experiences with their breast cancer despite the fact that their experiences are compelling stories about breasts and masculinities, more specifically breast cancer and masculinities. The majority of the literature is composed of medical case reports of male breast carcinoma and comparisons of male-to-female malignancy (e.g., Benjamin and Riker 2015; da Silva 2016). When men's experiences have been addressed within these reports, the story presented is often about their emasculation, contested masculinity, or spoiled identity as a "real man" (Bunkley et al. 2000; Donovan and Flynn 2007). Punctuated is how a man feels askew when one of his "pecs" [pectoral muscle], a symbol of masculinity and strength, is removed by the mastectomy (Pituskin et al. 2007) or feels troubled by the unnerving effects of post-surgical hormonal therapy—erectile difficulties, lowered libido, and hot flashes (Farrell et al. 2014; Ruddy et al. 2013). The argument has been that masculinity and chronic illness/disability are always inconsistent with one another because bodies are men's physical capital and contribute to their symbolic masculine capital (Bourdieu 1984, 2001; Connell 1995).

As with the disruptive nature of any other cancer diagnosis, the discovery by men that they have breast cancer is expected

to present an ontological assault (Kleinman 1988) in which some of the most basic assumptions that people hold about themselves and the world are thrown into disarray (e.g., the cancer diagnosis will suspend the body-self congruence the men took for granted; Bury 1982) and impose an existential odyssey (Frank 1995) that at least involves confronting the mortal danger of a life-threatening disease. With a breast cancer diagnosis, the men are also grappling with the reality they have breasts, seemingly an oxymoron because it is commonly thought that men have a chest, not breasts.

The question that begs to be examined is: How do men's experiences with discovering they have breasts as a result of their cancer diagnosis, and having a breast removed through a mastectomy, affect their masculine subjectivities and practices as they go about managing the identity turn of living with a life-altering chronic illness that is also now culturally wrapped in feminizing pink? Anticipating body-self disruption and identity dilemmas (cf. Frank 1995) arising from men's breast cancer diagnosis, the present study aims to better understand how men come to live with having breasts and having breast cancer. One particular interest was whether or not the age of the man at diagnosis and recency of diagnosis differentially affect the men's lived experiences with their breast cancer.

Unlike the assault-disruption trope presented by most male breast cancer studies, our starting point was the sociological view of the "marginal man" who lives in two not merely different but sometimes antagonistic cultures—in this case, the cultural ideals of hegemonic masculinity (Connell and Messerschmidt 2005) vis-à-vis the "pink ribbon culture" associated with breast cancer in the United States (Sulik 2011). When a man shaped by one culture, such as the gender norms defining hegemonic masculinity and emphasized femininity (Connell 1995), is brought into intimate contact with a culture of a different context, such as breast cancer's pink ribbon culture (https://thebreastcancersite.greatergood.com/clicktogive/bcs/home), he is likely to sense he is on the margin of each culture. Unlike other men, he is conscious his has breasts and, unlike others with breast cancer, he is one of the rare men within the nearly cloistered world of breast cancer care (Ehrenreich 2001; Sulik 2011). This marginal man (Park 1928; Stonequist 1935) feels more or less a stranger (Simmel 1908/1950) in both cultures, and he will experience what du Bois (1903, p. 5) recognized as the peculiar sensation of "double consciousness." It is as if he must always regard himself through the eyes of two others that present clashing images: being a man and having breast cancer.

The rise of U.S. pink ribbon culture repositioned breast cancer from a stigmatized disease into a social movement based on "deeply held beliefs about gender and femininity" (Sulik 2011, p. 9). Breast cancer's powerful association with pink symbolically genders it as a woman's illness. Because they are not women, breast cancer organizations have had a history of marginalizing men (Fentiman 2018; Francis 2018; Quincey et al. 2016). As Ehrenreich (2001, p. 47) argued, a "culture of pink kitsch" and corporate-sponsored gatherings are accompanied by a "dilute sisterhood of cyber (and actual) support groups," and there is little about them that is inclusive to men.

Men with breast cancer equally occupy a "not-real-men" status as a result having breasts and a needed mastectomy. Because of the tyranny of Western cultures' hegemonic masculinities, any visible marker, such as dark skin color, lack of body wholeness, having breasts, or wearing the kippah or taqyiah "skull cap" of a non-Christian group, can marginalize a man. Most of these marginalized men live with their double-consciousness (i.e., they are men and they are members of a devalued minority). They engage in many masculinity practices consistent or complicit with the traditional heteronormative, White, whole-bodied hegemonic ideal as they live with their "other" status. Slevin and Linneman's (2010, p. 492) captured a core commonality of marginal men's double consciousness when an 85 year-old gay man asserted his primary identity as a man: "Hey, I am not a gay, just a gay…I'm a man before I'm a gay man."

The story of a marginal man who lives with a double consciousness is fundamentally unlike the cancer assault-disruption story. It does not presume one, normative masculinity. Men who live with the intersectionality of two (or more) cultures end up "widening" (StGeorge and Fletcher 2014, p. 369) what is normative and produce an array of masculinities which can be more inclusive of corporeal differences, cultural contexts, or sexualities (cf. Anderson 2009; Coles 2009). Within social relations they present themselves as the men they are, and they "do masculinity" in many ways that affirm being a man to others and to themselves. For example, any marginal man living within intersecting cultures may work, watch sports, marry, have children, become a homeowner—actions that reflect the prevailing "package deal" values (Townsend 2002) associated with adult masculinity in Western cultures and reinforce traditional cultural discourses about being a man. Yet, on inspection, multiple forms of masculinities are regularly constructed and exist on a much more horizontal plane in terms of power. The "manhood acts" (Schrock and Schwalbe 2009, p. 279) displayed do not reveal a marginal men's absolute approbation of the traditional cultural standards for being a man any more than his narrative fails to reveal his racial and ethnic heritage, biography within a class position, generation, stage in the life course, or experience with a gender-atypical illness.

This article reports on a qualitative study designed to listen to men's breast cancer career stories. The guiding question was "What are men's dis/embodied experiences as they journeyed their breast cancer career?" This question looks beyond the expected assault-disruption story.

Method

Participants

The men we interviewed were from differing geographical locations throughout the United States: seven from New England, three from southern states, three from western states, two from the Midwest, and two from east coast states. They may all be men from the United States, but they live within cultural and historical places that differ regarding gender and gender relations. The youngest was born February 1962 and the oldest January 1927; at the time of the interview they ranged in age from 37 to 82. A majority ($n = 10$, 59%) were age 50 or older at diagnosis, which is consistent with national epidemiological data. Only four men were age 45 or younger at diagnosis. All of the men were partnered or married at diagnosis, and most ($n = 14$, 82%) were (re)married when interviewed. One of the two who was never married was gay and partnered at the time of diagnosis and the interview. The sample was predominately White ($n = 15$, 88%), yet included one African American and one Native American man. About half of the men ($n = 9$, 53%) were no longer working at the time of the interview; only three of these men left the labor force due to their cancer-related disability. All but three men (82%) had gone beyond a high school education; six (35%) had earned post-baccalaureate degrees.

Procedure

Our study was designed to use conversational interviews to draw out men's breast cancer narratives. It was approved by the IRB at the authors' home institution. Pseudonyms are used in the present article. During a three-month period (15 June-15 September 2009), 17 men with a history of breast cancer or currently undergoing treatment were interviewed. Recruitment was multi-method. Given the very low incidence of breast cancer among men, letters were initially mailed to all practicing oncologists within a 75-mile radius of the researchers' home institution in Massachusetts. The letter asked the physician to pass along a recruiting advertisement to her/his male breast cancer patients who could then choose to contact the researchers. This strategy resulted in 11 participants. Two additional participants were "snowball referrals" where a participant reached out to another man with breast cancer and that man contacted the researchers directly. Four of the participants had been identified in newspaper articles published in the preceding 6 months and were recruited by surface mail.

Seven interviews were face-to-face at a site the participant selected, usually his home; ten were conducted by telephone due to their geographical distance. The interviews were unstructured, in-depth, and, as is customary with conversational interviewing (Gray 2013), audio-recorded. The conversational interview was chosen because it facilitates a relaxed, nondirective approach to elicit the men's own concerns with and stories about their breast cancer. The men were the experts.

To determine the men's dis/embodied experiences during their breast cancer career, they were asked to retell their cancer story including the details of their everyday lives before and following their breast cancer diagnosis. Consequently, one man would begin his story with the mammography exam, another with his experience of his first wife's breast cancer followed by his own experience. The interviewers probe whenever an important matter had not been fully covered—such as the meaning of signs and symptoms, decision-making to seek a diagnosis, with whom they disclosed their breast cancer diagnosis and mastectomy, and the effects of the breast cancer experience on the sense of being a man. The timing of the follow-up questions and probes was determined during the interview because they asked the men to expand on an idea or to provide clarification. Available as an online supplement is the list of the primary questions and probes; it is not a step-by-step, semi-structured interview protocol. The researchers held a copy during the initial interviews to better assure each interview covered common ground.

For all but one telephone interview, both authors participated in the interview, which typically lasted 90–150 min. The research literature on interviewing seems to assume one-on-one interviews; however, as Bechhofer and his colleagues (Bechhofer et al. 1984) observed decades ago, there are advantages to two interviewers when using lengthy conversations as the source for collecting data. Forewarning the participant that two interviewers will be involved eliminated any surprise. The beginning of the interviews typically involved introductions and chatting to develop rapport, and this exchange often led to the participant asking questions, such as how the researchers became interested in men with breast cancer. As the conversation progressed, typically one of the interviewers was quiet whenever the other asked a question, and typically one of the interviewers took more extensive notes, offered "uh-hum" recognition while note-taking, and entered the conversation when seeking clarification or asking a follow-up or new question.

To assure uniformity in collecting data on tumor size and perceived stigma, a brief page-and-a-half questionnaire was mailed to the participants with a stamped return envelope a week after the interview; the questionnaire is available as an online supplement. The men were asked to report exact diagnosis, tumor size/stage, lymph node involvement, and types of treatment. Included were single-item questions examining the man's comfort with telling other men their diagnosis, rated no or yes; being embarrassed by the mastectomy scar and the absence of a nipple, rated on 7-point scales ranging from 1 (*not really*) to 7 (*quite a bit*); and how much the mastectomy challenged their body image as a man and how much the hormonal therapy challenged their sense of masculinity, both

rated on an 11-point scales ranging from 1 (*not at all*) to 11 (*very significantly*).

Data Analysis

Qualitative researchers typically use one of several analytical methods to extract the themes that run through and across people's (cancer) stories, such as interpretative phenomenological analysis (Smith et al. 2009), thematic analysis (Bamberg 2006; Braun and Clarke 2006), narrative analysis (Clendenin 2006; Riessman 2007), and grounded theory analysis (Charmaz 2006). The stories men told about their breast cancer experiences were analyzed using the constant comparative method associated with constructionist grounded theory analysis (Charmaz 2006). This analytic strategy is principally about data compilation and does not necessitate the systematic step of generating theory (Charmaz and Belgrave 2012). Its defining component is detecting the meanings people create.

Logistically, the second author transcribed the interviews verbatim no later than the day following the interview. The researchers also talked with one another immediately or shortly after each interview, reviewed the themes and class of issues heard within the participant's interview, and after a day or two the researchers began the line-by-line coding of the interview transcript to identify themes and nascent coding categories. The development of thematic categories and their underlying structure is an iterative and lengthy process of listening. Coding went through distinct phases, which were consistent with what Charmaz (2006) identified as open-coding, focused coding, axial coding, and theoretical coding. Through this process, the themes developed reflect their "ground"—the experiences of men with breast cancer.

Initially, words and phrases were selected to describe themes within the data. From this preliminary stage of analysis 18 thematic categories were identified (e.g., diagnosis shock, body image, disclosure, taboo, coping strategies). The thematic categories were illustrated with bits of the narrative—lines, paragraphs, or segments. Working with the coded transcripts, a more detailed, or focused, interpretation of the categories concentrated on the specificities of discourses, commonalities across narratives, and variations in the ways in which a particular discourse was construed. Throughout the process the audio interviews were replayed and transcripts reread to further identify nuance to affirm categories and systematically fold these into subthemes. Replaying and rereading of the interviews often assessed one thematic category at a time. That is, to resolve whether a category or code was appropriately assigned to a man's narrative, the thematic categories and their illustrative segments were compared across other men's narratives. During the last phase of coding, what Charmaz (2006) called theoretical coding, the categories were further condensed to arrive at the main stories. This process of consolidating discrete themes into core ones concluded when existing themes were uncontested and no new themes were identified.

Results

The underlying question was "What are men's dis/embodied experiences as they journeyed their breast cancer career?" The men were asked at the onset of the interview "We'd like to start with you telling us your breast cancer story." Not surprisingly, all but one of the 17 men reported surprise and disbelief when diagnosed with their breast cancer, which is in keeping with the near invisibility of MBC as well as clinical MBC studies' assault-disruption story. We identified two overarching themes within the men's narratives of their breast cancer experience: body talk and embodiment of their breast. Body talk entails the ways in which men discursively regulate their reflexive and corporeal bodies (Crossley 2005; Gill 2008; Ussher 1997). In our study, men's body talk centered on their discovery of having breasts, the implications of their surgical wound and hormonally unruly bodies, and living with a cancer-injured body. Their narratives equally conferred how they came to embody having breasts. Renegotiated embodiment was talked about in terms of navigating foreign (women's) spaces, telling others about their breast cancer, and reformulating their subjective masculinities. Table 1 provides additional information about each participant, and Table 2 summarizes the two themes and their subthemes, along with coding definitions and prototypical examples.

Before reporting on this pair of themes, understanding the typical treatment trajectory provides an important context. Noted in Table 1, nearly all of the men ($n = 15$, 88%) were diagnosed with late stage carcinoma—stages II ($n = 7$, 41%) or III ($n = 8$, 47%)—and had delayed seeking medical attention at least 3 months despite a palpable tumor. Most of the men ($n = 12$, 71%) had a large tumor at diagnosis, ranging, as they described it, from the size of "half a ping pong ball" or a "bite-size Snickers [candy] bar" to "about the size of a nickel" [21.21 mm in diameter]. Three men waited a year or more, chiefly because they had no health insurance or a high deductible and were reluctant to pay out-of-pocket for a consult "if you don't need to." Like most of the others, the three self-diagnosed their slowly growing tumor as an ordinary sebaceous cyst, which transformed from a "pea size" lump into tumors ranging from 2.5 to 7 cm before seeking medical opinion. Nearly all of the men ($n = 14$, 82%) underwent a biopsy, and as many ($n = 14$, 82%) experienced a mammographic exam.

All 17 had a mastectomy, which was at least a modified radical mastectomy where the breast and axillary lymph nodes under the arm were removed; for many of these men, portions of chest wall muscle were also removed. One man initially had a lumpectomy, then 2 weeks

Table 1 Characteristics of participants

	Ethnicity	Marital status	Age	Education	Social class	Work status	Age at diagnosis	Year diagnosed	Months delay	TNM status	Mastectomy	Radiation therapy	Chemo-therapy	Hormonal therapy	Challenged body image	Scar stigma
Andrew	W	M	78	15	Middle	Retired	64	1994	≥9	T1b N0 M0	Yes	No	Yes	No	0	0
Brian	W	M	63	16	Middle	Employed	59	2005	≥3	T2 N3 M0	Yes	Yes	Yes	Yes/T&F	0	0
Chris	W	M	62	17	Middle	Employed	59	2007	≥3	T1b N1 M0	Yes	No	No	Yes/T	0	0
Fred	W	NM	68	10	Lower	Disabled	68	2009	≥3	T3 N0 M0	Yes	Yes	No	Scheduled	0	0
George	W	M	60	17	Middle	Employed	52	2000	≥6	T3 N1 M0	Yes	No	Yes	Yes/T&A	0	0
Henry	W	M	82	17	Upper	Retired	75	2002	≥6	T2b N1 M0	Yes	Yes	No	Yes/T&F	0	0
James	W	M	76	17	Middle	Retired	59	1994	≥6	T2b N0 M0	Yes	No	No	Yes/T	0	0
Jeffrey	W	M	38	16	Middle	Self-employed	34	2005	≥12	T3 N1 M0	Yes	No	Yes	Yes/T	0	0
Kenneth	NA	D	50	12	Working	Self-employed	47	2006	≥12	T3b N2 M1	Yes	Yes	Yes	Yes/T	0	1
Patrick	W	M	46	12	Working	Disabled	45	2008	≥3	T3b N3 M1	Yes	Yes	Yes	Yes/T	2	0
Randall	W	M	49	18	Upper	Employed	48	2008	≥3	T2a N1 M0	Yes	No	Yes	Yes/T	0	1
Richard	W	M	72	16	Middle	Retired	57	1995	≥3	T2b N1 M0	Yes	Yes	No	Yes/T	1	0
Stan	W	M	65	16	Middle	Employed	63	2007	<3	T1 N0 M0	Yes/Bi	No	No	Yes/T	5	3
Stephen	W	NM	65	16	Middle	Unemployed	63	2007	≥12	T3 N2 M0	Yes	Yes	Yes	Yes/T	0	0
Ted	W	M	64	17	Middle	Retired	38	1983	≥3	T2b N1 M0	Yes	Yes	No	No	0	0
Terry	W	M	51	16	Middle	Employed	48	2008	<3	T1 N0 M0	Yes/Bi	No	No	Yes/T	0	0
Thomas	AA	M	79	14	Middle	Retired	44	1976	≥6	T2b N3 M1	Yes/Bi	Yes	Yes	Yes/T	6	3

Hormonal therapies: A = Arimidex, F=Femara, T = Tamoxifen. Body image: mastectomy challenged masculine body image, range 0 (not at all) – 10 (very significantly); Scar stigma: the mastectomy scar embarrassing, range 0 (*not at all*) to 6 (*quite a bit*)

Table 2 Themes, subthemes, definitions, and examples

Themes Sub-themes	Definition	Examples
Body talk		
Having breasts	Remarks about having breasts and breast cancer	“I didn’t even want to think that I have breasts let alone have a cancer in my breast.” (Randall) “I discovered I have breasts. Uh, so I, I looked at it as ‘Hey I’m well aware that breast cancer for a woman is *a lot* more traumatic than it is for a man. It’s just *got* to be.” (Andrew) “So we decided to go ahead and do the bilateral mastectomy. You know, they weren’t doin’ me any good!” (Brian)
Surgical wound	Remarks about the mastectomy	“I didn’t have a shirt on; I do that on the beach. You know, after the surgery there’s obviously a scar there and no hair, you know, cause of the radiation. But I don’t care, you know.” (Kenneth) “So when I looked in the mirror the first time, it was a little scary because I had a scar all the way from under my arm all the way down to my navel diagonally. And, um, you know it’s strange because by then I had accepted it and I said to myself ‘Well this is just something I’m gonna have to live with.’” “(laughing) I asked my internist one time, I have a lady internist, and I said ‘Do you know where there’s a tattoo place where I could get (a nipple) tattooed on?’” (Richard)
Unruly bodies	Remarks about the ill-effects of breast cancer treatment	“First of all my hair fell out because of the chemo, and I immediately cut the rest of it off. I told the people at work that I just liked to have a bald head.” (Ted) “Well I didn’t do the hormonal therapy, I refused to do that Tamoxifen. That stuff is brutal! That stuff for men is absolutely ridiculous and terrible. I had more hot flashes, depression, too many side effects, I said forget it.” (Kenneth) “You start changing with age. I’m 60 now and, you know, things just aren’t what they used to be. And um, I’ll tell you this, the tamoxifen doesn’t help any of this!” (Brian)
Injured body	Remarks about the relativeness of a man having breast cancer	“Well something that changed me in 2000, I remember this, is there was an amputee from Vietnam getting chemo, he lost an arm in the war and I thought ‘Oh wait he’s handling this just fine’ and he had another kind of cancer, and I thought ‘This is ridiculous if I’m embarrassed.’” (George) “You know as far as cure rate, breast cancer is a higher cure rate than prostate cancer. So I was kind of fortunate I didn’t get prostate cancer. That’s the way you gotta look at it.” (Fred) “I mean, it’s one thing for me to have cancer but it’s another thing for um, you know, to see women who are in their 30s or something in the breast clinic. You just go ‘Oh geez.’” (Stan)
Embodiment of their breast(s)		
Navigating foreign spaces	Remarks about feeling marginal	“We’re men in this pink world and it’s uncomfortable. So you read some of the websites, you read some of the brochures that are available in the clinics and um, you know, you have a hard time even knowing that this is a disease that men can get.” (Randall) “Now at the V.A., my experience was probably a little unusual but maybe helpful in the sense that I did do treatment at a place where my gender was the dominant gender. Mostly men, mostly older, all with serious illnesses. But going over to (names another hospital), it is designed for women’s—I mean the mammography clinic is for women. The style is, is, a gender specific style. Namely female. And it makes perfectly good sense to do that, but that should be acknowledged so that for males there’s going to be a slight discomfort there.” (Brian) “You know it’s funny, you lose your dignity and I’m trying to think of another word—your modesty, in a hurry.” (Chris)
To tell or not	Remarks about disclosing their breast cancer	“Socially, I don’t bring it up. But obviously everybody knows, my circle of friends, everybody knows.” (Stan) “I don’t mind telling people I have breast cancer. And like I say, if its gonna help one guy. Oh yeah, so to me not talking about it I think is a disservice.” (Terry) “I go to tennis drills and they’re mixed drills, both men and women, and some of the women that know me they’ll want to see the scar. And they say ‘Is it,’ they’ll ask me, ‘Is men’s breast cancer just like women’s breast cancer?’ And I’ll say ‘Yeah, here I’ll lift up my shirt, here’s what it looks like.’” (Chris)
Reformulating masculinities	Remarks about masculine subjectivities and practices	“For the first several months I was wary about not wearing a shirt. Now, on the beach I didn’t have a shirt on; I do that on the beach. You know, after the surgery there’s obviously a scar there and no hair, you know, cause of the radiation. But I don’t feel a concern, you know.” (Kenneth) “One of the guys who I know got a call, the call was coming from the teenage son of a man that had, was diagnosed with breast cancer, and the teenage son was devastated because he thought that this meant his father was less that a man. And it just *floored* me. OMG, the naiveté of youth!” (Andrew) Well if you look back on it, I’m a mad man. I am from that era. So 5 years ago I got remarried. When dating I said ‘I’m sort of deformed now, I’ve got my left chest knocked out.’ She asked, ‘Well you were in the Marine Corps, what happened?’ And I said ‘Nah it’s breast cancer.’” (James)

later a mastectomy to remove the breast. Two men decided to have bilateral mastectomies to increase their chance of survival because they had a maternal family history with breast cancer. Three men developed metastatic cancer. One man’s clinical history included a four additional surgeries as a result of reoccurrence and/or metastasis; his last surgery involving another radical mastectomy and removal of several ribs. Post-surgical adjunct

treatments sometimes included chemotherapy ($n = 4$, 24%), radiation ($n = 4$, 24%), or both chemotherapy and radiation ($n = 5$, 29%). More common, however, was long-term hormonal therapy ($n = 15$, 88%). One of the two men not undergoing hormonal therapy was scheduled to begin hormonal therapy shortly after the interview; the other had early stage cancer and was advised by his physician that surgery was sufficient.

Body Talk

Having Breasts

Men's narratives commonly storied how they experienced their provisional breast cancer diagnosis as a "lightening strike." Being told their lump should be biopsied for evidence of breast cancer or being scheduled for a mammography was a moment in their slow identity turn of becoming men with breasts. Every man detailed how he was felt dumfounded with a cancer diagnosis and its location. James, a journalist, recalled:

> When the doctor told me I had cancer, it was a Friday and I went downstairs and I got in a cab and said "You break every record, I'll pay for the tickets, but I want to go to [names the bar] and have a drink." I went in there and the guys, you know the guys everyone knew, said "Hey, what are you up to James? Where ya been?" And I said, "I was just diagnosed with breast cancer." And the bar became quiet! (James)

All but one man reported in great detail his sense of the "nomic rupture"—he had breasts, not just a chest. For example, for Paul the diagnosis was "You know, it is a blow to the ego just to think, alright I have cancer. I'm thinking I'm invincible, I'm in great shape, how could *I* get cancer? And then you have *breast* cancer…I go honestly, you know, I never knew I had breasts." Patrick, a former marine from working class South Boston summarized several men's commonly storied, disquieting moment:

> When it was first diagnosed, I felt kind of like a freak, because I'm a dude. It's still considered a women's disease. Hell, like a lot of people, I had no idea guys could ever get it…And [my physician calls and] goes "Well, you have breast cancer." [long pause] And, then I was like [another pause], then I repeated, I go "Do you know this is Patrick?"…umm, I was thinkin' he's got too many reports on his desk and he's lookin' at, instead of Patrick, he's lookin' at Paula's report. And he's like "No, men get breast cancer and you have a very aggressive form." (Patrick)

Surgical Wound

The men conveyed mostly "skin deep" body image issues with their surgical wound. That is, most often ($n = 14$, 82%) the men commented that the mastectomy scar was visually disturbing yet minimally detrimental to their gendered lives. They said their surgery was unlike what any woman would likely experience, for whom her breast was recognized as a symbol of femininity, motherhood, and a female sensuality. As James remarked: "For women, it's just got to be traumatic…It's part of what makes a woman a woman." Or as Brian said:

> You know, I had a friend tell me the other day, he had a brother that was in bad shape with colon cancer. And he said "You were lucky, you didn't have it in any vital organ in your body!" And I said "Well you tell a woman that her breasts aren't vital!" (Brian)

These comments were not a discursive positioning strategy to make light of their mastectomy or to assuage wounded masculinity; rather, they were empathetic declarations that as much as their wound always mattered, their lost body part was not so gender-significant.

The disfigurement caused by the surgical wound did not go unfelt. Commonly, the men acknowledged how the mastectomy carved their chest, modifying their body image and affecting upper-body mobility. Describing the impact of his mastectomy, Patrick's metaphor illustrates an emphasis most of the men ($n = 11$, 65%) ascribed to the loss of muscle behind the breast tissue: "I'm a simple guy. You have a chicken patty and then you go get a chicken nugget, as far as muscle. So now I have a chicken nugget. They took out the chicken patty." Later in the interview, Patrick reflected on his loss of arm mobility: "I was always a physical guy. Boxer. Marathoner. I used to be able to play catch with my daughter. Now I cannot throw. I'm limited to kicking a soccer ball." Throughout Patrick's narrative were comments on how breast cancer surgery re-sculptured his muscled body and how this necessitated amended masculinity practices—becoming a man who fights against cancer rather than getting in "the [boxing] ring." Patrick was one of the four men (see Table 1) who rated the mastectomy as a challenge to his embodied masculinity.

Wives and intimate partners were instrumental to men's post-mastectomy body image and masculine subjectivities. Every married man talked about his wife as his cancer partner and how important her support was. Discussing his initial unease with how he looked, James revealed: "The big thing was when I came back from the hospital, how did my wife look at me. And so for the first time she looked at me she said 'It's a dimple.' And, I said, 'Okay, cool, whatever you want to call it…'".

For a few men ($n = 4$, 24%), they were guarded and avoided unwanted attention or queries about their bodies. The unique deformation produced by the radical mastectomy (i.e., large quantity of muscle extraction, loss of a nipple, the asymmetry) was, they believed, conspicuous and unwanted attention was distressing. For them, wearing a tailored shirt or a golf shirt might highlight the asymmetry. These four wrestled with the social expectations that body wholeness matters. Stan commented: "I miss my parts. It looks strange, you know." More commonly, however, men ($n = 13$, 76%) commented that they came to accept their disfigured chest:

> I was kind of self-conscious the first year. But um…It is a sizable scar…right down to, you know, to the ribs…It doesn't really bother me. I go on vacation or go swimming at the beach. I'm not self-conscious. I don't feel like people are staring at me. I really think a lot of people don't even notice. (Jeffrey)

Representing the majority ($n = 13$, 76%), Jeffrey voiced a body/self-presentation that tended to normalize the mastectomy as necessary for tumor removal. The scarring was a badge of survival. One older man [Andrew] succinctly put it, "Walking around with a scar is minimal compared to the options."

Unruly Bodies

Living with breast cancer is associated with the unruly bodies created by the adjunct hormonal therapy. Only two men reported no ill side effects. For a majority ($n = 15$, 88%), the side effects ranged from lowered libido and the unpredictability of erectile function to fatigue, vertigo, and episodic hot flashes. Henry mentioned "Sometimes I have to ask her [his wife] 'Is it getting hot in here?' and she would say, 'No, I'm freezing!'" Chris described his sudden mood alterations and feeling suddenly hot and retold us how his wife wittily said "Welcome to my world!" The side effects were severe enough that three men sought an alternative to Tamoxifen, an estrogen modulator. Brian recounted his decision to "forget this" after 2 months; with his oncologist's encouragement he said he tried it again for another very brief period, but concluded "nah, nah, nah, ain't doing it!" He then began a course of Femara, which is aromatase inhibitor.

By comparison, Stephen stuck with the Tamoxifen therapy and summarized his odyssey as "I have to deal with these feelings! It's like watching Oprah [a television talk show] everyday." He continued to emphasize that the issue with Tamoxifen was not that he was feeling feminine, it was that he was not himself as he knew:

> Being a man you think emotions are like following the Oakland Raiders [U.S. football] with a beer in your hand… But, uh, to be, uh, ruled by your emotions. I mean, I *have* PMS, I *have* hot flashes, I *have* emotional explosions…I have things where I react, where my emotional reaction is the primary reaction. That is not a male experience in life…I have to now think "Is this me?" (Stephen)

The sexual lives of many of the men ($n = 9$, 53%) were interrupted by their hormonal therapy, and this was reported as distressing by some. The men who were distressed typically were the younger participants who had not previously experienced any aging-related erectile change. Despite the distress, the men near unanimously interpreted their flagging libido or loss of erections as a cost of surviving cancer. The disruption to penile-vaginal intercourse was, they knew, drug determined, explainable, and thus a "not me" problem. Jeffrey best captures the matter-of-fact perspective the younger men held: "Not having the desire, I wasn't too much aware of the impotence…I have only another year to wait." Noteworthy, across the interviews the men regularly mentioned the importance of hugs and touch as well as how they and their wives or intimate partners still desire the sexual intimacy of touch.

Injured Body

Sharing the identifier of a mastectomy, the men also shared the wound that they "are," not were, men with breast cancer. A majority of the participants ($n = 10$, 59%) were still living with post-surgical treatments at the time of the interview and were keenly aware that they live with breast cancer; the others ($n = 7$, 41%) were equally mindful of their status as a breast cancer patient in-remission. James, and many others ($n = 11$, 61%) referred to the invasive cancer as "it" and their scarred, and at times unruly, body as "me." A man about the same age as James, in his mid-70s, remarked how his sense of being a man was not threatened, partly due to his age; he proposed that "Younger men define masculinity differently and their physical bodies are more critical whereas older men can see past that" (Andrew).

Despite their injured body, the men also knew their injured bodies were unlike 99% of other breast cancer patients because, as men, they were managing breasts and masculinity. Even with a mastectomy scar, some new physical limitations, and, in general, an injured body, they felt privileged. They knew women had more seriously wounded bodies. Randall summarized: "Women have to go through a lot more." Mentioning his experience in a breast cancer support group in which he was the only man, Ted disclosed: "I heard the worst stories there. It made me cry. Still brings tears to my eyes."

Embodiment of their Breast(s)

Embodying the reality that they had breasts was a lengthy process, most often taking a few months of reeling before the men self-identified as a man with breasts. As well, the men's embodiment of their breasts appeared contingent on both historical time and personal resources. Trajectories of embodying their breasts began with navigating foreign (women's) spaces, then decisions to disclose their breast cancer diagnosis or not, and finally amending their subjectivity about what corporeally makes a man a man.

Navigating Foreign Spaces

The oddity of being a man scheduled for a mammography exam ($n = 14$) was both troubling and enlightening, and most men typically retold what they experienced as surreal. Fred evoked the image: "It's like being the only guy in the sorority house." George noted: "I don't spend a lot of time in a lingerie department at Nordstrom's [a department store], but this was too similar." Most men ($n = 11$, 65%) used a similar anecdote of being out-of-place. Here is a typical example of how men never anticipating their need for the exam reported their aghast:

> You go in to this clinic, and uh, you're really about the only guy. Oh there's some other men that may be there with their wives. But you're really the only guy patient, and then you're filling out the forms and the forms are all for women—when did you have your last [menstrual] period, and when did you have this, and all this other shit. So, oh my God. I was like "I am a guy, what am I even doing here?!" And it's just a shock, it's just a shock. (Stan)

Most ($n = 14$, 82%) men's stories also recapped the awkward interactions with how healthcare professionals did not know what to say/do with a man's body in the gendered space of the breast clinic. For example, nearly half ($n = 7$) of the men related that they felt clinic staff purposely isolated them when they arrived for the mammography exam. Other times the men recounted the awkwardness of a breast clinic's protocol for body privacy. Kenneth disclosed:

> And uhh, after the, ah, mammogram I go in for the sonogram, and she gives me a robe, and I was like "I don't need a robe to walk around. You need me to have a robe?" And she goes "Well, no…" and I go "I walk around the beach like this." [laughs]…Then she does the sonogram thing and she throws a towel over me, and I go "What are you doing?" and she goes "Oh, sorry, it's a habit." (Kenneth)

In sum, the men's narratives routinely included some account of the incongruity a breast clinic produces vis-à-vis their taken-for-granted masculinized bodies having chests, not breasts. The mammography exam was a positioning moment; younger men more often addressed the dissonance of having breasts and storied accounts of self-out-of-place, whereas older men's discursive emphasis included their unanticipated appreciation of women patients' anxiousness. One older man emphasized his discomfort of invading *their* hallowed space:

> Now the other thing is… I mean, the mammography clinic is designed for women…I didn't want to intrude on their world. I mean, being a man, and when you're the only man in the room with 12 women and you all know what you're there for, it's, it isn't about having a weird disease. It's about I'm intruding…And I, mostly…strange kinds of empathetic and sympathetic feelings. Like I, I felt sorry for the women that I saw there... you know, I thought more about that than myself. (Stephen)

The men commonly spoke to how much they felt alone—being the peculiar man with breast cancer, the one-and-only man with breast cancer their physician or surgeon ever knew. Each man was aware that other clinic patients may not think of him in terms of having breasts. He too had not thought of himself having breasts or needing robes for privacy.

To Tell or Not

Embodying the reality that they had breasts was a lonely process for nearly all the men because they knew no other man with breast cancer with whom to talk. Patrick's comment is telling:

> This is not a club I wanted to join…the first time I knew I had breasts is when the doctor told me I had breast cancer. Ya know what I mean? If we were playing basketball and you bump me in the chest I'm *not* gonna say, "ahh, you hit me in the breast." Ya know? (Patrick)

One possible strategy to manage their sense of being an oddity was to conceal the oddness from others—work colleagues and maybe even family members. They were concealing the fact they had a life-threatening cancer and its location. Its location was their oddity. Most felt, as Stephen remarked: "There's apparently—and I didn't ever personally experience this—but I've heard it *anecdotally* [his emphasis], men who are embarrassed about breast cancer…won't talk about it to anyone." Only a few of the men ($n = 4$, 24%) reported a sense of stigma or ever being troubled with telling others that they

had breast cancer (see Table 1). A majority ($n = 13$, 76%) disclosed their breast cancer diagnosis to friends or coworkers, when appropriate. Jeffrey summarized this majority: "I certainly didn't keep it, you know, a secret or anything…I didn't put a sign out either." Kenneth commented: "Socially, I don't bring it up. But obviously everybody knows, my circle of friends, other Vets [veterans], everybody knows." Henry, who lived in a retirement community, said: "I don't really talk about it cause there's no need to…around this place everybody has something…but, uh, the people I have mentioned it to, particularly here, take it in stride. Oh, okay, you got that." Ted reported:

> Honestly, what is there to be…[pause] to be ashamed of! If you have a knot on your lip [pause], wouldn't you go and see about it? And see what it is? You know I had a knot in my chest so I went and saw about it. And, um, to me there's nothing de-masculating about me telling this experience. (Ted)

The tempered ease among most men about disclosing their diagnosis or scarred chest was never about a sense of lost manhood or being ashamed of living with a "woman's disease." Rather, the guardedness of disclosure was the wariness of having to again manage a stopped conversation. Randall exemplified this pattern of being comfortably open yet cautious of disclosure:

> My wife and I were talking to this other couple we had just met, talking about different things. And somehow it came up, cancer came up, and my wife said to this couple "Oh, my husband just got done going through chemo." And, "Oh, what kind of cancer did he have?" "Oh, he had breast cancer." And their look was like, you know, like WHAT? And so we get that sometimes; there's a little hitch. (Randall)

There was one notable exception to the men's managed openness. Thomas was one of the oldest men we interviewed and had been profoundly troubled by having cancer and mortified by acquiring breast cancer when he was diagnosed at age 44. He elected to not tell anyone other than his wife, not even his children. He also actively hid his cancer treatment from work colleagues, including his nausea. When the interviewer probed: "At one point did you tell people?" Thomas replied, "NO. I had asked my wife not to tell anybody. Don't tell my mother, don't tell my father, don't tell my children—don't tell anybody. I didn't tell nobody." It took Thomas 20 years to tell his children. He was diagnosed in the mid-1970s, when a cancer diagnosis of any kind was publicly regarded as the equivalent to a death sentence; it was also an era when people were so reluctant to talk about breast cancer that [First Lady] Betty Ford's disclosure captured national attention. In the 1970s, his cancer was, for him, a gender assault. He commented that the type of political work he was doing in Washington DC compelled, he felt, concealment: "If you've got cancer you're not 100% and therefore you're maybe not somebody we appoint." He added: "It was also a male thing. I liked my work. And men don't get breast cancer…if I start[ed] telling people they were gonna think I'm gay or something." The interviewer asked: "Looking back, if you had begun this experience in the past decade, do you think you would do the same thing, in not telling?" The man quickly responded: "No. If I was to do it now, uh I would tell. In fact…that's one of the things that I do now, is to tell my story." The cultural stigma of having cancer, even breast cancer, had receded.

Reformulating Masculinities

In many understated ways, men's breast cancer stories disclosed how they amended or reformulated their masculine subjectivities and practices as they embodied having breasts and cancer. The pace at which these men transitioned from perhaps feeling as if they were "freaks" when diagnosed into being men who happened to have breast cancer varied, principally in terms of the historical time and the age-related discourses around masculinities. Regardless of age, men diagnosed within the past decade or so mentioned their awareness of the culture discourses on masculinit*ies*, unlike men diagnosed three or four decades earlier who lived with the more restrictive norms regarding gender. As the youngest man in the study commented:

> I think among old men they almost consider it to be a stigma, they almost don't want to tell people, you know, it's some kind of, I don't know, a black mark, but I never looked at it that way…I think people younger would just view it a little differently, you know it's cancer, it's something they have to deal with, it doesn't really matter what type of cancer it is. (Jeffrey)

Context equally mattered. Within the medical community nearly all the men were acutely aware that they were the only man with breast cancer. They felt and were unusual. Nearly all ($n = 14$, 82%) were likely the only man with breast cancer their surgeon had encountered. James retold a story about his surgeon:

> So I asked her on the day that I was to be operated on, I was sitting and I said "What did you do last night? You didn't drink or anything did you?" And she said "Of course not! I stayed up most of the night looking at literature." And I said "Well there isn't any literature on guys." And she said: "Well I looked at literature for women with small breasts." And she said: "You have tight pecs [pectoral muscles], I don't know how many

> incisions I'm gonna have to make." And I said "Well this is sort of like an experiment isn't it, doctor?" (James)

By comparison, outside the medical community nearly all of the men were indistinguishable from other men. Given this, they were initially reluctant to identify themselves to acquaintances or work colleagues as men with breast cancer. For example, one older man who was a high school teacher initially told his students he had "chest" cancer: "It was embarrassing at first" [George]. But within a month, all his students knew he was being treated for breast cancer, and he said he was comfortable—adding the identity of a man living with breast cancer to being a teacher. Amending their subjective masculinities to embody being a man with breast cancer and a mastectomy was a common "coming to terms," and their discursive conversations revealed their subjectivities were amended, more than reformulated.

Some men's narratives now and then involved a pointed self-presentation during the interview consistent with traditional masculinities, such as when Jeffrey referred to being "relatively muscular":

> I was kind of self-conscious the first year or so but um, I'm in pretty good shape, I'm relatively muscular, not super muscular, but I'm toned, I'm in shape, and I think a lot of times unless I'm really up close to people, I think a lot of times they don't even see it… I'm not self-conscious. I go on vacation or go swimming at the beach, I don't feel like people are staring at me. (Jeffrey)

Thomas, the old man who had concealed his cancer despite two mastectomies, similarly commented: "Well what I see is a reasonably presentable me. And I think I survived, uh, as well as I did by every morning when I got up I looked in the mirror and I said 'I can beat this thing because I'm tough.'" Kenneth, who was self-employed, commented: "It's kind of my philosophy of my whole life. You know, it's another hurdle…Hey God throws you another hurdle, jump over it, and keep on running." This type of masculinist discourse was more prevalent among the men whose employment required a masculinist public persona, such as a contractor or attorney.

However, regardless of whether they were still in treatment or years into remission, the majority of these men rebuked certain stereotypic conceptions of masculinity. For example, most of the men spoke about their changing masculinity practices, such as the importance of doing masculinity "right" by letting go of the stoic, tough guy self-reliance. Also in contrast to the standards of traditional hegemonic masculinity, they reported now prioritizing relationships and the emotional work that goes into relationships. Some told stories of casting aside the fear of losing their respectability by telling others or seeking support, such as when Andrew said, "That's another guy thing, you don't think you need to talk to someone till you *really* need to talk to someone." As Jeffrey commented:

> I think you're forced to think about issues and it does kind of give you perspective and you kind of realize what's most important. And some things I think can be turned for the good from the experience, um, maybe get a little more grounded and maybe reevaluate what's most important. (Jeffrey)

Most of the men disclosed ways that their masculinity practices changed. They now sought out close friends and partners for emotional support; many regularly consulted physicians; and nearly all said they were comfortable talking with friends, and sometimes acquaintances, about their non-normative bodies and cancer experience. These conversations were typically one time exchanges—that is, other people and even partners/spouses did not revisit the men's breast cancer experiences once the issue was discussed. Putting into words their lived experience was difficult. Stephen explained:

> Breast cancer, for me, means a whole complex of experiences, of realizations. It's like being in the military, you know. You meet somebody who's been in the military, you don't have to say anything. But if you meet someone who hasn't, there's not a way in the world to describe what it's like. (Stephen)

Every man also unveiled a decision to take charge and become socially active, principally in terms of raising public awareness about male breast cancer. Put differently, the men found their marginalization seeded an unexpected quest to inform. Some actively hounded breast cancer organizations and charity events to include them as a "poster boy" to symbolize that men too can get breast cancer; some made themselves available to the media; one business school professor inspired his marketing students to address the hegemony of the pink-ribbon campaign; and several volunteered to mentor any man newly diagnosed with breast cancer and attend "medical rounds" for a new cohort of nursing and medical students. The men's call to social action was because they were men with a breast cancer career and a story about how they embodied the intersection of breasts and masculinities. Chris commented: "Two years as a thriver I knew it was time for me to help others. Not only must we fight back, we must give back."

Discussion

Two meta-themes were within the men's narratives of their breast cancer experience: body talk and embodiment of their breast. These themes emerge within the incongruent cultural contexts of hegemonic masculinity discourses and the U.S.

pink ribbon culture surrounding breast cancer. Long-standing social discourses of breasts as a sign of femininity (Langellier and Sullivan 1998) and as incongruent with being male (Dozier 2005), coupled with public health campaigns raising awareness of breast cancer (Sulik 2011), have powerfully gendered breast cancer as a woman's illness. Not surprisingly, early on the men felt out-of-sync with their diagnosis and bodies. Shortly into their cancer career, the men we interviewed also revealed their keen awareness of their marginal man status and double consciousness. They acknowledged that they were men who now have a distinguishing mastectomy scar reminder of having or had breast cancer and that, in their eyes, their breast cancer care experience revealed that they were the less injured among virtually all others with breast cancer because their mastectomy, unlike women's, results in a scarring of their chest and not the removal of a gendered body part. This gendering of a man's breast vis-à-vis a woman's not only reproduces normative views of embodiment, it is men's keen awakening to how cancer care practices become a policing of gender embodiment writ large.

All of the men had been diagnosed with a life-threatening cancer and lived with a mastectomy, which resulted in scarring and asymmetry of the chest; nearly all also faced or would face 5 years or more of high doses of estrogen, very often yielding loss of libido, erectile dysfunction, and bodily experiences similar to menopause. No man was unmoved by the cumulative experience. Their gendered clashes with the diagnosis, mammography, biopsy, mastectomy, and adjunct treatment are what underpinned the men's discursive body talk, where their musings addressed breasts and masculinities as well as their surgically wounded body and estrogen-boosted unruly body.

All of the men initially felt marginal vis-à-vis the culture of hegemonic masculinity, which does not link having breasts and masculinities or envision a man becoming a patient within a breast clinic, and they felt marginalized as patients within the breast clinics. The men's conventional sense that breast clinics were women's spaces (cf. Quincey et al. 2016) was affirmed by clinics' policing of gender with modesty norms and segregating men patients into separate waiting areas. While wrestling with dual senses of marginalization, their embodiment of living with breasts, at least one removed by mastectomy, revealed the double consciousness of being a man with a "counter-gender" illness (cf. Leonard 2004; Solimeo et al. 2011).

Embodiment of their breast cancer and mastectomy was, generally speaking, a slow process, slower for some than for others. In general, embodiment was slower among older men, whose gender beliefs were partly rooted in traditional masculinity ideologies (Thompson and Langendoerfer 2016), compared to contemporary hybrid masculinity ideologies (Bridges and Pascoe 2014) that shield men from the demands of traditional masculinity. Embodiment was also slower among the men whose breast cancer diagnosis was not recent—that is, in past times when Western cultural taboos and superstitions once associated with breasts and breast cancer governed social discourse, such as how women's sexuality remained largely silenced and breasts were usually spoken of in a modest way (Howe 1981) and how breast cancer was a "dirty secret" and not publicly disclosed (Reagan 1997; Sulik 2011). Men diagnosed 30–40 years back lived within more stigmatizing times in terms of breast cancer as a taboo subject, much less a man with breast cancer.

Embodiment trajectories were also affected by the men's aging. Unlike most of the middle-aged men at the time they were diagnosed, the older men had already endured more effects of corporeal aging, including erectile changes, and some had also experienced invasive treatment for a cardiovascular disease, prostate enlargement or cancer, and/or hernia repair. The aging men's masculinity practices and subjectivities reflected the "softening" (Mann et al. 2016, p. 605) and "widening" (StGeorge and Fletcher 2014, p. 369) of masculinities that come about with changing bodies and expanding fields of practice (Coles 2009). The older men's narratives emphasized relational selves and their everyday life as family-centric, no longer workplace-centric; more often mentioned were the adventures of grandfathering, time spent in recreation and chatting with friends, or how their later life sexuality was narrated in terms of intimacy and touch (cf. Sandberg 2013).

Practice Implications

A number of social theorists (e.g., Bauman 2000; Featherstone and Hepworth 1991; Turner 1996) have noted that bodies are a means of displaying self. Our reflexive bodies are in addition to the fleshy, material body. The reflexive body is a site of personal self-expression and, at times, amendment and re-invention. Before their diagnosis, the men in our study varied greatly in terms of their approximation of the esteemed fit, hard body. Still, they identified as men. After their mastectomy, the body reflected in the mirror every morning differed significantly from who the men once were. Even so, although their breast cancer reminder—their surgically-sculptured chest— set them apart from other men, the men felt their bodies, lives, and identities converged more with other men than diverged from men. That is, these men's comparison remained other men who shared their veteran status, employment experiences, and so on. Across the interviews, some men talked about the normalcy of their work lives; some men emphasized their ongoing involvement in religious communities; some addressed their military experience; and other men called attention to being fathers and/or grandfathers. Their corporeal bodies may well be less-normative, when displayed or talked about, but their lives remained more normative than not.

The stories these men voiced about their bodies, breasts, and masculinities do not fit the emasculation story that men with breast cancer are wrestling with a spoiled identity and stigmatized post-mastectomy body. Cushman and colleagues (Cushman et al. 2010, p. 22) warn how the discourse of "emasculation" reinforces a singular, idealized masculinity and ignores the broad range of lived masculinities. Consistent with this perspective, Manderson (1999) and Gerschick and Miller (1995) eloquently summarized how men with altered or less-than-whole bodies know they are different, maybe even stigmatized, yet they maintain their identities as men. The men in their studies revised masculinity practices to manage their lack of body wholeness, and they maintained and acquired masculine capital in ways aside from strength or body wholeness. Some of the recent research on masculinities and chronic illness brings to light this more complex, nuanced view and describes numerous patterns of lived masculinities among men with troubling chronic illnesses (Gibson and Kierans 2017; Hurd Clarke and Lefkowich 2018; Wenger 2013; Wenger and Oliffe 2014; Wentzell 2013). On the whole, the men's comparison standard was of themselves now vs. earlier, rather than the homophobic aspect or emasculation aspect of hegemonic masculinity discourses.

The emasculation story others have proposed also appears to be more the observer's point of view (Sakalys 2000), not the voice and stories of the men who live with breast cancer. The story likely draws on the initial dismay men experience with diagnosis and treatment—the you-gotta-be-kidding-me moment. The men in our study experienced the distancing of a marginal man caught between the incongruous cultures of masculinities and the U.S. pink ribbon breast cancer community. They talked about amending their identity rather than a marked reformulation. Their chest has breasts, and they had become lifetime members of the involuntary breast cancer club. Nonetheless, their everyday lives were defined by being husbands or partners, friends, fathers, and grandfathers, and they were mindful that loss of a breast is deeply troubling for women, less so for themselves. Breasts do not typify men or masculinities. Practitioners would be advised to not expect a sense of emasculation to be a troubling undertow, but rather to hear that men have a life-threatening cancer and that is what is at issue. Its location is secondary and wholly unexpected.

Limitations and Future Research Directions

Although our study has limitations, it contributes to studies of aging men and masculinities in distinct ways. First, the U.S. men interviewed for our study were not a clinical sample of the recently diagnosed. They were community-based and a somewhat diverse group, differing most by age, as well as class, geographical location, illness histories, and age at diagnosis. Because these participants came to live openly with breast cancer, our study likely uncovered the voices of men who reconciled a disrupted body-self relationship and accommodated the meaning of having a (lost) breast. To what extent are the findings in this study an artifact of the participants who are open and wanting to talk? Using a cliché to question, are the participants in this study the "tip of an iceberg"—that is, only the men who are not concealing, who seem to be not terribly fretted by breast cancer's challenges to masculine subjectivities? Consequently, perhaps our findings are not generalizable to a larger population. Prospectively following even a small group of men from diagnosis to their 3-, 5- and 10-year anniversary would better determine what coping and masculinity practices become commonplace among men living with breast cancer. Differences among the participants also highlight a need for new research to determine how age-, class-, and ethnic-based masculinities affect the experiences among men when living with a gender-atypical illness. For example, the older men in our study who lived with aging bodies and softened masculine subjectivities to matched their age capabilities were less troubled by their discoveries that they had breasts and breast cancer.

Second, distinct and incongruous connections among masculinities, breasts, and health experiences need further attention. Most of the men in our study seemed to have taken significant health risks by discounting the initial signs of breast cancer, and this pre-diagnosis behavior may illustrate the masculinity practices consistent with how hegemonic masculinities can undermine health (cf. Courtenay 2000). When breast cancer disrupted their lives, these men re-evaluated their body-self relationship and integrated taking responsibility for their health, perhaps also as a take-control masculinity practice. Their post-mastectomy stance to accept the troubling side effects of hormonal therapy as they "fight" their cancer also seems to be consistent with men amending traditional masculinity practices (cf. Gibson and Kierans 2017; Wentzell 2013) or reformulating their masculinities through questing and public advocacy. Whether or not these transformations in men's subjectivities took place primarily as the result of men's breast cancer experiences needs to be disentangled from the fact that these men were mature, most often older, and we recognize that aging prompts men to reconsider the guidance of traditional masculinities, especially in terms of health practices (O'Brien et al. 2005; Robertson et al. 2016; Thompson and Langendoerfer 2016). As well, some of these men had experienced other health challenges or were likely old enough to recognize their impermanence (cf. Carstensen 2006); this could also account for why some of the men more readily embodied their breasts and breast cancer.

Conclusion

Our study identified sufficient evidence that nearly all 17 the men living with breast cancer were initially dispirited, yet not compromised as men nor forced into a closet. Just the opposite. Although incredulous with the diagnosis and thunderstruck with the need for a mastectomy, the men became accustomed to the cancer-initiated changes in their bodies and lived openly, and often vocally, as men with breast cancer. Perhaps research using several focus groups of men with breast cancer from different generations or age cohorts, of men and women with breast cancer, and a mixed group of men with either prostate or breast cancer or both could sort out the intersecting effects of age and masculinities on men discovering and embodying their breasts.

Throughout the present narratives were stories of men's agency and their widening of traditional masculinities. They volunteered to provide testimony at breast cancer events, urged breast clinics and their own physicians to allow them to mentor new male breast cancer patients, or pushed pink ribbon organizations to be more inclusive and include them as "poster boys" in breast cancer calendars or for newspaper articles (cf. Blackstone 2004). They argued that had mentors been available at the breast clinics and oncology treatment sites, the men's initial horrors could have been lessened. The men all mentioned that they had never met another man with breast cancer until they personally began reaching out (cf. Farrell et al. 2014). They wanted to find others like themselves and compare experiences. Perhaps medical centers with breast clinics can recruit men who have lived with breast cancer to volunteer as mentors and erase the lonely experience the men in our study lived.

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Compliance with Ethical Standards

Conflict of Interest There are no conflicts of interest.

Ethical Approval The research project was approved by the College of the Holy Cross Human Subjects Review Committee in May, 2009.

Informed Consent Participants provided their informed consent at the scheduling of the interview and again at the onset of the audio recording.

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