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Masculinity and the Body: How African-American and White Men Experience Cancer Screening Exams Involving the Rectum

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Abstract

Past research on prostate and colorectal cancer disparities finds that barriers to screening, such as embarrassment and offensiveness, are often reported. Yet none of this literature investigates why. This study uses masculinity and health theory to examine how men experience two common screenings, digital rectal exams (DREs) and colonoscopies. In-depth interviews were conducted with 64 African-American and white men from diverse backgrounds, aged 40–64, from North Carolina, USA. Regardless of race or education, men experienced DREs more negatively than colonoscopies because penetration with a finger was associated with a gay sexual act. Some men disliked colonoscopies, however, because they associated any penetration as an affront to their masculinity. Because beliefs did not differ by race, future research should focus on structural issues to examine why disparities persist with prostate and colorectal cancer. Recommendations are provided for educational programs and physicians to improve men's experiences with exams that involve the rectum.

Keywords

prostate cancer screening; colorectal cancer screening; health disparities; African-American; masculinity

After skin cancer, prostate cancer is the most common and colorectal the third most common cancer among men in the United States (American Cancer Society, 2007; 2008). Health disparities persist for both cancers with higher incidence and mortality rates among African-American men compared to white men (ChengWu, Chen, Steele et al., 2001; Clegg, Li, Hankey, Chu, & Edwards, 2002; Grossfeld, Latini, Downs, Lubeck, Mehta, & Carroll, 2002). Because these cancers are more likely to be cured when detected early, the American Cancer Society recommends annual screening for all men beginning at age 50 or before, depending on risk factors (2007). While screening reduces colorectal cancer incidence and mortality (United States Preventive Services Task Force, 2002), efficacy of screening for detecting early prostate cancer to reduce mortality is controversial (Weinrich et al., 2004). Given the current lack of evidence, the American Urological Association and the United State Preventive

Services Task Force recommend that physicians inform their patients of the risks and benefits of screening and assist men in making their decisions (McFall, Hamm, & Volk, 2006; Weinrich, 2004).

Much of the research on prostate and colorectal cancer beliefs, knowledge, and screening finds that barriers to screening include African-American men's perceptions that DREs are "embarrassing" and colonoscopies are "offensive," but none of this literature investigates why men report these attitudes (e.g., Allen, Kennedy, Wilson-Glover, & Gilligan, 2007; Bloom, Stewart, Oakley-Girvans, Banks, & Chang, 2006; Greiner, Born, Nollen, & Ahluwalia, 2005). Masculinity and health theory may provide insight into why men report negative attitudes about exams that involve the rectum. In the past, research on gender and health has focused on the consequences of the cultural and medical devaluation of femininity for women's health, while men's gender has been taken for granted (Courtenay, 2000). For example, prior research has shown that men are more likely than women to engage in behaviors that risk their health but are less likely to access the healthcare system (see Courtenay, 2000, for review), yet little social science research has illuminated why men's constructions of masculinities result in these different health behaviors. This oversight perpetuates the mistaken cultural assumption that those behaviors are inherent in men (Courtenay, 2000; White, 2002). Furthermore, research on who the "men" are in men's health needs greater exploration (Courtenay, 2000). Men construct masculinity differently depending on their social structural location and the social context (Connell, 1998; Segal, 1990). These constructions most likely result in different health beliefs and behaviors (Schofield, Connell, Walker, Wood, & Butland, 2000).

This study examines how men's constructions of masculinity affect their attitudes toward prostate and colorectal cancer screening. We analyze in-depth interviews with 64 men, 35 African-Americans and 29 white men in the United States, aged 40–64, from diverse socio-economic backgrounds. We investigate how constructions of masculinity by African-American and white men with diverse backgrounds affect their experiences of exams that involve the rectum. Without such an analysis, the social processes behind their beliefs and behaviors are invisible, which leaves us with essentialist explanations (e.g., "that's just what men do"). Examining the social processes behind men's beliefs will offer insight into how to overcome men's reluctance to be screened and how to improve the experiences of those who get screened.

BACKGROUND ON DIGITAL RECTAL EXAMS AND COLONOSCOPIES

Medical practitioners routinely use DREs in combination with other tests to screen for prostate cancer, and colonoscopies with other exams to screen for colorectal cancer. The digital rectal exam is performed by a doctor putting a gloved finger into the rectum to examine the prostate, which lies directly in front of the rectal wall, to determine if it is larger than it should be or if there are any unusual growths on the prostate. The doctor will also determine if there are growths in the rectal cavity; this exam lasts up to 15 seconds. Twenty-four hours before a colonoscopy, a person must prepare their colon by adhering to a clear liquid diet and taking a laxative to clean out the colon. The exam itself consists of the insertion of a colonoscope, a long, thin flexible instrument with a lens on the tip that allows doctors to look at the entire colon. A colonoscopy typically lasts 20 minutes, but if polyps are found, it can take another 10 minutes to remove them.

Differential rates of screening are believed to play a key role in racial disparities in prostate and colorectal cancer mortality. Several studies on prostate cancer focus on African-American men's lower screening rates and attribute those to their beliefs and attitudes, including the fear and embarrassment of having a DRE (Allen et al., 2007; Forrester-Anderson, 2005; Sanchez et al., 2007; Webb et al., 2006). One study finds that even when education is controlled, African-

American men report more fear and anxiety of DREs compared to white men, which influences their lower screening rates (Consedine, Horton, Ungar, Joe, Ramirez & Borrell, 2007).

Major barriers to having a DRE among African-American men relating to their masculinity are discomfort, embarrassment or the belief that the exam is associated with homosexuality (Allen et al., 2007; Bloom, 2006; Sanchez et al., 2007; Webb et al., 2006). Most of these studies rely on samples of African-American men and create the impression that something about African-American men in particular results in their greater resistance to DREs. Yet research that compares across race suggests that those beliefs are not held by African-American men alone (Consedine et al., 2007). Furthermore, none of these studies investigate how or why the DRE challenges men's masculinity and sexuality. This area of research is untapped; such concerns have only been noted anecdotally (Consedine et al., 2007).

Research on colorectal cancer also focuses on adherence to screening. Unlike the prostate cancer literature, much of this literature compares men to women because colorectal cancer affects both. It also often contains samples of whites and African-Americans. Several studies find that of the various barriers, discomfort, embarrassment, and pain are commonly reported (Bleiker, Menko, Taal, Kluijt, Wever, Gerritsma et al., 2005; Denberg, Melhado, Coombes, Beaty, Berman, Byers et al., 2005; Janz, Lahkani, Vijan, Hawley, Chung & Katz et al., 2006). Similarly, in research that focuses on African-Americans, fear of colorectal screening is cited as a major barrier (Greiner, Born, Nollen, & Ahluwalia, 2005). One qualitative study finds that embarrassment and "perceived 'offensiveness'" was a concern of focus group participants; it quotes an African-American man to illustrate these sentiments: "probing around in my rectum...[is] treading on my masculinity" (Beeker, Kraft, Southwell, & Jorgensen, 2000, p. 268). Yet this study does not analyze why an exam that involves the rectum would affect an African-American man's masculinity. Overall, most of this research descriptively explains men's and women's attitudes to screening without specifically analyzing why colorectal screening is embarrassing or offensive.

MASCULINITY AND HEALTH THEORY AND RESEARCH

Very little research has examined the effects of masculinity on health practices (Gough, 2006). Masculinity is a complex, fluid concept and does not refer to a particular characteristic or a role. Rather, it refers to a set of culturally created beliefs, identities, and practices that are constructed through interactions between individuals in various contexts (Courtenay, 2000; Gough, 2006). The most socially dominant type of masculinity, hegemonic masculinity, is associated with power over women, and racial and sexual minorities (Connell, 1987; 1995; Kimmel, 1994). Hegemonic masculinity is not a fixed type of masculinity. It is an idealized form of masculinity that most men cannot literally enact but can benefit from because it is a normative idea of what manhood is (Connell & Messerschmidt, 2005). Complying with hegemonic masculinity can both benefit and harm men. For example, those men who do not have social statuses that reflect hegemonic masculine ideals can validate their sense of selves as men by engaging in practices that are associated with masculinity and that can also hurt them. For example, some young, poor African-American men act tough and put themselves in physical danger to gain the respect of their peers (Rich & Stone, 1996).

Health beliefs and behaviors are an arena in which men's adherence to hegemonic masculinity can have consequences for their health when they reject behaviors they associate with femininity or homosexuality (Courtenay, 2000). For example, young, healthy men may delay visits with doctors because of a desire to avoid what they view as a feminine characteristic, seeking help (O'Brien, Hunt, & Hart, 2005). Men who subscribe to dominant masculine ideals and need help negotiate their sense of masculinity to justify receiving care. For example, older men with illnesses seek care only after they have endured symptoms on their own, a

conventional masculine way of coping (O'Brien, Hunt, & Hart, 2005). Clearly, constructions of masculinity intersect with men's health beliefs and practices in complex ways.

With regard to cancer screening, men must negotiate their vulnerability of seeking preventive health care, in addition to the fear for some of finding out they have cancer (Myers, Wolf, McKee, McGrory, Burgh, Nelson, et al. 1996). The literature identifies some barriers for men, especially African-Americans, to prostate and colorectal cancer screenings including fear, embarrassment, and offensiveness. Thus far research has not investigated why men hold those beliefs and whether the reasons for those beliefs differ by race or socioeconomic status. This study extends past research by using masculinity and health theory to investigate how a racially and socio-economically diverse group of men experience cancer screening exams that involve the rectum. The findings will inform educational programs and physicians on how to overcome men's reluctance to undergo cancer screenings that involve the rectum, and how to improve the experiences of those who do get screened.

METHODS

Study Design: Sample and Interviews

The data for this paper were from in-depth interviews with 64 men, aged 40–64, from diverse socio-economic backgrounds. This study is part of a larger project on African-American and white men's beliefs, knowledge, and screening for prostate and colorectal cancer. The larger study consisted of two in-depth interviews for each man for a total of 128 interviews. During the first interview, general topics on beliefs about health, illness, cancer, and general cancer screening tests were discussed. The first meeting allowed the interviewer to develop rapport for the second interview, which covered potentially sensitive topics on men's beliefs, knowledge, and screening practices for prostate and colorectal cancer. In this paper, we focus on data collected from the second interview.

Two male researchers conducted the interviews and gave men a choice of different private locations to meet. Some men preferred their own homes, while others chose conference rooms in churches or in the department where the researchers work; all of these locations were private to ensure quality recording of the interviews. Based on a semi-structured interview guide, men were asked what they know about the prostate and colon, prostate and colorectal cancer, prostate and colorectal cancer prevention and screening, digital rectal exams, prostate specific antigen blood test, sigmoidoscopy and colonoscopy, and barriers to screening. Prior to questions on specific screening tests, each man was read a description of prostate and colon cancer screenings from the American Cancer Society, regardless of his level of knowledge. As is standard in qualitative interviews, follow-up questions were used to clarify vague responses. Each participant was assigned a unique identification number to preserve anonymity. Interviews ranged from one to two hours, and each was tape-recorded and transcribed.

The sample was recruited from several counties in North Carolina including small and medium size towns, and urban areas. Interviewers worked with different groups in each area including churches, social services, and men's groups, to locate and recruit African-American and white men between the ages of 40–64 who have not had prostate or colorectal cancer. The goal in sample recruitment was to obtain a balance of African-American and white men from rural and urban areas across three educational attainment levels: low education, which was defined as high school graduate and lower; medium educational attainment, which was defined as some college; and high educational attainment, which was defined as college graduate and higher.

The initial goal of sample recruitment was to obtain a balance between men who never had a DRE and those who have. However, most men had the DRE either when they enrolled in the military in their youth or as part of a routine exam. Therefore, we focused on recruiting men

who had not had the DRE specifically for cancer screening to compare with those who had it as part of a cancer screening.

The total sample includes 65 men; the one man who self-identified as gay was excluded from this analysis. Sexual identity was not a criterion for inclusion in the sample, yet all but one of the men self-identified as heterosexual. Overall, the sample of 64 men includes 19 men with low educational attainment; 16 with medium educational attainment; and 29 with high educational attainment. The low educational attainment group contains an over-representation of African-Americans, and the sample overall is highly educated. However, the sample is relatively large for a qualitative study, and has a unique combination of African-American and white men with diverse educational backgrounds.

Data Analysis

A coding dictionary was developed by the research team through discussion and consensus. Each transcript was first coded and passed on to a different investigator for second coding. Discrepancies that arose between the first and second coding were discussed and resolved at regular team meetings through consensus. As new issues arose in the data, the team collectively agreed to add or collapse codes. ATLAS.ti, a qualitative analysis software program, was used to code and analyze the data. Data analysis consisted of sorting the men into three educational attainment groups and by race within each group, and running analysis reports based on prostate and colorectal codes for each group. The prostate and colorectal codes covered men's discussions about the description and function of the prostate and colon; the purpose of prostate and colorectal screenings; men's experiences of these screenings; how they think other men experience the screenings; and barriers to screening.

Summaries were generated for each educational attainment group and for racial groups within each educational attainment group, and then distributed to the research team for identification of salient themes. Through discussion and consensus, the team established the major and minor themes about how men experienced exams involving the rectum and the implications of those experiences for men's health.

RESULTS

We analyzed African-American and white men's accounts on DREs and colonoscopies to investigate how they experience these examinations. Two themes emerged from the data. Men experienced DREs and colonoscopies negatively because they "dislike penetration," and men objected to DREs more than colonoscopies due to their "association of DREs with gay sex."

DISLIKE OF PENETRATION

Overall, the most common sentiment among those men who disliked DREs and colonoscopies was that the exams were "embarrassing" or "invasive." For DREs, some men could not explain in detail *why* it was unpleasant. In response to follow-up probes, men either repeated that they disliked it or said that part of their body was "personal." For example, one African-American man with low educational attainment (#43) said his doctor "violated" him and that "men don't like for people going up in...the rectum." When the interviewer asked him why, he replied: "I don't know! I'm a man, and I just don't feel, I don't feel comfortable like that!" Similarly, a white man with low educational attainment (#1) who has not had the DRE said he would prefer a colonoscopy because he "doesn't like the idea" of what is done with the DRE because it is "just part of the body guys feel uncomfortable about."

These views were shared by men across racial and educational groups. For example, a white man with high educational attainment (#27) said: "It's very undignified, that's what (laughs),

I don't have anything else to add. (Tell me why it's undignified?) Well, that's the most personal part of a man besides his penis, it's just, I guess, you'd never want anyone to see that part of you (laughs)." An African-American man with high educational attainment (#2) said: "Well, not something I'd volunteer for if I could help it, it would be uncomfortable. (Why would you be uncomfortable?) Just, I'm not particular about having somebody's finger up my butt basically."

Men assumed that the rectum was inherently a private part of the body that no man would want another person to see or to penetrate. In the same way, the most common reason given by those men who associated colonoscopies with their masculinity was that they or other men did not like anything "going through the rectum" because it was "a problem for a lot of men...ain't no easy test where you got to do that" (#64, African-American man, low educational attainment) or that the "invasive nature of it" was the hardest part (#34, white man, high educational attainment). Some said their "biggest fear" was "someone placing something in my rectum, that's how most men are" (#8, African-American man, medium educational attainment) or that "something's up in your rectum would be kind of a compromised position for me" (#7, white man, medium educational attainment). A few men explained that men do not want to have a colonoscopy because "of that kind of macho stuff" (#61, white man, medium educational attainment).

Discrepant Views of High Educational Attainment Men: DREs—Although all men discussed their dislike of penetration, many of those with high educational attainment reported discrepant beliefs about the DRE. In the discussion of their own perspectives, they focused on the usefulness of the exam: "it's a good measure" (#18, white man); "you see the reason for it" (#15, white man); "practical and useful" (#49, African-American man), and "I figure early detection is a lot more important than the inconvenience of a test that's not painful" (#58, African-American man).

In contrast, when these men explained why other men dislike DREs, they projected reactions onto other men that the DRE is an affront to masculinity. In these accounts, they suggested that they dislike the exams themselves: "usually when you hear people talk about it, they begin to cringe...over the thought of...the invasive technique" (#18, white man); "they don't like it, it's not a manly thing" (#15, white man); "they feel like it's pretty, intimate and it's an invasion" (#49, African-American man); and "they feel that it is...demeaning (laughs), and that it, I guess, insults their manhood" (#58, African-American man).

Discrepant Views of High Educational Attainment Men: Colonoscopies—Like DREs, men with high educational attainment most often gave discrepant answers about their views of the importance of colonoscopies and how they think other men experience them. Again, men demonstrated a tension between two constructions of masculinity as they switched from knowledgeable to essentialist views of men's bodies. In response to what they think about the colonoscopy, most said the test is "the number one method of detecting colorectal cancer" (#9, African-American man) and "a "good test (because) they (doctors) can make a quick diagnosis" (#63, white man). In contrast, when men talked about their perceptions of others' attitudes, many thought that, like the DRE, the colonoscopy was "invasive" (#16, white man) or more specifically, that "certain parts of the body weren't made for entrance in a man" (#33, African-American man).

ASSOCIATION OF DRE WITH GAY SEX

Several men explained that they dislike the DRE because they are not "gay" while only one man, a white with low educational attainment, associated a colonoscopy with homosexuality. The following quote suggests why men generally experience the DRE as more problematic

than colonoscopies: “The finger test got a serious stigma with it...the camera is not a human contact and the finger is human contact. And in that part of the body area, you know, it’s just a, a stigma with it” (#34, African-American, low educational attainment).

Other respondents elaborated why they or other men associate DREs with gay sexual behavior. Some men may fear the DRE because they may become stimulated during the exam. Those men may have a difficult time if they have an uncontrollable, and unwanted, physical response during the exam. For example, a white man with medium educational attainment (#24) said that some men fear: “Somebody’s gonna consider them gay....I had a friend that had one that, and he got an erection, and it embarrassed him to death in front of the doctor when...he got hard.”

A white man with medium educational attainment (#7) provided additional insight about why men sexualize DREs, namely childhood heterosexual socialization and a lack of experience with health-care exams:

I think probably a lot of them feel the same way I do about it, it’s not very comfortable, kind of embarrassing....(And why do you think they feel that way?)...I just think it’s the way that men are probably brought up, and, you know, raised up as to...be exposed to another man like that in that kind of setting.

An account from an African-American man with medium educational attainment (#10) pointed to the media as a further reason that men may associate DREs with gay sex in general, and with violence in particular:

I think it has something to do with, I was watching Family Guy the other day, the other night on television, and he went to the doctor and had one, and he started having all these illusions about being raped by the doctor (laughs) and, becoming submissive or something like that. And I think that men have a hard time with that. (And why do you think that is?) I guess it has something to do with, I don’t know, maybe it has a homosexual connotation to it I think.

Some African-American men were distinctly adamant that they dislike acts associated with gay sex. An African-American with high educational attainment (#55) said that because of his job in the sports field, he and his friends are aware of what “our bodies need to do,” so they get regular screenings. If he was not in this line of work, however, he would have a difficult time; he imagined what his response would be: “Let me get this straight, you’re going to take your finger and you’re going to put it where to check on what? I don’t think so, you know, homey don’t play that. We ain’t swinging that way.” Also, an African-American with high educational attainment (#14) stressed his role in intercourse as he explained why he hates the DRE, which he said is: “an insult to my manhood....(And the reason that you don’t like the finger test is because of the invasiveness?) Invasiveness, and maybe just call me homophobic. I don’t play that. I’m the screw, not the screwie.”

Consequences—One consequence of the emotional experience of the DRE is that some men may avoid or delay the exam, as a white man with medium educational attainment (#17) explained. He has not had a DRE in ten years because he is “waiting for a different way to test rather than going through the rectum.” A second consequence of the emotional impact of the DRE is that some men do not talk with other men about the exam because they fear teasing. When they do talk about it, they either joke or complain about it to minimize the toll for their masculinity. For example, an African-American with low educational attainment (#34) said: “It wouldn’t be anything that I would tell my friends about,” because they would tease him: “I bet you enjoyed that.” He said that the “fear of being teased...(about) gay stuff” is why he wouldn’t tell other guys about it. A white man with medium educational attainment (#25) talked

about his friend who complained: “Man, I hate it, I dreaded that part about that, getting that done’...because of the embarrassment of it.”

A final consequence is the potential harm to doctors as an African-American man with high educational attainment (#14) explained when he discussed the psychological toll of the DRE. He said that if he is not in the right “mental state,” his doctor might get hurt:

I hate it. It’s one of the most dangerous tests a doctor can give me. For him. (For him?) Yeah. Because it depends upon my mental state how I am going to respond to that test. Hopefully my mental state is analytical, scientific, and within control. I don’t want it to be in my normal reaction of protection. Because I may be old but even old rattlesnakes can kill you (laughs).

EXCEPTIONS

Just three men, all African-American and one from each educational attainment level, viewed the DRE and the colonoscopy only as medical exams. These men did not associate either test with their masculinity. The man with low educational attainment (#26) said that the DRE is a “good” test and that other men are like him: “(they) don’t think about it at all (because) it’s there for a minute and then gone.” Similarly, he said the colonoscopy is a “useful” test. The man with medium educational attainment (#6) said “that every guy should have one (DRE) at least once a year,” but that he viewed the colonoscopy as “more in-depth” and “more scientific” than the DRE. Like the others, the man with high educational attainment (#9) said that both exams are “necessary” for detecting cancer.

DISCUSSION

Past research on racial disparities in prostate and colorectal cancer finds that barriers to screening include beliefs that DREs are embarrassing (eg., Allen et al., 2007) and that colonoscopies are offensive (eg., Greiner, Born, Nollen, & Ahluwalia, 2005); this study draws on masculinity and health theory to investigate why. Most men in this study, regardless of race or socioeconomic status, disliked the DRE with a range of views from “it’s uncomfortable” to “I’m not gay.” In contrast, most men believed the colonoscopy is a “good” test because it is “scientific.” Some disliked colonoscopies, however, and the reason those men who experienced these exams as an affront to their masculinity was similar to that of most men who disliked DREs: they disliked penetration into their rectums. This finding provides insight into why past research finds some men dislike colorectal screenings due to their offensive nature (Beeker, Kraft, Southwell, & Jorgensen, 2000). In the present study, men who generally asserted that exams involving the rectum were “invasive” associated their rectums as part of their masculinity that requires protection.

Those who explained why they disliked DREs in particular emphasized that they experienced it as a gay sexual act. Some men objected to penetration by a finger more than a medical instrument because of an aversion to gay sex. The data suggest that in the context of a rectal exam, many men support a dominant construction of masculinity by denouncing a masculinity they perceive as inferior – that is, being “gay.” Indeed, a key way that hegemonic masculinity is maintained is by marginalizing those with less power, especially non-heterosexual men (Connell, 1995; Kimmel, 1994). The consequences of this marginalization of an inferior masculinity were not just men who objected to DREs, but included some men who avoided the exam altogether, “dreaded” their physicals, did not talk about the exam for fear of teasing by friends, and in one case even felt violent toward his doctor.

Men who disliked DREs overlooked the purpose of the exam for their health as they essentialized that part of their body as inherently off limits. This negotiation of masculinity

and health could result in a health paradox (Courtenay, 2000). When men prioritize their masculinity by resisting an exam involving the rectum, they could risk their health by allowing undetected cancer to grow. Furthermore, when men refuse to talk about the importance of the exam with other men, they could put other men's health at risk by not sharing important health information.

As with all qualitative data, we found exceptions (Esterberg, 2002). Three men, all African-American and one from each education group, said that DREs and colonoscopies are "good tests" and they did not discuss any negative views about either exam. Yet, only three men presented this view, which is striking in a sample of 64 men. Most men found exams that involve the rectum to be problematic, especially DREs.

We found presentations of masculinity unique to two groups: those with high educational attainment and African-American men. First, men with high educational attainment presented conflicting definitions of masculinity as they provided different answers about how they and other men experience DREs and colonoscopies. The interview itself was likely a presentation of masculinity in the social interaction between the interviewer and the respondent (O'Brien, Hunt & Hart, 2005). Compared to those with less education, men with more education and similar cultural capital (Bourdieu, 1973) likely viewed the meeting with the interviewers, both of whom were college educated, as a conversation between equals. These men may have been conscious about presenting a knowledgeable self when asked direct questions about their own beliefs, in contrast to their views that the exams are an affront to masculinity when they discussed other men's fears. Their accounts suggested that although they are part of an educated group who usually complies with preventive health-care practices generally (Calnan & Rutter, 1986), they view exams involving the rectum as negative. This finding suggests that health-care providers need to improve the administration of DREs and colonoscopies for all men, regardless of their educational level, to reduce men's negative associations with the exams.

Second, although most men in this study dislike penetration, African-American men were distinctly adamant about their aversion. Their lengthy explanations why they object to homosexual acts provide insight into one of the reasons why racial disparities persist with DRE rates. Past research finds that African-Americans generally disapprove of homosexuality and are specifically more likely to condemn gay family members and friends than whites (Lewis, 2003). Religion and education do not explain African-Americans' seemingly greater dislike of homosexuality; both of those explanations affect whites' disapproval more than African-Americans' (Lewis, 2003, p. 75). More research is needed to understand African-Americans' attitudes and beliefs about homosexuality (Lewis, 2003), yet geographic region is important to consider in African-American men's constructions of masculinity in relationship to the health care system (Lichtenstein, 2004). Being African-American in the Southeast, a politically conservative region with a strong history of racial discord generally, and within the health-care system specifically, may result in some African-American men strongly asserting their heterosexuality as a way to compensate for their marginalization in the hierarchy of masculinities (Connell, 1987). In other words, African-American men who reacted to the DRE by insisting that they "don't swing that way" could be resisting a health-care exam that they perceive further marginalizes them. Therefore, intervention efforts to increase informed decision-making about screening among African-American men need to take place in settings that African-American men trust (Allen et al., 2007).

The implications of this study need to be interpreted in light of its limitations, which include the sample of heterosexual men from North Carolina. Perhaps gay men have different concerns about DREs and colonoscopies that are not discussed here. Also, men from other geographic regions may react differently than men in this study to exams that involve the rectum. However, our relatively large qualitative sample of African-American and white men with diverse

educational backgrounds provides unique data on how men experience DREs and colonoscopies.

Our study has implications for future research and for improving men's experiences with exams that involve the rectum. Unlike past research that argues cultural differences in beliefs about the DRE are one of the barriers for African-Americans to undergo prostate cancer screening (e.g. Woods et al., 2004), this study found that, regardless of race, most men disliked the exam due to their association of it with an inferior masculinity. While a sub-set of African-Americans were distinctly adamant that they disliked acts associated with homosexuality, larger studies are needed to determine if such sentiments significantly affect screening rates. With regard to colorectal screening, we did not find racial differences in men's beliefs. Most men said colonoscopies are "scientific" exams, although some experienced these exams as an affront to their masculinity. Because beliefs differ little between African-American and white men overall, our study suggests that future research should focus on structural issues to investigate why African-American men are screened less for prostate and colorectal cancer. Lack of insurance, access to health-care, income, low literacy, and other structural issues all likely account for racial disparities in cancer screening. Using culturally-sensitive educational materials as well as training doctors to connect with African-American men by building a respectful relationship may be particularly important for helping African-American men to increase their use of the health-care system (Allen et al., 2007; Woods et al., 2004).

To improve men's experiences with exams that involve the rectum, three areas of men's health need to be addressed. First, unlike girls and women in the United States, men are not taught at an early age the importance of regular physical exams (Courtenay, 2000). Women's greater use of the health-care system is a learned behavior that can also be taught to boys and men (Courtenay, 2000). In particular, women typically undergo vaginal exams as teenagers and consequently learn at young ages that regular medical exams involve doctors examining their genitals (Regan, 1997). Men are not socialized into the medical system in the same way; not until later in life are their rectums examined on a regular basis (Regan, 1997). Arguably, if men learn at younger ages that physicals include doctors examining the rectum, they may experience the exams as less of an affront to their masculinity than they do when they reach midlife. In particular, education at a younger age could help dispel the association of a DRE with a gay sexual act.

Second, men need accessible information about the purpose of DREs so that they can make informed decisions about whether to get them. Our data indicated that some heterosexual men avoided rectal exams because of an aversion to gay sex. Education that dispels their fear of penetration may help them overcome that aversion. Such education should have a dual focus. First, it should include clear information to explain the need for the test, and second, it should include psychosocial support (Oliffe & Thorne, 2007) to alleviate concerns about exams they believe are "invasive." African-American men, in particular, may need to get this information and support in settings they trust given that they may have stronger negative beliefs about homosexuality.

Finally, our study has two implications for how doctors need to be aware of heterosexual men's concerns about exams that involve the rectum. First, although research shows that health-care practitioners learn how to de-sexualize physical exams for themselves (Giuffre & Williams, 1994), our research finds that many male patients sexualize DREs in particular. Perhaps the doctor's gender influences whether men sexualize the DRE. In only a few interviews in this study, men discussed their doctor's gender. Those who said they preferred a female doctor said they did not experience the DRE as a gay, sexual act when a female doctor performed it. However, those who said they preferred a male doctor said that they would not want a female doctor to examine their rectums. Whether men generally prefer female or male doctors has not

been researched extensively (O'Brien, Hunt, & Hart, 2005). Future research could investigate if men experience rectal exams less negatively if their doctor's gender aligns with their preference as well as why the doctor's gender matters for their experiences.

Second, because men view "scientific" exams such as colonoscopies as more acceptable, doctors should emphasize the scientific basis for the DRE exam. Language used to describe the exam should be devoid of any sexual connotation. For example, doctors should use the phrase "examine the prostate" not "feel the prostate." Another way to alleviate potential concerns would be to provide information to patients before the exam that some men may have an involuntary erection, and that such a response does not indicate sexual stimulation. The use of simulated patients and role-play scenarios are effective educational strategies for medical schools to teach sensitive examination skills to students (Lane & Rollnick, 2007). In sum, acknowledging that many men avoid or dread cancer screening exams involving the rectum due to concerns of masculinity and sexuality, doctors should be sensitive to men's concerns, and should explicitly frame these exams as scientific procedures.

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