THE KNOWLEDGE AND ATTITUDES OF ITALO – AUSTRALIAN MEN TOWARDS PROSTATE CANCER

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Abstract

An increase in long levity for Australian men combined with an increase in the detection of prostate cancer has led to a situation where more men die with prostate cancer than from the disease (AHTAC, 1996:xii; Weller, 1998). However, carcinoma of the prostate is the second most common cause of cancer death in men in Western countries (Holmes, 1993). Consequently, men who develop urological symptoms and are seeking information about screening, sequelae after diagnosis, treatment options and side effects (Crapp, 1998).

The increase in the incidence of prostate cancer in Australia has certainly been followed by an increase in prostate cancer awareness. However, the public’s level of knowledge on the subject has never been systematically assessed (Laws et al, 2000). Importantly many men are unaware that urological symptoms can be attributed to benign lower urinary tract problems such as Benign Prostatic Hyperplasia (BPH). Instead they believe that symptoms are those of prostate cancer.

Men regard prostate cancer as a serious and life-threatening disease and they assume, as is the case with breast and cervical screening, that early detection is the key to successful treatment (Ohehir, 1996; Pinnock, Wakefield, et al.,1998) however, this is
not the case. Sladden, (1994) called for prospective studies to test the hypothesis that men with prostate cancer detected through screening have better health outcomes than those who are not screened. Results from this type of research are not yet available. Further, there are problems with existing methods of screening. Whilst the most commonly used form of screening is palpation of the prostate by digital rectal examination (DRE), 40-50 per cent of cancers are beyond reach. (Sladden, 1993: 1386). Consequently screening using DRE alone is not reliable. DRE is often used in combination with a serum prostate specific antigen (PSA) test. However, this blood test carries an unacceptably high false positive result rate (Hirst, 1996). In order to gain a definitive diagnosis a biopsy of the prostate is usually taken. Unfortunately the complications form per rectal biopsy include haemorrhage, septicaemia, and psychological stress (Hirst, 1996; Taylor, 1993 ). In consideration of the problems associated with current methods used to screen men, the Urological Society of Australasia (1993) stated, as a matter of policy, that it was entirely inappropriate to screen for prostate cancer, and it may even be harmful (Taylor, 1993). In addition several national guidelines now recommend (Royal Australian College of General Practitioners, 1996; Australian Cancer Society, 1995; Australian Health Technology Advisory Committee, 1996; National Health & Medical Research Council, 1996) that screening not be performed.

The public is unlikely to be aware of these medical guidelines as they depend largely on information supplied by their General Practitioner (GP) with whom men have infrequent contact and short episode of contact (Selvin et al. 1999). However, research by Girgis et al. (1999) indicates that GPs continue to authorise testing and Australian men continue to request the tests for prostatic cancer because they believe screening per se to be beneficial. Further to this point, men’s spouse / partners are encouraging of men to have a check up and been screened. This encouragement is most likely fostered by men’s health literature encouraging men over 40 to have a general check up. Selvin et al. (1999) found that, of 391 men surveyed, aged between 40 and 80 years, 56% (220) stated that they had been tested for prostate cancer by either PSA or DRE at some time. The reasons advanced for GPs performing screening tests on asymptomatic men are that they are unaware of the guidelines or they are aware but continue to screen for medico legal reasons. For example, if a patient, who was asymptomatic at the time of requesting to be screened and was refused screening but later presented with prostate cancer litigation may take place (Laws et al., 2001)

Laws et al., (2001) contend that in the interest of generating informed consumers of health services that Australian men be aware of this state of play need. A group of Australians most in need on information are those from Non English Speaking Cultures as there is no literature available for them. Research by (Drummond et al, 2001) provides insight into the lives of 20 Italo-Australian men. It attempts to draw on their perceptions and understandings of prostate cancer and prostate cancer awareness from their unique perspective.

Laws et al. (2000) concluded that …
their GP, men are more likely to assume that screening is beneficial and that they are acting responsibly with respect to promoting their own health (Pinnock, 1998).

Interviews with Italo-Australian men

Italo-Australian men were selected for this study because they are one of the largest migrant groups in South Australia. There were three objectives within the study, the first being to gather qualitative data, though the use of semi-structured, in-depth individual interviews, pertaining to Italo-Australian men’s understanding of the function of the prostate including prostatic problems. Secondly a thematic analysis of this material would provide some sort of evidence to enable the researchers to identify the major sources of information on prostatic problems for Italo-Australian men. The third objective of this project was to identify the major sources of information on prostatic problems for Italo-Australian men particularly in relation to: (i) the level of satisfaction with the accessibility of current information on prostate cancer, (ii) the barriers to men accessing information that may aid them in giving informed consent on screening and treatment options and (iii) the way in which Italo-Australian men would prefer to acquire their information on prostate cancer in a culturally appropriate way.

Method

The men were asked identical questions with respect to the guided questionnaire. The interviews will be semi-structured with guided questions used only as examples for the interviewer. According to Patton (1990:283)

“An interview guide is a list of questions or issues that are to be explored in the course of an interview. An interview guide is prepared in order to make sure that basically the same information is obtained from a number of people by covering the same material.”

Further, Patton suggested that interview guides allow the interviewer to freely explore, probe and ask questions that will elucidate and illuminate that particular subject. As men’s experiences of prostatic problem may be considered sensitive issues, questions were directed at the respondents in a manner that would best draw on their individual perspectives and experiences. Consequently, each man had his own dominant theme, or themes, to emerge from the interview.

Privacy, anonymity and confidentiality were maintained at all times from first contact with participants to storage of the transcripts following the completion of this report. During the study, only the chief investigator and the interviewer had access to the data. The names of all the participants were removed from the transcripts and numbers were assigned instead. This ensures anonymity and confidentiality.

Emergent Themes
When analysing these interviews using cross case methodological analysis it was evident that certain themes were not unique to one individual. Rather, it became apparent that some issues and topics were prevalent amongst the entire group. Importantly, the themes were broken down into explicit and non-explicit themes. Explicit themes were the themes to emerge directly from the interview data. Each interview was studied individually and the issues raised were listed. Issues from all the interviews were brought together to assist in the construction of themes.

A number of important themes emerged from the in-depth interviews with the Italo-Australian men. There were also important themes that emerged from the interview process such as willingness to participate, willingness to divulge information in the presence of a spouse and cultural diversity in terms of what part of Italy the participant was born and raised in. However, this second group of themes were not explicit and will be dealt with later in this paper. In the first section, thematic analysis is restricted to interview data, including individual interviews and the focus group interview that was used to clarify issues and act as a form of triangulation thereby strengthening research rigour, validity and reliability (Patton, 1990).

The men were asked identical questions with respect to the guided questionnaire. However, the manner in which they responded to these questions directed the immediate ensuing line of inquiry. Therefore, each man had his own dominant theme, or themes, to emerge from the interview. When analysing these interviews using cross case methodological analysis it was evident that certain themes were not unique to one individual. Rather, it became apparent that some issues and topics were prevalent amongst the entire group. Importantly, the themes were broken down into explicit and non-explicit themes. Explicit themes were the themes to emerge directly from the interview data. Each interview was studied individually and the issues raised were listed. Issues from all the interviews were brought together to assist in the construction of themes.

Non-explicit themes were next to be analysed. This required the researchers to utilise inductive analysis to crystallise less obvious themes. Issues relating to cultural background, regional differences and experience of immigration coalesced into the main non-explicit themes to emerge from the interview data.

It is important to note that although the themes emerge as ‘stand alone’ themes they are, in many instances, interconnected. Significantly, the themes represent what many of the Italo-Australian men identified as issues, but they are themes and they do not represent every individual.

Issues pertaining to further clarity alerted the research team to the need for triangulation of data. This was achieved through the formation of a focus group. This additional approach strengthened the validity and reliability of the study and the additional data contributed greatly to the formulation of the recommendations. The explicit themes will be explored within this paper. The abbreviated form of rich descriptive data will serve as a representation of the dominant themes. Significantly, the themes have been tabulated for easy identification.

Explicit themes
Table 1 identifies the major explicit themes to emerge from the in-depth interview data. Data from the focus group has been included in the overall thematic analysis because of its ability to clarify and validate themes that emerged in the individual interviews.

Table 1 Explicit themes derived from interview data

<table>
<thead>
<tr>
<th>Explicit theme</th>
<th>Overview</th>
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</thead>
<tbody>
<tr>
<td>1. Little knowledge of prostate cancer</td>
<td>Italo-Australian men do not have a strong understanding of the function or location of the prostate gland within the male body. Similarly, their understanding of prostate cancer is limited.</td>
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<tr>
<td>2. Belief in the biomedical model</td>
<td>Italo-Australian men generally adopt a reactive approach to health management. Most of the men claim to wait until symptoms occur before attending their GP. Further, the GP is their primary source health information.</td>
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<tr>
<td>3. Cancer as a death sentence</td>
<td>Most of the men perceive cancer as a terminal illness, that is, cancer is seen as incurable and ending ultimately in death.</td>
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<tr>
<td>4. The prostate taboo</td>
<td>Italo-Australian men find a degree of difficulty in discussing issues surrounding the prostate. The prostate represents something other than a physiological component of the male body. Further, the malfunctioning of the prostate is perceived as an issue closely aligned with masculine identity.</td>
</tr>
<tr>
<td>5. Obtaining health information</td>
<td>Gaining health information is largely through the GP. However, it was noted that Italian clubs would be an ideal place to disseminate prostate cancer information to men over 50 years of age. Also radio, television, ethnic language newspapers and brochures with graphics are good sources of information for Italo-Australian men.</td>
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</table>
**Little knowledge of prostate cancer**

The data provide strong evidence to indicate that very few of the men within the study had a full understanding of where the prostate is within the male body and, in particular, what it does. All of the men had heard of ‘the prostate’. Only a few knew where it is actually located within the male anatomy. Even less clear was its function within the body. One man stated:

> I have even had it operated on and taken out and still don’t know where it is or what it does

Another man stated:

> Oh yes, I have heard about it (prostate cancer) but I do not know what the prostate is. It belongs to the bad diseases.

Lack of understanding about the prostate becomes a problem where prostate cancer awareness is concerned. Most men seem to know that prostate problems have something to do with urination. Often terms used to describe symptoms include ‘restriction of water works’, ‘reduction in water flow’ and the like. However, there appears to be a reluctance to undergo prostate examinations and a lack of understanding of the need for immediate attention to any problems ‘down there’ (as some of the men interviewed put it).

> I don’t think I was really up to knowledge. I didn’t know much about it and come to think of it, it didn’t scare me a great deal.

One of the men typified the perceived understanding of many of the participants about the prostate and prostate cancer when he claimed to know a lot about these two issues. He stated that:

> Well first of all it’s mainly in older men and the rings get bigger and blocks the flow, and that’s as much as I know.

However, as the statement indicates, there is very little working knowledge of the prostate or of the significance of enlarged prostate in the context of illness and with respect to cancer. These are important findings because they provide health care professionals with some idea of the level of understanding about prostate cancer and the role of the prostate in the male body.

**Belief in the biomedical model**

The biomedical model of health has had a significant impact on the way in which Western culture perceives, understands and determines health and illness. Western medicine has had a long history of a ‘wait until something doesn’t work and then go to the doctor to get it fixed’ approach. This notion of medicine ‘fixing’ the problem emerged frequently in the interviews.
There has been a substantial move in Western medicine towards health promotion and illness prevention (called 'primary health care'). For example, evidence has shown that screening for breast cancer promotes early detection of cancer, facilitating earlier treatment and hence a better prognosis. The desire for this type of primary health model emerged frequently in the interview data.

Unfortunately this model cannot be applied in the case of prostate cancer because the tests are not specific enough. That is why several national guidelines recommend that screening for prostate cancer should not be done (Sladden, 1994). However, the perception in the community is that screening is valuable and that people are doing 'the right thing' if they present for screening. This perception is reinforced by GPs continuing to perform screening despite the national guidelines to the contrary. Laws et al. (2000) argued that this confusion has implications for informed consent to screening and treatment. NESB men stand to be even more confused because of problems with understanding spoken and written English.

Even if symptoms are present they may not indicate prostate cancer. Hirst (1999), in reporting on Australian guidelines on lower urinary tract symptoms in men that were developed by the National Health and Medical Research Council, stated:

\[\ldots\] most men nowadays quite logically think that if they have some urinary symptoms, they might have prostate cancer. After all, everybody’s talking about it. And there’s absolutely no evidence that you’re more likely to have prostate cancer if you’ve got urinary symptoms than if you don’t. So age for age, if you’ve got a man, let’s say 55, and he’s got urinary symptoms, he’s no more likely to have prostate cancer than if he’s 55 and has no urinary symptoms.

The men interviewed assumed that prostate cancer, along with many other types of ailments, is most appropriately treated via early detection and prevention. Whilst there was a strong notion that the prostate was susceptible to problems such as cancer; alarmingly, as has been noted already, many of the participants within this research knew very little about the prostate and its role and function in the male body.

One of the men provided a perspective that many of the men in the research alluded to — an attitude prevalent within the Italian community. He stated:

Nobody can predict that, people are worried when they are told they have a disease. Then it seems that the end of their life has come. Nobody is worried and nobody goes for regular checks. It would be a prevention to go and see the doctor just for a check up, like women do for breast cancer to make sure that everything is fine. Nobody does it unless there is a recommendation to do it. Only a few people agree to be intimately checked unless there is a specific reason to undergo such an intimate test.
Interestingly when another man was asked whether early detection with respect to cancer was important the reply indicated that it was the medical practitioner’s duty to detect problems rather than the responsibility of the individual to provide preventative care. He claimed:

Of course it’s important but that depends entirely on the doctor because if the doctor doesn’t pick it up the general person doesn’t know does he? And I know so many cases when the doctor hasn’t picked it up.

However, it is the following attitude that permeates the majority of interview data relating to the ability of biomedicine to ‘fix’ the problem. Similarly, the analogy of ‘body as a machine’ (Messner, 1993) is prevalent throughout, further enhancing the ‘fix it’ ideology.

Yes, I can’t fix it myself. So, it’s like a car. If it goes ‘bang’, ‘bang’. If you can’t fix it, you gotta go and see the mechanic before it drops off all together. It’s the same with the human being.

The participants in the research identified their GP as their primary source of information where personal health is concerned. However, this is somewhat problematic in that few men went to their GP simply for a regular health check. In most instances the men sought advice from their GP as a consequence of ill health. It was on those occasions that they might seek further advice or clarification on health issues. For example, it took some time for one of the men to seek assistance from a local GP:

First of all I had heart problems. I remember when I went to see the local doctor for the first time. I told him that I was feeling chest pain.

Another man stated:

No, I go to the doctor because I have problems with my back. Now I also have cholesterol and high blood pressure, I am taking three tablets for these. I should go to the doctor once every month but the last time I saw him was three months ago, as I am feeling well. What do I have to go for?

And another:

No I don’t worry about it at all actually. Unfortunately I am like that in a lot of my things when it comes down to my health, I do not worry about it until it comes along. I am not the type that panics or gets concerned about health. Sometimes my wife says I am a bit of a fool because I let it go too long without complaint.
Similarly, when the men experienced prostate problems, they went to their doctor, as one man explained:

> Well the urine wasn’t going properly so it obviously forced me to see my doctor

These types of attitudes held by the men are crucial barriers to the early detection of prostate cancer, as well as many other illnesses that may impinge upon longevity and quality of life.

**Cancer as a death sentence**

A poignant issue to emerge from the data is the fear that most of the men have of the word ‘cancer’. Admittedly, cancer has been linked historically with ideas of incapacitation, morbidity, mortality and death. As a consequence of the historical associations and their understanding of the word, most of the men in the study, when asked to identify what cancer and prostate cancer meant to them, spoke with a sense of foreboding. It is arguable that this has significant implications where cancer detection and treatment are concerned in terms of maintaining positive attitudes and adhering to biomedical treatment regimes such as radiation and chemotherapy. To understand that cancer does not have to be a ‘death sentence’ is an important element in successfully treating the illness.

However, the sense of fear permeating the interviews was significant. The perceived idea that cancer is synonymous with death left some men feeling ill at ease. With respect to the word ‘cancer’ one man stated:

> It makes me feel goose bumps, fear. When you are young it is very difficult to think about cancer or diseases. Now as soon as you feel a little pain your mind goes to consider things like cancer. It becomes like an instinct.

For another man cancer has been a significant factor in the loss of family members. As a consequence his perception of cancer, and its implications, is narrow.

> We always talk about the bad disease. Lots of people in my family passed away of it and I believe that it will be my destiny as well.

Further he claimed:

> I lost all my family members because of that and I think it can happen to me as well.
However, one of the most touching statements within this theme represents many of the men and the way they feel about the word ‘cancer’:

It means that someone’s destiny has got to the point of no return. There might be some isolated cases that can be cured, but not all. The majority end up dying because there is no cure. It also depends on the individual, on his or her initiative. If someone neglects it? You should be positive but unfortunately there is no certainty.

The statement is interesting in that the fear invoked by the word ‘cancer’ is akin to the ‘fear of the unknown’. Though most of the men have had friends or relatives who have developed cancer, unless they have had it themselves cancer remains somewhat abstract to their lives. It is this sense of the unknown that probably has the biggest impact upon the men and their perception of the illness.

**The prostate taboo**

As this research has identified so far, the prostate is not a very well-defined part of the male anatomy, even for men. Many males in this study have difficulty in identifying where the prostate is located and explaining its function, and most of the men know that their peers have the same difficulty. It may be that men are developing an aversion not only to understanding the prostate, but also to learning about it because of the perception that most males are ‘supposed to know’. There are times in a man’s life when he does not seek advice or assistance for something he thinks he is supposed to know. This may be a consequence of the masculine myth that knowing about the male body ‘comes naturally’ and is a rite of passage into manhood. Generations of fathers failing to communicate with their sons regarding important issues of manhood have perpetuated this myth. It is not the place of this report to challenge such a myth nor is it the place to intervene. However, it is crucial in developing a sense of understanding of how these men have come to view their anatomy, particularly parts of their anatomy that are not discussed in public.

For example, one of the interviewees, when asked ‘Was any health knowledge passed on from your father to you, his son?’, said:

Not especially at that age cause I was seventeen to eighteen I suppose, certainly that subject wasn’t on the menu

A revisit of this question in the focus group in relation to asking the men about personal and sexual hygiene did not draw an appropriate response. There was a tendency to either discard the question or respond in a tangential manner.
The focus group meeting was a very important way to clarify a number of issues with respect to how the men felt about their prostate. Throughout the individual interviews there was a sense that most men regard the prostate as a guarded area within the male anatomy, a symbol of their masculinity. Their limited understanding of the prostate often involved incontinence and impotence. These are two possible consequences of prostate malfunction and they are not conditions that a real man would have.

One man indicated that if it had not been for frequent urination during the night, and worrying about being incontinent, he would not have sought assistance:

   Slower flow, little bit of burning I think. But it was mainly the getting up at night that really got me and if it hadn’t been for that, I wouldn’t have worried about it.

However, a very important point was to emerge from the focus group interview with respect to men’s age and the issues that can be discussed in relation to the body and specific body parts and functioning. It was claimed that as men become older the likelihood of the body breaking down is far more significant. Therefore most men within one’s peer group are beginning to experience some physiological malfunction. As a consequence it was argued that men generally begin to feel a little more comfortable about discussing such health issues with their male counterparts.

As one man claimed:

   As you become older you go to see a doctor more often you discuss about your problems and you don’t feel embarrassed, whilst when you are young you feel more embarrassed.

Importantly though, other than one’s GP, such conversations about ‘private areas’ of the body would still only be discussed with very close associates such as long-term friends or other male family members. Conversations would also occur with other men who had similar ailments.

   Oh yes I would do that I don’t mind at all because in one area that person has to be in the age like me more or less if I talk to a young one they couldn’t care less. I have got my wife’s brother and he has been into this situation and really we talk and talk.

For another man, reaching a particular age and having undergone surgery for prostate cancer meant that he was in a position to provide advice to other males experiencing symptoms similar to the ones he experienced prior to the operation. This made him feel in a position to guide other men and allay the fears that have already been identified with respect to cancer. He stated that:

   I would feel comfortable to be talking to somebody and even giving advice. As a matter of fact, only a couple of weeks ago, I think I was talking to somebody and he said ‘oh I get up to go to the toilet more often than I used to’. Then I said ‘that is how I used to be and then I finished up having an operation and now I don’t get up at all’ and so it was more or less.
Therefore, age and retirement are important considerations within this group of men as far as talking openly about the prostate and prostate cancer are concerned. This has significant implications for primary health care, as it seems that only when these Italo-Australian men have reached retirement age, and most likely have experienced some illness, will they begin to communicate with peers about their health. It is at this stage that communicating in one’s peer group and being involved in a close social support network of friends become important components of one’s maintenance of health.

**Obtaining health information**

An interesting theme to emerge from the interview data was that most of the men were quite adamant about where health information should be gathered by Italo-Australian men. A number of very practical suggestions were made. Three important clusters of suggestions formed sub-themes, the first closely aligned to biomedicine.

A number of men claimed their GP was the primary source of information with respect to health information. But most men visit their GP only when they are suffering from an illness so this is not an ideal primary health care model. One man exemplified the thoughts and perceptions of others by claiming:

Well, if you do not feel well the first thing to do should be to go to the doctor. There you can find all the information that you want.

**Note:** Although it was not a major sub-theme the men in the focus group interview identified gathering information from their GP and other medical doctors as problematic. That is, they claimed health care workers generally spent minimal amounts of time with patients to properly explain procedures and assist with specific health concerns. This was not consistent with information provided in the individual interview statements and highlights the importance of focus group interviews in clarifying and extending issues that have emerged. In relation to medical and nursing staff one man stated:

No they do the job and off you go next one in.

For another man intimidation was a significant factor in not obtaining the appropriate information from his GP. He aptly claimed that:

Well Marcus said that he wasn’t intimidated. In my case it is yes because one, you are talking medical terms and you agree ‘yes yes all right’, and they don’t talk our language some of the times. I am not talking Italian. I mean plain terms. Therefore sometimes you do say ‘yes, yes go ahead’ because you just don’t want to feel silly.
A second sub-theme to emerge from the individual interviews in relation to obtaining health information was the importance of television, radio and print media, particularly Italian programs and newspapers. The focus group reiterated these claims, providing further support for the idea of placing appropriate information in these areas. Within the individual interviews it was evident that those men who read Italian papers such as *Il Globo* identified this as being an appropriate publication for health information. Likewise, the men who listened to Italian-speaking radio programs made similar suggestions.

A number of men identified television as being the ideal place to locate specific prostate health information. Some men suggested that information coming from SBS (the Special Broadcasting Service) would reach many males, especially if it were in appropriate time-slots such as prior to and following soccer programs or Italian movies. However, there were several men who watched ‘Good Medicine’ and argued that this would be the most appropriate place to deliver health information. Importantly, with respect to SBS broadcasting, the men suggested that prostate cancer awareness community announcements could be made in such a way as to be easily adapted to reach a number of different ethnic cultural groups and not just the Italian community. This is an important suggestion.

Finally, a third sub-theme to emerge in relation to dissemination of prostate health information was of a social nature. Many men wanted interaction with others to help them find out important health information. This is why seeking information from one’s GP is so important. Most of the men at some point indicated a desire to talk to someone to clarify the information they had either just been told or that they had read in a pamphlet. Notably, a number of men claimed that having regular speakers at the Italian clubs, which many Italian men frequent, was a good way to disseminate all types of health-oriented information. It would then allow the men to clarify any misunderstood points or issues and adds a social touch, which most of the men considered to be important. One of the men noted that organising a speaker at the Italian club would be a good idea and stated that:

I think that speaking straight to the people is the best way of disseminating the information.

Another man identified the importance of personal contact by claiming that even a pamphlet combined with personal contact is an appropriate method of obtaining prostate cancer awareness information because:

If it is in some newspaper or publication, if I haven’t got it, it does not interest me because I don’t have it. But if someone gave me something saying ‘prostate cancer’, I would read it.
Non-explicit themes

Four major non-explicit themes have been identified to assist in understanding the overall perceptions and attitudes of Italo-Australian men towards prostate health.

Table 2 Non-explicit themes derived from the interview process

<table>
<thead>
<tr>
<th>Non-explicit theme</th>
<th>Overview</th>
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<tbody>
<tr>
<td>1. English as a barrier to understanding health information</td>
<td>Understanding English and conversing in the language pose a significant problem to many Italo-Australian men so there have been barriers to health education and health promotion with respect to prostate cancer awareness.</td>
</tr>
<tr>
<td>2. Cultural implications as barriers</td>
<td>Cultural factors played a factor in obtaining in-depth qualitative data from the participants in this study. The interviews also revealed that cultural issues play a role that may be detrimental to health.</td>
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<tr>
<td>3. Regional differences</td>
<td>The Italo-Australian men interviewed highlighted the differences between the various regions of Italy in which they were raised. Most of the men were patriotic about their region, often at the expense of other regions.</td>
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<tr>
<td>4. Interviewee profile</td>
<td>The Italo-Australian participants came largely from labouring and trade backgrounds. This demographic had an impact on health issues.</td>
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English as a barrier to understanding health information

For the majority of the men interviewed, the English language has often been a barrier to various aspects of their lives. As new immigrants the men experienced difficulties in reading and writing basic English. They developed a sense of inferiority with respect to the English language and, for many of them, this has had a lingering effect. This effect is particularly noticeable when the men come into contact with professionals whom they perceive as being highly educated and above them in terms of social hierarchy. Since these factors are relevant with respect to their GPs a number of the men confessed to feeling somewhat inferior to their GP and a little intimidated in their presence. Some of the men also perceived that a significant communication barrier existed between them and their GP and this created a chasm that was difficult to bridge. Where health information is concerned the men opted simply to take their GP’s advice without reservation. This was simplest way of dealing with their lack of English communication skills. One of the men highlighted this issue by stating that:

Some professionals, they do take time to explain it to you but if there is a block in communication or some obstacles in communication then it would be hard for the professional to try and explain.

Not only did the lack of English language skill create a deep-seated inferiority for the men with regard to more accomplished English speaking individuals, it also created a significant amount of difficulty for them in understanding information presented to them in English. This included specific health promotion material and other primary health care information that is highlighted periodically in daily newspapers and other popular printed media. When asked if Italo-Australian men know enough about prostate cancer one of the men said:

Many of them do not grasp all the information that is conveyed in English. I do believe that they don’t read the newspaper and listen to the radio. Maybe the Italian radio but that is too limited indeed. Some programs on the mass media are very useful but I reckon more than 50 per cent of them cannot get access to such information.

Because of the men’s inability to grasp the complexities of the English language their ability to understand contemporary health issues in general, and prostate cancer specifically, is very limited. As a consequence it is understandable that the men rely upon going to their doctor when they feel ill as their primary method of disease and illness detection.
Cultural implications as barriers

One of the interesting culturally related issues to emerge within this research project became obvious during the interview process. It was also an issue that, arguably, affected the revelation of rich, descriptive information within some of the interviews.

A number of the Italo-Australian men had invited their wives to be a part of the interview process. The original research methodology had specifically stated that men’s opinions and attitudes would be sought via in-depth individual interviews with respect to prostate cancer and prostate cancer awareness. However, in some instances it was the perception of the research assistant that the women added to the data by clarifying facts, times and dates and so forth. However, it is possible that, as a consequence of the spouses’ presence, some of the interview data may not be as rich as it could have been.

While having the wives present at the interviews was perceived as a being a barrier to obtaining as much in-depth information as possible, it was important for the research team to understand the cultural underpinnings that had led to such an occurrence. Within the Italian community a woman’s role in marriage is not insignificant. She does not sit back and allow her husband to make all the decisions. She is just as involved as he is in considering important family-related matters. A research project such as this one, involving both the Anti-Cancer Foundation of South Australia and the University of South Australia, was an important meeting that warranted both husband and wife in attendance. It was particularly important that wives be present because Italian women are often perceived as the health care providers within the family. Some of the men viewed their wife’s presence as being crucial to the meeting to provide accurate health information with respect to their health history and because often it is the wives who find our the necessary information and pass it on to their husbands.

In some instances the women’s presence at meetings was particularly valued when the men found difficulty in either finding the appropriate words to express themselves or elaborating upon information they may not have felt comfortable in divulging. For example, in one interview, a participant was asked if he had ever heard of prostate cancer. After a long pause his wife said:

His father had a prostate cancer. I keep telling him to go to the doctor to have it checked. He is scared. He is embarrassed about the procedure.

It is not clear whether the presence of a spouse was a significant limitation to obtaining the richest, most descriptive information possible from each of the participants. One of the research team members found that specific questions were modified in the focus group interview to accommodate the presence of a woman. That is, several of the questions were not as probing as they would have been with only men in the focus group. In recognition of this situation, at the time the interview was taking place the team spontaneously embraced this cultural attitude (of the Italian community) rather than probe deeper at the risk of embarrassing the interviewees and the women.
The research team also identified another cultural barrier to accessing health information for the Italo-Australian men involved in this research project — their strong identification with Italian culture and an inability to relinquish their ties with the Italian community. Understandably, maintaining links with one’s cultural heritage is important in terms of self-identity. However, when the ties impinge upon personal health these links must be questioned. Living in a country such as Australia, with little or no Italian written prostate literature, will be difficult for men who identify solely with the Italian language for fear of not wanting to remove themselves from the past. The research team has addressed this issue within the recommendations.

**Regional differences**

The research team became aware that the regional origin of the interviewees played an important part in determining the depth of information gained at interview. The key interviewer stated that it was widely recognised among Italians that men from southern Italy keep their thoughts to themselves and do not enter into discussion freely with people they do not know well. There was tacit agreement among the men at the focus group that men from southern Italy would be less likely to divulge information about themselves or their families to anyone outside their community.

By way of explanation it was stated by both groups of men (the individual interviewees and the three men in the focus group) that southern Italy has always been known as an agricultural area whereas northern Italy is perceived as being more contemporary, particularly in terms of embracing new technologies. Men from southern Italy were believed to have lower levels of education than those in northern Italy and as a consequence were less likely to be exposed to and welcome new ideas. Linked to the rural background was the idea that men from southern Italy valued a more traditional form of masculinity. The masculinised ideology that accompanies labouring occupations is well documented throughout the world as is the fact that, ultimately, this particular view of manhood affects men’s health (Connell, 1995:93–95).

The activities of informal organisations were also cited as a reason for men not wanting to reveal their true thoughts or offer information. Although the men who mentioned this in interview fell short of naming the Mafia, the implication was clear.

The men at the focus group qualified their comments by saying that some men from southern Italy would feel comfortable with disclosing details about themselves and their health status but, generally, we as researchers could expect considerable resistance to our in-depth questioning. The focus group members warned us that should we do further studies we should expect discussions about health issues to be guarded.
**Interviewee profile**

The research team agreed it was essential that interviewee profiles, including immigration details, should be included in the report to provide some demographic details of the cohort of participants. Whilst these profiles were not themes in the true sense of thematic analysis they did assist in understanding some of the major themes to emerge.

It was noted that many of the men had come to Australia as a consequence of the economic situation in Italy. As one claimed:

> There was not many jobs in post war Italy at the time.

On the other hand some of the men came to Australia to be reunited with family members who had migrated to Australia at an earlier time. Conscription issues back in Italy also intimidated several men. Coming to Australia eliminated the chance of being conscripted.

It was evident from the individual transcripts that most of the men found their early experiences in Australia quite daunting. Most of them would have liked to return home to Italy after the first few weeks. However, their financial plight left them in a situation where they had to 'make do' with the resources available to them. It is not surprising that the men associated with other Italian men who were facing similar circumstances. Such friendships provided them with a sense of camaraderie in the face of adversity. This could be one of the reasons why many of the men did not achieve a good grasp of the English language — if they associated with other Italian men they did not need to explore a new language.

Because they were immigrants with little knowledge of the English language most of the men ended up in labouring positions or working as tradesmen. Only one of the men had gained a university degree but there were several in middle management positions.

The men came from regions all over Italy and they now live in a broad range of metropolitan Adelaide suburbs.

In terms of health each of the men rated himself as being in fair or very good health despite the fact that some of them had a history of heart disease, cancer and other serious conditions. Most of the men had not experienced any prostate health issues but some had experienced a range of issues from frequent urination as a consequence of prostatitis to cancer (see graph).
Figure 1 Percentage of men interviewed who had experienced prostate-related symptoms

OUTCOME

Finally, an underpinning objective of the research project was to develop recommendations for the construction of educational programs including recommendations for medical practitioners and other health workers in terms of overcoming the barriers to Italo-Australian men gaining adequate information to support informed consent.

REFERENCES

AHTAC (Australian Health Technology Advisory Committee) (1996), *Prostate cancer screening*, Canberra: AGPS.


