“I can’t just sit and feel sorry for myself”

Norwegian men’s construction of masculinity after cancer treatment

Mirjam Ostevold

A thesis submitted for the degree of Professional Doctorate

Department: Tavistock & Portman NHS Trust
University of Essex
Date of submission for examination March 2023

ACKNOWLEDGEMENTS

What an amazing journey this has been! I am deeply grateful for the support I have received from so many people along the way.

First of all, thank you to all "my men" from Bergen, Trondheim and Oslo who were willing to take part in a research project none of us quite knew how to approach. Thank you for the coffee, for the desire to contribute to the research, and for the transparent conversations about the good and the bad in life. Most of all, thank you for the opportunity to get a glimpse of what it was like to be men who have gone through cancer treatment.

To my supervisors: Many thanks to Britt, who has challenged, guided and supported me through this time and who believed in me when I myself did not. Lennart, you have been a great help and inspiration - without your encouragement I would never have dared to go for this!

Thank you to my colleagues: Janiche, I am so grateful for your faith in me and for not letting me pass up the offer at Tavistock. My leader Olav, thank you for the financial support that enabled me to take on this project. Kari Felicia, thank you for your cooperation and help with recruiting participants. My good doctor-friends Line, Heidi, Toril and Sari - without your love and support I would have given up long ago.

The biggest thank you goes to my Dear Bjørn, Maja, Benjamin and Noah. Thank you for your generosity- for putting up with me being both mentally and physically absent for periods these years. You guys are the best!

ABSTRACT

This research is a small-scale, qualitative research study conducted with 24 participants, to understand what peer support can provide for Norwegian men who are undergoing cancer treatment. A triangulation of research methods has been used. With the help of the Norwegian Cancer Association, action research was done with three groups of men in Bergen, Trondheim and Oslo. An ethnographic study was conducted with the first group in Bergen, and semi-structured interviews were done with each group after each cycle had ended. Areas of literature that are relevant to my research, concerning men's experiences of peer support, gender in health care and family therapy with families experiencing physical illness have been reviewed.

Systematic text condensation was chosen as the method of analysis. The findings showed how the men in this research construct their lives, post-cancer treatment, in line with their preconceptions of Norwegian masculine values. The men felt alone in their illness, and the group contributed to cohesion, increased coping and improved psychological well-being. It was found that the participants were concerned that women in the group would make it difficult to use masculine approaches in the conversations.

The research suggests professionals need more knowledge of how gender influences the experiences of illness, and of how peer support can supplement cancer care. The knowledge arrived at in this research adds to professional understanding of men's needs in rehabilitative work, and to how professionals may be able to support families after cancer treatment.

Content

1.0 Introduction to the study

As a family therapist working with families suffering from cancer, I experience more women seeking therapy than men. In addition, more women than men attend activities at the resource centre where I work. In the field of cancer care, the nursing service is clearly dominated by women (SSB, 2019), and as much of the support services have been formed by women nurses, it has led me to wonder if the services provided are formed *for* women. In my master's degree in systemic psychotherapy in 2018, I looked at the importance of healthcare personnel for the patient's experience of hope. I noticed all the couples I interviewed at the time emphasized the importance of meeting others in the same situation. However, I had not asked about this. This made me think this was a phenomenon we needed more knowledge about. Over the past ten years the rates have been stable, with prostate cancer as the most frequently occurring form of cancer (Kreftregisteret, 2021), yet few men attend our activities. As a family therapist, I wish to gain more understanding about men's experiences and their need for care as they go through serious illnesses. In this study, this is therefore assessed in the light of systemic theory. I also wanted to explore which factors caused the men not to participate in activities. The hope is to provide more knowledge for myself and other practitioners, so that we can become better helpers for families suffering from cancer and other serious illnesses.

1.1 The aim of the research

This research was aimed at understanding why Norwegian men participate less in activities offering support after cancer treatment, than women. This was experienced at my own workplace, and before going into this study I carried out some inquiries with the Norwegian

Cancer Assossiation, The Vardecenters and the Learning and Mastery centres in Bergen, Oslo and Trondheim. They had the same experience: fewer men than women joined rehabilitative activities. The exception was when there were purely physical rehabilitative activities, then participation was equal between the sexes.

The goal was also to understand what the needs of the men are, and how Norwegian health care can facilitate better peer support for men. Using action research, ethnography and semi-structured interviews, I show how the participating men talk about their positions as men who are in the post cancer treatment phase. In this way, the research aims to provide an understanding of how Norwegian men are different from Norwegian women in their way of coping. This knowledge is essential for health care workers, and it may provide knowledge to develop better services aimed at men. For family therapists, this knowledge is important for understanding how families can help men suffering from cancer, and how families address issues concerning gender.

To address these issues, I decided on the following research questions:

How do men in Norway experience peer support during cancer treatment?

With the sub questions:

- *How do peer support during cancer treatment affect men's mental health?*

- *How can Norwegian health care facilitate peer support for men with cancer?*

- *How can knowledge in this area be applied in systemic psychotherapy?*

1.2 Structure of the thesis

This thesis is divided into seven chapters. This first chapter is an introduction to the thesis, describing the aim and the research questions of this research. The second chapter orients the reader to the Norwegian context. Chapter three will present a review of the relevant literature concerning men's experiences of peer support, gender in health care and family therapy with families experiencing physical illness. The fourth chapter explains the methodology of the research conducted. Chapter five shows the findings. The sixth chapter discusses the findings in light of the relevant literature, as well as implications for practice. The seventh chapter consist of concluding remarks.

1.3 My choice of a systemic approach

This research is based on a systemic approach (Gail, 2018). I am a nurse and a systemic psychotherapist, and I have experienced how a systemic understanding can contribute to change, from a linear understanding to a circular insight into relationships. By the use of a systemic approach, this research may connect and make visible different aspects in relations-in the health care system, in the groups and in the society (McCarthy and Simon, 2016). The use of a systemic approach can challenge and add new knowledge, to both the participants, their families and the wider system of health dominated by a positivist paradigm. To create circularity in the research process, action research was chosen as the main research method. The action research method can help to illuminate the circularity of an interaction, and it challenges conventional processes of knowledge production (Gaventa and Cornwall, 2015). By adding ethnography and semi-structured interviews, the choice of methods supported systemic thinking and enabled me to take different perspectives on how the men created knowledge through their social practices. I will elaborate on this in chapter four.

1.4 Clarification

Gender: There are different ways to identify one's gender. In this project, all participants were born as, and identified as men. In this thesis, the findings are linked to the traditional concept of a ‘Norwegian man’, and no participant in this research overtly identified differently.

Masculine hegemony: Hegemonic masculinity in this thesis refers to a normative ideal of how a Norwegian man should be, what qualities he should possess in order to have a high status in a masculine hierarchy (Connell and Messerschmidt, 2005). This ideal is used in the discussion of the research's findings in order to gauge how the men, who participated in this research, position themselves in relation to perceived expectations of masculinity.

*Vardesentere*t: In this thesis, some of the participants talk about Vardesenteret. Vardesenteret is a centre, which is a two-party collaboration between seven regional health authorities in Norway and the Norwegian Cancer Association. It is a centre where cancer patients, relatives or people who have lost a family member, can receive help and support through psychotherapy, and participate in physical or digital courses or other activities. Voluntary efforts such as peer support are an important part of the centre’s supportive activity.

2.0 The Norwegian context

Here, I will describe the Norwegian context in which the research took place. Both the participants and I understand sickness and gender from a perspective of the Norwegian culture, and an understanding of this culture will be important to understand the perspectives expressed in this research.

2.1 Norwegian families

According to Norway's Ministry of Foreign Affairs, since the 1960s equality is one of the reasons for the strong economic development and improved living standards.(Regjeringen, 2022). Today, an average Norwegian family consists of 2.2 people, but as many as 1 in 5 Norwegians live alone (SSB, 2022). The social construction of what a Norwegian family is, is constantly changing and developing. A family is often defined by constellations in which three generations are connected to each other through mutual relationships (Lorås & Ness, 2019). The majority of Norwegian couples live in heterosexual relationships (SSB, 2022), but in recent decades the social attitude towards this form of cohabitation has changed. . Discourses around sexuality have changed, and other forms of cohabitation are equally accepted. There are relatively few differences between different classes in society, which may be due to a long-term and strong focus on values such as equality. Around 70% of all women are working (SSB, 2019), The government's vision is that all citizens should have equal rights regardless of gender, sexual identity, ethnicity or ability to function, which contributes to Norway being among the very best in international rankings when it comes to equality and living conditions.

The modern Norwegian is much less dependent on traditional rules and frameworks related to work, family and gender. This has created a philosophical debate about individualism, and the responsibility it entails. Being successful becomes the individual's responsibility (Bauman, 2001). The liberation from inherited expectations has created a society in which the individual is exposed to other, but equally strong expectations. A performance culture, where expectations of being successful at school or work, having a perfect body, an exciting and active sex life, getting lots of likes on social media, and living a harmonious lifestyle. A good Norwegian must also enjoy and display a love for outdoor activities (preferably with their family) - an important marker for displaying health, initiative and physical strength.

2.2 Cancer care

If a GP suspects that a patient has cancer, a message to this effect is sent to the specialist health service. The Ministry of Health decided in 2013 that if cancer is suspected, the person should enter a fixed patient pathway. The purpose of this pathway is for cancer patients to experience a well-organised, comprehensive process without unnecessary delays in assessment, diagnostics, treatment and rehabilitation. The government's aim with this process is that 80% of all cancer patients should start treatment within 20 working days after the referral has been received (omsorgsdepartementet, 2013). This means that many patients start their treatment quickly. To remove the cancer, patients must go through extensive treatment. Most forms of cancer require surgical treatment, during which the tumour(s) are removed from the patient's body. In some cases, cytostatic is given to shrink the tumour before surgery to kill cancer cells and to prevent them from growing. Radiotherapy is commonly used to reduce tumours and as a supplement to surgery to reduce the risk of recurrence (Kåresen and Wist, 2012). In 2021, 36,998 new cancer cases were registered in Norway, and most people who get a cancer diagnosis survive the illness. (Kreftregisteret, 2022b). Many cancer patients experience late effects after cancer treatment, and many have to live with these effects for the rest of their lives. Examples of late effects include fatigue, neuropathy, heart rhythm disturbances, chronic pain or exhaustion, sterility, impotence or distended bowel (Kreftforeningen, 2023). Rehabilitation after cancer treatment is not a fixed part of the patient pathways, and it is up to the patient or the health care worker to seek participation in a rehabilitative activity.

2.3 Masculinity

In Norway, there is currently a debate about the contradictions of feminine and masculine values in our society. I return to this topic later in the thesis, here however I want to note that some men have expressed their views in the media, where they talk about an experience of masculine characteristics not being accepted, because feminine values have priority in Norwegian society (Njå, 2023). The disagreement appears to be between feminist women and men who are in opposition to what they describe as society which promotes discriminating behaviour against men. When the Canadian psychologist and researcher Jordan Peterson visited Norway in spring of 23, arenas sold out to hear him talk about the crisis of masculinity. This shows how men in Norway are concerned with gender and the power between the sexes. Studies among young students show how girls achieve better in schools, and how it is possible that teachers contribute to gender differences in education (Gustavsen, 2017). Most health care workers in Norway are women (SSB, 2019), and experiences of feminine values and gendered power also occur in cancer care. In 2022 the Norwegian government set up a men's committee. This committee shall, in 2024, deliver a public report containing an overview of the equality challenges Norwegian men face throughout their lives, and suggests solutions to these challenges. It is an aim in this thesis to discuss the participants` experiences of feminine values in health care. I will return to this topic in the literature review, to examine how masculinity is considered among health care workers generally and later discuss the experiences of the men, who participated in this research.

2.4 Self-help groups

In Norway, self-help groups are a widespread phenomenon. In 2014 the Ministry of Health and Care launched a national plan for this work, with the aim that all Norwegians should know what self-help is, and how self-help can be accessed and used when there is a need for it (Helsedirektoratet, 2014). "Self-help is built on the value base that all people have resources within them. They have experiences, characteristics and abilities that they can use to improve their everyday life."(SelvhjelpNorge, 2021). There is a National competence centre for self-organized self-help groups and, the task of this institution is to contribute to national knowledge of the activity, and to be a resource for the groups. A self-help group is a supplement to public help, and is a place where people who have a problem can meet others in the same situation. The groups are considered useful in preventative, health-promoting and rehabilitative work (SelvhjelpNorge, 2023). The groups organize themselves, and the goal is for the participants to use their inherent resources to take responsibility for their own life situation (Helsedirektoratet, 2014). In a report written by Brottveit (2014), he claims that cooperation between the health system and volunteers is necessary. The autonomy of the groups is important and the self-help groups should not be led by professionals, as they will easily be associated or confused with a treatment model. In working on this project, I contacted the head office for information about their work. The daily manager informed me that the subsidy from the national budget was dramatically cut for 2023. This means that the national resource centre loses the ability to finance its operations and maintain its activity, the offer will be shut down by the end of May 2023.

3.0 Literature Review

Introduction

As this research aims to understand more of what the needs of the men who have experienced cancer care are, and how Norwegian health care can facilitate peer support for these men. I now turn to a review of the relevant literature considering men's psychological health in relation to cancer and to cancer treatment, and their experiences of peer support in this field. This literature review is both critical and analytical. I will look at areas of literature that are central to my research question, and the methodology of the literature review will be described. The review is divided into three sections. The first section addresses peer support, the second section focuses on gender perspectives in health care and the final section examines systemic psychotherapy practice with physical illness. In health care, the biological term "male patient" is used, but I will avoid this term except when it is necessary for example when quoting from a medical context. I will generally use the terms 'man' and 'men'.

3.1 Research Strategy

To review the literature relevant to the research question, a systematic literature research was conducted. Different databases were searched and the search took place between 26. October and 29. December 2022. The databases include APA PsycInfo, APA PsycArticles, APA PsycBooks, APA PsycExtra, Psychology and Behavioural Sciences Collection, PEP Archive, Education Source, ERIC, SocINDEX with Full Text, MEDLINE and Google scholar. Cinahl plus with full text, where much nursing research is available. In addition, I also searched the Norwegian universities' database Oria. However, when interesting studies have emerged in the readings I used a traditional approach, which implies searching manually through relevant journals. In this search, I also looked for research in which immigrant participants might be included. Unfortunately, I could not find research in which the experiences of men of non-Norwegian heritage were described or analysed.

Initially, I searched under the terms ‘peer support’, ‘men’ and ‘cancer’. This was too extensive, so I had to limit my search. I chose not to include physical activity, as I wanted to look at the experiences of groups in which the focus was not on physical rehabilitation. A great deal of research has been carried out within cancer care, and to limit the search, research on palliative care, quality of life, women, internet-based support groups, fathers or children was excluded. This helped narrow down the results. I decided to include studies carried out in Europe because it seems that outside western society, having cancer may be a taboo or may not be a diagnosis as such (Nordvåg, 2017). This may therefore be a completely different context than what the men in Norway experience. I wanted to exclude research from before 2010, because I wanted to access the most up-to-date material. However, in the research concerning systemic psychotherapy in health care I chose to include research from 1993 as I found it particularly relevant to this review. The studies reviewed are chosen as they provide different knowledge on the experience of men in peer support groups. Research on peer support for men seems mostly to focus on prostate cancer, and the consequences of impotence is often the focus in these groups (Steginga *et al.*, 2005; Handberg *et al.*, 2014).

Retrieving adequate literature concerning systemic psychotherapy in health care was hard, since systemic therapy is a common term in medical treatment. Systemic therapy here means equal supply of medication throughout the body (Hovig *et al.*, 2001), so I needed to avoid using that phrase in my searches. In addition to the previously mentioned databases, the Norwegian universities’ database Oria has been searched and the initial search provided over one million papers. By using expanders, which searched within the full text of the articles and equivalent subjects, and by limiting the search to research only including patients and medical care, I was able to narrow it down somewhat. Finally, I got help from a librarian at the hospital library where I work. She also searched the platform Web of Science. However, most of the research we found was not applicable, as it did not concern systemic psychotherapy approaches, or was not relevant in any other way. To find papers relevant for this review, I had to go to other sources, such as “Fokus på Familien”, which is the Nordic Journal for Family and Relational Work, and Journal of Family therapy. It seems to me that there is little research carried out in medical care using systemic psychotherapy approaches. During the reading of the texts, the term Medical Family Therapy appeared, leading to new, relevant findings on systemic psychotherapy approaches.

The selected articles are presented before I compare and contrast them.

3.2 Peer support for men: The studies reviewed

Four articles and one report are reviewed. In this review, it has been an ambition to include studies that provided knowledge about a wider group of peer support for men living with and beyond cancer. The papers have therefore been chosen because they provide different aspects of peer support for men. In the following, a short description, the methodology and the findings of the articles are presented. The Critical Appraisal Skills Program (CASP) appraisal tool was used to appraise the studies identified (Appendix 1). In this section, I have chosen to extract the areas concerning experiences of peer support and men’s mental health in particular for comparison and critique. I present the papers here before I evaluate and interpret the findings.

Handberg et al. (2014a) Men's reflections on participating in cancer rehabilitation: a systematic review of qualitative studies 2000-2013

This paper gives an overview of the findings of several qualitative studies in Europe, and it was interesting to see what experiences men in Europa have in common. This paper is a review of qualitative studies of men's reflections on participating in cancer rehabilitation. The researchers systematically searched nine databases to identify qualitative papers published between 2000 and 2013. Papers were excluded if they did not relate to the aim of the review, were quantitative, and addressed rehabilitation regarding palliative care, included children, if the study was exclusively focused on quality of life, if they only reported on women or if the genders of the informants were unknown. This makes the research relevant to my field of interest. 15 studies were analysed using Interpretive Description. Handberg *et al.* (2014) concluded that existing qualitative literature offered insight into the relationship between men's reflections on their changed life perspective, masculinity, orientation towards a normal life and getting back to work. Even though this paper is not about peer support groups specifically, it gives a thorough overview of men’s experiences of rehabilitation, which includes peer support. The authors are transparent about the use of a professional librarian for the literature review. Their research strategy was included, showing that it was carried out through a thorough search and several databases are included. This instils trust in me as the reader that the search has been accurately done. The researchers provide a presentation of each step of the analysis, and record the discussions between the researchers. The transparency in this area strengthens the reliability of the review. In addition, this study is interesting because it gives a general view of qualitative research across Europe and includes research with men with different cancer diagnoses. After the active treatment, men may have to live with impairment or disability which can decrease their experience of a meaningful identity (Handberg *et al.*, 2014). It is possible that the discourse surrounding men and masculinity is one of the reasons for the lack of research in this area, and the researchers consider few men attending rehabilitation activities as a sign of this experienced discrepancy. This suggests seeking peer support may be considered as showing signs of weakness, emotions and dependence. Handberg *et al.* (2014) conclude their review by stating that more research is needed on the underlying factors of men's participation in rehabilitation from the health professional perspective. This review provided me with a good starting point, and it created a curiosity to look at the experiences of individual participants.

Cecil et al. (2010) 'It's hard to take because I am a man's man': an ethnographic exploration of cancer and masculinity

This qualitative study from Northern Ireland provided a deeper understanding into the men's experiences, and provided findings I did not see in other papers. This qualitative study used semi-structured interviews conducted at the participants' homes, and intended to "identify sociological issues of concern that present challenges to masculinity and to male identity" (Cecil *et al.*, 2010). The eight participants were men, with a history of cancer and beyond active treatment. The researchers seem to be positioned as social constructivists, as they seem to focus on how the men created meaning through their interactions, and in this way how their narratives emerged. The transcriptions are analysed using content analysis. The men were asked about their family situation, occupation, medical history, their information and support needs, and in addition their experience, if any, of support groups. In these interview themes there does not seem to be a particular focus on the economic consequences. However, this study brought up the issue of economic concerns and body image, which is interesting, as these particular findings are not displayed in the other papers reviewed. They linked the financial concerns to the ability to work, and suggested this might be related to a kind of hegemonic masculine outlook, in which, a man is considered the provider for his family. This finding led me to think the safe environment and the individual interview at home may have provided a space where the participants could speak about issues that were taboo in other settings. The researchers provide a clear rationale for examining the impact of cancer on masculinities and are transparent about the process of deciding on a research method, and this study is the only one where the participants are conveyed the possibility of withdrawing. It is not clear how the ethnographic study is conducted in this research. As it claims to be an ethnographic study, I do not understand how semi-structured interviews can provide an ethnographic exploration. To me, this makes it unclear if the explorations are in line with the findings. I like that the researchers of this study have visited the men at home, and I wish the authors would have reflected more on how that possibly contributed to the quality of the conversations. The researchers suggest that cancer undermines some salient aspects of what it means to be masculine in our society, as receiving emotional support from others would not seem to be consistent with several pillars of hegemonic masculinity such as strength, stoicism and independence. The bodily changes affect the men, and Cecil *et al.* (2010) found that just like women who have had a mastectomy feel a sense of change of body image, so do the men. The bodily changes for women are acknowledged as loss, grief and a changed self-image. To strengthen the reliability of this small study, I wished to look at other studies to see if there were similar findings.

Vickery (2022) it's made me feel less isolated because there are other people who are experiencing the same or very similar to you': Men's experiences of using mental health support groups.

To learn more about research concerning how peer support groups might be experienced, I reviewed a study from South Wales which included 19 men as the participants. The researchers do not provide information about the ethnicity of the men. This study explores how men can benefit from a peer support group, how it may affect the participants' mental health and reduce loneliness. This is a qualitative study, in which the researcher interviewed participants in support groups about the topic of men experiencing emotional difficulties, in order to explore the perceived benefits to the men of participating. By using semi-structured interviews with each participant separately, this study is the only one of those I have reviewed which is transparent about the ethnicity of the participants; they are all white British men. This is valuable information, as I would expect research with men from different ethnic backgrounds would provide different information. This paper is not about men who have had cancer, men do experience psychological distress from and after cancer treatment (Dahl *et al.,* 2014). I have therefore chosen to include it in this review as it gives valuable information about the subject. The transcriptions were analysed using thematic analysis. The findings showed how the men attending appreciated the sense of mutual understanding of experiences and joint respect in the group. Vickery (2022) writes that he focused on the positive aspects of peer support, because negative experiences were not frequently mentioned. However, two participants said that they disliked the number of activities and the guest speakers. It would have been interesting to know what it was about these activities the participants disliked, if it was the activities themselves, or the topics the guest speakers addressed. What would they like to do instead? This information would have given an idea of the way men who normally do not seek these groups, think. The participants justify their attendance in terms of helping others. Support groups provided a safe space with opportunities to reconstruct traditional masculine norms through mental health support to others. This gave men a sense of purpose, which further facilitated mental health management. The researcher noted that there were social benefits from attending support groups for men who may have limited social networks or were experiencing isolation.

Öster et al. (2013) Sharing experiences in a support group: men's talk during the radiotherapy period for prostate cancer.

So far, the papers I have reviewed have pointed to knowledge about rehabilitation, provided deeper insight into British and Scandinavian men’s reflection on masculinity and to the functioning of peer support groups for some men who had had an experience of cancer and treatment. To gain more knowledge of different needs, I wished to see if men who were undergoing cancer treatment at the time of study experienced different needs than men who had finished their treatment.

This qualitative research study was carried out together with nine men from two support groups during radiotherapy. The groups gathered 6 times for 90 minutes, and a male nurse led it. The research used qualitative content analysis to study conversations between men in the groups. The aim of the study was to describe the experiences shared by the men who, because of prostate cancer, were going through radiotherapy. The researchers recruited by using health care workers as recruiters. They do not describe how this was done, but refer to the participants as being consecutively chosen. As they do not clarify the process of recruitment, I wonder if they have considered the ethical issues of how participants may feel pressured into participating. Describing this process would have given information about the participants' own initiative to be part of the project. The researchers have a large group of potential contributors but end up with few participants, and it would have been interesting to read their thoughts on why only nine men wanted to participate.

Nevertheless, this study gave valuable information about how the conversational support groups gave the men a forum which made sharing possible, and the findings of this paper may indicate that men going through cancer treatment have a bigger need to share experiences than men who have finished their treatment. Attending peer support groups seem to help alleviate the feeling of being outside a masculine discourse (Öster *et al.*, 2013), as meeting men in a similar situation, sharing experiences of living with the disease, and feeling allied to each other were shown to be valuable to the men. It would have been interesting if the researcher had identified interaction in the peer support groups which seemed to have hindered the connection between the men. Öster *et al.* (2013) addresses the subject by reflecting on the presence of group leaders (and researchers), and how it may have hindered the men from expressing criticism. If the participants were able to communicate in other ways, for example in a diary, the negative experiences from the conversation in the group interviews could have come to light. This study conveyed the experiences of men with prostate cancer, which may differ from other men because of the impact prostate cancer has on men's sexuality. This made me want to look at studies in which the experience of men with other cancer diagnoses had been researched.

Saastad (2016) «Å være mann og håndtere sykdom» To be a man and manage illness

This report was included because it brought forth the men's own thoughts on how they wanted rehabilitative activities to be organized. This report is from a collaborative project between Reform - Resource Center for Men and Oslo University Hospital. The project was carried out in Norway, where 16 men and 9 woman partners participated in interviews with three different focus groups. The aim of the study was to find out whether men need separate offers to better cope with their disease. In addition, it aimed to assess in which ways different forms of masculinity and ideals of masculinity can be a burden for men affected by illness, but also if masculinity can constitute resources for coping. The report suggests that it is possible that the discourse surrounding men and masculinity is one of the reasons for lack of research in this area, This supports the findings of the study by Vickery (2022). The findings of this report indicated that many men seek health care too late, as they prefer to sort things out themselves. Some men under-communicate or downplay their health problems, as traditional ideals of masculinity lead to illness being considered an expression of personal weakness. This report brings in valuable perspectives from the men's partners; for example, one wife said that her husband "lost his pride" when he could no longer work. This statement links the ability to work to a sense of identity. The orientation of the project seems to be a critical realism, as the researchers assume that cancer is a reality, but they also show that they have to work towards accessing and exploring the men's own experience before developing activities. In this project, he has chosen to inform the participants in the three focus groups orally about the project's purpose and method, and that the results would be published in the form of a report. Permission for this was given by all participants. The researcher considered collecting written consent from the participants, but this was considered as unnecessary since the audio recordings from the conversations were deleted. This seems strange to me. As this project has all the ingredients of research, the ethical implications should have been considered, and the participants should have had the opportunity to access written information about the project and the implications of participating. The author describes some steps of the data analysis but provides no references about the methodology used. This makes the method unclear to me as a reader, and the methodology of the analysis not being transparent makes the results less reliable. However, the findings are in tune with other research reported on in this review.

3.2.1 Male cancer patients' mental health

One of the research questions of this project concerned how meeting others affected mental health of the participants, as receiving a cancer diagnosis nearly always results in psychological distress. Even with good prognosis such as testicular cancer, many men face fear of death or relapse. The research included in this review shows the divergence between the men's experience of psychological distress and the experiences of expectations from the surroundings, which seems common to both the Norwegian and the English context. In all the papers reviewed, men express a wish to regain the masculine position they had before they became ill, to regain the masculine status they experienced as healthy men (Cecil *et al.*, 2010; Handberg *et al.*, 2014; Saastad, 2016; Vickery, 2022). The experience of being in limbo appears to be a source of mental distress. Different issues were affecting the men’s psychological well-being. In accordance to the findings of Cecil *et al.* (2010), financial issues were of concern to the participants. Vickery (2022) agrees with this, and it seems that the men’s worries about their commitments as providers were a main concern in his research as well. However, the Scandinavian studies do not mention financial concerns in their findings. There may be various reasons for this. One might be that the financial services are different in different countries. The studies find that men do not mention their disease or discuss it with anyone, because they want to protect their loved ones, or they do not want to be perceived as ill or weak (Öster *et al.*, 2013; Handberg *et al.*, 2014). However, in Saastad (2016) the female partners talked about the men as silent and angry which they attributed to lack of communication. Saastad (2016) does not elaborate on this, but it is reasonable to assume that the lack of communication is an experience of the men not talking about their concerns or discomfort. The bodily changes, such as impotence (Cecil *et al.*, 2010), bowel functions (Öster *et al.*, 2013) or physical weakness affect the participants’ body image, and (Cecil *et al.*, 2010) find that just like women who have had a mastectomy, men feel a sense of change of body image too. The bodily changes for women are acknowledged as a loss, grief and a changed self-image. It is my impression that except for the consequences of impotence, psychological impacts of physical changes on men are seldom addressed in the literature. In an extensive, Norwegian publication about psychological reactions to physical illnesses, there is a whole chapter about men’s sexuality, but nothing about masculinity and social structures in sickness (Dahl *et al.*, 2014). The studies reviewed here thus provided an understanding of how men have experienced mental stress as a consequence of cancer illness.

3.2.2 Experiences of peer support groups

The research papers included here address men's experiences, and give a description of how groups may be important for mastering illness It appears that men are interested in groups if the reason for gathering is not directly or implicitly about their concerns. The participants in the Norwegian report stated that they wanted to be able to play ping pong or do other activities (Saastad, 2016). Handberg *et al.* (2014) found peer support helped the men through a difficult period, and this can be linked to the finding that peer support helped the men talk about subjects they could not discuss with others, and experienced the group as a safe place (Öster *et al.*, 2013; Saastad, 2016; Vickery, 2022). The knowledge presented by the research in this review brings me to reflect on if anything is missing from the picture. None of the studies have included critical statements of negative experiences in their findings (Cecil *et al.*, 2010; Öster *et al.*, 2013; Saastad, 2016). The findings of Handberg *et al.* (2014), who are reviewing 15 papers, do not write anything on the topic. Even if the researchers wished to promote peer support, presentations of deviations from what the majority of the participants said, would have demonstrated the different voices of the participants. I believe the transparency would have given the studies greater validity. It would also have been helpful for future work if negative aspects were highlighted, as this would help inform future peer support activities.

Several studies included in this review have found that humour is an important factor for peer support for men (Öster *et al.*, 2013; Saastad, 2016), as it helps men cope with the severity of their disease (Handberg *et al.*, 2014), and it is a key ingredient in their interaction. This makes me think humour is men’s way of maintaining an emotionally resilient discourse surrounding their gender.

3.2.3 Summary of the reviewed literature

Through reviewing these papers, it appears that experiences of men from different countries in Europe are similar concerning the constructions of masculinity and serious illness. I have learnt that economic and bodily changes are a part of the concerns men have, and that joining a peer support group might reconstruct the experience of the masculine role, facilitate mental health management and help prevent isolation. This review also shows how men position themselves within a cancer patient discourse, and that men in treatment have a greater need to discuss experiences than men who are no longer actively treated. Further, the Norwegian paper suggested that specific activities aimed at men are needed.

In this review, I have looked at the broad lines of qualitative research in this field, carried out by Handberg *et al* (2014), before I have looked more closely at a few studies, especially relevant to my research as they highlight some of my areas of interest. Cecil *et al* (2010) have provided a valuable understanding of how the bodily changes affect the men's experience of masculinity. This study gives an awareness of how the bodily changes may affect the the way the men consider themselves. Vickery`s (2022) findings that the men found peer support to be helpful for men with mental health issues is interesting, because it goes against the general view that men cannot use such support, while the findings of the Öster *et al.*, study (2013) show how peer support helps men in cancer care cope with loss of sexual functions. Generally, these studies show how men can benefit from meeting others in groups. As my research takes place in Norway, it is helpful to see how Saastad (2016) suggested how the masculine ideal surrounding Norwegian men could explain why this area is poorly researched.

None of the papers reviewed included diversity of sexuality or ethnicity. This means that questions remain about how people identifying as LGBTQ+ or of non-Norwegian or European identities experience peer support in masculine settings. If a person is biologically born as a male and identifies as a woman, how will this affect this person's position in the gender discourse concerning illness, and how would they experience the peer support groups? Today, we do not view gender in the same way we did just a few years ago.

The cancer strategy of the Norwegian Ministry of Health and Care Services states that cooperation between voluntary organizations and the public health service should be further developed to provide good services (Regjeringen, 2018). Through all my searches looking for research about peer support, I have not found any studies looking into the possibilities of peer support as a part of somatic health care. However, Handberg et al. (2014) concludes their research by stating that more research is needed on the underlying factors of men's participation in rehabilitation from the health professional perspective. Accordingly, it seems there is a common understanding in all studies that peer support activities are best led by professionals. This makes me wonder about the ontology of the researchers, and whether in this area of research, education and learned knowledge is positioned as having more power than experiential knowledge (Hall, 2001).

3.3 Presentation of relevant literature: Gender perspectives in health care

In this section, the aim is to review research carried out on gender in health care, in order to understand how men as patients are viewed in the healthcare system. In this part, one book and two articles are reviewed.

Madsen (2014) Mænds sundhed og sygdomme (Mens health and illnesses)

In this book written by the Danish psychologist Madsen, it is claimed that the health inequality between the sexes is grounded in psychological, cultural and societal ideologies. The literature here is a dissemination of knowledge, not presented as research. Madsen describes how the Danish health care system could become much better at meeting the masculine psyche, whether it applies to prevention, recruitment for treatment or overall understanding of a man's self-experience as a patient and in rehabilitation. In his book, Madsen explains that family patterns become rigid when in a crisis. He writes that the reason for this is that men avoid identifying as patients but focus on the life beyond and after the illness, as part of a coping mechanism. While women react to serious diagnosis with for example self-blame, sadness and guilt, men react with feelings of shame, irritation and being violated by an external source (Madsen, 2014). Knowing the differences in reactions might be valuable when health care professionals meet with ill men. He argues that the health care system needs to develop procedures to take care of the psychological needs of especially elderly men who suffer loss or illness, as they are in danger of developing depressions. I would have liked Madsen to write something about why elderly men need different procedures. Showing emotions and sharing mental health issues are currently more valued than before, so it may be that younger men do not have the same view of the masculine hegemony because this phenomenon has been challenged and has changed. Madsen is concerned with how the men in crisis are met by health care workers. He argues that people tend to do more of what they think works when they experience crisis, and for men that might lead to increased withdrawal and anger (Madsen, 2014). This may be difficult for both the family and health care workers, but Madsen has suggestions for how health care workers can show support. He suggests that rather than thinking that one must “take care of” or “help” the man, health care workers need to give the patient advice and options. Even though Madsen

(2014) tries to convey a different way of caring, he seems to have a positivistic approach. This impression is derived from the way he presents his arguments as general truths, his statistics and the way he stereotypes men and women's reactions, rather than considering the evolving of the gender roles and individual dispositions. He brings little new information and gives a stereotypical presentation of both men and women as patients and nurses. Despite his book being only a few years old, there are no reflections on how patients with gender incongruity are affected by meetings with health care workers. It seems Madsen (2014) is constructing a discourse of "how to help male patients" and is using his knowledge and experience in the field to acquire authority. Even though statistics in his book are revealing that men are most unhappy about not meeting other patients in cancer care, he does not give this any further attention. To get a different view on the field, I went on to see if there were different findings from women researchers.

Lien (2014) The gender-neutral patient in nursing – the meaning of gender in female nurses care work for male cancer patients

In this article from Norway, Lien (2014) explored how gender was played out in treatment situations in which female nurses working in cancer care tried to talk with male patients, about their emotional reactions to illness. The article is based on fieldwork conducted in a cancer clinic, where it was designed to provide knowledge of discourses among women nurses in cancer care, through contextual and ethnographic descriptions. It aimed at exploring how the nurses experienced and interpreted the ill men's need to talk about their life situation in relation to illness. In this research, she explored how care theories and discourses about intimacy within Norwegian nursing played a role in the relationships between the ill men and the nurses. She also looked at challenges the female cancer nurses experienced in communicating in their daily interactions with men in cancer treatment. In her article, Lien

(2014) questioned whether men and women have different needs for care in contact with health care workers. In her analysis of the nurses` stories, she looked at theories of masculinity, and interviews with male nurses in the education field. I found this article very interesting, as it highlighted differences in gender approaches within Norwegian health care. The institutional ethnographic approach was an appropriate research method, describing the nurses' practice. Lien (2014) conducted interviews with three men who are teachers at nursing academies, seven female nurses, and one female- and two male doctors at the same department, in addition to informal conversations with hospital staff at an oncology department in Norway. In this article, she has also studied some of the Norwegian Cancer Association's information material aimed at prostate cancer patients, and has included this in her ethnography. Lien (2014) found that female hospital staff often viewed the men's partners as an active part in their meetings, and that the doctors portrayed wives as their husbands' secretaries. In their practices, nurses described how the men at the hospital often used humour and gallows humour in talking about their poor prognosis, and how women seldom used humour to talk about the illness advancing (Lien, 2014). This is supported by the research carried out by Öster *et al.* (2013), Handberg *et al.* (2014) and Saastad (2016) who all found humour to be an important coping mechanism for men, as it helps them keep a distance to difficult emotions and to stay within the masculine discourse. One physician said he avoided talking about difficult issues, and kept a "macho appearance", which he alluded to as a discourse of women being more competent than men to talk about difficult emotions. Lien (2014) here suggests that in this situation, this doctor represented a hegemonic masculine position, and maintained a verbal distance as part of the masculine social game, and through that, the sick man's masculinity and dignity were cared for. The female nurses used different techniques to get the men to talk about their emotions, and Lien (2014) points out two discourses the nurses operate within to justify this; the health care openness discourse and the local nurse discourse about enabling patients to regain control in their own lives. She questions whether an unintended consequence of nursing’s normative femininity, and the Norwegian nursing education’s curriculum which insist on closeness and dependence as basic principles, can become a devaluation of men’s life experiences and breadwinner orientation (Lien, 2014). Lien (2014) concludes her findings by stating that the discourses of intimacy and the ideals of openness can become a burden rather than a help for some men. In treatment situations, the care-discourse carried out by women as partners and nurses, comes into conflict with the discourses surrounding masculine hegemony. Conclusively she argued for the need for gender perspectives in nursing and caring theories. This study showed how the discourses about care were executed in a particular setting in a Norwegian hospital.

Lilleaas and Fivel (2011) «For mye av det gode? – Kvinners involvering i menns helse og sykdom» (Too much of the good? Women’s involvement in men’s health and illness)

In this article by two Norwegian feminist researchers, the authors examine how partners of men with prostate cancer experience handling expectations from those around them, and the extent to which they get involved in their partner’s illness. The authors interviewed six partners of men with prostate cancer. The researchers aimed to find out what happened when the partner got a life-threatening diagnosis, and they were driven by the desire to gain more knowledge about some of the mechanisms that lie behind women partners’ involvement in men’s health. Although the research was aimed at shedding light on women’s experiences, it also gives a helpful perspective to help understand the systems surrounding men suffering from illness. Semi- structured interviews were aimed at extracting experiences, and were an appropriate research method to examine the experiences of the female partners. One of the interesting points in this article is that Lilleaas and Fivel found information about men’s health aimed at women. This was a common phenomenon until the late 2000s, in information pamphlets from doctors, commercials and in weekly magazines. In this literature, they found that men were infantilized. An advertisement the researchers found in a Norwegian magazine in 2007 showed a woman lying in the double bed and anxiously looking over at her husband's place, which is empty. The point of the advertising text was that women had to pay attention if the man went (too) often to the toilet at night. The advert suggested that if the man took the advertised product regularly, he would avoid any nightly visits to the toilet. This suggests that the Norwegian health care system maintains a discourse of men not being involved in issues that may affect their health. The authors believe that the strong involvement in men's health and illness, like many women seem to practice, will contribute to adverse health behaviour in men because it relieves them of responsibility for their own health. In a film made by the prostate cancer association, erectile dysfunction is displayed as something that contributes to reduce men’s ability to give and receive love. This prejudice supports the concerns in which the men displayed in the research carried out by Cecil *et al.* (2010), and contributes to reduced body image. I liked this article because of how it shed light on the male hegemony from a feminist perspective, and showed how the practice surrounding men and health is a burden for both the men and their women partners.

3.3.1 Summary of the reviewed literature on gender perspective in health care

The findings of this review showed that health care workers experienced women partners of men as the most active partner in meetings. Both Madsen (2014) and the research papers Lilleaas and Fivel (2011) and Lien (2014) showed that female partners to men with serious illness take care of the family’s health overall. Madsen was concerned by how female health care workers met the men’s need for support with feminine values. In the research from Lien (2014), the female nurses seemed to have a similar understanding of men not knowing what is best for them, as they “tricked” the men into talking about their emotions. Neither Lien

(2014), Lilleaas and Fivel (2011) nor Madsen (2014), reflect upon age. It would be relevant to see if younger men have the same experience of masculine hegemony as middle-aged and older men, or if ideas surrounding this have changed with time.

While I find Madsen’s writing somewhat stereotypical and positivistic, the work of Lilleaas and Fivel (2011) and (Lien, 2014) are interestingly providing new information and expand the understanding of the differences between men and women in health care. It seems clear that the authors have done a thorough job in researching and analyzing the material, and even though they have clear statements, they stay humble indicating that they do not possess the truth of the matter. Reading this literature provided a new understanding of masculinity in health care and gave a broader perspective of how it may be experienced to be a man in Norwegian hospitals. The female value perspective was new to me and made me reflect on many meetings I have had with men during my time at the hospital. The knowledge broadened my understanding and made me realize how I might have been influenced by this broader discourse without even noticing, how it may have influenced my encounters with families and couples who have sought my help, and guided my punctuation in our conversations.

3. 5 Presentation of relevant literature: Systemic therapy with families experiencing serious illness.

As it is an aim in this research to learn how knowledge from this area can be applied in systemic psychotherapy, this section consider systemic work with physical illness as this provides many parallels to the more specific issues found in working with cancer sufferers. Norwegian family therapists have little knowledge about how physical illness affects men and their families. , and here I have looked for knowledge from therapists in the medical field, as

I aimed to learn more about how family therapists work in medical settings. Two articles and two book chapters are included because they highlight different points of view in relation to systemic therapy with physical illness. In the following, a short description, the methodology and the findings are presented.

Altschuler (1993) Gender and illness: Implications for family therapy

This article from the UK “Journal of family therapy” is included because it gives important inputs on the aspect of the male gender in systemic therapy. In this paper, Altschuler (1993) argues for the importance of having a conscious relation to gender when working with families dealing with a life-threatening or chronic illness. The particular contribution of the family therapist is highlighted, including suggestions about how systemic interventions can be introduced to enhance the capacity of those involved in addressing the transitions demanded by such illnesses. This paper is thirty years old, which makes some of Althschuler’s statements less relevant as society and constructions of gender have changed much over these years, however there are interesting aspects of her research, which I wish to address. Altschuler has a social constructionist approach in her paper, as she is concerned with how the language constructs reality for the families. She suggests that metaphors, still used today, surrounding illness and treatment are often related to military and masculine jargon, such as “fighting the illness”, or the patient’s ability to maintain a “fighting spirit” (Altschuler, 1993). These metaphors, used in peoples’ everyday language, contribute to the expectations of men to be strong, stoic and independent, which Cecil *et al.* (2010) demonstrated in their research. When this was written, gender constructs were not the focus of family therapy or how it impacted families experiencing illness, according to Altschuler (1993). I believe gender constructs are still lacking focus in Norwegian family therapy today. Altschuler (1993) addresses the gender perspective in families, suggesting that systemic approaches can help families reframe and maintain their understanding of masculinity and femininity, provided the therapist is aware of her own presuppositions when it comes to gender. This is a particular concern with Altschuler 81993) as she claims that meeting patients who distances themselves from their intimate relationship may present a challenge to a woman therapist. In line with the research reviewed above (Handberg *et al.*, 2014; Saastad, 2016; Vickery, 2022), Altschuler (1993) also finds the disabling effects of illness linked to the masculine role. She suggests that a systemic approach may enable the man (or the family) to re-evaluate his views on masculinity or femininity, and to create alternative narratives of life. Reading this research made me curious to see if newer literature could expand the knowledge presented in this research, so I went on to look at newer literature.

Robinson et al. (2020) Systemic family therapy in medical settings

To review more updated knowledge on systemic therapy with physical illness, I decided to look at this chapter in the American Handbook of systemic family therapy. Here, the authors discuss the present status of systemic therapy practices within medical settings and propose several ideas for further advancing the practice. The perspective on systemic work includes the collaboration with health care workers and different systems. I find this relevant and interesting as I am the only systemic therapist working in a Norwegian hospital, and collaboration with health care workers is a part of my working day. The authors state that systemic therapists have found employment in health care settings such as psychiatry, but it is time that systemic therapy finds its position in medical care because it may highlight how relationships influence the health of the patient and the family as a whole (Robinson *et al.*, 2020). This is in agreement with the claims of Altschuler (1993), that systemic therapists can contribute by showing how the discourses surrounding gender affect the interactions of the families. The authors claim that the job of a family therapist in medical care is to “carefully address the major decisions that must be made" (Robinson *et al.*, 2020 p.6). By this, Robinson *et al.* (2020) means the therapist need to help the family start a dialogue amongst the family members. They are also concerned about how the therapist needs to focus on the families' strengths more than dysfunctions caused by the illness. There are some things I hesitate about this chapter. There is a great deal of abbreviations that are not explained, and the language seems positivistic, presenting claims as facts rather than observations. An example of this is: "Medical Family therapists help patients to increase their level of agency by communicating available treatment options, overcoming obstacles for health maintenance, and ensuring that patient beliefs and desires are heard and respected." (Robinson *et al.*, 2020 p. 11). Reading this chapter, I get an impression that one of the main tasks of a systemic therapist in medical care is to navigate between the different medical systems on behalf of the family. There may be nuances in the English language that I do not understand, but from reading this chapter I visualize the patient as a bystander while the therapist functions as an advocate on the patients' behalf. Even though the different aspects of medical care constitute a system, I find this to be on the side of what a systemic therapist should do. I believe a systemic therapist should help the patient (or the family) to realize they are an equal part of a system, and to help them identify as a balanced partner in dialogue with the medical health care workers. From this chapter, I cannot find that Robinson *et al.* (2020) reflect on the family therapist position in a system. Leaving this out makes me wonder if they think the therapist is a neutral part. They further argue that family therapists in medical care should have knowledge about biomedical facts. This will provide the needed ability to relay crucial information to patients as this will help them understand the common psychosocial impacts of the illness. I do agree with this. To be able to help families living with illnesses, it will be a strength for the therapist to know for example, that conditions treated with high levels of corticosteroids can potentially experience mood swings, restlessness, inner restlessness and sleep disturbances

(Helseinformatikk, 2021) as this will affect the family. After reviewing this chapter, I felt a need to look at a more social constructionist approach and went back to Althschuler's work and to review her book: Working with chronic illness.

Altschuler *et al.* (1997) Working with chronic Illness

This book is part of a series, which introduces readers to the theory and practice of counselling and psychotherapy across a wide range of topic areas. The book has contributions from other authors, but Altschuler was the only author of the chapter reviewed here. Even though Altschuler has recently written about chronical medical conditions in the Handbook of Systemic Therapy (Wampler *et al.*, 2020), I preferred to review this chapter because of its practical education of systemic therapists in how to do therapy with persons who are physically ill. I have chosen to review a chapter written by Altschuler on *Using family therapy techniques in your work*, but have also looked at sections named *How do this relate to gender* and *What does an illness mean to an adult's sense of self*? The writing by Altschuler *et al.* (1997) was somewhat a contrast to how Robinson *et al.* (2020) viewed a family therapist in medical care. They held the first and most important thing a systemic therapist could do when meeting families is to listen, as there was potential healing in the families' experiences of someone listening to the their story. She claimed that the self is affected by physical illness, as physical illness may change a person's ability to maintain their usual lifestyle. The listening could provide the families with the security they need, that the listener was ready, unafraid and unembarrassed to understand what the families faced, whether it was death, anger or fear. In her later work, she used silence to connect with a woman who has suffered trauma (Altschuler, 2020). Here. Altschuler *et al.* (1997) suggested that systemic therapy in medical care does not differ from other settings, as they illustrated how the therapist's way of asking questions may extend, reframe or define the way in which the family viewed their experience. They stated that sessions are most useful when what is addressed reflects a shared understanding or co-construction of what the family and the therapist felt was important. This is in contrast to Robinson *et al.* (2020) who wrote that the job of a family therapist in medical care is to address the major decisions. They considered that the family therapists needed to help families understand the common psychosocial impacts of the illness. Altschuler *et al.* (1997) is in line with this when they suggest that the therapists may comment on what others have found helpful and provide information through comments like: "I`m not sure this is helpful for you, but other families/couples…"

In this book, Altschuler *et al.* (1997) again looks at gender, and raise the important issue of power. The authors express that unlike most professions, medicine combines the exercise of power and high status with intimate care. This is in tune with Lien (2014), who acknowledged how female nurses tricked men into talking about their emotions. This was an example of how they thought that this was objectively the only way you could get better, and the same thing can happen with systemic therapists. Family therapists must balance skills and personal limitations. Too much of one or the other can create distance between the therapist and the family, and limit the perceived emotional support the families (Altschuler *et al.*, 1997). To help the therapist reflect on their own professional competence on the subject, Altschuler *et al.* (1997) ask some helpful questions about how gender influences decisions about physical and emotional care. They question if gender influences the balance between intimacy and distance in the therapist's work, and how gender is expressed through feelings and styles of communication in professional relationships with families and co-workers.

I really enjoyed reading how Altschuler *et al.* (1997) show how systemic therapy may help families shift from victimization to an experience of greater control over their own lives. She did this by encouraging systemic therapists to acknowledge pain and grief caused by the illness, and at the same time help patients enhance stories of themselves as competent and in control of their own lives. To me, Altschuler *et al* (1997) are showing how the systemic therapist can be a difference that makes a difference in the medical system (Bateson, 2000). After reading her book, I wanted to look at some therapists who had applied systemic therapy in their therapy with physically ill people.

Leitch and Martin (2022) Meeting the entire older person: Systemic working with elders and physical frailty.

This article was chosen because of its focus on meetings with a marginalised group, namely elderly people with physical illness. It resonates with me, as I view men suffering from late injuries caused by cancer treatment as a marginalised group**.** In this article from Context – the magazine for family therapy and systemic practice in UK, the authors suggest that elders often face multiple injustices and marginalisation in their later life. The article is split in two, with Martin writing the first piece, Leitch the last. It was particularly interesting to see how the authors were concerned about the physical wellbeing of the patients before starting therapy, as I viewed this as an effort from Martin to convey to the older man that the balance of power in this relationship differed from the relationships with the hospital staff. Although you cannot completely equalize the power dynamic between them (because as a professional she has a more powerful position in the encounter (Hall, 2001), Martin shows here that she wants him to experience that she is ready, confident and fearless for what he brings. Martin states that paying attention to physical wellbeing is important when working in mental health settings when people experience physical health difficulties. She shows this by presenting a case where she started the conversation by asking the ill man what he needed to be comfortable, and how she will know if he started to feel uncomfortable. She then brings the man’s wife into the conversation by asking her what she would notice, and if she will help Martin to understand if her husband is uncomfortable. I think this is brilliant, and it exemplifies how the therapist is open and unafraid to talk to this man about his concerns. I have an understanding of these authors as social constructionists, because they show how through the use of language and the dialogue with the patient, a mutual understanding of the situation these elderly people are in, is constructed. The systemic approach helped the man to feel recognized and as an important part of the system, as he told Martin “he was surprised to be asked these questions as professionals only usually asked him about specific medical problems and medication he should take” (Leitch and Martin, 2022). Focusing on the physical comfort and practical issues rather than on emotions is also a good way of acknowledging the man (Saastad, 2016). Martin goes on to describe how she asked her client about what gave his life meaning, and how this helped him create a new narrative, which seemed to help reposition him within the masculine hegemony. I think this story in a beautiful way shows how systemic therapy complements health care, in line with Altschuler *et al.* (1997) thoughts on how systemic therapy can help from victimization to an experience of being in control.

3.5.1 Summary of reviewed literature on systemic therapy with families experiencing serious illness.

The literature reviewed has shown how contextual gender discourses have a major impact on how families construct their thinking concerning illness, and systemic therapists need to be aware of this in their work. It has displayed how systemic therapy offers people and the medical system a new understanding of the importance of each part of the system, and how a systemic approach can provide a safe space for the families to feel understood. Therapeutic approaches can help the families create a new understanding of the patient as able and in control over their own life, as Leitch and Martin (2022) described in their paper. Starting the therapy by showing concern for the patient’s well-being they make it clear for the family that they are valued and that they want the family to feel in control. Opening the conversation by talking about the physical consequences of the illness may appeal to men, rather than starting with the emotional consequences of the situation. The reviewed literature highlights the importance for a systemic therapist to be aware of one's own orientation to and ideas about gender in the meeting with the families, and to acknowledge we are part of a system that promotes gender discourses. Altschuler (1997) describes several gender discourses and the consequences of them: as the way in which women expresses one's emotions can be different from men. This may lead to expectations that the other is unable to fulfil, as women tend to be more concerned with the emotional consequences of the disease, while men often focus more on the physical consequences. The therapist can help the families become aware contradictions and restrictions, and help them navigate by carefully starting a dialogue concerning gendered expectations (Robinson et al., 2020). The literature reviewed shows how systemic psychotherapy can help families and men reflect on discourses to find their place in the masculine hegemony. In the literature about systemic therapy I have reviewed, nothing had been written about peer support, or how meeting others with shared experiences may create coherence and expand the families' understanding of their situation.

3.6 Conclusions

In this literature review, various qualitative research approaches and generic literature showed how men are affected by cancer illness. The literature showed how the men experienced psychological stress caused by a feeling of loss of masculinity (Cecil *et al.*, 2010; Handberg *et al.*, 2014; Saastad, 2016; Vickery, 2022), concerns linked to being the family's main provider (Cecil *et al.*, 2010; Vickery, 2022), a need to protect the surroundings from their concerns (Öster *et al.*, 2013; Handberg *et al.*, 2014; Saastad, 2016), and feelings connected to bodily changes(Cecil *et al.*, 2010; Öster *et al.*, 2013). The men who had been part of peer support groups experienced the groups as a safe place, and they helped alleviate the feeling of being outside a masculine discourse (Öster *et al.*, 2013; Saastad, 2016; Vickery, 2022). Humour helped the men cope with the severity of the illness (Öster *et al.*, 2013; Handberg *et al.*, 2014; Saastad, 2016), a strategy also noted as prominent by female nurses when men talked about poor diagnosis (Lien, 2014). Using humour about their situation was not in line with how female nurses felt men should talk about their emotions (Lien, 2014), so they took "responsibility" for the men and tricked them into talking about their feelings (Lilleaas and Fivel, 2011). To provide help in line with the men's need, health care workers must gain more knowledge about men in crisis (Madsen, 2014). Systemic therapy can help ill men restore the feeling of being masculine by challenging ideas surrounding illness and the way they affect the self, and create alternative narratives. (Altschuler, 1993; Altschuler *et al.*, 1997; Robinson *et al.*, 2020; Leitch and Martin, 2022)

Norwegian health care is considered as one of best in the world (Shneider *et al.*, 2021). Still, there are many ways to improve. By law, the Norwegian Health Care system is required to provide patients and next of kin with education and training to cope with their diagnoses (Regjeringen, 2018). However, the guidelines for this work are unclear, as there seems to be a gap between the specialist health care and the municipal health care service in which patients often feel left alone (Regjeringen, 2018). Meetings with others who share a similar illness can provide a helpful understanding and give new knowledge about one's own situation (Skirbekk *et al.*, 2018). Despite this knowledge, international and Scandinavian studies have found that men tend to wait too long to see a doctor, and to withdraw from social arenas when they become seriously ill (Hansen 2005; Gordon 1995 Simonsen 2006; White 2006). A study by Walshe and Roberts (2018) found that peer support programs normally appealed to well educated, middle-aged women, and most of the studies in their review were carried out with women participants. Above all other research that has been carried out among cancer patients, breast cancer patients have participated the most. With this presentation, it appears there is a need for more knowledge about gender and about systemic thinking in Norwegian health care. In Norwegian health care today, there is little, if any focus on how care is affected by gender. There is a large dominance of female nurses in Norway, and most likely it will stay that way for a long time (Karlsmoen, 2021). The curriculum at the nursing academies seems to be stuck in outdated thinking about how to practice good nursing towards patients (Lien, 2014), and the difference in gender does not seem to be a topic in the training nor is it a focus in health care services. The literature reviewed here show there is a need for more knowledge about men's coping mechanisms concerning illness. There is also a need to make health care professionals aware of how peer support groups enhance the men's coping by using their own resources. These observations have led me to reflect on whether there has been a category fallacy in this field, in that peer support programs have been designed for women cancer patients, and are not in line with men needs. With this review, the aim was to examine previous research in this area, to see what knowledge exists about men in the field of peer support, systemic therapy and health care, and from this consider how my research can contribute to this field.

I believe the findings of my research will fit well into the findings of the literature presented here, and may further provide knowledge on how Norwegian health care can create a place where men find peer support a valuable addition to the medical treatment. In particular, it extends the issues which need attention in order to offer constructive peer support to men who may themselves be caught up in a masculine hegemony which makes it difficult for them to seek psychological and emotional help.

4. 0 Methodology

4.1 Introduction

As this research aims to provide an understanding of how Norwegian men are different from Norwegian women in the way they cope with cancer, and how Norwegian health care can facilitate peer support for them, I needed a methodology fitting for this task.

As a researcher, I find myself in between ontological positions. My point of view changes, affected by the context in which I am in at a certain moment (Bateson, 1979). In the positivistic hospital environment, I find social constructionist ideas liberating and promote this way of thinking. Foucault is considered to be a constructivist, yet his descriptions and ideas about power made a huge impact on my ontology and the way I see the health care system. However, in settings where the social constructions are strongly proposed, I tend to object. Social constructionism regards any opinion as good as the other (Hacking, 2000), and I think social constructionism can be too critical to positivist knowledge. In my work, I have seen people decline medical treatment that most likely would have saved their lives for alternative sources of healing, such as herbs, shamans or the power of their thoughts. This has come from environments that has an alternative construction of cancer and how it can be cured. Seldom have I felt so much sympathy for any patients as when they realize their constructions failed, and that the cancer has progressed to terminal stage.

The movement between the ontological positions is also following me in my epistemological approach to the research. In carrying out the research, I want to be creative and the participants’ voice to be strong, challenging and create change. At the same time I want to create a path to the rest of the researchers in my work environment, using a method that I hope will be acknowledged.

Critical realism as an epistemological position is the position I will take on while doing my research. In both ontology and epistemology, I feel most at home in this paradigm. Critical realism can be understood both in tension with these two philosophical positions and with a partially overlapping interest. That is, from both a postmodern and critically realistic position one rejects the idea of a privileged perspective on, or understanding of the world. This position allows me to combine my positivist and social constructionist values (Clark, 2009). I believe it to be a fact that cancer patients need help from the Norwegian health care system, and that this is the best alternative for their recovery. However, this system needs to interact and to adapt to the feedback from the patients. The choice of carrying out an action research study accords with my position as a critical realist, as it allows me to address an issue I know needs changing, but I do not have the knowledge how to do so without the knowledge of the participants (Heimburg and Ness 2021).The semi structured interviews elucidated the participants' experiences and provided valuable feedback that could be used to adjust the next cycle.

In this process, I noticed myself going back and forth between positivism and social constructionism. for example in the ethnographic part of this research, I became active in the conversation, adding a question about illness if I felt the conversations were too shallow (as I felt it). I wanted to steer the participants’ conversations to what I thought was most useful for the findings. On the other hand, I have been aware of conveying the experiences of the participants and have tried to display how their understandings were shaped through the interactions in the group.

In my discussion as a critical realist, this position has allowed me to debate and challenge the absence of men in rehabilitative settings, and to make claims about femininity and masculinity, family therapy and health care (Thomassen, 2006).

The method of research was a response to an inquiry made by a man living with cancer. He wanted to take part in an activity where there were not mostly women, because he did not feel at home there. He had problems connecting with all the women's knitting going on in some of the groups, and wanted to meet people in a different way. Preferably other men living with cancer, but he found it difficult to locate other men suffering from cancer and wanted an arena where men could talk on their own terms. This gave an opportunity to explore the social phenomena of men's experiences with peer support. Furthermore, it was desirable to demonstrate this to the hospital staff, with the hope to form a systemic understanding of the experiences of Norwegian men living with cancer. The aim was also to provide an increased understanding and systemic awareness in the meeting with these men and to empower them to increase the experience of mastering their own situation. To do this, a qualitative approach was viewed as appropriate, and as a systemic therapist it was natural to do a collaborative action research (Simon, 2018). A key value to me as a systemic therapist is that people are best suited to find out what they need themselves, and I am passionate about bringing forward the knowledge from the participants to systemic therapists and the health services.

4.2 Description of the research

In coherence with my ontological and epistemological point of view, I have found that a qualitative study will be relevant to shed light on the research question:

How do men in Norway experience peer support during cancer treatment?

With the sub questions:

- How do peer support during cancer treatment affect men's mental health?

- How can Norwegian health care facilitate peer support for men with cancer?

- How can knowledge in this area be applied in systemic psychotherapy?

In this study, a triangulation of methods is used to explore the men's experiences of peer support. Action research was conducted in three cycles. The first cycle took place in Bergen, the second in Trondheim and the last cycle in Oslo. In every cycle, a group of men who had experience as cancer patients, participated in different activities. In the first cycle, an ethnographic study was done. After the first cycle in Bergen was done, an evaluation was done before the next cycle was started in Trondheim, and the Trondheim cycle was evaluated, and the experiences applied to the Oslo Cycle. In the cycles in Trondheim and Oslo, I did not attend all the meetings as in Bergen. There, I attended the first meeting and came back to do the interview three weeks after the group was finished. Semi-structured interviews were conducted with all the three groups after the groups were finished.

4.3 Ethics

Working with the groups, there were several ethical issues to consider. When the participants were reflecting and revisiting their experiences, it could lead the participants to experience increased psychological strain. When participating in the study, the men shared medical details which could bring forward unprocessed feelings. One participant had a relapse from his cancer illness during the course of the study and this may have created anxiety in other participants. With the Participatory Action Research (PAR), a problem could be that when the study was finished, there might be a void, as participants potentially would have no ongoing support from each other. To ameliorate this, several offers of support were made available to the men. The research was done in collaboration with the Norwegian Cancer Association, who helped recruit participants and arranged for the groups to use their premises for the meetings.

I had arranged a debriefing with a psychologist if unexpected, undesirable situations occurred, and in case of accident or injuries during the activities. The Norwegian Cancer Association insured all the participants during the activities. If any of the participants needed individual help, a psychologist would be available during and after the research. The men were informed about a specialist psychologist they could contact at any time without the researchers knowledge, during and after the study was over. In addition to this, the Norwegian Cancer Association had local resource centres in the three cities, where staff members were made available for support if needed.

To empower the participants, and to lift up the participants' ability and qualities to help each other, trained peer supporters were recruited as participants. These had a role as facilitators and participants in the research, and had training from the Norwegian Cancer Association courses for peer supporters. The peer supporters had long experience in taking care of other participants' emotional needs as cancer patients in different phases, and had an extra task in detecting if a participant was not included the group, or for some reason fell out of the fellowship, and to take action to help the participant and the group. This was especially important in the groups where I did not attend the activities. The idea was that if the PAR project was a success and they wanted to continue, the peer supporters gained experience in running the groups, and could start new groups together with the Norwegian Cancer Association. The trained peer supporters wanted to keep the groups going after the research, and gave the men the opportunity to have one- to one peer support.

As a systemic therapist, I have long experience in working with group dynamics. I had meetings with the peer supporters along the group activities, and I contacted the peer supporters after every meeting to hear how the meeting had gone and if there was something they wanted to discuss with me. This was done to reflect together with them as facilitators, if any problems emerged in the group.

4.4 Reflexivity

Madden claims we see others in light of our own history, social positions, culture and power (Madden, 2010), which is true also for this research and for me as a researcher. My background, understanding and experiences have led me to my punctuations in this research. The motives behind this research do not simply come from a need to bring out the men's experiences, but also have a resonance in myself and my position. As a trained nurse, and now a family therapist at a hospital, I myself have experienced a hierarchy. In my work as a nurse, I experienced the frustration as a newly trained nurse of not being heard by the doctors when my suggestions were overlooked, even sometimes ridiculed. In my work as a systemic therapist, I have repeatedly experienced the families' desperate attempts at dialogue, and to achieve a desired response from health care professionals, and I have listened to their desperation to receive the treatment they believe might save them from dying. As the only family therapist, I have also experienced that my competence has been questioned, and that the need for my competence in the specialist health service has been criticized by other professionals. This has given me a desire to bring forward knowledge from a different angle within the system.

In the first cycle, I did an ethnography. To make distinctions in what we observe, we need to know when we hold the objective in parenthesis and without parenthesis (Maturana, 1988), which implies I need to be aware of what my observations are, and distinguish between my perceptions and the participants' experiences. I was a woman researcher in a group consisting of only men participants, and what I observe in this situation starts with punctuations made by me (Foerster, 2013). One might argue a woman researcher cannot understand what it is like to be a male cancer patient, which is true in the sense that I have no experience of having cancer or living up to the social expectations of the male role. However, the experience of being a male cancer patient varies from person to person, and like me, any male researcher would also bring his presuppositions into the research. As a woman researcher I discovered how my reality has been ‘without parenthesis ‘before the interactions with the participants. This means that I had accepted my assumptions as basic properties, independent of the influence of thoughts and ideas that surrounded me, and I was blind to my influence in the construction of what I observed (Maturana, 1988). Through the interactions with the participants, I achieved (even if only momentarily) to see the relations ‘with parenthesis’, which implies that I am aware, as a human being, a living system that changes as I am in contact with other living systems (Maturana, 1988). Discoveries and punctuations of differences in language, behaviour and appearances have contributed to curiosity and perhaps a wider understanding of the groups’ relations.

In the beginning of the ethnographic study with the Bergen Cycle, I was afraid the participants would withdraw from the research. This made me feel responsible for the participants’ wellbeing and I wanted everybody to feel included, particularly at the start of the research. This need for everyone to feel included might be my own internal feminine values; I had to take “care of” these men. During the Bergen cycle, I experienced these feelings without understanding what they were. In hindsight, I think that if someone withdrew during this ethnographic study, it could have given valuable insights about myself as a researcher, about the group and about my relations to the group. My concerns about this, affected my presence in the group, and I was particularly concerned with one of the participants. This is elaborated in the description of the Bergen cycle. I believe this may have been a reason why the participants throughout the cycle were concerned about whether I got what I needed from the group.

4.5 Action Research

To get knowledge of how Norwegian health care can facilitate peer support for men with cancer, Action Research was considered to be useful. Action research is about co-creating knowledge that solves practical problems by developing new patterns and opportunities for relationships and organization (Heimburg and Ness, 2021) As I wanted the research to be as inclusive as possible, action research was chosen as an overarching method. This research method challenges the claims of a positivistic view of knowledge which holds that in order to be credible, research must remain objective and value-free (Brydon-Miller *et al.*, 2003). As a critical realist, this method was chosen because I knew a change was needed for men in cancer care, but I did not know what these changes may entail. Action research is suitable when one has identified an area that needs change, and fitting as a first step in organizational change (David Coghlan, 2020; Heimburg and Ness, 2021). In this project, it was a goal to develop a service that would attract more men. The participants, not the experts, should be the ones to decide the nature and operation of this activity that had potential to change the experiences of many Norwegian men suffering from cancer. (Brydon-Miller *et al.*, 2003). Participation implies engagement and engagement implies responsibility (Reason and Bradbury, 2008). By doing action research, the groups would hopefully live on though the Norwegian Cancer Association after the research was over. The research is based on participatory action research (PAR), but is not a fully PAR research, as I formed the research question and did the analysis on my own, as the participants had no training as researchers. However, the findings have been brought back to the first group in order to receive their view on it. Doing this increases the validity of the findings, as the participants were able to verify the results (Johannessen et al., 2016).

4.5.1 Recruiting participants

To best access information about the research question, participants were selected strategically. Unfortunately, the health of the man who first contacted me did not allow him to participate any further in the research. The first step after his inquiry was to arrange a meeting with the Norwegian Cancer Association, to help recruit peer supporters as co-researchers and facilitators of the groups. The Norwegian Cancer Association has local offices throughout Norway, and has many active peer supporters. Even if this qualitative study is not enough to draw any conclusions based on the findings, I wanted to see if there were similarities between the men's experiences in groups from different locations in Norway, and decided to have three cycles, the first in Bergen, the second in Trondheim and the third in Oslo. In order to bring out different perspectives in the research, all types of cancer diagnoses were included. Two peer supporters were recruited as participants and to be the groups facilitators in every group. This was a choice made in designing the groups, believing it would give me more space to observe the participants and to better balance the power between the group and myself. Trained and well-suited peer supporters were identified and approached by the Norwegian Cancer Association and invited to join the study). The possibility of running the groups after the research was over was suggested to the peer supporters, this provided per supporters who were motivated for the teamwork and gave them a sense of ownership to the research. To be able to reflect on their experiences, I considered it best if the participants had finished their treatment. I believed this would give the participants some distance and be able to reflect in a different way than if they were in the middle of treatment. This choice was made because of my experience from practice, namely that during treatment the emotional turmoil might be a hindrance to stepping back and to reflecting more generally. The peer supports had a complex role in this research. It might have been a challenge for them as they needed to include, take care of the participants and contribute to the research at the same time and they did not have the advantage of having experiences of attending a research program the way I had.. The Norwegian Cancer Association and I tried to facilitate as best we could, by offering practical and emotional support during the research as well as after. Except for the peer supporters, who were trained by patient organizations in Norway, I primarily wanted to recruit participants without experience from work in patient organizations. The reason for this was that, as much as possible, I wanted participants not to have sought contact with peers earlier. This was because the input from men, who had not sought out supportive activities would provide good information about how to attract this group in the future.

To recruit further participants in Bergen, I used my work place's Facebook page. I experienced a great response to our Facebook post, and it spread across the country. Out of fifteen men, I noticed a relatively high number of men suffering from breast cancer wanting to join the group. Breast cancer is relatively uncommon for a man, with only about 25 cases a year in Norway (Kreftregisteret, 2022a). Unfortunately, they all lived too far from Bergen to be able to commute to the meetings, but this response made me reflect on whether that diagnosis can be an extra difficult experience for a man. There was no ethnic diversity in the group in Bergen; all participants came from the same Norwegian cultural and ethnic background. In Trondheim and Oslo, we made a greater effort to recruit a wider range of participants. Information about the study was sent to hospital departments, partner organizations, patient organizations and the municipal cancer care service with an appeal to inform potential participants. The local Norwegian Cancer Association also attended meetings with different cultural organizations in order to recruit. Despite this effort, we did not manage to recruit participants with different cultural backgrounds than Norwegian.

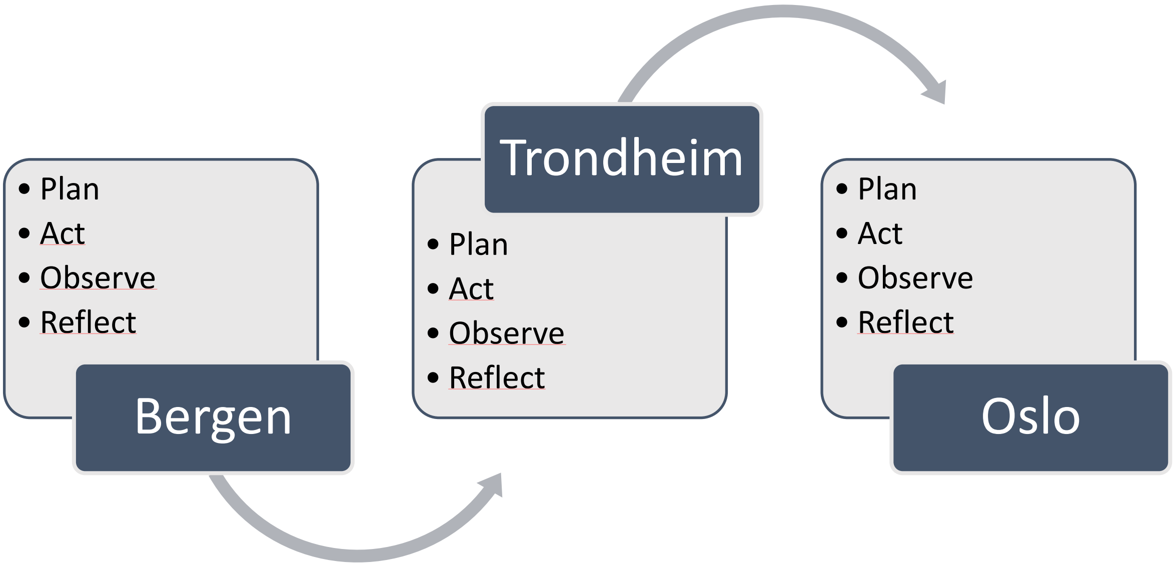
The group in Bergen consisted of ten participants, the group in Trondheim had five participants, and the group in Oslo had eight participants. The composition of age varied from

37 to 75 years. with most of the participants in their 50s or 60s. I did not enquire about social class identities, however my impression was that most of them belonged to the middle class on the basis of their professions or lifestyle. Many participants were employed, and the men's occupations varied from parking attendant to manager in a large company. There was a slight preponderance in the groups of retired or disabled people due to late injuries after cancer treatment. All participant signed consent forms (appendix 2), and were informed that they could leave the research whenever they wanted until the analysis was complete. They were also informed that leaving would have no consequences for the participants' eventual future treatment. In Trondheim and Oslo, the peer supporters ran the groups by themselves.

In all of the groups, I attended the first gathering. This was a decision made following the group in Bergen, in which the participants gave feedback that it was a good way of framing the group. By doing this, I formed an impression of the groups' composition, which made a better foundation for advising the peer supporters during the cycle. Because I had met the groups' participants and spent time with them, I could reflect together with the peer supporters when they came across dilemmas. For instance, a dilemma was whether it would be possible for the group to do activities such as guided tours etc. because of one participant's disabilities. In reflecting with the peer supporters about this, they often found the best way to solve the problem, was to have a dialogue with the participant about their thoughts on this.

4.5.2 The cycles

The three cycles of the research were conducted as illustrated under:



Ideally, it would have been desirable that the same participants could have been involved in all of the research steps to make this research closer to the standard PAR design. Because the participants were included at different stages and from different cities, some decisions had to be made by me alone. However, in every step of the research, from designing the research project to the analysis, there has been participation from different men who have had cancer.

Bergen Cycle:

Before the Bergen Cycle, I had a meeting with the peer supporters, one local and one national coordinator from the Norwegian Cancer Association. In this meeting, I presented my ideas for research in this area, and invited the others to join in with their thoughts. In this planning phase, we spent time talking about the best way to recruit, whom we wanted to recruit and how we should strategically market the opportunity to participate. In this phase, the peer supporters were given the responsibility in the group, to look for participants who seemed to have problems blending into the group, or if someone needed extra support. The peer supporters and I decided to have regular meetings during the group, to talk about the dynamics and to help each other notice if anything was happening in the group or with the participants that the peer supporters wanted to discuss. We decided to go for six gatherings for the groups. This was done to give the men some time to form relationships, and to reflect on experiences in the group, and whether the experience changed over time.

We planned with the participants. In the first meeting, the entire group were asked to bring forward ideas of what they would like to do together as a group. This resulted in the action phase in which the group went hiking, spending time talking together, a psychologist came to talk with them about living with fatigue, a cooking class with a chef and a guided tour of Nordnes, a district in Bergen. In this cycle, I carried out the ethnographic participant observations. This provided an opportunity to observe how the group interacted, and how the participants' relations developed during the activities, and I used it to compare the findings in my analysis of the semi-structured interviews. In one of the meetings, the Bergen group discussed what they believed was important in order to develop a group for men.

After the cycle in Bergen, a meeting was arranged with the peer supporters in Trondheim, one local and one national Norwegian Cancer Association representative. the peer supporters from Bergen also participated, and they shared their experiences with the peer supporters in Trondheim. In this meeting, the Bergen Cycle was discussed, and recommendations based on the experiences of the cycle were given. In the Bergen group, the attendance had been very good, except for one time when the group went hiking. Some participants did not show up for this activity, as they were afraid that they would not be able to keep up with the rest of the group, due to late affects from the cancer treatment. This was brought forward to the Trondheim group. They also highlighted the experience of sharing a meal as important, it had an important function as an ice breaker particularly in the first gathering. The peer supporters in Bergen conveyed they did not see signs of disagreement or challenges between the participants, but still believed the communication between the peer supporters and myself was helpful, as it made them more aware of their role and gave them a sense of responsibility.

Trondheim Cycle:

Recruitment in Trondheim was a difficult task. The Norwegian Cancer Association made a great effort to be present in several different venues where men gathered, however, the recruiting was slow. The pandemic may also have contributed to people becoming concerned about participating in group activities. The group in Trondheim initially consisted of four participants and two peer supporters. However, one participant left after the first meeting after writing a short mail to me; he did not explain why he left, or respond to the mail I sent him. I remember this man as quite outspoken, and it became clear he had made an impact on the group. I will elaborate on this later on in the thesis. The cycle of this group was different from the one in Bergen. At the first meeting in Trondheim, the group planned the activities they wanted to do together. As part of my evaluation, I wanted to get a better insight into the participants' experiences along the way. I therefore handed out notebooks to each individual and encouraged them to write down their thoughts about their participation in the group. I explained that this would be useful knowledge for me to understand what it was like to be part of this project, and no one but me would read what they wrote. None of the participants did this, except for one peer supporter who wrote down a few details about what the group had done. At the first meeting, they could not come up with anything other than eating out, but because two of the participants had a tracheostomy, going out to eat was not a good choice. Having a tracheostomy makes it difficult to eat and talk at the same time, and because people with a tracheostomy often have a voice that is somewhat weaker than others, it can be difficult in public places to have a conversation due to background noise. They decided to discuss it again next time they met. This group only did one activity (a guided tour) and spent the other five meetings drinking coffee and talking. Because of the pandemic restrictions, there was a pause in their meetings for some time. When I met the group for the interview, I got a feeling that these men had become friends during the time spent together, because of the way they talked together. The group seemed to have developed an internal humour, where they joked about their own and others' conditions without fear of hurting each other. The participants in Trondheim also laughed more during the interview than the other groups.

After the last meeting of the group, the peer supporters from Trondheim evaluated and reflected on the cycle together with the national and local representative from the Norwegian Cancer Association, and the new peer supporters from the next cycle, Oslo. The experiences conveyed from the Trondheim cycle to the next cycle in Oslo, were that they would have had more activities if it had not been for the pandemic. The peer supporters stated that the visit to the museum tied the group together and gave them things in common to talk about. They wished they could have done activities once or twice more, but they were happy with the relationship in the group and how they had connected over cups of coffee.

Oslo Cycle:

The group in Oslo consisted of two peer supporters and seven participants. Despite a great effort from the local Cancer Association, there was no ethnic or race diversity in this group either. In this group there were four men with prostate cancer. In the first meeting they had many ideas about what they wanted to do, and they decided to take a guided tour next time they met. After this meeting one of the participants contacted me and wanted to withdraw. He explained this as a consequence of his serious late injuries as a result of the cancer treatment. This meant that he could not go anywhere without a bathroom nearby, and he saw that it could be difficult to join the group in its activities. I tried to ask him if there was anything we could do to meet his needs, but he declined, and responded he did not want to be a burden to the group.

In evaluating this group, the peer supporters wished they had started the group in a somewhat different way. They had chosen to end the group with a meal together, and they had experienced this as the gathering that had brought them together the most. The peer supporters had found the conversations we had between the meetings as helpful. When I came back to carry out interviews with this group, they had many questions about how they could start new groups. The geographical distance between the homes of the participants was far, but they expressed that they wanted to bring this concept to their local communities.

4.6 Ethnography

Ethnographic studies are studies of human interaction, where the researcher notices “behaviour, events and occurrences in light of context and time” (Madden, 2010). As a researcher, I was curious about how men communicated, both verbally and non-verbally, and an ethnographic study was carried out with the Bergen group in order to acquire some insight into what encounters between the men might look like, what they talked about, how they talked and if there were things they did not talk about. According to Fangen (2010) participant observation helps the researcher to reflect on methodology, theoretical positions and ethical issues. The choice of methods in this study has been considered through a process of much reflection, and the ethnography has entailed many ethical considerations. In addition to carrying out the ethnography alone, I also wanted to conduct interviews with the groups. This was in order to gain an understanding of how my experience and the men's experience may have been different, which helped me to understand what I had seen (especially the use of humour). Elsa Jones (2003) states that family therapists tend to see similarities in our encounters with others. She claims that we can only learn something new "if we can experience the differences, contrasts or incompatibilities between different ideas" (Jones, 2003). This underpins the reason for doing an ethnographic study: that in order to understand how to create a change for men who have gone through cancer treatment, we must look into the differences in our understanding of coping with illness. My position in this project has been that I cannot gain this insight without participant observation as part of the research. The participant observation also helps me ask better questions in the group interviews. As a critical realist, I felt I could help create a change for these men, but I needed to understand the culture of their relations.

A possible pitfall of an ethnographic study can be that one adopts the participants' thoughts and ideas without exploring how this coincides with "our ideas about social relations and what it means to be human” (Shah, 2017). Part of this process therefore became using my systemic view to wonder how this related to the knowledge I already possessed as a nurse, researcher, and woman. The knowledge from this ethnographic study should therefore not replace my worldview, but merge and give a greater understanding and wonder at the inequalities I saw. An opposing challenge with the use of ethnography can be that the researcher is unaware of their own understandings and built-in knowledge. I may still have blind sports, but during the time after the group - through the interviews - my own notes and other research and literature - some of the doors to this self-insight have been opened.

In the first cycle in Bergen, ten men participated in the group, and I joined the activities. There were six gatherings, each with different activities. During the activities, I observed and took pictures, and later on described what I noticed while I was participating in the activities (Appendix 3~~)~~

As part of the ethnography, I used a camera to take pictures or make small videos, and I watched these later. For a novice researcher like myself, this helped to notice things I did not notice at the time of the activity, and it helped get a more second order perspective on my observations (Luhmann *et al.*, 2013). I could watch it several times to reflect on what was emerging through the interactions, especially the nonverbal communication became much more apparent in the videos. This was helpful when I did the analysis, as it gave an opportunity to reflect on the bodily communication between the men. Pictures of the group during the guided tour displayed communication I did not observe during the activity. In the ethnographic study, I did my best to notice how the men behaved, what they talked about, how they reacted, and held their bodies. I also tried to notice what they did not talk about. In this phase, I tried to stay aware of the fact that the way I display what I see is not what is reality (Foerster, 2013), and the participants may have experienced their interactions very different than what I did. In following the group, I might also have had more focus on some things than others, as one participant stood out from the others. He was younger than the rest of the group, and he was shy. I noticed that I focused more on him than on the others, as he often did not get a word in when the others talked. I felt a responsibility for this man's wellbeing in the group, and I was also worried that he might leave the research, which would be unfortunate as the rest of the group was very homogenous. Because of this, I might subconsciously have given him more attention than the rest of the group.

Having an ethnographic gaze (Madden, 2010) while being fully involved in action research has been challenging, and there are probably areas of interest I have overlooked. In three of the meetings with the group, the group brought in external expertise to enlighten a subject, such as the guide, a chef and a psychologist. This allowed me to take a step back and look at the groups' communication from a different perspective. This was helpful in noticing the small details of the interactions, which was difficult to focus on when I was actively participating in the group. After the analysis, I brought the findings back to the men in the first group, to get their reflections on my findings. I took notes in this meeting to be able to add the comments to my findings. As in the interviews, also this conversation took sharp turns from one topic to another, not all relevant for this research. However, the men's response was that they could relate to what was brought forward, especially the feeling of loneliness. The way of talking together also resonated with the participants, they confirmed that they had discussed the way of talking together as a group. They could not explain why this was, they called it a "gender thing". They further discussed how they had leant on each other, and how the group had a positive effect on their mental health, as they called it. They felt strengthened by being together with the other men, and felt more equipped to meet everyday life knowing they were not alone, and that they had a place to talk to others who could understand.

4.7 Semi structured interviews

As a systemic therapist, curiosity is my main tool. Systemic psychotherapists ask questions to understand what our clients' challenges are, and to help them reflect on what is right for them (Simon, 2014). Therapy is different to interviewing, as therapy seeks to reflect and solve problems, while semi-structured interviewing seeks a grasp of a person's reflections on an issue, not to solve (Kvale *et al.*, 2015). That was why, in addition to the ethnography and the action research, I also carried out semi-structured interviews with the groups. Three weeks after each cycle had ended, I met the group again to ask them some questions based on issues and details about which I had become curious during the ethnographic phase with the first group. The reason for waiting three weeks was to let the participants have some time to reflect on the experiences they have had with the groups, - maybe this could give them some time to process their thoughts and feelings. Group interviews gave the participants the possibility to reflect together and bring in different perspectives, which might not have happened in separate interviews. Interviewing in groups gave a better understanding of the different understandings, and how they were influenced by each other. However, interviewing in groups may have caused some of the participants to feel constrained to say what they really felt. As the interviewer, I tried to notice what was going on in the group and to help all aspects forward in a safe environment. To create a safe space for the men to speak their minds, the participants and I spoke before the interview started about how it would be if someone in the group had deviant views from the rest of the men. I was clear that different opinions would be helpful for the research, and very welcome. Semi-structured interviews use an interview guide as a starting point, while questions, topics and order can vary, and one can move back and forth between the questions (Johannessen *et al.*, 2016). With this, there is a possibility for the participants to interact and discuss the questions. As a researcher, I was interested in listening to how they constructed an understanding of their needs as men who had had cancer. To do this, I designed an interview guide (appendix 4). The first question was designed to introduce the participants to the theme, and aimed to retrieve memories and reflections, before the rest of the questions attempted to elaborate their experiences. In all the groups, the participants spoke about many of the topics, without me asking first. The interviews were recorded, transcribed and the de-identified research data was stored on the hospital`s research server, a separate for secure storage of research data.

The triangulation of the methods of research: action research, ethnography and semi-structured interviews gave the opportunity to study the phenomena of peer support for men who have had cancer, from different perspectives. With the help of action research, the men affected by cancer were able to construct an activity for the project driven by their own experiences. The action research engaged the groups, and led the men to take responsibility for running the groups. Situating the cycles in different cities may have given the study better grounds for generalizing than if they had been carried out in one location, as the cultures of the different parts of the country vary somewhat. The ethnographic study gained insight into how these men interacted and communicated, and helped construct valid questions for the interviews (Kleinman, 1987). Finally, the semi-structured interviews enabled the participants to reflect on their experiences together as a group.

4.8 Data analysis using systematic text condensation

In order to analyse the interviews, I have used the method of systematic text condensation (STC). STC is a method developed by the Norwegian physician and researcher Malterud (Kirsti Malterud, 2017). The method was chosen because of a desire to be able to collaborate and speak directly with researchers in my qualitative professional environment. My impression is, medical qualitative researchers in Norway often choose STC when doing a qualitative study. The reason for this might be that it is developed by a Norwegian physician who has been an instigator of qualitative research within the medical education. By acquiring knowledge about the use of this method, my hope was that this would give opportunities for collaboration with the health services to mix systemic, qualitative research with qualitative research in order to shed light on phenomena within somatic health. STC is a social constructionist approach (Malterud, 2012). It is inspired by (Giorgi, 2012) phenomenological approach, and has many similarities with other methods, such as thematic analysis. However, it differs in initially concentrating on a few topics and code groups (Kirsti Malterud, 2017). The method has four steps, I have chosen to split the first step in two. The first step in STC is to form an overall impression and extract meaningful units. However, to me this very much felt like two steps and I therefore have chosen to visualise it in my description of the process.

Step One- forming an overall impression. The first thing I did was to listen to the interviews on the audio recorder. I did this several times, and I noticed how the participants' voices changed, where they paused and how they spoke to each other. I also noticed how what they were saying affected me emotionally, and I noticed that some of the statements made different impact on me than they did at the time they were said. One of the participants made statements that deviated from the topic we were talking about during the interview. However, his statements made much more sense when I heard them again. I discovered that he was on the topic, but coming from a different perspective. In this, it was important to be aware of my own preconceptions when dealing with the text (Kirsti Malterud, 2017). Based on the ethnographic study in Bergen, meeting and interviewing the groups, I had preconceptions of what I was going to see in the transcriptions. An example of this was disappointment with what the participants characterized as little follow-up from the hospital, and the feeling of loneliness. The research question was written down on a sheet that was easily visible, in order to keep the focus on possible answers to it. Malterud emphasizes that in this phase one should have a bird's eye view – try to see the text as a larger context (Kirsti Malterud, 2017). Therefore, I searched for preliminary themes emerging in the participants' and stories, and these were noted down in a notebook. In this step, the subjects of belonging, a feeling of being alone, gender, and relations to health care workers seemed to stand out from the transcriptions.

Step two - Meaningful units. This step of analysis helped in distinguishing which parts of the text were relevant as an answer to the research question, called meaningful units (Kirsti Malterud, 2017). An example of a meaningful unit was: *It gets more personal here? Mhm, like talking about illness and such in the group rather than at home? At home it's like, telling a bit about problems and; now they are doing like this and that and eh, but nothing more than that.* The transcriptions were printed in several colours, and the participants were given a colour code in the text that could be linked with the various participants' statements. Statements from participant no. 1, in the Bergen group got blue text etc., participant 2, in the Bergen group got yellow colour, etc. This made it easy to distinguish the different participants' statements from each other. The coding involved selecting the text that spoke to the themes that stood out in the first step, and answered the research questions. In this step, 168 meaningful units relevant to the research question were identified.

Step three - Code groups. Code groups were developed by getting input and ideas from the text. This was a step of organizing the material before it was subjected to further analysis, and in this process, all the interviews were reviewed again. In this step, statements from the informants that could shed light on the issue were targeted, and it became apparent that some of the meaning units could go into more than one code group, while others could be merged into one group. After this step was done, the 11 code groups initially identified were: A sense of community, Feeling lonely, Experienced expectations, The Activities, Humour in the group, Grief, Fear, Hope, Ambivalence, The Norwegian health care system and Going forward.

For every code I identified, I read through the transcriptions again to see if there were any meaningful units missing under this code.

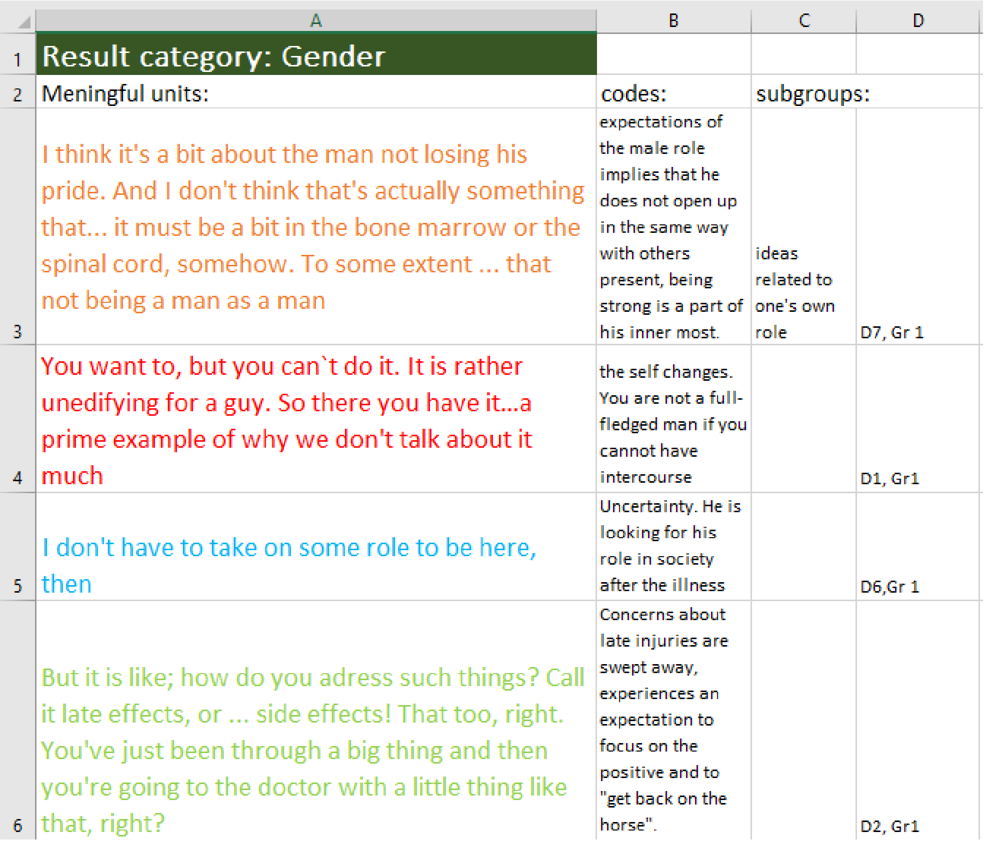
Step four-describing. Here, the meaning of the statements was extracted from what was found in the meaningful units under the different codes (Kirsti Malterud, 2017). Parts of this step were carried out together with my supervisor. Text that was not perceived as relevant to the problem was discarded. Some of the texts were quotes from one participant, others were dialogues. The parts of the transcripts that were considered relevant were given a preliminary heading, and I started entering it all into an Exel sheet to get an overview (see appendix 4). In this process, I found myself going back and forth between step three and four. The name and content of the code changed as the meaning of the text emerged, and after analysing the meaningful units more closely in this step, I went back to step three, where I narrowed the code groups down to eight groups.

Step five- result categories. During the work on this step, four result categories seem to stand out in particular. Emphasis was placed on the fact that the findings were supported by several informants, so that it would form a code group, and code groups relevant to the research question formed a description that formed a result category. In this step, I had to negotiate with myself as some of the groups were too small, and they were not taken further despite the fact that they were perceived as relevant.

A part of the fifth step was to write out the findings as a few sentences where the essence of what I had found was presented, this was to be done as close to the participants' statements as possible. For example, the result category of the finding: "Being a Norwegian man" was this text: *It may appear that the participants have an idea that men should be* ***men****. Being positive and full of courage seems to be both an expectation and a characteristic. Several say that they have been alone with their thoughts for many years, and even if they feel various difficult feelings, they don't show it outwardly. It seems that they rather go alone with their thoughts.*

After this, a synthesis of the analysis was made. This was supposed to be done by connecting the essences extracted in the analysis. The synthesis conveys common features with variations from several stories summarized through analysis (Kirsti Malterud, 2017). In addition to the statements from the interviews, my reflections from the ethnography and action research were added to the findings from the text. The synthesis of the result category "The Norwegian man" was: *It may seem that the participants have heavy burdens on their shoulders, the expectations of their own role appear high. Some of the participants made statements that can be understood to the extent that being a "real" man is linked to being able to perform sexually. Others who have not experienced this side effect attribute being a "real" man to being able to contribute to society, at work, and in practical tasks at home. This is not discussed with others outside the group, and several of the men convey an experience of searching for who they are, now that life has changed. At the same time, these worries are swept away, with an underlying understanding that one should always appear positive and steer steadily forward (this is also something that characterizes the conversation between the men, where they aim for a positive tone). In order to achieve this, it may appear that the men stay active to keep heavy thoughts away. However, it is expressed by several that the impression given to the surroundings is not in tune with what is happening on the inside. Several express that they are afraid that if they show their true feelings, they will lose control* *completely. They seem to experience expectations from the surroundings that the men should not show emotions, and they have experienced a need to talk to others but have resisted this need in order to maintain their image.*

In the illustration shown on the next page, I demonstrate how the meaningful units were coded. The table also shows how the codes were organized in subgroups before they finally resulted in larger categories. In this process, I carried out the steps many times, and had to go back and forth in the analysis. Discussing my findings with my supervisor gave different perspectives and opened up new understandings of the meaningful units. Even after I started writing, I had to go back to the analysis as I realized how statements connected with the context it was given in, and this expanded or changed the statements’ essence. Finally, the names of the result categories were also adjusted as I wrote and discovered new nuances in the statements from the participants.



	A	B	C	D
1	Result category: Gender			
2	Meningful units:	codes:	subgroups:	
3	I think it's a bit about the man not losing his pride. And I don't think that's actually something that... it must be a bit in the bone marrow or the spinal cord, somehow. To some extent ... that not being a man as a man	expectations of the male role implies that he does not open up in the same way with others present, being strong is a part of his inner most.	ideas related to one's own role	D7, Gr 1
4	You want to, but you can`t do it. It is rather unedifying for a guy. So there you have it...a prime example of why we don't talk about it much	the self changes. You are not a full-fledged man if you cannot have intercourse		D1, Gr1
5	I don't have to take on some role to be here, then	Uncertainty. He is looking for his role in society after the illness		D6,Gr 1
6	But it is like; how do you adress such things? Call it late effects, or ... side effects! That too, right. You've just been through a big thing and then you're going to the doctor with a little thing like that, right?	Concerns about late injuries are swept away, experiences an expectation to focus on the positive and to "get back on the horse".		D2, Gr1

4.9 Summary

In this chapter I have shown the methods I have used for researching Norwegian men's experiences of peer support. I have explained my position as a critical realist in this work, and I have shown how the different methods have been used to address the research questions. Finally, I have described the method of analysis and how I have extracted the findings from the transcriptions that has been presented.

In the process of doing the PAR, the covid pandemic provided extra challenges to both recruiting and the implementation of the groups. In Trondheim, we had huge problems with recruiting because of the restrictions, and at one point I had to decide if I should drop the cycle in Trondheim, and do two cycles with the same group in Bergen. However, I decided to wait and eventually the group came together as planned. In the interview, this group talked about their experiences in a different way than in Bergen and in Oslo, which expanded the understanding of the phenomenon researched and provided different perspectives to the findings. In addition, the group in Trondheim expanded and is still running today – so it was worth to wait the extra weeks.

Doing Participatory research was a good way of connecting with men who had experience as cancer patients. During the groups, several conveyed a feeling of gratitude for the possibility to contribute to increased knowledge in this area and it felt rewarding just to see how the men connected over their common experiences.

Doing this analysis was a difficult and somewhat lonely task. As a systemic therapist, I felt the need to have more voices into the analysis process, and to discuss the findings with others. I tried to partially mend this by bringing the findings back to the first group, and along the process I discussed it with my supervisor. Unfortunately, I could not get Kirsti Malterud who designed the analytic method to supervise me in this process, but I was fortunate to be invited to her teaching at the university, and I had a conversation with her about the process which was really helpful. The STC was a useful tool to ensure that I mitigated findings in line with what the men were concerned with, but it provides little space for creative interpretations and conclusions (Malterud, 2012). When I started to present the findings, I noticed that STC was not a tool providing a deeper understanding i.e. of the underlying reasons why men talk in a more positive way than women do. For me, this was a very important aspect that I would like to investigate. I therefore decided to put aside STC's way of presenting the findings, and chose to look more closely at some of the participants' statements. Based on the ethnographic study and the synthesis, I have delved into some of the participants' statements to get hold of what was conveyed, as I see it. Through this combination, I was able to further elucidate the impressions and observations gained from the ethnography. This felt necessary to understand and reflect more on the participants’ experiences. To ensure the findings were in line with men`s experiences, I took these back to the group in Bergen for their input and validation.

5. Findings

In this chapter, I present the findings from my ethnographic observations from the first group of participants, and from the systemic text condensation analysis I carried out on the transcriptions of all three /interviews. The interviews were carried out in Norwegian. In translating the statements of my participants into English, some of the meaning of their statements may be lost on the way. Expressions and ways of speaking specific to the Norwegian language might be difficult to convey directly. Therefore, I will present the Norwegian word or phrase and its meaning in my analysis. Elaborating the Norwegian words or expressions will give a deeper feel for how the statement was communicated, and therefore a better understanding of the analysis.

After carrying out the text condensation analysis on the interview material in the way I have outlined in the previous chapter, I found that participants in their talk focused on four preoccupations. These were (1) The ethos of the Norwegian man, (2) Thoughts on women joining the group, (3) Joining the group and (4) Group values. These findings were specific to this context of joining a group of men who all had suffered or suffer from cancer.

5.1 Ethnographic summary

Before the findings are presented in depth, I will provide a summary of the ethnography carried out in the Bergen group. The aim of the ethnographic phase was in order for me to experience as closely as possible the way the men interacted and communicated with each other. The observations provided an experience of how these men who had joined the group used peer support in the group, how they coped with their conditions and how they conveyed these experiences in a group. The observations also helped me formulate the questions for the semi-structured interview phase in a more experience near way (Kleinman, 1987).

I have explained the composition and details of the group in the methodology chapter. The group with whom I carried out my ethnographic observation was located in Bergen, Norway's second largest city, located on the west coast of Norway. To give a bit of context, I want to outline how Bergen's inhabitants can be understood by the rest of the country's population. This can also have an impact on how the men see themselves. In Norway, the people on the west coast’s main income is by fishing. The people of Bergen differ from the rest of the western coast in that they are known for their patriotism for the city, and because of this, they are often perceived by other Norwegians as boastful and self-consumed. The group in Bergen was placed in the city centre. Most of the meetings were held in the local facilities of the Norwegian Cancer Association, as this was a room that was spacious enough for the group, and we were allowed to use the premises for free.

At the time of the ethnographic study, the covid pandemic and accompanying restrictions had implications for the Norwegian population generally. At the first meeting, we therefore had to sit individually at desks, one meter apart. This made me very uneasy about the effect on the participants. As in all the groups, the first meeting started with a presentation of what participation in the project entailed, and why we the professionals needed more knowledge about how men suffering from cancer experience peer support. I noticed the men seemed tense as they were listening, some of them had their arms crossed, others leaned back on their chairs, waiting. They looked at me, not each other. I noticed that several of the men nodded in recognition when I presented research suggesting that we need more knowledge. After my presentation, one of the peer supporters took over and introduced himself, and encouraged those who wanted to do the same. Everyone introduced themselves in turn, and shared their experiences of being affected by cancer. They talked about the day they received their diagnose, some shared details of where they were, or how they had been told by the doctors. They also shared how long the cancer treatment had lasted, and if they were declared cancer free. One man was very eager to ask questions, he had recently finished his treatment. The men seemed more relaxed at this point as they looked at each other, nodded and verbally encouraged each other by saying “mhm” or “yes!”, to the other participants’ stories. Despite sitting at separate desks a meter apart, I could see the men engaging in each other’s stories, sharing and confirming experiences the others have had. Some even started their presentation by saying to another participant that they could recognize themselves in one of the others' stories. This part was supposed to take 45 minutes, but it ended up being over an hour and a half during which the participants conversed and exchanged experiences. After this time, I told the participants we were going across the street to a small café where we would have a snack, and where the conversation could continue. In this gathering, unfortunately, there was no room for one of the participants to sit together with the other men, so he sat with me at another table. In the group interview after the group was over, this man had talked in such a way that I had the impression that he was more distant from the group than the other participants; he called the group a community while the others talked about the group as friends. I wonder if this would have been different if he got a different start with the group. In one of the gatherings, the group decided to go on a short hike, and one of the participants was going to guide the group through a scenic area. At the time the hike was supposed to start, there were four men missing from the group. While the group waited, the text messages and emails started to come in from two of the men who wrote they were on a business trip. Some of the men turned up in jeans, while two had on hiking clothes, and they started discussing where they would go. I was busy answering the messages, and noticed the group had agreed to a ten minute walk to an area with benches and possibility of a bonfire. While we walked to this area, another participant sent an email without explaining why. This happened on the second gathering, and I was really worried the men were dropping out. In addition to that, this activity was suggested by the man who did not get to sit by the table with the others, and I know he was looking forward to show the group the particular area we were going to. Even though the cancellations had nothing to do with him, I was afraid he took it personally. However, the men who joined were very enthusiastic about the beautiful scenery.

The men in the group used humour in a way that struck me as somewhat alien, perhaps because I am a woman. I noticed they responded to each other in a different way than women do, I think. For instance, humour where often used when someone said something emotional or shared something difficult. An example of this could be if one said something about his difficulties living with neuropathy, but followed up his own statement with laughter. It seemed to be a way of avoiding talk about difficult feelings. Sometimes other participants used humour as a response. This use of humour confused me, and I was sometimes surprised at the response from the group at some of the jokes, which I felt showed the participant's vulnerability. I viewed them as invitations to a deeper conversation about emotions and wished someone would follow up with in-depth questions, or show more empathy than I experienced from the group.

Statements from different participants, which I felt opened up for deeper conversations, were not followed up, and the group moved along quite quickly without going further into the participant’s experience. An example of this was when one of the participants told the group he had been to the doctor and got bad results, indicating that he had a relapse of his illness. At that point another participant turned to me and asked if they could meet regularly after the research was over. I expected the sad news to be taken up with some sort of obvious empathy. It was not until later when I went through my notes, I realized this participant showed empathy through practical support. I believe he asked, so the man with the relapse could know he was not alone.

As the ethnographic study was part of the action research, it was a challenge for me to balance the different roles this entailed as a researcher. As an ethnographer, I would like to have the opportunity to stop, observe and notice what happened in the relationships between the men and between the men and myself. However, as an action researcher, I was part of the operation of the group, and the peer supporters expected me to be hands-on in what was happening. It quickly became clear that the group saw me as the leader. This created a balance of power that I found challenging as the men turned to me for suggestions and answers, and expected me to take responsibility for arranging the activities. My effort to change this was to try to leave the decisions to the group, and when I was asked about my opinion, I returned this question to the group. After a few gatherings, this changed as the peers became more confident in their roles and the group got to know each other better. It was in the gatherings in which external resources were brought in that I had the best opportunity to observe the tone between the participants, their use of humour and how they cared for each other. For example, when the group was visited by a female psychologist to talk about late effects, the men shared how fatigue affected their lives and their view of themselves, in a way they had not done previously. In this meeting, the men shared their vulnerability by talking about how difficult it was not to be able to participate in activities like before and how this changed the ideas they had about themselves. I noticed the voices of the men were lower, there were less use of humour and some men stared at the table or floor when they shared these thoughts. The atmosphere of this particular meeting was different from the others. The men seemed to show a vulnerability I had not seen before. In this meeting, I reflected upon what created this change, without reaching a conclusion. It might have been the presence of a female therapist, it might have been the subject which created reflections about the self after cancer illness, or simply having a possibility to talk about these things which they may never have had before. At the last gathering, the men cooked a three-course meal together, and the change between the first and the last gathering was significant. In the last meeting, everyone laughed, the power of the voices was considerably stronger and the men turned their bodies towards each other, apparently open with their arms relaxed along the sides. They helped each other set the table and joked about how their wives should have seen them doing such a good job. During this last gathering, one of them gave a small speech. In this, he said that they agreed the group was the best thing that had happened since they were finished with the treatment. After the speech, another man added how important the group had been in helping him talk about his experiences for the first time. I observed how his voice started quivering, and he stuttered before he went on to say thank you for being allowed to participate. He was clearly emotionally affected by the occasion.

Despite this incident, after spending a total of fifteen hours with the group participants, I found it striking how little they talked about how they were feeling about having gone through cancer. I also noticed my own frustration when other participants did not follow up on statements which I felt could have opened up for deeper conversations, as with the participant who had received bad news. Because of the perception that at this point they did not talk about the illness, I was unsure whether the men felt participating in the group was supportive. Although they seemed to be on good terms with each other, I wondered what they got out of this. Therefore, I was surprised to hear in the interviews how they expressed their feelings of being supported.

Doing the ethnography was very useful for me in this research. If I had not spent time with the men and seen how they communicated, I would probably have thought, for example, that laughter during the interviews were expressions of nervousness, and not a way of communicating. These were valuable observations that I experienced by spending time with the group, and which triggered my curiosity for understanding this way of communicating.

5.2 Presentation of the findings

After all the groups had been interviewed, systematic text condensation was used to analyse the material from the semi-structured interviews. After the analysis, I was left with four result categories. As earlier mentioned, these were; The ethos of a Norwegian man, Thoughts on women joining the group. Joining the group and Group values. As I achieved an overview of the material which emerged from the use of the different research methods, nuances appeared, and the data and the overall findings became clearer to me.

5.2.1 The ethos of the Norwegian man

Throughout the ages, images of the typical Norwegian man have been presented as a tough Viking, and the former prime minister Brundtland said in a televised speech: “it is typically Norwegian to be best» (Brundtland, 1994). This might be the basis for the participants’ idea of what it is to be a Norwegian man. From the STC analysis they attributed being a man to be positive, strong and not dwelling on the past. In the following I will show this with statements from the participants.

The most prominent idea emerging from the interviews, was related to being a man with reduced functional capacity. In this statement, the participant is addressing the issue of not being able to have sexual intercourse:

> “You want to, but you can't do it. It is rather unedifying (“*lite oppbyggende”*) for a guy. So there you have it…an example of why we don't talk about it much” Participant 1, group 1.

The phrase “*oppbyggende*” in Norwegian means building or constructing, it can also be used in a more spiritual way, as being strengthened or developed religiously, spiritually or morally

(NAOB, 2023). *"Lite"* means little, and the use of the phrase "*lite oppbyggende*" indicates that it tears down, instead of building up. This statement gives an image of his self changing as a consequence of the illness. It implies that he feels less of a man, his reduced functional capacity is making him think less of himself. It is interesting that he changes the personal pronoun from singular in the first sentence to plural in the second sentence, as if he is speaking on behalf of not only himself, but also several others, which in a way of course he was, as he was speaking in the group. This might be because he experiences talking about loss of sexual functioning as a taboo, and using plural pronoun helps him distance himself from his statement, or it can be his experience from interacting with other men. He is displaying an idea that unedifying experiences should not be talked about. This is supported by another participant's statement talking about the loss of sexual functions:

> "I think it's a bit about the man not losing his pride. And I don't think that's actually something that... it must be a bit in the bone marrow ("beinmargen" or the spinal cord («ryggmargen»), somehow. To some extent ... that not being a man as a man. You don't go out and tell the world that... there are not many people who are tough enough to talk about what happens below the belt - many men get psychological challenges with that, you could say. *Hmmm!* So, I think there is a brake there, that is. *Hmm*. A barrier that is incredibly difficult to overcome. *Hmm. Yes. Hmm*. (---)" Participant 7, group 1.

This participant does not have a diagnosis that indicates that treatment has made him impotent. In itself, that is interesting, because it possibly shows how a potent man thinks about this. This statement implies that the participant links his identity as a man connected to his ability to perform physically, the pride is in being able to do so. In Norwegian, the phrase "ligge I beimargen, eller ryggmargen" ("in the bone marrow" or "spinal cord"), suggests something is part of one's innermost, integrated in a person. The phrase is related to the use of the term soul (NAOB, 2023), which is again connected to the self or the conscious part of a human. If this ability is a part of one’s body, the bone marrow or the spinal cord as the participant suggests, not being able to perform, may create a feeling of shame. The consciousness of being an incomplete man comes through in the phrase “not being a man as a man”. When something is shameful, one may wish to keep it a secret, not share with most people. The participant uses several words implying obstacles to overcome before one can speak of experiences, such as words like “utfordringer”, that translates as ‘challenges’, “bremser”; ‘brake’, “barrierer”; ‘barrier’, and “komme over” which means to overcome something. The participant states that to talk about it one has to be tough, and that there is a brake there, which has to be overcome. This implies that there is an internal as well as external resistance surrounding this theme, perhaps from the men’s surrounding cultural, political and social context, which has become internalised. The use of the word “brake” suggests that there is hesitation towards listening to these challenges. The words ‘challenges,’ ‘barrier’ and ‘incredibly difficult’ suggest having to overcome an obstacle course before he can talk about it. Towards the end of the participant’s statement, several of the other participants joined in with encouraging sounds, confirming his statement. This suggests that the participant is saying something, which the other men recognize as chiming with their own experiences. This internal barrier is displayed by another a participant, who talked about not being able to build the terrace that his wife would like to have (and that he wanted to build). When he noticed he was getting fatigued, he spoke sternly to himself: "Now you must not sit down, you can handle that." This short statement shows how sitting down did not accord with his own expectations of what he should be able to accomplish.

> Showing ability seemed important to the participants, and one participant verbalized how he wanted to display himself to his surroundings:“I have quite a few friends who wonder, really, I love to show off that I'm out skiing, so I film when I go down all the

> slopes, they think I'm fitter than they are, right? Heh, but it has its price when you've come home and done your session, right- but eh- I'm not sitting in front of the TV screen, withering away. It's different but. I have said I can’t sit around feeling sorry for myself, I have to do something for myself” Participant 3, group 2.

To be active, and show this to his surroundings seems to be important to this man. This is done as a response to the concern of others about how he is doing. Here, he is saying that he films himself to show to his friends, to let them know how fit he is - possibly even fitter than they are. The part he emphasizes filming, is down the slopes. Not the part where he is struggling to get to the top, or perhaps where he falls. His film highlights nature, speed and activity, providing images that contribute to the friends’ understanding of this man as a person of vitality and excess strength. However, this seems to have a cost. When he gets home, he has to rest for the remainders of the day. He chooses to spend the rest of the day in bed for a film to show to his friends, when he could have chosen not to go skiing- and been on his feet the whole day. The motivation behind this, what makes him find it worth doing, is shown in the statement: “I am not sitting in front of the TV screen withering away”. Being active is a valued Norwegian outlook, and it gives an image of a healthy, person with excess strength. One wonders if the film helps build his self-image, as he uses the word “love” about it, even though it seems to have a high price. In addition, it seems he feels obliged to be active, because he says he cannot sit around. Even though this man has to live with visible, severe physical disability for the rest of his life, he does not feel he can sit and feel sorry for himself. As if it is a point of no return, if you start feeling sorry for yourself, you have lost out to the illness. One might wonder if he imagines that being less active will make him wither, or make his illness progress. In his statement, feeling sorry for one self seems to be unacceptable. One can assume that his friends will applaud his skiing videos, which may contribute to an increased sense of mastery. This may again make negative thoughts about his situation less prominent, and perhaps there is a hope that they will disappear. The example of this man shows the recursiveness between the social ideal and the individual man, in which a man displaying his activities creates an appraisal from others. This has led this man to think that he needs to show more positivity to maintain the image of himself as a positive man who will not succumb to his physical impairment. As he continues to display this, he is rewarded by being placed into the discourse of being a masculine man.

The drive from within to stay positive is displayed by another participant:

> “Now I am the person I am, so if I meet a wall, I go around it. I don't stand around knocking, and I always have, it's always been my job to find a way out. I was born positive, full of courage, always! Going the right way. Mhm So I've never been there, I've never felt sorry for myself. I just have, that's how it is” Participant 3, group 3.

This participant is telling us that positivity is part of who he is. He does not let anything distract him from being positive, under any circumstances. Positivity has been an important factor in different aspects of his life; it has even been part of his working carrier. This statement indicates that he has had to find a way out in several situations; however, he does not seem to let himself reflect upon this. Being positive seems to be deeply rooted in him, as he says he was born positive. This participant had late effects from his treatment that one would assume made it difficult to constantly stay positive. He needed to be near a restroom at all times, which reduced his ability to take part in activities he used to enjoy. He also experienced involuntarily defecating, and sometimes had to use nappies. Still, he is telling himself and us that he has never felt sorry for himself. He also always goes the right way, he says. I assume that the right way is to stay positive. This leads me to think that this man has an expectation from within, from the surroundings or both, that he shall not pity himself. Self-pity might be going the wrong way.

Another participant shared with the group that he did not cry in the presence of others, even if he knew he needed to. He went down to the basement, cried on his own and got back up to his family. In this statement, he says something more about the felt external expectations:

> “Ladies cry, ladies have snot and ladies think it's perfectly fine. Men aren't there, men don't want to be there, because you are the man of the house, you have to go to work, you have to air the litter box, you have to take out the trash, you have to shovel the snow - it doesn't fit the stereotypical male role to be like that - even if you need it and you have to.” Participant 1, group 2.

In this statement, the participant distinguishes who can and cannot cry. The use of the word snot, is “snørr” in Norwegian. One uses this word about children with runny noses or people crying profusely. It creates an image of someone crying a lot, and he says women think it is fine. In other words, he would not think it is fine to cry and have snot. If one cries profusely, they are not on top of the situation, may not have an overview of their surroundings, and they may display vulnerability. He says he is the man of the house, which indicates a traditional view that he must be on top of the situation. He justifies this with a list of the responsibilities he has as a man. It seems his idea of being the man of the house is to take responsibility for getting things done, making sure everything is in order. All these activities are aimed at making the everyday life run smoothly. He uses the term “stereotypical male role”, recognizing an idea of a generalised way for men to behave. Crying does not fit with his ideas of what a man can allow himself to do, even if he says he needs it and has to. To me, this indicates that this man recognizes that there is a pain in this situation that he needs to address, but he cannot allow himself to do so.

It seemed that the participants agreed that it was difficult to reconcile the expectations of one's own role with having to show vulnerability when women were present. I will show this in the findings about women in the group.

5.2.2 Thoughts on women joining the group

The groups were asked how they thought it would make a difference if women joined. Overall, it seemed participants were positive to women in other settings, but not in these groups: The men expressed that if women had joined the groups, this would have affected the men's dialogue, and they would not have shared as much as they have in these groups.

> "I don't think I would have been so open if there had been women present. I... it's the first time I can say things that I haven't said at home or anywhere else. *Yes*. Just. I don't tell those closest to me because you have to wear a ... a mask. (--) Eh, I even got a phone call today about how it's going and then I lie and say it's going well, but it really didn't go very well. And if there had been women here, I think I would have lied, instead of being honest. *Hmm*. You're supposed to be a bit tough ("tøff") and you're supposed to ... But I felt that you could leave that outside here when you walked in. *Hmmm!* You can sort of...everyone sort of needs to be weak ("svak") and small ("liten") once in a while. *Yes.* And I have felt that I can be that here. And that's a big ... if there were ladies and women involved, it wouldn't have given me the same. In other settings it's clearly positive, but not exactly in what we've had here (---)"
>
> Participant 1, group 1

This participant is sharing his thoughts about how he would feel restrained if women participated in the group. The group was a place where he had spoken about things he had supressed, since he had been diagnosed. The participant tells us he often needs to wear "a mask", even with the people closest to him. He states that he could not have been as open as he has been in this group, and the use of the word mask indicated he would have to present himself as something he is not. Originally, a mask is often thought of as something that hides our identity, and presents an image of another person. However, the use of the word mask in times of a pandemic might also give ideas of wearing a mask for protection. This might indicate that if there where women in the group, he might feel a need to protect himself from something unknown. In this group, he has felt he could leave his mask outside when he walked in with the rest of the men. This group has provided a place where he can allow himself to take of the mask and be vulnerable. He showed this vulnerability by telling the group that he has had a phone call from the doctor with a relapse of his illness, which he has not told his wife. The participant used the Norwegian phrase "*svak og liten*" which means to be 'weak and small' conveying vulnerability, and is often used to describe new born animals. He describes the experience of being able to be vulnerable in the group as a big thing for him. He would not have shown this vulnerability if there were women present.

Another participant had thoughts about how women talked differently than men:

> "Yes, if you ask us what we think, then, then, in a one to one context, there is no uh, uh…difference. But in a group, I think maybe that uh the women will do, dominate uh a bit more, that uh that I think. At least my experience, then, sometimes if there are a lot of them, it's hard to get a word in, eh at least, occasionally" Participant 5, group 3

His statements were stuttering, and this man held back with his answers and participation in the conversation, and was late to speak in the interview. However, his statements were clear, and he was not afraid to voice his opinion. If the settings are different, like in physical activities or teaching, the participant welcomed women. However, he is concerned women will take over the conversation when he says it is his experience that when there are a lot of women it is hard for him to get a word in. This might possibly point to women steering the conversation in a different direction than what he wishes, or approaching subjects in a way that does not feel right for this man. It might also be that this participant has experienced that more women than men tend to join groups, and that he is afraid the men would soon be outnumbered.

How the women possibly steer the conversation is stated by another participant:

> “I imagine that ladies... they might have dug even further into each other in a way. Yes; "how are you *really*" (“virkelig”)? We stop at some point, we might be able to have a bit of dialogue and then we go in and out a little bit... don't seem to have a goal of getting right into the innermost core of all emotions. We go a little out of it, and into it ... But maybe, if I had to guess, had this been a women's group, I think illness conversations would have been much more thorough, detailed, and ... yes!” Participant 2, group 1

This participant is showing how he experiences the difference in the way men and women speak. In describing that women “dig further”, it seems he has a presupposition that women are drawn to deeper conversations, in which one is expected to display vulnerability. Emphasizing the word ‘really’ (in Norwegian “virkelig”) makes us visualize someone going further than what is said on the surface. He talks about how men go in and out of their conversations, and there is not a goal of talking about all the feelings connected to their situation. In this, he implies that the men’s way of speaking might have been neglected if the women where present. He states that men go in and out of dialogue, while women go deeper. This may represent something that seems threatening to him and his desire to talk about different matters in a different way.

5.2.3 Joining the group

In all the groups, several participants referred to the others as friends, and described the environment in the group to be positive and relaxing. In the groups, there were also expressions that indicated that the link between the participants was somewhat uncertain. Despite this, several participants stated that they felt lonely with their illness, and that the group was a forum where you could talk to each other in a different way than outside the group.

Several participants said they felt left alone after the treatment was over:

> “When you leave the hospital - you go out into the void (“tomrom”)- and you don't feel any belonging in any place, really. You have no sense of belonging at work, you have no sense of belonging in your circle of friends - and you feel no sense of belonging at the Vardesenteret” Participant 1, group 2

This participant is addressing the feeling of being alone with his illness. Feeling left alone by the hospital services was something participants in all the groups addressed. This statement indicates the participants’ experience of leaving the hospital as different man than when he came in. He describes the feeling of leaving as going into a void. A void is the space between something. The Norwegian word *“tomrom*” used by the participant, is a void, thought of as a place with no life, it is a desert (like outer space), and the use of the word is often linked to a loss. When one finds oneself in this void, it might be difficult to know how to navigate out of it. This participant’s void is his experience of not belonging, not being able to identify with neither of the groups he mentions. He has tried to connect with his colleagues, but because something has changed, he is unable to connect with them as he used to. The way he describes this, is by saying *he* has no sense of belonging. This implies that the coworkers may feel he belongs, but he feels differently. He has experienced a disconnection, perhaps from the fact that he is not able to do as much work, or have to have different tasks than he did before he got sick. He also uses the phrase “circle of friends”. A circle of friends draws a picture of a group of friends that are faced towards each other, connected, and are including one another in a circle. If this man has experienced his relationship with his friends in this way, he now feels he is outside the circle, while his friends are still unified as a group. He is also talking about Vardesenteret, and how he has no sense of belonging there. Even though Vardesenteret is for people just like him, who have been ill and gone through cancer treatment, he does not feel like he belongs there. One might suspect that this is linked to his statement of leaving the hospital. If he identifies as a cancer patient, it might be even harder to connect with colleagues and friends. In all the areas, it seems that not belonging is a conclusion he has made on his own, after recognizing something is different. He is describing this as a lonely place, where he has experienced a disconnection from people he usually would have a relationship with. In this group, it seems he has found a place where he connects with others who are in the same void.

Another participant explained how he felt the group offered a sense of belonging he had been missing:

> “I feel an extra strength in you who ... with whom I connect. *Hmm.* And so ... we belong (“ tilhører ”) to each other! *Hmmm!* I think it has been a fantastic experience, so. It...it does something deep in my heart (“hjerte”). That security in knowing that we can be honest with each other” participant 4, group 1.

This is a powerful statement from a participant, who has experienced a deep connection with the other members of the group. The use of the phrase “belong to each other”, is a strong statement, and is in Norway usually used in relations that are within the family (Hansen, 2021). Spouses, or children and parents belong to one another. These relationships are usually based on love, respect and trust. His statement suggests that he may have felt disconnected at some point, or have been longing for a connection to others. Maybe the feeling of disconnecting came when he was diagnosed, or when he started contemplating his situation. It is also interesting that his statement about connecting and belonging is encouraged by other participants, and may inspire him to go further in his explanation. He is describing the experience in the group as fantastic, and says it has changed something in his feelings. The change is connected to the use of the word “heart”, which is often used to describe deep, positive emotions. It seems the positive change comes from knowing that he can be honest about his situation with the others. The relation to the rest of the group has perhaps given him an experience of devotion, respect and trust.

Another participant in the same group supported this experience of belonging:

> “I feel like it's the first time since I got sick that I have a sense of belonging somewhere. That ... that I'm ... Now I haven't been part of a cult *(several chuckles)* - but I feel that I can be a bit like that ... a place where you ... we feel a bit limited (“ vingeklippet”) and so ... here is like the first place where we can say what we mean around ... without being afraid of anything ... and ... we are friends, so to speak *Exactly! Hmmm!* Without us knowing if we actually are, but I at least have the feeling that it's good to be here, then. And it's the first place I've been since I got sick - yes, three years ago almost.” Participant 1, group 1.

This person has felt alone ever since he received his diagnosis three years ago. He compares the experience of being in the group to being in a cult. Cults are smaller tight knit groups away from dominant groupings, and in a cult, there are norms only members of the cult know about, and they follow it to be a member (Skoglund, 2011). Even though cults are strongly linked to negative patterns and distorted worldviews (which is probably why the other participants chuckle), the members are often portrayed as very unified. In using this term, the participant expresses a feeling of being in a unified group, on the side of the rest of society. The participant used the word “*vingeklippet*” about himself and the other participants in this sentence. *Vingeklippet* is translated to ‘limited’ in English, but in Norwegian this term describes the clipping the wings of a bird, a most likely painful and violent action applied by the surroundings. For birds having their wings clipped, definitely limits them from doing what they would naturally do, and for a person this must be a subjectively painful experience . It can also point to the feeling of being limited by the society in what one can talk about.

Perhaps he feels limited by his family or by the expectations by others. He moves on to insinuate that the men are friends, but adds that he does not know if they really are. This gives me the idea that the participant is hesitantly searching for confirmation that they are friends, trying to explore or negotiate with the other participants' understanding of what the group is. In this statement, the loneliness he has experienced these three years comes forth, he shows his vulnerability and desire to connect to the other participants.

However, one participant was unsure if the group felt the same connection as he

> “Hehe, no, so this has given me a lot, we can talk about all sorts of things, then you touch on it a bit, and then it doesn't go into depth, right? And that's the advantage of mixing the types of cancer. And I think the tone between us guys, you can't just put ten people together, they have to have chemistry (“kjemi”)! Hmmm! I feel like I have chemistry with most people here! I don't know if it's mutual, but. At least I feel it!” Participant 3, group 3.

The participant states that one must choose which people one puts together in the groups, however, this is not the case for the group he is in. He further elaborates this with the statement that the participants have to have chemistry. The use of the word “chemistry” in Norwegian is “kjemi”, and is used as a metaphor for the connection between two people. The chemistry can be good or bad. This term is used in romantic relations, but is also used for describing the first impression of connection with new relations. If one does not have chemistry, it usually implies that there is a distance between the two parties. In saying he has chemistry with most participants, he is implying that there might be someone he does not feel the same connection to as others. In this, he is saying that this group has not connected the way it might have, if the men had been handpicked to the group. Then he goes on to say that he feels he has chemistry, but he does not know if the chemistry is mutual, a statement that is quite similar to, or can be perceived as, a question to the group. This may indicate that this participant is unsure if the rest of the group likes him, and his statement is an invitation to the others to confirm his place in the group. He wants to connect, but may have a feeling that someone in the group does not want to. Another participant uses a different label to share his experience in the group. “I want to lift up the community (“fellesskapet”), eh. Or getting together, really. Is something I've been looking forward to, then. Not to sort of ... even if there has been a goal and meaning, it somehow hasn't been, then. Eh” Participant 6, group 1.

This participant was younger than most of the participants of the group. In the section from which this statement emerged, the participants are talking about their experiences being in the group. While the rest of the group labelled the participants as friends, and seem to agree, this man was more reluctant. He did not come forward with his view until later in the conversation, when he was invited, and he seems to come from a different angle than the rest of the group. He is using the word ‘community’, which is more distanced than friendship as it involves a more abstract notion of a collection of people. With this, he implies he does not view them as friends. In addition, in his statement it is difficult to understand exactly what he is talking about. There are some statements that do not make immediate sense, and a lot of hesitation and incomplete sentences. This may be a way of avoiding talk about his relations to the others. In a group where there is a collective understanding that the relationship is as deep as a friendship, one can imagine that it is difficult for this man to openly disagree. His hesitation may also indicate he may be saying things he does not actually mean. It is almost as if he is contradicting himself when he says he has been looking forward , and in the next sentence, he says: “not to sort of”, without ending the sentence. He then talks about how the group has had a goal and meaning for him, but again that it has not had it. I thought at the time that this man is ambivalent, or wants to say something else than what he feels he can say.

There seemed to be a common understanding that the conversations in the groups were different from those with family and friends. Several participants talked about how the conversations differed from talking with others.

> "It's a completely different conversation here than it is with them, the ordinary people around (--) It's on a completely different level. You somehow don't want to talk about those things, easier to talk about in a group like this?” participant 6, group 3

The groups seemed to provide the participants with an arena in which the understanding for one another’s situation is helpful. The experience of living through cancer illness and coping with the consequences led the participants to talk about their situation on a different level than they could with others. This participant uses the term ordinary people about his surrounding friends and family, which implies he does not view himself as ordinary because of his experience. The term “different level” together with “ordinary people”, may imply that he finds this to be at a higher level and that the participants are not ordinary people. This is why, it seems, he can be freer in these conversations. He states that he does not want to talk about things concerning his illness outside the group. He feels responsible for not telling other people things they cannot handle emotionally, and it seems that conversations at the level of the group, releases him from his responsibility of being careful with his word. I take this to be in his use of the word “easier”, which may point to him feeling that he does not have to take responsibility for the participants’ reactions.

5.2.4 Group values

Through observation and interviews, it became apparent that the men found it important to talk together in a positive way. The fact that one could come without any demands was positive. Even though there was little talk about illness in the groups, some men stated that they found answers to their questions by listening to other people's stories. The use of humour had an important role in the groups. Humour was used to bring up topics that were difficult to talk about, or to show care for others in a playful way.

I joined the Trondheim group on their first meeting, and one of the men talked for some time about how he did not trust the health care services. However, I did not perceive him as particularly complaining. I was more concerned with him stating that “one could think oneself well”, but none of the men in the group mentioned this in the interview. The group seemed to focus on a perceived negativity, and when they were asked about their most prominent memory from gatherings with this group, the response from the participants came quickly:

> “The northerner who came in and moaned for a quarter of an hour … *Yeah* who left, he was so stereotypical. Then I felt like no, this is a waste of time. *Hmm* If that's how we're going to sit in six or seven meetings m-m, then- it's something like that, not that it's a good memory, it's such a very clear memory of how a group shouldn't be, *hmm* how the theme and focus should not be *Mhm* Not to say anything bad about him, the man has his issues, but he became such a stereotype for me, that it's the wrong way to go… “Participant 1, group 2
>
> (This was followed by two other participants commenting --)
>
> “Yes, it has been important that there has been little whining and complaining in this group here. Yes, mhm it hasn't been that place-“Participant 4, group 2
>
> “I can't remember either that there has been-“Participant 2, group 2

In this example, it is interesting to see how the participants interact, and create a common understanding. The responses from the two other participants seem to show a consensus that complaining about ones situation is unhelpful. There seemed to be an agreement that negativity did not have any place in their group. In this, there is an understanding as participant 1 is stating, that complaining is negative and unhelpful. Participant 1 is engaged when he is uttering his statements, and there are few filler words or hesitation such as ‘ah’ or ‘ehh’ in his statements. The statement shows a participant who seems upset, as he has a lot to say about this. His engagement may dictate how the rest of the group responds, however, their verbal support with “Hmm” and “Mhm” to his statement gives an impression of agreement, and might encourage him to continue.

The first statement shows how participant 1 labels the other man “northerner”. This may be because he does not remember the man’s name, but remembered he came from the farthest north of Norway. He also uses the word “stereotypical” twice in his first statement. Labeling someone stereotypical in Norway, gives an idea of a negative person with undesirable qualities. Historically, Norwegians have looked down on people from the north, and labeled them as primitive and vulgar (Hellstad, 2010).The use of the two labels together can create an image of a person with undesirable, negative and unintelligent attitudes.

In this statement, participant 1 says it is not a good memory, but a clear memory. This indicates listening to the other man made an impact on the participant. The different positions held by these men caused some disturbance with this participant, and he says the theme and focus should not be on the negatives. Participant 1 has a diagnosis where the possibility of a relapse was high, and one can only wonder how it was for him to sit and listen to the man from the north. He provides a clue as he describes how he felt it was a waste of time, and it was how a group should not be. Participant 1 is expressing that moaning is a waste of time, and the wrong way to go for the group. This implies that the group needs to have a positive tone in their conversations. The other participants seem to agree, as they are encouraging his statement about that not being the way a group should be. Participant 2 and 4 chime in, and says that there has not been negativity in the group. These statements create an illustration of how one is welcomed in the group, this is not the place for men who cannot stay focused on the positive. Even though I never heard from the man as to why he did not want to stay in the group, he must have felt a resistance from the others. Thinking back to the first meeting, there was not much response to his statements. His statements created an uncomfortable atmosphere, and several participants discretely contradicted him, without looking directly at the man, but looked at the participant with the potential relapse that would be lethal. It seemed that already in this meeting they were united in avoiding falling into what they considered a complaint-trap.

Talking about their difficulties was carried out in a subtle way, as this participant from group three explained:

> "I just have to ask a follow-up question. Because you said you always, in a way, get something from the group, what is that *something*, can I ask you about that X?" (Interviewer to participant 4)
>
> "Yes, the *something* is that you always have some vague questions that may not always be easy to ask, but through the dialogue, you come across little uh stories and uh experiences and such, and then you might get some answers to that *something* you are thinking about" (Participant 4, group 3)

All the groups seemed to have a way of talking about difficulties and obstacles without discussing these in depth. The above statement suggests how this has shown itself as a value in the group. In this statement, the participant tells us how he is getting answers to question he might not want to ask directly. He explains how he is getting what he needs from the group without asking for it. One might get the impression that he is beating about the bush, instead of asking directly. This may have to do with thoughts, which may not be properly sorted out, perhaps he is unsure how to present his question, or what to ask for. Despite his hesitation to ask, he is able to extract knowledge he can apply to his own situation. He says he has questions that are not easy to ask. This may point to topics he is shy about, or perhaps the group is communicating that there are topics they do not wish to discuss. When he is talking about this, he elaborates and uses time to come forward with stories and experiences, and how they gave him answers. This was very much the feedback from all the groups; they understood their own situation differently after listening to the experiences of the others. It seems this participant had experienced some hesitation for some reason, but through listening to others, he had found a way of integrating his own story with the others.

The participants talked about difficulties, but they often framed them in a way that made them lighter. As I have already noted, they used humour when approaching each other, as shown in this statement:

> "Yes, how is your onion ("løk") doing by the way? So not *that* onion, that is, but the eating (the group laughs)" Participant 3, group 3.

This participant is following up on a conversation he had with one other participant at their last meeting, when they were preparing and cooking food for each other. They were talking about the other participants' problems with indigestion after the cancer treatment, and there were various things the other participant could not eat (such as onions). This participant had lived with the same challenges for many years, and had shared his experiences. Now, he is inviting the other to share how things have been since they last spoke. By reference to "the onion", he is using a hidden sexual reference. In Norway, "the onion" is a euphemism for a penis. By using this euphemism, he is setting the context for this conversation, and is laying the premises for the other participant's response. Framing it as a joke ensures the conversation is kept light and positive, even though these challenges may be difficult to handle and reduce life quality for the two participants.

The participants also used humour to address topics that were about themselves.

> "But as my partner said earlier, if you had been a horse, I would have shot you hehehe" Participant 1, group 2

In this, the participant is talking about how bad odds he is having with his diagnosis. He is also suffering from severe late effects due to the heavy treatment he has been through. The use of the metaphor of himself as a horse creates an image of a creature who has less value than humans, who is put down when it does not fulfil its duties or is no longer wanted. This participant is, in the same way as in the statement above, laying the premises for how the statement is supposed to be understood. It is not an invitation to elaborate, or to ask about the participant's feelings concerning the subject. It seems there is a pain he needs to express, but without wanting to talk about it further. I took this statement back to the first group, and when I read the statement to them, they all chuckled. When the group were made aware that this statement could be interpreted in another way, they were genuinely surprised that I could interpret it as anything other than humour. One participant said he had said the same thing to his wife! They reflected on the way this was said, and concluded that this raw form of humour probably never would have been said in a group with women.

5.3 Summary

Analysing my data from the ethnographic observations and the group interviews, I think that my findings show how these Norwegian men are affected by cancer experience both in terms of internal and external expectations and presuppositions. Being positive appears to be an important value for the individual participant, but also for the group, and it seems to be defining how a man should cope with physical illness. The participants display a "positivity discourse", in which negativity or critical thoughts do not fit with cultural ideas or the social expectations of how a man must deal with difficulties. Through this project, the groups provided the participants a space they could not access elsewhere. In these groups they could namely talk about their situation on their own terms, in a way they felt comfortable with, and safe to do so. The men in this study communicated having had an experience of understanding from the other participants, in which they could not find outside the group; and found this to be helpful. Some of the men felt very close to the group and talked about the others as friends, but it was also implied in some statements that a few participants felt more distanced from the others. To approach difficult subjects the participants used humour, and humour was also used as context markers to avoid focus on difficulties. It seemed that the men had ideas that if they did not stay positive, they would be placed outside of what is masculine. They gave this as a reason for keeping the group for men only. If women had joined the groups, the men would have felt that they could not talk openly, and they believed the conversation would have been steered by the women. The participants felt it would not be possible to stay positive or keep the conversations light, if women had been present. This idea came from the belief that women want to dig deeper into difficulties, which would collide with the men's value of keeping a positive mindset. As a woman joining the groups' talk about this, I could have been concerned with the matter of equality, and perhaps have had an experience that women were treated unfairly in the men's conversations about gender. I experienced that the men communicated their opinions with vulnerability and respect, yet there was a discovery of what they could gain from meeting only other men. Although what was communicated was only an expression of these men's experience, I thought that this was knowledge that both the health care system and family therapy might benefit from when meeting ill men.

6.0 Discussion

The aim of my research has been to gain insight into men’s experiences of peer support, and to offer a different perspective to health care workers and family therapists working with men suffering from cancer. I wanted not just to understand, but also to explore how such a space for peer-support could be set up or constructed. This research has therefore combined exploring and taking action. The men’s thoughts and my own ethnographic experience presented in this research provided a complex picture. In this chapter, I will discuss the findings of my study, and address topics especially relevant for systemic therapists and health care workers in this field. I will particularly discuss the men’s experience of self, the need to stay positive, constructing masculinity, masculinity in relation to feminine power within the groups, and One-ness and Me-ness in the groups.

6.1 A gendered way of being.

The way the men in the groups communicated, talked and interacted showed a gendered way of being ill. The men appeared to be changed because of the implications of the illness, and they suffered because of what the cancer had caused. In order to navigate in relation to their understanding of masculinity, it seemed the men had chosen to actively use positivity as a way of operating. By doing so, it appeared that the men experienced living in line with their understanding of what it means to be masculine, striving to be like other men who are not ill.

6.1.1 The illness changes the self

According to Foucault *et al.* (1988), our self is formed in light of the society we are a part of, and we understand our selves according to the prevailing discourses surrounding us. As seen in the findings and the literature review, men who have undergone cancer treatment generally experience psychological distress (Dahl *et al*., 2014) This is because of the difficulties they have in living up to the social expectations of what it is like to be a healthy man. The men in this study had a perception of their self changing because of the illness, and they therefore viewed themselves differently after the treatment than they did before.

Many of the men in this study were unable to work. However, none of the men expressed worries about their family's financial situation. I found myself wondering why this was not brought up by the participants. Although Norway has relatively good support schemes, income will decrease by about 34% for people who are unable to work (NAV, 2013). Perhaps this was not addressed by the men, because displaying their concerns felt incompatible with masculine identity and behaviour or it would have drawn attention to their deficit. Being unable to support their families as desired might have been experienced as shameful and a taboo, and keeping in line with the earlier topic of positivity, it may have been considered as out of bounds of the talk, either in the groups or individually.

In addition to the ability to take care of one’s family, the masculine self seemed to be attached to the ability of achieving physically. Culturally, physical activities such as hiking and skiing are considered important for Norwegians, and this cultural heritage may be an extra burden on the men suffering from late effects of cancer and cancer treatment. Several of the men were disabled and even though this could be fatigue or other disabling conditions, it was mentioned as a “little things”. Going through surgery, medical treatment and radiology seemed to affect not only the men’s bodies, but also their self-image (Dahl *et al*., 2014). The men used words describing how they struggled with their bodies. They shared examples of how they reprimanded themselves or toughened up to complete tasks, and struggled to accept their bodily change, and described how they were trying to pull themselves together, as if they were was addressing someone who were lazy. Struggling with their bodies can be understood as a hinder to stay within the masculine hegemony. Experiencing late effects was seen as a defeat, and it changed the way the men perceived themselves as the changed roles in the family and insecurity about the future took hold of them. The participants statements suggest how they experienced their bodies failing to act in ways which could construct and maintain a sense of the self as masculine. It seemed to me that they were unsure of who they were without these opportunities to do physical work. One participant expressed how good it felt to be able to take the bus to work and how he felt work strengthened him. Cecil *et al.* (2010) report similar findings, that being able to work gave the men a sense of belonging and functioned as a validation of their own value as men. The man skiing used a different technique to retain his sense of self. Showing his skills gave this man, who had been very ill, an opportunity to show his strength and gain credit from others and this helped restore his own self-image.

The embodied and emotional experience of being impotent affected the men's sense of themselves as persons. When speaking about this the way the men spoke to each other changed, their voices dropped, their bodies were huddled together and it became quieter in the room. I felt that this was a difficult subject to address. As reported in chapter five, one man said that it was a part of the bone marrow or the spinal cord of masculinity to be a potent man, and changes below the belt led to psychological challenges. As in Cecil *et al.* (2010), the finding of this study supports that the men felt a sense of change in body image. I argue that the change did not just lead to a change of body image, but also to a change of the self, and it was as if they felt that they were not real or authentic men.

One participant stated that he felt he often had to wear a mask, even with the people closest to him. According to Goffman (1959), this statement suggests that this man felt he needed to display himself as others wanted to see him, or perhaps as he wanted others to view him. He was possibly playing a part in telling himself and his family that life was better than he really felt it was. Similarly, other participants expressed feelings of loneliness in the aftermath of cancer treatment. The reasons for this may be multifaceted. Norway is considered one of the countries in the world with highest living standard for the general population (Shneider *et al.*, 2021). As a consequence and as has been argued by Donaldson and Poynting (2004), this might indicate that Norway is a society, in which displaying oneself as masculine is particularly important for establishing relations of distance and dominance over other men. This could make it very difficult to be open about personal struggles, especially for a man. As I described in the findings, the men's statements implied both internal and external barriers to talking about difficulties. This is one of the reasons I believe the groups were so important for many of the men and that this in line what Foucault meant when he said "The care of the self is the care of the activity" (Foucault *et al.*, 1988, p. 25). Through the meetings, the men shared a similar experience and recognized the feeling of vulnerability in the other men regardless of diagnosis. Perhaps a new style of "care of the self" was becoming available to the men through these groups.

6.1.2 The need to stay positive

In the analysis, the need to stay positive became apparent in different ways. This research suggests that this need led the participants to avoid and shy away from forms of expression that were associated with feminine values, such as crying or spending time talking in-depth about their feelings. This accords with the research of Cecil et al., (2010), Öster *et al.*, (2013) and Handberg *et al.*, (2014) who found that camouflaging weaknesses, or simply not talking about it, is a phenomenon common for men from different parts of Europe, it is a men's habitus. Bourdieu's concept of habitus refers to the way persons develop attitudes and dispositions, and the way their attitudes and dispositions are practised (Bourdieu, 1977). The Norwegian gender researcher Lilleaas (2006) introduces the term 'physical preparedness', and proposes the physical preparedness as part of a man`s habitus, a bodily ability to stay "on-guard" in certain situations (Lilleaas, 2006). Being positive can be regarded as a necessary bodily "position" for oneself or others to survive during periods of life (Sundby, 1999). It is as if positivity becomes part of the men`s physical preparedness. Thus, one participant identified himself as always positive, no matter what. Another participant stated that he repressed all things as best he could, so when his friends asked, he always said everything was fine. The positivity seemed like a survival mechanism for the men, as if you start feeling sorry for yourself, you have lost to the illness. This may come from the men growing up with this positivity discourse as part of embedded patterns of masculine gendered practices, challenged and transformed of social phenomenon's throughout social history (Smith, 2016).

According to social norms, to possess stoicism, independence and strength is considered masculine (Cecil *et al.*, 2010), and these values may be very difficult to live up to if one suffers from a serious illness (Dahl *et al.*, 2014). It may seem as if the men had an idea that if they stopped being positive, it would lead them to cave into feelings of despair, sadness or feeling sorry for themselves. This had to be minimized, in order to maintain a masculine identity. Some of these men suffered from the late effects of their treatment, leading to difficulties maintaining a normal everyday life, yet they claimed negativity had no place in their life. This can be seen as an expression of executing courage and perseverance, factors that were important for the men in maintaining hope that things will get better, and may indicate that the positivity also worked as a behavioural dimension of hope (Rustøen, 2001). By acting positively, this behaviour engendered hope. This behaviour was viewed as masculine and could be considered a dimension of the way men constructed their preparedness. Positivity may also be viewed as an attractive feature in a partner, and by being positive, the men were displaying themselves as an attractive relation (Smith, 2016). The way the men spoke about their way of handling their illness, suggested an understanding that they were operating from an idea that being positive was the only accepted way of handling the late effects of cancer, this was their discourse of positivity.

As it is estimated that 20% of all cancer patients become depressed (Dahl *et al.*, 2014), the positivity placed a heavy burden on the men. For men who were unable to behave or talk within the discourse of positivity, this may have caused further psychological discomfort (Dunn *et al.*, 2018). The men could have chosen to stay out of the discourse- chosen not to be positive. The participant who went down to the basement could have chosen not to pull himself together, yet he did. From the men's statements, it seemed self-pity was wrong, or even a taboo. However, on the other hand, Kåresen and Wist (2012) suggest that receiving a diagnosis, having a relapse or living with the late effects from the illness or treatment; challenges men's ability to stay positive and may cause fear and bitterness (Kåresen and Wist, 2012). Feeling shame or guilt for not keeping positive, may have caused extra strain on the men (Dunn *et al.*, 2018), yet it appears as if they are taking on a role towards others. It may seem that the men are wearing a mask that represents a role, the role they strive to live up to, the one they want to be (Goffman, 1959). It is possible that in the interaction with relationships such as a family, these men see it as part of their task to reduce the stress in the system (Brown, 1999). In order to achieve this balance, they will put their own needs aside in order to achieve balance.

I wonder how this affects men who are terminally ill, as sorrow and pain take up much room and energy in the process of facing death. Receiving a diagnosis, a relapse or entering the palliative phase challenges the ability to use positivity as a behavioural tool. In facing these challenges of experiencing positivity as an unavailable tool, Langer *et al.* (2009) found that some men turn to withdrawal from communicating with their families altogether. Nicholas (2000) found that in this phase another masculine idea may become constructed, namely withdrawing from communicating with their families about their life ending (Nicholas, 2000). The dominant discourses often rule out opportunities for men to talk openly about being sick, and that cancer forces men to confront their own vulnerabilities in ways that are incongruent with dominant ideals of masculinity (Smith, 2016). As my research has shown, feelings displaying vulnerability are not in accordance with being on top of the situation, and the men, unable to uphold the dominant ideals of masculinity, construct alternative ways of coping, which nevertheless leave them just as isolated and unsupported.

6.2 Constructing masculinity.

This study explored the construction of the masculinity- albeit the material also gives some indication of femininity as seen through the eyes of these vulnerable men. The background of this research, was to understand why men did not take part in joint activities with women- and this lead to a discovery of how the men were shaped by their experiences in the social environment (Luhmann *et al.*, 2013). By noticing this, relations of power emerged both inside and outside the group. This particularly emerged when I looked into Norwegian health care, which also provided an understanding of how women's values affect the ill men. The men constructed masculinity through interactions with the surrounding environment and in the groups, both through language and bodily positioning. Within the groups, constructing shared knowledge of how to live ones life according to masculine ideals provided some men with power over others, and defined who did and who did not belong in the group.

6.2.1 Masculinity in relation to feminine power

Masculine hegemony refers to a normative ideal of how a man should be, what qualities he should possess in order to have a high status in a masculine hierarchy. Masculine hegemony is not a static masculinity, it constantly develops and becomes more nuanced (Connell and Messerschmidt, 2005). In this research, I explored an understanding of what I call the Norwegian masculine hegemony, to understand how the men construct themselves post cancer treatment. When a man becomes seriously ill, he will try to operate within his understanding of this phenomenon (Lilleaas, 2006). Norwegian gender roles have developed rapidly, with women becoming more equal and active in various arenas of the society (Lien, 2021). Through the gender equality process, women have gained more cultural power, which have given the female values more obvious presence in health care. As the female care is a larger part of the hospital, it provides more execution of power, locally expressed through routines as argued by Lien (2014). Feminine care values have gained more credibility in how men should handle their illness. This has led to a change of outlook within health care; feminine knowledge conveyed through the education may influence how nurses emotionally involve in men’s relation to being ill- while the previous way of handling a crisis was to keep quiet, men are now encouraged to talk about their feelings (Lien, 2014).

Connell and Messerschmidt (2005), argue that the conflict between the men’s bodily preparedness and the feminine values will lead to an oscillation between acceptance and rejection of the female ethos of care. Through this vacillation between feminine and masculine outlooks, a new understanding of masculinity will emerge. The men in this research seemed caught between the increased public expectations about openness, and a strong attachment to masculine identity transmitted through culture, heritage and social values. This is supported by Lilleaas (2006), who suggests that what happens in the family when a man becomes seriously ill is to be seen in the light of the gender division of labour and the (power) relations which are produced and reproduced. The men have to juggle between an outlook of examining emotions, and at the same time keeping resilient and stoic as part of their masculinity. Hence, several participants agreed that women in groups were a positive thing, yet not in the peer support groups. This supports the idea that the men felt women were more advanced in talking about emotional topics, and that the operation of the idea of openness which women express is problematic to operate within the positivity discourse.

Feminine knowledge of care can be seen in Bourdieu’s terms, where it provides women with cultural capital and power. Cultural capital implies that the women have a “form of value associated with culturally authorized tastes, consumption patterns, attributes and skills” in these settings (Bourdieu, 1983). In Norway, there are more female family therapists and nurses (SSB, 2019), which may be seen as an example of an area where one might see this cultural capital. The men experienced power in the relation to their female partners, as the women wanted the men to talk more about their experiences, as was also reported by Saastad (2016). The men on the other hand, often withdrew to maintain a protective buffer, and maybe this was an act of the men’s bodily preparedness, to maintain their positions in the relationship as attractive partners. So, for example, one participant explained he felt he had his wings clipped before he entered the group. I believe this was an expression of how the men in this study felt caught between the expectation of being open, as had been conveyed to them by the health care professionals, society and from their families, and their own expectations to stay within the frames of perceived masculinity. However, as the men navigate between the dominant values of feminine care and masculine hegemony, the men show their agency by valuing side-by side sociality more than intimacy and do not convert into expressing emotions the same way women do (Rennoldson *et al.*, 2013). These observations are supported by other research, which has shown how men experience a discrepancy between the psychological distress and the expectations from the surroundings (Ussher *et al.*, 2006; Dunn *et al.*, 2018; Vickery, 2022).

During the ethnographic phase, none of the men commented on the fact that I was a woman, which was interesting, considering I was together with them for six weeks. I wonder if it could be that they viewed my role as a researcher more important than the fact that I was a woman, as they often talked to me about how important it was to know more about the psychological effects cancer has on men. Some of the participants stated that if women had participated in the groups, they believed the tone of the conversations would have been more serious. Adding women to the group could have deprived men of the opportunity to use humour as a tool (Attardo, 2015). The men brought forth that they did not want sympathy from outsiders, but they needed a place where they could show their vulnerability. The resistance to having women in the group is in accordance with the findings of Rennoldson *et al.* (2013). They found that if men are encouraged to talk openly about their cancer and associated emotions, it may be in conflict with their preferred identity positions as protective, self-reliant and stoic. In the groups, the men often had a practical approach to the problems, emotions were rarely mentioned. Very often they had practical advice for each other about how to deal with challenges, and challenges were often connected to concrete issues, like not being told about the municipal services or not being able to climb a ladder because of neuropathy. By having a forum where they could share their experiences concerning challenges they experienced because of the cancer treatment, they gained a sense of belonging, and through common understandings, the men were able to construct a masculine outlook with which the whole group could identify. Some men justified their attendance in the group by contributing to research, and admitted they would never have joined the group had it not been a research project. A few of the men expressed how they had been alone with their thoughts for several years after the treatment, and talked about conflicting desires or feelings by entering a new arena. By positioning themselves as helpers, and not as someone who should be helped, this might have been a way for the men to show themselves as they wanted others to view them (Goffman, 1959).

6.2.2 Masculinity within the group

From observing the conversations between the group participants, I saw their interactions as negotiations about how one could suffer and live in line with one's understanding of masculinity at the same time. The men appreciated the groups, they said that the groups had been helpful to them, as they could talk to each other in a way that they could not do with others. This meant conveying difficult experiences, and feeling of loneliness (Dunn *et al.*, 2018; Ueland *et al.*, 2021).

Through the men’s stories, there emerged an experience of coming out of the hospital feeling left alone and powerless. The feeling of powerlessness may be connected to the description of a void, stated by one participant - the treatment is over, but one does not identify as well. However, being a part of the group provided the men with a sense of power. Being part of the group provided strength- through the constructing of a fellowship, the men created an alternative masculinity, which provided them with a feeling of power, which they felt they had lost. This supports the findings of Vickery (2022) in which the men talked about developing a new role, identity and purpose through the support from the group. The participants were able to show emotional vulnerability, within the context established. Often the men approached emotional conversations by making a statement and then leaving the subject to talk about something else, before eventually re-entering the subject from a different angle. This is illustrated in the conversation between two men in the first group:

"It's the biggest thing that has happened in my life!" Mmh ... Or; "one of the biggest" - perhaps with a negative ring, heh (several chuckles)! - but it's ... well, it's hard stuff, right! Hmm. So it's ... mmh" Participant 2, group 1

(---)

“But we have, where I come from, we have ... I probably mentioned it - there it is much like here; we are a group that sits and chats about everything” Participant 3, group 1.

Here, the first participant makes a statement that suggests he finds the cancer to be the most negative thing that has happened to him. Instead of offering verbal support or recognize his statement, another participant tells a story from a different group he is part of. This can be seen as an example of how the participants, by avoiding the conversation to become too emotional, constructed a way of talking positively within the group. Adamsen *et al.* (2001) have made similar observations; statements that went against a positive way of talking were met with silence or a change of the theme of the conversation from the rest of the men, indicating that the statement was inappropriate - it might pull you down. This way, the body language participated in generating social practice, and the participants communicated both verbally and bodily to refine ways of social behaviour (Connell and Messerschmidt, 2005). From my ethnographic observations, another example of using the body to generate social practice could be seen when the group had decided to go for a short hike. In that gathering, several of the men did not attend, and some of them stated that they did not want to hinder the group by walking slowly. This is an example of an example of how the body was used in a conscious choice to maintain a positive attitude. By not participating, the men chose to withdraw when they could not do so positively.

The participants remained within the positive frame when they talked about their difficulties, by using humour and self-irony. Statements concerning intimate matters or personal difficulties were followed by laughter, indicating this was an appropriate response from the listeners. Williams (2009) has found that men use humour to establish a sense of solidarity or social connectedness with others, and this supports the findings of this study. For example, one participant reached out to another by asking him how his “løk” (onion) was doing. This participant`s presentation of the question shaped the context in which the statement was to be understood. Without asking directly about subjects that were vulnerable, he used humour to create a common language. In this setting, one can argue humour was used as a ritual to create a relaxed and safe atmosphere. This helped diverge the attention from this vulnerable and dangerous subject, and created a space where the men could talk about difficulties without losing their integrity. Thus, humour was an acceptable way of talking about difficult issues and avoiding emotional intimacy. While the humour helped the men connect, some felt unable to access positivity as a framework for communication, and who also did not use humour as a ritual. During the conversations, a participant listened to the others and picked up information from what they were discussing, instead of asking directly. Perhaps, as he did not have the positivity as an accessible tool at this point, he consciously withheld his questions because he did not want to step outside the way of talking that was being constructed in the group. This can illustrate why men withdraw from gatherings where they are unsure whether they can access humour and positivity as a way of communicating.

According to Jenkins (2008), identifications are made through symbols and rituals. It is reasonable to believe the man from the northern part of Norway did not identify with the Trondheim group, as he left after the first gathering. Following Goffman (1961), one may consider this group as a closed unit, because of their common experiences as cancer patients. Talking positively was a symbolic activity to show one`s belonging (Goffman, 1961). For the other members of the group, it was the man from the north's obligation to be appropriately engaged in the positive discourse. From the statements given by the group, he did not display a positive mind-set that connected with the rest of the group, and the men saw him as a man who chose to stay outside of their idea of masculinity. They regarded this as an undesirable trait, unacceptable and incompatible with participation in the group. Failing to use humour as a ritual, was seen as a symbol both of his lack of commitment and of connection, and became a lack of acceptance of the definition for participation. From the men’s statements, it seemed that this man was perceived as a threat to the group. As a woman, I experienced this man as open (and understood his statements to be honest), while the other men perceived him as negative. The different perspectives made it apparent that there were markers I did not understand, while the men did. It was as if the presence of this man threatened the rest of the group’s positivity, and I got an impression that his statements placed the group outside a positivity discourse. When he made critical statements, the men became on-guard, and their bodily preparedness kept the men within their idea of masculinity. Through the group’s conversation, they joined an identity, and by defining him as an outsider, they established their own dominance and power, further legitimised by using language to ridicule the particular participant. This dehumanizing was used to create a distance, to distinguish who was in and who was out of the community. By calling each other “kompiser” (mates), they drew closer to each other and defined the group. Participants who did not share the positive language either adjusted to the group as shown by the man who listened instead of asking, or were rejected by the other men like the man from the North (Hay, 2000). Keeping a humorous tone and staying positive therefore contributed to the men’s experiences of constructing their identity in line with Norwegian ideals of masculinity.

6.3 One-ness, Me-ness and Us-ness in the group

The groups alternated between One-ness and Me-ness as described by Cano (1998). Cano describes the work of Bion, how groups cooperate in repetitive pattern; One-ness, where members experience an “oceanic feeling of unity”, or Me-ness, where the members are just “unaffiliated individuals” whose only purpose is to solve a task (Cano, 1998). Participants spoke about a feeling of resistance before becoming part of the group, because they were unsure of what they would meet, and were worried that there would be a focus on problems. To them it seemed negativity was perceived as phenomenon incompatible with feeling connected. The loneliness following the end of treatment led the participants to seek fellowship with others, and several of the men expressed a sense of “joining a powerful union with an omnipotent force” (Cano, 1998), by using statements such as “connection deep in his heart”. This feeling of One-ness was a phenomenon that provided the men with a sense of belonging.

The work of Cano (1998) provided an understanding of the processes the participants and group as a whole went through in forming an identity. It became clear that the interaction in the groups was different. Despite the fact that I did not attend all the gatherings in Trondheim and Oslo, I became aware that the dynamics in the various groups unfolded differently than in Bergen. The group in Trondheim used the language to define who had their place within the group, and reading Cano made me aware of a third co-operative pattern in the Trondheim group. In this group, where the One-ness became most apparent, there seemed to have been formed an Us-ness in addition to the One-ness. This formed as the group talked about their unity as a fellowship of mates. The exclusion of the participant from the north seemed to have brought them closer, as they all agreed he was not good for their unity. As he was perceived to be negative, it seemed he made a choice incompatible with the rest of the group’s idea of positioning. This knowledge of how to talk provided the participants with the power to define who were suitable for participation in the group and who was not, and to regulate the behaviour of the participants accordingly (Hall, 2001) . Negativity seemed to have no place in the content of the community that was supposed to construct solidarity and support. Their talk created a unity and an Us-ness, as if it was them- against him.

In my last meeting with the Oslo group, I experienced a greater degree of Me-ness. Although the participants talked about each other in generous terms, there were several observations in this group that I reflected on afterwards. While the men in Trondheim leaned forward into the conversation, several of the participants in Oslo had a slightly more laid back body language. That the men should continue together as a group was not mentioned during the interview in Oslo, while this was discussed frequently in the other groups. The need to keep a distance to the illness or to identify as healthy may cause the men to withdraw from the One-ness. For some of the participants, joining the group's One-ness implied identifying as a cancer patient, which could be difficult (Öster *et al.*, 2013). This may explain why some men do not participate in rehabilitation activities. Perhaps they experience it as a declaration of defeat if they participate in activities that focus on the disease, participating becomes a symbolic act of acceptance and identification as ill. For some men, identifying as affiliated members enable them identify as healthy or well, and distancing oneself from the group can be part of the physical habitus.

6.4 Summary

During this research project, I was interested to discover how the men were shaped through their encounters with each other and with their surroundings. However, as "It is impossible, in principle, to explain any pattern by invoking a single quantity" (Bateson, 1979 p.53), the findings of this research may not apply to men outside these groups or even to all men everywhere. As the ideas of masculinity are constantly being negotiated and changed, it was not the goal of this research to convey a conclusion about men's construction of masculinity. The goal was to present an outline of how these Norwegian men might be positioned and position themselves when they come together to support each other about difficult life events, such as a serious physical illness.

In this work, different philosophers have influenced my understanding of the men's experience. Foucault's`(1988) ideas about the technologies of self created an understanding of how the men's self changed from consequences of illness, their perceived role in relationships and in society was changed by the illness. Their ideas of prevailing discourses about masculinity changed the way they looked at themselves. Foucault's ideas about power also gave meaning to the mens `experiences with feminine care values, where the power is exercised through the women's language in interaction with the men. To me these fits in with Bourdieu's (1977) theory about how women may be considered to have more power because of their knowledge, their cultural capital, in this field perhaps particularly in Norway. According to Goffman (1959), the men tried to handle this by displaying themselves as they think others wanted to see them, or perhaps as they want others to see them, to connect with their socially constructed masculine self again. It may seem that the men are wearing a mask that represents a role, the role they strive to live up to, the one they want to be (Goffman, 1959 p. 10). Bourdieu express similar ideas with the concept of habitus. Habitus refers to dispositions and attitudes developed through practice and mostly outside awareness (Bourdieu, 1977, p.78). The men in my study took on a role and an emotional stance towards others, which seemed to them to encompass positive attitudes to please family and friends , without the more complicated and less valued feelings and emotions behind these attitudes being easily expressed.

The men expressed gendered power in their meeting with feminine knowledge of care. Thus in Bourdieu's terms, the way emotions ought to or should be handled provides women with cultural capital and power. Cultural capital implies that the women have a "form of value associated with culturally authorized tastes, consumption patterns, attributes and skills" in these settings (Bourdieu, 1983), and that the same authority is not conveyed by the way the men express emotion and feeling. However, the men oppose this power by taking “care of the self” which emerged as an available attitude and outlook to the men who participated in the groups. Following Goffman (1961), one may consider the groups as closed units, because of their common experiences as cancer patients. To maintain their bodily habitus, the men used the groups to define who belonged, by defining us-ness, me-ness and one-ness as described by Bion (Cano,1998) Talking positively was a symbolic activity to show one`s belonging (Goffman, 1961). In these groups the men felt a connection and talked about their experiences in line with the perceived masculine ideal. This way the men cared for themselves and re-constructed their bodily habitus.

The knowledge extracted from this small study offers a new perspective to systemic therapists working with men suffering from cancer (Bateson, 1979). Even though we as systemic therapists position ourselves as not knowing and meet men and families with curiosity, openness and interest (Anderson, 2005), we operate from the context we find ourselves in, the values we inhabit and the experiences we have had (Watzlawick *et al.*, 1967). I believe feminine ideas about the importance of expressing emotions are dominant within Norwegian family therapy today, and this research offers a different approach.

7.0 Conclusions

In this chapter, I will show how this research is placed within systemic theory. Possible implications for practice will be discussed. Lastly, I will suggest further research in this area.

7.1 Implications for systemic therapy

This research has attempted to connect the dots of a pattern, to expand my understanding of Norwegian men going through cancer treatment. Through working with the different groups, a pattern of the individual men struggling alone, and to live up to their masculine ideals emerged. This seemed to explain the observation made in much of the literature and which accords with my own experience; that men who suffer from cancer hide away from social activities in order to maintain positive. When they joined the groups, they were able to construct masculinity based on their shared position within a positivity discourse. The study has described the context in which the men create meaning, by showing a divergence from the relations to female values, the influences of the masculine hegemony and their relations to each other. In this sense, the study is an attempt to provide feedback to the health care system. The voices of the men who have participated, have provided an understanding of what the phenomenon of illness looks like from their perspective, how the men struggle with both physical and psychological issues, differences in gender and health, and how men affected by physical illness construct their masculinity through this physical illness. This knowledge provides the health care system an opportunity to facilitate change in this area. The knowledge I myself have gained through the research has affected my meetings with families suffering from cancer, and the implementation of knowledge of men`s experiences may contribute to a change in how other therapists meet ill men. From the statements of the participants, I think it is fair to say that this research made a difference with the men participating.

The findings from this study provides systemic therapists with an expanded understanding of Norwegian ideas about gender differences, which in therapy will help offer a different way of understanding for the men and families undergoing cancer treatment. This knowledge helps the therapist form hypotheses that can be explored together with the families, and knowledge extracted here may provide tools to challenge thoughts and ideas about masculinity, which can help the men create narratives about themselves as competent and in control of their own lives. As Altschuler (1993) suggested, I believe this knowledge contributes to family therapists recognizing our own basic assumptions as blind spots in our understanding of gender, and how our knowledge of language gives us power over the families we wish to help. In addition, the recursiveness of the methods of this research with the participants being involved in every step, has shown how new knowledge can come from a change of perspective, such as when the users are involved in creating knowledge. It is my belief that this has benefitted the men, and given an outcome of this research that would not have been achieved without the engagement of the men. I hope this research will inspire systemic therapists to explore the power that lies in action research. New dynamics, relations and understandings arose that would have been difficult (if not impossible) without the involvement of the men who were the participants at crucial stages. Through the meetings with the men, I have learnt how they feel inferior to women when it comes to how to deal with the consequences of physical illness. I saw how much it meant to them, to have a community where they could meet and join each other in a positive within the discourse of positivity, and where no one said it was the wrong way to act. I have also discovered how important my nursing background was in my understanding of these men, as I discovered through this research that my encounters with men have been characterised by feminine caring values - without parentheses. This research has given me a grasp of another way of understanding illness, and has provided a deeper understanding of how interdisciplinary knowledge can complement each other.

7.2 Implications for Norwegian health care

The strength of this study has been the establishment of groups, and to research this, which turned out to be an important form of help for the men. Through which men who have undergone cancer treatment could experience a community or friendship with others. In the Norwegian government's cancer strategy 2018-2022, it is stated that it is a goal to "further develop the cooperation between voluntary organizations and the health service in order to provide good services to patients and relatives" (Regjeringen, 2018). This research has shown that co-operating with the Norwegian Cancer Association, and setting up groups for men was not difficult and that this activity can have high returns in terms of contributing to increased coping for men who are living with cancer.

One of this study's sub-questions was whether men's mental health improved by participating in groups. Although the men did not discuss their mental health, it seemed clear from their statements that the group was part of a process where the participants experienced empowerment. One of the success factors of the groups, I believe, was the presence of the trained peer supporters. They had progressed further in their rehabilitation, or had learned to live with their late injuries after the cancer treatment. The participants’ encounter with these peers was an essential part of their experience of empowerment. Due to the increasing amount of elderly people, it is likely that in years to come we will be more dependent on voluntary work in the Norwegian health system, this research may suggest one way of cooperating with voluntary organisations. This research has shown how patients, peer supporters and organisations outside the hospital setting can help understand the patients’ experiences, create change and contribute to mastery of the illness suffered by patients.. This action research has been carried out with little resources from the health care, and it enables a high degree of user-participation.

As for systemic psychotherapy, the experiences of the men in my study may offer Norwegian health care workers knowledge about feminine care values, and how these values may affect men going through cancer treatment. Recently, it was brought to my attention that the Norwegian cancer Association has a new approach in its communication aimed at men. In the past, they have made informational videos that were more characterized by emotions related to post cancer experiences, which seemed to me to be much influenced by feminine values. In the new videos, promoted by a young Norwegian athlete who himself has had cancer, self-irony and humour are used to normalize life with late effects. In these videos, humour is used as a framework for communicating changes in life post-cancer, this shows how the focus on masculine forms of communication is increased within cancer care.

7.3 weaknesses and strengths of the study

The limitations of this study include, among other things, the lack of diversity in my sample. Despite extensive efforts, I did not succeed in recruiting participants from different ethnic or racial backgrounds. The study's participants were mainly over the age of fifty-five, which means that these findings indicate the experience of this age group. Future research could be directed towards the experiences of younger men.

The manufacture of knowledge is not value free. As a trained nurse and a family therapist, I am used to talk in depth about emotions concerning life and death. This probably made me preoccupied with the difference that the men did not go in depth on their feelings, which may have been a strength but also a weakness of the study.

Positioning myself as a critical realist has been challenging. On the one hand, as a systemic, not-knowing therapist, it has been difficult to claim understanding and knowledge on behalf of the participants. This may be a weakness of my study, that in some cases I have become too vague in my claims. On the other hand, throughout the ethnographic phase, I may have fallen into the positivist pitfall and steered my participants' conversations towards topics that I felt were important.

Another limitation may have been the ‘complex roles of the peer supporters. Even though considerable effort was made to facilitate their role, they may have experienced the complexity of their role as challenging and perhaps overwhelming at times.

The complex methodology with the triangulation of methods may have caused my focus to be more on some aspects of the research than others. This may have led to missing important information that would have given a different outcome to the research. If this study had been a mixed methods study, the generability might have been enhanced. . However, due to the limitations of time I might also have missed important details. In the end the results are mine deriving from my particular engagement with participants at a certain time and context. I nevertheless want to claim that my findings are important and that taking these seriously will add to the development of good practice in Norwegian cancer care of men.

With the group in Bergen, where I did my ethnography, I can see that my cultural capital and position as a woman, therapist, nurse and a researcher, may have been the reason why the men checked whether they were being “good” participants, or if they provided the knowledge I needed. In addition, as I have described earlier, in the beginning of the project I experienced a position of power over these men and it was difficult to get rid of this feeling. When the men were planning the activities, they turned to me to get my approval. I stayed as passive as I could in their planning, but as the participants wanted to please me, this may have guided the choices the men made.

A study with younger men might have given completely different findings. In Norway today, there is a new masculine talk among adolescents, called Sigma. This conveys the expectation of a “Popular, successful, but highly independent and self-reliant person, typically a male. One step above an alpha male, thinks it`s funny and cool to disrespect women” (Dictionary, 2021). This might indicate how masculinity is changing, and how positivity may lose its position for ill men in the future.

7.3 Suggestions for future research

Through the action research, I had follow-up conversations with the peer supporters facilitating the groups. These conversations often focused on the experiences of the peer supporters, and any practical issues that might come up. These conversations have not been the focus of this study. Yet, it would be interesting to study if the talks had any affect, and whether it would have changed the groups had these conversations not been made, or if the peer supporters had discussed their experiences with the group.

Most of the men in this research had families. Investigating how the groups affected the families of the men who participated in the groups has not been the focus of this study However, this too would be interesting to look at, because it might suggest how the role of the families in the aftercare of a cancer diagnosis could improve.

I would suggest that a systemic approach be used to shed more light on the experience of being a patient in the Norwegian healthcare system generally, as this can bring about a new understanding of the recursiveness interaction between the sick, the surrounding systems and dominant ideologies.

7.4. Concluding remarks

Through this research, I have now a better grasp of how it may be experienced to be affected by a serious illness. The experience has given me insight into how I, over many years as a professional in the Norwegian health system, may have met ill men with feminine values I have not reflected upon. Despite my good intentions, my lack of awareness in this area may have made me unable to meet their needs in therapy.

I feel a great sense of gratitude that I have had the opportunity to do this research. My gratitude is especially towards the men in the ethnographic phase. My experience of being together with the group was that they embraced this research, shared their vulnerability and experiences they had not shared with anyone before. This fills me with humility and gratitude, and it is my hope that through this thesis I have taken care of the trust they showed me.

It is my wish that the knowledge gained through this research can help both men and professionals understand how it may be experienced to be a man suffering from cancer, understand the men’s reactions and see how peer support may help restore the men’s feeling of self in a context in which hegemony is predominantly masculine.

8.0 References

Adamsen, L., Rasmussen, J. M. and Pedersen, L. S. (2001) ''Brothers in arms': how men with cancer experience a sense of comradeship through group intervention which combines physical activity with information relay', *Journal of clinical nursing*, 10(4), p. 528.

Altschuler, J. (1993) 'Gender and illness: Implications for family therapy', *Journal of Family Therapy*, 15(4), pp. 381-401.

Altschuler, J. (2020) 'Working with Chronic Medical Conditions', in Wampler, K. S., Miller, R. B., Seedall, R. B., McWey, L. M., Blow, A. J., Rastogi, M. and Singh, R. (eds.) *The Handbook of Systemic Family Therapy, Set*. Newark, UNITED KINGDOM: John Wiley & Sons, Incorporated.

Altschuler, J., Dale, B. J. c. and Byng-Hall, J. (1997) *Working with chronic illness. A family approach*. 1st edn. Macmillan Press.

Anderson, H. (2005) 'Myths About "Not-Knowing"', *Fam Process*, 44(4), pp. 497-504.

Attardo, S. (2015) 'Humor and Laughter', in *The Handbook of Discourse Analysis*. pp. 168-188.

Bateson, G. (1979) 'Chapter I: Introduction, and Chapter II, Every schoolboy knows', in *Mind and Nature*. 1st edn. London: Wildwood house. I and II.

Bateson, G. (2000) *Steps to an ecology of mind*. Chicago: University of Chicago Press.

Bauman, Z. (2001). *Flytende modernitet*. Oslo: Vidarforlaget.

Bourdieu, P. (1977) *Outline of a theory of practice.* (16). Cambridge University Press. Available at: https://www.cambridge.org/core/books/outline-of-a-theory-of-practice/193A11572779B478F5BAA3E3028827D8. 113

Bourdieu, P. (1983) 'The field of cultural production, or: The economic world reversed', *Poetics (Amsterdam)*, 12(4), pp. 311-356.

Brottveit (2014) 'Rom for selvhjelp: Det skal to til for å danse tango'. Norsk institutt for by- og regionforskning.

Brown, J. (1999) 'Bowen Family Systems Theory and Practice: Illustration and Critique', *Australian and New Zealand Journal of Family Therapy*, 20(2), pp. 94-103.

Brundtland, G. H. (1994) *Det ble typisk norsk å være best*. Oslo: Den norske regjering (Accessed: 26.10.2022).

Brydon-Miller, M., Greenwood, D. and Maguire, P. (2003) 'Why Action Research?', 1(1), pp. 9-28.

Cano, D. H. (1998) 'Oneness and Me-ness in the baG?', in 1 edn. Routledge, pp. 83-94.

Cecil, R., Mc Caughan, E. and Parahoo, K. (2010) ''It's hard to take because I am a man's man': an ethnographic exploration of cancer and masculinity', *Eur J Cancer Care (Engl)*, 19(4), pp. 501-509.

Connell, R. W. and Messerschmidt, J. W. (2005) 'Hegemonic Masculinity: Rethinking the Concept', *Gender & society*, 19(6), pp. 829-859.

Dahl, A. A., Aarre, T. F. and Loge, J. H. (2014) *Psykiske reaksjoner ved somatisk sykdom : symptomer, diagnostikk og behandling*. Oslo: Cappelen Damm akademisk.

David Coghlan (2020) 'Organization Development: Action Research for Organizational Change', in Bradbury, H. (ed.)*The SAGE Handbook of Action Research*. SAGE Publications Ltd(Downloaded: September 28, 2021). 114

Dictionary, U. (2021) 'Sigma' ImAraptors. https://www.urbandictionary.com/define.php?term=Sigma.

Donaldson and Poynting (2004) 'The Time of Their Lives: Time, Work and Leisure in the Daily Lives of RulingClass Men', in (ed), N. H. (ed.) *Ruling Australia: The Power, Privilege and Politics of the New Ruling Class*. University of Wollongong Australia: Australian Scholarly Publishing, Melbourne, pp. 127-153.

Dunn, J., Casey, C., Sandoe, D., Hyde, M. K., Cheron-Sauer, M. C., Lowe, A., Oliffe, J. L. and Chambers, S. K. (2018) 'Advocacy, support and survivorship in prostate cancer', *Eur J Cancer Care (Engl)*, 27(2), pp. e12644-n/a.

Fangen, K. (2010) *Deltagende observasjon*. 2. utg. Bergen: Fagbokforl.

Foerster, H. V. (2013) 'FIRST DAY: Building Blocks, Observers, Emergence, Trivial Machines', in Fordham University Press, p. pp. 1.

Foucault, M., Hutton, P. H., Gutman, H. and Martin, L. H. (1988) *Technologies of the self : a seminar with Michel Foucault*. Amherst: University of Massachusetts Press.

Gail, S. (2018) 'Eight Criteria for Quality in Systemic Practitioner Research', *Murmurations*, 1(2).

Gaventa, J. and Cornwall, A. (2015) *The SAGE Handbook of Action Research*. Third Edition edn. Edited by Bradbury, H. and Reason, P. London: London: SAGE Publications, Limited.

Giorgi, A. (2012) 'The Descriptive Phenomenological Psychological Method', *Journal of Phenomenological Psychology*, 43(1), pp. 3-12.

Goffman, E. (1959) *The presentation of self in everyday life*. Garden City, N.Y: Doubleday.

115Goffman, E. (1961) *Asylums : essays on the social situation of mental patients and other inmates*. New York: Doubleday.

Gustavsen (2017) “Longitudinal relationship between social skills and academic achievement in a gender perspective.” http://hdl.handle.net/11250/2483312

Hacking, I. (2000) 'WHY ASK WHAT?', in Harvard University Press, p. pp. 1.

Hall, S. (2001) 'Foucault: power, knowledge and discourse', in London: Sage, pp. 72-81.

Handberg, C., Nielsen, C. V. and Lomborg, K. 23 (2014) 'Men's reflections on participating in cancer rehabilitation: a systematic review of qualitative studies 2000–2013'. pp. 159-172.

Hansen, L. R. (2021) 'Fordi min mor støtter mig med hjertet: En artikel om familiens betydning i behandlingen af svær spiseforstyrrelse', *Fokus på familien*, 49(1), pp. 42-62.

Hay, J. (2000) 'Functions of humor in the conversations of men and women', *Journal of pragmatics*, 32(6), pp. 709-742.

Heimburg, D. v. and Ness, O. (2021) *Aksjonsforskning : samskapt kunnskap som endrer liv og samfunn*. 1. utgave. edn. Bergen: Fagbokforlaget.

Hellstad, V. (2010) *"Nordlendinger uønsket" : en studie av nordnorsk identitet i møte med Oslo*. Master thesis. Universitetet i Oslo (Accessed: 26.10.2022).

Helsedirektoratet (2014) *Nasjonal plan for selvorganisert selvhjelp*. Oslo: Helsedirektoratet. [Online]. Available at: https://www.helsedirektoratet.no/rapporter/nasjonal-plan-for-selvhjelp-2014-2018/Nasjonal%20plan%20for%20selvhjelp%202014-2018.pdf/_/attachment/inline/a2bd6fc5-8f09-4149-8cca-9b531b99118f:d2ee4b453880124272c4074cd333d875783e2a31/Nasjonal%20plan%20for%20selvhjelp%202014-2018.pdf. 116

Helseinformatikk, N. (2021) *Lindrende behandling med kortikosteroider* [medical information page]. Available at: https://nhi.no/sykdommer/kreft/lindrende-behandling/kortikosteroider-palliasjon/ (Accessed: 27.12.2022).

Hovig, E., Myklebost, O., Aamdal, S. and Smeland, E. B. (2001) 'Gene therapy in cancer', *Tidsskr Nor Laegeforen*, 121(4), p. 482.

Jenkins, R. (2008) *Social identity*. 3rd edn. London: Routledge.

Johannessen, A., Christoffersen, L. and Tufte, P. A. (2016) *Introduksjon til samfunnsvitenskapelig metode*. 5. utg. edn. Oslo: Abstrakt.

Jones, E. (2003) “Reflections under the lens: observations of a systemic therapist on the experience of participation and scrutiny in a research project,” *Journal of family therapy*, 25(4), pp. 347–356.

Kreftforeningen (2023) *senskader-voksne* [webpage]. Available at: https://kreftforeningen.no/om-kreft/senskader-voksne/ (Accessed: 17.02.2023).

Kreftregisteret (2021) 'Kreft i Norge'. Oslo: Kreftregisteret.no. Available at: https://www.kreftregisteret.no/Temasider/om-kreft/.

Kreftregisteret (2022a) 'https://www.kreftregisteret.no/Temasider/kreftformer/Brystkreft/'. 25.03.2023. www.kreftregisteret.no: Kreftregisteret. Available at: https://www.kreftregisteret.no/Temasider/kreftformer/Brystkreft/.

Kreftregisteret (2022b) 'Kreft i Norge' 08.06.2022. 17.02.2023. Kreftregisteret.no: Kreftregisteret. Available at: https://www.kreftregisteret.no/Temasider/om-kreft/.

Kvale, S., Brinkmann, S., Anderssen, T. M. and Rygge, J. (2015) *Det kvalitative forskningsintervju*. 3. utg., 2. oppl. edn. Oslo: Gyldendal akademisk.

Kåresen, R. and Wist, E. (2012) *Kreftsykdommer: en basisbok for helsepersonell*. Oslo: Gyldendal akademisk. 117

Langer, S. L., Brown, J. D. and Syrjala, K. L. (2009) 'Intrapersonal and interpersonal consequences of protective buffering among cancer patients and caregivers', *Cancer,* 115(S18), pp. 4311-4325.

Leitch, H. and Martin, E. (2022) 'Meeting the entire older person:

Systemic working with elders and

physical frailty', *Context*, (184), pp. 21-24. https://www.aft.org.uk/page/Context. Available at: https://www.aft.org.uk/page/Context.

Lien, M. I. (2014) 'Den kjønnsnøytrale pasienten i sykepleien – betydninger av kjønn når kvinnelige sykepleiere gjør omsorg for kreftsyke menn', *NORMA*, 8(2), pp. 132-150.

Lien, M. I. (2021) 'Mellom universalisme og feminisme: en sosiologisk analyse av kjønn og omsorgsbegrepet i sykepleiefaget', *Tidsskrift for samfunnsforskning*, 62(3), pp. 233-250.

Lilleaas, U.-B. (2006) 'Det sterke kjønns sårbarhet', *Sosiologisk tidsskrift*, 14(4), pp. 311-325.

Lilleaas, U.-B. and Fivel, P. I. (2011) 'For mye av det gode? – Kvinners involvering i menns helse og sykdom', *Tidsskrift for kjønnsforskning*, 35(4), pp. 310-326.

Lorås, L. and Ness, O. (2019) *Håndbok i familieterapi*. 1. utgave. Bergen: Fagbokforlaget.

Luhmann, N., Baecker, D. and Gilgen, P. (2013) *Introduction to systems theory*. Cambridge: Polity Press.

Madden, R. (2010) *Being ethnographic : a guide to the theory and practice of ethnography*. London: Sage.

Madsen, S. A. (2014) *Mænds sundhed og sygdomme*. Frederiksberg: Samfundslitteratur.

Malterud (2012) 'Systematic text condensation: A strategy for qualitative analysis', 40(8), pp. 795-805. 118

Malterud, K. (2017) *Kvalitative forskningsmetoder for medisin og helsefag*. 4. utg. edn. Oslo: Universitetsforl.

Maturana, H. R. (1988) 'Reality: The Search for Objectivity or the Quest for a Compelling Argument', *The Irish Journal of Psychology*, 9(1), pp. 25-82.

McCarthy, I. and Simon, G. (2016) *Systemic Therapy as Transformative Practice*. Farnhill, UK: Everything is connected Press.

NAOB, D. N. A. o. N. A. D. (2023) *NAOB – Det Norske Akademis ordbok (Norwegian Academy Dictionary)* (Accessed: 24.10.22).

NAV (2013) *Uføretrygd* [web page]. Available at: https://www.nav.no/uforetrygd#hvor-mye.

Nicholas, D. R. (2000) 'Men, Masculinity, and Cancer: Risk-factor Behaviors, Early Detection, and Psychosocial Adaptation', *J Am Coll Health*, 49(1), pp. 27-33.

Nordvåg, H. B. (2017) 'Fordømte nordlendinger. Og søringer. Og bergensere.'.

omsorgsdepartementet, H. o. (2013) *Sammen mot kreft. Nasjonal kreftstrategi 2013-2017*. Oslo: Departementenes servicesenter.

Reason, P. and Bradbury, H. (2008) *The SAGE handbook of action research : participative inquiry and practice.* 2nd. SAGE.

Regjeringen (2018) *Leve med kreft. Nasjonal kreftstrategi (2018-2022)*. Oslo: Helse- og omsorgsdepartementet.

Rennoldson, M., Brennan, J., Tolosa, I. and Ismail, T. (2013) 'A discursive psychology analysis of emotional support for men with colorectal cancer', *Psychology & Health*, 28(11), pp. 1323-1336. 119

Robinson, Adam C. Jones , Daniel S. Felix, Douglas P. McPhee and S., K. (2020) 'Systemic Family Therapy in medical settings. ', in Wampler, K. S. (ed.) *The Handbook of Systemic Family Therapy, Set*. Newark, UNITED KINGDOM: John Wiley & Sons, Incorporated.

Rustøen, T. (2001) *Håp og livskvalitet : en utfordring for sykepleieren?* Oslo: Gyldendal akademisk.

Shah, A. (2017). Ethnography? *HAU Journal of Ethnographic Theory*, *7*(1), 45–59. https://doi.org/10.14318/hau7.1.008

SelvhjelpNorge (2021) *Selvhjelp Norge – Strategi 2021-2023*. Norway.

SelvhjelpNorge (2023) 'Derfor ER SELVHJELP OG SELVHJELPSGRUPPER VIKTIG I FOLKEHELSEARBEIDET!' selvhjelp, N. k. f. s. Oslo: Selvhjelp Norge. Available at: https://selvhjelp.no/wp-content/uploads/2022/07/BRO-1_Derfor-er-selvhjelp-viktig_Print-%E2%80%93-ny.pdf.

Shneider, Shah Arnav, Doty M Michelle, Tikkanen Roosa, Fields Katharine and II, W. R. D. (2021) *Mirror, mirror 2021: Reflecting poorly*. www.commonwealthfund.org: Fund, T. c. [Online]. Available at: https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly.

Simon, G. (2014) *Systemic inquiry : innovations in reflexive practice research*. Farnhill: Farnhill : Everything is Connected Press.

Simon, G. (2018) 'Eight Criteria for Quality in Systemic Practitioner Research', *Murmurations*, 2(1), pp. 40-62.

Skirbekk, H., Korsvold, L. and Finset, A. (2018) 'To support and to be supported. A qualitative study of peer support centres in cancer care in Norway', *Patient Educ Couns*, 101(4), pp. 711-716.

Skoglund, A. (2011) *Sekter*. Oslo: Humanist. 120

Smith, S., Inhorn, M. (2016) *Handbook on gender and health.* Edited by Gideon, J. Edward Elgar Publishing.

SSB (2019) *Arbeidsmarkedet for helsepersonell fram mot 2035.*Statistisk sentralbyrå. [Online]. Available at: https://www.ssb.no/arbeid-og-lonn/artikler-og-publikasjoner/arbeidsmarkedet-for-helsepersonell-fram-mot-2035 (Accessed: 28.01.2023).

SSB (2022) *Familier og husholdninger.* Statistisk Sentralbyrå. Available at: https:// https://www.ssb.no/befolkning/barn-familier-og-husholdninger/statistikk/familier-og-husholdninger (Accessed 19.08.23)

Steginga, S. K., Pinnock, C., Gardner, M., Gardiner, R. A. and Dunn, J. (2005) 'Evaluating peer support for prostate cancer: the Prostate Cancer Peer Support Inventory', *BJU Int*, 95(1), pp. 46-50.

Sundby, J. (1999) *Kvinners helse i Norge*. Oslo: Regjeringen.no. [Online]. Available at: https://www.regjeringen.no/no/dokumenter/nou-1999-13/id141704/?ch=1 (Accessed: 17.01.23).

Saastad (2016) *Å være mann og håndtere sykdom - en utfordring : hvordan tilpasse et lærings- og mestringstilbud for menn?* Oslo.

Ueland, V., Dysvik, E., Rørtveit, K. and Furnes, B. (2021) 'Homeworld/Alienworld: a qualitative study about existential experiences after cancer treatment', *Scandinavian journal of caring sciences*, 35(3), pp. 701-709.

Ussher, J., Kirsten, L., Butow, P. and Sandoval, M. (2006) 'What do cancer support groups provide which other supportive relationships do not? The experience of peer support groups for people with cancer', *Soc Sci Med*, 62(10), pp. 2565-2576.

Vickery, A. (2022) "It's made me feel less isolated because there are other people who are experiencing the same or very similar to you': Men's experiences of using mental health support groups', *Health Soc Care Community*. 121

Walshe, C. and Roberts, D. (2018) 'Peer support for people with advanced cancer: a systematically constructed scoping review of quantitative and qualitative evidence', *Curr Opin Support Palliat Care*, 12(3), pp. 308-322.

Wampler, K. S., Miller, R. B., Seedall, R. B., McWey, L. M., Blow, A. J., Rastogi, M. and Singh, R. (2020) *The Handbook of Systemic Family Therapy, Set*. Newark, UNITED KINGDOM: John Wiley & Sons, Incorporated.

Watzlawick, P., Bavelas, J. B. and Jackson, D. D. (1967) *Pragmatics of human communication : a study of interactional patterns, pathologies, and paradoxes*. New York: Norton.

Williams, R. (2009) "Having a laugh': masculinities, health and humour', *Nurs Inq*, 16(1), pp. 74-81.

Öster, I., Hedestig, O., Johansson, M., Klingstedt, N. and Lindh, J. (2013) 'Sharing experiences in a support group: men's talk during the radiotherapy period for prostate cancer', *Pall Supp Care*, 11(4), pp. 331-339.

Appendix

Appendix 1: Example of the procedure of Critical appraisal

Author(s)	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Were the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?
Handberg et al. (2014a) Men's reflections on participating in cancer rehabilitation: a systematic review of qualitative studies 2000-2013	Yes	Yes	Yes	Yes	Yes	No	No	yes	yes	Valuable and necessary
Cecil et al. (2010) 'It's hard to take because I am a man's man': an ethnographic exploration of cancer and masculinity	No	Yes	Can`t tell	Yes	Yes	Can`t tell	Yes	Can`t tell	yes	Valuable and necessary
Vickery (2022) it's made me feel less isolated because there are other people who are experiencing the same or very similar to you': Men's experiences of using mental health support groups.	Yes	Yes	Yes	Yes	Yes	Can`t tell	No	Yes	Yes	Valuable
Öster et al. (2013) Sharing experiences in a support group: men's talk during the radiotherapy period for prostate cancer.	¨Yes	Yes	Yes	Yes	Yes	No	Can`t tell	Yes	Yes	Valuable

Saastad (2016) «Å være mann og håndtere sykdom» To be a man and manage illness	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Can`t tell**	**Yes**	**Can`t tell**	**Yes**	**Valuable**
Lien (2014) The gender-neutral patient in nursing – the meaning of gender in female nurses care work for male cancer patients	**Yes**	**Yes**	**Yes**	**Can`t tell**	**Yes**	**No**	**No**	**Can`t tell**	**Yes**	**Valuable and necessary**
Lilleaas and Fivel (2011) «For mye av det gode? – Kvinners involvering i menns helse og sykdom» (Too much of the good? Womens involvement in mens health and illness)	**Yes**	**Yes**	**Yes**	**Can`t tell**	**Can`t tell**	**No**	**No**	**Can`t tell**	**Yes**	**Valuable and necessary**

Appendix 2

NHS
The Tavistock and Portman
NHS Foundation Trust

How do men experience peer support during cancer treatment in Norway?

Bergen, 08.11.2020

CONSENT FORM

This form was in Norwegian at distribution.

The overall purpose of this study is to look at men's need for psychosocial support from other men who are undergoing or have undergone cancer treatment in Norway, how peer services for men can be further developed, and how this knowledge can be applied in systemic psychotherapy. The study will be conducted by Mirjam Ostevold, together with co-researchers from The Norwegian cancer society.

Participation in this project will involve partaking in various activities decided upon collectively and an interview. There will be video-recordings of you and your group during the activities, clips from the recordings will be shared with you and your fellow participants for reflections in an interview. Anonymised quotes may be used in publications.

It is voluntary to be a co-researcher and participate in the project. If you wish to participate, please sign the declaration of consent on the bottom of this page. You can withdraw this consent at any time and without giving any reason. This will not have consequences for any further treatment. If you withdraw from the project, you can demand that the collected samples and information be deleted, unless the information has already been included in analyzes or used in scientific publications. If you later want to withdraw or have questions about the project, you can contact Mirjam Ostevold, mobile 48215172 or email, mirjam.ostevold@helsebergen.no

A thesis will be written as a result of this study. Relevant publishing platforms for findings are the Norwegian professional journal of Nursing, the professional journal of Oncology, the Norwegian Cancer Society's member magazine, and The Journal of Family Therapy. It will also be relevant to attend various conferences to disseminate findings.

AM WILLING TO PARTICIPATE IN THE PROJECT

Place and date Participants signature

Appendix 3

Gathering 2- going hiking

The group has agreed to meet at the car park at Ternebekktjørna at 4.30pm. Before this gathering, I recieve an email from a participant who felt he was not able to go for a walk due to late effects from treatment and several operations. We agreed that he would come, and that we could adjust the hike, where some can go for a walk while others can sit at the picnic area. I am going directly from my workplace by bus. At the end-stop I get off. After only 100 metres, a lovely place reveals itself, and I spend some time just admiring the scenery. Large pine and fir trees encircle a lake, and the area has a beautiful sandy beach. Wide walking paths seem to go on both sides of the water. Several families are here, and the children play in the water with the beautiful afternoon sun as a backdrop, while their parents are watching. It is sunny and 20 degrees, it almost feels like summer in September. A group of young people have found a nice spot on the beach. The smell of barbecue makes me aware of their disposable grill, and the conversation is loud as they play music from a portable speaker. This does not seem to bother any of the families around them. At the car park, a couple of the participants have arrived, including the young man. It was his suggestion that we should go on this hike. He is wearing hiking clothes and a backpack. I notice the two other participants wear jeans. I tell him that I've been told that one participant can't come, and he nods as I speak. I can't read his expression, but he quickly replies that we can all walk together to the picnic area, which is 10 minutes away. While we are talking, two other participants arrive in the same car, they have agreed in advance to meet. I think to myself that it's a good sign, they have established a friendship already after the first meeting. When the time is 4.30 p.m., six men have arrived, and we are still short of 3 participants. None of these have informed me that they are not coming. I check my e-mail, and there is a message from one of them: "Hey, I probably have to skip the group today, have a nice hike. Say hi to the guys from me" I feel uneasy, and wonder if the participants are about to leave the group. I inform the group, and they answer yes, and nod as they look at me. While we are standing there, another participant calls, and tells me he is on a business trip. I share this with the group, and turn to the young man. I ask him where he wants to take us. He looks at me, I perceive his gaze as somewhat uncertain. He says he thought we could walk towards a picnic area, which is ten minutes away. I wonder if it feels uncomfortable for him to do this. He stutters and blushes as he speaks in a low, but clear voice, as if he is practicing not to be shy. I feel sympathy for the participant, and there is something about him that makes me feel a need to help him be more confident in the group. The men turn and walk towards the picnic area. One of the peer supporters tells about his hiking experiences in the area. He talks about different routes, and asks the young man if you can get there or there by going this way? The young man replies. I notice that he stutters a little and that his voice is still low, but clear. The other men listen, there is little talking between the men. As we walk, I think of the men who didn't come. Have I done something that makes them not want to participate? When we arrive at the picnic area, it is a nice place with benches and tables, and a pergola with a roof in case of rain. The men sit down on the benches, and I find coffee and wraps from my bag. As there are more of us than there is room for at the group of benches, I quickly place myself next to it, so that none of the men are physically placed outside the group. One of the peer supporters must also sit here, and I suspect that he made the choice based on the same thinking. Some of the men start talking about hunting, one has a hunting license. Several hunting stories from this participant is told. It may seem that the other participants do not have the same experience or interest, but they listen and respond politely to what is said. One of the men turns the conversation to wild plants and plants that do not belong in Norwegian nature. The group splits into two conversations, some continue to talk about the hunt, while another talks about growing their own food. The young man does not offer any input, but nods politely when one of the participants sitting near him talks about plants. Eventually the conversation turns to various dishes. I feel that the personal conversations they had in the previous gathering seem far away today, and I am hoping for the peer supporters to take the initiative to open up for an exchange of experiences. I probably have a need for this, and want to help the men a little along the way. I feel that an opportunity opens up when they talk about food and ask the men if they have had any experience of the experience of food tasting different after the cancer treatment? The men start talking and take turns talking about their experiences of food and digestion after operations and chemotherapy. One says that he did not notice anything during his treatment, but afterwards he put on a lot of weight. Another man says he has had a lot of problems with diarrhoea after the radiation, and that it has been tiring. He couldn't leave the house for a while, as he was afraid he wouldn't be able to reach the toilet if he needed to. Now, everyone participates in the conversation; Two of the men have urostomies, and they agree they have had to cut back on carbonic acid and oranges, but other than that they are doing just fine. There are some exchange of experience about foods that are not good, or they have been told are not good for them, but is working just fine according to the participants. The conversation gets more lively, and they take turns talking. I look at the young man, he is still silent. From what he told us last time, I know he has a lot of experience with this. We make eye contact, and I ask if he has any experience in this area? He has. He says that he has had a lot of trouble after bowel cancer, and starts to say something about how he has experienced this. In the middle of his story, he is interrupted by another participant, who wants to say something about his similar experience. The young man and I make eye contact, and I nod and smile encouragingly. He continues. The other participant eventually stops talking, and the other men show interest in his experience and ask him about it. My phone rings and it turns out that a participant has got the time wrong. I had completely forgotten about this man, and that stresses me. I therefore abruptly get up to meet him, not knowing what happens to the conversation after I leave. On the way to the car park, I meet the man who arrives late. He seems stressed, and comes towards me with quick steps and is short of breath. He forgot the time, he says. On the way back to the others, I inform him of what the group has done so far and he apologizes again for being late. When we return, the topic of conversation has changed. The participant who just arrived gets a wrap and coffee. I give him my seat, and find a new seat slightly outside the group. The latest participant explains he got the time wrong by an hour. The young man says that for him, Thursday is the worst day, and the timing of our meetings is bad. One of the others immediately asks if it would help him if we met half an hour later. I think to myself that half an hour doesn't help for someone who has small children. He probably need two hours, at least. The young man looks at the other participant and he gently answers yes. There is no more talk about this. The newcomer is updated on what the others have been talking about in the group. A man turns to me and tells me that the way the participants were placed at the first gathering was not ideal. The rest of the group agrees with this. Because of Covid-19 restrictions, the group sat two meters apart, and they sat at separate desks. One man says that there was too much distance between the participants, which made it practically difficult to hear what was said. Another points out that it was unnatural to sit like that, it was like being at school again. The group laughs. One of the participants looks at the clock and says he has to get going, and gets up. This causes the rest of the group start to break up. When the men leave the place, they take a long time. They stop, gather in small and large groups and there is a lot of talk between the various participants. I want to take a picture of the group, so I can't get hold of what they are talking about, but one participant gestures and shows the others which hiking opportunities exist in this area. Two other participants are standing closer together and talking in a low voice, I think they might be talking about their illness. The young man has his bike parked by the picnic area, the men comment on how nice his bike is. It seems proud, as he smiles a crooked smile I haven't seen before. He gets on his bicycle to go home. The rest of the group goes towards the car park, and there is a lot of talk about how nice it is here, two men are having a conversation about where they have a cabin. Two others have mutual acquaintances, it turns out. Their conversation has a light and bright tone; I see smiles and raised eyebrows. We meet a man with two dogs, and a participant starts a conversation with the dog owner. The rest of the group engages with the dog owner and the dogs, and they discuss different breeds that they have had and ask the owner about different things. For the rest of the walk, those who have had dogs talk about experiences they have had as dog owners, the rest of us listen. At the front of the car park, one of the participants says this has been a nice hike, but he can't understand what I can get out of this? They smile and one other shakes his head a little while the man laughs gently. We would like to help you with what you need to do, but we don't know how to do it? I try to say that I want to see how they talk together, what they talk about and what they don't talk about. They seem to settle down with this, and ask about where and when we will meet next. The men go to their cars; I walk towards the bus stop.

Appendix 4

Semistructured interview

1. How has it been to be you in this group?

2. What is your most prominent memory from gatherings with this group?

3. What do you think it is that makes you remember this particularly well?

4. Has this group changed anything in relation to your illness?

    - Why do you think it happened/didn't happen? When did you notice this?
    - Do you think anyone else has noticed? Who?

5. What do you think this group would be like if women also participated?

6. Why do you think it is difficult for men to gather as a group?

- Is there anything we can do to change this?
    - How?

5. How can such a group affect the mental health of other men affected by cancer? (positive, negative?)

Appendix 5.

Example of the analysis of the category the Norwegian man (later the ethos of the Norwegian man)

Result category: Gender

Meningful units:	codes:	subgroups:	
I think it's a bit about the man not losing his pride. And I don't think that's actually something that... it must be a bit in the bone marrow or the spinal cord, somehow. To some extent ... that not being a man as a man	expectations of the male role implies that he does not open up in the same way with others present, being strong is a part of his inner most.	ideas related to one's own role	D7, Gr 1
You want to, but you can`t do it. It is rather unedifying for a guy. So there you have it...a prime example of why we don't talk about it much	the self changes. You are not a full-fledged man if you cannot have intercourse		D1, Gr1
I don't have to take on some role to be here, then	Uncertainty. He is looking for his role in society after the illness		D6,Gr 1
But it is like; how do you adress such things? Call it late effects, or ... side effects! That too, right. You've just been through a big thing and then you're going to the doctor with a little thing like that, right?	Concerns about late injuries are swept away, experiences an expectation to focus on the positive and to "get back on the horse".		D2, Gr1
Ladies cry, ladies have snot and ladies think it's perfectly fine. Men aren't there, men don't want to be there, because you are the man in the house, you have to go to work, you have to air the litter box, you have to take out the rubbish, you have to shovel the snow - it doesn't fit the stereotypical male role to be like that - even if you need it and you have to	He needs to be active, contribute. If he lets his emotions go, he is afraid they will take over and he loses control of himself.		D1, Gr 2

I have a definite impression that men don't talk about the disease, but, I've got it sort of like that and I don't think it's getting any better either - and I don't think that's lucky either	Misses that men talk more about their experiences related to the disease, need someone to talk to.	D2, Gr2
I have quite a few friends who wonder, really, I love to show off that I'm out skiing, so I film when I run down all the slopes, they think I'm fitter than they are, don't they right? Heh, but it has its price when you've come home and done your session, true - but eh - I'm not - I'm not sitting in front of the TV screen and withering away. It's different but.. have said that I don't sit around feeling sorry for myself, I have to do something myself	presents a glossy image on social media to not appear weak or vulnerable	D3, gr 2
What I, I, I feel - the point is that I started working, and then I was so unsure of how I should be - And I feel it gives me strength, but at home I see the weakness - so, I have major memory problems. No, it's a good thing I take the bus to work like everyone else every morning and - It's important	His value is linked to the fact that he can contribute in the same way as others	D1, Gr 2
she (the nurse) came in to me and introduced herself - and - I've heard talk that you're in quite a good mood, even if you have no larynx. But just wait, the depressions will come - she said. Because I worked - I worked concretely to keep my spirits up! I had children myself, yes, I had my old mother mhm, so I just had to be big and strong. Mhm So she just - the depressions, they come.	in order to fulfill my duties as a man, I must not give in to feelings. My family's welfare is my responsibility, I cannot appear weak.	D4, gr 2
So I think, as I said.. as I've said to the guys here before, that I'm such a repressor, I uh, I live with what I have and hehe.. Mhm I really repress all things as best I can so when friends ask me, so.. yes, it's fine! It's fine. Yes, so uh it happens that I have to elaborate a bit then, but uh..that's enough. Yes. And I don't feel the need, or, I kind of don't have the need to do pity talk about these things, I don't. No.	Must keep things inside, does not want to talk about difficulities	D4, gr 3

I think it's a bit about the man not losing his pride. And I don't think that's actually something that... it must be a bit in the bone marrow or the spinal cord, somehow. To some extent ... that not being a man as a man. You don't go out and tell the world that... there aren't many people who are tough enough to talk about what happens below the belt - many people get challenges there, you could say. Hmmm! So, I think there is a brake there, that is. Hmm. A barrier that is incredibly difficult to overcome. Hmm. Yes. Hmm. (---)	Experiences shame that he cannot perform. Ties the self to sexual performance, loses his identity after the cancer treatment. Something outside himself does not allow space to talk about this.	D7, Gr 1
But it's the... folk soul, and the... way of being, that makes it - we're quite introverted - and uh-	society expects us to keep problems to ourselves.	D1, Gr2
You kind of don't want to talking about those things... Easier to talk in a group like this?	As a man you should keep your problems to your self	D6, Gr 3
No, that is, now I am the person I am, so if I meet a wall, I go around. I don't stand around knocking, and I always have, it's always been my job to find a way out. I was born positive, full of courage, always! Going the right way. Mhm So I've never been there, I've never felt sorry for myself. I just have, that's how it is,	Expectations of himself that he will take difficulties head on, the self is formed based on this expectation	D3, gr 3
we are very, yes, a bit like you, I'm not negative, eh I'm positive about most things	Ideas in society make it unmanly to be negative	D6, Gr 3
It's important to enjoy yourself when you're sick, so - that, there's nothing to wonder about! It keeps your mind off everything like that, so it...	Distracts himself to avoid thinking that the disease threatens his life	D4, Gr1
But I sort of told myself "Now you don't have to sit down, you can handle that."	You are not allowed to feel sorry for yourself.	D4, Gr 1
Now I can only speak for myself, then. But when, after such a long time, I start to feel a need, to meet like-minded people, so to speak, then there must be something building up somewhere..	Have resisted the need to talk about experiences	D7, Gr 1

Appendix 6:

Example of synthesis-The use of humour

There was a lot of use of humour in the groups. The humour seemed to be used to create unity by framing the conversation in the group. One of the participants said that if he had been a horse he would have been shot, a statement which was brutal, but which was said in such a way that it changed the atmosphere in the group, and they laughed and joked about their own situations. Humorous statements were used in the groups to interrupt themselves or to turn the conversation around when things became personal. It seemed difficult to talk about one`s late effects without self-irony. Humour was also used to show concern without being private, such as when one contestant asked another how his onion was doing. This was a reference to a nutritional problem that the man had talked about earlier, but it could also be taken as a reference to the man's penis, and the group burst into laughter when this was said.

Appendix 7

	Search words	**Results**
#1	**Peer support* AND men* AND cancer***	**120 000**
#2	**Peer support OR Fellow patient OR Same diagnose**	**43 852**
#3	**Peer support groups* AND men AND cancer patients* AND Scandinavia (or Norway, Denmark, Sweden, Iceland and Finland) NOT female* NOT Physical activity***	**27,771**
#4	**peer support* AND cancer***	**1376**
#5	**Cancer* AND Peer support* AND Male NOT children**	**528**
#6	**peer-to-peer AND cancer***	**241**
#7	**patient support AND cancer**	**1282**
#8	**peer support* AND neoplasm**	**962**
#9	**support AND between patients AND cancer**	**2679**
#10	**Patient participation AND Cancer**	**3865**
#11	**peer - to - peer support AND neoplasm**	**21**
#12	**peer relations AND Neoplasms**	**42**
#13	**Experience AND peer support AND cancer**	**513**
#14	**Peer support groups* AND Male* AND Cancer***	**14**
#15	**self help groups* AND male OR masculine Or Masculinity AND Norway**	**70**

#16	**mental health AND male AND Norway**	**6182**
#17	**mental health AND male AND Cancer* AND Norway**	**267**
#18	**systemic therapy (or family therapy or systemic approach)AND medical care**	**1 409 144**
#19	**Illness and groups**	
#20	**(systemic therapy or family therapy or systemic approach) AND medical care NOT (mental health or mental illness or mental disorder or psychiatric illness)**	**838 308**
#21	**(systemic therapy or family therapy or systemic approach) AND medical care AND families NOT (mental health or mental illness or mental disorder or psychiatric illness)**	**576 381**
#22	**Systemic therapy AND Peer support**	**396**
#23	**Systemic Theory AND Peer support**	**73**
#24	**Psychotherapy AND Illness**	**2**
#25	**Systemic psychotherapy AND illness**	**0**
#26	**Systemic therapy AND illnesses**	**1102**
#27	**Systemic therapy AND serious illness**	
#28	**Systemic therapy AND Cancer**	
#29	**systemic psychotherapy AND (cancer patients or oncology patient s or patients with cancer)**	**13 586**
#30	**Systemic therapy And Chronic illness**	**25**
#31	**Systemic therapy And Illness**	**84**

#32	**Systemic therapy AND Health**	**25**
#33	**Systems Theory AND Health care**	**1 035**
#34		
#35	**Medical AND family therapy**	**1 159 657**
#36	**gender AND health care**	**1 063 325**
#37	**gender AND health care NOT (transgender or transsexual or transexual or gender variant or gender non-conforming)**	**954 693**
#38	**gender AND nursing NOT transgender**	**28 758**
#39	**male AND nursing NOT transgender**	**302 242**
#40	**masculinity AND health care**	**682**
#41	**Gender perspective AND nursing**	**178**
#42	**Male gender AND Medical NOT transgender**	**9409**
#43	**male gender AND perspective AND medical NOT (transgender (or transsexual or transexual or gender variant or gender non-conforming)**	**77**
#44	**feminine values AND health care**	**3**
#45	**gender values AND nursing**	**2**
#46	**Men AND Gender AND Nursing**	**27**
#47	**Men AND Gender AND Health**	**149**
#48	**Men AND Gender AND health care**	**59**
	With the help of a librarian	
#49	**TI ((("Systemic therapy" OR "systemtic therapies") N2 ("famil*" OR "couple*")) OR "systemic psychotherap*" OR "relation***	**3596**

	therapy" OR "famil* therapy" OR "couple* therapy" OR "couples councel*" OR "couple's councel*") OR AB ((("Systemic therapy" OR "systemtic therapies") N2 ("famil*" OR "couple*")) OR "systemic psychotherap*" OR "relation* therapy" OR "famil* therapy" OR "couple* therapy" OR "couples councel*" OR "couple's councel*")	
#50	**(MH "Couples Counseling") OR (MH "Family Therapy")**	**8393**
#51	**S49 OR S50**	**9431**
#52	**TI ((Cancer* OR tumor* OR tumour* OR malignant* OR neoplasm*)) OR AB ((Cancer* OR tumor* OR tumour* OR malignant* OR neoplasm*))**	**630 348**
#53	**(MH "Cancer Patients") OR (MH "Neoplasms+")**	**669,136**
#54	**S52 OR S53**	**858,334**
#55	**TI ("Chronic*" OR "long-term" OR "late effect*" OR "latent injur*") OR AB ("Chronic*" OR "long-term" OR "late effect*" OR "latent injur*")**	**507 042**
#56	**(MH "Chronic Disease") OR (MH "Recovery") OR (MH "Cancer Fatigue") OR (MH "Cancer Survivors")**	**123 569**
#57	**S55 OR 56**	**574,137**
#58	**S51 AND S54 AND S9**	**41**
# 59	**TI (("Gender-neutral" OR "gender neutral" OR "meaning of gender" OR "masculine"**	**6212**

	OR "Masculinity" OR "gender role*" OR "gender-relations" OR "female care practices")) OR AB (("Gender-neutral" OR "gender neutral" OR "meaning of gender" OR "masculine" OR "Masculinity" OR "gender role*" OR "gender-relations" OR "female care practices"))	
#60	**(MH "Gender Specific Care") OR (MH "Gender Role")**	**6239**
#61	**S59 OR S60**	**11004**
#62	**"cancer*" OR "malignant"**	**569,557**
#63	**(MH "Cancer Patients")**	**48,008**
#64	**S62 OR S63**	**569,557**
#65	**S3 AND S6**	**452**

Appendix 8

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Regional committees for medical and health research ethics

Assessment

We refer to the application for approval of the research project. The application was considered by the Regional Committee for Medical and Health Research Ethics (REK south-east D) at the meeting on 02.12.2020. The assessment was made on the basis of the Health Research Act § 10.

This is an interview-based project that will include 24 men who live with, have undergone, or are in treatment for cancer. The purpose of the project is to contribute to a clearer picture of what the needs of male cancer patients are, how the psychosocial support offered is experienced, and how men may respond to psychosocial support in cancer treatment.

Data on cancer diagnosis and whether the participants are in ongoing treatment will be collected, but the committee perceives this is to be done in order to get an overview of the group's composition. Beyond this, no health information should be asked. In the committee's view, the study is primarily aimed at obtaining new knowledge about recruitment for psychosocial services for men. The committee therefore considers that the project, as presented in the application and protocol, will not provide new knowledge about health and illness. The project therefore falls outside REK's mandate under the Health Research Act, which presupposes that the purpose of the project is to provide "new knowledge about health and illness", see section 2 and section 4 letter a) of the Act.

Approval from REK is not required to carry out the project. It is the research institution's responsibility to ensure that the project is carried out in a responsible manner with regard to, for example, rules on confidentiality and privacy as well as obtaining local approvals.

Decision:

Rejected (outside mandate)

The project falls outside the scope of the Health Research Act, cf. § 2 and § 4 letter a). Approval from REK is not required to carry out the project.

The committee's decision was unanimous.

With best regards,

Find Wisløff

Professor Em. Dr. med.

Manager

Appendix 9

The Tavistock and Portman NHS
NHS Foundation Trust

Mirjam Østevold

By Email

7 May 2021

Dear Mirjam

Re: Trust Research Ethics Application

Title: How do men in Norway experience peer support during cancer treatment

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

Paru Jeram

Secretary to the Trust Research Degrees Subcommittee

T: 020 938 2699

E: academicquality@tavi-Port.nhs.uk

cc. Course Lead, Supervisor, Research Lead