Title
Men with cancer and their experiences of marital relationships. A struggle for control and balance

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Abstract
Presently, there is a general understanding that health, illness and rehabilitation should be studied in a relational context, and that people’s experiences, perceptions and practices in relation to health and recovery are formed relationally and contextually. The aim of this paper is to consider and discuss how men experienced their marital relationships, after being diagnosed with cancer. The empirical material is based on the authors’ ethnographic fieldworks, including participant observation and interviews with men who have or have had cancer. The analysis is informed by the American anthropologist Michael Jackson’s notion of intersubjectivity and his argument that intersubjectivity continually and dialectically moves between the complementary poles of compassion and conflict. We demonstrate how the men appreciated their partners’ support and care, but also that the cancer disease and the treatment could cause marital friction and tension. Due to their new life circumstances and subject positions, the men continuously shifted between the poles of compassion and conflict, struggling for balance and control, including negotiations of how to perform their masculinity.

Keywords: ethnographic fieldwork, challenges, intersubjectivity, compassion, conflict

Introduction
Research has shown that men and women experience and cope differently with crises related to their health, disease, treatment and rehabilitation (Courtenay 2000; Courtenay and Keeling 2000; Madsen 2007). Internationally, there has been increasing attention to the health and illness of men, with specific focus on health inequalities and the social relations of gender (Annandale and Hunt 2000; Larsen and Christensen 2008), and the influence of health, gender and masculinity (Nissen 2017; Connell and Messerschmidt 2005; Sabo and Gordon 1995).

Overall, men with cancer are less likely to seek medical attention and help than women (Handberg, Nielsen and Lomborg 2013). Even though men with cancer have rehabilitation needs, they often hesitate to engage in the offered rehabilitation programs (Handberg, Lomborg, Nielsen et al. 2015; Handberg, Nielsen and Lomborg 2013; Ingholt and Tjørnhøj-Thomsen 2014). Some studies have addressed why existing rehabilitation programmes do not appeal to men and how to resolve this issue (Handberg, Nielsen and Lomborg 2013; Ingholt and Tjørnhøj-Thomsen 2014).

Research on men with cancer has mostly focused on prostate cancer, which is one of the five most common types of cancer among men (e.g., Oliffe, Mróz and Bottorff et al. 2015; Cecil, McCaughan and Parahoo 2010; Langelier, Cormie, Bridel et al. 2018; Tsang, Skead, Wassersug et al. 2018; Alexis and Worsley 2018). This body of literature focuses primarily on treatment related side-effects (e.g., erectile dysfunction and loss of libido), men’s experiences, needs and quality of life during treatment and rehabilitation as well as the psychosocial assaults of cancer and particularly on masculinity (e.g. Connell and Messerschmidt 2005; Stapleton and Pattison 2014; Baker, Wellmann and Lavender 2016; Cecil, McCaughan and Parahoo 2010; King, Enas, Moore et al. 2014; Oliffe, Mróz, Bottorff et al. 2015). Generally, there is evidence that health behaviour and management are closely linked to cultural and societal notions of gender. Notions
of gender and masculinity, are socially constructed and shaped by time, life experiences and different subject positions, such as being seriously ill (Nissen 2017; Connell 2012; Connell and Messerschmidt 2005).

In Denmark, as well as in other Scandinavian countries, gender equality discourses have been on the political and social agenda for years. The challenges of, e.g. feminism and changes in working lives of men and women have contributed to the availability of various masculinities (Nissen 2017). Research shows that it is not possible to identify hegemonic masculinity ideals in a Danish context. These are often rejected by the men themselves in contrast to a more equality friendly masculinity. (Bloksgaard, Christensen and Jensen et al. 2015:165).

Recently, there has been an increasing body of research studying health, illness, recovery and rehabilitation in a relational context (e.g. Ervik, Nordøy and Asplund 2013; Resendes and McCorkle 2006; Boehmer and Clark 2001a and 2001b). It has been argued that the experiences, perceptions and practices of men and women are constituted and formed relationally and contextually (Connell 2012; Lavery and Clarke 1999; Schofield, Connell, Walker et al. 2000; Umberson and Montez 2010). Furthermore, there is an increasing analytical awareness that social relations cannot be assumed to be solely supportive (Umberson and Montez 2010). They may also be stressful, burdensome, conflictual and ambivalent at the same time. People may, therefore, want to free themselves from, dissolve, or avoid certain relations to protect one’s self/themselves (Peletz 2002, 1995). A number of studies have explored marital challenges in relation to men with prostate cancer and their partners, primarily in the context of sexuality (Bottorff, Oliffe, Halpin et al. 2008; Champers, Pinnock, Lepore et al. 2011; Dieperink, Mark and Mikkelsen 2015; Ezer, Chachamavish and Chachamavish 2011; Manne, Kissane, Zaider et al. 2015; Northhouse, Mood, Montie et al 2007;
Regan, Lambert, McElduff et al. 2014; Sanders, Pedro, Bantum et al. 2006). Prostate cancer has, therefore, been expressed as a ‘couple’s disease’ (Zhou, Kim, Rasheed et al. 2011; Katz 2016). Few studies, however, have focused on the relational and marital challenges experienced by men with other types of cancer (e.g. Hagedorn, Dagan, Puterman et al. 2011; Jenewein, Zwahlen, Zwahlen et al. 2008; Tuinman, Fleer, Sleijfer et al. 2005).

The focus on relational challenges caused by illness and the concept of a “couple’s disease” invites us to briefly consider the cultural context of marriage that may shape marital relationships. The American historian John R Gillis argues that establishing a romantic relationship with another person (of same or different sex) is “the sign of adulthood in modern Western culture” (Gillis 1996:133) and that romantic love between just two people still seem to form the basis for marriage and/or life-long partnership – even though the institution of marriage these years is challenged (e.g. Hull, Meier and Ortyl 2010). Gillis uses the term “the perfect couple” to capture the characteristics of modern conjugality. Conjugality here pertains to the social and culturally specific characteristics of the marital relation (or the marital-like partnership). According to Gillis, “The perfect couple now must be everything to one another – good providers, super sexual partners, best friends, stimulating companions – roles that earlier generations turned to others to fulfil” (Gillis 1996: 151). Thus, the marital relationship seems to be loaded with coinciding expectations and reciprocities – making the relationships strong, but also fragile - not the least when affected by illness.

Based on the current body of literature, our starting point was that the understanding of how men perceive and manage cancer and the treatment implies attention to social interactions and relationships with partners (Boehmer and Clark
Men with cancer and their lives with partners are inextricably intertwined: ‘men’s lives are lived in relation, not in isolation’ (Courtenay and Keeling 2000:245). Grounded on the premise that social relations may be supportive and stressful at the same time (Holter 2003; Wilson, Barrineau, Butner et al. 2014; Umberson and Montez 2010), this paper explores how men with cancer perceive and experience their marital relationships and conjugality in everyday life situations. Marital relationships are defined here as either the relationship between two persons who are married, engaged or otherwise close and intimate. For the remainder of this paper we use the term ‘partner’.

Methods

This paper is based on our ethnographic fieldwork within the field of cancer rehabilitation in Denmark at the Rehabilitation Centre Dallund, Funen (Hansen and Tjørnhøj-Thomsen 2008; Tjørnhøj-Thomsen and Hansen 2013). Hansen conducted her ethnographic fieldwork in 2013 (study I), which included participant observation and informal interviews at a five-day residential cancer rehabilitation programme designed for men with cancer. Several months later, she performed ethnographic interviews with these men in their homes. Tjørnhøj-Thomsen conducted her ethnographic fieldwork (study II) between 2002 and 2004 also at the Dallund Centre at nine weekly residential cancer rehabilitation programmes; eight of which were designed for both men and women with cancer, and one was designed solely for men with cancer.

Furthermore, Tjørnhøj-Thomsen and her colleagues did an interview study of men’s perception of cancer rehabilitation (study III) in 2014 in collaboration with Copenhagen
Centre for Cancer and Health (http://www.kraeftcenter-kbh.dk/en; Ingholt and Tjørnhøj-Thomsen 2014). Although the three studies of Hansen and Tjørnhøj-Thomsen took place over the last 15 – 16 years, the interviews and field notes demonstrated that the men’s experiences with marital relationships during a cancer trajectory had surprisingly much in common throughout this time span. Thus, similarities found throughout the empirical material points to a cultural stability, related to ways of dealing with cancer and close social relations. Therefore, we decided that the empirical material from all three studies (2002 to 2014) was to be included in this paper.

**Settings**

The Rehabilitations Centre Dallund was established in a castle, Dallund Castle’, a restored old, white medieval castle on the island of Funen in the southern part of Denmark, situated in the rural countryside, surrounded by a lake and a park. Between the years of 2001 and 2015, the castle hosted the rehabilitation centre, which was managed by the Danish Cancer Society. The centre offered a five-day-long residential rehabilitation programme to people who have or have had cancer. Most of the participants were women. A few of the courses invited a relative to participate. Since the establishment of the centre, it has been a challenge to attract men to participate in the programmes (Høybye, Dalton, Christensen et al. 2008). Special programmes were therefore developed to encourage men’s participation, but only a few such programmes were available throughout the year. All programmes were free of charge for participants, if they were referred by their municipalities or general practitioner. The programmes consisted of physical activities, and workshops that focused on diet, psychological and sexual matters. The content of the programmes was adjusted weekly based on the needs of the target group (Hansen and Tjørnhøj-Thomsen 2008; Tjørnhøj-
Thomsen and Hansen 2013). Counsellors of different health professionals with many years’ experience designed and led the programmes. In the programme, ‘Men and cancer’, where Hansen did her fieldwork, the session on ‘sexuality’ was for instance modified to include themes including masculinity, sexual and urinary problems.

The Copenhagen Centre for Cancer and Health offers municipal rehabilitation. This programme is presented as an option for all ‘citizens affected by cancer, including cancer patients, relatives and surviving relatives’ (http://www.kraeftcenter-kbh.dk/en). Depending on the citizen’s wishes, the rehabilitation may include diet counselling, physical training, stop smoking courses, and patient education, sessions with psychologists and social workers.

**Participants**

Hansen’s study included 18 men (study I) and Tjørnhøj-Thomsen’s included 16 (study II). In Hansen’s study the men were between 50 – 75 years old, with a concentration around 60 years. In Tjørnhøj-Thomsen study (study II) the men were between 35 – 75 years old, with a concentration around 60 years. In both studies, the men came from different geographical areas of Denmark. Most of the men in the two studies were married or had a partner, children and some also grandchildren. The men were informed of the rehabilitation programmes from one of the following places; a rehabilitation programme in their hometown, their local hospital, friend(s) with cancer, or from their general practitioner. Tjørnhøj-Thomsen’s interview study (study III) included semi-structured individual interviews and one focus group interview with men with cancer from the region of Copenhagen, between 35 and 80 years, with a concentration around 60 years. For the very few men in Tjørnhøj-Thomsen’s studies who were under 50 years
of age with younger children, their close social relationships were centred around their concerns for the future of their children. The focus of the men over 50-years of age who had older or adult children and grandchildren was on the content and form of their close social relationship with their partner. This paper addresses the men over 50 years that have had a partner for many years.

**Data generation methods**

The two fieldwork studies (study I and II) consisted of participant observation and informal talks (e.g. Tjørnhøj-Thomsen and Hansen 2013, Tjørnhøj-Thomsen and Hansen 2017). Participant observation took place during sessions, workshops, activities, breaks, meals and socializing in late afternoon and evenings. Hansen conducted ethnographic follow-up interviews with 11 men from the programme ‘Men and cancer’ (study I). These interviews took place in the men’s homes and lasted between one-to-two-hours. Tjørnhøj-Thomsen conducted informal interviews with the men during fieldwork, except from one-interview, which was conducted in one participant’s home.

The interviews in study I and II consisted of open-ended questions relating to the men’s experiences of dealing with a cancer disease. The men were invited to talk about what they felt most was important to them. Therefore, their answers often took a narrative form. All interviews were digitally recorded and transcribed verbatim by Hansen and Tjørnhøj-Thomsen. During participant observation in both studies, field notes were written mostly as scratch notes, key words and memos. Later these notes were written as full and coherent narratives. In study III, Tjørnhøj-Thomsen and colleagues conducted 11 individual interviews and one focus group interview with six men. The interviews were carried out at a place of the men’s own choosing - most often, at the Copenhagen Centre for Cancer and
Health. This study was also explorative, in the sense that the men were encouraged to talk about how their illness had affected their lives and social relationships, and how they had perceived the rehabilitation programme. All interviews were digitally recorded and transcribed verbatim by Tjørnhøj-Thomsen or a research assistant.

**The analytic process**

The initially analysis of the empirical material in all three studies consisted of closely reading the fieldnotes and transcribed interviews to identify emerging themes. Inspired by the concept of collaborative analysis (Cornish, Gillespie and Zittoun 2013), an analytical dialogue of our shared body of data was initiated. The dialogue included the discussing of cross-cutting themes, and possible perspectives and interpretations of the empirical material. Across data we found that the partner often played an important role in the men’s illness stories. The men explicitly stated that their partner had been vital to them during their illness and treatment, which was for example, demonstrated by the partner’s support and care when accompanying them to their consultations and treatment. However, our empirical material also showed that from time to time, the disease, the treatment and the side-effects caused marital friction and tension. These themes were also apparent in the literature, demonstrating that social relations between men with cancer and their partner could be both supportive (compassion) and stressful (conflict) at the same time (e.g. Boehmer and Clark 2001b; Bottorff, Oliffe, Halpin et al. 2008; Champers, Pinnock, Lepore et al. 2011; Courtenay and Keeling 2000; Umberson and Montez 2010). To deepen our understanding and conceptualisation of the dynamics of the marital relationships experienced by the men; we turned to American anthropologist Michael Jackson’s notion of intersubjectivity (1989, 2002).
Theoretical approach

The philosopher and phenomenologist Edmund Husserl was the first philosopher to engage in the systematic use of the term “intersubjectivity” (*Intersubjektivität*) (Zahavi 2011). Phenomenologists have ascribed intersubjectively a central role in human life, whether their focus has been in the form of a concrete self-other relation, a socially structured life-world, or a transcendental principle of reasoning (Zahavi 2011).

In his phenomenological informed anthropological work, Michael Jackson (1989, 2002) stresses that the intersubjective mediations are at the heart of all relationships; demonstrating some of the dilemmas, struggles and challenges that being-in-the-world always entails. This understanding of intersubjectivity seemed highly relevant to our analysis of the characteristics of marital relations challenged by cancer. According to Jackson, intersubjectivity is, ‘… a site of constructive, destructive and reconstructive interaction’ (1989,8), instead of just a synonym for ‘shared experience’ or ‘fellow-feeling’ (ibid.,4). Jackson argues that intersubjectivity continually and dialectically moves between the complementary poles of compassion and conflict (ibid.,4). While compassion affirms identity, conflict confirms difference (ibid.,4). Jackson’s argument that compassion affirms identity and conflict confirms difference is complex to unpack analytically because he does not explain why he has chosen the transitive verb ‘affirm’ and the intransitive verb ‘confirm’. However, he writes that intersubjectivity is “… stepped in paradox and ambiguity” and that intersubjectivity continually moves between positive and negative poles (ibid., 8-9). Compassion and conflict are complementary to each other, meaning that conflict will always be part of compassion and vice versa. Jackson’s understanding of intersubjectivity as dynamic, continuously changeable,
constructive, deconstructive and reconstructive (ibid.,8) places the ambivalent ‘nature’ of social relations in the forefront.

Furthermore, Jackson argues that the driving force of intersubjectivity is a struggle for control and for achieving balance. He terms it, ‘…a matter of balancing, dynamic equilibrium’ (Jackson 1998,18). He defines balance as an ‘ongoing dialectic’, in which a person strives to manage his or her own fate. This struggle for control implies continuing governance and adjustment between self and other, involving both self-reflection and dialogue (ibid.,18). Jackson suggests that human beings need to balance between their own world, and the world they consider to be other or non-self (ibid.:18). Balance is a matter of control, and Jackson argues that a disease is never just about a loss of a function, a disability or a handicap. There is, ‘… always a reaction on the part of the affected organism or individual, to restore, to replace, to compensate for and to preserve its identity’ (Oliver Sachs quoted in Jackson 1998,17). This theoretical approach allows us to show how marital relationships in the context of a cancer, may simultaneously be supportive and demanding, compassionate and conflictual, constructive and destructive; thereby, deepening our understanding and conceptualisation of the dynamics of the marital relationships experienced by the men.

In the following we present the men’s illness stories in terms of compassion and conflict. Although they may be understood to be complementary to one another, we have analysed them separately.

**Compassion**

As we read Jackson (1989, 2002), he uses the concept of compassion understood as a feeling of awareness towards people’s emotions, as an attempt to understand how they
feel, and as a desire to help. In the following, we have selected some exemplary stories from the men, focusing on marital support.

**A desire to help**

When the men talked about their partner, they often reflected on how their partner was an advocate for them in relation to their disease and their course of treatment. Arthur, a 70-year-old man with oesophageal cancer, expressed how his partner had played a crucial role in his illness story and he talked about his wife’s support with pride, respect and gratefulness. In one instance he had to wait a long time for his first consultation with the doctor where he should receive his cancer test results. Arthur described his wife’s support in the following way, ‘You know my wife is a health professional – and she called the hospital and asked them if they wanted a dead man on their hands, because I wasn’t able to eat anything. So, my wife pushed them by insisting to see me sooner’. Arthur’s wife was also the one who negotiated with doctors and health professionals during his treatment. Arthur remembered her calling the hospital and asking, ‘Who is the boor that treated my husband?’

Like Arthur, the other men also related that their partner played a crucial role in their illness and rehabilitation story. Often the partner was the one who took charge during difficult times, if it was needed.

Arthur expressed that he was also experiencing marital friction at home, because he felt that having cancer had made him less tolerant. Nevertheless, like many of the other men in the programme(s), Arthur phoned his partner every day (study II). Arthur said with a touch of sarcasm, I call her, ‘Just to let her know that I am still alive and that the staff haven’t killed me’ (study II). A few of the rehabilitation courses included partner participation. When the partners participated, they often took on an active role.
They were attentive to the men’s well-being and needs, and they asked questions on their behalf. For example, a partner inquired about treatment options, vitamin supplements and diet.

All the programmes had a presentation round on the first day and some of the partners used the expression, ‘We have cancer’, emphasizing that they considered the cancer as being a shared problem, which also caused them suffering. The following excerpts from a focus group interview with men with prostate cancer, also points to the importance of the partners’ relational work,

*I came home and told my wife that I have just been diagnosed with cancer and will need to have surgery and there will be a lot of side-effects. We had a long deep conversation, which resulted in us agreeing that this is a shared problem that we must solve together. And I think we have been quite good at it. It may sound a little absurd, but our relationship has been strengthened. My wife has been good at encouraging me, even though I have been intolerable sometimes, [...] she has still stuck it out (study III)*.

Another participant from the focus group said,

*My wife has been fantastic. Sure, she was fantastic before the illness; but since the cancer, she has just taken over all the things one needs to do, like sending messages to people telling them about my illness and the like. [...] When we are attending a party, she takes it upon herself to make sure we get home in time. I get tired easily now because of the treatment, and if we don’t get home before I get too tired, then the next day is completely ruined. She is also the one who has insisted that we hold on to love and sex. I have not thought much about it, but she has been the one who take the lead (study III).*
These examples show how the men experienced their partner as someone who has the desire to help and support them in a constructive and compassionate way. The men did not object to their partner’s interference, support and care, and most of them expressed gratefulness to their partner’s supportive acts.

**A feeling of awareness**

During an interview with Adam, a 69-years-old man with leukaemia, Adam used the expression ‘therapy’ when he reflected upon the support and care he received from his wife and family during his illness, treatment and rehabilitation. He said, ‘In relation to therapy, my family has been fantastic; my wife and children. So, I don’t need professional therapy. I have all the support I need’. Later in the interview, his wife entered the sitting room and asked whether we were ready for lunch. She stayed with us a short while and listened to our talk, placing her hands at Adam’s shoulders and said, ‘I was born an optimist and face the things that come. When the doctors at the hospital said something, I believed it. I believed them when they said that they could not cure him, but he could still lead a normal life’. Adam nodded his head and continued: ‘This way of dealing with things has to do with our life experiences as self-employed in the labour market. We have learned to take what life offers’ (study I).

During an interview in the home of Frederik, a 61-year-old man with lung cancer, he emphasized that ‘there have been many positive things in my life; my wife and two healthy children’; then went on to say,

*I think that we have adapted to the situation. My wife is very sweet, and she agrees that we shall organize our life to cope with my cancer. Before my cancer,*
we had a camping car, but we had to sell it, when I became sick. It was too cold, especially during wintertime. Then, we decided that a summerhouse was a better fit. So, we bought a house in the countryside where we can do a lot of walking. We agreed on this - or rather - my wife agreed with herself that this could be good for us (he smiled and laughed a bit while saying this) (study I).

These examples show how the men experienced their partner as someone who showed an awareness toward their emotions attempting to understand how they felt. In the interview study (study III) the men expressed gratefulness to their partners’ efforts to maintain their relationships under the pressure from the disease and treatment in many ways. By gently touching Adam’s shoulder and by addressing the future in an optimistic way, his wife displayed support and care and Adam confirmed their relationship and conjugality by referring to their common lifestyle. This was also highlighted by two of the men. One man had been married for 47 years and hoped he would live long enough to celebrate his golden wedding anniversary; and another talked about how his partner had agreed to organize their daily life by what he was capable of managing.

**Conflict**

As we read Jackson, he uses the concept of conflict in two ways; 1) as potentially always present in a relationship, and 2) as an incompatibility in the structure of a social relationship, which may lead to specific disputes, challenges, ruptures and sometimes to violence (Jackson 1989,4,76; 2002,66-67). The theme conflict includes the subthemes ‘loss of strength’ and ‘sources of friction’. Conflict was experienced by the men in all three studies. Some of the men expressed that they felt a lack of understanding from
their partner, because their partner had not experienced cancer themselves, or the men felt that they themselves now had ‘a short fuse’.

**Loss of strength**

Across all three studies, we found that many of the men felt so overwhelmed by their illness and loss of vigour and energy that they found it difficult to initiate anything themselves. During an interview with Peter, a 60 year-old-man with a lymphoma in his abdomen, he told how he and his partner always had enjoyed traveling around Denmark, staying at different hotels one or two nights and going out to dine at different restaurants. But this activity that brought them joy now turned into an activity which caused friction due to his loss of strength and stamina. He said,

> We went on a trip to Odense. I was not feeling very well, but I thought I could manage. We checked in at the hotel and went out for a walk. I felt I was getting worse, so I told that to my wife. Then she said, “Oh, stop that nonsense now!”,

> But it wasn’t nonsense. Then she said that it was always her who had to call the hospital in Aalborg to ask the doctors what to do, whenever I was feeling bad. I know that. Everything is on her shoulders, and she gets so scared, immediately, when I am not feeling well. This is a good example of how our life as man and wife has become now. - We were going out to have dinner at a nice restaurant.

> We had booked a table at a restaurant and we were on our way, but then I started feeling unwell. So, - I was standing on the sidewalk and said – “I think I am going to throw up” – “Oh”, she said, ignoring what I said, and continued,

> “Come on, we have a reservation and only have to walk a few minutes more”.

> However, I could not continue. We had to go back to the hotel – I was feeling so sick – and it didn’t help much when she said, “Take it easy now” – because I did
take it easy. It was not intentionally. Now I am thinking – Holy shit, how strong I must be. I need to be the strongest of us two (study I).

Charles is a 60-year-old man with lung cancer, married to a woman 17 years younger than him with children from a previous marriage. Although Charles, like the other men, appreciated his partner’s support the friction between them increased as his decreased strength became more and more apparent,

She could not take it, she had been so supportive the entire way, but in the end my disease also had severe consequences for her and she could not manage. She began saying things like: “You look like a 90year-old man” [...] And this was when I started the last cycle of chemotherapy. Everything felt awkward and bad. Hearing that I looked like an old man was the last thing that I needed to hear.

The examples show how conflicts were present in the men’s experiences of the marital relations with their partner and how these were played out differently depending on the context. The men expressed that these increasing frictions were often caused by their decreasing strength and stamina. This also indicates that bodily strength, often associated with masculinity, when weakened, affects the men’s sense of self and their relationship with their partner.

Sources of friction

During the rehabilitation programmes (study I, II), the men often discussed some of the marital friction they had experienced. For instance, during a group session, Tony, a 60-year-old man with prostate cancer said, ‘I don’t like to say this – and I’m not sure if I’m the only one who has this problem, but I have a short fuse when it comes to my wife’.
Then, Frederic continued the discussion by saying, ‘I know what you mean. It’s so frustrating. I have never been like that before, but now I explode just like a jack-in-the-box over nothing, especially if it is my wife – but also if it is my grand-children’. During an interview with Christian, a 59-year-old man with lymphatic leukaemia, in his home, he revisited the discussion they had had at the rehabilitation centre saying, ‘I think that the relatedness between Nina and I, … I am much more aware of avoiding potential situations where conflicts, could arise - if you know what I mean, and I keep my mouth shut. Otherwise ... We are living as we did before in a way’ (study I).

During participant observation and ethnographic interviews in the three studies, we often heard the men stating that people who haven’t had a cancer disease could not really understand their worries, anxiety, fatigue and all the other side-effects that follow when living with a cancer disease. They experienced that even their partner, close relatives and friends did not really understand their condition. This perceived lack of understanding could cause friction in their marital relationship. Jens, a 54-year-old man with colon cancer phrased it in this way,

> It dawned on me after a long time, people could not understand what it was like to have cancer. Now I do not expect them to understand anymore. The only way one can understand it, is if he or she experienced having cancer themselves. I have spent a long time on this, trying to explain this to my wife.

Later in the interview, Jens reflected on a visit he and his wife had with a psychologist, he said,

> The psychologist and my wife were telling me how I should react. But they don’t know anything about it [suffering from cancer]. Certainly, they know in terms of
knowledge and facts, but because it is my body, we are talking about, they can’t understand how I feel, only I can .... Also, in relation to my wife, who is very close to me, I wanted to say, “Don’t you get it, woman”. When you are well, you cannot really understand. Fortunately, you could say (study I).

While performing participant observation during the presentation round at one of the rehabilitation programmes, Ken, a 48-year-old man with prostate cancer announced that he and his partner were going through a crisis. She wanted to help him, but he saw the help as a negative thing and felt like she fussed over him, so he did not want her to attend the rehabilitation programme with him, ‘Therefore, I am here alone, and she is attending a course at a folk high school. We need to be separated for while’. Later at a session with the sexologist, Ken said that he was not interested in being intimate with or having sex with his wife because of his erection problems, ‘This has been very hard for my wife to accept’. At the same time, he felt he was being criticized if his wife wanted to talk about their sex life. On the last day of the programme, many of the wives came to pick up their husbands. For most of the men, it was a joyful reunion. However, for Ken and his wife this was not the case. Ken’s wife stood completely alone as she awaited her husband, who was reluctant to join her (study II).

Peter’s story about his partner’s reaction to his weakness illustrates their marital friction. Conflict and friction caused by bodily weakness was also articulated by Jens, who expressed that it was a painful experience to realize that not even his wife was able to fully understand the impact of the cancer disease on his everyday life. Ken felt that the help and care that his wife gave him was too overwhelming and had the effect that he could not manage intimacy with her. These examples illustrate how incompatibility
in the structure of the marital relationship led to conflict. Furthermore, some of the men strongly perceived a lack of understanding from their partners in relation to the fact that they did not have a cancer disease.

Discussion and Conclusion

The conceptualization of cancer as ‘a couple’s disease’ (Zhou et al. 2011; Katz 2016), draws attention to social relationship. In this paper we have focused on marital relationships and explored their central place in the men’s stories about their cancer illness. Using Jackson’s phenomenological understanding of intersubjectivity as our analytic approach, we have demonstrated that marital relationships can be compassionate and conflictual at the same time. The cancer disease and the treatment thus also challenge the notion of what Gillis conceptualizes as the “perfect couple” who now must be everything to one another (Gillis 1996: 151). One reason for this is that the men, because of their illness, have changed, and their bodies and capacity performance have weakened. This collides with predominant notions of masculinity and leads to a reconfiguration of marital roles which again leads to compassion and/or conflict.

Jackson argues that compassion is an affirmation of identity (1989,4). Our findings challenge this understanding. We found that compassion should rather be understood as an affirmation of conjugality between the men and their partner. As evident in the men’s stories, which involved illustrations of how the partners enacted and wove together a strong sense of conjugality between them. In relation to the other pole, conflict, Jackson argues (ibid.,4) that conflict is a confirmation of difference. We found that conflict counteracted compassion between the couples and formed an incompatibility in the structure of their social relationship and conjugality, which led to new marital challenges and friction (ibid.,4,76; Jackson 2002,66-67). From the men’s
stories, the mismatch within their marital relationship occurred when they themselves and their partner interpreted the same situation differently. Thus, our analysis has contributed to a deeper understanding of how men with cancer and their partners are continuously negotiating their marital relationship between the poles of compassion and conflict. We have shown how compassion and conflict alternated between being in the foreground and the background throughout an ongoing, dynamic and flexible process in their marital relationship. Although we only include the men’s experiences and perspectives, it seems as if this struggle for control engage both the men and their partners in an ongoing relational work. A work which seems to be difficult both emotionally and cognitively, and where the men and probably also their partners try to perform, manage, embody and adjust their individual and common fate and future.

This struggle for balance and control to reach a dynamic equilibrium also includes negotiations of how to perform their masculinity due to their new life circumstances and subject positions. Furthermore, these negotiations take place within a cultural context that has great expectations to the bearing capacity of conjugality. The notion of a “couple’s disease” thus walk hand in hand with Gillis’ notion of the “perfect couple”. But, as we have argued, these notions must be disentangled to understand how the partners experience and manage serious illness in their relationships.

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**Ethical considerations**
The Danish Data Protection Agency has approved study I, study II and study III. All men gave oral and written informed consent in study I, II, III. It was clarified that they could withdraw from the studies at any time. An information letter accompanied the written material send to the men from the rehabilitation programmes at the Rehabilitation Centre Dallund a few weeks before the programme started.

Author contribution
Hansen wrote the first draft for this paper. Tjørnhøj-Thomsen contributed in the next drafts of the paper. Hansen and Tjørnhøj-Thomsen analysed and interpreted the empirical material together, and both revised it critically and approved the final manuscript.

Conflict of interest
The authors declare no conflict of interest, and the authors alone are responsible for the content of the manuscript.

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