

Masculinities, humour and care for penile cancer: a qualitative study

Abstract

Aim: To explore how men with penile cancer construct humour in relation to their diagnosis and treatment.

Background: Functionalist, relief and incongruity theories attempt to account for humour but there is a dearth of empirical evidence in nursing care. This is particularly so in relation to a condition like penile cancer where some nurses think that humour in their interactions with patients would be inappropriate.

Design: The study employed a participative, mixed-qualitative-methods design.

Method: Focus groups and patient-conducted interviews were both used during a one-day 'pilot workshop' in March 2011. The data were initially analysed using framework analysis. This paper explores the theme of humour in depth.

Findings: Humour helped participants make light of their condition, which meant that they could laugh about the consequences of treatment ('laughing about urination') and build rapport with health professionals ('humour with health professionals'). Nevertheless, the use of humour was less important than the treatment of their cancer ('humour discounted') and there was a fear that they would be subject to ridicule because of their condition ('fear of ridicule').

Conclusion: The findings suggest a combination of functionalist, relief and incongruity theories of humour; the emotions these men experience are contained (functionalist) and released (relief) through humorous interaction, and the potential for comedy lies in an incongruity between what is expected socially and the experiences of these men, for example around expectations that men use urinals in public toilets. Nurses should continue to use humour to build rapport with patients, should they judge this to be appropriate although they may want to avoid jokes about sexual and urinary functioning until after treatment.

Keywords; masculinities; penile cancer; penis; qualitative methods; participative; nursing; patient involvement

Summary Statement

Why is this research needed?

- Functionalist, relief and incongruity theories attempt to account for humour
- Some argue that nurses should avoid humour in relation to sex but it can help build rapport with patients
- There is a dearth of empirical evidence about humour in nursing care, particularly in relation to penile cancer

What are the key findings?

- Humour helped participants make light of their condition, which meant that they could laugh about the consequences of treatment ('laughing about urination') and build rapport with health professionals ('humour with health professionals').
- The use of humour was less important than treatment of their cancer ('humour discounted')
- There was a fear that patients would be subject to ridicule because of their condition ('fear of ridicule')

How should the findings be used to influence policy/practice/research/education?

- The findings suggests that the emotions these men experience are contained and released through humorous interaction, and the potential for comedy lies in an incongruity between what is expected socially and the experiences of these men
- Nurses should continue to use humour to build rapport with patients, should they judge this to be appropriate although they may want to avoid jokes about sexual and urinary functioning until after treatment

INTRODUCTION

As a rare condition for which treatment has potentially devastating consequences for sexual functioning, penile cancer would seem to fit into an area that some nurses say should be excluded from any attempts at humour in nursing practice (Hunt 1993). Nevertheless, research has found that men with penile cancer talk about employing humour as a coping strategy (Witty et al. 2013). While there is a great deal of opinion-based literature about humour in health care and nursing, there is a dearth of empirical research (McCreddie and Wiggins 2008). Consequently, the aim of this paper is to explore how men with penile cancer construct humour in relation to their diagnosis and treatment. This is achieved through an analysis of a humour theme from a participative, one-day workshop where men with penile cancer identified those aspects of their experiences that impacted on their quality of life and which they wanted explored in further research. Before introducing the study, we shall explore how men's health research relates to three theories of humour.

Background

The functionalist theory (Billig 2005) specifies that humour is part of social interaction rather than a discrete moment of comedy. Humour is built up through interaction and the break out of laughter is part of the enjoyment (Bergson 2008[1900]). Indeed, humour can smooth the flow of conversation (Norrick 1993), conferring a positive emotional state, which will add to the interpersonal relations between those involved (Francis *et al.* 1999). In health services, humour can facilitate empathy and the quick communication of persuasive messages (Du Pré 1998). Additionally, humour can be used by patients to voice complaints in a non-threatening way (Du Pré 1998). Despite its implicitly comedic focus, humour can be a vehicle for serious meaning (Mulkay 1988). Humour is therefore a useful resource in healthcare because it can help health professionals develop rapport while dealing with the mortality of the body. Many men appreciate the use of humour by health professionals

because they find it comforting to speak openly about their health in a 'laid-back and friendly' environment (Smith *et al.* 2008). Sharing a joke with a health professional reduces the power imbalance and makes men feel 'normal' and in a position to discuss their vulnerabilities (Oliffe and Thorne 2007). Outside the health domain, men use humour to form bonds with their companions in male-dominated settings, such as the British working class 'pub' (Williams 2009).

Relief theory is a combination of Victorian ideas about physiological release of nervous energy (Bain 1859, Billig 2005) and the Freudian conception of tendentious jokes as expressing something socially censored (Freud 2001[1905]). Combining these ideas, relief theory is a description of humour as the enjoyment of the socially taboo. For example, complaining about work to your friends and saying that you want to 'shit on your manager' isn't 'just a joke' but a way of breaking social conventions that proscribe public acts of defecation, particularly on those above us in the employment hierarchy.

Consequently, humour is a mechanism for managing tension, which can help us evade embarrassment (Goffman 1967) or avoid taking problems (too) seriously (Kelly and Dickinson 1997). Given the nature of healthcare, it is little surprise that humour is found in approximately 85% of nursing interactions (Adamle and Ludwick 2005). Humour may confer health benefits for those working in healthcare as, for example, nursing educators who make use of it have lower emotional exhaustion and higher levels of personal accomplishment (Talbot and Lunden 2000). In healthcare interactions, humour can dissipate emotion by signalling a time-out from an anxiety-provoking situation (Smith *et al.* 2008). Men can find that ill-health makes them feel vulnerable in front of other (male) health professionals and humour is one way of dealing with their vulnerability (Smith *et al.*

2008). Outside the health setting, men find that humour provides a freedom from social expectations elsewhere in their lives (Williams 2009, Nardi 1998).

Incongruity theory focuses on the cognitive aspects of humour, and particularly on a specific joke or pun (Giora 1991, Billig 2005). Humour is achieved through an incongruity between the ideas in the joke. For example, the following joke has an incongruity between the meaning of the word 'tank': there are two fish in a tank and one turns to the other and says, 'Do you know how to drive this?' (Billig 2005). The theory extends beyond the semantics of words to encompass behaviour and social norms; an incongruity between the two may well be met with laughter. This could be seen as an evolution of social standards because behaviour or ideas expressed socially are subject to the 'test of ridicule' (Shaftsbury 1999[1711]) and those that are met with laughter are identified as inappropriate and should therefore be avoided or discarded. The reason humour may be used to voice complaints in a non-threatening way (Du Pré 1998) may be because it signals that the topic of discussion is in some way incongruous with what is expected. There is one case in the limited humour and men's health literature where a man with prostate cancer thought a doctor's 'happy go lucky' way of discussing his feminisation through hormone therapy was insensitive (Chapple and Ziebland 2002). The doctor was arguably drawing on an incongruity between what it is to be a man and the effects of hormone therapy, which the patient found inappropriate. Nevertheless, there is an unclear distinction between light-hearted raillery and contemptuous ridicule. The doctor may have thought he was initiating friendly banter whereas the patient experienced it as ridicule, which highlights the importance of context, power relations and the interpretation of meaning. Discerning an acceptable balance of humour relies on social norms and the experiences of speaker, audience and subject, which means that the theory

is difficult to tease apart and apply to real life nursing situations. This might explain why there is little in nursing or men's health research that relates to incongruity theory.

THE STUDY

Aim

The aim of Patients' Experiences of Penile Cancer (PEPC; Branney et al. 2011) was to explore men's experiences of the diagnosis and treatment of penile cancer and create a patient-based information resource on the award-winning website, healthtalkonline.org (previously called the database of patients' experiences (DIPEX); Herxheimer *et al.* 2000). The primary study incorporated in-depth audio-visual narrative interviews with men from across the UK who have been diagnosed and treated for penile cancer. PEPC included a one-day pilot workshop in March 2011 that explored the quality-of-life aspects of their healthcare that men with penile cancer thought most affected them and which they would they would want exploring in the main phase of PEPC (Branney et al. under review). While humour was not a main theme of the findings, it was discussed and was particularly contentious. Consequently, the workshop provides a unique opportunity to explore patients' perspectives on humour and masculinity.

Design

The workshop employed a participative, mixed-qualitative methods design (Branney et al. under review).

Sample

When researching rare conditions, the sampling rationale is reversed; rather than aiming to recruit sufficient participants to achieve data saturation, the aim is to work out how best to use the information gathered given the limitations to recruitment (Branney et al. under review). Using a maximum variation sampling strategy (Marshall 1996), we selected participants to reflect diversity in terms of severity of diagnosis, type of treatment and age.

However we were aware that we would be limited by the variety of patients available and interested in the study. As patients often take a companion to healthcare visits, the workshop also provided opportunities for companions to engage in discussions parallel to the focus groups and interviews. We aimed to recruit 5 to 10 participants through a single UK supranetwork multidisciplinary team (a team of health professionals providing care through a geographically co-located network across institutional boundaries; National Institute for Clinical Excellence 2002), allowing the formation of two focus groups (A & B), with all participants interviewing someone from another group (A>B, or A<B).

Data Collection

Participants were divided into two focus groups, where they discussed their experiences of penile cancer and identified a list of key topics (the interview schedule) that could be used in interviews about their condition. Subsequently, participants interviewed each other using the interview schedule they created in the focus groups. Both the focus groups and interviews provided the flexibility to explore the priorities of the participants, and the interview meant that it was possible to explore the experiences of individuals in detail. The focus groups and interviews were recorded using digital audio recorders and transcribed.

Ethical Considerations

Ethical review was conducted by a body independent of the researchers (for more details, see (Branney et al. under review)). Participants chose whether they were to be identified by their first name or pseudonym.

Data Analysis

A primarily top-down thematic analysis was employed because it would allow us to focus exclusively on the topic of humour while giving us enough freedom to follow the data. At the initial coding stage, a researcher (PB) read the transcripts of the focus groups to identify, all instances where humour was a) discussed explicitly and/or b) there were signs of laughter.

Qualitative data software (Nvivo) was used to manage coded transcripts. In line with functionalist, relief and incongruity theories, humour was broadly conceived as functional (humour, laughter, 'ribbing', etc. where specified as achieving something), emotional (release of emotions) and cognitive (an incongruity between ideas and/or social expectations). The 'humour' codes were then read as a group to find similarities and differences across them. Codes were read for both their content and the interaction between those speaking. Using a word processing file (Microsoft Word), the codes were combined or 'chunked' into potential themes and then the researcher wrote notes trying to summarise each quote and describe each theme. The chunking, summarising and describing steps were repeated until the researcher felt the theme descriptions provided an adequate interpretation of the quotes.

Rigour

Rigour in the analysis was enhanced through the use of two researchers and by discussing the findings with an advisory panel of charitable representatives, clinicians, researchers and patients (Mays and Pope 2000).

RESULTS

Ten men aged 35 to 84 (see Table 1) attended the workshop with three men accompanied by their wife. Most reported that their primary treatment was a surgical excision of the glans (glansectomy) (N=6), although the sample included removal of a small part of the glans and replacement with skin from elsewhere (glans-resurfacing; N=1), radiotherapy (N=1), excision of the entire penis (total penectomy; N=1) and one where it was unknown. All described themselves as white and heterosexual; seven lived with their wife/partner and the remaining three were widowed and/or single. Four themes emerged from the analysis; laughing about urination, humour with health professionals, humour discounted and fear of ridicule.

Laughing About Urination

Urinary functioning is one aspect of their experiences of penile cancer where the men 'have to look on the positive side' and we see this enacted as participants talk and laugh about their difficulties urinating. The inability to stand up and urinate was a key part of this humour (see Extract 1), which indicated that sitting down to 'pee', particularly in public toilets that have urinals, was abnormal:

Extract 1

Alan: Some have to sit down.

Rodger: When I first...he [the urological surgeon] said 'If you don't feel like standing up, sit down'.

Alan: I sat down for about two months.

Rodger: And I found it was a lot easier to sit down and do it.

Barry: I did that for years me.

Norman: You know where it's going!

Rodger: That's right, I think at the end of the day depending on what the conditions are when you go into the toilet, whether you're in your own house or you're out, you take the preference of either sitting down or standing up.

Norman: Well if I go to the toilet now in a public toilet here or anywhere else, I always use the cubicles. There's something here that says....

Rodger: Don't stand up!

Norman: No. If I stand up I always use the cubicles. There's something psychologically saying 'It's not going to happen but something just might'.

Bernard: I always sit down, I have to sit down.

Barry: Yes.

Bernard: Because I don't know which way it's going to come out.

Laughter.

Bernard: If I stood up I might shower him at the side of me.

Alan: You spray everybody.

Bernard: I don't know which way it comes out.

In Extract 1, the participants are talking about whether they sit down or stand up when they urinate and laughter breaks out. In the discussion, urinary dysfunction is being subject to the test of ridicule, but the laughter is far from mocking. Indeed, it would be what Billig (2005) calls unlaughter – a stony silence, leaving someone to laugh alone – that would ridicule the topic. As in other parts of the focus groups, the conversation in Extract 1 moves with ease between participants as they add their personal experiences ('I found it was easier to sit down') and some confirm handling urination in a similar manner ('I did that for years'). The extract suggests an atmosphere of *bonhomie* (confirmed by Rodger in Extract 3) between the participants as the humour builds and erupts into laughter; the laughter is followed by Bernard and Alan noting that 'You spray everybody [with urine]' indicating that it is socially taboo, while suggesting an interpretation that the group are momentarily revelling in the metaphorical act (through the laughter) of urinating on each other:

Extract 2

Rodger: The thing that's surprised me today is the openness around the table. When you're on your own your mind's going and you think 'I'm not going to say anything to anybody' and here we're having a bit of a laugh.

Humour with Health Professionals

When participants talked about times during their diagnosis and treatment when humour arose, interactions with health professionals were particularly salient. Indeed, participants talked about health professionals as people who were taught to promote a positive attitude [or

at least to encourage their patients to avoid talking about the undesirable aspects of their condition (see Extract 3)]:

Extract 3

Barry: But they're taught aren't they, not to look on the negative side. Well first when I was up at [town] they never ever wanted me to talk negative. Always look on the positive side.

In terms of a positive attitude, humour was (re)constructed as something that health professionals used interactionally to ease a medical procedure or to put the patient at ease. Rodger (Extract 4) talks about the specialist penile cancer nurse jesting ('had a right card with me') about the removal of the dressing and stitches from his penis after surgery to remove the cancer. The jesting is presented as something designed to prevent thoughts about suffering ('you didn't sit there and think 'God, I'm going to suffer here') while stitches are removed from the penis. There were times when patient-initiated humour went unreciprocated, which added a serious tone to the interaction. Barry talked about joking with a surgeon prior to surgery about having the 'full blown job... a sex change' and says that she responded with, 'We don't look on the negative side':

Extract 4

Rodger: Well she [the specialist penile cancer nurse] had a right card with me because when we were having the stitches out she was saying 'It might hurt' I said 'Okay'. She was pulling away and we were having a bit of a joke and a laugh, she said 'I haven't got a bad job really you know. It's not every day you see a man's penis as part of the job. It's not a bad perk is it?' That sort of eased the situation away.

...

And the thing that she did was actually put you at ease. She were straight, she said 'This might hurt' and certain things like that. At the end of the day, the other thing she

said was 'He [the urological surgeon] does a very good job but the only trouble is he stitches it on the inside and on the outside as well. It's a hell of a job to get the dressing off without hurting' but she's told you, you didn't sit there and think 'God, I'm going to suffer here'. The joke was 'It's not every day you see a penis, I've got a good perk to my job haven't I?'

Participants talked of the interactions with health professionals as having an emotional effect. It is through these encounters that men could 'look on the lighter side'. Nevertheless, participants talked about each patient being different. In Extract 5, Norman talks about patient and health professional relationships with a metaphor for a physiological reaction where loved ones are attracted to one another ('get the chemistry right') highlighting the emotions invested in the relationship:

Extract 5

Barry: What you're going to do this afternoon in my opinion is what we've just done now. We've all talked about, you know like you're getting interviewed by your doctor or it'll be like when I said to Mr [surname], when he told me he was cutting me at the base (inaudible). He said 'Well put it this way, you'll never stand up and pee at a football match' (inaudible). That was him jesting with me...

Rodger: That's the lighter side of it isn't it?

Alan: You do, yes.

Barry: To like put you at ease but there again it all depends on how you are as an individual.

Norman: Of course, yes.

Rodger: At the end of the day you know how to be...

Norman: You've got to get the chemistry right between the two of you.

Barry: I mean some can just sit on the edge of the bed and not say anything. But with me I've always been a bit of a nobblerⁱ and everything and I think with being like that with the consultant he could banter with me then. When you put a bit of a lighter side on it, it just made you feel a little bit better.

Humour Discounted

Although the participants identified how humour can be useful to diffuse and ease difficult situations, participants were also critical of the use of humour in relation to their condition, particularly to their diagnosis and the period before surgery. Indeed, hearing that their condition is 'treatable' does much for their emotional response to their diagnosis. If we take 'looking on the lighter and brighter side' as a metaphor of weight and redemption, then Norman and Bernard (Extract 6) illustrate this in their response to hearing about an effective treatment ('Takes a lot of weight off your shoulders') even if one response is modified ('*I didn't exactly walk out on air*', emphasis added), perhaps because of the consequences of surgery:

Extract 6

Rodger: But the thing is, when you first go in, depending on what the situation is they turn round and they say 'It's treatable'. That's the ...more than banter....it doesn't matter whether it's option 1 or 2 or 3, it's treatable and that's what puts you at ease.

Norman: Takes a lot of weight off your shoulders.

Bernard: It does. Mr [surname] said that to me 'It's treatable' and I didn't exactly walk out on air but I felt a damn sight better.

Given the weight placed on to 'staying positive', the critiques of humour are carefully managed. This can be seen in Extract 7 where Alan uses a linguistic discounter ('but') to highlight that his positive assessment of humour ('we've all been light-hearted and good-humoured') is less important than how he felt on his way into hospital. Note that Alan uses

metaphors of excretion ('crapping myself' and 'worried sick'), which can be interpreted as highlighting the excess of his emotions as if they were leaving his body. While humour may have helped Alan to discuss his experiences in the focus group and interview, he suggests that he would have found its use inappropriate on the day of his operation:

Extract 7

Alan: I think we've all been light-hearted and good-humoured about it but we must remember that personally when I went into hospital the day of the operation I was crapping myself. I was worried sick.

In the participant-conducted interviews, the question around humour ('Tell me about times that made you laugh') caused some difficulties for Norman and Alan (Extract 8). While Norman does respond to the question at length and talks of sharing his experiences with other men on the ward, he continually discounts its relevance ('I can't think of any time that made me laugh', 'It's a very strange question', 'But the illness and the diagnosis and the operation, none of those made me laugh'). While signalling that humour is inappropriate, Alan engages in what Schegloff, Jefferson and Sacks (1977) call interactional 'self-repair' to maintain communication. Furthermore, Alan highlights that humour only has a place after treatment, with fellow patients who were going through similar situations. Interestingly, Alan doesn't mention health professionals in Extract 8, which suggests he may have found it inappropriate if humour was used by somebody who could not empathise with his experience:

Extract 8

Norman: Can you tell me about a time that made you laugh?

Alan: I can't think of any time that made me laugh! I think that the times that made me laugh really were after the operation. It's a very strange question to ask me! I went for the operation at [hospital] of course in July 2006 and I was in hospital for a week and I shared a ward with nine men – we were ten men – nine were prostate cancer

patients and I was the only penile cancer patient. It's quite remarkable really because although we were all rather poorly we shared each other's experience and we made the best of it and that was the time when I had a laugh. But the illness and the diagnosis and the operation, none of those made me laugh. I was glad to *get all* those over and done with.

Fear of Ridicule

Participants talked about a fear that they would, because of the location of their cancer and/or the consequences of treatment, be the subject of ridicule. In Extract 10, Bernard describes the activities of ridicule and uses the phrase 'lot of' twice to illustrate that the fear is about a constant, on-going process rather than a one-off instance. Nevertheless, Bernard says that because he 'wasn't bothered who knew' and that 'People knew that I had it', he wasn't ashamed. In their talk, the fear of ridicule is inter-subjective because it relies on what the subject imagines of the other and how the subject responds as a consequence:

Extract 9

Bernard: Jokes, innuendos, lot of talking, lot of mickey taking and you'll never live it down. People knew that I had it, I wasn't bothered who knew about it because they knew that I'd suffered down below all that time, so it wasn't a shame on me or my wife, they knew what it was.

Male dominated contexts were central to the fear of ridicule. Alan had said that he told 'everybody' about his condition but when the participants discussed people at work; he explained that he had not told his colleagues in a factory. While some types of factories, such as textiles, have and are largely populated by women, Alan is talking about an engineering company that he says predominantly employs men. These men are a 'different breed altogether', which explains how they can be differentiated from 'telling everyone' while indicating a metaphor of a different species of mammal lacking the ability to sympathise.

Bernard's use of the British colloquialism for ridicule is apt given the potential difficulties with urination post-treatment; 'take the piss out of you':

Extract 10

Alan: I used to work in a factory with lots of men and I think I would have been scared of it getting out then because men in a factory are a different breed altogether.

Bernard: In other words they'd have just done nothing but take the piss out of you all day.

Barry: In more ways than one.

General agreement.

Alan: It's cruel.

DISCUSSION

The aim of this paper was to explore how men construct humour in relation to their diagnosis and treatment for penile cancer. Using a participative, mixed-qualitative-methods design, the study found four themes in relation to humour; laughing about urination, humour with health professionals, humour discounted and fear of ridicule.

Williams (2009) found that men talked about using humour to form bonds with companions, although the use of one-on-one interviews meant that he was unable to observe this directly. In the current study, the way talk in the focus groups moved easily and participants added to, paraphrased and confirmed what each other said is indicative of an atmosphere of *bonhomie* and companionship. While the focus of the functionalist theory of humour is on social interaction, a key aspect of the theory in nursing care is that emotions are managed through these interactions (Francis *et al.* 1999) and that the health professionals are seen as 'normal', and therefore someone with whom patients can discuss their vulnerabilities (Olliffe and Thorne 2007). The metaphors of bodily excess suggest that humour, particularly with health

professionals, helps to contain emotions that may be experienced as physically exceeding the bodily boundaries.

In 'laughing about urination' it is possible to suggest that what we observe in the data is some sort of social release of emotion which is achieved through conversation. That is, the participants are laughing about the changes in the way they urinate as a consequence of treatment, and this laughter is a release of the emotions about such difficulties (potentially achieved through the formation of an in-group their experiences are normalised). The metaphors of excess do suggest certain releases that are socially unacceptable ('crapping myself') and therefore need containing. In this context, laughter potentially provides a mechanism allowing the releasing of emotions in an acceptable way. An alternative explanation is that it is humour which builds as the participants talked of their difficulties when urinating, which then leads to the release of laughter. It may be that the laughter is a relief from the difficulties they were discussing through which they can have positive experiences in relation to their condition. This would suggest a combination of functionalist and relief theory; that emotions are both contained and released through humorous social interaction.

That the participants joked and laughed about the ways they urinated after treatment signals and reinforces an interpretation that the way they urinate is in some way abnormal. The humour relies on a social incongruity between how they urinate and what is expected. In the examples given, standing up to urinate and using urinals in public facilities are central. In the theme about the fear of ridicule, the risk therefore is that they will be the subject of humour because they fail to live up to expectations about urination. That the participants talked about the fear that others could be cruel shows both that these are emotional experiences and that

they are inter-subjective (because they are imagining what others will think of them). In the theme of 'humour discounted', the risk relates to an incongruity between the seriousness of their condition and the silliness of things about which we can laugh. Rather than choosing between functionalist, relief and incongruity theories of humour, this paper suggests a combination; the potential for comedy and ridicule lies in an incongruity between what is expected socially. The emotions these men experience as a consequence of the incongruity are contained and released through humorous interaction.

Limitations

This study recruited a maximum variation sample to ensure that the widest possible range of experiences were included. Ethnic and sexual diversity was limited and none of the participants had undergone laser therapy (one of the least invasive forms of treatment that is used for early stage disease). Further research could explore humour about the diagnosis and treatment of penile cancer with wider groups of men.

The one-day workshop model used in this study was designed to allow a short but intense period of involvement in the development of research. Participants interviewed each other and it is possible that they lacked the expertise of an experienced researcher. The workshop could be extended over a longer period to allow for the development of participant's interviewing skills. This long-term involvement is evident in the Macmillan Listening Study on cancer research priorities where people with cancer collaborated with researchers to design and facilitate discussion groups (Corner *et al.* 2007). Nevertheless, the point of a one-day model is to open up patient involvement for those lacking the confidence, time, or skills necessary for engagement over the duration of a study. What this study demonstrates is that the one-day model was sufficient for men with penile cancer to laugh together and explore

intimate emotions, such as fear of ridicule. Consequently, the one-day workshop model could be one part of a strategy for patient and public involvement.

CONCLUSION

While some argue that there are 'no-go' topics for humour in nursing care, this research both supports and contradicts such arguments. The use of humour could discount the seriousness of penile cancer, and men fear that because of the location of their tumour or the consequences of treatment they could become the subject of ridicule. Nevertheless, humour can help men to stay positive and they can even laugh with each other and with health professionals about the consequences of their treatment. Nurses should continue to use humour to build rapport with patients although they may want to avoid jokes about sexual and urinary functioning until after treatment.

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Table 1: Participant Characteristics

Name/Pseudonym	Age Group	Relationship status
Group A		
Alan	35-44	Married
Rodger	55-64	Married
Norman	75-84	Married
Barry	65-74	Single
Bernard	75-84	Married
Group B		
Big D	55-64	Married
Jerry	65-74	Single
John E	55-59	Single
Frank	75-84	Single
Tom	55-64	Married

ⁱ Not to be confused with ‘nobler’, we transcribed this Northern English term with two b's as it seems somewhat similar to the meaning of ‘nobble’ as achieving something through devious means. Our interpretation is that ‘a bit of a nobbler’ is someone who is persistently joking, achieving interaction through humour that is inserted surreptitiously.