

Surviving Testicular Cancer

The Lebanese Lived Experience

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Background: Testicular cancer is thought to have a great impact on its survivors, yet there has been limited literature on the topic globally and no literature on the topic in Lebanon and the Arab region.

Objective: The purpose of this study was to explore the lived experience of Lebanese testicular cancer survivors and gain an in-depth understanding of the psychosexual aspect of their experience.

Methods: A hermeneutic phenomenological approach with semistructured digitally recorded interviews and observational field notes was utilized. A purposive sample of Lebanese testicular cancer survivors, aged between 18 and 50 years, in remission for at least 3 years, and willing to share personal information was recruited. Interviews were transcribed verbatim in Arabic. Data saturation was achieved at the seventh interview; a total of eight informants were recruited. The opening question was, "Tell me about your life since you got treated for testicular cancer," and was followed by probing questions. Two to three weeks after the initial interview, informants were called to validate the investigators' primary analysis.

Results: Six core themes emerged: cancer perception in the Lebanese culture; "do not show, do not tell"; cancer experience is a turning point; fertility, manhood, and relationships; coping with cancer; and preserved aspects of life.

Discussion: The findings provide an in-depth understanding of the experience of Lebanese testicular cancer survivors with a focus on the psychosexual aspect of this experience. The results suggest the need to educate patients about testicular cancer and its effect on their fertility.

Key Words: cancer survivors • Lebanon • phenomenology • psychosexual • testicular cancer

Reproductive malignancies, though not the most common types of cancer in men, may have a great impact on their lives. Testicular cancer (TC) is the most common cancer type in young men, affecting 211,209 men in the United States (National Cancer Institute, 2013). In Lebanon, according to the latest cancer registry, TC accounts for 2.2% of cancer cases among men. Of those with TC, 21% are aged between 25 and 54 years and 4.1% are younger than 25 years (Salim, Adib, & Daniel, 2003). Although the life expectancy of TC survivors worldwide is similar to that of the healthy male population, many TC survivors might face problems secondary to cancer, its treatment, or both (Dahl, Mykletun, & Fosså, 2005).

Lebanon is an Arab country located in the Middle Eastern region with 4.3 million inhabitants (The World Bank, 2013). Generally speaking, the Lebanese perceive cancer as a debilitating illness that leads to suffering and eventually a painful death (Doumit, Huijjer, & Kelley, 2007). To present, no studies addressed the lived experience of TC survivors in Lebanon.

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Globally, the literature on TC survivors is limited. Most of the studies conducted about TC survivors are quantitative and address quality of life (QOL) with the majority conducted in Europe (Huddart et al., 2005; Joly et al., 2002; Osmańska, Borkowska, & Makarewicz, 2010; Rossen, Pedersen, Zachariae, & von der Maase, 2009; Skoogh, 2012; Vidrine et al., 2010). QOL questionnaires may cover some aspects of the experience of TC survivors but do not describe it thoroughly. In addition, no disease-specific QOL instrument for TC survivors has been developed yet (Dahl et al., 2005). The literature on TC lacks data regarding the influence of pretreatment issues, such as employment status, economic concerns, mental disorders, sexual and relational difficulties, and preexisting comorbidities on adaptation after treatment (Dahl et al., 2005).

Compared to the healthy male population, many French TC survivors were found to report a decrease in their sexual enjoyment, decreased desire, infertility, and difficulties borrowing specimens from sperm banks (Joly et al., 2002). Furthermore, American cancer survivors who were infertile reported anxiety about dating, tension, and fear from rejection in intimate relationships (Nieman et al., 2006). In comparison to healthy men, Danish TC patients who received chemotherapy and underwent retroperitoneal lymph node dissection reported more physical symptoms and sexual dysfunction (Rossen et al., 2009; Rossen, Pedersen, Zachariae, & von der Maase, 2012). Chemotherapy was also found to cause limited physical and social functioning

as well as fatigue in a sample of American and Dutch TC survivors (Vidrine et al., 2010). It was also found to lower testosterone levels, which increased the risk of infertility in a sample of British TC survivors (Huddart et al., 2005). Moreover, chemotherapy caused higher levels of anxiety, depression, and aggression in a sample of Polish TC survivors (Osmańska et al., 2010). Skoogh (2012) found that Swedish TC survivors who received chemotherapy reported language difficulties and disturbed body image secondary to the excision of their affected testicle. Several Norwegian TC survivors displayed fear from cancer recurrence, which was found to be positively correlated with mental distress, chronic fatigue, and anxiety (Fosså, Dahl, & Loge, 2003; Skaali et al., 2009).

Only two qualitative studies about TC survivors appear in the literature (Brodsky, 1995, 1999); both were conducted in the United States. Using a qualitative descriptive research design, Brodsky (1995) studied the views of TC survivors about the impact of the disease on their lives. TC was found to affect the informants' "identification self, interpersonal self, body self, and achieving self" (Brodsky, 1995, p. 83). Residual physical effects of the disease affected some of the informants' relationships with others, whereas others reported that TC was an opportunity for them to achieve personal and professional growth (Brodsky, 1995). Brodsky (1999) later explored the experience of young men who underwent treatment for TC using an ethnographic research design. The following themes were identified: "feelings of shock, disbelief, and despair; physical and emotional trauma; and a renewed appreciation of life" (Brodsky, 1999, p. 65).

In Lebanon, only few studies offer an understanding of what it means to live with cancer (Doumit et al., 2007; Doumit, Huijjer, Kelley, Saghir, & Nassar, 2010); none address the experience of TC survivors. Although the impact of cancer and its treatment on the TC survivors' relationship was apparent in the studies by Brodsky (1995, 1999), no emphasis was put on the psychosexual aspect of their experience. In her ethnographic study about infertile Lebanese and Egyptian men, Inhom (2004) reported a sense of emasculation, secondary to infertility and assisted reproductive technologies. These findings suggest that exploring this aspect in Lebanese TC survivors is worthwhile. In brief, the literature lacks qualitative studies that offer an in-depth exploration of the lived experience of TC survivors, which leaves healthcare providers with little information about the needs of this population and TC survivors with several unanswered questions. Nurses, in particular, play a key role in the care of TC survivors in various stages of their illness, yet they have little guidance on how to address their concerns—especially those pertaining to their psychosexual health. The purpose of this study was to explore the lived experience of Lebanese TC survivors and gain an in-depth understanding of the psychosexual aspect of their experiences.

METHODS

Design

The hermeneutic phenomenological approach was used to explore the lived experience of Lebanese TC survivors and gain

an in-depth understanding of the psychosexual aspect of their experiences. On the basis of the work of Martin Heidegger, this research approach is focused on the subjective experiences of individuals (Finlay, 2009). It aims at exploring the world as experienced by the individuals themselves through the use of their own life stories (Kafle, 2011). This approach was also selected to bridge the gap between what is known about the lived experience of TC survivors in the West and what is not known about it in the wider Arab region, specifically in Lebanon (Streubert & Carpenter, 1999).

Sample and Setting

A nonprobability purposive sampling was used. Those who were included in the study were residents of Lebanon who hold the Lebanese nationality, aged between 18 and 50 years, free from TC for a minimum of 3 years, and willing to share personal information and participate in the study. Those who did not consent to digitally recording the interview were excluded. Residents of Lebanon who do not hold the Lebanese nationality were also excluded because it was believed that the informants' cultural background may play a key role in shaping their experiences. In addition, the approval of the institutional review board at the American University of Beirut was obtained. Informants were recruited from the clinic of an oncologist and the clinic of a urologist.

Procedure

The clinic nurses, who were both women, identified informants who fit the inclusion criteria from the clinic records and called potential informants by phone using a standardized script in Arabic to tell them about the study. Nurses then asked those interested to participate to contact the primary investigator (PI) by phone. It is worth noting that the PI was a young man, which was thought to have influenced the research positively. On the basis of anecdotal evidence from the experience with cancer patients, it was presumed that men in this study would feel more open to thoroughly discuss their experiences with a male rather than a female researcher. In an attempt to enhance transferability of data, a heterogeneous sample in terms of age, marital and socioeconomic status, time since diagnosis, and type of treatment received was selected. Twenty-three TC survivors were approached, of whom eight were recruited into the study. The remainder were not recruited either because they changed their phone numbers, were living abroad, or refused to openly discuss their experiences.

Data were collected by the PI between March 2012 and February 2013 using a combination of face-to-face digitally recorded interviews and observational field notes. At the beginning of each interview, the PI obtained an informed consent. Given the sensitive nature of the study, informants were asked to tick a box if they agree to participate in the study and another box if they consent to digitally recording the interview instead of signing their name. Interviews were conducted in a place and time chosen by each informant. Two informants chose to conduct

the interview in their home, two chose to be interviewed at work, and three informants chose the PI's office to talk about their experience. One informant chose to have the interview conducted in the PI's car because he was busy and could not find a private place to share his experience. Anonymity was promised through the use of fictitious names while reporting study findings. Informants were notified that they may be uncomfortable with some of the sensitive questions. The plan was to provide those who display psychological distress during the interview with the contact information of a clinical psychologist. Nevertheless, none of the informants needed to be referred to counseling.

Before each interview, demographic data (age, marital status, highest level of education, and current occupation) were collected in writing in Arabic. Interviews were conducted by the PI in Arabic. Most interviews lasted around 40 minutes and started with an icebreaker: "How are you doing these days? Are you working? Studying? How is your overall health?" Next, each informant was asked, "Tell me about your life since you got diagnosed with TC." Probing was utilized to enrich the data and elicit more explanation of the phenomenon of interest. Probing questions were, "What changed in your life since the diagnosis/treatment? How do you see yourself after you got treated? How was your sexual life affected after you got treated for TC? What about your personal relationships? What about your sexual performance? What about your fertility? Were there any problems?" Before each interview, informants were told about field notes taking. The informants' emotional reactions were documented by the PI immediately after each encounter to minimize distraction. Each interview was transcribed verbatim and then summarized. Two to three weeks after the initial interview, the PI contacted the informants by phone to arrange a 20-minute phone interview during which the summary of the transcripts was read thoroughly. Next, informants were asked to critically evaluate the summary and provide their feedback. The purpose of this interview was to validate whether the PI's summaries reflected the informants' experiences. All informants agreed on the summaries; thus, no modifications were made.

Data Analysis

Fictitious names were used to ensure anonymity. Data collection and analysis took place concurrently to accommodate new insights. Conventional content analysis was used to analyze both verbal and nonverbal data. This approach is known to allow new insights to emerge from the data and is best used when little is known about a certain phenomenon (Hsieh & Shannon, 2005). The PI employed bracketing through keeping his preconceived ideas about the experience in check during each interview. Codes were identified and then clustered, and a category scheme was developed to organize the data obtained. Transcribed data were read with a fresh eye, and underlying clusters of concepts were identified. Following the development of a category scheme, the data were reread thoroughly, and themes that connect the various categories were identified. Manual methods were used

during analysis. Each category was translated to English, typed, printed, and color coded for differentiation. The categories were then clustered and synthesized into themes. Every core theme that flows from the categorical clustering of data collected was supported by excerpts from the informants to underline the influence of the phenomenon on their lives. Findings from the field notes were used to enrich the data through illustrating the reaction of the informants to the investigator's inquiries. Accuracy of translation from Arabic to English as well as dependability were ensured by having the PI and a coinvestigator independently read all eight transcripts, analyze them, identify the underlying codes, translate them to English, and then compare findings. No discrepancies were found between the Arabic and the English versions of the codes. In addition, there were no disagreements regarding the analyzed data. Data saturation was achieved after the seventh interview. An eighth interview was conducted to verify data saturation.

RESULTS

The age of informants ranged from 32 to 50 years with a mean age of 41 years. On average, they were interviewed 6 years after completion of treatment. Six informants were married, and two were single. Their educational backgrounds ranged from elementary to university education. The sample included businessmen, managers, skilled laborers, an engineer, and a bank employee. Five informants underwent excision of one of the testes (orchiectomy) and chemotherapy, two underwent orchiectomy alone, and one underwent orchiectomy together with radiation therapy. Six core themes emerged: (a) cancer perception in the Lebanese culture; (b) "do not show, do not tell"; (c) cancer experience is a turning point; (d) fertility, manhood, and relationships; (e) coping with cancer; and (f) preserved aspects of life.

Cancer Perception in the Lebanese Culture

While telling their stories, informants provided accounts that reflected the prevailing societal beliefs about cancer. The word "cancer" had a great impact on many of the informants and their families. Tarek's preexisting notion about cancer made him link it to suffering: "I know that the cancer patient will suffer... I was still wondering what is happening to me, then that's it; I have cancer." Adnan linked cancer to death. He said, "You reach a stage when you say that it's over; I am gone because people think that cancer is fatal."

Some informants expressed a certain degree of distress because of the way people perceived them. Bassem expressed his frustration from people's pity: "You see people saying sorry Bassem, I tell them, 'why are you sad?' I am not sad, why are you bowing your heads? Are you feeling sorry for me? Raise your heads; I am walking with my head held high."

"Do Not Show, Do Not Tell"

The initial reaction for many informants was not to tell anyone about their diagnosis. Tarek said, "My sister doesn't know that I

got sick with cancer...she still doesn't know. I took chemotherapy and lost my hair. . .I didn't want anyone to see me and go tell my sister." Khaleel tried several scenarios to hide his diagnosis: "My biggest worry was that I don't want my parents to know about the subject. . .I told them that I have to undergo a surgery because I have a kidney stone. . .I took chemotherapy and told them that I am losing my hair while showering. . . ." Khaleel shed a few tears while talking about this aspect of his experience.

Most informants were selective in choosing who to tell about their diagnosis to avoid becoming the talk of the town. Dani concealed his diagnosis from many people in his entourage. He said, "I didn't want to tell anyone. . .especially here in our village, if they knew that I was sick, the news would spread in the whole village. Thank God, nobody knows."

Cancer Experience Is a Turning Point

Most informants reported not having heard about TC before they were affected by it. Many discovered the disease accidentally. Therefore, going through the ordeal of the illness and its treatment and then proceeding to their usual lives created a turning point for them.

The negative influence of cancer and its treatment on the overall health was noted in responses of many informants, especially those who received chemotherapy and radiotherapy. After chemotherapy, Younes' creatinine increased. He said, "After surgery I was supposed to take six cycles of chemo but I took five because my creatinine increased." Tarek talked about a tendency toward fatigue and physical exhaustion: "After chemo, there was a time I used to play football but then I felt that my knees cannot hold me anymore so I stopped." Bassem related chemotherapy to his inability to conceive: "Chemotherapy took my fertility away. . .I can't have kids anymore." Many informants expressed their fear from cancer recurrence. Tarek said, "Up until now, from the time I do a CT scan. . .and the alpha fetoprotein [alpha-fetoprotein], I feel that I am in a different world." This is a Lebanese expression that denotes anxiety. Adnan's worry from recurrence pushed him to do frequent tests: "The doctor told me to do them [follow-up tests] every six months, but I am doing them every three months for reassurance."

On the other hand, for some informants, cancer was seen as an opportunity to make positive changes in their lives. Wassim said, "My life changed, it became healthy. I stopped smoking and stopped alcohol. . .I followed a totally different diet." Many informants perceived that defeating cancer paved the way to a new start. Bassem said, "As long as I have a good health and as long as my outlook on life is right, I want to move forward and not take a step back. . .I forgot about the past. . .I have to evolve and grow; I can't remain the same."

Many informants perceived that defeating cancer paved the way to a new start.

Fertility, Manhood, and Relationships

A number of informants referred to cancer and its treatment as the two main causative factors of their infertility. Fertility served as a determinant of their identity as men and partners. Khaleel felt pressured to marry being the only son in the family: "I was 40 years old, I was not young anymore. In Lebanon it is unusual for an only son to stay single till 40. Usually the only son marries early." The importance for a man to be able to conceive also shaped how Khaleel perceived himself: "An infertile man. . . the way people perceive him makes him want to beat himself. . . I suffered. . .a man is about sex and kids to a certain extent."

Adnan's fertility status did not affect his relationship with his wife. Although he was concerned about his fertility, his wife told him: "I don't care; I just want you to get better." Dani, who was single at the time of diagnosis, had concerns about being rejected: "If I want to propose to a girl and she would know that I have only one testicle, she might reject me."

Coping With Cancer

Informants relayed various means that helped them cope with the ordeal of their illness. Most informants identified their faith in God as the primary reason for overcoming cancer and enduring its treatment. Wassim's faith in God helped him surmount the infertility that resulted from cancer and its treatment. He said cheerfully, "The faith I have in God and his prophets is extraordinary. . .I started with the treatment [to conceive], I went to visit the shrine of a prophet, came back, and underwent the procedure and now my wife is pregnant!" Moreover, fatalism was imbedded in many of the informants' responses. Tarek said: "When the Creator wants to do something, he just does it, that's the Creator's will; I can do nothing about it."

Most of the informants felt supported by their partners, especially those who were married. Wassim said, "The good thing about her [his wife] is that she stood by my side. . .hand in hand, we were able to overcome this bad stage and start a new life." Despite learning of his infertility, Khaleel's wife accepted it and still wanted to marry him: "When it [assisted reproduction] didn't work, we used to get upset, both of us, at times she used to calm me down."

Many informants reiterated how the supportive approach of their physician and acquaintances who happened to be health-care professionals was instrumental in raising their hope in dealing with cancer. One of the factors that helped Bassem endure his treatment was his relationship with his oncologist: "He gave me self-confidence. . .he was fighting the disease with me." Fouad felt comfortable talking about his diagnosis with his brother-in-law who happens to be a physician: "I was scared. . .what helped me is that my brother-in-law is a doctor. . .it was somehow comforting."

Knowing men who were living with one testicle helped some informants cope with their condition. Younes said, "I know someone who has been living with one testicle for a long time. . .he has kids. That's another factor that helped me cope."

Some informants sought information about cancer and its prognosis in order to cope with their diagnosis. Tarek said,

"I used the Internet and saw that there is 98 to 100 percent cure rate. . .that's how I calmed myself." Others opted not to seek information about the negative consequences of their illness. Nervousness was noted in Bassem's voice as he said, "My doctor told me to do a sperm count, I refused. . .the result would affect my psychological well-being. . ."

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Preserved Aspects of Life

All informants started the interview by stating that their lives are good and they are currently in good health. Most of them were able to preserve elements of their physical and psychological health. The physical tiredness from cancer and its treatment was temporary; none of the informants stopped working because of their illness. When asked whether chemotherapy annoyed him, Tarek said, "When I first took chemo I did not feel anything. . .the third day after chemo I used to go to work. . .I got nauseous a few times but everything was tolerated."

Most of the informants denied a decline in their sexual performance. An example is Bassem who laughed and said, "My sexual performance was very good; I am still like before. We used to laugh, my wife and I, and I used to tell her chemo is improving my performance." Only a few informants reported lack of sexual contact with their partner at the time of diagnosis and during treatment. Adnan said, "Sex is a kind of pleasure; during the first stage you will definitely not think about it. . .but after I was done, everything got back to normal."

Most of the informants did not report changes in their body image after orchiectomy. Younes said, "it's all about the looks, and the looks don't really matter to me." Adnan reported mild changes in his body images. He laughed and said, "At first, you notice changes in your clothes while sitting, and you lose the balance, they [genitals] become in one place. . .this bothered me in the beginning but now it's normal just like anything else."

None of the informants had his resected testicle replaced by prosthesis. Adnan said, "I did not put prosthesis; I don't want this stuff to enter my body. It might cause me problems on the long run." Wassim believed that an artificial testicle does not define manhood: "This [prosthesis] is not what will make me a man. I don't feel anything is missing."

DISCUSSION

The study findings are congruent with those of similar studies that address long-term TC survivorship. For many informants, culture played a key role in defining cancer as a source of suffering. Furthermore, several informants displayed an aversion to the pitiful reactions people had toward them. Both findings are consistent with those of two studies conducted by Doumit et al. (2007, 2010). The first study was about the lived experience

of Lebanese cancer patients receiving palliative care, and the other was about Lebanese women living with breast cancer. The association of cancer with suffering and death is not limited to the Lebanese culture. However, in this study, many informants never heard of TC, discovered it accidentally, and were not aware of the curability of their disease, which explains the anguish they anticipated when they learned of their diagnoses.

Social Support

Although not verbalized explicitly, a number of informants chose not to benefit from the social support that is a characteristic of the Lebanese culture at the time they needed it the most. They opted to conceal their diagnosis from their family members either to protect them from the bad news, to protect themselves from their family members' reaction to the news, or to avoid becoming the talk of the town. Furthermore, in an attempt to keep their cancer a secret, many informants created several scenarios that also served as another source of anxiety and distress. These findings are consistent with those of Doumit et al. (2007), whereby several informants identified themselves as a source of worry to their loved ones. On the other hand, worries and concerns about families were not found in the studies by Brodsky (1995, 1999). Informants from these studies focused primarily on their own experiences rather than that of their families'. One reason could be the individualistic nature of the Western culture versus the collectivist nature of the Middle Eastern culture in which the family is highly valued.

Cancer Experience and Fertility

The cancer experience as a whole served as either a negative or positive turning point in the lives of many informants. Positive changes perceived by Lebanese TC survivors are similar to those identified in the studies by Brodsky (1995, 1999), whereby informants reported a renewed appreciation of life and perceived the cancer experience as an opportunity for growth. Lebanese TC survivors seemed constantly concerned about cancer recurrence; for some, it was an obsession. In their study on TC and fear from cancer recurrence, Skaali et al. (2009) similarly found that 31% of TC survivors displayed fear from recurrence.

Fertility was identified among the most sensitive topics during cancer aftermath, especially that most of our informants were looking forward to starting a family at the time of diagnosis. In Lebanon, men who are only sons are usually expected to marry and conceive because they convey the family name to the next generation. This was identified as a source of distress for certain informants. In addition, the concern of parents regarding their sons' ability to conceive served as another stressor. In contrast, American informants did not express their families' concerns about their fertility in the studies by Brodsky (1995, 1999). These findings again highlight the importance the Lebanese culture attaches to fertility and the involvement of one's family in these matters. Inhorn (2004) found that "Infertility is not only a stigmatizing and potentially emasculating condition for Middle Eastern

men, but the technologies designed to overcome it add additional layers of stigma and cultural complexity.” (p. 163). Although none of the Lebanese TC survivors expressed a sense of emasculation, some believed that, when fertility is affected, masculinity becomes at stake. In addition, many informants, especially those who received chemotherapy, identified cancer treatment as the primary reason for their fertility problems and the decline in their capacity to endure physical effort. These findings concur with those by Rossen et al. (2009), who found that patients who receive chemotherapy tend to report more physical symptoms in comparison to healthy subjects, and Fosså et al. (2003), who found that chronic fatigue among TC survivors exceeds that of the general population. In addition, Huddart et al. (2005) found that failure to conceive was noted among those who received chemotherapy. Furthermore, tension and rejection in intimate relations were identified among the psychosocial concerns cancer survivors have (Nieman et al., 2006). Data from the study on the experience of Lebanese TC survivors agree with the findings of Nieman et al. (2006), especially that many TC survivors regarded their fertility status as an important predictor of the success or failure of their relationships.

Coping

Faith in God was an essential coping strategy used by Lebanese TC survivors and is at the core of the Lebanese cultural beliefs in response to health and illness. Similarly, reliance on God and divinity was identified by Doumit et al. (2007) as a core theme in the study about the lived experience of Lebanese cancer patients receiving palliative care. Most of the informants in relationships stated that the whole cancer experience brought them closer to their partners and strengthened the bond between them. Similar findings were identified in the study by Brodsky (1995), where informants verbalized their appreciation of those who were emotionally involved in their care. Ancillary coping strategies that appeared exclusively in this study and were poorly explored in the literature were seeking information about cancer, feeling supported by healthcare professionals, and knowing someone with one testicle.

Most of our informants were young, educated, and have access to resources that allowed them to learn about their illness and subsequently cope with it. Furthermore, the informants' physicians played a vital role in dissipating the anxiety associated with cancer and its treatment. In the Lebanese culture, physicians often give their personal mobile phone numbers to their patients and answer their concerns outside the confines of the clinic. This aspect of care serves as a source of social support. Moreover, having a nurse or a physician in their entourage helped many informants cope, as they felt that there is always someone they can revert to. In addition, seeing other men living with one testicle and leading normal lives was reassuring to some of the informants and gave them hope to build a family and advance in their lives.

Interestingly, some informants refused to know whether they can conceive or not. It is believed that this coping strategy was

sought because of its protective effect. Unexpectedly, similar findings were presented by Brodsky (1995), who stated, “Interestingly, a few had chosen to remain ignorant, yet were curious about their fertility status” (p. 88). Certain life aspects were preserved after cancer and its treatment. These aspects include functional health, sexual performance, and body image. Following cancer, many informants seemed determined and looked forward to grow. Their outlooks on their professional lives shifted to the better. These findings are congruent with those of Brodsky (1995), whereby many informants perceived professional growth as a means for self-achievement and prosperity.

All study informants denied a decline in their sexual performances. Those who adopted a healthy lifestyle after cancer and its treatment reported an improvement in their sexual performances. Sexual enjoyment was absent for many informants during cancer and its treatment. Nevertheless, it was regained after cure. These findings are similar to those of Brodsky (1995), whereby only two men reported a decline in orgasmic sensation because of cancer treatment and one man said that sex was pleasurable but not as enjoyable as it used to be.

Only a few Lebanese TC survivors reported changes in their body image. Nevertheless, the feeling of loss was short-lived. They all refused to have their excised testicle replaced by prosthesis. Informants in the study by Brodsky (1995) went through the same stages. They were first shocked to see alterations in their body image; however, these feelings declined with time. Like Lebanese TC survivors, none of the informants in the study by Brodsky (1995) reported feeling different after orchiectomy, and their sense of manliness remained unscathed.

Implications for Practice and Research

Oncology nurses and physicians play a key role in addressing cancer patients' needs and concerns through educating them about cancer and its treatment. Such educational offerings often lack topics that tackle sexuality and fertility. The findings may inform counseling these patients in a way that addresses the areas of concerns. Because fertility was identified by many informants as a determinant of their identity as men and partners, sperm banking must be integrated in the routine care offered to TC patients before cancer treatment. Besides, as women are counseled to do regular breast self-exams, the findings suggest that young men ought to be counseled to do regular testicular self-exam for early detection of this curable disease. This can be achieved through awareness campaigns in schools and colleges, which not only serve to raise awareness about TC but also serve to dissipate knowledge deficits regarding this malignancy. Another recommendation is to arrange informal support groups that would put newly diagnosed TC patients in touch with long-term survivors. Such support groups would allow newly diagnosed patients to gain a better insight about what awaits them during and after treatment. In terms of future research, a longitudinal study whereby patients are recruited shortly after diagnosis and followed up after cure would allow capturing the disease trajectory.

LIMITATIONS

Generalizability was not attempted in this study; instead, transferability was sought through recruiting a heterogeneous sample. Given the sensitive nature of the study, informants may not have been totally forthcoming in their description of their experiences. This was anticipated because an open discussion of such a sensitive topic is uncommon in the Lebanese culture. Some hesitancy was displayed in the beginning of some of the interviews, but informants eventually felt at ease as they discussed their experiences. Accidental alteration of the data was prevented by double checking the transcribed data, analyzing all interviews independently by the PI and a coinvestigator, and comparing the findings thoroughly. In addition, the PI utilized probing in the event of an unclear reaction during the interview and made sure to conduct a second interview to ensure that all informants agreed with the summary of their first interviews.

CONCLUSION

This study serves as the only initiative that offers an exploration of the lived experience of Lebanese TC survivors and offers an in-depth understanding of the psychosexual aspect of this experience. Most of these findings reflect the peculiarities of the Lebanese culture, mainly when it comes to the involvement of the family throughout the entire experience. Some informants identified the collectivistic nature of the Lebanese culture as a source of distress and opted to conceal their diagnoses from their entourages.

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REFERENCES

Brodsky, M. S. (1995). Testicular cancer survivors impressions of the impact of the disease on their lives. *Qualitative Health Research*, 5, 78-96. doi:10.1177/104973239500500106

Brodsky, M. S. (1999). The young male experience with treatment for nonseminomatous testicular cancer. *Sexuality and Disability*, 17, 65-77. doi:10.1023/A:1021455813897

Dahl, A. A., Mykletun, A., & Fosså, S. D. (2005). Quality of life in survivors of testicular cancer. *Urologic Oncology*, 23, 193-200. <http://dx.doi.org/10.1016/j.urolonc.2005.03.004>

Doumit, M. A. A., Huijjer, H. A.-S., & Kelley, J. H. (2007). The lived experience of Lebanese oncology patients receiving palliative care. *European Journal of Oncology Nursing*, 11, 309-319. doi:10.1016/j.ejon.2007.02.008

Doumit, M. A. A., Huijjer, H. A.-S., Kelley, J. H., El Saghir, N., & Nassar, N. (2010). Coping with breast cancer: A phenomenological study. *Cancer Nursing*, 33, E33-E39. doi:10.1097/NCC.0b013e3181c5d70f

Finlay, L. (2009). Debating phenomenological research. *Phenomenology & Practice*, 3(1), 6-25.

Fosså, S. D., Dahl, A. A., & Loge, J. H. (2003). Fatigue, anxiety, and depression in long-term survivors of testicular cancer. *Journal of Clinical Oncology*, 21, 1249-1254. doi:10.1200/JCO.2003.08.163

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15, 1277-1288. doi:10.1177/1049732305276687

Huddart, R. A., Norman, A., Moynihan, C., Horwich, A., Parker, C., Nicholls, E., & Deamaley, D. P. (2005). Fertility, gonadal and sexual function in survivors of testicular cancer. *British Journal of Cancer*, 93, 200-207. doi:10.1038/sj.bjc.6602677

Inhorn, M. C. (2004). Middle Eastern masculinities in the age of new reproductive technologies: Male infertility and stigma in Egypt and Lebanon. *Medical Anthropology Quarterly*, 18, 162-182. doi:10.1525/maq.2004.18.2.162

Joly, F., Héron, J. F., Kalusinski, L., Bottet, P., Brune, D., Allouache, N., . . . Henry-Amar, M. (2002). Quality of life in long-term survivors of testicular cancer: A population-based case-control study. *Journal of Clinical Oncology*, 20, 73-80. doi:10.1200/JCO.20.1.73

Kafle, N. P. (2011). Hermeneutic phenomenological research method simplified. *Bodhi: An Interdisciplinary Journal*, 5, 181-200. <http://dx.doi.org/10.3126/bodhi.v5i1.8053>

National Cancer Institute. (2013). *Surveillance epidemiology and end results: SEER stat fact sheets: Testis*. Retrieved from: <http://seer.cancer.gov/statfacts/html/testis.html>

Nieman, C. L., Kazer, R., Brannigan, R. E., Zoloth, L. S., Chase-Lansdale, L., Kinahan, K., . . . Woodruff, T. K. (2006). Cancer survivors and infertility: A review of a new problem and novel answers. *Journal of Supportive Oncology*, 4, 171-178. http://www.researchgate.net/publication/7112088_Cancer_survivors_and_infertility_a_review_of_a_new_problem_and_novel_answers/file/9fcfd50f4652da908.pdf

Osmańska, M., Borkowska, A., & Makarewicz, R. (2010). Ocena jakości życia, nasilenia cech lęku i depresji u pacjentów ze złośliwym zarodkowym nowotworem jądra w trakcie chemioterapii i po zakończonym leczeniu onkologicznym [Evaluation of quality of life, anxiety and depression in testicular cancer patients during chemotherapy and after anticancer treatment]. *Psychiatria Polska*, 44, 543-560.

Rossen, P. B., Pedersen, A. F., Zachariae, R., & von der Maase, H. (2009). Health-related quality of life in long-term survivors of testicular cancer. *Journal of Clinical Oncology*, 27, 5993-5999. doi:10.1200/JCO.2008.19.6931

Rossen, P. B., Pedersen, A. F., Zachariae, R., & von der Maase, H. (2012). Sexuality and body image in long-term survivors of testicular cancer. *European Journal of Cancer*, 48, 571-578. <http://dx.doi.org/10.1016/j.ejca.2011.11.029>

Salim, M., Adib, M. D., & Daniel, J. (2003). *National cancer registry: Cancer in Lebanon 2003*. Beirut, Lebanon: Ministry of Public Health.

Skaali, T., Fosså, S. D., Bremnes, R., Dahl, O., Haaland, C. F., Hauge, E. R., . . . Dahl, A. A. (2009). Fear of recurrence in long-term testicular cancer survivors. *Psycho-Oncology*, 18, 580-588. doi:10.1002/pon.1437

Skoogh, J. (2012). Towards a retained health in testicular-cancer patients—long-term cognitive function, missing a testicle and psychological needs (Unpublished doctoral dissertation). University of Gothenburg, Gothenburg, Sweden. Retrieved from <http://hdl.handle.net/2077/28874>

Streubert, H. J., & Carpenter, D. R. (1999). *Qualitative research in nursing* (2nd ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

The World Bank. (2013). *World development indicators 2013*. Retrieved from <http://databank.worldbank.org/data/download/WDI-2013-ebook.pdf>

Vidrine, D. J., Hoekstra-Weebers, J. E. H. M., Hoekstra, H. J., Tuinman, M. A., Marania, S., & Gritza, E. R. (2010). The effects of testicular cancer treatment on health-related quality of life. *Urology*, 75, 636-641. doi:10.1016/j.urology.2009.09.053

Adaptation of a Communication Interaction Behavior Instrument for Use in Mechanically Ventilated, Nonvocal Older Adults: Erratum

In the article that appeared on pages 3–13 of the January/February 2014 issue, some of the definitions in Table 2 were not correctly emphasized. These should have been in italics, as shown below. We regret this error.

TABLE 2. Patient Interaction Behaviors and Definitions

Category	Behavior	Definition
Positive behaviors	Acceptance	After the nurse offers/performs a health-related or comfort-providing function, the patient says “yes” or “mmhm”; thanks the nurse; and nods affirmatively with the head, eyes, or hand, expressing agreement, acceptance, or satisfaction. <i>Patients can utilize AAC strategies (e.g., writing, alternative yes/no signals, communication boards, or speech generating devices) to show agreement, acceptance, or satisfaction. May receive a “present” if the nurse provides a plan of care for the rest of the shift (e.g., nurse offers to change patient’s bed/linens after the physicians comes back and finishes a procedure. The patient nods yes to accept the plan).</i>
	Following instructions	Engaging a behavior (within the patient’s actual capabilities) in response to an appropriate request or instruction by the nurse, <i>within 10 seconds</i> of the request. For example, posture changes, answering questions. <i>If patient’s response is ambiguous and not interpretable to the nurse, then this behavior is absent.</i>
	Visual contact	Looks the nurse in the eye when the nurse asks a question or addresses the patient while the nurse is at the bedside (unless the nurse is engaged in incompatible technical procedures, <i>assessment of monitor, or interrupted by family, clinical or other healthcare professionals</i>), regardless of whether the nurse is looking at her/him. <i>Patient may receive a “present” if the nurse is out of the frame, but it is clear that the patient is focused on and responding to the nurse.</i>
	Physical contact	Touches, pats, or hugs the nurse. <i>Includes attention-getting touch and touch for comfort (e.g., reaching out to nurse to pat their arm or shake their hand. Does not include grabbing for support during position changes).</i>
	Request	Verbal, digital, or manual indications initiated by the patient to express a need or request, followed by the corresponding nurse appropriate behavior (e.g., requesting a glass of water, pain medication, etc.).
	Smiling	Lifting lips corners while looking at the patient in the eyes. <i>Exceptions may be made if the patient has a neurological deficit (facial droop) or other impediment that does not allow one corner of the mouth to raise.</i>
	Maintaining attention	Keeps sustained eye contact while the nurse provides an explanation, information, instruction, or appropriate comment. <i>May receive a “present” if the nurse is out of the frame but the patient is still focused on and responding to the nurse.</i>
	Laughing	Lifting the lips corners or congruently opening the mouth. <i>Patients may appear to take an extra breath while their chest and shoulders rise. It may appear to be more of a chuckle.</i>
	Praise	A clearly distinguishable gesture or message expressing gratefulness or approval of an action by the nurse.
Negative behaviors	Disagreement/negativity	Verbalization <i>or actions</i> expressing opposition to nurse’s, <i>includes threatening gestures, striking, or refusal.</i>
	Disgust	<i>Gestures or facial expressions indicating disgust, exasperation, annoyance, or frustration. Examples are head shaking, turning away, upward eye movement, or eye roll. To determine if the eye roll/movement is an expression of disgust, the rater must take into account verbal context and other nonverbal indicators.</i>
	Ignoring the nurse	Same definition as the category for nurses in absence of a justifying situation such as being asleep or unconscious.

Note. These definitions have been revised from the previous version by de los Ríos Castillo and Sánchez-Sosa (2002). Changes to the original definitions are identified with italics. Adapted with permission.

REFERENCE

Nilsen, M. L., Happ, M. B., Donovan, H., Barnato, A., Hoffman, L., & Sereika, S. M. (2014). Adaptation of a communication interaction behavior instrument for use in mechanically ventilated, nonvocal older adults. *Nursing Research*, 63, 3-13.

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