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The Hidden Double Burden: Formation Mechanisms of Stigma and Nursing Strategies for Male Breast Cancer Patients

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Abstract

Background: Although the incidence of male breast cancer is low, it is accompanied by significant stigma, placing patients under the dual pressures of "disease stigma" and "gender role conflict." Male breast cancer accounts for less than 1% of breast cancer cases. These patients often face delayed diagnoses and have unmet psychosocial needs. Existing research largely focuses on female patients, lacking exploration of the "dual stigma" experienced by males [1]. **Objective:** "When the breast becomes a vessel for male disease, patients must battle not only the tumor but also the stigmatizing label of non-traditional gender identity." This paper aims to reveal the mechanisms behind the formation of stigma and to develop targeted nursing strategies. **Methods:** By selecting eight male breast cancer patients treated in the breast tumor surgery department of a tertiary tumor hospital in Guangzhou from January 2022 to February 2025, and using interviews and scale surveys, this study aims to uncover the mechanisms of stigma formation in male cancer patients, providing evidence for gender-sensitive care and improving patient quality of life. **Results:** Three main paths leading to the "double burden" were identified, and a "triple-combination" nursing framework was proposed. Significance: This work fills a gap in the psychosocial research of male breast cancer, develops an interdisciplinary care intervention program, and promotes gender-sensitive care practices.

Keywords

Breast Cancer, Male, Stigma

1. Introduction

Illness Stigma is a complex socio-psychological phenomenon where patients suf-

fer from social devaluation, exclusion, or self-denial due to their illness. Its essence is the process where the social power structure degrades individual identity through the label of disease [2]. Male breast cancer has unique epidemiological characteristics, with an incidence rate of 0.5% - 1%, but it is often misdiagnosed and has a poor prognosis. Due to a lack of awareness, male patients on average experience a delay of 6 - 10 months from symptom onset to diagnosis. Research by the Cancer Research UK shows that at the first consultation, 40% of male patients have lymph node metastasis, and 15% have distant organ metastasis [3]. The delay in seeking medical attention is three times higher than that of females. Many men, upon discovering a lump in their chest, assume it is fat accumulation or inflammation, leading to a delay until the condition worsens [4]. Additionally, the high rate of misdiagnosis is a major challenge for male breast tumors. Due to low vigilance for male breast cancer by doctors, many patients are misdiagnosed with gynecomastia or lipoma, missing the optimal treatment window. According to a study in the British Journal of Cancer, by the time male breast cancer is diagnosed, over 40% of cases are already in the late stages, compared to only about 20% for females. This diagnostic delay directly results in a significantly lower five-year survival rate for male breast cancer patients compared to females [5] [6]. Existing research primarily focuses on female patients, with insufficient evidence on the stigma mechanisms and intervention strategies for males. The male breast tumor disease itself, such as physiological pain and treatment side effects, combined with a deviation from gender roles, like damaged masculinity and social identity crisis, contributes to the stigma. Based on Link & Phelan's stigma theory, it encompasses stereotypes, isolation, status loss, and discrimination, imposing a double burden on male breast tumor patients. Given this, the present study conducts in-depth interviews with 8 male breast cancer (MBC) patients to understand the current status and formation mechanisms of their stigma, aiming to enhance understanding and recognition of stigma among MBC patients, help reduce their stigma, provide evidence for gender-sensitive care, improve patients' quality of life, and call on society to increase awareness of MBC, move beyond cognitive misunderstandings, create a relaxed social environment for MBC patients [7], develop interdisciplinary nursing intervention plans, and promote gender-sensitive nursing practices.

2. Subjects and Method

2.1. Study Subjects

The study selected 8 male breast cancer patients who were hospitalized for treatment in the Breast Tumor Department of a cancer hospital in Guangzhou from January 2022 to February 2025. Inclusion criteria: 1) Clinically diagnosed with MBC, aged 18 years and above; 2) Aware of their condition and capable of normal verbal communication; 3) No history of mental illness or cognitive impairment; 4) Patients are aware of the study and have signed the informed consent form. Exclusion criteria: 1) Unable to communicate normally or suffering from mental

illness; 2) The patient and/or their family members refuse to participate in the study (Table 1).

Table 1. Supplementary demographic characteristics form.

Medical Record	Age	Stage	Treatment Method	Occupation	SSCI Score
1 Liao**	68 years old	T1N0M0 Ⅰ A	Surgery	Retired	64
2 Yang**	68 years old	pT1cN0Mx	Surgery + Chemotherapy + Endocrine	Retired	73
3 Gu**	74 years old	PT1cN0snM0LB1	Surgery + LHRHa + AI	Retired	54
4 Lu**	37 years old	PTisN0M0	Surgery + Endocrine	Engineer	76
5 Peng**	68 years old	cT1N0MO	Surgery + Endocrine	Retired	48
6 Li**	58 years old	Pt1cN0snM0LB	Surgery + Endocrine	Retired	60
7 Li**	43 years old	PTisN0M0	Surgery + Endocrine	Farmer	40
8 Chen**	47 years old	T1N0M0 Ⅰ A	Surgery	Farmer	39

Note: SSCI Scoring Method.

Uses a Likert 5-point scale (1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Always). Total score range: 24 - 120 points, with higher scores indicating more severe illness stigma.

2.2. Research Methodology

This study simultaneously analyzed medical records and conducted one-on-one semi-structured interviews, each lasting 30 to 45 minutes. Utilizing the SSCI scale (Stigma Scale for Chronic Illnesses) and the Chinese version of Link's in-depth interview by Xu Hui, 8 patients were interviewed. The thematic analysis method was used to extract the core dimensions of stigma from these interviews and to develop a series of stigma scales. Drawing on many years of experience in the breast oncology department, the interview outline was determined to include the following content:

1) When you noticed an abnormality in your chest, did you consider the possibility of a breast-related disease?

2) After falling ill, do you feel that the attitude of those around you has changed? If so, please tell me the specific changes.

3) Had you heard about male breast cancer before?

4) At the time of diagnosis, what was the most difficult thing for you to accept?

5) Have you ever felt ashamed because of your illness? Can you give an example?

During the interviews, the researcher did not apply any inducement or intervention on the interviewees and showed respect for all expressions made by them without judgment. The entire interview was recorded synchronously; the researcher listened attentively and also carefully observed the changes in the interviewees' facial expressions, speech speed, and movements, and recorded them in

a timely manner. The researcher also promptly clarified and confirmed the interviewees' feelings and viewpoints.

2.3. Statistical Analysis Method

Within 24 hours after the interviews, the recorded material was processed. Combined with on-site notes, the first set of transcripts was compiled and sent back to the interviewees for confirmation. Once verified as accurate, the analysis work began. Colaizzi's seven-step phenomenological analysis method was used for analysis. The researcher summarized and concluded the results of the data analysis, incorporating their own perspectives, and ultimately arrived at the themes of this study.

3. Results and Findings

The stigma formation mechanism model for Male Breast Cancer (MBC) (Dual Burden Pathway) has three main pathways.

Pathway 1: Socio-Cultural Construction

Socio-Cultural Mechanism

Dissolution of Masculinity: The metaphor "mastectomy = loss of masculinity" (e.g., Xiang**: "I'm afraid to let my friends know, fearing they'll mock me as being like a woman." Huang**: There's an unconscious bias in the language of friends and family, like when visiting, they say, "How could you get this disease?" I felt so unlucky—a grown man getting a woman's disease, I felt ashamed. Yang**: Requested that the doctors don't write 'breast cancer' on the diagnosis, but rather 'chest tumor').

Media's Female Centricity: The absence of male images in breast health promotional materials (e.g., Ye**: "There is too little knowledge about male breast cancer in social media and hospital bulletin boards. When I felt the abnormality in my chest, neither I nor my family ever considered a breast-related issue, and we didn't know which doctor to consult." Chen**: "When I went to a rural community hospital for a check-up, the doctors didn't consider breast-related problems." Chen**: "The first time I was admitted and lying in the hospital bed waiting for the attending doctor, the caretaker shouted loudly: 'No family members on the bed!' My fellow patients were staring at me, and I felt very embarrassed. During my hospital stay, Dr. Wang (the attending physician) came with three female students to discuss my rare condition for over 20 minutes by my bedside, highlighting the differences in treatment from female breast cancer, with other female patients and family members nearby—I felt so tormented for those 20 minutes!").

Healthcare System Mechanism and Gender Embarrassment in Examination Settings: Breast ultrasound rooms are predominantly occupied by female patients, requiring separate examination times for men (e.g., Tan**: "During the pre-surgery ultrasound, the patients and their families in the waiting area were talking about me privately." Chen**: "While in the ward, I could consistently feel the strange looks from fellow patients and their families.").

Pathway 2: Individual Internalization Process and Self-Stigmatization

Concealing the Illness, Refusing Emotional Expression: (e.g., Ye**: "When I learned about my condition, I told myself, 'I can't appear weak.' I never shared my true feelings with my wife. In reality, I am also very afraid of this disease and don't know how long I will live.")

Family Relationships: Excessive protection from a spouse/children reinforces the perception of a pathological identity (e.g., Tan**: "I am constantly supervised by my children; they seem to always remind me of my identity as a patient." Ye**: "I rarely go out to dine with my friends now. I am afraid they will treat me differently, and I prefer to be alone.").

Pathway 3: Structural Oppression and Policy Gaps

Exclusion from Public Health Campaigns: Male breast cancer is not included in public health promotions, leading to the entrenchment of social perceptions.

Economic Exclusion: Insurance denial and employment discrimination lead to the materialization of stigma (e.g., Chen**: "I'm only 47 years old, at the peak of my career and earning potential, but this illness has knocked me down completely. I feel like I'm a useless person now." Ye**: "The insurance I purchased provides a compensation ratio that is far too low.").

4. Discussion and Recommendations

4.1. It Is Urgent to Promote Awareness of MBC-Related Knowledge

A follow-up study by the MD Anderson Cancer Center in the United States revealed that the incidence of postoperative depression in male patients is four times that of female patients [8], yet only 5% of males receive professional psychological assistance [9]. This absence of a "physical-psychological" dual treatment leads to a 5-year survival rate for male patients that is 19% lower than that of female patients. This study found that stigma associated with male breast cancer is a widespread and common phenomenon.

4.2. Nursing Strategies

Disease Cognition Reconstruction

Individual Level: Destigmatization Empowerment

1) **Establish support groups for male breast cancer patients to reconstruct illness narratives through peer education.** Create exclusive male support groups: online communities for sharing personal journeys on the road to cancer survival. Research, such as that conducted by the "Male Breast Cancer Global Alliance," can help reduce feelings of loneliness.

2) **Cognitive Behavioral Therapy (CBT):** Correct irrational beliefs such as "disease = demasculinization." For example, neutral colors should be used in breast cancer awareness activities, like white instead of pink ribbon [9]. Appropriately increase the representation of male patients in imagery used in breast cancer wards.

4.3. Healthcare System Level: Gender-Sensitive Care

1) **Develop "Male Breast Cancer Care Guidelines":** Introduce a psychosocial

assessment module. Use formats like illustrated booklets and short videos to emphasize the scientific fact that "breast cancer has no gender boundaries," such as the pathogenicity of BRCA2 gene mutations in men. Provide treatment guidelines specifically for men, like the NCCN Male Breast Cancer Guidelines [7], to help patients understand their treatment options.

2) **Training for Medical Staff:** Avoid verbal violence (e.g., "Men can get this disease too?").

Healthcare providers should actively use gender-inclusive language (e.g., avoid expressions like "Ladies, please pay attention to breast health").

4.4. Social Policy Level: Structural Support

1) **Promote Public Awareness:** Invite male patients to participate in public service advertisements to break gender stereotypes. Share case studies by inviting recovered MBC patients to discuss their experiences publicly. These can also be included in patient health education videos played in wards. For example, there was public advocacy by American actor Richard Roundtree.

2) **Legislative Protection:** Include male breast cancer in critical illness insurance coverage and prohibit employment discrimination. Design visual materials for flat chest reconstruction surgery (Flat Closure) for male patients after mastectomy to reduce body anxiety. Collaborate with businesses to develop support plans for MBC patients returning to work (e.g., flexible working hours, avoiding physical labor).

5. Conclusion

In summary, the stigma experienced by male breast cancer patients is caused by the "dual burden" of "disease stigma" and "gender role conflict." From a nursing perspective, a "trinity" approach can be employed to improve and reduce the stigma experienced by these patients, thereby enhancing their treatment outcomes and quality of life [10]. This also presents a new perspective for nursing, shifting the focus from "symptom management" to "identity reconstruction." An example is the community intervention experience of the UK's "Male Breast Cancer Coalition." However, clinical exposure to male breast cancer patients is limited, leading to sample limitations. For instance, it does not encompass LGBTQ+ groups or ethnic minorities. Future research requires an expansion of the sample size to include more diverse samples, thus improving representativeness and generalizability, and employing random sampling methods to reduce selection bias and enhance the external validity of the study. Long-term effects of nursing interventions should be tracked. The stigma experienced by male breast cancer patients is the product of the interaction between structural oppression and individual experience. Breaking the "disease-gender" dual shackles requires cross-system collaboration. Nursing practice should balance clinical care and social equity, promoting a paradigm shift from "hidden burdens" to "visible support."

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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