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Title

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Permalink

<https://escholarship.org/uc/item/09z226sp>

Journal

Oncology Nursing Forum, 41(5)

ISSN

0190-535X

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Publication Date

2014-09-01

DOI

10.1188/14.onf.509-516

Peer reviewed



Published in final edited form as:

Oncol Nurs Forum. 2014 September ; 41(5): 509–516. doi:10.1188/14.ONF.509-516.

Latino Men and Familial Risk Communication about Prostate Cancer

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Abstract

Purpose—This study investigated how familial communication about prostate cancer risk and screening affects sons of men with prostate cancer. It is important to engage Latino families shared decision making toward early detection because first degree relatives of men with PCa are at heightened risk and Latino men are diagnosed at more advanced stages of disease than Non-Hispanic White men.

Methods—The team conducted semi-structured interviews with seventeen sons of PCa survivors. Eight participants completed a follow up interview an average of seven months later. Therefore, our sample includes twenty-five transcripts. The sons are Latinos living in Southern California. Data were analyzed with a mix of a priori topical codes and grounded theory techniques.

Results—Sons were under informed about both familial risk and screening options. They became sensitized to PCa, desired information, and held protective intentions. Hopeful intentions came up against cultural taboos around sex, reproductive health, and intimacy that limited discussions between fathers and sons. Fathers were a valued source of information, but play various roles, which affect sons' screening intentions. Open communication between father and son promoted awareness of screening and familial risk.

Discussion—Uncertainty about familial risk and screening options, especially early detection strategies, was exacerbated by cultural taboos around PCa. Fathers could have been primary and credible advocates for shared decision making, but sons found it difficult to learn from their fathers' experience.

Nursing Implications—Findings from our study can inform community based interventions with Latino families, help to culturally tailor health messaging, and sensitize clinicians to a group which needs concerted counseling about PCa risk and screening.

Introduction

This study investigated how family communication about familial risk affects sons of men diagnosed with prostate cancer (PCa). The research team's previous work with men affected

by PCa sensitized us to the complex role affected men play in informing first degree relatives, particularly sons, about increased risk and early detection (Maliski, Connor, & Litwin, 2012). Using interviews the research team focused on familial risk awareness, screening knowledge, and protective actions of unaffected sons of PCa survivors.

Background and Significance

Brothers and sons of Latino men with PCa are an unsuspecting at-risk group for PCa. Shared decision making ideally includes a discussion of familial risk. However, this assumes that families communicate risk and cancer histories and also that unaffected relatives have regular access to preventative care. There have been few studies on familial risk communication and screening decision making for men with PCa, much less Latinos (Tilburt et al., 2011). It is important to investigate how families do or do not spread information about risks through their social networks and the implications this has for at-risk relatives' informed decision-making about screening choices (Palmquist et al., 2010). Several studies with the general population show that perceiving risk is not enough to prompt preventative behavior or screening (Beebe-Dimmer et al., 2004; McDowell, Occhipinti, Gardiner, Baade, & Steginga, 2009). McDowell et al. (2009) point out that if a relative's diagnosis of PCa acts as stimulus for screening, health promoters need to capitalize on the opportunity to inform both the affected man and the family about familial risk and screening options.

There is compelling evidence that men with a first degree relative (i.e. brothers or fathers) diagnosed with PCa have increased risk of developing PCa compared with men without a family history of PCa (Brandt, Bermejo, Sundquist, & Hemminki, 2010; Ola Bratt, 2007; Colloca & Venturino, 2011; Madersbacher et al., 2011). Unaffected first degree male relatives (FDMRs) of affected men are more likely to undergo screening which may in turn inflate the number of unaffected first degree relatives who are diagnosed (Brandt et al., 2010). Still, there is a general consensus that unaffected FDMRs of men with PCa are an at risk group in need of education and informed decision-making support (Brandt et al., 2010; Ola Bratt, 2007; Colloca & Venturino, 2011; Madersbacher et al., 2011). This is especially true in the context of uncertainty about screening efficacy. Scientists do not agree on the role PCa screening should play and this uncertainty trickles down to clinicians and men seeking information. Current guidelines in the U.S. advise men at average risk of developing PCa to engage in shared decision making at 50 years old and older, while men with higher than average risk of developing PCa should engage between the ages of 40 and 45 years old depending on their risk factors (Qaseem, Barry, Denberg, Owens, & Shekelle, 2013).

Risk and screening awareness is particularly important for Latino men given that they are disproportionately diagnosed with non-localized PCa requiring aggressive intervention ("American Cancer Society," 2013). PCa is the leading cancer diagnosed in Latino men at 29% of new cancer cases in 2012 estimates. While incidence of (124.9/100,000 people¹) and mortality from (17.8/100,000 people¹) PCa are lower for Latinos than Non-Hispanic White (NHW), Latino men are diagnosed with later stage disease than NHW men ("American

¹Based on data from 2005-2009

Cancer Society,” 2013; Bradley, Given, & Roberts, 2003; Gilligan, 2005; Klein, Nguyen, Saffore, Modlin, & Modlin, 2010). McFall (2007) studied race/ethnicity as a factor in screening rates. She found that awareness was a determining factor in current and lifetime use of PSA exams, independent of race/ethnicity. However, Latinos were less likely to be aware of the PSA exam than NHW men.

Therefore, increasing awareness about screening options among Latino men is critical to engage them in shared decision-making. The diagnosis of Latino men at more advanced stages of the disease is a disparity which is not well understood. This study sheds light on how health risks are talked about between fathers and sons.

Methods

Subjects

The data presented here were collected as part of a larger study, which included men with PCa and a separate group of first-degree relatives of PCa survivors. Affected men and unaffected FDMRs who participated were not necessarily related; each group was recruited separately meaning that there is not correspondence between accounts from men affected by PCa and sons whose fathers experienced PCa.

After receiving approval from the University of California, Los Angeles (UCLA), Office for the Protection of Research Subjects, men with PCa were recruited from the Men’s Health Study, a longitudinal survey conducted by the UCLA Department of Urology. In this recruitment group our criteria were: local men who were treated for PCa, self-reported as Latino, and had at least one FDMR. In the second recruitment group, the criteria were: local men who were first degree relatives of a man treated for PCa and self-reported Latino. These men were recruited through community advertisements. The analysis of data from men diagnosed with PCa focused on disclosure networks and was reported previously in this journal (Maliski et al., 2012).

This analysis includes 25 transcripts from 17 sons whose fathers were affected by PCa. An effort was made to interview each son twice to help with member checking and confirmability. Of the 17 men who completed a first interview, eight completed a second interview. Follow up interviews were completed at an average of seven months after the baseline interviews.

Procedure

Data were gathered using semi-structured in-depth interviews which varied in length from 30 minutes to 45 minutes. Patients were contacted by phone and verbally consented and an interview was scheduled. In person, bilingual male interviewers obtained written consent and interviewed participants in the language of their preference (Spanish or English) in participants’ homes. Demographic data were collected with a brief questionnaire which did not include insurance status. Interviews were recorded and transcribed verbatim in the language conducted. The team translated Spanish transcripts to English (Lopez, Figueroa, Connor, & Maliski, 2008). Ten participants were interviewed in Spanish and seven in English. The follow up interviews were a convenience sample to help the interviewers focus

more on the sons' decisions making processes about their own health. An effort was made to follow up with each participant, but only eight were available. The follow up interviews used the same interview guide, but stressed questions about the sons' personal health behaviors, knowledge, and decision making. The interviewers follow up on topics from the baseline interview with each man, e.g. if a son talked about needing to make an appointment the interviewer asked about this in the follow up interview.

Analysis

The research team did line-by-line coding to capture important actions expressed in the data. The team used broad a priori codes to assess sons' general knowledge of screening practices and familial risk. These two a priori topical codes were determined based on the previous analysis of data from men with prostate cancer with FDMRs (Maliski et al., 2012). These men expressed a great desire to promote screening by their FDMRs. Using Atlas.ti 7 the first author coded the transcripts into categories identified from the topical coding using grounded theory techniques. The first author identified categories such as information sources, screening knowledge, screening intentions/actions, facilitators and barriers, and areas of uncertainty and desired information. During debriefing sessions, in which summaries of the category coding were reviewed by the senior author, the research team saw complex relationships emerging between the level of family communication, knowledge of familial risk for PCa, knowledge about early detection, and screening actions. After creating analytic tables to track primary sources of communication and awareness of familial risk and/or screening the team found that fathers were a critical figure in the narratives. A team decision was made to focus theoretical coding on communication between fathers and sons. The research team refined ideas through debriefing meetings and memoing. Memoing was done in Atlas.ti 7, using three types of memos – theoretical, commentary, and audit trail.

Results

The sons in this study were mostly Mexican-Americans who had lived in the U.S. since childhood, middle class, and younger than men targeted for early detection. Demographic data from three of the 17 sons were not available. Of the 14 who were administered the demographic survey there is great variability. The sons had a median age of 37 years old at the time of interview but a range from 25 to 43 years old. The median income per household of the group was \$60,000 with a minimum of \$21,600 to a maximum of \$120,000. The large range in income is attributed to a range in education and amount of people living in one household. Households ranged from three people to up to seven. Data were not collected about whether the sons were married. Five sons had not received any post secondary education while eight had some college and/or were college graduates. Sixty-four percent of sons were born in a Latin American country, with Mexico the most dominant country of origin. Sons showed a high degree of acculturation with 76% spending their early childhood in the U.S. Sons largely had diverse social networks comprised of Latinos and other ethnic groups and the great majority of sons reported being able to speak and read in both Spanish and English. We did not find important differences in the transcripts based on the interview language.

Follow up interviews were analyzed for changes in awareness, information seeking, and father-son communication because the sons were sensitized to familial risk and screening through the baseline interviews, but this did not seem to be a theme. The follow up interviews reinforced and deepened themes from the baseline interviews.

Connecting familial risk to screening: awareness, knowledge, and action

Each participant's 1) understanding of familial risk, 2) knowledge of screening actions, 3) and screening actions (past history of screening, scheduling check up appointments, intention to bring up early detection with their doctor, or setting an age at which to start screening) were characterized. Classifications emerged for the three topics and the research team identified shared concepts in each class for each topic. The classifications used for each topic, the amount of participants who fit each classification, and the shared concepts are delineated in Table 1 below.

We compared the sons' levels of awareness to their intentions and actions. Four sons who understood their familial risk engaged in screening actions. Four of six sons who did not understand their familial risk did not enact any screening behaviors. One of the men who understood familial risk was so scared of having PCa that he avoided screening. Nine of the men who were uncertain about or did not understand familial risk did not enact screening behaviors. This sample suggests that sons who understand familial risk take screening actions more than sons who do not, although there is variability.

Interestingly, when assessing sons' reported general knowledge of PCa and screening, there does not seem to be a link between having a high degree of information and enacting screening behaviors. Across several topics studied, the five men who enacted screening behavior had varying levels of knowledge about screening exams. Men who were 40 years old or older had more screening actions, but some of the youngest in the sample (twenties) had good information about screening and familial risk.

I. Risk communication between fathers and sons

A. Fathers' diagnosis pattern influences sons' screening intentions—How the fathers of the sons were diagnosed influenced the sons' beliefs about when and why they should be screened. Twelve fathers of the sons were diagnosed because they had symptoms such as an inflamed prostate or urinary distress. Three fathers of the sons were diagnosed via an annual checkup. It is unknown how the remaining three fathers were diagnosed.

Seven men believed that having symptoms would prompt them to go for screening. Seven men believed that they needed screening when they reached forty years of age. Two sons, whose fathers were diagnosed with PCa via a regular annual exam, were committed to preventative checkups and talking to their doctor about PCa. Only one son mentioned screening at a young age as a possibility. Of concern, five of the sons whose fathers were diagnosed because of symptoms continued to believe that they would engage in prostate screening only if they develop symptoms. The sons who did not know anything specific about PCa screening associated screening with symptoms as illustrated below in a quote from a son who had little knowledge of familial risk or screening options.

What would make me consider [getting screened]? Wow, I guess it may be the basic obvious, like placing it, which is like what happened with my dad, is like I got to go to the restroom and I can't hold it. We have a problem and we need it to get it fixed. **P16 Baseline**

B. Father's communication style—Based on what the sons recounted of learning about their fathers' diagnosis and treatment the research team carefully characterized each of their fathers' role in risk communication. Three father roles emerged: educator (n=3), partner (n=4), or ascetic (n=9). The fathers who acted as educators unilaterally communicated their cancer process to their sons. Fathers and sons did not engage in discussions about PCa and sons did not ask many questions or participate in the treatment or recovery process. Fathers who acted as partners discussed their cancer with their sons and the sons were actively engaged in the process, e.g. accompanying their fathers to doctor's appointments and translating. The sons understood their increased risk and enacted screening actions. Finally, the fathers who were ascetic kept the details of their PCa private. Their sons knew they had PCa but very little more. Table 2 gives example quotes for each role identified.

Open communication (characterized by the son asking questions or being privy to the PCa experience) between father and son was the common denominator for screened men or men with a screening plan. Seven men reported that their father's advice or observation of his experience influenced their screening decisions. Additionally, the most proactive men (n=4) had multiple information sources within their social network with whom they talked about PCa, e.g. mom, sister, colleagues, and friends. These other information sources were much less prevalent and salient than fathers. Some of the men who were married only rarely discussed wives as people who would influence decision making. Those that had little contact with their family members (n=2) had little information about screening or familial risk and therefore few intentions.

II. Cultural taboos around PCa and screening

A. Cultural taboo within families about intimate health—A father affected by PCa emerged clearly as a powerful, but double-edged information source. The following excerpt from one son showcases the tension between wanting advice from his father, and being concerned about insulting his father by transgressing a cultural taboo. The son says that he cannot talk to his family, especially his father about sex or impotence; however, directly following this statement he identifies his father as having the biggest influence on his screening behaviors.

Participant 9: ...for my family, for most families, and all Latinos, you stay away from that conversation about sex and all the stuff, impotence and all that, specially with my dad. I wouldn't dare talk about that with my dad. It would be kind of, not insulting, but I have always been told that that's not the line you cross with parents. I mean, we don't talk about it. I don't think a lot of males talk about it with their family members, we sure Latinos, we feel uncomfortable...

Interviewer: ... is there anyone, or something else that may influence ... your decision to go to the screening?

P9: [I am] thinking the encouragement of my dad probably will be the biggest thing.

Baseline

Several sons commented on the cost of low family communication. Many were frustrated by their lack of knowledge and sought out information from friends, colleagues, and the internet. The sons talked about cultural taboos in the context of questions about with whom they talked to about their fathers' PCa and who or what would influence their screening decisions. Another participant insightfully summed up the tension between respecting taboos, but needing the family to be a source of information and protection.

So the ability to speak frankly, one has to get rid of whatever taboo, because it is simply a topic of health this. Meanwhile other studies, they speak with clarity, that the families that do not talk about those topics are those that are more commonly in the second stage or the third stage. The families that have more open communication they are the ones that at the early stage they realize. So that is the benefit of dialogue. The more dialogue in a family, the more possibilities to find it in initial stages, about prevention, and in that, they [the family] can help you a lot.

P6 Follow up interview

Half the sons associated lack of communication about PCa within their family to Latino cultural taboos about discussing sex, intimate body parts, and reproduction. One participant was asked specifically why he did not communicate much with his family about PCa. He answered,

Well the taboo in our family is, is that for some reason we don't talk about our body parts, we don't talk about literally anything that, that our clothes cover, we don't. So it's, it's, very typical, our, our culture we just don't communicate very well. **P6 Baseline**

Another participant also thought that lack of familial communication occurred because of Latino cultural values. He described Latinos as very diverse socio-economically, but having in common a taboo around intimate body parts. "These issues related with sex or, or, reproductive organs within our, within our system are very taboo within, our population..."

P8 Baseline.

Many sons did not know about a family history of PCa until their father was diagnosed. Below, a son recounts how startled he was to learn that many people in his extended family have been affected by PCa. This son could be at higher risk if multiple men in his family have had PCa.

Participant 9: ...we went to Mexico, and every time they [extended family members] call the house and they told me that they had it, and they turned out ok. All these stories kind of pop up as soon as someone focuses [on PCa]...all these stories start popping up, from my uncle and family members.

Interviewer: So they had the screening?

P9: They had the screening before - the logistics don't go into it because it is a whole male thing

Baseline.

B. Cultural taboo about the digital rectal exam—Participant 9's admission, "the logistics don't go into it because it is a whole male thing," is important. Eleven of the seventeen sons talked about the "taboo" associated with the digital rectal exam (DRE). Most of the men heard about the DRE through jocular, informal encounters in their social networks. The sons acknowledged the taboo but countered it with arguments about how it was important to overcome their discomfort and do the exam. One participant gives a bald summary of the way his peers interpret the DRE exam.

There's a whole... misconception that deals with uh, the sexuality of a male. ... you can hear within the guys talking about "I don't wanna, I don't wanna, I don't wanna give up my virginity." They say that they're gonna be raped since there is an insertion of the finger. ... and they still have this discomfort ... of being penetrated with the finger... Fear, fear of the unknown and fear, lack of information as well.

P4 Baseline

The peer pressure of the taboo is so strong that this same participant, who had been screened, commented,

I always laugh about it; I participate within, within the jokes and within the whole discussion of, of, uh, uh getting checked by doctors. I become part of it within the group. But inside of me I, I'm just playing with them...to be part of the group. But I don't feel comfortable. ...I look at it as uh, routine. A normal routine that I have to have in order for my own survival. **P4 Baseline**

This example from a son who played along with the public stigmatization of PCa screening while privately committing to regular screening is testament to the durability of the taboo, even if it did not prevent him from getting screened.

Discussion

Men at higher risk of PCa due to family history need to engage in shared decision making. Latino sons of men treated for PCa may have less opportunity or awareness of how to engage in shared decision making and may not have the information necessary to alert clinicians to their increased risk. This research identifies community health promotion opportunities to increase informed decision making about screening for PCa amongst Latino men. Our study extends previous work on familial communication about risk and the importance of culture (Ola Bratt, Emanuelsson, & Grönberg, 2003; Christophe, Vennin, Corbeil, Adenis, & Reich, 2009; Harris et al., 2010; Lagos et al., 2008; Palmquist et al., 2010; Shaw, Scott, & Ferrante, 2013; Vadaparampil, McIntyre, & Quinn, 2010; Wakefield et al., 2008). It follows up on our work with men with PCa about their disclosure patterns and communication with unaffected FDMRs (Maliski et al., 2012). Finally, there is a dearth of research specific to Latinos and prostate cancer despite the disparities observed in screening and stage at diagnosis which needs to be addressed.

Sons of men diagnosed with PCa have heightened interest in information regarding PCa but low awareness of familial risk and screening options. Many sons in this study are younger than the target group for regular screening; however previous research with Latino men and their wives suggests that prostate cancer diagnosis heightens interest and desire in adopting a range of health behaviors. Furthermore, the men with PCa who have FDMRs were very committed to promoting screening with their FDMRs. We propose that family members' (especially fathers') diagnosis of PCa can be a window of opportunity to increase awareness in Latino families. This is supported by 1) young sons (even the 25 year old) in our study did go out and find information about screening and 2) Some of the most poorly informed men in this study were approaching 40 years old, which depending on a variety of factors could be an age at which they engage in shared decision making with physicians about screening. Our study with Latino men found that cultural taboos around PCa diagnosis and survivorship, as well as with PCa screening, have an adverse effect on men's willingness to communicate risk within their families. On the other hand, sons sensitized to PCa desire information and intend to enact protective behavior.

The sons' perceptions presented here are an interesting rejoinder to the previously reported findings with men affected by PCa with FDMRs. Maliski et al. (2012) found that men affected by PCa with FDMRs hoped to communicate the importance of early detection to their FDMRs, but were highly selective about the depth of information disclosed, even to their adult children. They also stated they appreciated "respectful silence" from their relatives because they considered PCa an intimate issue. However, in this study, sons wanted more information and felt frustrated by cultural taboos that barred them from open conversations with their fathers. Ultimately, the sons in this study often did not have actionable information about risk or screening.

Sons see their father as an advisor, but get very few details about screening. Most notably, in this sample, the father's diagnosis experience greatly influenced the sons' beliefs about screening. This leads quite a few of the sons to believe that screening occurs because of symptoms, which limits consideration of early detection. The finding that over half the men in a diverse socioeconomic sample all spoke about DRE taboos is concerning. While sons in this study attested that they overcame the taboo, it is evidence of communication barriers in these men's social networks. Several sons linked Latino culture, especially in their father's generation, to poor communication about PCa and screening specifics. While discomfort with screening is not unique to Latino culture - men across ethnic groups are uncomfortable with the DRE (Shaw et al., 2013) - understanding cultural aspects of how information is presented and disseminated through social networks is critical to address taboo and stigma (Consedine et al., 2007; Consedine, Morgenstern, Kudadjie-Gyamfi, Magai, & Neugut, 2006; McFall, 2007).

Getrich et al's (2012) conceptualization of "machismo" is helpful in the context of this study because they capture a similar tension in masculine performances amongst Mexican and Mexican American men around colorectal cancer screening. It is important to note that the sons did not use the term machismo very often. However, the concept is valuable for thinking through culturally specific performed masculinities between father and son. Getrich et al (2012) point out that machismo, which is a cultural construct used by Mexicans and

Mexican Americans, can be seen as a barrier; it can be linked to homophobia, dominance, and stoicism. On the other hand, it is linked to a strong sense of family, protection, and responsibility (familismo) (Getrich et al., 2012). Machismo can prevent openness about intimate health topics. On the other hand, the values of familismo could facilitate awareness from within social networks, possibly having a greater impact. McFall (2007) pointed out that if awareness is a pivotal factor in screening behavior then continuing outreach through existing mechanisms may not address existing racial/ethnic disparities. Our research team posits that working intergenerationally through familismo is another approach.

Implications for Nursing

For some Latino men cultural taboos exacerbate an awareness deficit. The ambiguity about screening guidelines combined with under informed men and little communication about PCa within their social networks heightens the decisive role healthcare providers, especially nurses, play. First, they can alert sons to increased risk and second, they can provide actionable knowledge about risk and screening. Healthcare providers played an invaluable role as credible information sources when the sons encountered them. Interventions that empower fathers as mentors might have a dual benefit - giving fathers a sense of efficacy while promoting informed decision-making for sons. Education by nurses needs to include not only the man with PCa and his spouse, but also his adult children. Nurses can utilize “familismo” to facilitate informed decision making, through routine practice and interventions in this population.

Limitations

The Latino men recruited in this study come from a predominately Mexican or Mexican-American background and findings cannot be generalized to other Latino ethnicities. Finally, given fathers and sons were not recruited as dyads’, we were not able to see the link directly between a man and his son.

Conclusion

Sons whose fathers were diagnosed with PCa were both in need of and potentially receptive to actionable information in light of increased familial risk. For sons in this study, a cultural taboo surrounding sexual and reproductive health and the DRE is in tension with their desire for meaningful first person familial accounts about PCa. Health advocates have the opportunity to work with families to increase risk awareness and shared decision making about screening.

Acknowledgments

This research was funded by the National Institutes of Health/NINR through grant 1R21NRO10383 “Prostate Cancer Decision Making by Diagnosed and High Risk Low Income Latino Men.” PI: Sally Maliski

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Knowledge translation

- Latino sons of PCa survivors need concerted counseling about their increased risk and protective actions they can take.
- Nursing interventions can utilize Latino cultural values such as “familismo” to counteract cultural taboos which limit communication about PCa, especially the digital rectal exam.
- Nurses can clarify with Latino men that symptoms are not necessary to diagnose PCa.

Please talk about what your father's PCa experience meant for you.

- What had you heard about PCa?
- How does your father's diagnosis and PCa relate to you?
- What do you think your father's having had PCa means for your chances of having PCa?

Now, would you tell me about what you have heard about or know about PCa screening?

- What does that mean for you?
- Describe what happens during PCa screening.
- How do you feel about that?

Please talk about how you have or how you might decide on whether or not you would go for PCa screening.

- What kinds of things would you consider when deciding about screening?
- Who would you talk to about screening?
- What made it or would make it difficult to make a decision?
- Who or what would be helpful in making a decision?

After making a decision, you then have think about carrying out that decision. Please tell me about what would affect whether you would be able to carry out your decision about having PCa screening or not.

- What kinds of things would make it easier? harder?
- Who might influence whether you follow-through on your decision or not?
- What might make you change your mind about your decision?

Figure 1.
Abbreviated Interview Guide.

Table 1

Shared concepts recounted about risk and screening awareness and actions

Topic	Classification	n=17	Shared concepts recounted
Familial risk awareness	Understood increased familial risk	7	<ul style="list-style-type: none"> Concern about personal risk. Desire to take action. Consultation with family, social network, and healthcare providers.
	Uncertain about increased familial risk	5	<ul style="list-style-type: none"> Vague beliefs about PCa being "inherent." It is probable that he will have it; his father had it. Expressions of inevitability or fatalism.
	No awareness of increased familial risk	5	<ul style="list-style-type: none"> PCa is very common. Anyone can get it. It is because of bad luck that people get PCa.
Screening awareness	Knowledge of both the PSA and DRE exams	5	<ul style="list-style-type: none"> Awareness of the need for early detection to prevent diagnosis at an advanced stage. Advice from healthcare providers.
	Knowledge of either the PSA or DRE exam but not both	6	<ul style="list-style-type: none"> DRE is known about through social networks, often jocularly. PSA is learned about through healthcare providers and fathers.
	No knowledge of either PSA or DRE exams	6	<ul style="list-style-type: none"> Symptoms will tell him if he has PCa.
Actions	Engaged in screening actions	6	<ul style="list-style-type: none"> Age (40 years old or older) Awareness of early detection and familial risk.
	Engaged in lifestyle protective behaviors	5	<ul style="list-style-type: none"> Eating healthy. Avoiding smoking or drinking.
	Engaged in information seeking	11	<ul style="list-style-type: none"> Vague awareness of familial risk and intention to understand his personal risk.

Table 2

Fathers' communication style

Father's communication style	Illustrative quote
Father as educator n=3	[My dad] just tells me go [to frequent screenings]... he doesn't really go too much into detail. P12 Follow up
Father as partner n=5	[My dad] knew very little about it, but he knew that there was a scale and that the point system that measured the blood... the next time that he had an appointment I went with him and I asked the doctor specific questions... P7 Baseline
Father as ascetic n=9	They [my family] just tell me, you know, that [my dad is] sick, he's still in the hospital, and I go see him. That's about it; I go and I see him and that's it. I don't ask questions. P14 Baseline