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Communication and Intimacy-Enhancing Interventions for Men Diagnosed with Prostate Cancer and Their Partners

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Abstract

Introduction—The sexual dysfunction following prostate cancer treatments often leads to a reduction in intimate contact for couples. A number of psychosocial interventions have been developed to enhance intimacy in these couples. This paper reviews three of these interventions and is a summary of a presentation given as part of a symposium at the 2011 Cancer Survivorship and Sexual Health Meeting.

Aim—The goal of this presentation was to: (i) review three types of psychosocial interventions; and (ii) describe the methodological issues highlighted by these interventions.

Main Outcome Measures—Validated measures of relationship intimacy and communication.

Methods—To be selected, the interventions had to be: a randomized control trial, focus on a couples approach to therapy, and report at least one relationship outcome.

Results—The results were not consistent within or across studies, and suggest that some specific aspects of the interventions may be helpful for the patient, while other aspects of the studies may be helpful for the partner. The Northouse et al. study suggests that partners may benefit from a focus on couple work, as compared to the patient. The Canada et al. study indicates that when focusing on sexual functioning, working with a couple did not show significant benefit compared to working with a man alone. The study did show, however, that a sexual-based intervention can improve the use of erectile dysfunction treatments and suggests patients may benefit from specific focus on side effects of treatment. The Manne et al. study highlights the importance of targeting these interventions to couples who report distress, and for distressed couples, an intervention can show positive results.

Conclusions—Intimacy enhancing interventions can be effective for couples, while the partners may benefit more from couples work; the patients may benefit more from focus on specific side effects.

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Keywords

Prostate; Cancer; Treatment; Psychosocial Interventions for Men with Prostate Cancer

Introduction

Prostate cancer is the most commonly diagnosed cancer in men, with over 240,000 new cases expected to occur in 2012. Because of advances in screening and early detection, 90% of men are diagnosed at an early stage. Survival rates continue to increase, with close to 100% of cases surviving 5 years post-diagnosis [1]. The three treatment options for men diagnosed at an early stage are radical prostatectomy (RP), radiation, and active surveillance. Due to the trend toward younger age at diagnosis and the proven long-term benefits of RP, the number of men choosing surgery has increased over the past 10 years [2–5].

With excellent cancer control for men diagnosed with early-stage prostate cancer, the focus has shifted to quality of life issues after treatment. Although advancement in treatments have attempted to reduce the negative impact these treatments have on erections, 85% of men report having problems with erections up to 4 years post-treatment [6]. The psychological impact of erectile dysfunction (ED) is well established; men experience an increase in depressive symptoms, frustration, shame, disappointment, and lower general life happiness [7–10]. ED bother increases post-treatment and remains significantly high at least 2 years after surgery [8]. Additionally, the accumulation of the psychological side effects tends to result in an avoidance of starting an erectile rehabilitation program and non-compliant behavior for those who do seek out treatment [11].

The depression and bother related to difficulties with erections after treatment often result in a loss of sexual intimacy and avoidance of sexual situations, which in turn can also lead to relationship stress [7,9,12–16]. In a review of psychosocial research addressing patients with prostate cancer and their partners, Couper et al. (2006) found that prostate cancer has considerable psychological effects on the partner. While many partners believe the patient is more distressed, it is the partners themselves that actually report higher levels of distress. It is common for partners to comfort patients who experience sexual dysfunction while ignoring their own sexual needs [17].

Based on the evidence that supports high levels of distress in both men with prostate cancer and their partners, it is important to assess past interventions and discuss future directions for couples. This paper is a summary of a presentation given at the Cancer Survivorship and Sexual Health Meeting, which provided an evaluation of three psychosocial interventions for patients with prostate cancer and their partners.

Aims

The goals of this presentation were to give an overview of three different interventions intended to increase intimacy among couples facing prostate cancer as well as describe the methodological issues presented by each study.

Methods

We have selected three intervention studies to review. These three research studies are not meant to be an exhaustive list of psychological interventions. To be selected, all three had to be randomized controlled trials, focus on a couples approach to therapy, and report at least one relationship outcome. Furthermore, to give the audience an overview of the types of studies in the area, we selected studies with different therapeutic approaches, different strengths and weaknesses, and different implications for future research and clinical directions. In the end, the three studies selected seemed to be the three best methodological examples in this literature.

In describing the studies, the goal was to present an overview of the methods of the study, a description of the therapeutic approach used in the study, and summary of the results of the study.

Description of Studies, Therapeutic Approaches, and Results

Randomized Control Trial of a Family Intervention for Prostate Cancer Patients and Their Spouses

Overview—The goal of this study, conducted by Northouse et al., was to determine if a family-based intervention could help improve couples' management of the effects of prostate cancer and their quality of life [18]. Two hundred and sixty-three dyads were randomized to either the control condition (standard clinic care that addressed diagnosis and treatment) or the experimental condition (standard care plus the FOCUS program). Eligible men included those who were newly diagnosed, had biochemically reoccurring prostate cancer, or advanced disease. Assessments were administered at baseline, 4, 8, and 12 months.

Intervention—The intervention, named The FOCUS Program, is a supportive–educative intervention that consists of three home visits and two telephone sessions. The acronym signifies the five core elements of the intervention: *F*amily involvement, encouraging couples to work together; *o*ptimistic attitude, which supports short-term goals; *c*oping effectiveness, which emphasizes healthy behaviors; *u*ncertainty reduction, which educates couples on ways to live with uncertainty; and *s*ymptom management, which teaches couples how to deal with and manage symptoms. Because this study had three specific disease phases, content was tailored to the needs of the couples within each phase.

Measures—Quality of life was measured through a general quality of life measure, the Medical Outcomes Study (MOS SF-12), and the general Functional Assessment of Cancer Treatment (FACT-G). Appraisal variables were measured with the Appraisal of Illness or Appraisal of Caregiving Scales. Uncertainty and hopelessness were assessed with the Mishel Uncertainty in Illness Scale and Beck Hopelessness Scale, respectively. Coping resources were assessed with the Brief Coping Orientations to Problems Experienced Scale, Lewis Cancer Self-Efficacy Scale, and the Lewis Mutuality and Interpersonal Sensitivity Scale. The Omega Clinical Screening Interview was given to measure risk for distress.

Results—In general, the results were more positive for the spouses as compared to the patients. Patients in the FOCUS intervention reported less uncertainty about their illness and more communication with their spouses at the 4-month follow up. There were, however, no significant improvements found among any of the variables at the 8- or 12-month assessment time points for the patients. Spouses in the intervention arm reported better mental QOL and overall FACT-G scores at 4 months, but reported no significant differences in QOL outcomes at the 8- or 12-month follow up. Uncertainty, hopelessness, and appraisal of caregiving were also significantly lower than control spouses at 4 months, with uncertainty continuing to be lower for intervention spouses during the 8-month follow up. In addition, spouses who were administered the FOCUS intervention reported better communication during all three time points, higher self-efficacy at 4 and 12 months, and better active coping skills at 12 months. Lastly, intervention spouses reported less general symptom distress of their own at the 4- and 8-month assessments.

Pilot Intervention to Enhance Sexual Rehabilitation for Couples after Treatment for Localized Prostate Carcinoma

Overview—While the Northouse study addressed a variety of concerns relevant to prostate cancer survivors and their partners, Canada and her colleagues designed an intervention focusing specifically on sexuality after treatment and the utilization of medical treatments for ED [19]. Eligible men were those 3 months to 5 years post-surgery or radiation for localized disease. Eighty-four men and their partners were randomized to either receive the intervention together, or to have the man alone attend the sessions. Assessment time points took place at baseline, post-intervention, 3 months, and 6 months.

Intervention—Regardless of group assignment, all participations received four sessions of the intervention. Session one focused on the sexual history of either the couple or man alone. The following three sessions addressed the sexual impact of surgery or radiation, treatments for ED, coping strategies in sexual situations, skill training to improve sexual communication, general communication of feelings, and expression of affection. Techniques to target negative beliefs about sexuality and cancer were also addressed. Participants were given handouts and homework assignments during each session.

Measures—Sexual function was assessed using the International Index of Erectile Functioning (IIEF) for men and the Female Sexual Function Index (FSFI) for the women. The Brief Symptom Inventory (BSI) was given to measure psychological distress, including depression, anxiety, hostility, tendency to somatize, and emotional adjustment. Marital satisfaction was measured with the Dyadic Adjustment Scale (DAS) and quality of life was assessed with the Short Form Health Survey, specifically the physical (PCS) and mental health (MCS) summary scales.

Results—Results showed no significant differences between the groups at baseline or follow up. Since there were no significant differences between the groups, the groups were combined for further analysis. When combining the groups and analyzing changes from baseline, men's emotional distress scores, as well as male and female sexual functioning (measured by the IIEF and FSFI), were found to have significantly improved at the post-

treatment visit. These variables did, however, return to baseline by the 6-month assessment. Significant results were also found in the number of men using at least one form of medical treatment for ED, increasing from 31% to 52% from baseline to post-treatment, and falling just slightly to 49% at the 6-month follow up. The intervention did not improve marital adjustment, largely due to the high relationship satisfaction scores reported at baseline.

Intimacy-Enhancing Psychological Intervention for Men Diagnosed with Prostate Cancer and Their Partners: A Pilot Study

Overview—Similar to the previous study, Manne et al. designed an intervention for couples after treatment for prostate cancer [20]. The purpose of the study was to improve distress and relationship outcomes using an Intimacy-Enhancing Therapy (IET). Men diagnosed with localized prostate cancer within the past year were eligible to take part in the study. Seventy-one couples were randomized to either receive five sessions of IET or Usual Care, consisting of social work consultations. Assessment time points took place at baseline and 2 months post-baseline.

Intervention—Couples randomized to the IET arm received five 90-minute couples' sessions. Sessions focused on optimizing adjustment by strengthening the relationship, relationship enhancing communication including self disclosure, and relationship-compromising communications including pressure to discuss concerns and withdrawing from communication. The intervention, derived from Cognitive Behavioral Therapy and Behavioral Marital Therapy, sought to aid with discussion of concerns regarding cancer and the impact of treatment, and to maintain and improve emotional intimacy. Communication skills were practiced both in session and at home by the couples.

Measures—Psychological functioning was measured using the Psychological Distress Scale of the Mental Health Inventory, the Psychological Well Being scale of the Mental Health Inventory, and the Impact of Events Scale for Cancer Specific Distress. The Dyadic Adjustment Scale (DAS) and The Personal Assessment of Intimacy in Relationships were used to measure relationship functioning. Self disclosure, perceived partner disclosure and perceived partner responsiveness were assessed using scales adapted from Laurenceau and colleagues. Finally, mutual constructive communication and demand-withdraw communication were measured with subscales of the Communications Pattern Questionnaire (CPQ).

Results—IET did not significantly affect psychological functioning, relationship functioning, or relationship communication in either the patients or their partners. However, moderator analysis of baseline variables showed both beneficial and detrimental effects. Patients with greater cancer concerns and poorer communication showed an increase in self disclosure, perceived partner disclosure and perceived responsiveness. Interestingly, patients receiving IET who reported high levels of disclosure at baseline showed a reduction in this measure during the follow up time point. Partners as well showed both beneficial and detrimental moderator effects depending on certain characteristics reported at baseline. Partners who reported greater cancer specific distress, lower relationship satisfaction and intimacy, and poorer communication benefited more from IET, specifically with cancer-

specific distress, relationship satisfaction, and relationship intimacy. However, partners who reported lower levels of cancer-specific distress, high relationship satisfaction and intimacy, and better communication skills were negatively affected by IET. Finally, participants who reported lower baseline rates of mutual constructive communication and demand–withdrawal communication reported higher rates of these communication variables during their follow-up assessment.

Discussion

Although each of the chosen interventions show some benefit, the results are inconsistent, proving that further modification needs to be conducted. The first area to focus on is the content of the intervention. The Manne and Northouse studies addressed a variety of concerns regarding communication, the side effects of prostate cancer, and general quality of life, while the Canada study focused primarily on the sexual side effects, leading us to question the focus the intervention needs to have on both the partner and the patient in order to be effective. A large part of the intervention tested in the Canada study addressed educating participants about ED treatments and how to get the most benefit out of their use. Results indicated that this piece of the intervention showed a significant increase in the number of men utilizing ED treatments even 6 months later, which suggests that a more specific intervention focused on the side effects of treatment may be what is most helpful for patients. Both the Manne and Northouse studies indicated better relationship and communication outcomes, with reduced distress for the partners, suggesting partners benefit more from the “relationship” aspect of these therapies. Thus, an effective intervention may need to move away from a “one size fits all” type of therapy, and design specific aspects to help both the patient and the partner.

The second area of concern in these studies is the patient selection criteria, specifically the stage of disease, type of cancer treatment, and time from treatment. The Northouse study, which includes three different stages of prostate cancer (newly diagnosed, biochemical recurrence, and advanced disease) does address the fact that their intervention was tailored based on the stage of their participants, however this study also notes that there were significantly less participants in the advanced and recurrence groups than in the newly diagnosed group, which potentially hides any moderator effects a larger sample could have provided. Because of the unique issues that arise with each stage—treatment decisions, uncertainty about the future, side effects of each treatment—future interventions should limit their eligibility criteria to a specific phase of the illness in order to adequately deal with these issues. In addition, the length of time from treatment should be addressed. In the Canada study, participants were eligible if they had received treatment between 3 and 60 months previously. This gap in time is especially important when addressing the sexual side effects of prostate cancer surgery, as a delay in ED treatment can significantly impact overall recovery, which has the potential to effect a couple’s relationship.

All three studies show that couples need to be pre-assessed before an intervention begins. The Manne study illustrates that intervening on a couple who already reports high levels of communication and low levels of distress can have unintended negative effects. A potential explanation for this result may be that the intervention makes a couple more aware of issues

they were never concerned about, increasing their distress levels. Future studies should therefore assess potential patients and their partners to target only those who are reporting distress and relationship difficulties. Future studies may also want to consider having the couple voice their specific goals for therapy and target what is important to them. This could include how to deal with urinary incontinence, ED, communication skills, or treatment decisions. By addressing what is important to the couple, within a guided intervention, we may see more benefit as well as a lasting effect that some of the previous studies lack.

In conclusion, considering the number of men diagnosed with prostate cancer each year, it is important that the focus continues to be on the unique side effects of treatment. Sexual dysfunction and intimacy are especially important, as the vast majority of men experience a change in sexual functioning, and the impact can be severe [21,22]. Not only do future studies need to address the previously mentioned issues, but the homogenous patient samples limit results to be generalized to the prostate cancer population, and future research should work to include sexual and racial minorities. Finally, we need to recognize that while partners do often report more of a benefit from couples' interventions, the patient is equally important. In order to balance the outcome, relationship issues should be the main focal point for female partners while treatment for ED and avoidance of sexual situations may be the most important issue to address for male patients.

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