

THE PSYCHOSEXUAL AND PSYCHOSOCIAL IMPACT OF
PROSTATE CANCER ON THE PATIENT AND HIS PARTNER
WITH A CALL FOR A HOLISTIC APPROACH TO
TREATMENT

A DISSERTATION SUBMITTED TO THE FACULTY OF THE
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GARY R. PICKERING M.DIV., M.S.

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DISSERTATION APPROVAL

This dissertation submitted by Gary R. Pickering has been read and approved by the members of the Dissertation Committee for the American Academy of Clinical Sexology. The final copies have been examined by the Dissertation Committee and the signatures which appear here verify the fact that any necessary changes have been incorporated and the dissertation is now given the final approval with reference to content, form and mechanical accuracy.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Signature:

Date:

Rhonda Fine, Ph.D.

William A. Granzig, Ph.D.

Joel L. Kelley, Ph.D.

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VITA:

EDUCATION:

American Academy of Clinical Sexology Ph.D. Candidate.
Troy State University: Master of Science in Counseling
Christian Theological Seminary: Master of Divinity
Indiana Christian University: Bachelor of Arts in Psychology

EMPLOYMENT:

2001-Present: Florida Department of Corrections
Mental Health Specialist
Sex Offender Treatment Specialist
Rehabilitation Therapist
1992-2001: Self-employed in Sales
1982-1992: Presbyterian Church USA
Ordained Teaching Elder and Pastoral Counselor
1969-1975 U.S. Navy

LICENSURES:

Licensed Mental Health Counselor
State of Florida Department of Health

CERTIFICATIONS:

Certified Sex Offender Treatment Specialist
American College of Certified Forensic Counselor
National Association of Forensic Counselors

ABSTRACT:

Psychosexual and psychosocial issues significantly impact the cognitive, emotional and relational health of patients diagnosed and treated for prostate cancer, as well as their significant others. This impact needs to be recognized and incorporated into a holistic treatment plan that begins with pretreatment counseling. This holistic approach needs to embrace a broad range of patient options. Physicians need to consider the importance of their patient's sexuality when explaining these options. Finally post-treatment assistance as it relates to sexuality must be offered to the patient and to his partner, as they must redefine their sexuality.

At this time, this holistic comprehensive approach would go far beyond the current medical standard of care, which now focuses on the physical battle of destroying cancer cells.. Incorporating each patient's view of himself, his sexuality, his ability to perform sexually and his significant others view as well as their support is necessary in guiding the entire multidisciplinary treatment team toward improved treatment modalities, as they relate to the prostate cancer patient, thus enhancing his and his partner's overall psychosocial and psychosexual adjustment to treatment.

Sexuality is an integral part of how individuals define themselves. Understanding each cancer patients' view of their sexuality is essential in assisting them to make decisions. When treatment forces major alterations to the way they view themselves as sexual beings, far too often the patient and his partner will be left on their own to confront these changes, discovering limitations through their experience rather than being guided by professionals.

This work is an attempt to bring these issues to light in order to elicit change to the current medical standard of care for prostate cancer. This paradigm shift needs to encompass not only medical treatment of the cancer itself, but also the treatment of each

patient and his partner's psychosocial and psychosexual needs as well as their mental health. Recognition of the need for the assessment and treatment of these issues can create a treatment foundation that will assist the patient and his partner in working through these changes and adjustments in their lives. The multidisciplinary team approach will no longer leave the patient and his partner to fend for themselves.

Only through a professional multidisciplinary team approach, working together, will treatment outcomes be truly patient-centered for the prostate cancer patient and their significant other.

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Rationale for the Study:
Introduction:

Far too often we learn about our human sexuality through experience rather than instruction or research, unless circumstances are forced upon us where knowledge must be acquired. This is often the case with prostate cancer patients and their partners, and it was the case with me. Not to say I have not studied sexuality, as a Licensed Mental Health Counselor I took the required courses in “Human Sexuality” and attended lectures about sexual diversity and dysfunctional sexual behavior as it relates to sex abuse. Overall, I considered myself adequately prepared to discuss sexual issues. That is, until the day when I sat in my urologist’s office and was informed, “You have prostate cancer and tests show that if it goes untreated you will be dead in about four-and-a-half years.”

I remember telling the surgeon at the time, “You now have my undivided attention.” It sounded right, but it was not true. I don’t remember much about our discussion other than the treatment options and his recommendation for a radical prostatectomy. The cancer was traced back over the previous five years of inconsistent tests. The Prostate Specific Antigen (PSA) scores crept up slowly and even then were only 4.7. However, after the biopsy was completed, the Gleason scores were between 7 and 8 on a scale of 10. The cancer was far too close to metastasizing, if it had not already done so. In addition to the little I heard that day, I could only think about how my wife and children would be affected. My thoughts centered on the fact that my grandchildren should not have to see their grandfather buried at such an early age. I chose surgery to make sure the cancer had not spread. Only afterwards did I realize the full impact of my decision. My life, how I viewed myself as a sexual person, as well as my sexual relationship with my wife were significantly impacted by the surgery, and still is to this day.

After surgery, I learned firsthand how integral sexuality is to our perception of ourselves and how we define ourselves. Through this experience, I came to believe that a better understanding of our sexuality is essential for prostate patients and their partners in order for them to make fully informed decisions when a prostate cancer diagnosis is given. When this occurs, patients and their partners are thrust into making life-changing decisions. Major alterations in the way the patient sees himself as a sexual being often follow. Prostate cancer affects not only a man's physiology and self concept as a social being, but also impacts the couple psychosexually and psychosocially, as all aspects of their relationship may be altered by treatment, including their sex lives, level of intimacy, attraction, love, communication, the role one plays in their relationship and their financial security. In addition mortality issues arise.

Sexuality is such a major issue for men who are post-prostatectomy, as men have become conditioned to believe that their self-worth and their self-esteem are rooted in their physical strength and sexual abilities, especially the ability to achieve and maintain an erection suitable for sexual penetration. Men who are unable to measure up to these standards are considered undesirable, inadequate, and second-rate citizens in the social pecking order, at least in our own minds, if not in others'. Even though we may hear over and over again that this is just a myth, it can and will affect how we see ourselves and how we relate to others, especially in a psychosocial/sexual frame of reference.

Statement of Problem:

In 2012 approximately 240,000 new cases of prostate cancer will be diagnosed in the United States and about 28,170 men will die from the disease. It is estimated about one male in every 6 will be diagnosed with some form of prostate cancer in his lifetime.

Prostate cancer is the second-leading cause of cancer deaths in men. (American Cancer Society, 2012).

The process of adjusting to the aftereffects of prostate treatment can seem overwhelming. A prostate cancer patient is faced with a multitude of uncertainties about himself, his relationships with others, and the impact his disease will have on his life. Adjustment takes time, and without a holistic approach to treatment which includes the sexual element, the patient and his partner may take longer to adjust than is necessary or they may never adjust, thus causing additional pain.

As one part of a multidisciplinary team treating the prostate cancer patient, the one focus of the clinical sexologist should be to develop a treatment program that will help the patient and his partner both emotionally and psychosexually, starting from the diagnosis through the post-surgery healing process and beyond. The goal becomes not to merely help patients adjust and to see themselves only as survivors of cancer, but also to assist them in growing as sexual beings. All too often, the issue of developing a greater insight into what it means to be a sexual being after prostate cancer becomes solely the patient's responsibility once he is discharged. It is time for the entire treatment team, from the surgeon to the clinical sexologist, to adapt a holistic plan in order to treat the whole patient including his partner.

One of the major causes of death for men in the United States is prostate cancer, and it is the second most common cause of death from cancer. Among cancers, prostate cancer is one of the least progressive, as evidenced by up to 93% of men living up to five years and 72% living up to a decade past diagnosis and treatment (American Cancer Society, 2010). Statistically, 80% of prostate cancer diagnoses are in men greater than age 65 (Helgeson & Lepore, 1997). Studies suggest about 29% of men ages 30 to 40 and nearly 64% of men

ages 60 to 70 will develop minute-sized cancers contained within the prostate (Sakr, & et al, 1994). Approximately one in every 6 males will develop some form of prostate cancer at some point in his life, while approximately one male in 30 diagnosed with metastatic cancer will die due to complications related to the metastasized cancer (Jemal, Thomas, Murray, & Thun, 2002). The American Cancer Society estimated that there were approximately 27,360 deaths in the United States due to prostate cancer in 2009 (American Cancer Society, 2010).

Traditional Treatment vs. a Holistic Approach:

There is a diverse assortment of treatment choices for the patient who is diagnosed with prostate cancer. When the cancer has been determined to have a low Gleason score or remains confined within the prostate gland itself, treatment options usually involve surgery, radiation or “watchful waiting.”

The surgical preference for localized or low-grade cancer, meaning cancer that has not metastasized, is the radical prostatectomy, which involves the surgical removal of the whole intact prostate (American Cancer Society, 2010). Although removal of the entire prostate is the surgery most often performed, the prostate cancer patient actually may have a variety of surgical treatment options, depending on the surgeon’s specialization.

Nonsurgical preference for a cancer confined to a generalized area includes external or internal irradiation. External beam radiotherapy utilizes high energy X-rays or radioactive particles aimed at the malignancy contained within the prostate (Eton & Lepore, 2002). Internal irradiation involves the implantation of radioactive seeds directly into the prostate gland.

Another option available for localized prostate cancer is watchful waiting. With watchful waiting, direct treatment is postponed and the cancer is watched for any signs of

further development. Since most prostate cancers develop slowly, watchful waiting is the favored approach especially for older patients with low-rated cancer and little or no presenting medical issues involved.

For metastasized prostate cancer, chemotherapy, hormone treatments, or a combination of both can be employed to minimize the metastasis. The treatment of choice is usually various hormone therapies. Antiandrogens are a common form of hormone therapy as a component of nonsurgical treatment, with the goal of reducing the amount of androgens responsible for cancerous cell growth. As a result of this treatment, testosterone production is halted by hormone analogs that produce luteinizing hormones. For men with metastasized cancer and failed hormone treatments, chemotherapy is the remaining option (American Cancer Society, 2010).

Each individual or combination of treatment options has its own particular side effects that can decrease the patient's quality of life (Gray, Klotz, Iscoe, & et al, 1997; Lintz, Moynihan, Steginga et al, 2003). The side effects from these treatments can include but are not limited to the following: hot flashes, loss of muscle mass, fatigue, rectal pain, diarrhea, urinary incontinence, increased breast size, bone loss, and liver dysfunction (Altwein, et al, 1997; American Cancer Society, 2010; Gleave, et al, 1999; Herr & O'Sullivan, 2000). Clark, et al (2003), concurs that patients diagnosed and treated for prostate cancer appear to exhibit greater levels of dysfunction in their bowel, urinary, and sexual activities. Compromised sexual ability also is often reported by prostate cancer patients as a side effect directly related to prostate cancer treatment. For some patients, because of age or physical health, the ability to engage in sexual intercourse prior to prostate cancer treatment was already compromised. Add to that the erectile dysfunction that is frequently a result of prostate cancer treatment and the patient is likely to continue to suffer from the

psychosexual and psychosocial impact of cancer treatment long after the cancer itself has been eliminated.

The most basic function of any man during sex is to have an erection and maintain it until orgasm. The extent of the damage and effects of the prostate cancer treatment to each man will vary depending on the treatment process used and the extent of damage done to the nerves during treatment (Jarrett, 2007). The removal of nerves and tissues or damage done to them largely depends on the extent of the cancer, the treatment involved, and the skill of the surgeon.

When considering treatment options, the decision as to which part or tissue should be treated or removed is very crucial. The doctor's first order of business is to save the life of the patient with as little damage or tissue removal as possible while still eliminating the cancer. However, in order to get all of the cancer, the surgeon could be removing tissue that includes parts of organs that control vital functions, including sexual ones. Cancer cells that spread to any other parts of the prostate are sure to cost the patient more tissue (Jarrett, 2007). This can greatly affect the patient's ability to have full erections post-treatment, depending on how much nerve damage was done or how much of the nerve tissue was saved. If the patient was experiencing sex-related difficulties prior to treatment or surgery, there is a greater chance the problem will increase. However, the less damage or tissue removed during surgery, the greater the chance for post-treatment erection.

One of the benefits of improved treatment methods is that erections for the prostate cancer patient can be a post-treatment reality, whereas in the past, removal of the prostate gland guaranteed impotence. Today, the removal of or damage to greater portions of the prostate and surrounding tissue and nerves does not necessarily signal the end of sexual intercourse between the patient and his partner. The couple can utilize medications, as well

as new techniques and therapies to achieve and maintain erection; but they can only do so if they are made aware that such options exist. They also need guidance in order to effectively implement them and to overcome any embarrassment or reluctance to discuss and attempt them.

Unfortunately, while information concerning treatment side effects is often provided follow-up treatment to help the patient and his partner adjust physically and emotionally to these side effects has been given little or no consideration. The couple may be informed of some tools to help them regain a fulfilling sexual life, but treatment ends at that point. The cancer has been treated; the patient and his partner may now resume life without any further need for assistance. This is just not the case. The couple has been thrust into the unfamiliar territory of post-cancer life, and ending treatment at this point is akin to asking them to order from a menu written in a foreign language they have never seen. They are in need, and yet have no idea what it is or how to ask for it.

Truly effective prostate cancer treatment must include the formation of a multidisciplinary treatment team of medical professionals and a treatment specialist/clinician that works with the patient and his partner to create and implement pre- and post-treatment plans. For example, impotence is a physical side effect that can now be treated medically; however, a patient also suffers an emotional impact when his ability to maintain an erection and satisfactorily participate with his partner in intercourse is threatened. This is when the clinician proves essential to the team and the patient's positive outcomes, because all too often the element of relationship and feelings or love is removed from the treatment process just as effectively as the cancer is removed. Together, it is the treatment team's duty to inform the patient of all of his treatment options; to discuss the negative side effects he may experience that can prove to be physically, emotionally and

sexually distressing; and to prepare the patient and his partner for these outcomes. Not to do so is paramount to falling short of the “Do no harm” vow.

In the pre-treatment stage, a discussion of partial prostate removal vs. removal of the entire gland is one example of what must take place. A couple may be directed to pre-surgical counseling to prepare them for coping with erectile dysfunction, incontinence or other potential physical and sexual side effects from treatment.

A holistic treatment approach calls for additional recognition of the need for the assessment and treatment of all of these issues. It creates a treatment foundation that will assist the patient and his partner in working through this change in their lives. The medical doctor treats the disease; the clinician helps the patient understand his pre- and post-treatment options for physical health and an active sex life, as well as assists him in working through his own feelings about the psychosocial and psychosexual issues he experiences.

On the physical side, medications such as antagonist drugs that reduce physical complications and positively affect the patient’s mental health (Eton & Lepore, 2002) can be recommended side-by-side with techniques to achieve and maintain erection. One way some patients are achieving erections is through the use of alprostadil, a medication which is injected into the patient’s penis (Jarrett, 2007). It has afforded some patients the possibility of achieving and maintaining a full erection during sexual activity until orgasm. The amount to be injected and the need for adjustment should be done only after consulting the medical doctor.

Brachytherapy also has a good reputation for prostate cancer treatment. This therapy does not require removal of the prostate, which naturally makes the patient still capable of having an erection afterwards, depending on the strength of the treatment and the amount

of nerve damage done (Jarrett, 2007). Brachytherapy involves treating a smaller region of the prostate with internal radiation therapy. The strength of the radiation tends to drop off in time, as newer types of radiation have a shorter life span and thus do less damage in the long run. If the treatment involves removal of any part, the patient should still be able to demonstrate ejaculation. Although no semen is evident during ejaculation because it ends up in the patient's bladder, the patient still has the natural ability to achieve an erection.

In the holistic approach, the clinician can help the patient understand that a satisfying sexual relationship with his partner is possible using appropriate techniques and treatment methods such as these to bring about mutual enjoyment.

To reiterate, the goal of holistic prostate cancer treatment process is to assess, identify and treat all of the effects experienced by a patient and his partner, including the physical, psychosocial, psychosexual, and emotional repercussions. This will assist the couple in openly sharing their perceptions of the treatment process on their quality of life and the relational aspects of their life. Prostate cancer treatment creates physical side effects which, in turn, affect the entire social and sexual relationship of the patient and his partner.

The assessments used by the clinician to evaluate the behavior of a patient are based on the patient's physical dysfunctions and the couple's perceptions of their health, sexuality, and relational decisions. These provide an overview of the behavioral impact of the cancer treatment (Clark, et al, 2003). During the cancer treatment process and post-treatment outcomes, the clinician will measure, analyze, and evaluate the patient's behavioral processes, including feelings of regret, fear, loss, frustrations, and other emotions, as well as psychological factors that affect his perception of his health and relationship. One such assessment tool the clinician can use is the Health Survey SF-12 Short Form to evaluate the physical and mental health of patients undergoing treatment (Litwin, 1999).

The patient in the post-treatment phase is learning to deal with the dysfunction of his bowels, bladder and erections, but he is also likely to be experiencing higher levels of insecurity in relation to his interpretation of the masculine cultural norm and perceived sexuality. Some patients also experience a decrease in self-worth and self-confidence, as well as an increase in concerns about the cancer reappearing. Patients' perceptions and experiences in regards to their past cancer treatment decisions tend to be projected onto their current issues of health and physical dysfunction. The patients' ability to successfully work through the maelstrom of issues battering them mentally, physically, and emotionally largely depends on the breadth of treatment options they receive at the hands of the treatment team.

The clinician's ability to help patients and their partners work through the anxieties and problems associated with sexual intimacy, issues of masculinity, and their perceptions about cancer control will greatly influence the couple's view of their sexual and health functionality. Masculine feelings and perceptions of sexuality, as well as concerns about follow-up cancer screening, often directly relate to the level of confidence and belief systems displayed and supported by the treatment team. The more holistic the approach by the team, the greater the influence the team will have in dealing with the patient's issues. It is paramount for the treatment team to understand that there is a discernible and often significant difference in the patient's overall quality of life prior to and following treatment. The lack of intervention after treatment greatly affects the patient's perceptions, lifestyle, and relationships. The assessment, prognosis, and intervention by the treatment team will result in greater positive outcomes for the patient and his partner. Without this approach, aggressive interventions for cancer control can impact the patient's masculine and sexual self-image, and he has a higher chance of negative outcomes (Clark et al, 2003).

Clearly, the problem of impotence alone can have a negative impact on men who have been treated or are undergoing treatment for prostate cancer (Bokhour et al, 2004). This problem has greatly affected the lives of many prostate cancer patients. However, the psychosocial, psychosexual and relational issues have received less attention by treatment teams in the past because medical practitioners have been reluctant to look beyond treatment as usual. Although most patients are now becoming more aware of the effects of prostate cancer treatment and the impact it brings to their lives, there is still a lack of understanding about the social and emotional impact beyond the issue of erectile dysfunction. The effects and the causes have a major influence on the patient's sexual intimacy, relationships, and self-image.

The patients and partners who are encouraged to share their experiences and concerns about the diagnosis and treatment outcomes find it easier to share the problems related to their sexual habits and the effects of erectile dysfunction. With treatment, these patients can come to understand the significance of the resulting consequences in their lives and learn how to work through them before they become a huge detriment to their self-view and relationship. Impotence and its relative psychological and psychosocial implications have the potential to deeply affect the sexuality as well as the masculinity of the patients and can be a major focus in a holistic view of treatment. The most common issues male patients have expressed are concern for their partner's satisfaction, their ability to interact comfortably with women in general, and their own self-perception as a man in relationship. A patient's self-image as he views himself in comparison to the masculine cultural norm is highly relevant to his own view of his erectile dysfunction.

One study conducted by Bokhour et al (2004), focused on patients' perceptions based on their experiences, including the long-term consequences and side effects of the

treatment. What became evident to Bokhour was how important it is for the clinician to understand that different patients experience different levels of perception concerning their erectile dysfunction immediately following treatment and for some time after adjustment to the treatment. This also holds true with men facing the recurrence of cancer. Perhaps even more important than what was discovered regarding patients' perceptions about erectile dysfunction is the fact that Bokhour's study exposed the scarce attention and low research priority given to the damaging outcomes of prostate cancer treatments.

Impotence, or any form of erectile dysfunction, has a significant emotional impact on the patient and his partner, which they may not know how to deal with, either individually or as a couple. The clinical sexologist in the process of treatment needs to keep in mind that asking the patient or his partner about the extent of the problem may trigger some masculinity issues that could close the discussion. However, given the opportunity, most patients clearly perceive the problem as something that could change their relationship and lifestyle and needs to be confronted in the therapeutic setting rather than on their own. Assessment in the treatment process needs to evaluate the outcome of the prostate cancer treatment on the quality of life of the patient, as well as measure and evaluate the emotional, psychosexual and psychosocial impact of the treatment as it relates to the patient's self-image and perceived sexual issues.

The results of Bokhour's study should serve as a guide to clinicians prior to treatment when helping patients choose treatment options, as well as when giving them information on the issues of erectile dysfunction and its impact on their lives. The clinician also needs to understand that patients should be able to set the boundaries between clinical interaction disclosure and what they feel they should discuss. It is imperative for clinicians to be sensitive in assessing the meaning of erectile dysfunction to their patients.

The discussion about treatment should include the possible outcomes of treatment and the general impact because each case and its outcomes will be different. An assessment of the patient's current sexual functioning and attitudes may also help the clinician assist the patient in coming to an informed decision about the kind of treatment he is going to choose. Through these efforts, the clinician can assist the patient in becoming prepared for treatment and avoid being shocked by the outcomes.

After the diagnosis of cancer has been given, the clinician should assist the patient in understanding the complexity of the treatment process. At one point, the focus of therapy should be directed toward the psychosexual, psychosocial, and relational issues that the patient and his partner may encounter during and after the treatment process. If the patient and his partner are prepared for the possible stressors, there is a greater chance the couple will be able to make progress quicker and feel they have a resource they can turn to and trust when they hit a relational roadblock. It is imperative that patients be given the opportunity to receive counseling prior to the choice of treatment type and after treatment in order to assist them in managing the outcomes of the treatment. The clinician may also assist the patient in being prepared for the possible impact of the dysfunction as well as the feelings the patient may experience about the condition and the effect of the dysfunction on his relationship and sexual life.

The clinician can also take this opportunity to explain to the patient the availability of prescriptions for correcting any erectile dysfunction such as the transurethral medications alprostadil and sildenafil. The patient may also be prepared for the means by which some prescriptions are administered, because some patients may not feel able to self-administer medications in the manner required. Patients need to be assisted in comprehending to what

extent assistance is available to overcome their erection problems. Most men want to be sexually active, and a trained clinician can assist them in achieving this.

In order for all of this to happen, treatment as usual has to be expanded to include the techniques of counseling required by these patients during the clinical interaction. The assessment and treatment should not be done without the proper counseling training. It is important that sexuality, image perception, confidence issues, social issues, and the patient's view of his masculinity are included in the clinical interaction by a trained clinician. Bokhour's research indicates that men engaged in the treatment process tend to reveal that they fear sexual dysfunction and the fact that they may be (or are already) unable to perform sexually, but they also see this as something that can be worked through. They tend to focus the discussion about their post-treatment problems in terms of its impact on their sexuality and their concerns about their masculinity. It is evident that members of the treatment team need to be sensitive to the outcomes of treatment, the physical erection problem in particular, as well as the psychosexual and psychosocial effects. Patients given the opportunity in counseling to discuss their concerns tend to focus more on erectile dysfunction than the cancer. They express even greater concern about the possible change to their self-image as it relates to their masculinity and sexual functioning than about the success of the surgical treatment (Bokhour et al, 2004).

Bokhour's study reinforces the idea that erectile dysfunction has a significant influence on the lives of patients and their partners. A holistic view of treatment reaches beyond a compartmentalized view of treatment and assists patients in choosing the type of prostate cancer treatment best suited for their situation. It also provides a realistic perspective of the effects treatment can have and the possible impact the outcomes of each treatment modality can have on the patients' lives. The patient is better served by the treatment team

when he and his partner are made aware of the possible changes they are facing as well as the social, sexual and self-image challenges that can occur post-treatment. The clinician and the treatment team as a whole should be open to this holistic approach to guiding and supporting patients through these changes.

A clinician's focus should center on helping the patient and his partner adapt to their new medical condition. For the treatment to be effective it needs to include the patients' psychoeducational, psychosocial and psychosexual adjustment. Helgeson and Lepore (1997), consider the diagnosis and treatment of prostate cancer to be very important for men who place significant value on their interpretation of the masculine cultural norm. The complications caused by prostate cancer treatment frequently will cause embarrassment and frustration for the patient. In cases where a patient and his partner find it difficult to express their concerns about treatment and the treatment team is reluctant to intervene, negative results of any complications resulting from treatment only increase.

The degree of openness between patients and practitioners relates proportionally to how well the needs of the patient and his partner are successfully addressed. In order to enhance the likelihood of achieving the best possible patient outcomes, providers of medical care need to be able to enhance their modes of treatment and create an atmosphere that promotes frank, honest discussions of difficult and uncomfortable issues. Without these enhancements, certain forms of treatment can compound the patient's problems.

For medical practitioners and therapists, it becomes vitally important to evaluate the emotional impact treatment has on the patient and his partner. This information will serve to assist them in adapting the treatment process to their patients with a holistic mode of treatment. Although in the past focus has been placed on the physical effects of treatment,

the limited amount of research being carried out proves that psychoeducational, psychosocial, and psychosexual treatment has proven to be effective.

Through the holistic approach, the multidisciplinary treatment team can offer patients the latest medical treatments, point them towards support groups that may be helpful, counsel them about the emotional and relational impact they may face or are encountering, eradicate the cancer, and assess and treat symptoms that affect the mental health of the patient and his partner. Medical practitioners and therapists working in tandem can provide the types of intervention needed to form a comprehensive approach to the treatment of the patient's symptoms and challenges. Thus, they can increase the quality of recovery experienced by the patient and his partner prior to and following the medical treatment of the cancer.

Quality of Life:

For the medical community, far too often quality of life is defined only in terms of how much a patient's functioning in the physical realm is impacted or limited by the cancer and the chosen treatment modality (Cella & Bonomi, 1995; Cella & Tulsky, 1993). However, the treatment impact on the patient as it relates to mental health; social, psychological and psychosexual functioning; as well as the facility to engage in normal daily activities is what truly defines quality of life (Graves, 2003; Ware & Kosinski, 2001).

As a result of treatment-related issues and post-treatment health issues, men with prostate cancer can encounter considerable mental health issues and psychosexual distress (Eton & Lepore, 2002). According to a study conducted by Albertsen, et al (1997), men with prostate cancer describe a major reduction in mental health when compared to healthy men in the same age range.

Lintz, et al (2003) established that men with metastatic cancer indicate a major reduction in mental quality of life as compared to men diagnosed with localized prostate cancer. Emotional dysfunction, fear, and dysthymia are frequently described by patients diagnosed with cancer as they attempt to manage the effects of the disease and treatment on their physical and sexual well-being (Andryowski & Brady, 1994; Andersen, et al, 1989; Cella, et al, 1989). A tragic consequence to all this is that the patient diagnosed and treated for prostate cancer is more than four times likely to commit suicide than comparatively healthy men within the same age category (Llorente, et al, 2005).

Friedland, et al (1996), concluded that a holistic treatment approach which encompasses dealing with the mental health issues faced by men diagnosed and treated for prostate cancer compels the need to design an effective medical and psychological intervention process. Recognizing the issues that influence the mental and psychosexual health of the patient diagnosed and treated for prostate cancer can result in the entire treatment team's ability to understand and affect a positive adjustment to treatment outcomes (Andrykowski & Brady, 1994).

Beliefs:

A patient's belief that he has the ability to control his health plays a significant role in his ability to respond positively to treatment (Wallston, K. A., et al, 1994; Wallston, et al, 1978). The patient's health beliefs determine how well he is able to engage and fundamentally control the stressors that confront him. The patient's belief system can be seen as having either an internal locus of control or external locus of control. Internal locus of control implies by its very name that positive treatment gains are a consequence of the patient's ability to engage in the treatment process and strive toward positive treatment goals. (Turner, et al, 1992) Comparatively, external locus of control is differentiated by

belief that factors outside the patient's control can influence treatment outcomes. Such external factors are family and treatment experts (Guinn, 1998; Wallston, et al, 1994; Wallston, et al, 1978).

For Epping-Jordan, et al (1999) and Scheier, et al (2007), internal and external locus of control beliefs constitute a major impetus in the patient's ability to work through the diagnosis and treatment issues associated with cancer.

Research conducted by Cunningham, et al (1991), established that patients with cancer and significant internal locus of control also described an elevated sense of worth, the ability to be engaged in life and deal with the aftereffects of being diagnosed and treated for cancer.

Current Masculine Cultural Model:

Closely related to internal and external locus of control beliefs is the patient's own view of himself or his beliefs in relation to the current/dominant masculine cultural model (Helgeson & Lepore, 1997; Visser, et al, 2003). Factors related to the masculine cultural model considered to have a major impact on a patient's belief system are self-reliance and emotional control (Courtenay, 2000).

In their studies, Zakowski, et al (2003), reported increase in depressive disorder indicators in patients with prostate cancer when assessment revealed their approach to dealing with stress was to rely on restricted emotional effect and autonomous coping as the patients' style of expression within the strictures of the patients' interpretation of the masculine cultural model.

Janoff-Bulman (1992) and Charmaz (1991) reported that chronic, life-changing disease might be seen by the patient as a threat to emasculate his view of himself in relation to his

standing in the masculine cultural model. The aftereffects of the diagnosis and treatment of prostate cancer might be viewed as a lack of masculine strength.

Prostate cancer, specifically, was viewed as an attack on the patient's own view of himself within the masculine cultural model because of the possibility of declining physical health, loss of control of bodily functions as well as sexual functions, and an increase on dependence of others for his care and welfare (Helgeson & Lepore, 1997). Strict adherence to the stereotypical masculine cultural model may cause the patient greater psychological and psychosexual problems, unless these issues are identified and referrals to those trained to deal with them are utilized as part of the holistic treatment team process (Stansbury, Mathewson-Chapman, & Grant, 2003).

Bjorck, Hopp, and Jones (1999) in their research confirmed that patients diagnosed and treated for prostate cancer reported a perceived loss in their standing within their masculine cultural model and exhibited a marked decrease in their overall mental health. Helgeson and Lepore (2004) also found that patients diagnosed and treated for prostate cancers, who attempt to manage their treatment issues by self-reliance and emotional constraint are subject to an increase in negative thinking and exhibit dysthymic moods and effects. A prostate cancer patient's reaction as well as his general mindset regarding his view of the accepted masculine cultural model when he receives news of his prostate cancer diagnosis will give the clinician greater understanding of how the patient will respond to this life-changing news. Along with this greater understanding comes the ability to understand how the patient views this evolution in his change of identity during his cancer treatment process as it relates to his and his partner's overall gender issues. In the assessment process, the clinician can modify the holistic treatment plan agenda according to how the patient thinks about his view of the masculine cultural model and how his manhood relates

to the outcomes brought about by the cancer treatment. Another purpose behind assessing the patient and his partner's masculine cultural model is to reveal how the evaluation of the collected information obtained from the study reinforces the apparent necessity for including more qualitative treatment processes within the holistic treatment team concept. Gender identity concerns arise as a result of the treatment process with prostate cancer, and these concerns foster complications and implications that reach far beyond treatment of cancer as usual.

This research and the articles cited tend to agree that psychosexual and psychosocial behaviors are strongly related to the patient's reaction to the diagnosis and treatment outcomes and, if left unaddressed, can prove to be a risk to the patient's overall health. The shorter life span of some prostate cancer patients and the overall general elevated death rates are greatly credited to how the patient views his role within the masculine cultural model. This is in direct opposition to the idea that gender behavior is exclusively biological, as it explains the difference in gender health outcome. This, however, does not negate the fact that men are at a disadvantage when it comes to dealing with the diagnosis and treatment of cancer. For the most part, the male prostate cancer patient, because of a misguided adherence to the masculine cultural model, does not do as well with the cancer diagnosis as does his partner. The overall social/gender dissimilarity also includes those kinds of activities designated as being self-reliant. Further research into the masculine cultural models points out that economic resources put men at a greater risk of participating in unhealthy endeavors. The masculine cultural model says it is acceptable to participate in more dangerous careers, which only compounds their risk levels, accounts for the difference in gender-related mortality differences, especially in Western society. The clinician needs to be aware of the reality of this difference when treating the prostate

cancer patient and his partner. There are differences in the way each will view the diagnosis and treatment process. If the clinician is not aware of this, treatment will be hampered.

The importance of including this in the overall treatment process cannot be overemphasized. It is vital for the well-being of the patient and his partner for the treatment team to recognize how the patient and his partner view the masculine cultural norm and how this relates to their sexual well-being as individuals and as a couple. The roles and values of the patient and his partner are a direct expression of their perception of masculinity.

Gender Differences in Emotional Expression:

The male patient who is guided by the dominant masculine cultural norm is in general less likely to be demonstrative when it comes to feelings. Based on the cited studies on this issue, it appears there is a distinct gender difference when it comes to expressive manners. Yet looking beyond the dominant masculine cultural norm and appearances, what becomes important for the clinician/therapist to recognize is the obstacles that hinder the patient's emotional expression to their partner and other members of their support system. These obstacles, as well as perceived negative social beliefs, are the targets for further treatment concerns beyond treatment as normal when it comes to the prostate cancer patient.

When counseling the prostate cancer patient and his partner, the clinician needs to understand that men who are guided by the masculine cultural norm are, in the beginning, more likely to conceal their internal level of emotion. They may, in turn, find it harder to ask for and be open to receive the kind of social and emotional support that will allow them to be able to articulate their feelings and needs. Along with this difficulty comes the problem of internal blocks to their awareness of the existence of these issues. The cited

studies of masculine cultural norms as they relate to internal perceptions of support needs point out that while gender differences in perceived social support or conflict may vary from patient to partner, they have also been quick to highlight that open communication between partners makes dealing with the stress of cancer less uncomfortable and difficult. Being able to assess these needs and include them in a holistic approach to treatment is becoming evident.

As the clinician recognizes that obstacles and distress may exist in the couple's relationship, so should the clinician recognize that these issues may also be resting on the foundation of negative social beliefs. The consequence of negative social impacts may be the result of the patient having to shift his view of his partner. Whereas in the past, the relationship may have been one that was viewed as an equal partnership or a partnership where the man was the perceived base of support, now the roles have been reassigned, casting the partner as the major source of support and comfort. Men who rely on the masculine cultural norm do tend to have social barriers to emotional expression and the ability to seek out and receive comfort. This is important to note, because patients like this who have been open to receiving treatment beyond the norm have been able to gain greater emotional support from their partners. Furthermore, when a holistic approach to assessment and treatment has been incorporated, the male cancer patient tends to be more open to receiving help from resources beyond his immediate social arena.

Another area that is important for the clinician to be aware of consists of patients who are affected by a lack of support or understanding from their partner. There has been research into the effects of positive social and emotional support between partners, but little has been aimed at the potential for adverse effects when a low level of social and emotional support from the partner is assessed.

Studies indicate men are inclined to receive greater health benefits from committed relationships than women, and men are likely to experience more negative consequences from the loss of their partner. Some of the research attributes this to the fact that the partner was often the man's main focus of support, whereas women tend to have a broader support system beyond the marital or committed relationship. Combine the loss of a partner with a lack of social and emotional support and the effect can be catastrophic on the patient. However, none of this would even be assessed unless cancer treatment takes on a holistic approach to include a greater concept of what treatment needs to be.

In the course of this research, articles cited make clear the intimate connection between the emotional impact of the diagnosis and treatment of prostate cancer on the patient and his partner, as well as their relationship. There is a great need for informational resources that deal openly with these issues, plus an even broader need for established social support as a treatment tool. These studies make it clear that emotional support is of primary importance to patients and their partners. The ability of the treatment team to work with these relationships will have a positive impact on current emotional support systems and bring about greater adjustment outcomes to the treatment. Along with this, educational support groups geared towards giving informational guidelines tend to support effective treatment. Studies have clearly illustrated the effectiveness that assessment and reinforcement to the support system can have as important components of a holistic treatment process, and these components are clearly desired by patients as an enhancement to a better adjustment to the emotional support system. A major part of this holistic approach comes from someone trained to assess and treat the cancer patient's worries and concerns openly and with candor.

Holistic assessment of the patient and his partner, along with intervention by treatment team members qualified to deal with the psychosexual and psychosocial issues, increases the emotional support for the patient and his partner's adjustment to the entire cancer treatment process. Educational interventions aimed at offering informational support appear also to have a positive impact on their adjustment. There appear to be distinct psychological mechanisms involved in enhancing patient treatment through a holistic treatment approach that helps the patients support or redevelop internal self-esteem, restore perceived internal locus of control of their psychosocial and psychosexual processes, as well as instill optimism, provide meaning, and promote emotional control.

In relation to this, it is also important for the members of the treatment team to understand that while providing support to the cancer patient and his partner, it is paramount to understand the couple's reluctance to discuss the sexual and emotional issues they are currently facing while coping with the diagnosis and treatment outcomes of the disease. In addition, the conscientious treatment provider must be prepared to look past his own personal and cultural reluctance to discuss personal, emotional, and sexual issues and give attention to the patient and his partner's ability to work through their feelings as they attempt to relay to the clinician how they are handling their problems.

The willingness to develop a holistic approach to treatment which is geared to assist the patient and his partner to move beyond their diagnosis and treatment challenges demonstrates a move beyond treatment as usual toward supplying as much support as needed, but not so much that the patient becomes overwhelmed. As an aside to the holistic treatment team process, the patient diagnosed with prostate cancer may also find support from other patients in the support group process.

Studies conducted on patients and their partners have noted that when the diagnosis is first presented, the patient tends to give little thought to the post-treatment side effects. This lack of forethought tends to have a major impact on the patient's ability to stay focused on the after-treatment process and not question or lay blame on the pre-treatment process by asking why he was not given more information and why he did not have a greater inclusion in the pre-treatment decisions. In the end, even though treatment was successful in eliminating the cancer, many patients and their partners have expressed their dissatisfaction with not being made to fully understand the impact the side effects would have on their lives after treatment was completed. They were unhappy with the incontinence and sexual dysfunction, and they were dissatisfied with the amount of information or involvement they felt the treatment team members gave (or did not give) before treatment.

Following the diagnosis and subsequent treatment for prostate cancer, patients and their partners are usually expected to work through the issues which develop on their own, as well as adjust to the post-treatment conditions and learn to tolerate the overall impact forced onto their psychological and psychosexual make-ups, as well as on their social interactions with others. This is even more problematic in that the amount of written information to be found in one location for the patient, his partner and even the clinician regarding these treatment issues is negligible, at best, as is much documented information about the role that masculinity plays in the overall experience of prostate cancer. The conditions of limited data on the impact of prostate cancer on patients' perceived masculinity in terms of its shifting nature and cultural biases, as well as understanding the cultural point of reference that determines a man's own view of himself in relation to other men as an aspect of human behavior, is important as an assessment tool in the holistic

treatment approach. Most views of the masculine cultural norm give emphasis to inborn maleness as unidirectional and consequently restrict the wider view concerning the challenge the clinician may take as it relates to the prostate cancer experience.

If the clinician is open to the wider implications of masculine sexuality in regards to clarifying treatment issues with the prostate cancer patient and his partner, the result in treatment outcomes has the potential of being an invaluable experience. It is evident that the dominant role of the masculine cultural norm has led to the condition of cultural affectation and disingenuous understanding that has obscured how the male patient and his partner are given adequate treatment and support as well as psychoeducational materials that are able to incorporate that information into their ability to deal with the prostate cancer diagnosis and treatment experience.

For clinicians/therapists who become involved in the treatment of these patients, working through these issues blindly and without the knowledge of how destructive treatment could be that is carried out without understanding what the prostate cancer has experienced, could go blissfully on in ignorance or unresolved sexual prejudice, having done more to hinder or harm treatment outcomes than to further them. Without understanding the need for holistic assessing of how masculinity and sexuality are viewed by the patient and his partner, how is treatment as usual ever to be transformed? How is a greater paradigm of treatment to be expressed? This lack of understanding has created the need for greater effort in understanding the broader treatment needs of the patient and for supporting a holistic system of treatment that incorporates an improved sense of understanding regarding how the prostate cancer patient and his partner confront the prostate cancer experience, either alone or with the help of the treatment team.

Body Image and Prostate Cancer:

As part of the perceived masculine cultural model, men diagnosed with localized prostate cancer and just beginning to undergo treatment do not necessarily exhibit apprehension or distress concerning perceived body image. A few, however, do report concern when it comes to their own physical appearance or sexual abilities. Studies have indicated that body image concerns for men post-prostate cancer treatment are relevant, as side effects of treatment continue to worsen for some patients over time. Yet body image issues can be diminished when recognized as a counseling treatment issue, and other behavioral interventions such as partner support are reinforced.

Quality of life research has found that patients with at least three months of therapy as part of the overall treatment process are at decreased risk for body image concerns, except for issues related to other treatment modalities such as hormone symptoms. It also shows that medical outcomes are not predictive of body image concerns. Some issues associated with body image worry are not predictive of body satisfaction and may be issues with pre-diagnosis, yet they will contribute to patients' dissatisfaction with the treatment they've been provided. This is not the outcome when these issues are explored as part of the holistic treatment process. A variety of factors are relevant to body image issues, and a specific treatment focus on improving conditions of impotence and incontinence, as well as on weight gain or loss, has been found likely to impact body image satisfaction in men undergoing prostate cancer treatment.

One tool developed for research is the Gender Role Conflict (O'Neil et al, 1998). This has made it possible for the clinician/therapist to recognize factors at work in gender role conflict, such as competition, power and success, preventive emotionality, preventive demonstrative actions between men, and conflict between family as well as work relations.

The competition, power and success feature can be used to measure the male patient's rigid cultural desire to be seen by other males as unbeatable, as well as ahead of others in the dominant masculine norm. It can show the patient's focus, or lack thereof, on the importance of achievements, as well as influence over others. It can also be used to show the patient's need for self-gratification. For example, a high score on gender role conflict aspects of Power, Success and Competition illustrates that a patient is focused on successfully climbing the career ladder. This male patient also exhibits a strong need to be viewed as having greater intelligence and physical dominance over other males. For the clinician/therapist, men who score high on this scale will also strive to guard against showing any feelings of inadequacy to those around them, including their partner.

There is a correlation between the effect the diagnosis and treatment of prostate cancer has on the male patient's concept of his own masculinity and the relation between the patient's view of himself and those he perceives as having social power. For the purpose of an approach to holistic treatment, the issues relevant to the male patient's rationalized view of gender, physical, and sexual well-being and its relationship between mental health and social/sexual control must be part of the assessment/treatment goal. The male patient with low scores in overall physical and sexual well-being also assesses with significant impact on his ability to work through emotional issues. Comparatively, the male patient who views himself as not physically healthy but also not predominantly guided by the masculine cultural norm is able in the long run to maintain an acceptable level of emotional well-being. If these facets of masculinity are not understood, along with the clinician/therapist's recognition of his own preconceived ideas about what masculinity is or isn't, then treatment will be hampered.

Patients experiencing the diagnosis and treatment outcomes of prostate cancer face a significant assault on their emotional, social, and sexual well-being. The distressing truth is that currently there is inadequate information in a centralized location for the clinician and the patient to access and employ concerning the treatment hurdles that stand in the way of successful outcomes or the most up-to-date and effective treatments being utilized to enhance life after prostate cancer. Research from a holistic approach that demonstrates how these factors can be assessed, identified, and treated continues to grow at a slow pace; yet these issues highlight the essential aspect of how the patient views his relationship to the social pecking order in relation to other people, his own sense of self-reliance, his physical health and his ability to adequately engage his sense of self-control over his emotions. If nothing else, this study of the masculine cultural norm has made it clear that medical practitioners and clinician/therapists need to be cognizant of the factors that underlie relationships and social/sexual issues and how these can positively or negatively impact the ability of men to grow through the prostate cancer experience.

Cultural Sensitivity:

Review of the Masculine Cultural Norm for North America will by no means be the final word on treating the sexual issues of all male patients and their partners. There has been little research, for instance, on the lives of men of varying cultural backgrounds in regards to the impact of incontinence and erectile dysfunction following prostate cancer treatment. Nor has much study focused on how cultural beliefs surrounding urinary and sexual function and other cultures' definitions of masculinity influence the meaning given to these symptoms.

Understanding what these symptoms mean and the processes by which patients can manage and adapt to them is crucial for the development of culturally relevant

interventions that address these symptoms in all phases of the disease and treatment process (Maliski, et al, 2008).

For example, research shows that in the United States, African-American and Latino men will experience greater negative outcomes to prostate cancer than will European-American men. Socioeconomic factors can limit health care availability, to be sure, but cultural attitudes that develop within these groups should also be considered. Within the Latino masculine culture alone, researchers were able to identify five distinct masculine cultural groups when defining the term *machismo* (Torres, et al, 2002).

Cultural sensitivity is the extent to which a person becomes aware and respectful of the ethnic/cultural characteristics, experiences, rules, values, behavioral patterns, and spiritual beliefs of a particular cultural group and how these factors play into its approach to its own history, culture, as well as the sexual forces as they are integrated in the living processes of the particular cultural group (Friedman & Kao, 2008).

Cultural views affect the psychosocial and behavioral patterns of the patient and, if left out of the diagnosis and treatment process, will hinder the clinician's ability to develop a comprehensive treatment plan. The very values the patient and his partner hold dear about the nature of social relationships and sexuality, and the presence or absence of a comprehensive treatment plan to deal with the whole patient will affect the clinician's ability to be culturally sensitive (Halbert, et al, 2006).

As part of the culturally sensitive treatment plan, it becomes a matter of form to discuss incontinence and erectile dysfunction (ED) in order to assist the patient and his partner in becoming informed participants in making life-altering treatment decisions. These decisions as they affect future incontinence and ED will touch the very core of masculine and cultural identity (Maliski, et al 2008).

To this end it is evident that cultural awareness has its place within the context of the multidisciplinary treatment process. It is also important to all involved that clinicians and patients recognize that the clinician cannot be all things to all people but should strive to remain aware that different cultural views of masculinity need to be considered in order to customize the treatment plan.

Prostate Cancer Patient in Relationship:

Research sponsored by the National Prostate Cancer Coalition (NPCC) has ascertained that the partner of the prostate cancer patient maintains a vital position in the patient's ability to cope with the diagnosis and treatment process, as well as affords a base of emotional regulation and helps sustain a sense of daily normalcy for the patient (Skip Lockwood, spokesman for the NPCC). In fact, multiple studies on cancer patients as a whole conclude that one of the most significant factors that relates to the cancer patient's probability of overall progress when dealing with the diagnosis and treatment outcomes is his or her marital or relationship status. One study conducted with this hypothesis took into account the reports of 261,070 patients positioned at diverse locations throughout the U.S. (Lai, Lai & Krongrad, 1999). The objective of Lai's research was to verify the association between a patients' marital/relationship condition and possible positive outcomes post-treatment. The research restricted additional factors that could have swayed the outcomes of the study, such as age of the patient, treatment methods and outcome, and societal traditions. The research determined that married patients with prostate cancer exhibited a greater chance of positive outcomes than the unmarried, divorced, separated, or widowed patients (Lai, Lai & Krongrad, 1999). This study also revealed that unmarried and widowed patients exhibited the highest rate of negative outcomes (Lai, Lai & Krongrad, 1999). Overall, Lai's research concluded that various aspects of being married

or in a relationship assist the patient toward more positive outcomes (Lai, Lai & Krongrad, 1999).

Other relationship research supports Lai's conclusions. In fact, the primary element that ultimately helps the cancer patient survive is psychosocial and emotional support (Ganz, 2008). Some research even suggests that there is a correlation between general health and staying married. Cancer patients who are married or in a committed relationship confirmed these greater positive outcomes, as demonstrated in research conducted by Nelles, Joseph & Konety (2009). This close relationship deeply affects the cancer patient's probability for a positive outcome. Research which included married prostate cancer patients, or patients in a committed relationship and are diagnosed with prostate cancer exhibited evidence to support this hypothesis. That is, researchers found that a prostate patient's marital or relationship status was a conditioning factor in his experiencing greater positive treatment outcomes. The research-stated supposition is that marriage and commitment in relationship influence the patient's treatment outcome. Researchers' assessments based on the SEER (Surveillance, Epidemiology and End Results) database maintained by the National Cancer Institute verified the importance of relationship to the cancer patient's treatment outcomes. This is yet another factor that highlights the importance of a holistic approach to cancer treatment, one that goes beyond medical treatment as usual (Woods, Engel & Rankin, 2010). The results found on the SEER for prostate cancer patients became a subject worth considering. Once again, the patient's marital/relationship condition was shown to be a major contributing factor to positive outcomes. Therefore, it is important to be taken into account for treatment planning focus and outcomes.

Cancer, in the United States, comes only behind cardiovascular disease as a primary cause of death. In spite of improvements in technology and treatment methods for cancer and enhancements in diagnostic techniques, there were still 562,340 cancer deaths in 2009 (American Cancer Society, 2010).

The proposition that patients who are married or in a committed relationship are apt to have greater positive outcomes to treatment reinforces the idea that being married, staying married, or being in a committed relationship supports positive treatment outcomes (Coombs, 1991). The marital or relationship type of patients presented a significant contribution to the patient's ability to achieve these positive outcomes.

The tested group consisted of approximately 16% married males for the men's group and 8% married females for the women's group (Rothman & Greenland, 1998). For 1997 numbers in relation to Parker's study, there were approximately 294,100 cancer-related deaths for men and approximately 265,900 cancer-related deaths for women (Parker et al, 1997). Interpreted, these figures would come to 47,056 from $294,100 \times 0.16$ for the men's group and 21,272 from $265,900 \times 0.08$ for the women's group. The study showed that approximately 50% of men diagnosed and treated for prostate cancer and in a committed relationship could expect a more positive treatment outcome. Parker's research illustrates those cancer patients in a committed relationship exhibit a greater possibility for positive outcomes than the widowed, single, divorced, or separated patient diagnosed and treated for the same condition.

Research in this area has shown people in a committed relationship on average to be physically and emotionally healthier, with lesser death rates than single persons (Goodwin, et al, 1987; Gove, 1972; Ortmeier, 1974). The research outcomes demonstrated patients not involved in a committed relationship could expect decreased odds of positive outcomes

compared to cancer patients who are in a relationship. These conclusions have been consistent throughout the body of research (Kaprio, et al, 1987; Kvikstad et al, 1995).

The research outcome indicates to the clinician the drawback to a patient of continuing a solitary lifestyle when it relates to the diagnosis and treatment for cancer and should be an indicator to be added to the holistic treatment plan. This distinguishes the difference between people who are socially engaged from the people who live socially remote. This verified the contribution a committed relationship makes in terms of positive rather than negative outcomes to treatment goals. This also includes the consideration that should be given to the relationships with children, parents, and other relatives as it relates to the emotional support that is not available to the patient who is not in a committed relationship. The particular qualities of living in a committed relationship and the importance of continuing in the relationship are clearly to be considered within the parameters of the holistic treatment approach.

The cancer patient's social and emotional support systems are also important attributes of the committed relationship (Berkman & Syme, 1979; Ortmeyer, 1974). These support systems, as well as additional reasons such as frequency of physical contact, social remoteness, dietary program, and emotional fulfillment, contribute to positive or negative outcomes of treatment. Understanding the sway these systems maintain over the relationship and treatment outcomes can possibly bring about a greater understanding of the entire treatment process when it comes to working not just with the physical outcomes of treatment but also the psychosexual and emotional outcomes of prostate cancer treatment.

Throughout the diagnosis and treatment course, the social stability of the prostate cancer patient is significant to positive outcomes. A committed relationship enhances the

patient's social stability as well as positive treatment outcomes. Patients can often experience isolation and estrangement because of devastating disease-related concerns. The diagnosis and treatment procedures for cancer can also produce circumstances that can create feelings of isolation and anxiety in the patient. The distinctive emotional benefits that a committed relationship can bring to the patient include feelings of hopefulness and a sense of being protected from the damaging effects of the cancer.

The SEER study does not include assessment factors that are associated, but these factors, such as the socioeconomic condition of the cancer patient, should be included in the treatment plan assessment (Kato, Tominaga & Ikari, 1992). Other limitations to the SEER database include the fact that it only contains statistics derived from radiation therapy, surgery, and a combination of the two treatments. There were no chemotherapy or hormone treatment records found in the SEER database. These treatments, in and of themselves, cause other treatment-related issues for the patient which are no less important to the treatment process. Another drawback to the study was that patients' data, in particular when it related to the committed relational information, came from reviews of their charts (Dua, et al, 1999).

Supportive Needs:

The diagnosis and treatment of prostate cancer can generate considerable emotional, social, and sexual obstacles to be dealt with by the patient and his partner. To date, overall treatment modalities have been unsuccessful in recognizing the supportive needs of men and their partners living with the diagnosis and treatment of prostate cancer (Sharpley, et al, 2008). One study evaluated the members of self-help groups in Queensland, Australia (Jones, 2007). The research included men diagnosed and treated for prostate cancer and examined their overall requirements for recognition of their supportive needs. The

population researched consisted of 206 male participants with the age range of 48 to 85 years and a mean age of 68 years. Approximately 62% of the self-help group members took part in the SCNS or (Supportive Care Needs Survey). SCNS is an instrument utilized to assess and weigh perceived psychological and physical requirements as it relates to diagnosis and treatment. This tool also takes into account the health treatment conditions of the patient. These requirements can also be divided into the patient's care, quality of life, individual support systems, perceived sexual needs and dysfunction, and cost of living requirements. The researchers also assessed the available resources as well as the patient's ability to access these resources.

Approximately 33% of the participants exhibited a moderate to high expressed need for further information concerning their sexuality concerns and their psychological issues. Younger males tended to convey a greater desire for information related to sexual issues. Patients living in more urban communities tended to request information associated with psychological problems in dealing with their diagnosis and treatment. All of the respondents expressed concerns for daily living and physical domain issues during diagnosis and treatment. There was an expressed need for extended patient care and support after treatment for patients with lower educational levels, as well as limited comprehension of their cancer treatment and diagnosis. Approximately 55% of the respondents reported the willingness to use alternative treatments. Respondents who were younger and those with higher education levels showed a higher motivation level to conduct their own research as well as the willingness to use alternative therapies for dealing with their concerns. The respondents tended to prioritize interventions based on their socioeconomic, social, and educational level and their willingness and ability to seek out information to deal with their psychological and sexual needs. Areas of considerable

importance when assessing the patient should be included in a holistic approach to the treatment team concept.

It is also important to note that in the diagnosis and treatment of prostate cancer, just the thought of contracting the disease or experiencing the recurrence of it raises the patient's anxiety level because of the association with physical and psychosexual problems, as well as the emotional impact causing depression and fear. The fear of recurrence in the future tends to be an ever-present issue for the prostate cancer patient, and dwelling on these thoughts will increase the patient's anxiety. Following treatment outcomes, anxiety is also related to the physical problems that generate negative emotions and are apt to remain for extended periods of time (Massie & Holland, 1990). In Australia, prostate cancer is the most common disease among men, followed by lung cancer. Every year, there are approximately 1,522 men in Queensland diagnosed with some form of prostate cancer (Australian Health Technology Advisory Committee, 2008). Due to the recognized impact on a growing number of men and the greater openness to discuss, the psychosocial issues found among these prostate cancer patients is growing to become a major public issue. Until recently, the psychosocial issues have received little attention and awareness from the medical healthcare professionals (Glajchen & Moul, 1996; Altwein et al, 1997). As stated previously, the physical problems faced by patients treated for prostate cancer include urinary and bowel incontinence, as well as sexual impotence. The complications also include significant problems related to iatrogenic morbidity (various complications due to the action of a physician or a therapy the doctor prescribed) (Altwein et al, 1997). In order to understand the correlation of social support to a cancer patient's health outcome needs, a holistic assessment of the patient and his partner must become the standard for treatment.

Approximately 75% of patients who have undergone radical prostatectomy treatment described problems with some form of erectile dysfunction or even complete impotence for a period of 12 months after the treatment. Approximately 33% of patients who have received radiation treatment experienced similar erectile dysfunction issues for the same 12-month period following treatment (Talcott et al, 2007). The patient's willingness to exchange the ability to achieve an erection for the likelihood of eliminating cancer does not imply the patient and his partner are free of the emotional issues that come with treatment outcomes. Assessment of patients experiencing sexual dysfunction due to treatment outcomes reported feelings of depression and other cancer-related distress, such as fear of recurrence of the cancer and mortality issues (Helgeson et al, 1996).

Patients undergoing hormone treatment also report stress as it relates to the negative side effects such as hot flashes, mood swings, some degree of erectile dysfunction if not total impotence, as well as loss of sex drive (Guess, 2007). Other stress-related symptoms identified were a decrease in physical vitality and an increase in generalized body pains. Associated with these issues, patients assessed for treatment focus issues have reported some negative impact to their self-image, an increase in masculinity issues with unexpected impact to their sexual relationships (Arrington, 2008). Patients assessed in this study were shown to experience issues of apprehension concerning their cancer, the treatment process and progress, and the uncertainty concerning the overall physical outcome. The mental, psychosexual and psychosocial impacts on patients diagnosed and treated for prostate cancer are assessment issues that require acknowledgment by the treatment team (Shrader-Bogen et al, 1997).

There are many studies concerning the success or failure of prostate cancer medical treatments; however, the emotional and psychosexual, as well as social impact on men

dealing with treatment outcomes is an area that is in need of further research, particularly the influence of treatment modalities on personal and social arenas. Research is only beginning to define the total impact on the male prostate cancer patient, and greater sensitivity is required in the area of psychosexual or emotional support. Holistic care and treatment for the prostate cancer patient and his partner require a total needs assessment in all areas for appropriate supportive care to be effective (Bonevski et al, 2000).

A complete needs assessment takes into account all aspects of physical, psychosexual and psychosocial areas of the patient that require support. This will inevitably help develop greater support and enhanced quality of life for the patient. Patients diagnosed and treated for prostate cancer require additional information as well as clarification concerning the overall impact and expected outcomes of various forms of prostate cancer treatment. The ability of the treatment team to acknowledge the needs of the prostate cancer patient as important to the treatment process remains deficient in spite of the growing body of research and information that has been made available to health care providers and physicians. A large number of patients, once having undergone treatment, assert they were not given enough information concerning the aftereffects of the treatment such as erectile dysfunction, pain and incontinence (Moore and Estey, 1999).

The “Two Against One Connections Program for Patients and Families” (Torre, Joe 2001) was a program developed after a survey was taken in 2000 of couples struggling with the diagnosis and treatment issues of prostate cancer and was an educational initiative program sponsored by the National Prostate Cancer Coalition (NPCC). At that time, the American Cancer Society was predicting more than 198,100 new cases of prostate cancer would be diagnosed and 31,800 men would die from the disease. One in 10 American men would develop prostate cancer, mostly after the age 65. At that time, prostate cancer was

and still remains the single most common form of non-skin cancer and the second leading cause of death for men in the United States. In this particular survey, 302 spouses of men diagnosed with prostate cancer were surveyed by telephone from December, 2000, through January, 2001. The results of the survey were estimated to have a margin of sampling error of +/- 6 percentage points.

The results can be found in the Two Against One's 68-page pamphlet and its companion website (www.2against1.com) created to assist the prostate cancer patient and his partner throughout the trial of diagnosis, treatment and the aftereffects. Personal accounts from celebrities such as singers Billy Davis Jr. and Marilyn McCoo as well as other couples are included, giving testimony of their own prostate cancer struggles. Cancer information targeted particularly towards African-American males, whose mortality rates are more than twice those of white men, is also included. The information targeted in the cited information highlights treatment options for the prostate cancer patient: prostate removal, radiation, and hormonal therapies for reducing the production of testosterone (which, for some cancers, actually stimulates the tumor growth). In an additional initiative, NPCC launched an outreach program called "Taking Care of the One You Love" to encourage those affected to learn more about prostate cancer.

Self-Help Group:

Research conducted in Australia, Canada and the United States shows the need for greater comprehension and information dissemination and encourages the development of self-help prostate cancer programs with a holistic approach. Studies done in the United States and Canada highlighted a statistically substantial number of respondents treated for prostate cancer who reported being very disappointed about their overall cancer diagnosis and the information made available to them by their doctors and medical professionals

during the treatment process. The greatest area of dissatisfaction concerned the aftereffects of treatment, specifically impotence and incontinence (Kunkel et al, 2000). The material made available to patients by physicians did not fully address the patient's relevant needs such as sexual, psychological, social, and patient care. It is evident the physician's appraisal of the impact on the patient's total quality of life is limited (Kemmler, 1999). Studies in Australia have also revealed a number of unmet needs of patients there who were diagnosed and treated for prostate cancer.

Directing patients toward a self-help or support group for prostate cancer patients can be another helpful tool for the clinician in the holistic approach to treatment and healing. Members of these groups tend to share a greater depth of knowledge through their exchanges in the self-help groups along with a level of emotional support from other members who were diagnosed and treated for prostate cancer (Rainess-Kules & Axelrod, 2006; Gray et al, 1997). The group's support function over time grows to be a significant source of information and emotional support. The researchers mentioned above explored the awareness of the patients concerning their perceived needs as it related to their supportive care and other issues of concern, and went on to explain the types of expanded therapy options the group members chose outside of conventional treatment and delineated their conclusions.

The levels of needs that group members identified as ongoing and unfulfilled varied from moderate to high. The personal concerns highlighted by group members fell within three main categories that were identified as the health system, sexuality, and psychological/emotional support. Approximately 33% of male self-help group members identified these issues as important to them as well as lacking in the treatment process. The research has also identified the types of substitute therapies for prostate cancer the group

members sought and their outcomes (Kerr et al, 2002; Gray et al, 1997). This population's identification of unmet treatment concerns as it relates to the common prostate cancer side effects of sexual dysfunction and urinary incontinence echoes the same result found in research conducted by clinics and general hospitals.

Within the self-help group setting, members can share their collective body of information regarding helpful techniques and methods of care. They also may form a relational bond based on empathy because of their shared affliction and common purpose in desiring to overcome and heal from the effects of prostate cancer. No single medical practitioner or clinician can provide all of the answers to every aspect of prostate cancer diagnosis, treatment, aftereffects and life impact. Additional support from others sharing the same experience can be informative and promote healing.

Researchers have found in the populations they studied that cancer patients residing in urban areas tended to be more open about their cancer concerns than those living in rural populations. Cancer self-help groups in urban areas tend to also be larger in number than rural self-help groups. Also self-help groups in urban areas have been meeting for a longer period of time and show more involvement in what would normally be personal areas of concern for men. These factors are probably what contributed to a greater intervention process into the psychological issues of the patients and their partners.

In general, it has been shown that men tend not to utilize services for their emotional support. Yet it has been shown that men who do avail themselves of the services available to them in self-help groups also exhibit an improvement in emotional stability, indicating a place within the holistic treatment concept (Ashton & Fuehrer, 1993; Rickwood & Braithwaite, 1994). Self-help groups can and do provide a legitimate area in support of the cancer patient and his partner. Research has shown the importance of self-help groups as a

mental health tool for decreasing the overall force of the emotional impact of the diagnosis and treatment for prostate cancer, as well as decreasing self-imposed social isolation (Gregoire et al, 1997). Holistic treatment recognizes the necessity for making intervention for the individual psychological issues as they relate to the patient's personal needs. In order to do this, it is important to spend time with the patient and his partner assessing those needs with the goal of developing a holistic treatment plan. A thorough assessment of the cancer patient requires the clinician consider the psychosocial, overall support systems, and existing related psychosexual factors of the patient and his partner (Bogart, et al, 2000). Peer support is an important consideration in assessing the patient's ability to feel at ease with their diagnosis and treatments as well as diminishing their concern about possible cancer return. Self-help support also has proven to be a motivating tool to help the patient recognize the positive impact psychoeducational programs can have on their lives (Meyer and Mark, 1995).

Research into the needs of the prostate cancer patient, has proven the requirement for an efficient and broader treatment modality to include effective mental health treatment systems that can provide accurate information about the patient's diagnosis and treatment outcomes. Those who have participated in the research have made clear their need for diagnosis and treatment information and support. Prostate cancer patients and their partners require information and emotional support during times when they may feel the most unsure concerning available treatment modalities and outcomes. During this time they may also be concerned about the apparent lack of resources available to them. The function of the holistic treatment team concept as well as inclusion of the self-help group is to provide the support and information so badly needed at such a desperate time. Despite the availability of self-help groups and treatment options approximately 33% of the

prostate cancer patients interviewed continue to report few readily available sources of mental health treatment and overall treatment information. Prostate cancer patients and their partners report moderate to high concern that because of the lack of holistic treatment, physicians were the only source for advice when it came to side effects, test results interpretation, and treatment follow-ups. Far too often the patient felt there was not enough time allotted to dealing with these needs. This coming, when the physician has limited time available to the medical needs of the patient.

The research indicated that prostate cancer patients and their partners favored receiving diagnosis and treatment information and counseling from their primary physician/treatment team. Thus indicating there is a patient and physician/multidisciplinary treatment team process which have become elemental to the patient's expectations. This is evidence of the needed evolution in the physician/ multidisciplinary treatment team expansion in the standard of care skill level that helps the patient comprehend his circumstance, and makes the treatment process patient centered, rather than cancer centered. With this evolution in thinking comes a greater responsiveness to the psychosocial and psychosexual needs of the patient and his partner (Fallowfield et al, 2001).

The level and type of psychosocial/psychosexual/psychoeducational treatment depends on a large part on treatment characteristics and their overall outcomes making the patients need for an increase or decrease of support usually based upon the patients and his partners level of treatment involvement and comprehension. In the short term there may be involvement with the whole treatment team or significant parts of it based upon the patients assessed needs. In contrast, long-term treatment may require decreasing overall support, to individual members of the treatment team, again based on the identified needs of the patient and his partner. This level of treatment is consistent with where the patient is

in relationship to their concerns for disease recurrence, emotional impact of treatment, as well as psychosocial support and psychosexual needs. The identified patient needs are the driving force to this process (Bellizzi, et al 2008).

Needs-Driven Treatment:

Research linked to the unmet concerns of prostate cancer patients requires further study in order to develop holistic treatment plans that fully meet prostate cancer patients' ongoing needs. The results of past studies have found that men have greater social and psychological concerns about sexuality than women (Ani, 2010). This is true in both long-term and short-term effects of treatments for prostate cancer, chiefly when it came to patients' concerns about their sexual function. As predicted by the researchers, younger patients exhibited greater concern over their ability to function as sexual beings (Ani, 2010). Research has also indicated that when it comes to sexuality needs, how the patient responds is greatly dependent on the patient's life stage and emotional development. Older patients may have dealt with the emotional and social issues of decreased sexual drive previous to the diagnosis of prostate cancer. However, this is not always the case. Some older patients, for whatever physical or emotional reason, have not experienced or been forced to deal with the emotional and social impact of a decrease in their sex drive before their prostate cancer diagnosis. There is also a strong connection between a patient's view of his masculinity and his sexual drive. The emotional impact as well as the social anxiety of the patient's loss of sex drive is indicative of the cancer patient's implied relationship between his viewed masculinity, sexuality and relationship with his partner. How the patient views his own sexuality is a good indicator of whether the patient might experience sexual morbidity following diagnosis and treatment (Andersen, 1999).

How the patient and his partner view their sexuality, his masculinity, and their relationship is an important assessment consideration before, during, and after prostate cancer diagnosis and treatment. This is an invaluable part of the holistic treatment process in understanding how both the patient and his partner view possible sexual difficulties and psychological distress. The surgical treatment of prostate cancer does not stop with the successful elimination of the cancer. There is a responsibility on the part of the treatment team to understand the broader impact the treatment will have in terms of sexuality, psychological distress, and self-image that impacts the overall adjustment of the patient and his partner. Research methods that have incorporated the SCNS (Supportive Care Needs Survey) pinpointed the cancer patient's specific psychological concerns, resulting in the identification of moderate to high needs in regards to the way that sexual and emotional factors impact the patient's fears of disease recurrence (Sanson-Fisher et al, 2000).

The fear of cancer recurrence, anxiety and depression are prevalent in the assessment outcomes with the patient and his partner. The impact of this fear inevitably affects their view of quality of life as well as their future outlook (Girgis et al, 2000). Fear of the cancer recurring, especially for the patient who has undergone a radical prostatectomy where recurrence means the cancer has metastasized, has been shown as one of the major treatment concerns of the prostate cancer patient and his partner (Lee-Jones et al, 1997). Researchers in this area have strongly recommended individual as well as partner and group psychotherapy and psychoeducational treatment as important intervention tools for dealing with cancer patients' fear of disease recurrence. The fear that cancer is incurable and will cause inevitable death also needs to be addressed in the treatment process. Psychoeducational information concerning the true nature of cancer and cancer treatment's effectiveness is necessary to help reduce the patient's concern. This also consists of

expected and possible post-treatment results. However, unless this becomes important to the entire treatment team process, these issues are going to go largely unchallenged, the needs of the patient and his partner are going to be left unmet, and they will have to deal with these issues on their own. In holistic treatment approaches that are needs-driven, the patient and his partner will be encouraged to openly confront their feelings with the member of the treatment team trained to handle these issues with the goal of helping them identify and deal with any negative thoughts and feelings.

In developing needs-driven approaches, treatment teams need to be aware how patient demographics can be indicative of the level of unmet needs and concerns a patient may experience. Patients with identified lower comprehension skills are more likely to experience a greater range of unmet needs and social support. Patients at the beginning of the diagnosis process are more likely to experience greater levels of intervention as far as compensating for their emotional needs. Approximately 50% of prostate cancer patients tend to be open to alternative treatment modalities. The alternative treatment modalities were usually considered within the first 12 months before the final treatment process was decided upon. Exploration and preferences for alternative treatments varied considerably among cancer patients with comprehension and socialization as indicators of their openness to explore (Sipio, 2009). Also, patients who were active participants of self-help groups showed a greater tendency toward consideration of alternative treatments (Gray et al, 1997). Patients who were unable to feel total reliance on the physician or who felt their treatment team was inadequate to fully deal with their issues, as well as patients who were themselves unsure of conventional treatment outcomes, tended to consider alternative therapies (Sipio, 2009). Overall, patients who have been diagnosed with cancer in

comparison to other diseases are more likely to consider alternative therapies (Rodriguez, 2009).

Patients with higher levels of comprehension also were more likely to consider and suggest alternative treatment (Astin, 1998). The cancer patient's level of depression, physical symptoms related to post-surgery outcomes, and anxiety over the cancer recurring are also associated with the patient's probability for considering alternative therapies. The patient's view about treatment received and its eventual outcomes, as well as his level of discontent with conventional physician limits in dealing with expanded treatment needs speak to the need for treatment teams to consider a holistic approach of alternative therapy within the current treatment concept (Astin, 1998). In the conducted research, most patients considered alternative therapy outside of their physician's treatment process. Only a few did not, indicating a patient's perception that holistic therapies within the treatment process are complementary to the traditional medical treatment process (Druss & Rosenheck, 1999).

Research has shown that the diagnosis and treatment of the prostate cancer patient and his partner necessitates a broader intervention of support in their sexuality, social systems, and psychological needs than just curing the cancer. Research indicates that incorporating the patient's sexual function in relationship to his perceived masculine self-image are important areas of concern in the treatment of the patient and his partner. There is an identified need to develop a holistic treatment process that includes psychosocial, psychosexual and psychoeducational programs, as well as making treatment a patient-centered process to improve communication for the overall well-being of the patient (Fallowfield & Jenkins, 1999).

Advancements in prostate cancer treatment have produced the end result of an increased patient population who live longer with an increased awareness of negative changes in their quality of life. This information alone should encourage clinicians and patients to consider seriously what quality of life means in relationship to living after prostate cancer treatment (Wilding & Remington, 2005). The prostate cancer patient and his partner are exposed to a wide variety of challenges from the instant they hear, "You have prostate cancer." These challenges range from what choice of treatment is available to managing treatment outcomes, along with the potential prognosis that leads to facing the end of life. The patient's family is also impacted by the process in a variety of ways.

One thing paramount to be considered during the assessment process is the way that the partner deals with the prostate cancer patient's situation. There has been limited research in which the partner is the primary topic. There is some research into the impact cancer has on the psychosocial and psychosexual coping skills of the patient; however, there is little research that has been done on the impact of the entire experience on the cancer patient's partner. What little research has been done indicates partners tend to report greater emotional distress than does the cancer patient. The research also reports that the partner tends to believe that the cancer patient is the one who suffers the most distress. Research also reveals that the partner is less disturbed about the treatment's impact on the patient's sexual function than the patient is. Because modern prostate cancer treatments have reduced the number of deaths, the greater and expanded treatment challenge now includes dealing with the psychosocial, psychosexual, and the psychological impact treatment has on a growing group of patients and their partners (Wilding & Remington, 2005).

The patient's entire social group is affected by the impact the diagnosis and treatment of prostate cancer has on the patient and is an important assessment issue in the broader scope of the treatment process, but how the partner is affected should be particularly significant in the treatment process. Research has been conducted into how breast cancer and its treatment impacts the psychosocial and psychosexual quality of life for women, their partners and the broader social support of their families (Ben-Zur, Gilbar & Lev, 2001). Some research has also investigated the impact breast cancer has on communication between partners. Only lately has awareness of these issues been focused on the psychosocial and psychosexual impact prostate cancer has on the partner and family of the patient. The importance of these issues to successful needs-driven treatment is slowly becoming apparent as a holistic treatment process is being recognized as significant to the well-being of the patient and his partner. Consideration of these issues can guide the expanded development of the entire treatment team concept and give direction to developing a broader scope for the short-term and long-term treatment plan, as it focuses on treatment becoming patient-centered instead of cancer-treatment-centered. This broader concept will also help in assessing those particular psychosocial, psychosexual, and psychoeducational interventions that will be beneficial not just to the patient but also to his partner and family. Greater inclusion related to the psychological impacts on the prostate cancer patient's partner and family, no matter what stage of treatment the patient is in, is paramount to improving treatment outcomes. If treatment is undertaken with regard only to the patient's psychosocial, psychosexual, and psychoeducational needs and abilities, without inclusion of the partner as well as the patient's broader social support system, an essential treatment element is left out of the holistic treatment process.

For women, the issues associated with the diagnosis and outcomes of treatment for breast cancer, such as having to undergo a mastectomy and hormone therapy, can have a major effect on her self-image as a mother, wife and sexual partner. For the prostate cancer patient, the diagnosis and outcome of treatment such as prostatectomy, hormone therapy and other treatments, can also have a major effect on his view of himself as a father, husband and sexual partner (Couper, et al, 2006; Couper, 2007). Intimate sexual relationships can be affected on both physical and psychological levels, and the only person aware of them outside of the patient may be the partner. When a holistic approach to treatment is considered outside of just curing the cancer, the patient and the partner become central to the entire treatment process.

Coping Skills and Stress Management:

Medical advancement in the treatment of prostate cancer continues to improve, yet the recognition of the impact on the psychosocial, psychosexual and psychological stressors that result from the diagnosis and treatment of prostate cancer on patients and their partners, apart from quality of life findings limited to the physical impact of the disease and some progress in the area of erectile dysfunction rehabilitation, remains an area few surgeons and treatment teams are dedicated to including in the treatment process. The surgeon and treatment teams have an essential responsibility when it comes to the patient's decision making, coping, and adjusting from the time of diagnosis throughout the stages of the disease to the aftereffects of the treatment process.

The efficiency of psychosocial, psychosexual, and psychological intercession with the patient and his partner is going to depend on consideration of a wide variety of factors that

the surgeon and the treatment team, as commonly used today, may or may not be able to address without the specialized training needed to engage in these areas.

The use of cognitive-behavioral methodology for patients diagnosed and treated for prostate cancer has shown to be significantly effective in improving the assessed psychological impact and quality of life of both patients and their partners. Studies cited by Turner have been conducted that randomly chose patients and their partners for intervention. The patients and partners in these studies showed greater improvement than those relying on treatment as usual. The surveys carried out during the course of treatment were designed to assess the patient and his partner's level of quality of life and emotional adjustment to stress, and were able to show that cognitive-behavioral therapy had a positive effect on the patient and his partner far beyond treatment that was focused only on the elimination of the cancer without regard for the patient and his partner's overall quality of life. Patients and their partners consistently reported significantly improved objective health, emotional comfort, sexual functioning and an enhanced level in apparent quality of life. Research has also supported the hypothesis that treatment which includes cognitive-behavioral therapy enhances quality of life in prostate cancer patients, as well as their partners. When the philosophy of treatment as usual shifts to include a holistic view, then an increased emphasis on understanding of the sexual needs and dynamics of the prostate cancer patient in relationship with his partner becomes an inevitable part of the treatment process.

National and international clinical practice guidelines established by different national cancer society's, have begun to expand the documentation of recognized traits that relate to patients confronted by perceived changes in their sexual function after the diagnosis and treatment of prostate cancer (Turner, J. et. al 2005). Along with this, there appears to be an

increased emphasis in the literature concerning the significance the cancer patient places on their reproductive health. Researchers are beginning to highlight the greater need than is currently evident in cancer treatment circles for surgeons to advise and make available to patients referrals to treatment sources that can help with the patient's sexual and intimacy concerns. It is evident that far too many surgeons either do not know enough or are unwilling to provide the referrals that would give their patients the opportunity to articulate the emotional, psychosocial, or psychosexual needs they have and the concerns in these areas that confront them.

When it comes to the traditional norms in the diagnosis and treatment of prostate cancer, the patient's role in the process is viewed mostly as asexual due to the character of traditional medicine within the health care community. Patient-centered treatment with an open communication style becomes reality only when the holistic treatment team concept comes into play and begins to include the patient and his partner's sexual issues. When this happens, treatment as usual begins to evolve. Without this holistic concept of treatment, results have shown that many doctors, including treatment team members, tend to limit their conclusions concerning their patients' needs because they have an incomplete understanding of the broader treatment issues. Thus, it becomes difficult for them to make certain the end goals of treatment for the patient are totally accurate and complete. Treatment providers are amiss if they believe that patients will always share these issues. This is not the case. If patients feel that their issues are not important to the physician or treatment team members or have been confronted by hostility or prejudice toward their concerns, they will hesitate or even decide against bringing them out into the open.

The physician and the team members must be willing to be open to dealing with all the issues the patient and his partner are going through, or at least to understand that treatment

issues are much greater than just curing the physical cancer. It is vital that treatment team members either be able to expand the treatment team concept as it is generally conceived today or be willing to admit that there are issues beyond their ability to treat and refer patients to a treatment provider who can help them through these issues. Not too long ago, treatment was solely driven by the problem-based concept of, “See the cancer. Cure the cancer. Problem solved.” Today, treatment must be willing to risk tackling issues of intimacy and sexuality as well.

Being open to a broader range of treatment issues allows a greater range of open communication between the treatment providers and the patient and affords the members of the treatment team themselves the ability to contribute to positive and open dialogues with the patient and his partner about intimacy and sexuality, thereby expanding the treatment process. It is going to take time and awareness, as well as a willingness to broaden the current treatment goals, before a holistic, patient-centered treatment process that attempts to address all of a patient’s unmet and felt needs throughout the entire prostate cancer experience becomes the norm instead of the exception within the current referral system. When treatment goes beyond the physician as the central expert to that of including other specialists and clinicians who can help deal with all the issues faced by the patient and his partner, then a remarkable enhancement will occur in the lives of people dealing with prostate cancer.

The diagnosis of prostate cancer can be overwhelming to the patient and his companion or spouse. Following treatment, the resulting incontinence and dysfunction can result in further pain, trauma and confusion to the couple during an already stressful period. Studies report that a significant number of couples are ill-equipped to handle the physical and emotional impact the diagnosis and treatment of prostate cancer can have on intimate

relationships. Additionally, some patients are not equipped to handle a medical situation that they see as overwhelming to them personally and to their relationship. At a time when a greater degree of connectedness is needed between the couple, they are instead faced with relational confusion, humiliation and fear caused by the entire cancer experience and its effects.

In light of this, it is possible for the treatment team to help these couples understand there is hope, but not unless there is a broader view of what treatment means to the prostate cancer patient and his partner. There are options available to them that can create an equally enjoyable and satisfactory sexual relationship achievable in spite of impotence and incontinence. This is where the expanded treatment team is equipped to provide information to couples confronted by these issues that will help them find suitable solutions.

Patients and their partners who are actively involved in holistic treatment, and those who have successfully worked through the diagnosis and treatment of prostate cancer and its outcome, tend to stress the abundance of issues that confronted them, such as grief over the loss of an important part of their intimate life and fear that certain types of intimacy they formerly enjoyed are gone for good. They indicate that choosing to remain open about their fears was paramount to creating a greater intimacy. They also found that they had to be willing to fully engage in examining and redefining what intimacy really means to them in their personal lives, as well as in their relationship. In the end, they had to commit to being open to exploring and weighing a variety of options in order to find the solutions that worked for them. But unless treatment can reach beyond speculation, the couple will find the road much harder than is necessary and some couples will be unable to experience that greater intimacy.

Psychosocial, psychoeducational and psychosexual counseling supported by the cognitive process model can be utilized for patients and their partners to cope with the diagnosis and treatment issues associated with prostate cancer. Bandura's Self-Efficacy Theory has defined a variety of ways to deal with the patient's issues, including processes of regulating emotional states and elicitation of emotional reactions, the thinking processes involved in the acquisition, organization and use of information, activation to action. Level of motivation is reflected in choice of courses of action, the intensity and persistence of effort, the patient's beliefs about their capabilities to produce effects, and the patient's ability to exercise influence over his own motivation, thought processes, emotional states and patterns of behavior. Bandura's approach to therapy has been utilized successfully in helping patients develop positive mental health coping skills when dealing with health-related issues, including those of the prostate cancer patient. Bandura's treatment modality works to change the patient's beliefs about his self-efficacy. The patient learns to develop greater confidence in his own abilities and increase coping skills to engage the numerous demands related to the psychosocial, psychosexual and mental health stressors that come with the diagnosis and treatment of prostate cancer.

Psychological Factors:

When the Prostate-Specific-Antigen (PSA) test was still considered a major indicator of the presence of prostate cancer, research in the late 1980s and early 1990s was conducted to study the relationship of perceived psychological stressors and their effect on the disease (Cohen & Williamson, 1991). The researchers hypothesized that the presence of elevated psychological stressors would be the cause of some elevated disease scores and that low disease scores would be a natural by-product of low or no psychological stressors present (Aldwin & Revenson, 1987). At the time, the idea that disease scores were not a

primary indicator of some types of prostate cancer was not a deciding factor in the research. Based on the parameters of the study, the researchers came to the conclusion that it is possible to draw a relational connection between cancer scores and the level and type of psychological stressors experienced by the patient, as the cancer scores were affected to a point. The results of the study can also be interpreted to indicate the impact psychological stressors have on the patient's ability to seek out proper health care. There is also the relationship between the patient's affective expectations and its impact on the disease scores. Overall, research has been consistent in indicating that psychological stressors have a direct effect on the patient's health.

Research statistics that connect psychosocial support systems with the ability to lower patient stress indicators have been shown as important in assessing the patient. Stress, defined either as a condition typically characterized by symptoms of mental and physical tension or strain such as depression, anxiety or hypertension, can result from a negative reaction to a situation in which a person feels threatened or pressured. Stress has consistently been linked to higher rates of physical and emotional illness (Cohen & Williamson, 1991).

Stress or the inability to constructively work through it is closely related to the patient's susceptibility to greater health issues. When the patient is overly stressed, measured levels of antibody and cellular constructs of the immune system are found to be predictably lower (Ader, Felten, & Cohen, 1991). The patient's social support has also been connected to his ability to positively confront his psychological stressors and affect his overall physical health status. This is a primary assessment marker for the therapist as to how the patient views his or her social relationships, as well as the patient's ability to work through prostate cancer treatment. Positive views of the patient's social support are

directly associated with positive health effects and are seen as a major defense system against the negative effects of stress (Cohen & Wills, 1985).

A patient's behavior and habits, such as alcohol consumption, amount and types of foods ingested, amount and types of exercise the patient participates in, and even his sleeping habits have a direct influence on the patient's health. These habits, as well his psychological abilities to deal with stress, and his access to psychosocial support systems all have direct influence on disease vulnerability and on the immune system's ability to work effectively. This is further indication that psychological, psychosocial and psychoeducational assessment is necessary to develop an appropriate level of treatment. Differences in the levels of health and their intimate connection to stressors suggest greater consideration be paid to psychological stress and social support as predictors of physical susceptibility to disease and cancer treatment outcomes.

Research has also been found that focuses on factors that contribute to a subject's vulnerability to common viruses. Subjects were exposed to viruses in a controlled setting, and the results confirm that psychological stressors and psychosocial support systems can have either a positive or negative effect on the subject's susceptibility to virus (Cohen, Doyle, Skoner, Rabin & Gwaltney, 1997; Cohen, Tyrrell & Smith, 1991). It has been suggested that the same mechanisms at play with the virus studies are also at play with regard to disease levels and even to the patient's susceptibility to prostate cancer. The same could also be said of the negative or positive impact the psychological and psychosocial support systems have on the treatment team's ability to constructively deal with the patient's perceived stress and the social support system's extended role in the diagnosis and treatment of prostate cancer.

It is becoming evident that further studies into psychological stressors and other psychosocial support systems and their relationship to disease outcomes as it relates to holistic treatment is necessary. It should be understood that since research began in this area, a level of confidence in using the PSA test to predict prostate cancer has come into greater question by the American Cancer Society; however, research does support the connection between psychological and physical stress, as well as psychosocial support systems, to positively or negatively impact the disease and treatment process.

As stated, there is a notable lack of research focus on the impact prostate cancer has on partners and family members and the stress they experience when they are confronted with the patient's diagnosis and treatment outcomes. Some research has indicated that men in a committed relationship who have been diagnosed with prostate cancer evidence less anxiety about their care issues than men who are not in a committed relationship, in part because they can rely on their partner to help with their physical and social needs as well as find psychoeducational material (Davidson, Degner, & Morgan, 1995). In another study of prostate cancer patients and their partners, it was discovered that numerous partners believed that, on the one hand, the final decision concerning treatment belonged to the patient. On the other hand, partners believed that they were expected to help make the important treatment decisions. Regularly, the partner has taken on the decision-making role when it comes to acquiring the psychoeducational material upon which treatment decisions are made. Research also indicates that patients think of their partners as being truly equal when it comes to dealing with the diagnosis and treatment outcomes.

There is limited helpful empirical data to help the clinician understand and develop short-term and long-term treatment goals for the prostate cancer patient and his partner. There are few studies that have compiled the psychological, psychosocial, and

psychoeducational information in one place as it deals with the diagnosis and treatment stages. There are studies and statistics involving breast cancer patients and their partners' experiences and attitudes that show that breast cancer patients experience the greatest degree of emotional stress when they are first diagnosed; however, their partner's level of emotional stress is relatively consistently divided between reactions toward the patient's diagnosis and treatment outcomes (Northouse, 1989). Research has indicated that the breast cancer patient and her partner focused on available emotional support first in those areas that were most helpful in dealing with the treatment process. Also, it was found that partners felt that psychoeducational information, as well as the attitude of the treatment team members, was important in helping them through the diagnosis and treatment of the breast cancer (Northouse, 1989). Yet when it comes to the prostate cancer patient, research is lacking when it comes to identifying just how important available emotional support is to the male patient. The attitude of the treatment team members also seems of little importance when it comes to researching the male prostate cancer patient. Holistic treatment team members can look to the results of breast cancer studies that focus on psychosocial and psychosexual issues, effects and stressors for some common markers but cannot fully rely on their accuracy as predictors of the experiences or outcomes for the prostate cancer patient and his partner.

That being said, breast cancer studies have found the manner in which a patient and her partner cope with psychosocial and psychosexual stressors is often private in nature. However, when the couple is faced with diagnosis and treatment of breast cancer, relational problems may arise out of the different methods of dealing with the situation (Ptacek et al, 1994). This clearly points out the need for greater understanding on the part

of treatment team members in regards to the ways in which the prostate cancer patient and the patient's partner also view and deal with these stressors.

Research into patient and partner reaction to the diagnosis and treatment of breast cancer (Germino, et al, 1995) came to the conclusion that the patient's focus was initially on the cancer, while her partner's initial attention centered on her, himself, and their ability as a couple to access their identified support system. Partners tended to be apprehensive about their sexuality and familial interaction, but breast cancer patients were more concerned about the impact on their future as well as cancer recurrence. Cancer patients tended to find it hard to adjust to their new status as a cancer patient within the context of their view of themselves in relation to their extended family. Yet their partners tended to focus more on the emotional impact that the change in their situation made in their lives. This research identified the need for treatment team members to be informed of these issues being dealt with by both patients and their partners and to be able to adjust the treatment process to include and deal with these findings. In his research, Derdarian (1989) found that the moment in time when the cancer diagnosis is revealed is the moment of greatest distress for the couple. Other issues later involving their knowledge of psychosocial, psychosexual and psychoeducational concerns were just as important in helping increase the couple's ability to cope and develop positive outcomes to the treatment process.

Incontinence and erectile dysfunction are the main cancer treatment aftereffects of prostatectomy surgery, and occur with such regularity they should be high on the list of issues to be considered when assessing the treatment needs of the patient and his partner, prior to and after his release from the hospital. Yet these effects come at a time when resources and information are not as readily available to the patient. The full ramifications

of surgery are beginning to be felt, yet the surgeon remains focused on the cancer treatment process (as he should be). However, the patient and his partner may feel that they are on their own, attempting to adjust to the impact of these effects without the benefit of adequate resources, information or advice. If the treatment team takes on a holistic approach, these feelings of helplessness, ignorance, confusion, distress and even abandonment that a couple may experience can be alleviated. While the surgeon is focused on the mechanics of the treatment process, another member of the team who is trained to assess and treat the emotional impact should at this time be able to step up and assist the couple in working through their perceived stressors.

Partners married to men with prostate cancer also report difficulty communicating to their partner during and after treatment about the difference between intercourse and intimacy. They are not the same, and the couple's willingness to explore other means for expressing their love and commitment in the relationship than just penile/vaginal intercourse is of importance in treatment (Gilbert, Ussher & Perz, 2010). Cancer can sometimes bring about overwhelming changes in the patient and his partner's view of their sexuality, sexual functioning, as well as their ability to maintain intimacy in their relationship. There is also a considerable impact on their perceived quality of life as well as their psychological dependence upon each other. And yet their intimate relationship is often ignored in the traditional healthcare focus of treating and curing the cancer.

Research has shown the significance of how the partner of the prostate cancer patient is affected and participates in the diagnosis and treatment procedure, as well as the different ways partners approach their perceived role in relation to the prostate cancer patient. How all of this affects the patient's overall treatment outcome becomes an important assessment tool when developing a holistic treatment plan. Without a comprehensive assessment in

this area, just what kind and how much information is required by the couple to make treatment gains remains unclear, and will remain unclear until the treatment team begins to understand that such evaluations are important to the positive outcome of the treatment process.

Frequently, the need for these issues to be dealt with by the clinician trained to help the patient work through them reaches its peak when the diagnosis is first made and again later when the patient and his partner are struggling to cope with the outcomes of the cancer treatment (Davison & Degner, 1997). The psychosocial, psychosexual and psychoeducational issues of the patient's partner are of primary importance when helping the partner develop a greater understanding of her role in relation to the man she loves and how he finally adjusts to his new place in the world as a cancer patient.

Partners of prostate cancer patients become the primary caregiver after discharge from the hospital. Research has shown there is a significant amount of stress the partner will be exposed to as caregiver, but little has been studied to determine the impact this care-giving role has on the quality of the relationship. Some research has been done using the self-reporting instrument "Caregiver Quality of Life Index, Cancer" (CQUALITY OF LIFEC), but this instrument has a broader range than just partner caregivers of patients with prostate cancer and also includes caregivers of those with lung and breast cancer. The research using this instrument indicated a moderate relationship was present when it came to mental health adjustment, reaction to emotional distress, perceived increase in relational burden and the patient's overall adjustment.

What the treatment team needs to understand is that the patient and partner's mental health is intimately associated with their quality of life, and the ways that the diagnosis and treatment of cancer contributes to the emotional distress of the patient and his partner also

links to their perceived quality of life. It is imperative for treatment providers to understand that both the patients who have been diagnosed and treated for cancer and their partners/caregivers experience increased levels of emotional distress prior to, during and after the medical treatment is completed. Therefore, treatment goals need to be expanded to include the psychosocial, psychosexual, and mental health stressors of the patient and his partner throughout the treatment and recovery process.

The diagnosis and treatment of prostate cancer has the inevitable consequence of causing major changes in the lives of patients and their partners/caregivers. It first generates perceived distortions in life routines and roles of both patient and partner as adjustments to new psychosocial, psychosexual and emotional perceptions rise to be challenged (Ozer, Firat & Bektas, 2009). The partner's quality of life is challenged as the role of caregiver is expanded. Research has shown that partners/caregivers tend to exhibit an increase in symptoms of dysthymia, anxiety, psychosomatic disorders, limited social behavior, and relationship tension. Some research has indicated that partners tend to exhibit psychosocial, psychosexual and emotional distress on the same level as the cancer patient.

This, in turn, affects the quality of care the partner/caregiver is able to provide the patient. This becomes an important area of focus for the treatment team because as treatment is moved from the hospital setting to the home, the partner/caregiver takes on more responsibility as well as experiences a significant change in the relationship from partner to caregiver. If the treatment team cannot speak to these issues and changes, then the quality of care for the patient and the partner is limited and second-rate at best. It is crucial to expand the scope of treatment to include the partner/caregiver in a broader concept in the treatment process (Hudson, 2006). The issues that this broader treatment

team concept needs to include are those extra burdens the partner/caregiver perceives, the impact on family functioning, psychological distress, and any dysfunction in psychological adjustment. How well the treatment team reacts to the inevitable changes experienced by the patient and his partner, as well as the variations in the medical condition of the patient and his partner/caregiver, is an indicator of the treatment team's ability to provide adequate treatment.

The link between the treatment team's ability to medically treat the disease and its capability to also evaluate psychosocial, psychosexual and mental health issues is a direct reflection of the treatment team's ability to positively affect the patient and partner/caregiver's quality of life. Research has indicated that there is a high correlation between the expanded treatment team concept that includes evaluation and treatment of psychosocial, psychosexual, and mental health stressors, as well as treatment of the prostate cancer, and the quality of life of the patient and the patient/caregiver. Furthermore, this result is also supported by research findings that report a telling negative correlation between quality of life scores and treatment-as-usual modalities received by some test subjects (Rummans, et al, 2000).

Research has predictably hypothesized that when a patient and his partner/caregiver receive extensive evaluation and treatment for psychosocial, psychosexual, and mental health issues, especially as they relate to the expanded treatment team concept, all parties involved will experience more positive treatment outcomes, thus resulting in a greater positive impact on partner/caregiver quality of life and a better standard of care. Research has also indicated that unidentified patient needs and greater time devoted to the patient's physical needs by the partner/caregiver when treatment is not expanded are directly linked to greater partner/caregiver distress. Also, the more physical needs a patient has that go

unrecognized by the treatment team, the greater the negative impact there is on family support, finances and partner/caregiver time. As the partner/caregiver becomes more burdened by the issues ignored by treatment of cancer as usual, social isolation of the partner/caregiver becomes greater and the impact on psychosexual and mental health issues is compounded.

In expanding the treatment team concept with greater emphasis on patient and partner's psychosocial, psychosexual and mental health issue evaluations, there is developed a quality of life treatment process purposely intended to positively impact the total treatment experience of the patient and the partner/caregiver caring for the cancer patient. Research has shown that the expanded treatment team concept, along with expanded instruments of evaluation, have a universally positive impact on quality of life outcomes.

Sexual Factors:

Sexuality is difficult for most couples to talk about under the best of conditions. Conversations about impotence and sexual intimacy can be especially difficult and delicate following prostate cancer treatment. They are even more challenging when a couple needs to openly share with a treatment team member, especially if that team member is only focused on treating the cancer to the exclusion of all else, or if the team member has conflicting views or unsettled issues about the patient's sexual questions. These issues can be credited to the stressors related to a prostate cancer diagnosis and the complexity of preserving an open relationship as it includes discussions of sex and intimacy. Add to this the sexual challenges that result from treatment, and far too many patients end up needlessly frustrated by an experience that could have easily been dealt with in the beginning had the treatment team moved beyond treatment as usual. The couple who effectively deals with the associated sexual challenges is the couple who is able to

consistently monitor and keep their lines of communication open. But left to cope on their own devices, a significant number of couples will remain uninformed of the alternatives available to them for reinforcing their sexual intimacy, especially after prostate cancer treatment. These options range from direct interventions such as injections and oral medications to external devices such as pumps and even surgically implanted prosthetics to treat erectile dysfunction. The solutions are varied and can be customized to fit the individual needs and concerns. Beyond the medical realm is the knowledge a couple can gain through treatments with a sexologist in learning sexual intimacy beyond direct penile/vaginal intercourse. However, unless the medical support team is willing to take the initiative and be open to the possibilities beyond treatment as usual, couples will struggle on their own to reclaim their sexual intimacy. The treatment team which is sensitive to these issues and willing to assist the couple with difficult and uncomfortable sexual and intimacy concerns will be able to facilitate an open discussion with the patient and his partner and will be able to impart knowledge and assistance on dealing with the various treatment options available for restoring intimacy and sexual functions.

In the process of providing cancer treatment beyond treatment as usual, open communication about normally sensitive topics becomes indispensable between patients and physicians/treatment team members. They must aim for directness and strive to be as unambiguous as possible. The efficacy of communication in the treatment process is founded on the patient's perceived permission to experience and express his emotions and thoughts without feeling judged by any member of the treatment team. The ability to confront the thoughts and feelings that are associated with prostate cancer from the process of screening, diagnosing and treating the condition with efficacy and the ability to progress through the adverse effects on body image, perceived masculinity and any fear of sexual

dysfunction are typical aspects of the discussions held between patients, physicians and treatment team members. Despite this, the specific content of the communication with the male patient and his partner and how this applies to masculinity must stop being a subject of derision if the patient and his partner are to make greater treatment progress.

In one research, information was derived from interviews done with 33 Australian and 19 Canadian prostate cancer patients after treatment. These patients confirmed that the perception of holistic treatment and care helped them have a sense of confidence in the treatment process. Encouragement to explore expanded information resources counted as an effective strategy of communication. The patients involved were encouraged to expand their own investigation of prostate cancer and regularly made use of open communication about their current condition during the process of treatment. Study of the results showed the possibility that open discussion about all the treatment aspects of prostate cancer between doctors, treatment team members and patients is possible if encouraged (Olliffe & Thorne, 2007).

Prostate cancer, in its diagnoses, treatments, and outcomes, is complex and difficult and has the potential to undermine the foundation of open communication between the patient and the treatment team. The causes of prostate cancer vary and make it difficult for some patients as well as treatment team members to be open about the complexities in its effects on the patient. To be open about how the patient and his partner tolerate the disease and its potential to overshadow their view of life, along with the evident differences in opinions and prejudices about the impact of the disease, makes it difficult for the patient and his partner not to be discouraged by the whole process (Olliffe, et al, 2006).

Studies have been reviewed and cited and several themes concerning the patient's and his partner's view of sexuality, have emerged. The experience of men and their partners

after being diagnosed with prostate cancer and receiving treatment are those cited in this study.

A change in sexual patterns constitutes the major impact of prostate cancer and its treatment, with consequences being affected by choices, sexual ability impact due to age and physical strength, improvement expectations post-surgery, recognition of sexual patterns, and masculine cultural change. The changes in sexual patterns were seen as a result of how men perceived their masculinity in their cultural setting and the impact on sexual relationships post-treatment. This was influenced by the perceived reaction felt by the men's partners and the impact of age and social circumstances. The experiences patients and their partners went through are manifested in changed sexual patterns and affect overall sexual well-being and ability. An important point of treatment for the patient and his partner is to understand that their sexual well-being goes far beyond the ability of the penis to "perform." Until treatment is expanded to incorporate this greater understanding, the patient and his partner's sexual patterns will be limited. Mental health, emotions, and sexuality have to be included into new definitions of treatment as usual.

Most of the prostate cancer studies reviewed place a greater importance on how treatment affects rates of survival and quality of life. Very few studies focus on the issue of how the patient and his partner's sexual life is affected. As a result, research has become limited in its view of the patient's sexuality (Bertero, 2001). It is understood that when the initial diagnosis of prostate cancer is given, survival is the initial priority of treatment over concern for the post-treatment side effects. Participants in studies have stated their first concern was survival, which took precedence over their sexuality and related hurdles. These results are in line with the Jonler, et al (1994) report that indicates the problems faced by 52 male patients who were diagnosed with prostate cancer, received

treatment and encountered some side effects such as a 21% rate of incontinence and 12% rate of impotence. Slightly over 80% of men said that they had strong erections before receiving a cancer diagnosis. The men also said that their quality of life was positive and if they were to choose again, their option would be delayed treatment. The patients acknowledge that treatment saved their lives, but their perception of altered sexual ability indicates how complex perceived sexuality is and how deeply it affects personal relationships.

The patient's change of perceived sexual abilities reflects the adverse effect it has on the patient's quality of life and its impact on his perceived masculinity. As treatment expands to include the patient's perceived sexual abilities, then treatment will evolve to enhance the patient's expanded knowledge of sexuality beyond the limiting impact of prostate cancer. There is an increase in the amount of treatment information available to the patient about the impact on sexual relationships and sexuality of men if the treatment team will but leave itself open to a greater understanding of the world as it really is instead of the limiting factor of what treatment has become. It is essential for the treatment team to develop a supportive attitude in light of these challenging circumstances in order to help their patients and partners develop a greater understanding of their post-treatment potential to lead fulfilling sexual lives.

Research has indicated that prostate cancer survivors who sought treatment for their sexual problems after cancer treatment have turned to alternative means to try and resolve their sexual problems prior to seeking professional treatment. Less than half of patients sought treatment for sex-related complications after receiving the news that they had been diagnosed with prostate cancer, while twice that number sought treatment for sexual issues prior to diagnosis. Men are actually at greater risk of declining sexual performance as a

result of aging than of having their erectile functions decline because of cancer treatment, yet post-treatment cancer patients tend to seek out alternative means of being rehabilitated sexually. Studies indicate that men encounter numerous obstacles in the course of seeking professional help for their sexual problems.

Partners of the prostate cancer patient play an important but sometimes unrecognized role in the development of a healthy sexual rehabilitation. However, not all partners are supportive in finding solutions to the sexual issues. If this is not recognized by the treatment team, then these partners are less likely to participate in the treatment interviews. Approximately 43% of women showed little or no interest in helping their partners find treatment resources for sexual problems as a result of prostate cancer, and approximately 21% of them claimed to have given up after cursory attempts yielded unfavorable results.

The patient's impotence, as well as the stress of the diagnosis and treatment of prostate cancer, is seen to be a major cause of the partner's lowered level of concern when it comes to the sexual aspect of their relationship. Some research has indicated that the patient's partner would actively participate in sexual rehabilitation treatment if it had been openly discussed during the treatment process.

Assessment of the patient's sexual knowledge and identity of sexual issues prior to and following treatment for cancer is seen to be highly important in helping the couple grow in their sexual relationship. The focus or lack of focus on treatment methods changes how the patient views his sexual relationship after treatment, and will either help couples end their sexual life or help them evolve into enjoying a new phase of sexual experience. This suggests that the amount of openness the members of the treatment team have toward sexuality, as well as sex-related conversations, and how that openness is conveyed between

the treatment team members, will dictate the ability of the team to help their patients deal with their sexual issues.

Patients exposed to treatment teams who are open about the sexual impact prostate cancer treatment has are better helped in dealing with their identity and relationship challenges. Couples exposed to the broader treatment options exhibit a stronger desire to maintain their identities as far as sex is concerned. They view themselves as more than sexual beings limited by a restricted view of what their sexuality might have been. One of the aftereffects of prostate cancer is the possible end of penile/vaginal intercourse as they knew it. This has resulted in many patients becoming victims of a dysfunctional view of what sex really is, when a little extra effort on the part of the treatment team could have assisted the couple in making a satisfactory adjustment to their current condition.

The treatment team needs to understand that prostate cancer has more than just physical effects on the patient and his partner's life. It impacts the way a patient views himself socially, emotionally and sexually. The diagnoses and treatments of prostate cancer have the power to change the patient and his partner's definition of sex. This change can either be positively or negatively influenced by the willingness of the treatment team to engage in this process of conversation and direction that leads to change.

While research about other illnesses and their emotional impact on the patient and even the patient's partner is common in medical surveys, studies on the effect of the diagnosis and treatment on the prostate cancer patient and his partner are very limited. The lack of such materials, combined with ignorance about where couples should even look to receive treatment appears to not only be lacking for the patient, but also for the cancer treatment team members. Examining prostate cancer's extended effect beyond the mindset of, "There is the cancer; cure the cancer," becomes important because the disease affects its victims

physically, socially, emotionally, and sexually in ways that range from stigma to damaged identity and relationships. Patients and their partners exposed earlier to this broader scope of treatment have been able to better deal with these identity and relationship challenges.

Prostate cancer treatment is possibly the one major disease treatment that is known to noticeably bring about a negative physical impact in men. The damaging aftereffects of treatment in the form of erectile dysfunction or incontinence and their symptoms do a great deal of harm to a man's view of his masculinity. This indicates that the masculine cultural norms established by society as far as sexual behavior and masculinity are concerned are the social creations of patient's culture as opposed to biological facts. However, if there is not a broader aspect to treatment, the assessment of how the patient and his partner's sexuality are constructed becomes overlooked. Also, without this assessment, further attempts to help the patient and his partner redefine masculinity and sexuality become impossible. The emotionally devastating and frustrating effects of impotence can result in the patient's loss of self-confidence specifically as it relates to relationship issues. Most patients' post-treatment adjustment will include feelings of sadness, anger, and a loss of masculinity and self-confidence, as well as frustrations over the inability to satisfy his partner as he once was able to do. These problems could be alleviated, or at least lessened, for the countless men and women who are still being treated without consideration of the greater impact cancer treatment will have on them as patients and partners.

Medical science has developed new ways to improve the physical conditions of men who experience impotence. One cause of impotence during treatment is the medications prescribed during prostate cancer treatment. The treatment may bring temporary impotence during the course of the treatment or permanent impotence as an outcome of the treatment (Green, et al, 2010). Currently, there is no known technique to determine if the patient has

the potential to develop impotence because of the treatment. The severity of the condition, including the length of time that the patient may suffer the condition, is still unknown. Yet many patients are prescribed a treatment process and left to deal with the emotional impact and sexual aftereffects on their own. Medical science has not established specific conditions, factors, or causes that lead to the development of impotence during treatment. Men do stand a bigger possibility of remaining potent after the prostate cancer treatment if they were potent before the treatment than those who were already suffering from impotence. Normally, blood flows into the chambers of the penis when the patient experiences an erection. During arousal, the blood remains inside and does not flow outside the penis until after orgasm and the penis relaxes. This process may or may not work normally after the treatment for prostate cancer because the treatment may cause some damage to the nerve pathways. The extent of the damage on the ability to obtain or maintain an erection cannot be predetermined, and again, unless treatment has been broadened to include dealing with these concerns, the patient is left on his own to deal with them.

Multidisciplinary Treatment:

Once prostate cancer has been diagnosed in a patient, the treatment process itself takes on a multitude of complex and even divergent treatment modalities. Some of these issues will require a comprehensive evaluation process, including but not limited to the means of treatment, personal cost, personal gain and possible detriments of the chosen form of treatment to the patient. There are issues of under-treatment or over-treatment and the effects of chemical toxicity that some forms of treatment will have on the patient. Included in this list, and of no less importance, are the emotional and physical impact the diagnosis and treatment will have on the patient and his partner. The issues are multitudinous and

take years of education and clinical practice in order to begin to incorporate their impact into the treatment process. But the issues are too numerous and far too complex for one person to be able to deal with them all, so treatment often becomes unidirectional, with issues the patient and his partner may consider important being ignored. In response to this, cancer treatment has begun to evolve into a multidisciplinary team effort.

For some time now when it comes to women and cancer treatment, issues such as how a woman's view of herself as a person and how the diagnosis and treatment of cancer may affect her social role as partner or mother, as well as how treatment outcomes may affect her sexual functioning or response, have been considered a valid part of the overall treatment process and will include, if not a cohesive multidisciplinary treatment team, then at least the availability of multiple treatment specialists. Rising consideration is being given to the fact that this same kind of treatment approach should be employed for the prostate cancer patient and, by extension, his partner.

The shared approach of the multidisciplinary treatment process will require a significant paradigm shift in the treatment philosophy of medical doctors and clinicians for them to accept the fundamental concept of letting go of physician autonomy and working toward a dependence on the collective wisdom of the team. In order for the multidisciplinary treatment team approach to develop, a paradigm shift on the part of the clinicians must take place in order for them to adhere to the spirit of the approach. Where the culture of medicine tends to focus on physician independence, little attention is given to a collective decision-making process (Bellardita, et al, 2011). Yet in the end, the clinician needs to understand that it is not about the physicians' comfort level; it is about the quality of treatment the patient and his partner receive. The multidisciplinary treatment process has the ability to make available a greater level of care and information regarding

the disease and its overall treatment. When the patient rather than the favored treatment modality becomes the center of focus, treatment evolves and the patient, his partner and the treatment team win.

As for the makeup of the multidisciplinary treatment team, that becomes an issue of availability and focus of the treatment process. However, one system that may be looked to as an example is the Intermountain Healthcare based in Salt Lake City, Utah. It consists of 24 hospitals, 15 of which are urban and 9 rural. The organization also operates 130 community clinics and provides services for approximately 60% of Utah's residents. For this healthcare organization, the multidisciplinary treatment team process begins as soon as the patient is diagnosed with cancer. Care coordination starts as the diagnosis is delivered and the designated nurse navigator contacts the patient and explains in detail the purpose and function of the multidisciplinary team in developing the patient's treatment plan with an emphasis on communication among all treatment providers. The nurse navigator takes the patient history and overall well-being is assessed. If clinically indicated, additional diagnostic tests or procedures are scheduled. During this process the patient meets with other treatment providers, including a mental health specialist, a dietician and genetic counselor, a lymphedema specialist or physical therapist. Once these sessions are completed, the patient again meets with the nurse navigator to review the visits and the developing treatment plan. The treatment plan itself begins to develop over the course of the clinic visit and is based on the recommendations of the clinicians. Following this, the nurse navigator continues to provide support to the patient after the treatment begins and throughout the course of treatment (Litton, et al, 2010).

Clinical Sexologists' Contribution to the Multidisciplinary Treatment:

Impotence is the inability of the patient to achieve an erection or maintain an erection long enough during intercourse to achieve an orgasm. This condition is common to patients who have undergone prostate surgery, cryotherapy, or radiation therapy. Prostate cancer patients may also experience a decrease in sexual desire during intercourse after the prostate cancer treatment. Hormone therapy used to treat cancer can alter the sexual desires of the patient because it lowers testosterone production that controls and maintains sexual drive. The therapist during treatment needs to understand the relationship between the felt sexual need and the capacity to achieve sexual satisfaction. The patient and his partner's ability to work through these needs is something they may not have the capacity to accomplish on their own and, without the treatment team's expanded approach, may be left to deal with on their own. (Hall, 2009)

The social impact for the patient dealing with impotence may be a tendency to avoid flirting, relationships, and even sexual intercourse. The decision to avoid intimacy could cause relationships to deteriorate due to the misconception that rejection would result from the patient's personal inadequacy to satisfy the sexual needs of their partner. Intimacy plays a significant role in any relationship, whether sex has a major influence or not. Intimacy for the couple becomes multifaceted, including the intellectual expression and exchange between the two who enjoy the same interests. The cognitive exchanges of ideas and the sharing of opinions also tend to make the relationship grow. However, this is somewhat experiential to couples who want to know or enjoy each other. Again, this becomes impacted by the couple's ability to openly deal with a very sensitive area such as sex, and any blocked communication causes a negative impact on that intimacy. With treatment that is willing to assess and deal with these issues, the couple's chance of

working through them increases. The prostate cancer patient dealing with impotence may develop intimacy without being sexual, yet many patients give even this up because of the frustrations that build with their impacted sexuality. Where is help to be found if the patient is receiving cancer treatment as is the norm?

Prostate cancer treatment may trigger different feelings and perceptions among men concerning the treatment. Most men want to have the support of their partners and may ask their partners to accompany them during treatments or medical appointments, while some men, for personal reasons, would rather do it by themselves. Patients who decide to tackle the treatments alone still need to keep open communication with their partners, if not for their own morale and emotional support, then for their partner. There are interventions available for the patient who experiences a certain degree of impotence. The problem of impotence need not focus on the erection part alone. There are other parts of the process that may provide some probable solutions. The libido, erection, and orgasm are only part of the process that medical doctors may overlook in the desire to treat the cancer. Men still have the ability to enjoy sex even in the absence of an erection because they can still experience orgasm.

Couples may find that they do not need to have sexual intercourse in order to feel love or fulfillment in their relationship. These couples may come to realize that the intimate connection between them can be as satisfying as plain sex. However, for those who are unable to adjust to only emotional intimacy and express the desire to experience erection and vaginal penetration, there are possible treatments available to help the patient achieve success in this area. As stated, tools such as penile injections, penile implants, penile pumps and various new drugs could help the patient achieve an erection (UCSF, 2009). The vacuum erection devices and other urethral suppositories, as well as sex therapy can

also assist in treating impotence. The best way to overcome impotence after cancer treatment is for the therapist to spend time assessing and discussing the issues and possible treatment options with the patient and his partner. This assessment will help establish the severity and emotional impact of the impotence as well as help determine the type of intervention appropriate to the patient's needs. Obtaining treatment for impotence requires maintaining openness and an attitude that no subject is too embarrassing or unimportant in order to make treatment more effective.

There are some clinicians with specialized experience and training who work with sex therapy in an attempt to understand human sexuality as it relates to the prostate cancer patient and his partner (Azim, S.A. 2000). Their work is not just about psychology, nor is it just about sex education. An assortment of healing therapies and psychoeducational methods can be used by clinical sexologists to help the patient work through the impact that prostate cancer has had. Clinical sexology assists the patient and his partner through assessment, diagnosis and management of sexual issues faced by the patient, such as impotence due to the aftereffects of cancer treatment (Levine, Risen & Althof, 2003). Impotence, also called sexual dysfunction or erectile dysfunction (Kaplan, 1974), can be defined as an inability to attain or if attained, maintain an erection of sufficient duration to achieve an orgasm. This problem may not be caused by the physical effects of cancer treatment alone but may also be rooted in a number of possible emotional and physical issues such as experiencing performance anxiety prior to or during sexual activity, inability to reach orgasm, lack of sexual desire, fear of intimacy or other sexual and relational issues. According to clinical sexologists, sexual dysfunction can be the consequence of a mixture of conditions which include but are not limited to the following:

- * Social shyness or guilt over having sexual desires or thoughts.

- * Relational problems.
- * Disturbance of body image.
- * Cognitive dissonance concerning a lack of understanding or experience.
- * An inability to openly share sexual pleasure.
- * Physical disabilities or aging.
- * Sexual fears, inability to reach orgasm, early ejaculation, arousal or erectile problems.

Any one or a combination of these can contribute to sexual dysfunction.

It is essential for the clinician during assessment and treatment to note that any lack of intimacy can also have an effect on the sexual health of the whole relationship. The clinical sexologist may well attend to this in the treatment agenda. Such a treatment agenda, generally recognized as sex therapy, takes into account the patient and his partner's need of psychoeducation with the goal of helping them work through the impact of prostate cancer treatment and maintain a fulfilling sexual relationship. The therapist also works with the patient and his partner in a professional and safe environment in order to facilitate the patient's ability to feel comfortable and speak openly about their sexual issues.

A number of treatment methods can be used by clinical sexologists in an attempt to assist the patient in overcoming the identified sexual issues. One of the most efficient is the cognitive-behavioral approach (Phill, 2010). This includes psychoeducational techniques geared toward helping the patients achieve sexual fulfillment. With proper training and understanding, clinical sexologists can help the patient overcome problems that are impacted by diverse cultural beliefs that affect sexual behaviors.

The Impact of Prostate Cancer and the Need for an Expanded View of Treatment

Conclusion:

According to current available research cited, the impact of prostate cancer as it relates to the psychosocial and psychosexual viewpoint of the patient and his partner exhibits a wide range of concerns that are directly associated to the illness itself. These concerns include the physical side effects and the overall impact that cancer will have on the patient and his partner's life, extending from the moment when the diagnosis is first conveyed to them, throughout the treatment process recommended and beyond to the eventual outcome of the treatment received. Even though there has been some psychosocial and psychosexual research conducted, it has been limited. Within the research conducted, indications are that the impact on the psychosexual arena is a prevalent factor. Erectile dysfunction and urinary leakage problems are highlighted as most important to the patient, with erectile dysfunction rated as the most common complaint. Researchers have identified significant concerns of the patient and his partner beyond just the diagnosis and treatment outcomes. Studies have found that there is a need for psychosocial evaluation and intervention that varies according to age-specific factors which can moderate the impact of emotional stressors coupled with the impact of the diagnosis and treatment outcomes of the cancer.

Research has also been conducted into the connection between the patient's confidence levels and the treatment team's ability to assess the patient's situation, treat the cancer and help with the treatment's outcomes, as well as provide support and information as it relates to his diagnosis and assessment. An assessment was conducted on prostate cancer patients after treatment and concluded that choices made by the patient were connected to the emotional stress they experienced after they received treatment. Optimism on the part of

the treatment team was found to be a significant indicator of how much decision-related stress a patient experiences, with the appraisal abilities of the treatment team being a primary factor, as well as the team's ability to anticipate and evolve the treatment process to solve the identified issues of the patient and his partner. Factors that affect overall stress, but not necessarily decision-related stress, include cognitive avoidance, lack of social support systems and lack of psychoeducational services. Included in the area of decision-related stress is incontinence as well as erectile dysfunction due to treatment outcomes. The factors related to emotional distress following diagnosis of prostate cancer are identical to the factors found in decision-related distress processes. To treat these issues, the researchers have suggested that patients receive a greater range of support services than is found in treatment as usual.

The conjecture that a patient and his partner's attitude and belief in the efficacy of the entire treatment team has a direct influence on their emotional distress has been borne out by surveys conducted. Emotional distress levels at the time of diagnosis and at different intervals indicate that the patient and his partner's belief in the entire treatment modality has a direct mediating effect upon their appraisal of the impact the cancer had and largely determines his and his partner's outlook on the totality of their experience. The patient's assessed attitude as well as the impact appraisal play a significant part in how the patient views his emotional stressors and the treatment outcomes. This patient attitude affects his ability to engage coping skills as well as seek available social support systems and psychoeducational information. This corroborates the proposal that the expanded ability of the prostate cancer treatment team to anticipate and facilitate the patient's development toward a more positive outlook is paramount and goes beyond treatment as usual. This expanded assessment and treatment process will influence how the patient evaluates the

total threat of the cancer on his and his partner's psychosocial and psychosexual views. This, in turn, controls their emotional response to the treatment outcome. The treatment team's ability to assess, anticipate and help the patient and his partner develop a positive attitude is a major part of helping them respond to their perceived emotional stressors, as well as work through the aftereffects of treatment. The above research has found that specifics in the delivery and design of support interventions by the treatment team can have a major influence on how the patient and his partner deal with the psychosocial, and psychosexual impact on treatment outcomes.

Current clinical suggestions for the psychological care of cancer patients advocate early identification of patients with high levels of emotional distress as it relates to the diagnosis and treatment outcomes and the early development of assessment and treatment goals as they relate to the patient's identified psychosocial, psychosexual and psychoeducational concerns. The treatment team will then engage the couple in an in-depth assessment program during the entire treatment process. Research findings conclude that identification and early intervention, paired with long-term treatment goals and regular adjustments in treatment goals as the patient's view changes in relation to their experience of the treatment process, will considerably decrease emotional distress at baseline and predictably increase positive outcomes as longer term distress is handled. Screening and assessment should entail all of the psychosocial support systems, as well as the psychosexual concerns, as opposed to limiting the treatment to elimination of just the cancer without acknowledging the greater distress factors experienced by the patient and his partner.

The patient and his partner's own internal process of cognitive aversion, the extent to which they are forced to search for some type of support system as it relates to their own

cancer experience, and the amount of time and effort it requires to assimilate their own psychoeducational information will have a direct correlation to the level of ability a couple has to establish their own level of positive outcome and deal with their emotional distress. Their level of emotional distress without the intervention of a well-trained treatment team to help them cope with the inevitable treatment stressors rises significantly and has a cognitive impact that affects the patient and his partner's ability to positively appraise their situation. With the treatment team's dedication to help the patient and his partner develop greater problem-solving and coping skills comes an increased ability by the couple to actually utilize the information they received in order to better manage the challenges presented by the diagnosis and treatment outcomes for the cancer.

The prostate cancer patient who experiences sexual dysfunction may be doing so because of several reasons not just associated with the cancer treatment itself. These reasons can be linked to both physical as well as psychological factors in its etiology. However, these factors may not be as evident if the sexual dysfunction is only addressed in the post-cancer treatment phase, as is normally done. Prostate cancer therapies can and do have a direct impact on the patient's sexual function. These therapies, which include radiation therapy, surgery and chemotherapy, affect the patient's sexual function in different ways. Erectile dysfunction can also be linked to the type of medication administered to treat the emotional impact caused by the diagnosis and treatment of the cancer such as depression, physical pain, and other post-treatment side effects. Yet these and other issues may not be evident or sufficiently addressed unless the treatment team also includes professional clinicians trained to evaluate and treat these issues. Some of the psychological factors that can lead to sexual dysfunction include belief systems about the origin of prostate cancer, distorted cognitive beliefs, remorse and shame based on

dysfunctional self-image that at times goes together with false beliefs, dysthymia associated with negative self-image and social standing, a negative view of physical alterations to the patient's genitals as a result of surgical treatment, and the distress that impacts social and support systems as a consequence of the diagnosis and treatment of the prostate cancer. One might think that the older the patient is, the less their sexual desire impacts the way they feel about and see themselves as a sexual being in relationship. Yet contrary to this, current research points out, those older prostate cancer patients even in their 70s and 80s continue to see their ability to function as a sexual being in relationship as important to their daily functioning and shows they desire to still achieve an erection as well as vaginal penetration until orgasm. Any inhibition to their sexual ability has an emotional impact.

It is critical for a patient to understand the impending changes in his sexuality and view of himself as a sexual being; therefore, it is vital that we get past labeling sex-related issues as too embarrassing, too uncomfortable, and even too inappropriate to discuss. Frank discussions must take place between patient and a multidisciplinary team of medical doctors and treatment specialists/clinicians working together to treat the whole man. If these conversations do not occur, then the patient and his partner's ability to learn to adapt to their ever-changing sexuality becomes hampered. If the treatment specialist cannot help the patient/client get past these issues, then the ability to treat the patient is negated.

To quote Irving Stone's novel on Sigmund Freud, *The Passions of the Mind*, Dr. Josef Breuer's advice to Dr. Freud when Dr. Freud questioned him about the causes of hysteria in his patient, Anna O., Dr. Breuer's response was the following:

“How can anyone tell? These are the closed areas of the human mind. No one can get into them. Nor do we need to so long as we eradicate the symptoms and restore the patient to health.”

In conclusion, far too often the physician sees only the prostate cancer without seeing the patient. Yet we can change that, as multidisciplinary treatment teams form and open communication takes place in a holistic approach that considers all the needs of the prostate cancer patient and his partner. This is a lofty but achievable goal that can greatly enhance positive outcomes for patients and their partners and advance the standard of medical care. In another quote from the same novel, the character Dr. Jean Martin Charcot advises Dr. Freud,

“The greatest satisfaction a man can have is by seeing something new. That is, to recognize it as new. We must be see-ers [sic]. We must look and look until ultimately we see the truth ...Why is it that doctors see only what they have learned to see? That is the way to freeze medical science.”

References Cited:

Ader, R., Felten, D.L. & Cohen, N. 1991. Psychoneuroimmunology 2nd ed. San Diego Academic Press.

Albertsen, P.C., Aaronson, N.K., Muller, M.J. et al, 1997. Health-related quality of life among patients with metastatic prostate cancer. *Urology* vol. 49; pgs. 207-216.

Aldwin, C. M. & Revenson, T. A. 1987. Does coping help? A reexamination of the relation between coping and mental health. *Journal of Personality and Social Psychology*, 53(2), pp. 337-348.

Altwein J, Ekman P, Barry M. 1997. How is quality of life in prostate cancer patients influenced by modern treatment? The Wallenberg Symposium. *Urology*, 49, pp. 66-67.

American Cancer Society. 2010 What are the key statistics about prostate cancer? Retrieved November 23, 2010, from <http://www.cancer.org/Cancer/ProstateCancer/DetailedGuide/prostate-cancer-key-statistics>.

Andersen, B.L. 1999. Surviving Cancer: The importance of sexual self concept. *Medical and Pediatric Oncology*, 33 (1), pp. 15-23.

Andersen, B.L., Anderson, B., & DeProsse, C. 1989. Controlled prospective longitudinal study of women with cancer: Sexual functioning outcomes. *Journal of Consulting and Clinical Psychology*, Vol. 57 pgs 683-691.

Andrykowski, M.A., & Brady, M.J. 1994. Health Locus of Control and Psychological Distress in Cancer Patients: Interactive Effects of Context. *Journal of Behavioral Medicine*, 17, 439-458.

Ani. 2010, Cancer Surgery Leads to Sexual Dysfunction. *Times of India*. (, March 13)

Arrington, M. I. 2008. Prostate Cancer and the Social Construction of Masculine Sexual Identity. *International Journal of Men's Health*, 7(3), pp. 299-306. (November 10).

Ashton, W. A. & Fuehrer, A. 1993. Effects of Gender and Gender-Role Identification of Participant and Type of Social Support Resource on Support Seeking. *Sex Roles*, 28, pp. 461-476.

Astin, J. A. 1998. Why Patients use Alternative Medicine: Results of a National Study. *JAMA*, 279, pp. 1548-1553.

Australian Health Technology Advisory Committee. 2008. Prostate Cancer Screening. Canberra: Australian Health Technology Advisory Committee.

Azim, S.A. 2000. Comment on Schiavi, R.C. Psychiatrists Role in the Management of Sexual Disorders, *Current Opinion in Psychiatry*, 12m 12; 267-269

Bandura, A. 1977. Self-Efficacy: Toward a Unifying Theory of Behavioral Change. *Psychological Review*, 84, 191-215.

Bellardita, L., Donegani, S., Spatuzzi, A. L. & Valdagni, R. 2011, Multidisciplinary Versus One-on-One Setting: A Qualitative Study of Clinicians' Perceptions of Their Relationship With Patients With Prostate Cancer. *American Society of Clinical Oncology* 2011..

Bellizzi, K.M., Latini, D.M., Cowan, J.E., DuChane, J. 2008. Fear of recurrence, symptom burden, and health-related quality of life in men with prostate cancer. *Journal of Urology*. Vol. 72 Issue 6, pp 1269-1273.

Ben-Zur, H., Gilbar, O. & Lev, S. 2001. Coping with breast cancer: Patient, spouse, and dyad models. *Psychosomatic Medicine*, 63, pp. 32-39.

Bertero, C. 2001. Altered sexual patterns after treatment for prostate cancer. *Cancer Practice*, 9, 245-251.

Bjorck, J.P., Hopp, D.P., & Jones, L.W. 1999. Prostate cancer and emotional functioning: Effects of mental adjustment, optimism, and appraisal. *Journal of Psychosocial Oncology*, 17, 71-85.

Bonevski, B., Sanson-Fisher, R.W., Girgis, A. 2000. Evaluation of an instrument to assess the needs of patients with cancer. *Cancer*, 88, pp. 217B 225

Berkman, L. F. & Syme, S. L. 1979. Social networks, host resistance and mortality: A nine- year follow-up of Alameda County residents. *American Journal of Epidemiology*, 109, pp. 186-204.

Bogart, L.M., & Helgeson, V.S. 2000. Social comparisons among women with breast cancer: A longitudinal investigation. *Journal of Applied Social Psychology*, 30, pp. 547-575.

Bokhour, B. G. et al 2004. Sexuality after treatment for early prostate cancer: Exploring the meanings of erectile dysfunction. *Journal of General Internal Medicine*, 16(10), pp. 649-655. June 9

Charmaz, K. 1991. *Good days, bad days; The self in chronic illness and time*. New Brunswick, NJ; Rutgers University Press.

Clark, J. A. et al 2003. Patient's perceptions of quality of life after treatment for early prostate cancer. *Journal of Clinical Oncology*, 21(20), pp. 3777-3784.

Cella, D.F., & Bonomi, A.E. 1995. Measuring quality of life: 1995 update. *Oncology*, 9, 11 (Supplement): 47-60.

- Cella, D.F., Tulsky, D.S., Gray, G., et al 1993. The functional assessment of cancer therapy scale: development and validation of the general measure. *Journal of Clinical Oncology*; 11; pgs. 570-579.
- Cohen, S., Doyle, W. J., Skoner, D. P., Rabin, B. S. & Gwaltney, J. M. 1997. Social ties and susceptibility to the common cold. *Journal of the American Medical Association*, 277, 1940-1944.
- Cohen, S., Tyrrell, D. A. J. & Smith, A. P. 1991. Psychological stress and susceptibility to the common cold. *The New England Journal of Medicine*, 325, pp. 606-612.
- Cohen, S. & Wills, T. A. 1985. Psychological models of social support in the etiology of physical disease. *Health Psychology*, 7, pp. 269-297.
- Cohen, S. & Williamson, G. M. 1991. Stress and infectious disease in humans. *Psychological Bulletin*, 109, pp. 5-24.
- Coombs, R. H. 1991. Marital status and personal well-being: A literature review. *Family Relations*, 40, pp. 97-102.
- Couper, J. 2007. The effects of prostate cancer on intimate relationships. *The Journal of Men's Health & Gender*, 4(3), pp. 226-232.
- Couper, J., Bloch, S., Love, A., Maevean, M., Duchesne, G.M., Kissane, D., 2006. Psychosocial adjustment of female partners of men with prostate cancer: a review of the literature. *Psycho-oncology*, 15(11), pp. 937-953.
- Courtenay, W.H. & Keeling, R.P. 2000. Men, Gender, and Health: Toward an Interdisciplinary Approach. *Journal of American College Health*, 48(6), 243-246.
- Cunningham, A.J., Lockwood, G.A. and Cunningham, J.A. 1991. A relationship between perceived self-efficacy and quality of life in cancer patients. *Patient Education and Counseling*, 17:71-78.
- Davison, B. J., Degner, L. F. & Morgan, T. R. 1995. Information and decision-making preferences of men with prostate cancer. *Oncology Nursing Forum*, 22(9), pp. 1401-1408.
- Davison, B. J. & Degner, L. F. (1997). Empowerment of men newly diagnosed with prostate cancer. *Cancer Nursing*, 20(3), pp. 187B196.
- Derdiarian, A.K. (1989). Effects of information on recently diagnosed cancer patients' and spouses' satisfaction with care. *Cancer Nursing*, 12, pp. 285- 292.
- DiSipio, T. 2009. Health related quality of life among breast cancer survivors: Town and country experiences. Ph.D. thesis, Queensland University of Technology.
- Druss, B.G., & Rosenheck, R.A. 1999. Association between use of unconventional therapies and conventional medical services. *JAMA*, 282(7); pp 651-656.

- Dua, X., Freeman, J. L. & Goodwin, J. S. 1999. Information on radiation Treatment in patients with breast cancer: The advantages of the linked Medicare and SEER data. *Journal of Clinical Epidemiology*, 52(5), pp. 463-470. January 21)
- Epping-Jordan, J.E., Compas, B.E., Osowiecki, D.M., Oppedisano, G., Gerhardt, C., Primo, K., & Drag, D.N. 1999. Psychological adjustment to breast cancer. Processes of emotional distress. *Health Psychology*. 18, 315-326.
- Eton, D.T., & Lepore, S.J. 2002. Prostate cancer and health-related quality of life: A review of the literature. *Psychooncology*, 11, 307-326.
- Fallowfield, L., Ratcliffe, D., Jenkins, V., & Saul, J. 2001. Psychiatric morbidity and its recognition by doctors in patients with cancer, *British Journal of Cancer* 84 (8), pp 1011-1015
- Fallowfield, L.J. & Jenkins, V.A. 1999. Effective communication skills are the key to good cancer care. *European Journal of Cancer*, 35, pp. 1592-1597.
- Friedland, J., Renwick, R., & McColl, M. 1996. Coping and social support as determinants of quality of life in HIV/AIDS. *AIDS Care*, Vol. 8, Pgs. 15-31.
- Friedman, D. B., & Kao, E. K. 2008, A Comprehensive Assessment of the Difficulty Level and Cultural Sensitivity of Online Cancer Prevention Resources for Older Minority Men. *Preventative Chronic Disease*, Vol. 5(1).
- Fergus, K.D., Gray, R.E., Fitch, M.I., Labrecque, M., & Phillips, C. 2002. Active consideration: Conceptualizing patient-provided support for spouse care givers in the context of prostate cancer. *Qualitative Health Research*, 12, 492B514.
- Ganz, P. A. 2008. Psychological and social aspects of breast cancer. *Oncology*, 22(6). (May 1)
- Germino, B.B., Fife, B.L., & Funk, S.G. 1995. Cancer and the partner relationship: What is its meaning? *Seminars in Oncology Nursing*, 11(1), pp. 43-50.
- Gilbert, E., Ussher, J. M. & Perz, J. 2010. Renegotiating sexuality and intimacy in the context of cancer: The experiences of caregivers. *Archives of Sexual Behavior*, 39(4), pp. 998-1009.
- Girgis, A. Boyes, A., Sanson-Fisher, R.W., Burrows, S. 2000. Perceived needs of women diagnosed with breast cancer: Rural versus urban location. *Australian, New Zealand, Journal of Public Health*, 24, pp 166-73.
- Glajchen, M. & Moul, J. W. 1996. Teleconferencing as a method of educating men about managing advanced prostate cancer and pain. *Journal of Psychosocial Oncology*, 14, pp. 73B87.

Goodwin, J. S., Hunt, W. C., Key, C. R., & Samet, J. M. 1987. The effect of marital status on stage, treatment and survival of cancer patients. *Journal of American Medical Association*, 258, pp. 3125- 3130.

Gray, R. E., Klotz, L., Iscoe, N., Fitch, M., Fransenn, E., Johnson, B. J. 1997. Results of a survey of Canadian men with prostate cancer. *Canadian Journal of Urology*, 4, 359-365.

Green, H.J., Wells, D.J.N. & Laakso, L. 2010. Coping in men with prostate cancer and their partners: a quantitative and qualitative study. *European Journal of Cancer Care* **20**, 237-247

Gregoire, I., Kalogeropoulos, D., Corcos, J. 1997. The effectiveness of a professionally led support group for men with prostate cancer. *Urology Nursing*, 17, pp. 58B66

Graves, K. D. 2003. Social cognitive theory and cancer patients' quality of life: A meta-analysis of psychosocial intervention components. *Health Psychology*, Vol. 22(2), Mar 2003, 210-219.

Gleave, M E, Bruchovsky N, Moore M J, & P Venner 1999. Prostate cancer: 9. Treatment of advanced disease. *Canadian Medical Association, CMAJ*. 160(2): 225B232. January 26

Gove, W. R. 1972. The relationship between sex roles, marital status, and mental illness. *Social Forces*, 51, pp. 38B44.

Guess, B. 2007. Preventing and treating the side effects of testosterone deprivation therapy in men with prostate cancer; A Guide for Patients and Physicians. *Prostate cancer Research Institute*, 10(4). November

Guinn, B. 1998. Acculturation and health locus of control among Mexican American Adolescents. *Hispanic Journal of Behavioral Sciences*, 20, 492-450.

Halbert, C. H., Barg, F. K., Weathers, B., Delmoor, E., Coyne, J., Wileyto, E. P., Arocho, J., Mahler, B., Malkowicz, S. D. 2006. Differences in Cultural Beliefs and Values Among African American and European American Men With Prostate Cancer. *Cancer Culture and Literacy*, August.

Hall, K. 2009. Coping with Prostate Cancer; Quality Health Medical Advisory Board. <http://www.qualityhealth.com>

Hanash, S. 2001. Global strategies for disease detection and treatment: Proteomics. The Netherlands: IOS Press.

Helgeson, V.S. & Cohen, S. 1996. Social support and adjustment to cancer: Reconciling descriptive, correlational, and intervention research. *Health Psychology*, 1996, 15(2), 135-148.

Helgeson, V. S., & Lepore, S. J. 1997. Men's adjustment to prostate cancer: The role of agency and unmitigated agency. *Sex Roles*, 37(3/4)

- Herr, H.W., O'Sullivan, M. 2000 Quality of life of asymptomatic men with non- metastatic prostate cancer on androgen deprivation therapy. *Journal of Urology*, 163; pp 1743-1746.
- Hudson, P.L. 2006. How well do family care givers cope after caring for a relative with advanced disease and how can health professionals enhance their support? *Journal of Palliative Medicine*. 9(3), pp 694-703.
- Janoff-Bulman, R. 1992. *Shattered Assumptions; Towards a New Psychology of Trauma*. New York: Free Press.
- Jarrett, D. 2007, April 16. Prostate cancer and sex B my journey with prostate cancer one man's view. Retrieved from Ezine articles website: <http://ezinearticles.com/?Prostate-Cancer-and-Sex---My-Journey-With-Prostate-Cancer---One-Man's-View&ID=529005>
- Jemal, A., Thomas, A., Murray, T. and Thun, M. 2002. Cancer Statistics, 2002. *Cancer Journal for Clinicians*, 52, 23-47.
- Jones, J. 2007. Editorial. *Australian Journal of Advanced Nursing*, 24(3).
- Jonler, M., Ritter, M.A., Brinkman, R, et al 1994. Sequelae of definitive radiation therapy for prostate cancer localized to the pelvis. *Urology*, 44: pp 876-882,
- Kaprio, J., Koskenvuo, M., & Rita, H. 1987. Mortality after bereavement: A prospective study of 95,647 widowed persons. *American Journal of Public Health*, 77, pp. 283-287.
- Kato, I., Tominaga, S. & Ikari, A. 1992. The role of socioeconomic factors in the survival of patients with gastrointestinal cancers. *Japan Journal of Clinical Oncology*, 22(4), pp. 270B277. August
- Kemmler, G. et al 1999. Comparison of two quality-of-life instruments for cancer patients: The functional assessment of cancer therapy-general and the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire-C30. *Journal of Clinical Oncology*, 17(9), pp. 2932. September
- Kerr, J., Engel, J., Schlesinger-Raab, A., Sauer, H., Holzel, D., 2002. Communication, quality of life and age: results of a 5-year prospective study in breast cancer patients. *Oxford Journals*, 14(3), pp. 421-427.
- Kunkel, E. J. S., Bakker, J.R., Myers, R.E., Oyesanmi, O., Gomella, L.G. 2000. Biopsychosocial aspects of prostate cancer. *Psychosomatics*, 41, pp. 85-94. April
- Kvikstad, A., Vatten, L. J. & Tretli, S. 1995. Widowhood and divorce in relation to overall survival among middle-aged Norwegian women with cancer. *British Journal of Cancer*, 71, pp. 1343B1347.

- Lai H., Lai, S., Krongrad, A., Trapido, E., Page, J.B., McCoy, C.B. 1999. The effect of marital status on survival in late-stage cancer patients: An analysis based on surveillance, epidemiology, and end results (SEER) data, in the United States. *International Journal of Behavioral Medicine*, 6(2), 150-176.
- Lee-Jones, C., Humphries, G., Dixon, R., Hatcher, M. 1997. Fear of cancer recurrence: A literature review and proposed cognitive formulation to explain exacerbation of recurrence fears. *Psycho-Oncology*, volume 6, pp. 95-105
- Levine, S. B., Risen, C. B. & Althof, S. E. 2003. *The Handbook of Clinical Sexuality for Mental Health Professionals*. New York: Brunner-Routledge.
- Lintz, K., Moynihan C., Steginga S., Norman, A., Eeles. R., Huddart, R., Dearnaley, D., Watson, M. 2003. Prostate cancer patients' support and psychological care needs: survey from a non-surgical oncology clinic. *Psycho-oncology*, 12(8), 769-783.
- Litton, G., Kane, D., Clay, G., Kruger, P., Belnap, T., Parkinson, B. 2010. Multidisciplinary Cancer Care With a Patient and Physician Satisfaction Focus. *American Society of Clinical Oncology Journal of Oncology Practice*. Vol. 6, Issue 6 2010.
- Litwin, M.S. 1999, UCLA PROSTATE CANCER INDEX Short Form (UCLA_PCI_SF), including the RAND 12-item Health Survey v2 (SF-12 v2), UCLA, California.
- Llorente, M.D., Burke, M., Gregory, G.R., Bosworth, H.B., Grambow, S.C., Golden, A., Olsen, E.J., 2005. Prostate cancer: A significant risk factor for late-life suicide. *American Journal of Geriatric Psychiatry* 13:195-201, (March).
- Maliski, S. L., Rivera, S., Connor, S., Griselda, L., & Litwin, M.S. 2008. Renegotiating Masculine Identity After Prostate Cancer Treatment, *Quality Health Research*, October 2008.
- Massie, M. J. & Holland, J. C. 1990. Depression and the cancer patient. *Journal of Clinical Psychiatry*, 51, pp. 12-17.
- Meyer, T. & Mark, M. 1995. Effects of psychosocial interventions with adult cancer patients: A meta-analysis of randomized experiments. *Health Psychology*, 14, pp. 101-108.
- Moore, K.N., Estey, A., 1999. The early post-operative concerns of men after radical prostatectomy. *Journal of Advanced Nursing*, 29 (5), pp. 1121-1129.
- National Prostate Cancer Coalition (NPCC). <http://www.centerwatch.com/ctrc/NPCC/>
- Nelles, J. L., Joseph, S. A. & Konety, B. R. 2009, May. The impact of marriage on bladder cancer mortality. *Official Journal of the Society of Urologic Oncology*, 27(3), pp. 263-267.
- Northouse, L. L. 1989. A longitudinal study of the adjustment of patients and husbands to breast cancer. *Oncology Nursing Forum*, 16(4), pp. 511-516.

Oliffe J.L. & Thorne S.E. 2007. Men, masculinities, and prostate cancer: Australian and Canadian patient perspectives of communication with male physicians. *Qualitative Health Research*, 17, 149-161.

Oliffe, J.L., Thorne, S.E., Hislop, T.G., Oglov, V., Armstrong, E.A. and McKay, W. 2006. Holes in the Cultural Canopy of Cancer Communication. Oral presentation of paper at the Annual Meeting of the Society for Applied Anthropology- World on the Edge, Vancouver, BC, March 31/06.

Onel, E., Hammond, C., Wasson, J.H., Berlin, B.B., Ely, M.G., Laudone, V.P., Tarantino, A.E., & Albertsen, P.C. 1998. An Assessment of the Feasibility and Impact of Shared Decision Making in Prostate Cancer. *Urology*. 51(1), pp. 63B66.

Ortmeyer, C.F. 1974. Variations in mortality, morbidity and health care by marital status. C.E. Erhardt and J.E. Berlin (eds.). *Mortality and Morbidity in the United States*. Cambridge, MA: Harvard University Press, pp. 159B188.

Ozer, Z., Firat, M. Z. & Bektas, H. A. 2009. Confirmatory and exploratory factor analysis of the caregiver quality of life index-cancer with Turkish samples. *Quality of Life Research*, 18(7), pp. 913-921.

Parker, S.L., Tong, T., Bolden, S., Wingo, P.A. 1997. Cancer Statistics, 1997. *Cancer Journal for Clinicians*, 47: 5-27.

Phill, I.M. 2010. *Sex Therapy: A Cognitive Behavioral Approach*. Psychiatric Nursing 2010.

Ptacek, J.T., Ptacek, J.J., & Dodge, K. L. 1994. Coping with breast cancer from the perspective of husbands and wives. *Journal of Psychosocial Oncology*, 12, pp. 47-72.

Rainess-Kules, A., Axelrod, A. June 2006. Utilizing effective group models for prostate cancer patients and their families. *Cancer*, Vol. 75 Issue S7, pgs 1892-1896

Rickwood, D.J., & Braithwaite, V.A. 1994. Social-psychological factors affecting help-seeking for emotional problems. *Social Science and Medicine*, 39(4), 563-572.

Rodriguez, D. 2009. Complementary and Alternative Treatments for Prostate Cancer Learn the basics about alternative cancer treatment for prostate cancer. <http://www.everydayhealth.com/prostate-cancer/alternative-treatment.aspx>

Rothman, K. & Greenland, S. 1998. *Modern epidemiology*. 2nd edition. Philadelphia: LippincottBRaven.

Rumans, T.A., Bostwick, J.M., Clark, M.M., 2000. Maintaining quality of life at the end of life. *Mayo Clinic Proceedings*, 75, pp. 1305-1310.

Sakr, W.A., Grignon, D.J., Crissman, J.D., Heilbrun, I.K., Cassin, B.J., Pontes, J.J., Hass, G.P. 1994: High grade prostatic intraepithelial neoplasia (HGPIN) and prostatic adenocarcinoma between the ages of 20-69; an autopsy study of 249 cases. *In vivo* 8; 439.

Sanson-Fisher, R., Girgism, A., Boyes, A., Bonevski, B., Burton, L., Cook, P. 2000. The unmet supportive care needs of patients with cancer. Supportive Care Review Group. *Cancer*, 88, pp. 226-237.

Scheier, M.F., Helgeson, V.S., Schulz, R., Colvin, S., Berga, S., Knapp, J. & Gerszten, K. 2007. Moderators of interventions designed to enhance physical and psychological functioning among younger women with early stage breast cancer. *Journal of Clinical Oncology*, 26, 5710-5714.

Sharpley, C.F., Bitsika, V. & Christie, D.H.R. 2008. Psychological distress among prostate cancer patients: Fact or fiction? *Clinical Medicine: Oncology*, 2, pp. 563-572.

Shrader-Bogen, C. L. Kjellberg, J.L., McPherson, C.P., Murray, C.L. 1997. Quality of life and treatment outcomes: prostate carcinoma patients' perspectives after prostatectomy or radiation therapy. *Cancer*, 79, pp. 1977-1986.

Stansbury, J.P., Mathewson-Chapman, M., & Grant, K.E. 2003. Gender Schema and Prostate cancer: Veterans' Cultural Model of Masculinity. *Medical Anthropology*, 22, 175-204.

Talcott, J.A. 2007. Prostate Cancer Quality of Life: Beyond Initial Treatment and the Patient. *Journal of Clinical Oncology*, 25(27), 4155-4156.

Torre, J., Torre, A. 2001. Despite Serious Physical and Emotional Strain, Prostate Cancer Brings Couples Together, Survey Finds. *Business Wire Health Wire* Thousand Oaks, California.

Torres, J., Solberg, V., & Carlstrom, A. (2002) The myth of sameness among Latino men and their machismo. *American Journal of Orthopsychiatry*, 72(2), 163-181.

Turner, L.W., Sizer, F.S., Whitney, E.N., & Wilks. B.B. 1992. *Life Choices; Health Concepts and Strategies*; Second Ed. West Pub., Saint Paul, Minnesota.

Turner, J., Zapart, S., Pedersen, K., Rankin, N., Luxford, K., Fletcher, J. 2005. Clinical Practice Guidelines for the Psychosocial Care of Adults with Cancer. *Psycho-Oncology*, Volume 14, Issue 3, pages 159-173.

UCSF Medical Center 2009. Prostate Cancer & Its Treatment. *Prostate Cancer Advocates* October.

Visser, A., van Andel, G., Willems, P., Voogt, E., Dijkstra, A., Rovers, P., Goodkin, K. & Kurth, K.H. 2003. Changes in health-related quality of life of men with prostate cancer 3 months after diagnosis; the role of psychosocial factors and comparison with benign prostate hyperplasia patients. *Patient Education and Counseling*. 49:225B232

- Wallston, K.A., Stein, M.J., & Smith, K.A. 1994. Form C of the MHLC Scales: A condition-specific measure of locus of control. *Journal of Personality Assessment*, 63, 534-553.
- Wallston, K. A., Wallston, B. S. & DeVellis, R. 1978. Development of the multidimensional health locus of control (MHLC) scales. *Health Education Monographs*, 6, 160-170.
- Ware, J.E., Kosinski M. 2001. *SF-36 Physical and Mental Health Summary Scales: A Manual for Users of Version 1, Second Edition*. Lincoln, RI: Quality Metric, Incorporated,
- Wilding, G. & Remington, P. 2005. Period analysis of prostate cancer survival. *Journal of Clinical Oncology*, 23(3), pp. 407-409.
- Woods, S., Engel, A. & Rankin, W. 2010. Ethnicity and prostate cancer stage. *International Journal of Medicine and Medical Sciences*, 2(5), pp. 138-142.
- Zakowski, S.G., Harris, C., Krueger, N., Laubmeier, K.K., Garrett, S., Flanigan, R., Johnson, P. 2003. Social barriers to emotional expression and their relations to distress in male and female cancer patients. *British Journal of Health Psychology*, 8(3), 271-286.