Prostate Cancer: Sexual Implications and Navigating Counselling Within a Partnership

by

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A thesis submitted in partial fulfillment of the requirements

For the degree of

Master of Counselling (MC)

City University of Seattle

Vancouver BC, Canada site

March 30, 2016

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Abstract

This literature review will explore the effects of a diagnosis and treatment of prostate cancer resulting in impotency or sexual dysfunction on males and females individually or in partnership and consider different coping strategies that may be beneficial for the couple. The effects of prostate cancer are widespread. Having a diagnosis of cancer for anyone is daunting. Prostate cancer and treatment for it carry a high risk for impotency. In many forms of cancer it would be automatic that one would commence treatment as soon as possible. Due to the high incidence of impotency or sexual dysfunction, this factor plays an important role in the decision making process as to whether to treat the cancer or wait until it must be treated due to accelerated growth of the cancerous tumour. Waiting for the tumour to grow before treatment carries the risk of waiting too long and the cancer may then be terminal. Once a diagnosis is confirmed the couple may be at a loss as to how to proceed. This literature review will explore coping skills that may be beneficial to the client and his partner to more easily move through the process of diagnosis and after treatment if this has resulted in impotency. It is my hope that this thesis will be used as a tool to help couples develop skills they may not have to ease the transition and go on to have a satisfying life.

Acknowledgements

I would like to thank City University of Seattle for the use of their library data base. I would also like to thank Dr. Larry Goldenberg and Dr. RJ Wassersurg from the Vancouver Prostate Centre for their insight on ideas and information provided through verbal communication. A special thanks goes to The Vancouver Prostate Centre who enthusiasm and knowledge has allowed me to continue my research. A special thanks to Christine Dennstedt and Jacqueline Walters who's valued input has allowed me to complete this thesis.

Table of Contents

CHAPTER 1- INTRODUCTION

"Prostate Cancer is the most common non-cutaneous cancer in men" (Quon, Loblaw, & Nam, 2011, p. 1). Prostate cancer is steadily increasing and with the baby boomers population it is predicted that the incidence of prostate cancer may triple by 2021 (Quon et al., 2011). It has been estimated that greater than 80% of men who undergo treatment for prostate cancer will be rendered impotent (Siegel, Moul, Spevak, Alvord, & Costabile, 2001). Approaches to treatment have changed over the years and due to advances in approach and early detection, this percentage has increased slightly with the introduction of nerve sparing surgery. This is primarily due to new methods and skill of the surgeon. This chapter will outline the purpose, relevance, scholarly content, key terms, and structure of this thesis.

Purpose

This thesis will address the emotional needs of both the patient and the spouse or partner. There is quite an emotional difference at the prospect of losing the ability to have intercourse when given a diagnosis of prostate cancer in one's 50s in comparison to a diagnosis in your late 60s or 70s not only for the patient but for his spouse as well. This literature review considers the effects of prostate cancer treatment and how to assist with maintaining and enhancing the bond between couples as they face changes in their life. This review will discuss individual concerns as well as inter-relational components and review literature on favourable ways in which the couple can manage these concerns in unity. This thesis will address the coping skills both parties may need through the decision making process, pre-treatment, and post treatment.

Relevance

It is rare for a diagnosis prior to 50 but it does happen and the most common diagnosis is made in the mid to late sixties. According to Mandal et al. (2008) "The three major risk factors in

prostate cancer include age, race and family history. Incidence of this cancer increases around 15 times in men 65 years or older as compared to younger men" (Mandal et al., 2008, p. 274). Sexual function is variable among individuals and can change as one ages.

Although the incidence of prostate cancer is higher amongst men who are in their senior years, prostate cancer testing starts in men at around the age of 50 (or earlier if there has been a diagnosis of prostate cancer in their father or brother). Many men who are diagnosed with prostate cancer are married, co-habitating or in a relationship. According to the Canadian Cancer Society, 66 men were diagnosed daily in 2015 (Reference). It is estimated that prostate cancer is the third leading cause of death in men (ref.). Due to treatment options, which include but are not limited to, radical prostatectomy, radiation, or hormone treatment, sexual function is greatly impacted in addition to the possibility of incontinence and other symptoms due to treatment alone. The limited options for treatment may interfere with the decision as to when to treat the cancer. On the surface, one might say, treat it immediately. This view is not necessarily an educated one. According to Siegel, Moul, Spevak, Alvord, and Costabile (2001), the incidence of erectile dysfunction after radical prostatectomy and external beam radiation is greater than 80%. In 2007 The Prostate Cancer Outcomes Study reported that urinary leakage was more common with radical prostatectomy (35%) than with radiation therapy (12%) or androgen deprivation (11%) (Wilt et al., 2008). Bowel urgency occurred more often with radiation (3%) or androgen deprivation (3%) than with radical prostatectomy (1%) (Wilt et al., 2008). Erectile dysfunction occurred frequently after all treatments (radical prostatectomy, 58%; radiation therapy, 43%; androgen deprivation, 86%)" (Wilt et al., 2008).

Prostate cancer poses many issues that can promote controversy within the couple relationship emotionally and in regards to sexual function. The stress of a diagnosis of cancer

and not knowing which treatment to opt for are stressors when dealing with a diagnosis of any cancer. Prostate cancer is different in that the side effects of treatment can be damaging to the quality of life for both patient and partner due to the link between treatment and incidence of erectile dysfunction. The prospect of being rendered impotent can be very daunting for the couple. There are many treatment options for prostate cancer, including expectant management (watchful waiting) or active surveillance, surgery, radiation therapy, Cryosurgery (cryotherapy), and hormone therapy.

Counselling: Improving communication and connection

There are many considerations when looking at counselling for couples who are going through difficult times due to this type of diagnosis. The initial consideration is the possibility of feeling a great loss and grieving the potential loss of the inability to have sexual intercourse naturally. The thought of losing the ability for erectile function plays a role in the decision making for the physician and the couple. This thesis will consider the various aspects of male, female and couple perspectives on how erectile function or dysfunction relate to sexuality, as well as male relational self-esteem. Three theories in counselling that will be covered are: emotion focused therapy, Cognitive Therapy and Gottman's approach to couples therapy. There are many cultural differences in regards to self- esteem around sexuality, impotence and sexual dysfunction. This review will be based on a traditional North American perspective in the heterosexual community (Thompson Jr & Barnes, 2013). In doing so it is necessary to consider and understand the male perspective in regard to their active beliefs around what sexuality means to them (Clarke, Marks, & Lykins, 2015). The traditional ideology is that of equating sexual health with erectile function (Thompson & Barnes, 2013). There are many aspects to sexuality, for example…. If the patient holds a traditional understanding of what male sexuality is, one

should be aware that it is possible to eventually respond to prostate cancer diagnosis and treatment with depressive symptoms. The influence of the prospect of impotency and/or sexual dysfuntion can be so great that a couple, or a man, may wait on prostate cancer treatment until it is too late and the cancer has metastasized. A couple may find themselves in a tailspin of miscommunication and regret.

It has been well documented (Badr & Carmack Taylor, 2009; Nelson & Kenowitz, 2013) that communication and honesty may be the key to coping with marriage after a diagnosis of cancer. It is important that both individuals within the couple are supported within the relationship. Prostate cancer differs from other forms of cancer in that it directly affects the spouse. That is not to say that other cancers don't have effects on the spouse but prostate cancer is unique in that sexual function may be eliminated or greatly impaired through treatment. Good communication between the couple is imperative (Badr & Carmack Taylor, 2009). The spouse in particular needs to have support through honest communication from her partner to her and from her to her partner (Badr & Carmack Taylor, 2009).

Prostate cancer not only directly affects the patient but diagnosis and treatment also hold direct effects for their significant other. Cognitive therapy may be useful to create awareness of negativity and anxiety around the diagnosis for the couple. Through awareness and cognitions around concerns the couple can write the concerns down and bring them to counselling. Through this approach, the couple will have the ability to be proactive and any misconceptions may be averted early on in the sessions. The degree to which there is sexual dysfunction directly correlates with the degree in which communication is averted (Badr & Carmack Taylor, 2009). It is necessary to keep the husband engaged and forth-coming with honest reflections on his emotions. In a study by Madhyastha, Hamaker, and Gottman (2011) it was observed that one

spouse feeds negativity off the other. Once this pattern starts, it can be difficult to break. This negative relational interaction is detrimental to the couples' relationship. In these circumstances it will be necessary to establish who their positive support system is in relation to the couple as a whole. It is paramount to the marriage or partnership that awareness around negativity is actualised. The couple may be accustomed to being negative towards each other in the relationship and may not even realise they are engaging in negative acts or dialogue.

There is need for positive communication and to be mutually supportive towards each other throughout this trying time. Cognitive behaviour therapy, which will be discussed in chapter 4, has been shown to improve cognitive distortions around sexual function and its relation to masculinity (Siddons et al., 2013). Negative perception of erectile dysfunction greatly affects the interpersonal relationship and adds pressure to the significant other. These negative perceptions may include: " (1) Urinary Control; (2) Sexual Intimacy; (3) Sexual Confidence; (4) Marital Affection; (5) Masculine Self-Esteem; (6) Health Worry; (7) PSA Concern; (8) Cancer Control; (9) Informed Decision; (10) Regret; and (11) Positive Outlook" (Siddons et al., 2013, p. 2187). Concerns may be shared between intimate partners.

Couples face many issues on an ongoing basis in everyday life. Their communication style may have a direct impact on how satisfying their life is as they move forward. When being given a diagnosis of prostate cancer, couples face even greater issues that directly affect both partners. It has been found that distressed couples tend to look at the more negative aspects of their significant other than positive traits (Gottman, Swanson, & Swanson, 2002).

A tool that may be beneficial would be to get to the root of where vulnerability lies when living with and treating prostate cancer. Useful tools through emotion–based therapy may be helpful for the couple to learn. Emotion-focused therapy may be useful in determining where

vulnerability lies that couples face (McKinnon & Greenburg, 2013). The idea is that "demand, criticism and blame tend to elicit defensiveness and self-protection in the other partner, vulnerable emotional expression tends to evoke compassion and support" (McKinnon & Greenburg, 2013, p. 304). Tools that elucidate on emotional vulnerabilities may help create an open dialogue about fears around the diagnosis of prostate cancer. Also covered in this literary review will be literature on behaviour couple therapy and tools that can be used within that model.

Impacts on Male

According to Collins et al. (2013), "It is well recognised that prostate cancer treatments can adversely affect intimate aspects of a patient's relationship with their partner" (p. 3). "Intimacy and sexuality can be disrupted through persistent physical changes including impotence, loss of libido, urinary incontinence and bowel disturbance, which may, in turn, impact on perceptions of masculinity, changed work and social life and relationship difficulties" (Collins et al., 2013, p. 465). In this pilot study, cognitive existential therapy was correlated with a reduction in psychological distress in both partners but also found that there was more of a reduction in the partner opposed to the patient (Collins et al., 2013).

Psychological distress in regards to sexual function can hold a great challenge for the patient. According to Thompson and Barnes (2013), the association between masculinity and erectile potency is powerful. In addition, they found that men devalue behaviours that may be identified as more feminine such as vulnerability and fear (Thompson & Barnes, 2013). This may have bearing on the interactive styles and communication abilities that are necessary for honest, open dialogue between intimate partners and spouses. Thompson and Barnes point out that it is important to not look at male sexuality as solely represented by erectile function but this

may be difficult for some males as the traditional point of view is correlating erectile function with masculinity (Thompson & Barnes, 2013). In a pilot study by Collins et al. (2013), it was shown that there were positive results in regards to relational communication and understanding between patients and their partners or spouses.

> The physical side effects of prostate cancer treatment, including incontinence and erectile dysfunction (ED), are likely associated with anxiety and depression. The impact on mental health may be long term, and suicide in older men with prostate cancer has been reported. (Siddons, Wootten, & Costello, 2013, p. 2186)

A study by Nelson, Mulhall, and Roth showed that depression may be correlated with erectile dysfunction in men with prostate cancer three years post treatment. Other areas that were tested were, quality-of-life, anxiety /depression, and erectile dysfunction. Researchers wanted to see if erectile dysfunction was associated with depression regardless of quality of life and marriage. Erectile dysfunction was the largest predictor for depression (Nelson et al., 2011). The data in this study is suggestive that erectile dysfunction in men with prostate cancer can have long lasting psychological effects in excess of four years post treatment. Although prostate cancer is the most prevalent cancer in North America, there is little research on depression and its relation to prostate cancer and erectile dysfunction (Nelson et al., 2011). Thompson et al. found that men who were born in the 1950s and 1960s were more apt to endorse the traditional ideology of masculinity being associated with erectile function (Thompson & Barnes, 2013). In some cases, the fear of abandonment may take precedence over treatment for prostate cancer. This fear may be pivotal in the decision making process as to whether to treat prostate cancer immediately or wait. The dangers of waiting are that malignancy could grow and metastasize. Should this happen, prognosis will have changed and mortality rate will increase. There are many types of

loss associated with treatment of prostate cancer. Some being loss of desire, loss of seminal fluid, loss of spontaneity, and loss of adequate rigidity needed for intercourse (Wittmann, Foley, & Balon, 2011).

Impacts on Partner

There does not appear to be a wealth of information or studies on the effects of prostate cancer treatment for the patient's spouse or partner. It appears that men who are having difficulty with erectile dysfunction may not be willing to openly discuss the issue of impotency (Badr & Carmack Taylor, 2009) or they blame their spouse or partner for a lack of interest in sex (Wittmann et al., 2011). If men experience great disappointment in their sexual relationship with their partner, they may stop trying altogether (Wittmann et al., 2011). According to Wittmann et al. (2011), disruptions in spontaneity can be equally disruptive for the female spouse or partner. There are not many studies researching the use of aids to increase sexual intimacy but it has been suggested that a need to be open minded and have a sense of humour in trying aids alleviates distress around impotence (Wittmann et al., 2011). In addition, the wife or partner may try and protect her spouse by not bringing up this painful subject of impotence and it has been found that should this happen the result has been a poorer outcome for the couple and they may find they are drifting apart (Wittmann et al., 2011). Unfortunately not many empirical studies have not been done on couple communication and sexual problems as it relates to prostate cancer. Partners need to be included in the process of grief and problem solving. Men who are open to this process may achieve a better outcome in both sexuality and creating a closer proactive relationship with their partner (Wittmann et al., 2011). According to Badr (date), sexual dysfunction was not only found in prostate cancer patients but in their spouses as well. In a study of 90 couples, the man's erectile dysfunction negatively impacted the female's level of desire,

arousal, orgasm, and satisfaction with a reduction in sexual activity (Badr & Carmack Taylor, 2009).

It has been found that female partners may be less concerned about sexual functioning than how their partner's decreased function will affect the emotional intimacy of their relationship (Badr & Carmack Taylor, 2009). Often patients and their spouses avoid conversations about arousal and sexual intimacy after prostate cancer diagnosis and treatment causing distancing. Even though it may add more distress not talking about 'it' (Badr et al., 2009), it has been documented that "Partners have reported poorer lubrication, poorer orgasm function, and more sexual pain"(Badr et al., 2009, p. 738).

It has been documented that the involvement of a spouse or partner has a significant effect on the patient who has been diagnosed with cancer. The level of stress that is passed back and forth between the couple has a significant impact on their quality of life (Kim et al., 2008). Kim et al. looked at varying degrees of stress and noted as to whether it was dissimilar stress or similar stress. Dissimilar would be if one individual in the couple were stressed and the other not. Similar would be when the couple shared stress and perhaps feed off of the stress. It was found that the couple fare better if one of the two have dissimilar stress and the partner may feel their stress ease and in turn this will provide a better quality of life (Kim et al., 2008).

It is fair to state that the implications to the significant other are as distressing to the patient as it is to the partner. If the couple has experienced vibrant sexual intimacy within their relationship, it may be unimaginable as to what to expect or what will replace that form of sexual intimacy. While other cancers indirectly affect the spouse, prostate cancer directly impacts the sexual function and has a direct impact on the spouse (Manne et al., 2015). What the future holds for the couple is an unknown and that aspect in and of itself may garner fear. Depressive

symptoms may appear in the significant other if there is a communication breakdown (Badr et al., 2009). It has been reported that the husband may distance himself should the sexual dysfunction prevail (Badr et al., 2009). This distancing will create a communication gap and further exacerbate the distress for their significant other. Kim et al. (2008), "hypothesized that spousal caregivers being more distressed than the cancer survivors they care for would have a greater adverse effect not only on their own quality of life, but also the survivors" (p. 231). In a study on the effects of prostate cancer on partners' it was concluded that "from partners' perspectives, prostate cancer therapy has negative impact on sexual relationships and appears to worsen over time" (Ramsey et al., 2013, p. 3135).

The emotional effects of a diagnosis of prostate cancer have been well documented for the patient but there is very little on the implications for the significant other. There is symbiotic effect on both partners that will feed off each other. Studies have shown that marital satisfaction may decrease for the significant other after diagnosis of prostate cancer (Manne et al., 2015). Shame may be a little known aspect to look at for the partner of a cancer patient. Shame that may come with being selfish with the thought of the life changes that may have to occur when your partner faces the tragedy of death. Grief and loss must be addressed for the partner as well as the patient.

Key Terms and Phrases

> According to the World health Organization, the definition for sexual health is
> a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion,

> discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. ("WHO," 2006)

Structure of the Thesis

Chapter 2 will look at the various aspects of male perspectives on how erectile function or dysfunction relate to sexuality, and male relational self-esteem. There are many aspects to sexuality. If the patient holds a traditional sense of what the male sexuality is, he may respond to prostate cancer diagnosis and treatment with depressive symptoms—as described earlier in this chapter erectile dysfunction is the largest predictor for depression and may have long lasting psychological effects (Nelson, Mulhall, & Roth, 2011). Chapter 3 will cover the challenges that may face the partner in coping with treatment of prostate cancer.

Chapter 4 will investigate research around cognitive therapy and relationship counselling. It will review Gottman's couple's theory approach as it relates to the interpersonal relationship between couples facing prostate cancer. Both the eight predictors and the "sound relationship house" (Gottman & Gottman, 2013, p. 97) will be reviewed and integrated as a theoretical approach to identify and reduce conflict and improve couple communication.

Chapter 5 will consist of a summary of the previous chapters and limitations of this study. One of the limitations in this literary review is the demographic—North American couples. There is little consideration as to differentiation within marginalised and ethnic groups. There is no inclusion of religious considerations and how different religious beliefs may view treatment and the impact this may have on the individuals or couple. This study is also not inclusive of the GLBTQ community as this community has not been widely studied in regards to the effects of prostate cancer on GLBTQ relationships.

CHAPTER 2 - MEN

Prostate cancer is a disease that effects not only the individual who has this cancer but the effects of treatment forever change their relationship with their partner. Psychological distress in regards to sexual function can be a great challenge for the patient. One study described interviewing 10 men who were diagnosed with prostate cancer. In this study the main theme that was looked at was altered sexual function and five minor themes were also evaluated; "choice of consequences; age affecting sexual life; hope of improvement; acceptance of altered sexual life; and image of manliness" (Bertero, 2001, p. 245). An interesting point came out in this study—men often felt like they were choosing between death and sexual function (Bertero, 2001).

Studies are limited in regards to this point of having to choose between life with no or limited sexual function and death. As society evolves and times change, the views on sexuality may change in the future. According to Thompson and Barnes (ref year) found the association between masculinity and erectile potency a traditional one. Fear has been a factor in whether men undergo prostate cancer assessment and testing. The degree of fear correlates with men not either going for initial assessment or not adhering to further testing protocol once prostate cancer has been identified (Christman, Abernethy, Gorsuch, & Brown, 2014).

In men with prostate cancer there may be a greater possibility for stigmatization due to erectile dysfunction after treatment (Gray, Fitch, Phillips, Lebrecque, & Fergus, 2000). In the Latino community, the results of being fearful is so great in the screening process, (having a finger inserted into their anus is not manly) that this community has a greater incidence of late-stage prostate cancer because the men don't get tested in the early stages (Rivera-Ramos & Buki, 2011).

> The biggest fear of most men. It carries with it not only the fear of dying, like all cancer, but fears that go to the very core of masculinity –for the treatment of prostate cancer, whatever form it takes, almost invariably carries with it well-known risks of incontinence and impotence that strike directly at any man's self-image, pride, and enjoyment of life, and which, by their very nature, tend to make men reticent on the subject. (Arrington, 2008, p. 300)

As a therapist it may be necessary to consider and understand the patient's views in regard to his beliefs around what sexuality means to him (Clarke, Marks, & Lykins, 2015). There are many aspects to sexuality. If the patient holds a traditional sense of what the male sexuality is which may be that the idea of manliness stems from sexuality (Clarke et al., 2015), therapists may want to be aware that it is possible that the response to a prostate cancer diagnosis and treatment can be depressive symptoms for many men. In a study by Nelson et al. (2011) it was shown that depression is correlated with erectile dysfunction in men with prostate cancer three years post treatment. Other areas that were tested were quality of life, anxiety /depression, and erectile dysfunction. Researchers wanted to see if erectile dysfunction was associated with depression regardless of quality of life and marriage. Erectile dysfunction was the largest predictor for depression (Nelson et al., 2011). Depression in men post treatment has been documented (Nelson et al., 2011). In a study by Nelson et al., the hypothesis was that depression was independently associated with erectile dysfunction in men post treatment for prostate cancer. The results of this study indicated that there is a correlation between lower scores on erectile function and higher prevalence and more severe depressive symptoms (Nelson et al., 2011). Although changes in life generally may produce sadness and uncertainty as to what the future holds, depressive symptoms must be further evaluated in depth to those suffering from the adverse effects of prostate cancer

treatment. It has been found that one of the better tests for depression in this group is the IBI-D (individual burden of illness) index as this index provides more information than symptom severity (Sharpley, Bitsika, & Christie, 2014). In order to treat depression in this group, it may be advantageous for the clinician to identify the subtype of depression. Sharpley et al. (2013) identified five subtypes of depression in a group of men who had undergone treatment for prostate cancer. The subtypes included were "Melancholic, Depressed Mood, Anhedonic, Somatic, and Cognitive depression" (Sharpley et al., 2013, p. 817). It is important to identify which classification of subtype depression in treatment for depression for an individual's post prostate cancer treatment due to variations in symptoms in terms of type of which treatment would be most beneficial. By addressing the symptoms of each subtype, it was found that the individual would benefit from a more in depth comprehensive treatment program that addresses the variation of symptoms within treatment induced difficulties in prostate cancer patients post treatment.

Although prostate cancer is the most prevalent cancer in North America, there is little research on depression and its relation to prostate cancer and erectile dysfunction (Nelson et al., 2011). Thompson and Barnes (2013) found that men who were born in the 1950s and 1960s were more likely to endorse the traditional ideology of masculinity being associated with erectile function (Thompson & Barnes, 2013). Should erectile function be compromised due to prostate cancer treatment, it may be necessary to change the traditional belief system of the male in order to set him and his spouse or partner on a path towards having a good quality of life. A study has shown that cognitive group therapy amongst men post treatment for prostate cancer has been effective for improving quality of life (Siddons et al., 2013). The study consisted of a questionnaire pre and post group therapy. The results showed that there was a positive result in

mood, sexual intimacy, and masculine self-esteem post intervention. Cognitive group therapy intervention showed promising results (Siddons et al., 2013). Through therapeutic intervention it may be possible to clarify mortality and relational fears that the patient perceives. In doing so, the patient may be able to identify misconceptions and reconstruct these distorted perceptions in regards to these fears.

In most cases, men present with more than one negative symptom and distress around that symptom, post radical prostatectomy or radiation therapy, which are the two most common treatments for prostate cancer (Hsiao, Moore, Insel, & Merkle, 2014). In an extensive study it was found in that disease specific symptoms associated with urinary, bowel, and sexual function correlated with high levels of symptom distress "indicating that greater frequency and severity of symptoms were associated with higher symptom distress" (Hsiao et al., 2014, p. 443). This comprehensive study explored symptoms directly associated with the result of either radiation treatment or a radical prostatectomy for prostate cancer. The purpose of this study was to "explore the association between symptoms, symptom distress and strategies for symptom Self-management" (Hsiao et al., 2014, p. 444). The results indicated that certain coping mechanisms were particularly useful treating different symptoms. Teaching patients to use these strategies would decrease distress around their symptoms. In the case of urinary leakage, it was found that Kegel exercises and a protective pad alleviated symptoms and distress. In the case of bowel symptoms, drinking more water and taking fewer long trips were found to be helpful. In the management of sexual dysfunction, it was found that expressing feelings to their spouse and finding other ways to be intimate was helpful (Hsiao et al., 2014). Giving patients the tools and education to prepare them for what may happen and how to address it seems to be the best and logical approach.

Fear around whether to disclose or not has not been widely studied but according to a study, negative stigma may move men to minimise the symptoms and minimise the need for support (Gray et al., 2000). Stigma plays an active role in how others view prostate cancer patients and may treat them differently than pre-diagnosis. Many are unaware of the ramifications of treatment for prostate cancer, such as impotence and disturbed bowel and urinary function, and willingness of disclosure may be limited. The ideology around masculinity and its relationship between sexual dysfunction adds to the fear of how friends and family may view men post treatment (Gray et al., 2000).

In looking at the literature around the difficulties involved with prostate cancer treatment, the fears are not unfounded. The fear that surrounds how others will view the patients post treatment is also very real.

Traditional male viewpoints are such that an orgasm is a good indicator for sexual satisfaction (Salisbury & Fisher, 2014). Should men perceive this to be true, then lack of orgasm would correlate with sexual dissatisfaction and may be associated with depression after treatment. Educating men around variations of orgasm and explaining that they may have the ability to experience a dry orgasm may assist in changing their perceptions around orgasm and may minimise grief and loss that may be associated with lack of potency and orgasm. Even fairly successful treatments for sexual dysfunction will not render the patient to be the same sexually as he was prior to treatment (Wittmann et al., 2011). According to Collins et al:

> It is well recognised that prostate cancer treatments can adversely affect intimate aspects of a patient's relationship with their partner. Intimacy and sexuality can be disrupted through persistent physical changes including impotence, loss of libido, urinary incontinence and bowel disturbance, which may, in turn, impact on perceptions of

> masculinity, changed work and social life and relationship difficulties. (Collins et al., 2013, p. 465).

Men may mourn the loss of life as it once was. It may be that the consequences of prostate cancer treatment will render them to staying at home more often and not socialising as much due to incontinence. In essence, not living life as they were accustomed to living and having to adapt to changes that they never wanted to face.

Although the survival rate is high if prostate cancer is identified and treated in the early stages, the adverse post treatment difficulties can create many difficulties for the survivor. It has been documented that early psycho-social intervention is beneficial. Unfortunately there doesn't appear to be many models that approach the grief and loss aspect in these interventions. Wittmann et al., (2011) developed a framework to address grief and loss as a 'gateway' to address sexuality when encountering erectile dysfunction post hoc. This study points out the variations in sexuality and doesn't simplify the word 'sexuality' as to whether an erection can be achieved or not. This study covers many aspects of sexuality that can be affected. Some of the aspects include inability to respond to visual stimuli, disappearance of sexual fantasy, and lowered sex drive. These resulting factors may be either conscious or subconscious reactions to the symptoms that go hand in hand with prostate cancer treatment (Wittmann et al., 2011). Wittmann et al. (2011) go on to say that most men attain arousal but they physically cannot attain an erection that is firm enough for penetration. Although there is treatment for erectile dysfunction, many men do not adhere to treatment and tend to suffer in silence as not to appear unmanly (Wittmann et al., 2011).

Given the definition of sexual health as identified by WHO, it may be difficult to achieve sexual health as the altered sexual health pattern changes after prostate cancer treatment. Altered

sexual patterns due to treatment post treatment were viewed negatively by the male when looking at manliness within the realm of the effects on personality (Bertero, 2001).

The idea that manliness may be of consideration for the male when opting for prostate cancer treatment may be a clue that there is a need to change inherent perspectives as to what a man is and what manliness means. If manliness is strongly linked to sexual function, the male may have difficulty adjusting to his new life. It is important to identify the role sex or intercourse plays and how much of his persona is intertwined with his ability to not just attain an erection but also have intercourse and have an orgasm. It has been documented that penis function is always altered post hoc and intercourse will never be the same (Bertero, 2001).

> In the absence of a story that transcends sexuality, prostate cancer survivors seem trapped between conflicting messages about the significance of sex and sexuality. Either sex comprises the bulk of their identities, as evidenced by the fact that preserving their sex life was a primary value in treatment decisions, or sex means little to them, as downplayed in post-treatment accounts when there were no effective means of restoring prior sexual potency. Hence, what we need are new ways and a new willingness to talk about sex and identity, ways that reveal the fallacy of thinking about sex and gender as dichotomies rather than conceiving each as a located along a broad-ranging continuum of meanings. (Arrington, 2008, p. 305)

Understanding the perspective the male appears to hold in regards to his ability to sustain an erection will help to find ways for that same male to manage the side effects of prostate cancer treatment. A clear understanding as to what life may or may not hold for the patient and his spouse through dialogue with his health professional and perhaps with others that have gone through, or are going through treatment may be necessary in order to have a clear understanding

of possible outcomes of treatment. Discussions with his partner and dialogue around coping mechanisms and identification of existing negative perceptions may alleviate negative beliefs and self-talk around prostate cancer treatment. There are few studies that take into account how men feel in regards to being a husband when their sex-life has been altered. But it was identified in one study that a man may feel somewhat less of a husband post treatment (Bertero, 2001). According to a study on avoidance and intrusive negative thought patterns experienced by a couple after the man has been diagnosed with prostate cancer; it has been documented that if the husband and wife have congruent styles of managing stress around diagnosis and treatment, there are positive outcomes for both party's (Fagundes, Berg, & Wiebe, 2012). To investigate this further, Fagundes et al. (2012) studied 59 couples to investigate the degree to which intrusive thoughts or avoidance of thoughts around prostate cancer was present. It was found that through avoidance of negative thoughts in one person in the couple, the other managed with more negative affect. The same holds true with negative intrusive thoughts (Fagundes et al., 2012).

Investigating what will better assist the man who has been diagnosed with prostate cancer has come to the forefront in recent literature. Little had been studied prior to 2008. Interestingly it has been found that the best coping mechanism is through that of his partner—open and honest dialogue around all feelings of fear, insecurity, depression, anger, to name a few. A prostate cancer diagnosis is detrimental to not only the male but has a direct effect on his partner (Badr & Carmack Taylor, 2009) opposed to an indirect effect that other cancers may have. Because of this direct effect, many men may tend to be uncommunicative and internalise their emotions out of fear (Hsiao et al., 2014).

The treatment options all are detrimental to the survivor's psychological well-being. The effects should not be underestimated. Research has been scant over the last 10 years with

acknowledgment of these deleterious effects coming to light in research over the last two or three years. It has now been acknowledged that education, an open mind, counselling, and spousal support will be beneficial to prepare the survivor for what lies ahead and to validate current changes and feelings that occur throughout treatment.

The next chapter will look at prostate cancer through the woman's perspective and needs around the diagnosis and treatment. How the life partner copes is significant and enables the survivor to have a better chance of a positive emotional outcome should his partner understand their role and how this diagnosis and treatment can have long lasting, forever effects on her and their relationship as a whole. Negativity, avoidance, or both can deeply affect the other partner whether it be male or female. It is important to realise that a couple can move in a positive direction if their knowledge base around prostate cancer is clear and if the possible outcome is clear.

CHAPTER 3 - PARTNERS

This chapter will cover challenges that may face the partner or spouse in coping with effects post treatment of their spouse. The lack of control over the effects of treatment is a concern to not just the male in the relationship but can be daunting for the partner as well. There are many concerns regardless as to which treatment option is chosen. When different treatment options are considered the symptoms and effects to the male post treatment are similar. Doctors' primary concern is to remove the cancer, retain bowel function, and retain sexual function. The effects of treatment will have a direct effect on the partner as a caregiver. The level to which the partner can provide care and the difficulties associated with care are largely dependent on the resources of the partner. The effects of treatment may mean that the survivor may need extra help in day to day living (McCoy, Stinson, Bermudez, & Gladney, 2013). Stress and exhaustion may play a role for caregivers as most males diagnosed and treated are over 60 years of age and the assumption is that most caregivers will be around the same age. It may be difficult for the caregiver as communication of needs may not be forthcoming.

Spouses may feel shame or embarrassment around their feelings about how they feel in regards to not having a fulfilling sex-life. In a large study that involved 1,236 men, it was found that 13% of men achieved an erection firm enough to have intercourse and 8% returned to normal function post treatment (Neese, Schover, Klein, Zippe, & Kupelian, 2003). It may be that in some relationships partners may have not had intercourse for years prior to treatment, should this be the case, these partners may welcome not having intercourse. The effects either way are significant for the spouse positively or negatively. It may be that the male partner will blame the wife for a lack of interest in sex (Wittmann et al., 2011). It may not be a lack of interest but a disappointment and shame over sexual dysfunction. Men also may experience great

disappointment in their efforts at love making, and they may stop trying altogether (Wittmann et al., 2011). According to Wittmann, Foley, and Balon, (2011) disruptions in spontaneity can be equally disruptive for the female spouse or partner. Because communication may be difficult, the psychological and sexual needs of the caregiver may be overlooked.

Studies have found that the wife or partner may try and protect their spouse by not bringing up this painful subject of impotence and it has been found that should this happen, the result is often a poorer outcome in relation to psycho sexual function for the couple (Wittmann et al., 2011). Unfortunately not many empirical studies have not been done on couple communication and sexual problems as it relates to prostate cancer. Men who are open to this communication with their partner around sexuality may achieve a better outcome in both sexuality and creating a closer proactive relationship with their partner (Wittmann et al., 2011). According to Badr, Carmack and Taylor (date), sexual dysfunction was not only found in prostate cancer patients but in their spouses as well. In a study of 90 couples, the man's erectile dysfunction negatively impacted the female's level of desire, arousal, orgasm, and satisfaction with a reduction in sexual activity (2009).

It has been found that female partners may be less concerned about sexual functioning than with how their decreased function will affect the emotional intimacy of their relationship (Badr & Carmack Taylor, 2009). A study has shown that women are cautious around discussion of intimacy and sexual function with their partner. Women tend to be wary of causing distressing emotions in their spouse and often do not broach the subject (Conaglen & Conaglen, 2008). The result is often that patients and their spouses avoid conversations about arousal and sexual intimacy after prostate cancer diagnosis and treatment causing distancing, even though it may add more distress not talking about it (Badr & Carmack Taylor, 2009). It has also been

documented that “Partners have reported poorer lubrication, poorer orgasm function, and more sexual pain” (Badr & Carmack Taylor, 2009, p. 738). This may or may not have to do with general aging of caregivers.

Stress around caregiving may have a direct relationship to poorer health and depression for the caregiver. Should the male have incontinence due to treatment, employment and travel may be limited (Arrington, 2008). This may be distressful for the caregiver and dreams of travel and autonomy may be shattered in addition to fear around income loss and what this may mean for retirement (Arrington, 2000). If this distress is hidden, it may come out in other ways. For example depressive symptoms may appear in the caregiver if there is a communication breakdown within the couple. Kim et al. (2008) has reported that the husband may distance himself should the sexual dysfunction prevail. This distancing will create a communication gap and further exacerbate the distress for their significant other. Kim et al. (2008) “hypothesized that spousal caregivers being more distressed than the cancer survivors they care for would have a greater adverse effect not only on their own quality of life, but also the survivors” (p. 231). The importance of open communication cannot be undervalued. There is a correlation between open communication and happiness within the relationship. Partners may fall into a secret despair over their loss of sexuality or libido. As symptoms of sexual dysfunction worsen the partner may not want to add to their partner’s shame and not share their feelings around how treatment has affected them as a partner and caregiver. In a study on the effects of prostate cancer on partners’ it was concluded that “From partners’ perspectives, prostate cancer therapy has negative impact on sexual relationships and appears to worsen over time” (Ramsey et al., 2013, p. 3135). Not all studies show a negative pattern. It has also been shown that due to erectile dysfunction, some women have experienced more hugging, cuddling, and better foreplay

in the absence of an erection (Conaglen & Conaglen, 2008). This may be true for some as it is possible for partners to feel a sense of relief over not having to perform their duty to have intercourse or even need intercourse. In addition, sex may be a very small part of the relationship. Should this be the case, the partner may not feel a great sense of loss after treatment. In some relationships, the wife has had sex with her husband because it is expected that she satisfy his sexual needs (Duran, Moya, & Megias, 2011). In other cases when women are describing intercourse post prostate cancer treatment they have related their experience as being "hard done by" and a "a bit disappointing" (Conaglen & Conaglen, 2008, p. 153). It has been documented that in general 20% of marriages remain sexless (Brandon, 2011). One can extrapolate this to 20% of marriages remain sexless in couples who have been diagnosed with prostate cancer as well. In these marriages, the effects of prostate cancer treatment for the partner will vary greatly from the other 80% who have been living in a sexual relationship.

The emotional effects of a diagnosis of prostate cancer have been well documented for the patient but there is very little on the implications for the significant other. There is symbiotic effect on both partners that may feed off each other. Studies have shown that marital satisfaction may decrease for the significant other after diagnosis of prostate cancer (Manne et al., 2015). Within this, shame may be a little known aspect to look at for the partner of a post treatment prostate cancer patient. Shame that may come with being selfish with the thought of the life changes that may have to occur when your partner faces the prospective tragedy of death. For some partners, shame may also be part of the equation due the desire to not remain monogamous or have thoughts around sex with other partners (Brandon, 2011). Feeling the shame of your partner and not being able to openly discuss sexual dysfunction with clinicians, friends, or family may increase emotional isolation. The idea that shame may also be linked to the partner's belief

that the sexual aspect of her relationship may be superficial and validation may be needed around sexuality being important. Shame has not been seemingly addressed in studies in relation to partners of prostate cancer but it may be a consideration for future studies. Shame may interrelate with grief and loss of what life was prior to treatment for prostate cancer.

Whenever there is a great loss, the mixed emotions and degree of emotion felt will usually be reflected on how great the loss was. In other words, the reaction to loss is variable and changes from individual to individual. The varying degree of loss may converge all at once or remain steady. Whether a couple is sexually active or not, loss for the caregiver may occur with just the thought that sex may have been taken off the table. Variation between losses in individuals will occur between individuals. Anger, repression, and depression are normal reactions to the loss. The shame that is felt due to these reactions may constitute the need for "talk therapy" in order to effectively process the loss (Collins et al., 2013).

Sexuality for women can be very different than for their male counterparts. Sexuality is not held solely on whether intercourse can be achieved or not. Questions that may arise for the female may be; am I attractive, will my partner see me as attractive as he has in the past prior to prostate cancer treatment? Will he be willing to or be motivated towards having sex in absence of an erection? Will I (woman) feel like a sexual person in absence of proof (erection) that I am desired? Sexuality stems from within and it may be psychological for the woman. In other words, if you feel sexy, you are sexy. So the question is: How can the woman feel sexy if there is no erection to prove that she is sexy enough to create a visceral reaction in her partner? In addition, if the assumption could be made that sex is a way of showing love and commitment, do the partner and caregiver have to find other ways to express love and commitment in the absence of intercourse? Perhaps the best way to approach these questions will be to look into why women

have sex. Women's self-esteem is tied to their level of self-perceived attractiveness (Smith & Lynn, 2010), and women may engage in sex to boost their ego (Smith & Lynn, 2010). This can be problematic for women with low self-esteem and partners who have had treatment for prostate cancer. In a study it was shown that people value self-esteem more than doing favourite activities or eating favourite foods. In addition, it has been shown that individuals may go out of their way to pursue a boost to self-esteem (Bushman, Moeller, & Crocker, 2011). Given that sexual dysfunction is a known result of prostate cancer treatment, the partner may have to find other ways in which to gain self-esteem. Perhaps caring for another will increase self-esteem and life satisfaction. Studies have shown that when an individual shows compassion and caring behaviour for others, this increases self-esteem, confidence, and alleviates depression (Catarino, Gilbert, McEwan, & Bailao, 2014). In the same study it is reported that in some instances it can have a negative effect on the same feelings. The key is realizing what motivates the compassionate behaviour and whether it is true compassion or not (Catarino et al., 2014). If the caretaking behaviour stems from obligation to the exclusion of satisfying one's own needs, then this is linked to detrimental effects on personal wellbeing. Life will change post prostatectomy treatment.

The degree to which life will change is variable. The partner may take on a caretaking role and satisfaction of doing so may be dependent on the underlying motivation of the compassion needed. It has been reported that a feeling of entrapment in the role of caregiver may lead to depression (Martin, Gilbert, McEwan, & Irons, 2006). Although it may be true that leading a compassionate life leads to higher awareness and life satisfaction, should the partner find herself trapped into caring for their spouse, it may be detrimental to her well-being. The importance lies in self-care. If self-care is not adhered to, there is a higher chance of anger, guilt,

shame, and depression (Catarino et al., 2014). In a study it was reported that depression was associated with caregiver associated stress (Pinquart & Sorensen, 2004).

There may be loss that a woman faces in light of prostate cancer treatment. One of which is the loss of sexual satisfaction in the form of penile-vaginal penetration. Depending on how dysfunctional the ability to achieve erection post treatment for her partners, the reality is; sexual function is changed and is never the same as it was prior to treatment for prostate cancer (Neese et al., 2003). In a study on penile-vaginal penetration it has been reported that "frequency and simultaneous orgasm produced by PVI (penile-vaginal intercourse) (as well as vaginal orgasm for women) are associated with greater life, sexual, partnership, and mental health satisfaction" (Brody & Weiss, 2011, p. 734). In light of this, the partner of an individual who has been treated for prostate cancer will be adversely affected if they are accustomed to having sexual intercourse. In addition, research indicates that women tend to connect sex and love (Armstrong, England, & Fogarty, 2012). Given this research, women may find that not only their expression of love may change but their views on how to interpret love from their partner may have to change. The satisfaction of penile-vaginal intercourse in the 80% of sexually active marriages will forever be changed post cancer treatment (Armstrong et al., 2012).

Self-esteem may be a factor to consider in the emotional effects of prostate cancer for the partner. It may be that the partner has a perception that correlates self-worth with sexuality or more specifically, having her spouse maintain the ability to become overtly aroused through an erection as proof of desirability. Should a woman equate sex with self-esteem, it may be difficult for her to lose this perception without counselling and coping mechanisms in place.

Fear may be the biggest shared emotion between partners. Death is the obvious fear for both partners. But other fears may also come into play for the female partner, it may be that fear

stems from inevitable changes in the relationship. For example, in the absence of penetration, the couple may grow apart. The orgasm from vaginal penetration may not be achievable and the result may be that the hormone oxytocin (love hormone) (Armstrong et al., 2012) and other hormones are not released. Oxytocin has been equated with increasing romantic attachment and empathy. In addition, oxytocin has been associated with 'pillow talk' after intercourse (Denes, 2012) and this may result in less relational disclosures and in turn may have detrimental effects on the couple relationship. The fear for the partner is not dissimilar to the fear for the male. Both male and female in the relationship may need counselling to discuss emotional fragility and come to terms with their new life post prostate cancer treatment together.

Research has shown that through intercourse there are numerous health benefits. There is an increase in the ability to communicate, variable heart-rate, and lower resting blood pressure. In this research, levels of Oxytocin were studied. Oxytocin is a hormone that is released post coital orgasm. It has a relaxing effect to stressors. It was concluded that Oxytocin has a pro-bonding effect in couples (Denes, 2012). To elucidate further, should there be an effect on sexual function post treatment for the man, it may be difficult for the spouse to release Oxytocin as intercourse is unachievable. Thus resulting factors may come in the form of distancing, anger, guilt, shame, or even relief (Martin et al., 2006). Although bonding and communication may not be completely obliterated, the maintenance of the bond may be severed and it may be difficult to overcome this within the relationship. As the predominant demographic for prostate cancer is within the age group of 60-plus (Arrington, 2000), consideration should be afforded to general physical changes due to aging and whether sexuality is of primary concern for the female within the couple.

The aging process encompasses many variables, including gender and sexuality. In a study of age related changes in sexuality it was found that at least some of the women between the ages of 40 to 80 reported that desire and enjoyment of sex had increased over the years (Adams & Turner, 1985). The same study revealed that older women generally have less interest in sex than older men. This appears to be a contradiction but due to health, limitation to men, and inherent sex drive, variability can be extreme. In this study, the hypothesis is that women will be more likely to take sexual agency and report an increase in sexuality as they age. The conclusion was that women may have enhanced sexuality as they age (Adams & Turner, 1985). This is an older longitudinal study and in a more recent review it was been noted that there has been a desexualisation of sorts in older women in society (Brick, 2007). In this review Brick interprets the message to be that societal desexualisation of a woman after 60 years of age is not necessarily correct. Regardless of the many physiological changes in older women that can decrease a woman's sex drive, a woman past 60 can have a very satisfying sex life (Brick, 2007). Aging is another aspect to consider for the partner of a male post treatment.

An older caregiver faces particular challenges when it comes to caring for a man post prostate cancer treatment. The sexual aspect is only one of several considerations. The effects post treatment may have detrimental effects on the health of the older caregiver. The effects are contingent upon what treatment option was chosen and how well her partner is managing psychologically and physiologically. Should her partner remain incontinent, it may be physically challenging for the caregiver. Resentment for the woman may set in due to the loss of autonomy caused by limitations of travel and other limitations (Arrington, 2000) and a feeling of being overwhelmed may also be a resulting factor. The amount of support available either from family, community, therapeutic or medical may be effective in assisting the caregiver and allowing for

supportive groups in which to discuss issues aligned with being a caregiver and how others have overcome difficulties (Arrington, 2008).

The loss of intimacy may need to be addressed. Emotional intimacy may be lost if the partner has used intercourse as a primary means to show love and affection. Should intercourse be important to the caregiver, dialogue within the dyad around sex and intimacy may be important to have the ability to move forward and share ideas around intimacy. The partner may have to do research and introduce new ideas in order to have her needs met. Needs may come in different forms, both psychological and physical. The physical effort needed from the caregiver will be dependent upon the degree as to how treatment is affecting her partner. Effects are variable and consideration as to age, health of caregiver, and the support system in place may be a good place to start. As treatment varies between type and symptoms for the male post treatment, education around worse case and best case scenario may be warranted so the caregiver can adequately prepare for the period post treatment. The caregiver may benefit from being open-minded when it comes to coping strategies, which may include seeking other methods for sexual satisfaction, psychological and emotional struggles, and a way to understand and communicate difficulties arising. It has been documented that achieving a positive attitude and a sense of humour in the face of stressors and anxiety that comes with being a caregiver may alleviate stress in times of distress (Wittmann et al., 2011).

CHAPTER 4 – THE COUPLE

Prostate cancer poses many issues that can cause controversy within the relationship of the couple. In addition to the stress of a diagnosis of cancer the side effects of treatment can be damaging to the quality of life for both patient and partner due to the link between treatment and incidence of erectile dysfunction. The prospect of being rendered impotent can be daunting.

There are many considerations when looking at counselling for couples who are going through difficult times due to this type of diagnosis. After diagnosis it is has been shown that it is important to include both partners in all medical visits (McCoy et al., 2013). The information given at the doctor's office will be enlightening for both parties. Due to the outcome of treatment, this diagnosis is one that cannot be individualised to solely the male—it is a diagnosis for the couple. Both parties need to consider the consequences of treatment. The couple may go through many discussions as to when to treat the cancer. As they both become aware of the implications of treatment, fears, loss and shame may set in.

Many things can happen for the couple during the initial shock of diagnosis. Couples may find that the diagnosis brings them closer together or they may find that it may be the last straw and unhealthy marriages may separate or divorce. In cases where cancer has progressed to the point where immediate treatment is necessary, couples may not have this reflection period and may not have had time to digest what is happening and what to expect post treatment. Whatever the scenario, the results are the same in regards to sexual function and once treatment has ended the couple will have to explore new ways to express their sexuality. So how is this done? In some partnerships, communication has formed a pattern of living parallel lives in which the couple has limited depth of communication around sex. Other couples may have had good communication in the past but many have now found themselves with insecurities discussing

sexuality and what it means for them and the fears around what this diagnosis holds for them. It may be that the sexual relationship is not an issue for some couples and they don't consider impotency to be of consequence. Perhaps the age of the couple is such that they have been sexually active less and less and the sexual aspect is not of consideration. Whatever the scenario, good communication and an open mind may be the key to maintaining a close relational bond emotionally and sexually throughout the treatment process.

For those couples where the sexual relationship plays an important role in their relationship the initial consideration is the possibility of feeling a great loss and grieving the potential loss of the inability to have sexual intercourse naturally. Grief and loss may be even greater if the cancer is diagnosed at a young age. It is rare for a diagnosis prior to fifty but it does happen and the most common diagnosis is made in the mid to late sixties. Communication of loss, vulnerability, and expectations between the couple needs to be addressed throughout the decision process and after treatment (Badr & Carmack Taylor, 2009). The relational bond between the two must be maintained and nurtured. The more successful the couple is at nurturing this bond, the better the outcome. Learning to share and communicating grief, and fear is an important aspect towards creating a deepening relational bond (Greenberg & Goldman, 2015).

Chapter 4 will consist of a review of literature based upon three therapeutic models; Emotion Focused Therapy (EFT), Cognitive Behaviour Therapy (CBT), and Gottman's theory on couple's relational development. These models were chosen because they may be able to effectively target areas which are emotion based, changing any distortions in thought patterns around perceptions of self and relationships and reinforcing positive behaviour patterns. All three therapeutic models will cover how relationships may have the opportunity to grow stronger in the wake of life circumstances when given the diagnosis of prostate cancer. This chapter will

cover research around a couple's cohesiveness and how to create and maintain a close relational bond while developing or maintaining honest dialogue around concerns, fears, dissatisfaction, satisfaction, and sexual relational intimacy.

Emotion Focused Therapy

Emotion-focused therapy can be useful in determining vulnerability in the couple's relationship (McKinnon & Greenburg, 2013). Emotion Focused Therapy (EFT) recognises that there is a correlation between emotion, conscious thought, and action (Greenberg, 2015). The premise in this therapy is that initially there is an emotional response, followed by thought or intellectualization of this emotion. After meaning is attached to this emotion it is followed by an action. Awareness of the emotion and how to manage is at the root of EFT. In couple's therapy, through EFT the couple may be able to be cognizant of their emotion and gain the ability to effectively articulate this emotion which can lead to better communication between the dyad. The idea is that "demand, criticism and blame tend to elicit defensiveness and self-protection in the other partner, vulnerable emotional expression tends to evoke compassion and support" (McKinnon & Greenburg, 2013, p. 304). Tools that elucidate on emotional vulnerabilities may help create an open dialogue about fears around the diagnosis of prostate cancer.

Through EFT, the couple may be more productive with their emotions and use their emotions to form a basis for understanding themselves and their partner. The premise is to use skills learned through EFT and bring them into the present relationship and allow for positive articulations that are understandable to their partner. It is necessary to allow for acceptance of who you are and enable emotions in order for changes in cognition and behaviour to occur (Greenberg, 2015). According to Sue Johnson, a leading therapist in EFT, 70-75% of couples recover from distress in EFT. She goes on to say "Emotionally focused therapy (EFT) offers a

structured guide to effective dependency where partners can respond to such moments of disconnection in a way that ensures that a relationship will become a secure bond, a treasure —a pearl of great value" (Johnson, 2010, p. 133).

It has been documented that it may be necessary to have open and honest dialogue between the partners to allow for the life changes that need to occur ensuring that the couple maintain a positive marital bond (Wittmann et al., 2011). Through EFT it may be possible to tap into emotions and enable changes around cognition through recognition of the meaning behind emotions invoked through prostate cancer treatment and embrace the couple's new life around sexuality. The premise is that emotion is the base element in a relationship and should be recognised and verbalised (Greenberg & Goldman, 2015) in a way in which it can be understood in a meaningful and positive way by the partner. EFT allows for partners to feel their emotions in the present. In doing so attaching meaning to these emotions can move partners towards a change in cognition attached to these emotions. If a couple was to present with fear post prostate cancer treatment, the fear will be articulated and understood as to what exactly they are fearful of. Once this process has occurred, the couple will have an understanding of the fear carried by each partner. This fear may be the same or different for each individual. Once this has been understood, she or he has the ability to move away from this emotion of fear and attach a new, shared meaning that is more productive and proactive in their life beyond the effects of treatment.

Couples who share a sense of 'we-ness' have been shown to better cope with illness and its effects (Fergus, 2011). Through EFT, it may be possible to create or add to the idea that each individual identity within the dyad was shared and interdependent. Through maintenance or creating a shared identity, the couple may be able to view prostate cancer as a shared illness. A

study has shown that this improves the couple's ability to be resilient and to cope with the stressors that go along with illness and the effects of treatment (Fergus, 2011). Through EFT, couples create narratives that reveal their relationship and once emotional needs and perspectives are articulated, the couple can construct a new perspective that may better fit into their new shared life. Finding a common meaning to the experience prostate cancer and the effects of treatment may allow for an understanding of each perspective and a shared story may be created. This may allow for the couple to proceed united within this shared story (Fergus, 2011). While sharing these stories of connectedness, the result may be to alleviate resentment, fear and other negative patterns of behaviour like withdrawal (Manne et al., 2015) or anger that can be associated with a diagnosis of prostate cancer. Through EFT, the couple may have an opportunity to elucidate on what their experience is and join these experiences with their partners and co-create narratives. In creating these shared narratives, the couple may address issues that they have been avoiding and create a new understanding for each other and for their relationship. Holding back from sharing distress and perspectives with partners on relational and sexual concerns has been shown to be detrimental to well-being and to the relationship as a whole (Manne et al., 2015). EFT is a therapeutic intervention that may address these concerns.

Sadness often accompanies a cancer diagnosis. This sadness may be the potential loss of a loved one or feeling sad for yourself, your partner, friend, or family member. Most prostate cancer treatment has been effective at removing the cancer before it has metastasized. Prostate cancer may cause a loss for the relationship itself and for the ways that the intimacy that was once shared will be forever changed. Sadness may come about when feelings of being alone and distancing have entered the relationship. Sadness may come through not allowing for self-expression and repressed emotions. The partner with prostate cancer will need to have his

grieving recognised and be supported just as his partner will need to have her feelings of loss be validated and support offered to her. Often these feelings of sadness can either create conflict or bring a couple together. EFT is a form of therapy that is designed to allow for each other to articulate sadness, clarify differences, and share similarities in an emotionally safe environment. In EFT it may be important for the therapist to distinguish as to whether the sadness being elucidated is instrumentally good for the couple or detrimental (Greenberg & Goldman, 2008). For example, in some instances sadness can take the form of blame and resentment whereas in other times it can take the form of vulnerability and result in empathy. Should the therapist find that tears are being evoked, it is important to distinguish between tears of sadness or tears of deflection. In couples with prostate cancer, avoidance around discussing difficult emotions may come in the form of deflective tears. In EFT the therapist is attempting to discover the underlying feeling of an emotion so it can be shared and understood by the partner.

Cognitive Behaviour Therapy

Cognitive behaviour therapy (CBT) was first designed for treatment and management of depression. The usefulness of CBT may go well beyond that of its initial intent (Rosner, 2012). CBT addresses both the way one processes information and the resulting behaviour patterns that emerges from this thought process. CBT is a ‘problem focused’ type of therapy and when therapy is conducted by a skilled CBT therapist, it may have the ability to tease out distorted thought patterns that can plague couples given a diagnosis and prognosis of prostate cancer. The main cognitive distortion may be within their perception on the relationship between impotency, manliness, intimacy and sexuality. EFT and CBT interrelate in their methodology and CBT tends to overlap with EFT. While EFT attempts to uncover thoughts, feelings, and emotions, CBT assists in changing negative thought patterns. For example around their perceptions on sexuality.

Due to prior conditioning, learned thought patterns may emerge around sexuality from culture, family, and society as a whole (Christman et al., 2014; Arrington, 2008). It may be necessary to confront these learned thought patterns and weave more positive internal dialogue around internalised precepts. For example, a man may not feel 'manly' due to impotence (Clarke et al., 2015; Rivera-Ramos & Buki, 2011). Should this be the case, a reconstruction around thought patterns as to what 'manly' means may be helpful. Another example of thought patterns may be that couples may not be well informed as to what to expect with treatment and outcome post treatment.

A study that examined the relationship between treatment of prostate cancer and sexual, urinary, and bowel function has found that if cancer is inconsistent with the perception of the masculine role, bowel, and sexual function will be negatively affected over time (Hoyt, Stanton, Irwin, & Thomas, 2013). CBT may be a useful tool to change the perception of masculinity and integrate new language and ideas as to what constitutes masculinity. After this perceptual change the couple may have the ability to negotiate their relationship under a new positive ideology and have more open dialogue around sexuality and masculinity. The interpersonal relationship within the dyad is important. Survivors' quality of life increase if their partners' quality of life is good, thus forming an interdependent relationship (Segrin, Badger, & Herrington, 2012). Within this interdependent relationship, a couple may have discussions around their differences and be able to understand individual perceptions and distortions. It may be necessary to redirect and create new meanings for quality of life for the couple. The old perception may not fit with their new life post treatment. It may be that one partner's understanding is distorted in that the quality of life for their partner is better than they thought it was and according to Segrin et al. (2012) just having this information about their partner should change the quality of life for the individual

within the dyad. Fagundes, Berg and Wiebe (2012) found a correlation between intrusive negative thoughts for example, thinking about prostate cancer and these thoughts' negative effect on the partner. This in turn may create an atmosphere of having communicative avoidant behaviour. Should a couple find themselves in the situation of distressing thoughts, CBT may assist in recognising the distorted thought pattern and reconstructing a positive pattern as a dyadic experience. Avoidance of distressing thoughts is not allowing for open dialogue within the couple and can be destructive to the relationship (Fagundes et al., 2012).

As was suggested previously in the EFT section of this chapter, it has been found that it may be important for the couple to move forward united (Fergus, 2011). In couples therapy that uses CBT, it may be beneficial to treat the couple as a unit instead of individuals within that dyad. In this way CBT can address concerns and cognitive distortions that are held by the couple. The dyad will then have the ability to help each other change precepts if necessary and reinforce new ideas around current perceptions.

EFT and CBT may be beneficial for couples to relate ideas and express honest emotions around diagnosis. It may be necessary to address fears and perceptions in order for the couple to organise their thoughts and feelings around treatment and sexual function. Options and outcome information must be clear prior to prostate cancer treatment to allow for assimilation and processing of emotions. Couples need to act in unison to achieve a better quality of life (Fergus, 2011).

The maintenance of the couple relationship is important when they are faced with anxiety and distress. Couples may find themselves not recognising distress in their partner when they are themselves encountering personal stressors. Maintenance of the relationship can add to resiliency and inhibit feelings of loneliness and abandonment that the partner may encounter within the

relationship. Feelings around not being emotionally supported may be averted through relationship maintenance by recognising when the partner overtly demonstrates loving gestures. Should the partner not recognise these loving gestures, the result may be that these gestures will be omitted from the repertoire of body language shared (Gottman & Silver, 2015) and create monads within the relationship opposed to the dyad of a single couple relationship. Since studies have concluded that it is necessary for couples to move forward in a dyadic approach while facing adversity (Fergus, 2011), the health of a relationship may be contingent upon daily maintenance. Ways to increase cohesiveness within the relationship will be explored in the section below.

John Gottman: Relational development and cohesiveness

Gottman (2013) has done extensive research on interaction between couples. His theories have been based primarily on observations in an apartment setting laboratory. In this laboratory he witnessed how a couple interacts in a seemingly ordinary setting. In doing this, he had the ability to ask questions around their moment-to-moment perceptions when the couples reviewed his video (Gottman & Gottman, 2013). After extensive research they came up with eight predictors of divorce and /or couple misery "1. More negativity than positivity. 2. Escalating of negative affect. 3- Turning away. 4. Turning against: irritability, emotional disengagement, and withdrawal. 5. The failure of repair attempts. 6. Negative sentiment override. 7. Diffuse physiological arousal. 8. The failure of men to accept influence from wives" (Gottman & Gottman, 2013, p. 95).

John Gottman is a leading researcher on couples (Gottman & Gottman, 2013; Gottman & Schwartz Gottman, 2006; Gottman & Silver, 2015; Gottman, Swanson, & Swanson, 2002;

Madhyastha, Hamaker, & Gottman, 2011). He studies the immune-system responses of couples in a 'Love Lab' where immune responses are observed using electrodes while a couple spends the night in a lab that was transformed into comfortable apartment (Gottman & Gottman, 2013). The necessity for the transformation rested on the premise that the couple would relate to each other in the same way as they do in their own home. Through observations and empirical data on physiological responses, Gottman was able to predict divorce in over 90% of the couples (Gottman & Silver, 2015). Information from that study and decades of research led to the idea of incorporating preventative measures into the couple to add resilience and emotional health within the partnership (Gottman & Silver, 2015).

When working with couples that are going through prostate cancer treatment, the simplest mechanism for couples to practice is Gottman's approach to 'bids.' A bid is an overt action by the partner to form a connection. This bid can come in the form of a facial expression, communication, gesture, requesting help or doing something nice for your partner, to name a few. This action or 'bid' can be either acknowledged by the partner in one of three ways; positive, turning-towards response; criticized, turning-against response; or ignored, turning-away response (Gottman & Schwartz Gottman, 2006; Gottman & Gottman, 2013). Gottman found that couples who turned-towards each other 86% of the time in his love lab remained married and the couples who turned-towards each other 30% of the time got divorced (Gottman & Silver, 2015). When coping with stressors within a relationship such as prostate cancer diagnosis and treatment, it may be important for the couple to learn to recognise and turn-towards each other when a bid for attention or connection has been offered. Maintaining the relationship on a daily basis has been proven empirically through Gottman's research to help create an emotionally tuned-in couple. Gottman states that "while turning toward your partner's bids leads to the growth and

development of a loving relationship, "turning away" by ignoring your partner's bids has just the opposite effects" (Gottman & Schwartz Gottman, 2006, p. 237).

Gottman concluded that in order for a couple to achieve happiness together there has to be more positivity than negativity during conflict. There is a physiological response to negativity, which shuts down communication and creates distancing between the partners (Gottman & Gottman, 2013). In addition to this, it has been found that couples should avoid negative sentiment towards each other. Negative sentiment will allow the partner to look at the negative aspects of their partner even in the face of a positive interaction. The negativity will over-ride the positive (Gottman & Gottman, 2013) and the ability for empathy may be impaired. According to Gottman, men tend to ruminate over distressing thoughts more so than women (2013). Due to the inability to over-ride these negative thoughts a physiological reaction may occur called flooding (Gottman & Gottman, 2013).

> A defining characteristic of emotional flooding is that it disrupts higher-order cognitive processes such as those involved in problem-solving, thereby compromising the individual's capacity to respond adaptively in conflict situations. Importantly, this definition of emotional flooding emphasizes that the flooded partner will do anything to terminate the partner interaction associated with the sensation, typically engaging in overlearned responses that provide immediate escape (e.g., leaving the room)" (Mence et al., 2014, p. 13)

Should flooding occur in either partner it is important to take a break in order for the conflict to not escalate (Gottman & Gottman, 2013) and revisit the discussion once the physiological effects have waned.

These three therapeutic approaches may be helpful for managing stress and improving relational bonds within the couple. Couples may benefit from one or all three approaches. These therapeutic approaches are short term and if successful will either add strength or maintain the couple unit so they can face the challenges of prostate cancer diagnosis and treatment. It is important to find a therapist who the couple can connect with in order to have the ability to be emotive and feel safe and secure.

CHAPTER 5 - CONCLUSION

This thesis explored the coping strategies that may be beneficial for the couple after receiving a diagnosis and treatment of prostate cancer resulting in impotency or sexual dysfunction. In this thesis, discussion around treatment and how the effects of treatment may adversely affect sexual and psychological functioning as it relates to the male, female, and the couple were explored. A diagnosis of any cancer presents its own unique concerns that are cancer specific. All cancers hold the fear of death. Prostate cancer is not unique in this respect, but it is the treatment for prostate cancer that may have unique characteristics such as its impact on ejaculation, erection, sexual desire, self-esteem, and relational bonding achieved through intercourse that need to be understood and accepted by the patient and his partner. It is clear from this literary review that the retention of sexual function is of primary concern for the couple. Given that all treatments to date result in sexual dysfunction, education around preparing both parties emotionally and physically is necessary to maintain quality of life for both partners. For the male, maintaining urinary function is equally important to that of sexual function after survival (Hoyt et al., 2013). Sexual dysfunction deeply impacts the male emotionally and affects the quality of life for both partners (Conaglen & Conaglen, 2008). Sexuality is highly personal and its importance is variable within prostate cancer survivors and their partner. The variables include but are not limited to self-perception, functionality, health, attitudes, desires, behaviours, and relationships (Clarke et al., 2015).

This literature review illustrates that the debilitating sexual effects that are caused by treatment may have the couple not undergo treatment upon diagnosis or put treatment off for a later date (Bertero, 2001). This may cause metastasis, further complicate effects and may hinder complete removal of the cancer should one put off treatment (Bertero, 2001). Although the

oncologist can guide the patient as to when treatment may be considered as in watchful waiting, the decision is ultimately in the hands of the patient. The patient may feel that he is choosing between sex and death (Bertero, 2001). It has been recognised that in some cultures, testing for prostate cancer may be avoided due to perceptions that it is unmanly for a physician to put a finger up their anus to palpate the prostate gland in order to detect possible changes (Rivera-Ramos & Buki, 2011). In all instances, it is necessary to promote education around prostate cancer, its treatment and the outcome of treatment.

It has also been documented that if there is a spouse or partner involved, they should also be included in the educational aspects of prostate cancer (Wittmann et al., 2011)(Badr & Carmack Taylor, 2009). Couples counselling may be beneficial for couples to gain an emotional awareness for their personal concerns as well as understand the concerns of their partner. Through understanding of vulnerability and communication of empathy couples may have the ability to move forward together as a single unit. There appears to be a need for information in regards to sexuality for the male and for the couple. As sexuality is individualistic, couples counselling may help to address each individuals needs and uncover what sexuality means for the man, the woman, and the couple.

This thesis includes three distinct discussions and a review of literature around the effects of prostate cancer and its treatment. The first discussion is around possible male perceptions of how treatment effects the male; the second is around treatment effects for the female partner, and the third discussion is around the couple and what counselling options are best suited for a couple coping with the effects of prostate cancer, allowing for a better outcome and to allow for potential growth within the partnership and move forward united as opposed to two separate

entities moving forward simultaneously. The goal of couple counselling in this review is to treat couples as one entity much like how an individual is perceived as a single entity (Fergus, 2011).

In the past, prostate cancer diagnosis occurred most frequently in men who were over the age of 65 but with current testing guidelines, cancer detection has increased in the male population within the age range between 45-60 years of age (Quon, Loblaw, & Nam, 2011). Non-virulent prostate cancer is slow growing and discussions as to how and when to treat the patient is ongoing within the patient's medical team. Due to adverse effects on sexual function resulting from cancer treatment, an "active surveillance" approach may be taken (Mroz, Oliffe, & Davison, 2013; Ramsey et al., 2013). In this approach, PSA (Prostate Specific Antigen) and samples may be taken from the prostate to gauge and attribute a number to how progressive and extensive the cancer has become within the prostate gland (Mroz et al., 2013). Active surveillance is a type of treatment that can buy some time sexually for the couple but can also result in the cancer metastasizing and spreading. The fear of death is often a very real fear for both the male and his partner throughout active surveillance. Difficulties arise because there is not a 100% accuracy rate as to how much the cancer will spread and at what point it should be treated (Mroz et al., 2013).

I also reviewed the effect of prostate cancer treatment on a man. These effects range from erectile dysfunction, to depression, urinary incontinence, low self-esteem, and, depending on treatment type, bowel incontinence (Nelson, Mulhall, & Roth, 2011; Sharpley, Bitsika, & Christie, 2013). Education around outcome expectations post prostate cancer treatment is important for the male especially education around sexual function post cancer treatment (Brick, 2007). It may be equally important for the male to be offered and for him to seek counselling in order to alleviate stressors that come along with intense fear and chronic sexual dysfunction as

well as acute symptoms that may affect the male both psychologically and physically particularly in regards to coping mechanisms. An open and honest dialogue is necessary in order to get at intense and sometimes overwhelming feelings (Greenberg, 2015) for the male. Every man will react differently to being diagnosed with prostate cancer. Depending on the age at which prostate cancer was detected, sexual function may or may not be an issue if the male currently has had a reduction of sexual function due to age or other medical or psychological reasons.

Great strides have been made in addressing libido and sexual dysfunction and many seniors are reporting a full sex life well into their 80s and beyond (Syme, Cordes, Cameron, & Mona, 2015). Given these advances, it is important to address concerns around diminished sexual function for males post prostate cancer treatment and perhaps changing their perception around what life was and what life is now post cancer treatment through couples counselling. The repercussions of treatment affect the partner as well. Research by Wittman, Foley, and Balon uncovered that that there is a correlation between the psychological well-being of the spouse to how well-adjusted the male is post treatment (Wittmann et al., 2011). In addition, it is important to include the spouse in education sessions along with her male partner because the effects of treatment affect both partners. According to research by Madhyastha, Hamaker and Gottman, the spouse may experience similar psychological effects as the male post prostate cancer treatment (Madhyastha, Hamaker, & Gottman, 2011). In addition there may be care-giving stressors, travel limitations, resentments around sexual dysfunction and general changes that need to be made. There are some women who welcome a sexless union and who are relieved that that aspect of their life has changed. Partners who are unhappy together may choose to leave their partnership at this time as the stress around post treatment may be too much to endure. Some couples may stay in an unhappy relationship for many reasons. It has been noted in this

review that men tend to fare better with overall happiness if they have a partner to share it with (Madhyastha et al., 2011).

Couples counselling may be helpful for both partners to allow for open and honest dialogue. In Chapter 4, three counselling models; Emotion Focused Therapy (Greenberg, 2015; Greenberg & Goldman, 2008, 2015; Johnson, 2010; McKinnon & Greenburg, 2013), Cognitive Therapy (Collins et al., 2013; Mairal, 2015; Siddons et al., 2013; Warkentin, Gray, & Wassersuy, 2006), and the Gottman Approach (Gottman & Gottman, 2013; Gottman & Schwartz Gottman, 2006; Gottman & Silver, 2015; Gottman, Swanson, & Swanson, 2002) were presented to demonstrate techniques and concepts from each model that could be of use to couples attending counselling for prostate cancer. Effective tools that a couple can use in their relationship to learn to better navigate problems and concerns through honesty, reframing their beliefs where necessary and learning the skills that allow for gratitude, appreciation, and psychological comfort within the relationship were described.

Within the framework of emotion focused therapy, couples may have the ability for emotive dialogue in a safe environment to discuss their emotions and fears around the symptoms after prostate cancer treatment (Greenberg, 2015). This form of therapy assists partners to determine where vulnerability lies and enables each partner to listen and allow for recognition as to where defensiveness and blame may lie. This may be beneficial for the couple as blame may accompany sexual dysfunction (Siddons et al., 2013). Through allowing for each partner to share their vulnerabilities, empathy and compassion for the each other may be evoked. Learning tools that help clarify on the couples emotional vulnerabilities may help create an open dialogue about fears around the diagnosis and treatment of prostate cancer. The general premise within this model is that there is a correlation between conscious thought and action (Johnson, 2010). There

is an emotional response followed by cognitive recognition that makes the emotion more concrete. Once an emotion is discussed and shared, the couple may have a better understanding as to what each other perceives to be the main concern. Within this therapy, the couple must be willing to identify and express vulnerability without shame or guilt. Should they feel these emotions, overt expression and vocalization of these feelings may be beneficial in order for their partner to fully grasp the extent as to the effects of diagnosis and perceptions around treatment for prostate cancer. This therapy can be used singularly or simultaneously with cognitive therapy.

As discussed in Chapter 4, cognitive therapy allows for a reframing of ideas around perceptions as it relates to one's self, others, or their relationship dyad (Rosner, 2012). Life will be different and challenging for the couple after prostate cancer treatment. Through reframing old perceptions and creating new positive interpretations and perceptions, the couple may gain the ability to overcome past narratives within the context of how they were sexually and in their relationship and attach new meaning to how they are now sexually and in their relationship. Cognitive Behaviour Therapy is a 'problem focused' type of therapy and it may have the ability to tease out distorted thought patterns that can plague couples given a diagnosis and prognosis of prostate cancer. After treatment with CBT, and distorted thought pattern s have been replaced, the couple may come out with a 'can do' attitude instead of defaulting into set negative patterns that they may have in the past. The need to recognise where the negative perceptions lie in the wake of a new life is the basis for this therapy model. Although these perceptions may not have been negative in the past, a new life has emerged and recognising that old views of one's self and of the couple relationship may not be beneficial or hold true anymore. CBT assists the couple to recognise these patterns and change them for the betterment of the relationship. An open mind as

to what coping mechanisms may be needed to allow the partnership to move forward and embrace their new life together. Examples may be to try devices or prosthetics when it comes to intercourse. It may be beneficial to try penile injections or other medication to allow for intercourse. These preceding therapies hold much promise for the couple should they pursue counselling. The next theory has been effective in maintenance of the relationship on an ongoing basis.

The Gottman approach is helpful to use with couples undergoing prostate cancer treatment as it allows for an ongoing recognition and appreciation of each other within the relationship. Gottman used empirical data through observations and physiological responses on couples gathered from the love lab to determine which elements within a relationship may attribute to a healthy, long lasting union. The tools provided within Gottman's approach recognising 'bids' within the couple, may provide ongoing care, affirmation and an inherent loving relationship. Resentments may fade as bids are acknowledged. A bid is an overt action by the partner to achieve form a connection. This bid can come in the form of a facial expression, communication, gesture, requesting help, or doing something nice for your partner. Utilization of these tools takes practice but if bids are recognised and becomes habit for the couple, quality of life may improve for both partners and an appreciation for one another may ensue. Bids in the form of turning towards each other instead of away in adverse times may allow for positive continuity within the relationship as well as a proactive approach towards resentment and dissatisfaction. Listening skills may develop as a result of listening and recognising bids. Should this happen, couple's may be in a better position to react with empathy instead of resentment.

These short-term therapies may assist in bringing partnerships together with growth of stronger bonds through open and honest dialogue. These three therapies take couples from

identifying vulnerabilities, changing perceptions of themselves and of as a couple as a whole and having the ability to maintain positive dialogue before, in the middle of and after adversity and relational hardship. Because prostate cancer does not affect solely one individual within a relationship, it is necessary for both partners to attend information sessions, doctors' appointments, and counselling. It is the dyad that must be willing to move forward. Togetherness and mutual support has shown to have the greatest positive effect on moving forward after prostate cancer treatment.

Although the perception is that great advancements have been made in prostate cancer treatments, the treatment options offer little in regards to sexual function. Screening for prostate cancer is being executed at an earlier age and cancer has been more readily detected in younger men allowing for a decrease in mortality due to metastasis (Quon et al., 2011). In addition, great strides have been made in treatments available like robotic surgery, which has increased the chances of achieving an erection firm enough for penetration. Unfortunately, when you compare current treatments, the results on sexual function are similar. It appears as though the innovations are more akin to peddlers of hope at this point. There is not one treatment that has been shown to consistently and effectively salvage the nerve bundle surrounding the prostate in order to have erections either equal to prior treatment status or for most, have erections that are rigid enough to allow for intercourse to take place in the majority of men (Fergus, 2011; Hoyt et al., 2013).

In otherwise healthy men with good sexual function the determination of results lie solely in the skill and experience of the physician and the breadth of the cancer within the prostate gland. The physician has no way of knowing the extent of the cancer and whether nerve sparing surgery can proceed is determined during surgery and not prior to procedure. The resulting effects of radiation, radical prostatectomy, hormone, and other treatments options are similar in

regards to sexual function. It is imperative that the couple have all the information about prostate cancer and its treatment prior to treatment in order to have awareness and have the ability to properly prepare for symptoms associated with treatment. The results of this research indicate that counselling for couples going through prostate cancer treatment is highly recommended.

Future Research

The emotional and relational effects of prostate cancer treatment have been studied at length but there are a few areas in which there could be more studies. An interesting study would be around the possibility to ejaculate in absence of an erection. Studies around the percentage of males that may have this ability may be helpful for the male to overcome fear around losing the ability to orgasm. In addition, should the male have the ability to obtain and retain an erection, research on the differences between a dry orgasm and wet orgasm in which they are accustomed to experiencing may also be useful on both the emotional aspects and physical sensation. Other areas for consideration include the fear of abandonment for men that have been diagnosed with prostate cancer. Since it appears that men have great anxiety over erectile dysfunction, it is interesting that so little has been researched on the abandonment aspect for both the male and the female. The male may have this fear due to the resulting dysfunction, but the women may also encounter fear in which their partner may withdraw from the relationship (Nelson & Kenowitz, 2013).

Little research has been done on the emotional effects on single and homosexual males in regards to prostate cancer treatment. One limitation of this thesis is that it focused on men in heterosexual relationships. It would be interesting to look at the effects of prostate cancer on single and homosexual men as it relates to finding a relational partner. In addition, it would be

interesting to look at depression and suicide and whether this is correlative to effects of prostate cancer treatment.

Other ideas to study are ways to quantify treatment outcomes due to the ambiguity of erections and individuation of results. Although oncologists/urologists have statistics in regards to personal operation results, the sharing of results is limited due to variations as to where the cancer is in relation to the nerve bundle for each individual case. It would be interesting for researchers to have the ability to categorise cancer locations within the prostate and determine the probability of sexual retention given the skill of that surgeon in robotic surgery. Studies regarding variation of hormones released during intercourse in both male and female under normal conditions in comparison to hormones released in sexual acts that do not include penetration may be further considered (Denes, 2012). The latter consideration may be specific to the reinforcement of the relational bond of the couple. A question for further study could be: Do hormones act to increase the couple bond and is this bond not as strong if erectile dysfunction is a factor within the relationship? Depending of the outcome of this research: How can couples with sexual dysfunction release these bonding hormones in absence of intercourse or would it be useful for the couple to add hormone therapy into their life (Denes, 2012)?

Further research on group therapy for men and women may be useful to see if comfort and information sharing will assist in alleviating fears, increase their knowledge base of sexual aides and what has worked in the past. In addition, research that includes whether being connected with others going through a shared experience will add to the quality of life would be helpful (Brick, 2007). More research on prosthetics and other sexual aids in relation to self-esteem, sexual satisfaction and whether these tools enhance quality of life for the couple should

be considered and more research as to why sexual aids are abandoned eventually when they have been useful in the past (Kukula, Jackowich, & Wassersug, 2013)?

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