Living with prostate cancer
Voerman, Albert Elias

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Chapter 2

Psychosocial problems and adjustment in men with prostate cancer: A compilation of reviews

Nou, dat is eigenlijk twee punten, dat is de vermoeidheid die toch grote beperkingen geeft, en dat zijn ook de erectie-klachten want je sexuele leven is natuurlijk….is van een zeer matige kwaliteit. Dat stelt eigenlijk niks meer voor. En dan kan je zeggen, goed…je bent een oude man, want je bent 76, dan is de jeugd er ook wel af. Maar helemaal weg is het natuurlijk ook. Dus dat is ook een punt dat zwaar weegt. (Respondent 132)
Chapter 2

Introduction

Prostate cancer is one of the most common types of cancer worldwide (Black et al. 1997; Jemal et al. 2010). In 2012 over 11,000 new cases were diagnosed in the Netherlands and the incidence is rising every year (Dutch Cancer Registry 2014). Prostate cancer is rare in men under forty, and its incidence increases progressively with age, peaking at around seventy (Visser et al. 2002; Dutch Cancer Registry 2014).

In most cases the diagnosis is made in men who consult their doctor about urinary dysfunction. However, the diagnosis is increasingly being made by testing the blood PSA level (Dutch Cancer Registry 2014). Patients whose cancer is confined to the prostate can benefit from curative treatment. This mostly entails an operation (radical prostatectomy) or radiotherapy. Radiotherapy can take place externally or internally (brachytherapy).

 Patients with lymph gland metastases, remote metastases, or whose cancer has spread too far locally, can only be treated palliatively. A common palliative treatment consists of reducing the testosterone level in the blood, which is achieved by administering anti-androgens or the surgical removal of both testicles (bilateral orchiectomy). Combinations of treatments are possible at all stages of prostate cancer. In addition to the curative and palliative treatments ‘watchful waiting’ is a good and acceptable ‘therapy’ for patients with prostate cancer under certain circumstances (Sanda & Kaplan 2009).

The prognosis for prostate cancer depends to a great extent on the tumor stage and the degree of differentiation. If the tumor is diagnosed and treated while it is still at a local stage and has not spread, the prognosis for surviving a further five years is almost 100 percent in the United States and in the Netherlands. Nearly half the patients in whom metastases is detected at the time of diagnosis are still alive five years later (Dutch Cancer Registry 2014; Brawley 2012).

Many cancer patients experience feelings of anxiety, uncertainty about the future and guilt (Dunkel-Schetter et al. 1992; Fallowfield et al. 1990), feelings of depression (Van ’t Spijker et al. 1997; Massie & Popkin 1998) and post-traumatic stress (Passik & Grummon 2003). Twenty years of research into the psychosocial problems of men with prostate cancer has found that these men suffer from the same psychosocial problems as people with cancer in general, but there are also clear distinctions. Men with prostate cancer have specific problem areas unique to this cancer (Heim & Oei 1993; Helgason et al. 2001; Lintz et al. 2003; Roth et al. 2008; Nelson et al. 2009).

In 2004 we published a review on the psychosocial problems in men with prostate cancer, describing the relevant literature found between 1984 and 2002 (Voerman et al. 2004). In the years since this publication many studies on psychosocial aspects have been presented, including a series of reviews. In this chapter we will provide an update of the existing literature by summarizing review studies on the psychosocial aspects of prostate cancer published from 2003 to 2012.

The topics discussed will be divided into two categories: general psychosocial problems occurring in cancer patients (e.g. depression or anxiety) and prostate cancer-specific problems such as incontinence or erectile problems. The conclusions of the review we published in 2004 will also be presented and compared with the results of this updated review.
Reviews of psychosocial problems and adjustment

Research method

The main areas of psychosocial problems which can arise from prostate cancer and its treatment were used as keywords in a literature search for review studies addressing these areas or topics. The keywords used to search for literature were: prostate cancer or prostatic neoplasm along with emotional, depression, anxiety, coping, social support, counseling and education, impotence, erectile dysfunction and incontinence. The following databases were searched: Pubmed, Cochrane, Cinahl, Embase and Psychinfo. We used these keywords in each of the database fields. Only review articles were included in this survey. This search yielded 549 review articles. Inspection of the titles and abstracts for relevance reduced the number of studies to twenty. Finally, the Prisma Statement criteria for quality of reporting systematic reviews of studies evaluating healthcare interventions were applied to select qualitatively sound reviews (Liberati et al. 2009). The criteria applied were: 1) is there a clear description of the search strategy, and what keywords were used and in which databases; and 2) is there a description of the selection of studies? Thirteen review studies failed to describe a search strategy for the studies reviewed and were rejected from this survey. This left eight reviews meeting the quality criteria used in this chapter. The review by Voerman et al. (2004) and the eight reviews included are summarized in Table 1. The number of studies overlapping with the Voerman et al. review is shown in Table 1.
Table 1. Reviews of psychosocial problems in men with prostate cancer retrieved from 2003 to 2012

<table>
<thead>
<tr>
<th>Author &amp; Year</th>
<th>Title</th>
<th>Objective</th>
<th>Number of studies reviewed*</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voerman et al. 2004</td>
<td>Prostate cancer: A review of psychosocial problems and psycho-social interventions</td>
<td>To provide an overview of the literature on psychosocial problems and studies on psycho-educational and supportive interventions for men with prostate cancer.</td>
<td>23</td>
<td>Anxiety, shame, loss of manliness and limitations in daily life were found. Depression is a problem in patient subgroups. Few studies report interventions to be beneficial in participation in treatment decisions and in reducing levels of anxiety.</td>
</tr>
<tr>
<td>Bennett &amp; Badger 2005</td>
<td>Depression in men with prostate cancer</td>
<td>‘To summarize the current empirical knowledge base on depression in men with prostate cancer to inform psychosocial supportive care interventions for this population and chart directions for future research.’</td>
<td>25 (7)</td>
<td>The prevalence of depression is lower in men with prostate compared to women with breast cancer, but higher than in the general population of older men. Risk factors include metastatic prostate cancer, pain or other prominent physical symptoms and previous depression.</td>
</tr>
<tr>
<td>Dale et al. 2005</td>
<td>The role of anxiety in prostate carcinoma: a structured review of the literature</td>
<td>To systemically review the medical literature for high-quality articles which quantify anxiety levels in men with prostate carcinoma during all stages of the disease.</td>
<td>29 (2)</td>
<td>During screening the level of anxiety is highest, 63% exceed the caseness threshold. The lowest levels of anxiety are found in PSA monitoring after treatment, although these percentages still vary from 9% to 31% in localized disease and 12% to 62% in advanced disease.</td>
</tr>
<tr>
<td>Hsiao et al. 2007</td>
<td>Symptoms and symptom distress in localized prostate cancer</td>
<td>‘The purposes of this article are to (1) systematically review literature on symptoms and symptom distress in localized prostate cancer and (2) synthesize evidence of symptom distress applications and measurement in this group.’</td>
<td>15 (0)</td>
<td>Urinary incontinence, sexual dysfunction and bowel problems are most common in the literature. Reviewing symptom distress is challenging due to unclear definitions.</td>
</tr>
</tbody>
</table>

* The number in parenthesis is the number of studies overlapping with the Voerman et al. review (2004)

Text in quotes is cited from the abstracts of the papers
Table 1. Reviews of psychosocial problems in men with prostate cancer retrieved from 2003 to 2012 (continued)

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</tr>
</thead>
<tbody>
<tr>
<td>De Sousa et al. 2007</td>
<td>Psychological aspects of prostate cancer: a clinical review</td>
<td>‘This review looks at psychological issues in patients with prostate cancer from a clinical perspective, with the aim of highlighting these issues for the clinical urologist dealing with these patients. It also explores the consultation – liaison relationship between psychiatrists, psychologists and urologists as a team for the multimodal management of prostate cancer.’</td>
<td>105 (6)</td>
<td>Men with prostate cancer experience anxiety and depression. Erectile dysfunction and urine leakage can lead to depression and partner relationship problems.</td>
</tr>
<tr>
<td>Weber &amp; Sherwill-Navarro 2005</td>
<td>Psychosocial consequences of prostate cancer: 30 years of research</td>
<td>‘This review comprises a search of scientific literature published between 1970 and March 2004 with the aims of 1) identifying the terms used to define the psychosocial consequences unique to men treated for prostate cancer and 2) describing the research aimed at improving the lives of survivors through psychosocial interventions.’</td>
<td>122 (5)</td>
<td>Men experience high levels of unmet support needs and feel constrained in obtaining support, especially emotional support. The coping strategies applied are positive problem-solving, self-reliance, information seeking, self-distancing and avoidance.</td>
</tr>
<tr>
<td>Bloch et al. 2007</td>
<td>Psychological adjustment of men with prostate cancer: a review of the literature.</td>
<td>To systematically review the literature on adaptation to prostate cancer and subsequently integrate the findings and draw conclusions.</td>
<td>45 (5)</td>
<td>In cross-sectional studies, poor adjustment is found in relation to sexual problems, bowel problems, pain and fatigue. Active coping is more beneficial for adjustment compared to avoidance strategies.</td>
</tr>
</tbody>
</table>

* The number in parenthesis is the number of studies overlapping with the Voerman et al. review (2004)

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Table 1. Reviews of psychosocial problems in men with prostate cancer retrieved from 2003 to 2012 (continued)

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<tbody>
<tr>
<td>Roesch et al., 2005</td>
<td>Coping with prostate cancer: a meta-analytic review</td>
<td>To relate the coping categories to indices of adaptation in a meta-analytic study in men with prostate cancer.</td>
<td>33 (3)</td>
<td>Active approaches to coping with prostate cancer are beneficial psychologically, physically, and are positively associated with a return to pre-cancer activities.</td>
</tr>
<tr>
<td>Wittmann et al., 2009</td>
<td>The psychosocial aspects of sexual recovery after prostate cancer treatment</td>
<td>To conduct a review of the research literature on sexual problems following treatment for prostate cancer. The search yielded articles on (1) the treatment of erectile dysfunction, (2) men's psychological and culturally diverse adaptation to the sexual side effects; (3) the impact of prostate cancer on couples' relationships; and (4) interventions to promote sexual function.</td>
<td>102 (0)</td>
<td>‘Factors that characterize men seeking help are younger age, available sexual partners, better physical and psychological health, more education, greater financial well being and nerve-sparing surgical treatment.’ Concerning adaptation, the men in some studies ‘did not confide their emotional pain, instead, men coped by maintaining their competent roles, for example, “being an engineer”. Some studies have identified barriers men put up to limit expression of their distress about sexual dysfunction.’ ‘Couple relationships are affected by prostate cancer treatment. Communication within the couple is reported as an area of difficulty because couples often do not share their concerns; men and women report different needs for intimacy and guidance about recovery from treatment.’ ‘There have been very few interventions designed to help men or men and their partners manage changes in sexual function or well being.’</td>
</tr>
</tbody>
</table>

* The number in parenthesis is the number of studies overlapping with the Voerman et al. review (2004)

Text in quotes is cited from the abstracts of the paper
General psychosocial problems

Anxiety
Voerman et al. (2004) described four studies finding between 8% and 49% anxiety in men with prostate cancer at various stages and times after diagnosis. Dale et al. (2005) conducted a review study in which they differentiated the studies by the stage of the medical process the patient had reached. They reviewed 29 articles varying from studies of pre-screening to advanced disease or cured patients receiving a PSA check. Most men who choose to receive PSA screening did so for peace of mind, meaning to relieve worrying, especially when they have close family members with prostate cancer. Anxiety levels are highest during screening, with 63% of the men exceeding the caseness threshold. The lowest levels of anxiety were found in PSA monitoring after treatment, although these percentages still varied from 9% to 31% for localized disease and 12% to 62% for advanced disease. Younger age and more pain were correlated with higher levels of anxiety (Dale et al. 2005).

In sum, anxiety is prevalent at all stages of prostate cancer to different levels, the highest level being found during the time waiting for biopsy results, the lowest level being found during PSA screening. Age and pain are influential factors on anxiety in that younger age and higher levels of pain are related to higher levels of anxiety.

Depression
The review by Voerman et al. (2004) summarizes four studies on depression leading to the conclusion that the percentage of men suffering from depression is not higher in men with localized prostate cancer than in the general population of elderly men. Higher rates of depression are found for advanced disease. According to one study in the United States, men with advanced disease have a 32-times higher depression rate compared to healthy men aged 65 and older in the United States (Pirl et al. 2002). Bennett and Badger (2005) concluded, with caution, from their review of 38 studies that depression rates in men with prostate cancer is higher than in older men in the general population, but lower than in women with breast cancer.

The factors increasing the risk of depression are advanced disease, prominent cancer symptoms – especially pain and fatigue – and having a history of previous depression (Bennett & Badger 2005). Anxiety about having cancer and financial burdens can also increase the risk of depression (De Sousa et al. 2012).

Others found treatment regimes to be related to depression rates. Men who underwent radical prostatectomy, radiation therapy or hormone therapy were at higher risk of depression (Weber & Sherwill-Navarro 2005). The factors related to decreased depression are being older, being married, having social support outside the family and having less impairment in physical functioning (Bennett & Badger 2005). The reviews by Voerman et al. (2004) and Bennett et al. (2005) differed in their conclusions. This can be explained by the fact that Bennett reviewed many more studies with different depression measures.

In conclusion, depression occurs in men with prostate cancer with different prevalence rates, depending on multiple factors. However, there is no consensus as to whether depression in men with prostate cancer is more prevalent than in the general age-matched male population. Risk factors are having advanced cancer, suffering from fatigue and pain, fear of death, persisting treatment-related symptoms, and a history of depression. Protective factors are being older, being married, being more optimistic and having greater social support. These correlates of depression in men with prostate cancer are consistent with the results of studies in the general population (Sharpley et al. 2009).
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Coping and mental adjustment

Coping and mental adjustment are related constructs. Coping can be defined as a cognitive and/or behavioral attempt to manage (reduce or tolerate) situations appraised as stressful to an individual (Roesch et al. 2005). It can be classified in various ways, with the classical classification being problem-focused in contrast to emotion-focused coping (Lazarus & Folkman 1984). Adjustment mostly refers to psychosocial outcome variables such as mental health, quality of life or psychological distress. A successful coping strategy leads to better adjustment as reflected by a higher quality of life, better mental health and no or few symptoms of distress.

Voerman et al. (2004) described only two studies on coping and/or adjustment in their review. The first study investigated the relationship between appraisal (loss/harm, threat or challenge), coping strategies (fight or flight, helplessness, fatalism or avoidance), attitude (optimistic/pessimistic) and adjustment to prostate cancer (anxiety, depression and self-esteem). This study was conducted among only thirty men with prostate cancer. The results showed that men who remained optimistic despite their diagnosis exhibited less anxiety and had higher self-esteem.

Men who viewed the illness as a threat or a loss, or who reacted to the diagnosis with helplessness or anxious preoccupation, experienced more anxiety and depression and had lower self-esteem (Bjorck et al. 1999).

The second study by Lepore and Helgeson (1998) investigated the relationship between adjustment, operationalized as mental health, intrusive recollections, avoidance and social constraints. This study of 178 men showed that mental health was poorer in men with intrusive thoughts and social constraints. This relationship was stronger if these constraints came from the spouse. The more a spouse is reluctant to communicate, the higher the scores for anxiety and depression. This relationship was even more marked if the partner did not want to talk about emotional issues.

Weber & Sherwill-Navarro (2005) reviewed nine studies concerning coping with prostate cancer. They concluded that men apply a variety of coping strategies. Examples are problem-solving, enhancing self-reliance by seeking information about the disease, avoiding social isolation by being emotionally available, evaluation and redefinition of the self, the use of alcohol or drugs, and avoidance of the subject of prostate cancer. One study pointed out that avoidance strategies had positive effects such as less anxiety, decreased need for support and relief of the idea of bothering others with your problems (Gray et al. 2000).

(Roesch et al. 2005) studied more relationships between coping and adjustment. In their meta-analysis of 3,133 men with prostate cancer, they found that ‘approach’, problem-oriented and emotion-focused coping strategies were related to better mental and physical health. In contrast, avoidant coping strategies seemed to be related to lower physical and mental health.

Many more studies have been conducted since 2002. We can derive from these that physical factors, psychological factors and social factors influence adjustment. Physical factors include disease stage (Curran et al. 1997), pain, erectile problems, urinary problems and bowel problems. The psychological factors related to adjustment are coping strategy, subjective perception and attitude. The social factors are the presence of a spouse and of family or friends.
Reviews of psychosocial problems and adjustment

It can be concluded that poorer adjustment is related to advanced disease and to higher levels of pain, erectile problems, urinary problems and bowel problems. Problem-oriented and emotion-focused coping strategies are related to better mental and physical health. On the other hand, avoidant coping strategies generally seem to be related to lower physical and mental health.

Loss or threat perceptions and being pessimistic are related to lower self-esteem and higher anxiety and depression. Being able to talk about emotional issues is related to better adjustment.

Social problems
A cancer diagnosis also affects the patient’s social system. For example, it can affect aspects such as communication about the disease and the patient’s social network, most importantly including partner relationships. Voerman et al. (2004) concluded in their review that prostate cancer can lead to problems in the patients’ social lives. In particular, partner relationships are affected as a result of changes in the functioning of both partners’ roles. It is evident that partners play a crucial role in the social system and that prostate cancer can impose a heavy burden on the patient’s partner.

In their review, Wittmann et al. (2009) also concluded that couple relationships were negatively affected by prostate cancer and its treatment. Communication within the couple was reported as an area of difficulty because couples often do not share their concerns; men and women reported different needs for intimacy and guidance about recovery from treatment. It was suggested that the partner’s sexual function is also affected by the patient’s erectile dysfunction (Wittmann et al. 2009). Moreover, studies found higher distress levels (Kornblith et al. 1994; Cliff & MacDonagh 2000) and higher levels of anxiety and depression (Couper et al. 2006) in partners than in patients themselves.

In conclusion, there is little specific research on the social aspects of prostate cancer, with the exception of the influence of prostate cancer on the marital relationship, which has been studied quite extensively since 2002. Sexuality and communication are the aspects most often affected by prostate cancer.
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Prostate cancer specific problems

Erectile dysfunction
The penis and the ability to achieve an erection are important aspects of male identity. An inability to achieve erections and therefore the inability to have ‘spontaneous’ sex can elicit a variety of problems and consequences in the patients’ lives. Erectile dysfunction occurs twelve months after treatment in 52% to 75% of men treated with external beam radiation (Madalinska et al. 2001; Schapira et al. 2001) and in 72% to 93% of the men treated with radical prostatectomy (Potosky et al. 2000; Talcott et al. 1998).

The review by Voerman et al. (2004) summarizes six studies of erectile dysfunction, which appears to be very stressful for both prostate cancer patients and healthy elderly men. They concluded that men with erectile dysfunction were anxious and frustrated: there is a sense of loss and a sense of being less attractive as a sexual partner. Depression was also linked to erectile dysfunction.

Wittmann et al. (2009) described the areas of life on which erectile dysfunction has negative effects in their review. Loss of erectile function affects: 1) sexual ‘performance’: fear and reluctance to initiate sex, and the feeling that sex is awkward and unnatural; 2) relationships with women: the person becomes aware of his inability to perform sex and thereby loses a ‘pleasant’ sexual aspect in everyday contact with women; 3) sexual fantasies: there is no longer any physical or emotional response to an attractive woman and fantasies no longer exist; and 4) manliness: the loss of potency is associated with the patient regarding himself as being less manly. Some men think that they can no longer satisfy the sexual desires of their partner and are therefore scared that they will lose their partner. It is also evident that the inability to ejaculate is perceived as a loss. Hsaio et al. (2007), Weber and Sherwill-Navarro (2005) and De Sousa et al. (2012) all report similar findings to Wittmann et al. (2009). On how to deal with erectile dysfunction, Wittmann et al. concluded that men often did not disclose their emotional pain but rather cope by maintaining their competence roles, for example ‘being an engineer’. Some studies have identified barriers men put up to limit the expression of their distress about sexual dysfunction, such as working hard in order not to be vulnerable (Wittmann et al. 2009).

Contrasting conclusions, however, are drawn by Bloch et al. (2007). In their review of seven studies, they found that erectile dysfunction as a result of radical prostatectomy did not affect psychological functioning. They suggest that the pursuit of cure outweighs sexual concerns. Another study in this review showed that 12 to 24 months after surgery, adjustment measures are influenced by perceived social support, self-esteem and locus of control, whereas age, sexual dysfunction and its appraisal had no effect. However, Bloch et al. (2007) pointed to the limitations of these studies.

With the exception of the review by Bloch et al. (2007), all the studies point to erectile dysfunction being related to psychological morbidity, which includes decreased self-esteem, psychological distress and problems in the spousal relationship. Some men are even prepared to opt for a treatment which allows them to retain their potency at the expense of the time left to live (Singer et al. 1991).

Hypothesizing that care needs are a reflection of distress, Wittmann et al. (2009) describe three studies, which identified factors characterizing men seeking help for erectile dysfunction. Men who seek help for erectile dysfunction are younger, have sexual partners available, have better physical and psychological health, higher education
and greater financial resources and received nerve-sparing surgical treatment. They also cite a study that hypothesizes psychological barriers to seeking help for erectile dysfunction. Patients who have been treated by radical prostatectomy and have erectile dysfunction expressed interest in professional support. However, most patients found it too embarrassing to access it. For example, 74% of men after prostate cancer treatment and 93% of partners expressed a need to meet as a couple to discuss sexual dysfunction problems with a health professional. However, only 59% of them sought professional advice for sexual problems (Matthew et al. 2005).

It can be concluded that the ability to achieve an erection and sexuality is very important and related to many aspects of psychosocial wellbeing, including in older men. These conclusions are in line with the review by Voerman et al. (2004).

**Incontinence and urinary dysfunction**

Incontinence or urinary dysfunction is a commonly occurring problem in prostate cancer patients as a side effect of surgical or radiation treatment. This is often found in ‘quality of life’ studies (Litwin et al. 1995; Lim et al. 1995; Steineck et al. 2002). One year after treatment, urinary incontinence is found in 27% (Potosky et al. 2000) to 44% (Schapira et al. 2001) of men treated with radical prostatectomy.

In their review, Voerman et al. (2004) found two studies specifically focused on the psychosocial impact of incontinence. From these studies they conclude that incontinence or urinary dysfunction is a factor that restricts the everyday life of a substantial number of patients by causing them to avoid traveling, for fear of the possibility of visible wet spots and or urine smell. In a psychosocial context these symptoms can have negative effects such as shame, social isolation and lack of intimacy, and thus cause relationship problems (Voerman et al. 2004). The same was concluded by Weber and Sherwill-Navarro (2005). An increase in the severity of the incontinence was related to greater mental distress, social restrictions and social isolation. Urinary incontinence also influenced daily routines by affecting the decisions men made with regard to what to wear, how they spent their money, sleeping arrangements and patterns, social activities and activity levels; it also contributed to low self-esteem, anxiety, depression, anger and stress. Weber also described that the severity of incontinence was dependent on several factors, including the stage and grade of the cancer, the treatment and technique used, and the patient’s age (Weber & Sherwill-Navarro 2005). De Sousa et al. took this even further by concluding that urine leakage is more bothersome than erectile dysfunction. Urine or faecal leakage can lead to social withdrawal, which can lead to anxiety and/or depression (De Sousa et al. 2012).

In line with the other review studies, Hsiao et al. (2007) pointed out that erectile dysfunction, urinary problems and bowel problems are the three most reported symptoms of concern in men with localized prostate cancer. However, there is little consensus on the distress caused by these symptoms, mainly due to the lack of clear definitions of distress (Hsiao et al. 2007).

The general conclusion on urinary problems is that incontinence is a frequently occurring side-effect of the treatment. Since the review by Voerman et al. (2004), existing insights have been elaborated in other studies. In many cases, urinary problems reduce a patient’s freedom to decide where to go and when and what to wear, often leading to psychological distress including depression.
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Bowel problems

Bowel problems are not mentioned in the review by Voerman et al. (2004). They do occur, generally as side effect of radiation treatment, and are found in 28% to 36% of patients twelve months after treatment (Talcott et al. 1998; Potosky et al. 2000). Weber and Sherwill-Navarro (2005) stated in their review that the effects of radiotherapy are well documented. They include an increased risk of chronic bowel dysfunction, with the major symptoms being rectal urgency, loose stools and mucus discharge. According to Weber et al. (2005), no studies were identified which assess the effect that bowel dysfunction has on quality of life (QOL) for these men.

Hsiao et al. (2007) found bowel problems including faecal leakage among the most frequently mentioned symptoms of concern; however, they did not elaborate the impact of bowel problems on the psychosocial wellbeing of prostate cancer patients further.

In sum, bowel problems are among the most frequently reported symptoms of concern in men with prostate cancer; however, studies relating bowel problems to QOL or psychological distress are scarce.
Reviews of psychosocial problems and adjustment

Discussion and conclusion

Conclusion
This article discusses review studies about psychosocial problems in men with prostate cancer. The objective was to provide an overview of the problems that play a role within this patient group. This was done by retrieving systematic review articles on psychosocial problems. As a starting point, we used our review article (Voerman et al. 2004) of studies conducted from 1984 to 2002. The insights from this review were complemented with insights from reviews retrieved from the period 2003 to 2012. The various review articles are to a great extent consistent in their conclusions on most topics.

Box 1. Main conclusions on psychosocial aspects of prostate cancer

- Anxiety is prevalent in all stages of prostate cancer. It is at its highest level while waiting for biopsy results and at its lowest level in PSA monitoring after treatment. Older men experience less anxiety than younger men. Pain increases anxiety.
- Men with advanced disease and/or pain and fatigue are at a higher risk of developing depression, with a depression rate of about 12% being found.
- Men with prostate cancer apply a variety of coping strategies including problem-solving, information seeking and seeking support, but also avoidant strategies such as distancing or adopting a role such as the strong men. Avoidant coping strategies are associated with worse adjustment compared to approach or solution-oriented coping strategies.
- Social relationships: the level of spousal distress is higher than that of the patient.
- Erectile dysfunction, reported by up to 93% of the patients, is associated with anxiety, frustration, altered self-perception, decreased self-esteem and loss of quality of life. It affects sexual fantasies, daily interactions with women and the partner relationship.
- Incontinence occurs in up to 47% of the patients twelve months after treatment. In many cases it reduces the patient’s freedom to decide where to go and when, and what to wear, often leading to psychological distress.
- Bowel problems are among the most commonly reported symptoms of concern in men with prostate cancer (13-38%); however, studies relating bowel problems to QOL or psychological distress are scarce.

In general it can be concluded that men with prostate cancer face many physical and emotional challenges. No substantial differences were found in the symptom levels or coping or adjustment methods when we compare the conclusions of Voerman et al. (2004) and the reviews published later. Since 2003, more detailed studies have been conducted on specific topics. Comparison of the conclusions of the review by Voerman et al. (2004) and the more recent reviews can be confounded by the overlapping studies relied on in the conclusions.
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Despite persisting symptoms, most men with prostate cancer adjust reasonably well to their condition. Van Andel et al. (2004) found that after about one year post-treatment, general measures of wellbeing are as high as before diagnosis for men with local prostate cancer (Van Andel et al. 2004). Similar results were found by Korfage et al. (2005). Differences in the definitions of theoretical constructs and the use of different measurement instruments makes the comparison of studies difficult, compromising the conclusions. Methodological shortcomings in the individual studies were also described in the reviews, which compromise the quality of the evidence. Moreover, little information was found on mediating and moderating variables between symptoms including erectile dysfunction, urinary incontinence and psychological distress.

Clinical considerations
Since anxiety is the most prevalent psychological symptom at the time of diagnosis and while awaiting biopsy results, urologists should be aware of the patient’s mental state when deciding what treatment to commence. A qualitative study by Denberg et al. found that newly diagnosed men experience high levels of anxiety, which leads to undeliberate treatment decisions. Decisions at that point are based on wanting radical treatment as soon as possible, misconceptions about the treatment and anecdotes from other cancer patients (Denberg et al. 2006).

After treatment and especially once the disease is at an advanced stage, patients are at a higher risk of depression, depending on age, coping strategies or the presence of a partner and or social resources. Clinicians should be aware of this, in order to refer the patient to an appropriate form of support to prevent further compromising his quality of life. This is especially important, since studies have found that depression could be associated with elevated mortality in cancer patients (Onitilo et al. 2006; Pinquart & Duberstein 2010; Satin et al. 2009).

Special attention should be paid to urinary problems, erectile dysfunction and bowel problems. Although most men report a good quality of life about one year after treatment, we should not take these symptoms lightly. Most studies of the care needs of men with prostate cancer report needs in the area of sexuality more than one year after diagnosis, especially in younger patients (Steginga et al. 2001; Ream et al. 2008). The ability to achieve erection and sexuality are important subjects both for younger and older men, which deserve attention and which should be discussed in detail with the urologist before commencing treatment.

An overarching point of consideration is some men’s use of avoidant coping strategies or denial. Patients may tell their physicians that everything is fine but suffer nonetheless. The care giver should be aware of his or her own ‘intuitive feeling’ about the patient and use more probing questions if avoidance is suspected (Mikels et al. 2011).

In general it can be concluded that the psychosocial problems in men with prostate cancer are well described. It is however less clear for which subsets of prostate cancer patients psychosocial care should be recommended and what kind of interventions are most beneficial in terms of better adjustment. This is especially true in men with advanced disease. Studies of care needs and possible interventions for men with advanced disease are relatively scarce. The same is true of men treated by watchful waiting. There are few studies for this latter group of psychosocial aspects in the long term. Future studies could shed more light on these patient subgroups.
Reviews of psychosocial problems and adjustment

References


Chapter 2


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