Prostate cancer is the most common non-skin cancer diagnosed among men, accounting for an estimated 33% of all cancer cases, with more than 232,090 new cases diagnosed in 2005. Because the five-year relative survival rate for early-stage cancer is nearly 100%, the experience of diagnosis and treatment can have long-term effects on men physically, psychologically, and emotionally (American Cancer Society, 2005; Fan, 2002; Jakobsson, Hallberg, &...
treated for localized prostate cancer has increased substantially since the mid-1990s (Clark et al., 2003; Davis, Kuban, Lynch, & Schellhammer, 2001; Germino et al., 1998; Hu et al., 2004; Lee, Hall, McQuellon, Case, & McCullough, 2001; McPherson, Swenson, & Kjellberg, 2001; Penson & Litwin, 2003b; Ptacek, Pierce, & Ptacek, 2002). In general, health-related QOL does not differ greatly among the most commonly used treatment modalities. However, the type and severity of treatment-related symptoms differ among the treatment groups (Bacon, Giovannucci, Testa, & Kawachi, 2001; Galbraith, Ramirez, & Pedro, 2001; Incrocci et al., 2002). Men who have received surgery have fewer bowel-related complications, yet tend to experience more urinary incontinence, irritation, and blockage. Patients treated with different forms of radiation report more gastrointestinal, bowel, and rectal side effects. Both groups report diminished sexual functioning; however, surgical patients complain of more sexual side effects during the first few months after treatment (Egawa et al., 2001; Robinson et al., 2002; Steineck et al., 2002).

Reports of sexual dysfunction following prostate cancer treatment range from 33%–98% and have a direct and negative effect on health-related QOL and intimate relationships (Althof, 2002; Dahn et al., 2004; Kirschner-Hermans & Jäkke, 2002; Lilley et al., 1999; Schover et al., 2002b; Schwartz, Covino, Morgentaler, & DeWolf, 2000). Although many men seek professional help for their sexual dysfunction, these attempts did not resolve the underlying problems that may affect their intimate lives (Bertero, 2001; Bokhour, Clarke, Inui, Silliman, & Talcott, 2001; Eton, Lepore, & Helgeson, 2001; Harrod, 2003). Sexual dysfunction in this population is complex (Cooperberg et al., 2003); however, researchers and clinicians have focused primarily on erectile dysfunction and have not addressed issues of self-concept, desire, fantasy, or everyday interactions with intimate partners (Schover et al., 2002a).

Although most longitudinal studies have focused on survival and morbidity, some have focused on long-term QOL outcomes (Bacon et al., 2001; Bahn et al., 2002; Kim et al., 2001; Zietman, 2002). Most prostate cancer survivors report substantial adverse urinary, bowel, and sexual health outcomes two to four years after treatment, but some report QOL as more stable (Lee et al., 2001; Litwin, 2003; Litwin et al., 2001; Wei et al., 2002). Few research studies have followed patients with prostate cancer or couples longitudinally beyond five years post-treatment (Penson et al., 2003).

Prostate Cancer and Couples

Prostate cancer affects all members of a family, not just the patient, although few studies have reported on the dyadic experience (Feldman-Stewart, Brundage, & Mackillop, 2001; Giese-Davis, Hermanson, Koopman, Weibel, & Spiegel, 2000; Northouse, Templin, Mood, & Oberst, 1998; Skerrett, 2003; Wai-Ming, 2002). Men and women respond differently to the stress of a cancer diagnosis. Men tend to use more active coping strategies, whereas women use more passive coping strategies (Carlson, Ottenbreit, St Pierre, & Bultz, 2001; Feldman-Stewart et al.; Lavery & Clarke, 1999; Shields, Travis, & Rousseau, 2000). Even if treatment is successful, the quality of the couple’s relationship may be altered greatly (Malcarne et al., 2002).

Some researchers have noted that partners of patients with prostate cancer experience even more psychological distress than their mate, which currently is not well understood (Carl-
son, Bultz, Speca, & St. Pierre, 2000; Kiss & Meryn, 2001; Perez, Skinner, & Meyerowitz, 2002; Sestini & Pakenham, 2000). Fewer than half of men believed their partner supported them in their efforts to find help for their sexual dysfunction (Neese, Schover, Klein, Zippe, & Kupelian, 2003). However, partners may be more helpful by focusing on putting impotence into perspective and reassuring their spouses (Maliski, Heilemann, & McCorkle, 2001). Being part of a strong, positive relational dyad can buffer against psychological distress for patients with prostate cancer (Banthia et al., 2003). Partners of patients with prostate cancer may feel the need for more family-centered information to be better prepared to support their spouses after treatment (Butler, Downe-Wamboldt, Marsh, Bell, & Jarvi, 2000; Maliski et al.).

**Study Framework**

Health-related QOL for patients with prostate cancer is comprised of psychological, biophysical, functional, environmental, and social factors. Each person experiences specific symptoms related to these factors, which directly influence ongoing self-evaluations of his or her health status. This process enables men to determine the extent of the effect of diagnosis and treatment on their lives. Patients assess their health status by comparing actual life experience to what is normal for them and then determining which consequent adaptations are required (King et al., 1997; Padilla, Mishel, & Grant, 1992; Penson & Litwin, 2003b; Wilson & Cleary, 1995).

Cancer survivorship is comprised of lasting and complex combinations of physical, psychological, and social effects for patients with cancer extending long after treatment has been completed (Dow, 1990). Mullan (1985) further suggested that cancer survivorship has distinct seasons in which long-term survivors are challenged with physical, emotional, and interpersonal sequelae that result from the diagnosis, treatment, and recovery process beyond five years after treatment.

The family systems theory suggests that the impact of cancer is felt by the entire family, not just the identified patient. Family members may be influenced directly and indirectly by the impact of the diagnosis and subsequent treatments. Consequently, the entire family environment and social system must incorporate the experience into various system-related activities such as intimacy and communication, as well as finding functional and emotional balance (Minuchin, 1974; Morse & Fife, 1998; Wilson & Cleary, 1995).

Long-term physical symptoms from prostate cancer treatment can include impotence, incontinence, sexual dysfunction, and long-term bowel and bladder complications such as diarrhea, urgency, bleeding, or cystitis. Additionally, these outcomes may occur several years following treatment (Albert et al., 2003; Galbraith et al., 2001; Jani & Hellman, 2003; Penson & Litwin, 2003a; Talcott, 2003; Yarbro & Ferrans, 1998). Therefore, prostate cancer survivors may continue to experience treatment-related late side effects that can affect many factors associated with their health-related QOL and that of their partner for years after the initial treatment.

**Methods**

This follow-up longitudinal survey design study had descriptive, correlational, predictive, and comparative elements.
specifically to compare treatment-related symptoms that can result from any prostate cancer treatment strategy (Moinpour, Hayden, Thompson, Feigl, & Metch, 1990). Symptoms included were related to bowel, bladder, and sexual functioning. Items are scored on Likert-type and binomial scales and can be used individually. Items related to specific bowel, bladder, and sexual functioning were combined into three subscales. Reliability coefficients for the three subscales ranged from 0.42–0.93. The scale took approximately 10 minutes for the men to complete.

**Dyadic Adjustment Scale:** This instrument was designed to assess the quality of marriage and other similar dyads and satisfaction with the relationship (Spanier, 1976). The 32-item scale is constructed of four empirically supported components of consensus, satisfaction, cohesion, and affective expression. Items are scored on Likert-type scales, and the range of total scores for the measure is 0–151, with higher numbers representing increased marital adjustment and satisfaction. The internal consistency reliability coefficient for the measure is 0.96, and it takes approximately 15–20 minutes to complete.

**Procedures**

The men in this study participated in a previous prostate cancer QOL study and agreed to annual follow-up (Galbraith et al., 2001). A cover letter, questionnaire, and self-addressed stamped envelope were mailed annually to the men. Spouses or partners of the men who were participating in the study were contacted by telephone and invited to take part in the annual follow-up. If they expressed interest, they received a packet via mail that included a consent form, questionnaire, and self-addressed envelope for the return of study-related materials. Before each annual mailing, telephone contact was made with study participants reminding them to expect the questionnaire packet in a week or two. Each participant received his or her own packet to encourage individual responses and provide confidentiality. They were reminded to complete their own questionnaire and assure their responses would not be shared with their partner.

**Findings**

The average age of the men was 70 years, with the participants in the watchful-waiting group being the oldest and the surgical patients being the youngest ($F_{(5, 286)} = 5.1, p < 0.001$). Eighty-eight percent of the men were married or partnered. Seventy-one percent had at least some college education, and 36% had annual incomes of over $50,000, with the men in the proton beam therapy group reporting the highest incomes. In general, men in the low-dose mixed-beam radiation group reported better mental health than men who were in the conventional radiation group or the low-dose mixed-beam radiation group.

**Quality of Life**

QOL generally decreased among the groups over the four years ($F_{(1, 178)} = 27.5, p < 0.001$) (see Figure 1). At 5.5 years, the men who were in the watchful-waiting group had lower QOL scores than the men in the conventional radiation group or the low-dose mixed-beam radiation group.

**Health Status**

Physical functioning declined overall among all the groups over the four years ($F_{(1, 180)} = 11.63, p < 0.001$) (see Figure 2A). However, the men did not decline significantly in their ability to perform their physical (see Figure 2B) or emotional roles (see Figure 2C) over the course of the study. The men in the low-dose mixed-beam radiation group tended to score higher in their ability to perform their physical role functions than men in the surgery group.

Differences were found among the groups in their emotional role functioning ($F_{(6, 293)} = 2.52, p = 0.02$) at 2.5 years. The men in the low-dose mixed-beam radiation group had fewer role limitations caused by emotional problems at 2.5 years than did the men in the watchful-waiting group. Vitality also decreased overall among all of the groups ($F_{(1, 181)} = 12.71, p < 0.001$) (see Figure 2D). Again, at 2.5 and 3.5 years, men in the low-dose mixed-beam radiation group reported higher vitality scores than men who had received proton beam therapy only.

An overall change in mental health was not reported over the four years of the study (see Figure 2E); however, 4.5 years after treatment, men who had received low-dose mixed-beam radiation reported better mental health than men who were in the watchful-waiting group even though they did not report the largest difference. Note the positive, upward trend in mental health for the surgery and proton beam therapy groups although it did not reach significance.

Social functioning differed among the groups ($F_{(6, 298)} = 2.16, p = 0.05$). The watchful-waiting group reported the lowest scores 2.5 and 3.5 years following treatment (see Figure 2F), but no significant trends or differences in bodily pain were noted (see Figure 2G).

General health decreased in all groups over the four years of the study ($F_{(1, 181)} = 112.02, p < 0.001$). Men in the low-dose mixed-beam radiation group tended to report higher scores than men in the watchful-waiting group at 2.5, 3.5, and 4.5 years (see Figure 2H).

**Treatment-Specific Symptoms**

Gastrointestinal (GI) symptoms differed among the participants ($F_{(6, 286)} = 2.92, p = 0.009$). At 2.5 years, men in the low-dose mixed-beam radiation group reported fewer GI symptoms than men in the high-dose mixed-beam radiation group. In general, men in the low-dose mixed-beam
radiation group reported GI symptoms at a rate similar to men in the surgery group (see Figure 3A).

Overall, urinary symptoms increased over the course of the study ($F_{[1, 181]} = 4.28, p = 0.04$). However, this trend was driven by three of the seven groups, with men in the watchful-waiting group reporting the most urinary symptoms (see Figure 3B). In general, sexual symptoms tended to remain high ($F_{[1, 178]} = 10.04, p = 0.002$), with men in the watchful-waiting group typically reporting the most symptoms at 5.5 years (see Figure 3C).

### Symptom Trends Among the Groups

Treatment-specific symptoms were measured using response options ranging from 1–5, with lower scores indicating few or no problems and higher scores indicating more severe problems. The means for urine symptom scales ranged from a

### Treatment Group

- **Watchful waiting**
  - Men ($n = 21$)
  - Women ($n = 8$)
- **Surgery**
  - Men ($n = 39$)
  - Women ($n = 22$)
- **Conventional radiation**
  - Men ($n = 18$)
  - Women ($n = 11$)
- **Proton beam therapy**
  - Men ($n = 21$)
  - Women ($n = 15$)
- **Standard protocol mixed-beam radiation**
  - Men ($n = 37$)
  - Women ($n = 22$)
- **Low-dose mixed-beam radiation**
  - Men ($n = 25$)
  - Women ($n = 20$)
- **High-dose mixed-beam radiation**
  - Men ($n = 31$)
  - Women ($n = 27$)

### N = 192 men and 125 women

Overall, urinary symptoms increased over the course of the study ($F_{[1, 181]} = 4.28, p = 0.04$). However, this trend was driven by three of the seven groups, with men in the watchful-waiting group reporting the most urinary symptoms (see Figure 3B). In general, sexual symptoms tended to remain high ($F_{[1, 178]} = 10.04, p = 0.002$), with men in the watchful-waiting group typically reporting the most symptoms at 5.5 years (see Figure 3C).

### Symptom Trends Among the Groups

Treatment-specific symptoms were measured using response options ranging from 1–5, with lower scores indicating few or no problems and higher scores indicating more severe problems. The means for urine symptom scales ranged from a

### Table 1. Selected Demographic Characteristics for the Seven Treatment Groups

<table>
<thead>
<tr>
<th>Treatment Group</th>
<th>X Age (Years)</th>
<th>Married or Partnered (%)</th>
<th>Some College (%)</th>
<th>Yearly Income Less Than $50,000 (%)</th>
<th>White (%)</th>
<th>Black or Hispanic (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watchful waiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men ($n = 21$)</td>
<td>76</td>
<td>52</td>
<td>–</td>
<td>81</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Women ($n = 8$)</td>
<td>74</td>
<td>38</td>
<td>–</td>
<td>100</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men ($n = 39$)</td>
<td>67</td>
<td>58</td>
<td>–</td>
<td>82</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Women ($n = 22$)</td>
<td>65</td>
<td>68</td>
<td>–</td>
<td>86</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Conventional radiation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men ($n = 18$)</td>
<td>72</td>
<td>65</td>
<td>–</td>
<td>71</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Women ($n = 11$)</td>
<td>66</td>
<td>36</td>
<td>–</td>
<td>73</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Proton beam therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men ($n = 21$)</td>
<td>72</td>
<td>85</td>
<td>–</td>
<td>95</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Women ($n = 15$)</td>
<td>69</td>
<td>67</td>
<td>–</td>
<td>87</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Standard protocol mixed-beam radiation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men ($n = 37$)</td>
<td>71</td>
<td>78</td>
<td>–</td>
<td>95</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Women ($n = 22$)</td>
<td>65</td>
<td>73</td>
<td>–</td>
<td>91</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Low-dose mixed-beam radiation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men ($n = 25$)</td>
<td>69</td>
<td>76</td>
<td>–</td>
<td>84</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Women ($n = 20$)</td>
<td>65</td>
<td>65</td>
<td>–</td>
<td>100</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>High-dose mixed-beam radiation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men ($n = 31$)</td>
<td>68</td>
<td>81</td>
<td>–</td>
<td>90</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Women ($n = 27$)</td>
<td>62</td>
<td>67</td>
<td>–</td>
<td>85</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

$N = 192$ men and 125 women

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

The treatment group listed first has the highest health-related quality of life and health status scores; the group listed second has the lowest scores.

The treatment group listed first reported the lowest number of symptoms; the group listed second reported the highest number of symptoms.

C—conventional radiation; HD—high-dose mixed-beam radiation; LD—low-dose mixed-beam radiation; MB—standard protocol/mixed-beam radiation; PB—proton beam radiation; S—surgery; WW—watchful waiting

### Table 2. Summary of Differences Among the Seven Prostate Cancer Treatment Groups in Outcome Measures Over Four Years

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>2.5 Years</th>
<th>3.5 Years</th>
<th>4.5 Years</th>
<th>5.5 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health-related quality of life</td>
<td>LD versus WW</td>
<td>LD versus MB</td>
<td>LD versus WW</td>
<td>LD*, C versus WW</td>
</tr>
<tr>
<td>Health status*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical functioning</td>
<td>LD versus WW*</td>
<td>LD versus C*</td>
<td>MB versus PB</td>
<td>WW versus PB</td>
</tr>
<tr>
<td>Physical role functioning</td>
<td>LD versus WW*</td>
<td>LD versus C</td>
<td>MB versus WW*</td>
<td>LD versus S</td>
</tr>
<tr>
<td>Emotional role functioning</td>
<td>LD versus WW**</td>
<td>LD versus WW</td>
<td>MB versus C</td>
<td>MB versus WW*</td>
</tr>
<tr>
<td>Vitality</td>
<td>LD versus PB**</td>
<td>LD versus WW*</td>
<td>LD versus WW</td>
<td>LD versus WW*</td>
</tr>
<tr>
<td>Mental health</td>
<td>LD versus WW</td>
<td>LD versus WW*</td>
<td>LD versus WW**</td>
<td>LD versus WW</td>
</tr>
<tr>
<td>Social functioning</td>
<td>LD versus WW***</td>
<td>LD versus WW**</td>
<td>LD versus WW</td>
<td>C, LD versus WW</td>
</tr>
<tr>
<td>Bodily pain</td>
<td>S versus MB*</td>
<td>LD versus MB*</td>
<td>PB versus WW</td>
<td>WW versus MB</td>
</tr>
<tr>
<td>General health</td>
<td>LD versus WW*</td>
<td>LD versus WW**</td>
<td>LD versus WW**</td>
<td>LD versus MB</td>
</tr>
<tr>
<td>Treatment-specific symptoms†</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary</td>
<td>LD versus WW**</td>
<td>LD versus WW*</td>
<td>S versus WW*</td>
<td>C versus WW**</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>S versus HD**</td>
<td>WW versus HD*</td>
<td>S versus C*</td>
<td>S versus C*</td>
</tr>
<tr>
<td>Sexual</td>
<td>HD versus WW</td>
<td>MB versus WW</td>
<td>LD versus WW</td>
<td>MB versus WW*</td>
</tr>
</tbody>
</table>
Couples’ Experiences

The levels of association on outcome measures among couples’ self-reports of QOL, marital satisfaction, and health status were evaluated by using the men’s scores in a regression equation to predict their partner’s scores on the same variable. Additionally, the number of comorbidities for each member of the couple was used as a covariate to lessen the effect of differences in physical status. After removing the variance associated with the covariates, the partial correlation coefficient was a measure of the uniquely shared variance between a man and his partner on each of the outcome measures.

At 3.5 years, the couples’ QOL (partial r = 0.44, p < 0.01), marital satisfaction (partial r = 0.83, p < 0.01), and emotional role functioning (partial r = 0.30, p < 0.05) were significantly correlated. At 4.5 years, the couples’ QOL (partial r = 0.36, p < 0.05) and marital satisfaction (partial r = 0.94, p < 0.01) also were significantly associated (see Table 4).

Discussion

Quality of Life

The findings of diminishing QOL over time are consistent with other studies on prostate cancer survivors (Talcott, 2003). In general, men in the low-dose mixed-beam radiation group tended to report better QOL scores than men in the watchful-waiting group. However, the average age of men in the study was around 70 years; as a result, the aging process can cause poorer health outcomes overall in addition to surviving prostate cancer (Van Andel, Visser, Hulshof, Horenblas, & Kurth, 2003).

In the current study, no overall differences were found among the treatment groups as Sprangers (1996) suggested, but regardless of the symptoms, people often view their QOL as more favorable because they do not compare their current perceptions to pretreatment conditions. Rather, they compare themselves to their current self-image.

Health Status

Only scores on three of the eight health status scales significantly declined over the four years of the study among the seven treatment groups, specifically in physical functioning, vitality, and general health. This supports other findings that demonstrate stability of self-reported health-related QOL and health status over time (Lee et al., 2001). Additionally, significant differences were found among the treatment groups in emotional role and social functioning over the time frame of the study. In general, the low-dose mixed-beam radiation group fared better than men in the other treatment groups, especially in pain, vitality, physical functioning, and both emotional and physical role functioning. Men in the watchful-waiting group tended to report poorer outcomes than the other treatment groups over the four years of the study, especially in QOL, general health, and physical, emotional, and social role functioning. This is consistent with the perspective that men who opt for watchful waiting sometimes have worse health outcomes (Pickles,
Higher scores represent better functioning.

Higher scores represent more vitality.

Higher scores represent better mental health.

Figure 2. Health Status Outcome Measures (Continued on next page)
However, men enrolled in this study had been treated or followed for early-stage prostate cancer; therefore, these findings may not apply to men who have a more advanced stage of disease.

**Treatment-Specific Symptoms**

Self-reported urinary and sexual symptoms increased over the course of the study, with men in the watchful-waiting group having the most concerns. Men in the low-dose mixed-beam radiation group reported the fewest urinary concerns at 2.5 and 3.5 years after treatment, yet expressed more concerns than the surgical group at 4.5 and 5.5 years. Initially, the men who had received either low- or high-dose mixed-beam radiation tended to report fewer sexual symptoms. However, sexual concerns tended to increase for the high-dose mixed-beam radiation group. This is consistent with Penson et al.’s (2003) findings that radiation treatment for prostate cancer initially tends to result in fewer sexual side effects than other treatments, but men’s self-reported sexual and urinary symptoms should be followed over time.

Men in the watchful-waiting group primarily accounted for differences among the treatment groups in GI symptoms over the four years of the study. Men in other radiation groups, such as the high-dose mixed-beam radiation, conventional radiation, and standard protocol mixed-beam radiation, also tended to report more GI symptoms than other treatment groups over the course of the study.

**Trends of Increased Sexual Concerns**

Overall, men in the study indicated that they were more concerned with sexual issues than other prostate cancer treatment-related side effects. This trend has been supported by other studies that indicate men continue to have sexual challenges after treatment (Jenkins et al., 2004; Meyer, Gillett, Lockyer, & Macdonagh, 2003; Neese et al., 2003). Few men reported being able to have normal sexual relations, and even fewer reported that they were satisfied with their sexual functioning. Nearly two-thirds of the men indicated that they were not able to achieve erections that were adequate for intercourse, and more than half said that they had not had any sexual relations in the past month. Almost 60% of the men said that they were bothered “some” or “a lot” by their lack of sexual activities, but only about a quarter of the sample indicated that they had received nonsurgical treatment for impotency. This indicates a critical need for information and assistance for this group of men. Although these men were challenged in their ability to function sexually, most reported they still were interested in sex and bothered by this diminished functioning. Twenty-three percent indicated they were not bothered at all with their lack of sexual activities, which is consistent with other findings reporting that even though survivors of prostate cancer are among the aging population, most men continue to be concerned with maintaining an active sex life (Crowe & Costello, 2003; Harden et al., 2002; Harrod, 2003).

**Couples’ Experiences**

The researchers expected that couples’ health-related QOL, marital satisfaction, and health status would be associated, which was supported partially. Their health-related QOL and marital satisfaction were associated 3.5 and 4.5 years after initial prostate cancer treatment, but that association did not persist 5.5 years post-treatment. However, the sample size had decreased by the 5.5-year data collection point and may not have been adequate to demonstrate a significant association.

Few significant relationships were found among the eight dimensions of the couples’ self-reported health status. Perhaps
each member of the couple viewed his or her health status as more of an individual experience, whereas marital satisfaction and overall health-related QOL may have been seen as influencing the couple as a whole. Other research in the area of health-related QOL in couples has demonstrated that although the health experience of one member of a couple may influence the other, each person has individual health concerns and needs (Harden et al., 2002; Neese et al., 2003).

Clinical Implications

The primary objectives of this study were twofold. The first objective was to follow the QOL of men 2.5–5.5 years after their initial treatment for prostate cancer. The second objective was to determine how much the men’s health-related QOL, health status, and marital satisfaction predicted their partners’ outcomes on the same variables. In general, regardless of the type of treatment they received, their health-related QOL decreased over the course of the study. This finding is consistent with other reports that as people age, they tend to experience additional health challenges that translate into poorer health outcomes (Van Andel et al., 2003).

The men in the watchful-waiting group tended to report that they experienced as many, if not more, prostate-related symptoms than those who had received surgery or some form of radiation. Watchful waiting continues to be a viable option for men who have slow-growing disease or less than a 10-year life expectancy (Pickles, 2004). However, the findings in this study support the idea that men who are not seeking one of the active treatments for early-stage prostate cancer are still at risk for problematic health symptoms. Although watchful waiting is one of the treatment options available to patients with prostate cancer, it must be the correct choice for each individual patient (Wallace, Bailey, O’Rourke, & Galbraith, 2004).

Overall, sexual concerns remained high for men in the study. Other researchers have found that sexual issues remain salient for men even though they are aging (Van Andel et al., 2003). Most men were concerned about sexual issues and reported low satisfaction with their sexual functioning, but

Table 3. Average Scores of Symptoms Over the Four-Year Time Period of the Study

<table>
<thead>
<tr>
<th>Type of Treatment</th>
<th>Gastrointestinal</th>
<th>Urinary</th>
<th>Sexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watchful waiting</td>
<td>1.2</td>
<td>2.2</td>
<td>4.3</td>
</tr>
<tr>
<td>Surgery</td>
<td>1.2</td>
<td>1.5</td>
<td>3.7</td>
</tr>
<tr>
<td>Conventional radiation</td>
<td>1.6</td>
<td>1.7</td>
<td>3.8</td>
</tr>
<tr>
<td>Proton beam therapy</td>
<td>1.4</td>
<td>1.6</td>
<td>3.9</td>
</tr>
<tr>
<td>Standard protocol mixed-beam radiation</td>
<td>1.6</td>
<td>1.6</td>
<td>3.6</td>
</tr>
<tr>
<td>Low-dose mixed-beam radiation</td>
<td>1.3</td>
<td>1.5</td>
<td>3.7</td>
</tr>
<tr>
<td>High-dose mixed-beam radiation</td>
<td>1.6</td>
<td>1.7</td>
<td>3.8</td>
</tr>
</tbody>
</table>

N = 192
Note. Scores on symptom scales range from 1–5, with higher scores indicating more symptoms.
relatively few sought treatment. This is of particular interest in that the study was conducted during a time period where erectile dysfunction medications became available, but not all men who have received prostate cancer treatment respond to these medications (Meuleman & Mulders, 2003). However, additional treatments are available, and healthcare providers should follow up with their patients to determine treatment efficacy. Additionally, if men were continuing to report that they were not satisfied with their sexual life, alternative methods to approach this issue should be explored.

Prostate cancer clearly affects both members of a couple, but how couples manage this challenge is less clear. Some investigators and clinicians have identified issues that are salient to couples surviving prostate cancer, yet fewer have looked at interventions designed to assist couples as they navigate this experience (Maliski et al., 2001; Monturo et al., 2001; Neese et al., 2003). Nurses are in a prime position to help couples with some of these challenges. Not only can nurses educate couples about potential long-term consequences of prostate cancer treatment, they also can follow up to determine whether the information was useful and help them access additional resources if needed. Advanced practice nurses could increase their awareness of potential sexual problems and consequently individualize their sexual assessment if they know patients have been treated or are being followed for prostate cancer. They can offer suggestions related to possible treatment or educational options that would be appropriate for couples. In addition, nurses can assess the partner as well. Sexuality is a critical component of health-related QOL and marital satisfaction; therefore, these issues should not be ignored simply because patients are older. Sexuality and intimacy issues continue to be relevant, regardless of age. With this increased focus on meeting the information, communication, intimacy, and educational needs of couples surviving prostate cancer, nurses can affect how men and their partners live with the long-term challenges that prostate cancer and treatment bring to their health-related QOL and relationship experiences.

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Table 4. Partial and Zero-Order Correlations Among Couples’ Health-Related Quality of Life, Relationship Satisfaction, and Health Status at 3.5, 4.5, and 5.5 Years Post-Treatment

<table>
<thead>
<tr>
<th>Outcome Measures</th>
<th>3.5 Years</th>
<th>4.5 Years</th>
<th>5.5 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Partial Correlations</td>
<td>Zero-Order Correlations</td>
<td>Partial Correlations</td>
</tr>
<tr>
<td>Health-related quality of life</td>
<td>0.44***</td>
<td>0.51</td>
<td>0.36**</td>
</tr>
<tr>
<td>Dyadic Adjustment Scale relationship satisfaction</td>
<td>0.83***</td>
<td>0.83</td>
<td>0.94***</td>
</tr>
</tbody>
</table>

N = 126 couples
*p < 0.10, **p < 0.05, ***p < 0.01


References


