Identifying Problems Faced by Spouses and Partners of Patients With Prostate Cancer

Starlyn M. Hawes, BA, Vanessa L. Malcarne, PhD, Celine M. Ko, MA, MS, Georgia Robins Sadler, BSN, MBA, PhD, Rajni Banthia, PhD, Sandra A. Sherman, MS, James W. Varni, PhD, and Joseph Schmidt, MD

Purpose/Objectives: To describe problems chosen as targets of problem-solving therapy by spouses and partners of patients with prostate cancer.

Design: Descriptive, cross-sectional.

Setting: Spouses' and partners' homes.

Sample: Spouses and partners (N = 66) aged 32–79 years ($\bar{X}$ = 60 years). The sample was predominantly Caucasian (82%) and African American (8%).

Methods: As part of a randomized clinical trial, women received problem-solving therapy to help manage issues related to their husbands' or partners' prostate cancer. The issues they chose to address during therapy and the categorization of the issues fell into four groups: treatment and side-effect issues, patient issues, family issues, and spouse issues. Scores on the Social Problem-Solving Inventory–Revised, which measures everyday problem-solving skills, and the Profile of Mood States, which measures mood disturbance, were contrasted with the problems women chose to address.

Main Research Variables: Problems faced by spouses and partners of patients with prostate cancer.

Findings: The most frequently reported categories were spouse issues (e.g., women's emotional wellness, balancing their medical concerns with their husbands' condition) and patient issues (e.g., men's lack of communication, fear, or depression).

Conclusions: Findings of this study alert nurses to a variety of key problem areas for spouses and partners of patients with prostate cancer.

Implications for Nursing: Spouses and partners play a critical role when their loved ones have cancer. Understanding the problems spouses and partners face can help nurses design optimal supportive care interventions.

Key Points . . .

- Because spouses and partners play a critical role when men are diagnosed with prostate cancer, they need to be offered optimal support.
- A prostate cancer diagnosis uniquely affects patients' spouses and partners, but the associated problems seldom have been investigated. Healthcare providers should not assume that problems faced by spouses and partners revolve solely around treatment-related issues.
- Meeting the needs of spouses and partners throughout the illness trajectory is important to improve quality of life for both members of the dyad.

A cancer diagnosis disrupts the lives of newly diagnosed individuals and also has a significant impact on their families (Kurtz, Kurtz, Given, & Given, 1995). The American Cancer Society (2006) estimated that 234,460 new cases of prostate cancer will be reported in the United States in 2006, and an estimated 27,350 men will die from the disease, making it the second leading cause of cancer death in men. The combination of better diagnostic methods along with increasing screening rates has resulted in 85% of prostate cancers being detected while the disease is in the localized and regional stages (American Cancer Society). However, for prostate cancer, early diagnosis and treatment have not been shown to improve survival rates (Boehmer & Clark, 2001). What has increased is the time from diagnosis to death and, hence, the time during which the disease, treatment sequelae, and emotional consequences must be managed. Therefore, attention is being focused increasingly on improving quality of life postdiagnosis.

Starlyn M. Hawes, BA, is a research assistant at Rebecca and John Moores University of California, San Diego (UCSD), Cancer Center; Vanessa L. Malcarne, PhD, is a professor in the Department of Psychology at San Diego State University (SDSU) and a researcher at the Rebecca and John Moores UCSD Cancer Center; Celine M. Ko, MA, MS, is a doctoral student in the SDSU/UCSD Joint Doctoral Program in Clinical Psychology; Georgia Robins Sadler, BSN, MBA, PhD, is a professor of surgery in the School of Medicine at UCSD and director of community outreach at the Rebecca and John Moores UCSD Cancer Center; Rajni Banthia, PhD, is a postdoctoral fellow in health psychology at the University of California, San Francisco; Sandra A. Sherman, MS, is a doctoral student in the SDSU/UCSD Joint Doctoral Program in Clinical Psychology; James W. Varni, PhD, is a professor of psychology at Texas A & M University in College Station; and Joseph Schmidt, MD, is a professor of surgery/urology in the School of Medicine at UCSD. *Funding for this project was provided by the California Cancer Research Program (No. 99–00556V-10049), the National Cancer Institute (No. R25 CA 65745), and the Rebecca and John Moores UCSD Cancer Center Fund. The lead author was funded by the McNair Scholars program through a grant from the U.S. Department of Education (No. P217A030016). (Submitted July 2005. Accepted for publication October 10, 2005.)*

Digital Object Identifier: 10.1188/06.ONF.807-814

After undergoing treatment for prostate cancer, patients experience a variety of sequelae that diminish their quality of life, and no evidence shows that the intervention prolongs survival (Boehmer & Clark, 2001; Mishel et al., 2002; Siston et al., 2003). Treatment-related side effects, such as fatigue, incontinence, and sexual dysfunction, cause changes in patients' physical and mental well-being (Boehmer & Clark; Mishel et al.; Siston et al.). Patients have reported experiencing depression, threatened self-image and masculinity, and changes in the dynamics of their relationships (Boehmer & Clark; Clark, Bokhour, Inui, Silliman, & Talcott, 2003; Mishel et al.). Quality of life of patients with prostate cancer is compromised by the multitude of challenges they face. The challenges cause patients to experience varying degrees of vulnerability and, more often than not, lead them to minimize the impact of their illness (Gray, Fitch, Phillips, Labrecque, & Fergus, 2000a, 2000b; Lavery & Clarke, 1999).

Previous studies have shown that prostate cancer also affects patients' spouses or partners. Spouses have reported that prostate cancer diagnosis and treatment left them feeling distressed, anxious, depressed, and alienated (Keitel, Zevon, Rounds, Petrelli, & Karakousis, 1990). Various treatment side effects can lead patients to rely more heavily on their spouses or partners for practical (e.g., companionate, emotional, physical) and medical support (e.g., decision making, caregiving throughout the illness experience) (Fergus, Gray, Fitch, Labrecque, & Phillips, 2002; Thomas, Morris, & Harman, 2002). In turn, caring for individuals with cancer challenges caregivers' ability to adapt to an often unpredictable and complex illness trajectory.

Recognizing that spouses and partners actively participate in the illness experience and are affected in many ways is of great importance (Thomas et al., 2002). Spouses often become health advocates and, during medical visits, provide patients with emotional support, help facilitate communication between patients and physicians, and help make treatment decisions (Banthia et al., 2003; Davison et al., 2002; Fergus et al., 2002; Lantz, Fullerton, Harshburger, & Sadler, 2001). Maliski, Heilemann, and McCorkle (2002) found that the best way for couples to make medical treatment decisions was for each spouse to seek treatment information extensively and then jointly discuss their options, leaving the final decision to the husband. In support of this finding, results of a study by Davison et al. revealed that spouses preferred to play a collaborative role in medical decision making, leaving husbands in control of making the final decisions about treatment choices.

Spouses and partners of patients with cancer cope with competing demands. While providing emotional and physical support to the patient, spouses and partners often assume the role of primary caregiver for their loved ones along with balancing their own personal and work-related endeavors. Additionally, women with husbands who are at an age at which prostate cancer is common often are beginning to experience the physical consequences of the aging process and consequently have their own needs for support (Revenson, 1994).

Researchers have sought to determine which specific aspects of prostate cancer have the greatest impact on spouses. Davison et al. (2002) identified information preferences of couples at the time of a prostate cancer diagnosis. They found that spouses and patients rated prognosis, stage of disease, treatment options, and side effects as their most important information preferences at the time of diagnosis. Heyman and Rosner (1996) described issues that husbands and wives faced during various stages of prostate cancer. Issues revolved around fear of death, treatment decisions, loss of control, dealing with side effects, and recurrence. Jacobs et al. (2002) highlighted differences of opinion among healthcare providers, spouses, and patients in relation to the problems associated with a prostate cancer diagnosis. The researchers found that spouses, in comparison to patients, physicians, and nurses, cited medical decision making as their highest priority, whereas spouses and patients ranked fear of the unknown as their first or second most troublesome issue. Jacobs et al. stated that their findings suggest that psychosocial interventions should be considered for spouses because they reported experiencing distress as a result of their partners' diagnosis and treatment.

In recent years, researchers have had a growing interest in social problem solving and problem-solving therapy (D'Zurilla & Nezu, 1990; Kant, D'Zurilla, & Maydeu-Olivares, 1997); this research has extended to caregivers of patients with cancer (Sahler et al., 2002, 2005). Attention also has been given to assessing the therapeutic value of enhancing people's problem-solving skills (Ko et al., 2005; Malcarne et al., 2002; Sahler et al., 2002, 2005). Social problem solving has been defined as the way in which a person attempts to cope with problematic situations encountered in everyday life (D'Zurilla & Nezu). News of an illness, such as a prostate cancer diagnosis, may intensely challenge problem-solving skills that are otherwise adequate to handle everyday situations. Some individuals are optimistic and are able to more effectively handle problems related to major life events, whereas others are overpowered by the number and complexity of problems that accompany major life events and falter in their coping strategies (D'Zurilla & Nezu; Shewchuk, Johnson, & Elliott, 2000). Therefore, psychosocial interventions designed to help spouses and partners of patients with prostate cancer cope with the competing demands placed on them during and following the prostate cancer diagnosis trajectory are essential.

The design of therapeutic problem-solving interventions for spouses can be enhanced by a more in-depth exploration and description of the problems with which spouses and partners of men with prostate cancer are coping. Because little is known about which aspects of the prostate cancer experience are problematic for patients and spouses, the authors previously had conducted a pilot study to determine physicians', nurses', patients', and spouses' perceptions of problems facing couples coping with prostate cancer (Jacobs et al., 2002). Other studies that have tried to identify problematic aspects of the prostate cancer disease experience primarily have relied on survey instruments identifying broad areas of concern (Banthia et al., 2003; Davison et al., 2002; Keitel et al., 1990).

Although the present study tested the therapeutic value of offering an eight-session problem-solving skills training program for spouses and partners of men coping with prostate cancer, it also gathered additional information about the specific problems spouses faced. This article reports on the specific types of problems that were chosen by spouses and partners of patients with prostate cancer as the focus of their

individual problem-solving therapy interventions. Whether problem-solving abilities and mood disturbance were related to the types of problems women chose to work on in their one-on-one problem-solving therapy training sessions also was investigated. (A separate article is in preparation that will address the intervention results.)

Methods

Sample and Setting

The data presented in this article are a secondary analysis from an experimental intervention that tested whether giving a problem-solving therapy intervention to spouses or cohabitating partners of patients with prostate cancer would improve quality of life for both members of the dyad. Participants learned of the study through physicians, medical facilities, support groups, media coverage, churches, community organizations, and flyers posted throughout their communities. Potential participants were fully informed about the study; those who agreed to participate signed an institutional review board–approved written consent document. Inclusion criteria were as follows: (a) the participant had a spouse or cohabitating partner who was diagnosed with prostate cancer within the previous 18 months, (b) the participant had sufficient English proficiency to engage in the intervention and data collection, and (c) the participant lived in San Diego County in California or in close proximity. Exclusion criteria were a medical crisis as determined by a physician and a major diagnosed mental illness in either member of the couple.

Participants filled out a packet of questionnaires before being randomly assigned to the control or intervention arm. Spouses and partners who were randomly assigned to the experimental group were offered the problem-solving therapy (PST) intervention. The intervention used the acronym IDEAS to represent that participants were trained to (a) **I**dentify a current life problem, (b) **D**efine their options for solving the problem, (c) **E**valuate those options, (d) **A**ct on their plan, and (e) **S**ee if their plan was effective (Varni et al., 1999). A therapist met weekly with each woman in her home to teach her the working concepts of PST. To enhance the learning process, participants were asked to report a minimum of two problems that they believed were important to them and could solve during the intervention. The problems were recorded in the trainer's therapy notes.

Problem Categories

A coding system was developed to categorize the problems identified by spouses and partners. The first two problems chosen by each spouse or partner were listed and examined for themes and subgroups. Content-based categories that described and subgrouped the problems were developed, and coding rules were defined. Each problem had to fit explicitly into a category to avoid any coding discrepancies. The coding rules were pilot tested and then refined by the research team. A final system with four categories emerged from the process: treatment and side-effect issues, patient issues, family issues, and spouse issues. The categories, along with examples, are listed in Table 1. After the coding system was completed, two raters independently coded the problems that women had elected to address, with 91% inter-rater agreement for problem one (kappa = 0.77) and 90% inter-rater agreement for problem two (kappa = 0.70).

Table 1. Problem Categories With Examples

Categories	Examples of Problems Identified by Spouses and Partners
Treatment and side-effect issues	Gathering information about general medical treatments or insurance plans Frustration with patient's side effects (e.g., impotence, incontinence) Medication issues (e.g., new prescriptions, administering shots) Transportation issues (to and from medical treatment or meetings)
Patient issues	Patient's lack of action or sloppiness Patient's temper or verbal abuse Patient's smoking, exercise, or eating habits
Family issues	Scheduling dinner and other social events Relationships with children (financially dependent, living or not living at home) Telling family about diagnosis and treatment
Spouse issues	Responsibility of financial matters if patient dies Continuing with women's hobbies Balance of women's illness with patient's illness

Measures

The **Social Problem-Solving Inventory–Revised (SPSI-R)** (D'Zurilla, Nezu, & Maydeu-Olivares, 1996) is a 52-item self-report instrument reflecting a multidimensional model of social problem solving derived from a factor-analytic study of the original 70-item SPSI (D'Zurilla et al.). Participants rated each item on a scale of 0 (not at all true of me) to 4 (extremely true of me). The SPSI-R contains five subscales that measure two different problem-orientation dimensions (i.e., positive and negative) and three different problem-solving dimensions (i.e., rational problem solving, impulsivity or carelessness style, and avoidance style) (D'Zurilla & Nezu, 1990; Kant et al., 1997). The subscales can be summed to yield a total score ranging from 0–20; higher scores reflect better problem solving. The scale has been associated with self-esteem, emotional well-being, social adjustment, and social skills (D'Zurilla & Nezu; Shewchuk et al., 2000).

The **Profile of Mood States (POMS)** (McNair, Lorr, & Droppleman, 1992) is a 65-item adjective checklist designed to assess affective states (McNair et al.; Speca, Carlson, Goodey, & Angen, 2000). The POMS yields an overall distress score referred to as Total Mood Disturbance (TMD) as well as scores for six subscales: Fatigue-Inertia, Vigor-Activity, Tension-Anxiety, Depression-Dejection, Anger-Hostility, and Confusion-Bewilderment (Curran, Andrykowski, & Studts, 1995; McNair et al.). The POMS uses a 0 (not at all) to 4 (extremely) response format, and items for each scale are summed. Higher scores reflect higher symptom levels, with the exception of Vigor-Activity, for which a higher score reflects higher energy. TMD is calculated by summing all of the subscales and subtracting Vigor-Activity because it is negatively weighted (McNair et al.). Scores on the POMS can range from –32 to 232 for TMD. The scale has been used widely as a measure of mood disturbance, including in cancer (Cassileth, Lusk, Brown, & Cross, 1985; Curran et al.; Guadagnoli & Mor, 1989).

Findings

Sample Description

The sample was drawn from a larger sample of 172 spouses and partners who were randomly assigned to receive a PST intervention or standard care. Of the 86 spouses or partners assigned to receive PST, 69 completed the intervention. Of those, 66 had complete therapy notes and 65 identified two problems to work on in PST. A comparison of data from the spouses who had complete therapy notes and those who did not revealed no significant differences with regard to demographic variables or patients' stage of cancer.

Information on spouse or partner and patient demographics can be found in Table 2. Eighty-five percent of spouses and partners were married, and 15% were living as part of an established cohabitating couple. Thirty-seven percent of spouses and partners were 65 years of age or older, 76% had completed at least some college, and 57% reported a combined annual income of $50,000 or more. The ethnic distribution within the sample was relatively comparable to the local and national population (San Diego's Regional Planning Agency, 2003; U.S. Census Bureau, 2001). The underrepresentation of Hispanics and Asians or Pacific Islanders reflects the lower incidence of prostate cancer in these communities, the low proportion of these communities among the region's population aged 50 years or older, and a lower percentage who meet the English language proficiency criteria.

Table 2. Sample Demographics

Characteristic	Spouse or Partner (N = 66)		Patient (N = 66)	
Age (years)				
$\bar{X}$	60		64	
SD	10.72		9.54	
Range	32–79		44–86	
Latency from diagnosis (months)				
$\bar{X}$	–		4.79	
Median	–		3.00	
SD	–		4.14	
Range	–		0.5–18	
Characteristic	**n**	**%**	**n**	**%**
Ethnicity				
Caucasian	54	82	53	80
African American	5	8	6	9
Hispanic	2	3	1	2
Asian	2	3	2	3
Other	3	5	4	6
Level of education				
Some high school or technical school	1	2	3	5
High school or technical school graduate	15	23	10	15
Some college	24	36	15	23
College graduate	11	17	14	21
Graduate or professional school after college	15	23	24	36
Combined annual income ($)				
1–5,000	1	2	–	–
5,001–10,000	–	–	–	–
10,001–20,000	3	5	–	–
20,001–30,000	4	6	–	–
30,001–50,000	17	26	–	–
50,001–75,000	22	33	–	–
> 75,000	16	24	–	–
No response	3	5	–	–
Stage of prostate cancer				
I or II (T1 or T2)	–	–	52	79
III or IV (T3 or T4, M or N+)	–	–	9	14
No response	–	–	5	8

Note. Because of rounding, not all percentages total 100.

Problem Categories

Frequencies of the four problem categories are shown in Figure 1. Spouse issues were identified most frequently for problems one (30%) and two (44%). Most commonly reported spouse issues were emotional wellness (29%) and balance (29%). Spouse emotional wellness problems included the need for time for self, self-esteem, anxiety, temper, guilt, stress, or self-criticism, and her concern for her and her spouse or partner's declining health (e.g., her declining physical well-being as a result of his, her health problems and aging process and his recovery from prostate cancer treatment). Balance problems included balancing her medical condition with his medical condition, balancing her schedule with his, her organizational patterns, and her lack of experience with family finances. Other issues that were reported as spouse issues were lifestyle (26%) and work issues (16%). Lifestyle issues consisted of her health issues (e.g., eating habits, exercise regimen, physical pain, physical strength), continuing with preestablished hobbies (e.g., tennis, crafts), and sleeping alone while her husband or partner was away for treatment. Work issues revolved around workload and procrastination.

The second most frequent problem category selected by spouses and partners was patient issues for problems one (28%) and two (29%). A woman's lack of communication or dysfunctional communication (43%) with her husband or partner was the most frequently reported problem in this category. Dealing with his fear or depression (17%) and helping with his weight management (17%) were the next most commonly reported problems in this category. Fear or depression included the patient's overall fear of his prostate cancer, his potential death from the disease, and the woman's need to provide him with support for his depression. Weight management issues revolved around the patient's overeating, diet, and exercise. Another issue that was reported was inertia (10%), and problems in this area were the patient's clutter, lack of action, and sloppiness. Additional issues (13%) in this category included the patient's retirement or him not showing love or affection toward his spouse or partner.

The third most frequent category for problem one was treatment and side-effect issues (25%), whereas family issues (16%) was the third most frequent category for problem two. In the former category, 54% reported side-effect issues and 26% reported problems around treatment decisions. The most commonly reported side-effect issues were impotence (50%), incontinence (25%), and general side-effect issues (25%). Other issues (20%) reported as treatment or side-effect issues included insurance plans, the spouse or partner having to administer shots, and the spouse or partner having to help the patient with postoperative adjustment.

The problems given the most priority as family issues were linked to financially dependent children (36%) and

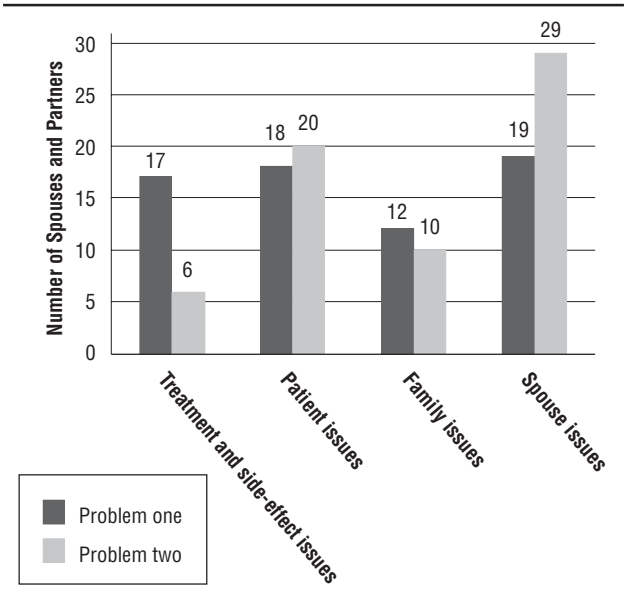

Figure 1. Frequency With Which Spouses and Partners of Patients With Prostate Cancer Chose to Work on Problems in Certain Categories

difficult in-laws (27%). Commonly reported issues related to financially dependent, adult children included the children living at home, their lack of financial independence, helping them find a job, and dealing with children's illnesses. Problems related to in-laws consisted of them being a burden or annoying to the spouse or partner or patient. Another problem reported in family issues was unwanted visitors (14%), typically friends and sometimes family members. Other problems (23%) reported in family issues were telling extended family members about the patient's prognosis and tasks to be completed around the house.

Demographic Analyses

Nonparametric analyses of the relationships of problem categories to the demographic and medical characteristic variables demonstrated that the type of problem the spouse or partner chose to work on did not differ according to her age, income, the patient's stage of diagnosis, the patient's treatment, or the latency between diagnosis and the couple's entry into the program. However, chi-square analyses showed that the number of spouses or partners who reported family issues differed significantly according to their level of education ($\chi^2 = 18.60$, $p < 0.05$). Spouses or partners who had completed graduate education were more likely to report working on family issues compared to those with less education.

Social Problem-Solving Inventory–Revised

The relationship between problem-solving ability and the problems that spouses or partners chose to work on during therapy was examined. Means and standard deviations are reported in Table 3. All participants scored within the normal range on the SPSI-R. When compared to published normative data for three adult groups, the current sample's scores reflect substantially better problem solving (D'Zurilla et al., 1996). Two one-way multiple analysis of variance (MANOVA) analyses were conducted with the SPSI-R total and subscale scores as the dependent variables and the type of problem worked on during PST as the independent variable for problem one and problem two. No significant differences were found in women's SPSI-R scores across the types of problems they worked on for either problem.

Profile of Mood States

Relationships between mood disturbance and the type of problem worked on during PST also were examined. Means and standard deviations of the POMS are listed in Table 4. All participants scored within the normal range on this scale. Compared to published normative data for three adult groups, the current sample's scores reflect substantially less mood disturbance (McNair et al., 1992). Two one-way MANOVAs were conducted with the POMS total and subscale scores as the dependent variables and the type of problem addressed during PST as the independent variable for problem one and problem two. For problem one, the MANOVA revealed significant differences among the four groups ($F = 3.4$, $p < 0.05$). Follow-up Tukey post-hoc pairwise comparisons revealed a significant difference between husband issues ($\overline{X} = 12.88$) and family issues ($\overline{X} = 5.17$) on the Anger-Hostility subscale ($p = 0.047$). No significant differences in POMS scores were found among the types of problems worked on for problem two.

Discussion

As patients and their spouses or partners begin the process of coping with a diagnosis of prostate cancer and its consequences, nurses are often the people to whom couples turn for guidance. Nurses are recognized for the supportive attention and guidance that they give to patients and the members of patients' support systems (Heyman & Rosner, 1996). When working with spouses or partners, nurses are benefited by having insight into the array of problems with which women may be coping. The current study shows that although four main clusters of problems were identified, multiple subtle variations of problems fall within these clusters. If healthcare providers focus on more obvious disease-related problems, they may fail to address crucial underlying problems in patients' relationships that could eventually compromise couples' management of treatment-related issues.

Spouses and partners were asked to select two problems that were important to them and potentially able to be remedied to address with a therapist over a series of eight one-hour sessions. The variety of problems in each of the four categories underscores the importance of understanding the specific nature of the problem as a precursor to contemplating intervention strategies. Within women's concerns about their own issues, multiple interventions could be used for handling problems such as emotional wellness, balance, and work issues because each of these issues poses a unique set of barriers to handling an illness effectively. Within women's concerns about their husbands' or partners' issues, very different interventions could be recommended for women dealing with their spouses' depression versus their husbands not showing affection.

Spouse issues represented the most frequently chosen problem category, with maintenance of a balanced life and emotional wellness as top priorities. This finding is consistent

Table 3. Problem Categories as Predictors of Problem-Solving Ability

	Problem Categories (N = 66)							
	Treatment and Side-Effect Issues (n = 17)		Patient Issues (n = 18)		Family Issues (n = 12)		Spouse Issues (n = 19)	
SPSI-R Subscale	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
Positive problem orientation	13.17	4.05	13.00	3.34	13.17	2.89	12.32	3.93
Negative problem orientation	9.53	6.14	8.56	4.34	9.67	6.53	11.32	6.02
Problem definition and formulation	12.47	3.02	11.39	3.53	12.67	3.82	11.26	3.14
Generation of alternatives	13.29	3.69	12.61	3.45	13.00	2.95	11.16	3.89
Decision making	12.05	3.80	10.50	4.26	11.42	3.34	10.21	3.38
Solution implementation and verification	11.18	3.68	10.28	3.85	11.17	3.90	9.42	2.55
Impulsivity and carelessness style	6.47	5.39	9.11	6.86	6.58	4.60	10.89	6.77
Avoidance style	6.41	5.11	4.67	4.00	4.92	3.75	7.68	5.46
SPSI-R total score	14.57	2.38	14.41	1.92	14.72	2.06	13.25	2.32

SPSI-R—Social Problem-Solving Inventory–Revised

with literature that demonstrates that a spouse is faced with the demands of balancing her worry about her husband's illness and its implications for her own well-being along with her own health and schedule, the patient's schedule, her job, home responsibilities, and trying to find a way to still have time left over for herself (Fergus et al., 2002; Lavery & Clarke, 1999). Although multiple demands compete for spouses' time and energy, Lavery and Clarke found that spouses of men with prostate cancer described diversionary activities (e.g., doing household tasks, gardening, writing, traveling) as helpful for controlling anxiety. Therefore, although competing demands may create stress for spouses and partners of men with prostate cancer, the demands also can paradoxically be a source of stress reduction. Healthcare team members can begin a discussion and exploration of what women deem as stressful and define as stress relief as they attempt to help women rebalance their lives.

Under patient issues, spouses and partners reported the most pressing issues to be lack of or dysfunctional communication, fear or depression, and need for weight management for their husbands. Boehmer and Clark (2001) suggested that men's communication patterns were the same before and after a prostate cancer diagnosis. They also found that patients seldom communicated medical issues to their spouses; conversely, physicians sometimes included spouses to facilitate effective communication. The results reported in the current study reinforce the important contribution healthcare providers offer when they assist couples coping with prostate cancer. Preexisting spousal communication problems do not disappear in the face of a life-threatening illness and may be exacerbated.

A significant number of spouses and partners chose to work on treatment or side-effect issues. Previous research by Jacobs et al. (2002) found that spouses ranked medical decision making as their highest priority. Issues related to medical decision making take on greater importance with diseases like prostate cancer because multiple treatment options need to be considered and insufficient evidence exists to endorse one course of action strongly over another ("Comprehensive Cancer Control," 2004). The findings of the current study reinforce the idea that medical decision making is a concern of spouses and partners of patients with prostate cancer.

Overall, treatment and side-effect issues ranked third among the first problems reported and fourth among the second problems reported, which may reflect women's perceptions that little can be done to relieve post-treatment side effects. This finding is consistent with those by Jacobs et al.

Table 4. Descriptive Results of the Profile of Mood States Subscales and Profile of Mood States Total Mood Disturbance and Their Relationship to Problem Categories

	Problem Categories (N = 66)							
	Treatment and Side-Effect Issues (n = 17)		Patient Issues (n = 18)		Family Issues (n = 12)		Spouse Issues (n = 19)	
Subscale	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
Tension-Anxiety	10.76	10.09	12.44	6.90	9.67	7.61	9.24	5.47
Depression-Dejection	8.76	11.04	12.55	8.87	9.58	13.09	11.36	10.63
Anger-Hostility	6.59	6.79	12.88*	10.71	5.17	5.31	6.26	6.48
Vigor-Activity	18.35	7.98	15.22	5.66	18.41	8.00	16.47	6.11
Fatigue-Inertia	8.88	9.66	9.83	6.98	9.67	9.78	8.89	6.53
Confusion-Bewilderment	8.35	6.74	6.78	3.80	6.08	4.83	6.84	4.56
Total Mood Disturbance	25.00	46.57	39.27	33.26	21.75	44.29	26.14	34.40

* $p < 0.05$

(2002) in which spouses ranked treatment side effects, such as erectile dysfunction, lower than medical decision making and personal fears.

Although the literature reports that a supportive network can positively influence the quality of life of patients with cancer, the current study revealed that family and unwanted visitors also could be a source of distress. Family issues reported by spouses and partners primarily revolved around financially dependent children and the management of unwanted visitors, including in-laws. Visitors, especially unwanted ones, demand energy from patients and spouses. Gray et al. (2000b) suggested that visitors who moved the focus of conversation away from patients' health issues and onto normal, everyday topics are likely to be more successful in providing emotional support for patients and spouses.

In general, demographics were not related to problem choice, with the exception that women with more formal education were more likely to choose to work on family issues. Problem-solving skill level was not related to the types of problems on which the women chose to work. Women who chose to work on husband issues during PST exhibited higher levels of baseline mood disturbance (specifically, anger and hostility). These findings suggest that specifically attending to their husbands' or partners' illness and issues that revolved around it may be associated with elevated levels of anger and hostility and mood disturbance, perhaps because of frustration and less potential to actually make changes in this area. Although the cross-sectional design of this study limits the certainty of causal hypotheses, the alternative, that spouses or caregivers who have high scores on the Anger-Hostility subscale of the POMS would be more likely to focus on husband issues, is not necessarily a logical hypothesis.

Recently, Manne, Babb, Pinover, Horwitz, and Ebbert (2004) reported results of a psycho-educational group specifically designed to reduce distress in spouses of men with prostate cancer by improving adaptive coping and marital communication. Unfortunately, the intervention did not result in reduced distress in the treatment group relative to a control group. However, improvements in adaptive coping were demonstrated in addition to increases in spouses' sense of benefits derived from the experience. Additional research is needed to find effective interventions to assist spouses in their vital role of supporting patients.

Limitations

Although the current study provided new insight into problems faced by spouses and partners of patients with prostate cancer, addressing its limitations is important. Because of the relatively small sample size, readers must be cautious in making generalizations from the findings. In addition, because the study uses a retrospective exploratory design, the possibility always exists that participants might have responded differently had they been maintaining a running list of problems from which they summarized their conclusions about their problems. The sample is relatively high in education and income, and cultural and socioeconomic differences could create differences in spouses' identification and prioritization of prostate cancer–related problems. Another limitation is that those who self-elected to participate in the study demonstrated relatively high problem-solving skills at their baseline assessment. Couples who chose not to enroll may have had lower baseline problem-solving skills, and inclusion of those couples might have yielded different data and outcomes. Their underrepresentation is unfortunate because they were the group for whom the PST intervention may have been most beneficial.

Nursing Implications

When couples are coping with prostate cancer, guiding and nurturing spouses or partners can be an indirect but exceptionally useful way to lend support to the patient. The high frequency with which participants elected to work on spouse issues reinforces the idea that helping women balance their multiple demands can yield benefits for patients and spouses or partners. Anticipating the potential problems that can arise can help healthcare professionals initiate conversations with spouses and partners related to the problem-solving process and thereby help set the course for optimal problem solving. Although treatment-related side effects are often unavoidable, involving spouses in medical decision making and providing them with a comprehensive overview of the possible side effects can help prepare them for the challenges. Family and friends may seek to support patients throughout their illness, but that well-intentioned support also can have negative consequences that challenge spouses or partners. Healthcare providers can help patients and spouses or partners to identify which outside visitors are constructive to couples and how to handle those who are not and offer suggestions for directing conversations along the most constructive pathways.

Findings from this study offer insight into the array of problems faced by spouses and partners of patients with prostate cancer. The problems most commonly reported were specifically related to spouses or partners and revolved around maintaining balance and emotional well-being in their own lives while lending support to patients. Communication problems, treatment decisions, and side-effect issues also were important foci. Being attuned to the multifaceted nature of the problems with which spouses and partners of patients cope can help nurses to more efficiently explore how spouses and partners can benefit most from professional support and appropriate interventions.

The authors gratefully acknowledge all of the spouses and partners who shared intimate details about their lives during their participation in this study. The following institutions, organizations, and healthcare providers in San Diego County, CA, were very generous with their time and effort in helping recruit for the study: American Cancer Society; Kaiser Permanente; Naval Medical Center San Diego; Informed Prostate Cancer Support Group; Oncology Therapies of Vista; Prostate Cancer Research and Education Foundation; Radiation Medical Group; San Diego Prostate Cancer Support Group; Solana Beach Presbyterian Church; The Wellness Community San Diego; University of California, San Diego (UCSD), Selenium and Vitamin E Cancer Prevention Trial; UCSD Stein Institute for Research in Aging; and Veterans Health Administration San Diego. The following were key figures in recruitment: Christopher Amling, MD, Israel Barken, MD, Donald Fuller, MD, Robert W. Hathorn, MD, Peter Johnstone, MD, Mehdi Kamarei, MD, Francisco Pardo, MD, Carol Salem, MD, Marilyn Sanderson, RN, Joseph Schmidt, MD, Stephen Seagren, MD, Kenneth Shimizu, MD, Clayton Smiley, MD, and Reverend Tom Theriault, PhD. The authors also would like to acknowledge all of the undergraduate and graduate students who contributed time, energy, and hard work in completing this research project.

Author Contact: Georgia Robins Sadler, BSN, MBA, PhD, can be reached at gsadler@ucsd.edu, with copy to editor at ONFEditor@ons.org.

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