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Brief Report

Cognitive Existential Couple Therapy for newly diagnosed prostate cancer patients and their partners: a descriptive pilot study

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Abstract

***Objective*: This paper aims to describe 'Cognitive Existential Couple Therapy' (CECT), a novel couples-based intervention for men with early stage prostate cancer (PCa) and their partners, and to report preliminary findings from a pilot study that investigated the acceptability and feasibility of the intervention and the measures to be used in a subsequent randomised controlled trial.**

***Methods*: A manualised CECT programme was delivered to 12 couples facing a diagnosis of PCa within the previous 12 months by psychiatrists and clinical psychologists. Participants completed measures of psychological distress, marital function and coping pattern before and after CECT. Semi-structured interviews were conducted with nine couples shortly after the completion of CECT.**

***Results*: The application of CECT was both feasible and acceptable as indicated by favourable participant compliance (10 of the 12 couples attended all six designated sessions), completion of measures before and after CECT and participation in semi-structured interviews by nine couples. Preliminary results included reduced levels of avoidance and hyperarousal after the programme, with this effect stronger in partners than in patients. Interviews demonstrated that couples valued the therapist's contribution to their overall care.**

***Conclusions*: Previous research suggests that a couple-focused psychological intervention is desirable in the context of early stage PCa. This pilot study has established that CECT is acceptable, feasible and valued by couples facing a recent PCa diagnosis and demonstrates a potential for reduced psychological distress following CECT. A randomised controlled trial is currently being undertaken to validate the efficacy of this novel approach.**

Keywords: prostate cancer; oncology; couple therapy; psychological distress; carer

Introduction

The diagnosis of prostate cancer (PCa) can impose a great psychosocial burden for both the patient and his partner [1]. Patients commonly report feeling overwhelmed with uncertainty about how their diagnosis and treatment choices may affect their opportunity for cure and their physical and psychosocial functions [2]. It is well recognised that PCa treatments can adversely affect intimate aspects of a patient's relationship with their partner [3]. Intimacy and sexuality can be disrupted through persistent physical changes including impotence, loss of libido, urinary incontinence and bowel disturbance, which may, in turn, impact on perceptions of masculinity, changed work and social life and relationship difficulties [4].

Psychological aspects of PCa treatment remain a low priority in routine clinical practice, and many men continue to be vulnerable to poor mental health outcomes as they report they should 'buck up' and 'get over it' on their own [5]. Some men strive to cope with changes, albeit ineffectively, by avoiding any discussion of salient issues with their partners [6]. There is evidence that partners initially experience higher levels of psychological distress than the patients themselves and report deterioration in the relationship following diagnosis [7]. Moreover, partners appear to remain distressed when they use maladaptive coping patterns of avoidance or self-blame [8].

A recent systematic review of psychosocial interventions for men with PCa and their partners [9] identified five couple interventions tested by randomised controlled trials (RCTs) [10–14]. These interventions focused on sexual needs [12], post-treatment symptom management or support [13,14] and coping skills [10,11]. Few significant changes were reported for patient or partner psychosocial function. We surmised that greater levels of improvement were not achieved because they were of insufficient intensity and duration, did not use mental health professionals to deliver the intervention, did not grapple with the patient–partner relationship directly or were not appropriately theoretically grounded.

The primary aim of this pilot project was to determine the acceptability and feasibility of a novel intervention, Cognitive Existential Couple Therapy (CECT), for recently diagnosed early-stage PCa couples. Our secondary aim was to ensure that the selected measures were acceptable and would enable us to explore changes in psychological function. We hypothesised that our couples-based intervention would be acceptable to the men and their partners and would result in reduced psychological distress, more adaptive coping and improved quality of relating.

Methods

Participants

The study was approved by Peter MacCallum Human Research Ethics Committee. Participants included 12 men undergoing treatment for early-stage PCa and their partners. Inclusion criteria included the following: (i) a recent diagnosis of PCa localised to the prostate gland (T1–T3, NO, MO); (ii) couples were married or living together for at least one year; and (iii) competent use of English. Couples were ineligible if either member had another active cancer or debilitating illness, an intellectual disability/dementia or psychotic disorder, or the couple was known by the treating team to have intractable relational dysfunction, such as a history of domestic violence or present separation.

Procedure

Participants were recruited during a follow-up visit with their oncologist/surgeon at the Peter MacCallum Cancer Centre (Melbourne, Australia). The study employed a pre-test, post-test single-group design whereby patients and partners independently completed measures before and after CECT. All but one of the couples who completed CECT were asked to participate in a semi-structured interview exploring their experience.

CECT intervention

Cognitive Existential Couple Therapy was adapted from a manualised group format (Cognitive Existential Group Therapy; CEGT), previously validated in early stage breast cancer [15], which integrates Moorey and Greer's cognitive–behavioural approach to coping with cancer [16] with Spiegel's supportive–expressive model [17]. It aims to address key existential and functional themes including the following: (i) death anxiety; (ii) fear of recurrence and living with uncertainty; (iii) coping with cancer treatments and their side effects; (iv) the impact of the diagnosis and treatment on the couple's relationship, including sexual impact; (v) relating with medical and other professional staff; (vi) family concerns; (vii) body-image and self-image concerns; and (viii) lifestyle effects and future goals.

The programme comprised six weekly 90-minute treatment sessions conducted privately for couples by mental health professionals (clinical psychologists and psychiatrists) (Table 1). The treatment was manualised and semi-structured but maintained some flexibility to address concerns nominated by individual couples on a brief questionnaire administered at the end of the first session (Table 2).

Couples were assigned homework tasks following sessions two to five. All intervention sessions were audio-recorded, and samples of the tapes were reviewed by team members not involved as therapists to aid the fidelity of intervention delivery. The therapists were supervised regularly and received feedback by one of the investigators with experience using CEGT.

Measures

Demographic data

Basic demographic information was obtained by self-report.

Table 1. The six CECT sessions and their corresponding themes

Session	Themes
1. Telling their story of PCa and its effects on their lives so far	Exploring aspects such as physical and psychological changes, changing care needs, managing symptoms
2. Communicating openly and honestly	Considering helpful and unhelpful communication patterns, analysing what works for the couple
3. Promoting mutual support	Investigating ways of promoting support between partners and from others, including family members, friends, the health team and the community
4. Coping with the future – an existential dimension	Understanding changes in life as a result of PCa, reordering priorities, reviewing existential outlook
5. Coping adaptively with PCa and its challenges	Exploring how the partners have coped with past adversity, considering the novel challenges of PCa, examining ways to cope better – by patient, partner and the couple
6. Reviewing and previewing	Synthesising the knowledge in previous sessions, reviewing what has been gained and what remains unfinished, planning for the future

PCa, prostate cancer.

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Table 2. Introductory survey to tailor CECT to couples' needs

Theme	Does this interest or concern you? *Circle yes, perhaps or no*			Please elaborate if you wish	
1. To obtain more information about prostate cancer and your (or your partner's) health needs	Yes	Perhaps	No		
2. To discuss your reactions, feelings and coping techniques	Yes	Perhaps	No		
3. To discuss the impact prostate cancer has on your (or your partner's) body and self-image	Yes	Perhaps	No		
4. To discuss the meaning of the cancer and its effect on your life	Yes	Perhaps	No		
5. To discuss concerns about your relationship with your partner	Yes	Perhaps	No		
6. To discuss sexual difficulties	Yes	Perhaps	No		
7. To discuss family matters, roles and children	Yes	Perhaps	No		
8. To share concerns about death and dying	Yes	Perhaps	No		
9. To discuss your future goals	Yes	Perhaps	No		
Other issues:					
10.					
11.					
12.					
13.					
Please select five themes that you would most value dealing with in therapy by placing their numbers in the adjoining boxes	☐	☐	☐	☐	☐

Treatment acceptability

Participant compliance rates (proportion of participants retained through the entire CECT programme) were recorded as an indicator of treatment acceptability. Nine couples completed semi-structured interviews exploring their experience of CECT.

Psychological distress

The Mental Health Inventory (MHI) [18] is a 38-item measure that includes a global mental health index and subscales of distress (depression and anxiety), well-being (positive affect and belonging) and cognitive functioning. The MHI has good validity and reliability and has been widely used with cancer patients [19].

The Impact of Events Scale – Revised (IES-R) [20] is a 22-item measure of the overall experience of a traumatic life event (the PCa diagnosis). The IES-R contains dimensions of psychosocial distress that are absent from traditional measures of depression and anxiety and has been well validated for use in general cancer groups including PCa couples [21].

Marital function

The Family Relationship Index (FRI) [22] is a 12-item measure assessing family function, including cohesion, expressiveness and conflict resolution. Our previous observational work with PCa couples found the FRI to have good acceptability [8].

The Cancer Support Inventory (CSI) [23] is a 65-item measure that was adapted to assess how partners rate their spouses' support, in relation to the PCa experience. With high internal consistency and construct validity, its value has been established in studies involving couples affected by cancer [24].

Coping

Brief Cope (BCOPE) [25] measured how participants coped with PCa, assessing 14 coping responses known to be either adaptive (e.g. positive re-framing, acceptance) or dysfunctional (e.g. substance use, self-blame). Derived from the 60-item COPE inventory, the BCOPE has good psychometric properties and has been utilised in other studies of PCa patients and their partners [10,21].

The revised Benefit-Finding Scale (BFS) [26] is a 17-item measure that assessed the perception that positive contributions resulted from the cancer experience. It has been validated in men with localised PCa, where early benefit finding has been positively associated with active coping strategies [27] and is a predictor of better psychosocial well-being.

Statistical analysis

Analyses were performed on data from 10 couples who provided complete data sets. Baseline demographic information was summarised using descriptive statistics. Intraclass correlations were calculated to ascertain the independence of the patients' and their partners' data, and in the absence of any significant correlations, patients' and partners' responses were treated as independent ($N=20$). Despite the usual assumption of interdependence, it was expected that patient and partner responses would be independent, based on our earlier clinical observations [7]. Changes in scores on outcome measures as a function of time and couple status (patient versus partner) were examined by repeated-measures multivariate analysis of variance, with repeated-measures factor of time (before/after intervention) and a between group factor of partner versus patient. Significance was assumed using an alpha level of 0.05 for the purpose of exploring the data, ensuring any small effect sizes were not missed, despite an inflated chance of obtaining Type

I errors. Treatment acceptability was evaluated by computing summary statistics on participant retention and treatment compliance.

Results

Participant characteristics

Twelve couples were enrolled (all partners were women), and 10 couples (median age = 64 years, *SD* = 8) completed the CECT programme and the pre-questionnaires and post-questionnaires in an average time of 71 days. Of the 10 patients, seven had tertiary education; five were retired and five were working. Of the 10 partners, six were working and four were retired. The patients had received various treatment types; six men had radiation therapy and four had various combinations of radiation therapy, hormone therapy and surgery.

Treatment acceptability

The CECT intervention was acceptable to couples as indicated by participant retention (10 of the 12 couples who consented received the entire treatment). The two couples who withdrew (one after the first and the other after the second session) reported they had no areas of concern when completing the introductory questionnaire and therefore did not feel it was necessary to continue. All measures were completed before and after CECT by the 20 participants, suggesting that the tasks were not too onerous and were feasible for use in a larger study.

Nine out of 10 participating couples who agreed to be interviewed about their experience of CECT revealed that it had been of value. They reported subjective benefits from addressing personal and emotional concerns, consolidating their relationships, increasing open communication about the cancer and its effects, validating their emotional reactions towards the cancer and establishing new priorities. A fuller analysis of these interviews is in preparation.

Psychological factors

Multivariate analyses indicated that the overall negative impact of the PCa experience, as measured by IES-R, was lower at time 2 (after CECT) than at time 1 (before CECT) in patients and in partners ($p = 0.013$). Other significant effects included a decrease in avoidance ($p = 0.021$) and in hyperarousal ($p = 0.019$) at time 2 in both patients and partners, indicating improved psychological function after CECT intervention. There were no significant changes observed on the intrusion subscale. Non-significant trends observed in univariate analyses suggested that the PCa had a greater negative impact in partners than in patients in the months after diagnosis ($p = 0.087$) and that this negative impact decreased in partners but not in patients ($p = 0.068$). No statistically significant differences were found for the sample as a whole by multivariate analyses conducted on the MHI, FRI, CSI, BCOPE and BFS measures.

Discussion

The primary objective of this study was to determine whether CECT is an acceptable approach for PCa patients and their partners and could feasibly be delivered in a comprehensive cancer care setting. CECT appears to be an acceptable treatment approach. Ten couples completed all treatment sessions and measures, and nine participating couples spoke of the benefits in structured interviews. An RCT is currently being undertaken to test the efficacy of this approach.

Our pilot study suggests that CECT can effectively address the key issue of patient and partner distress and patient-favoured avoidance coping identified in previous research [6], albeit with a greater initial benefit for partners than for patients. We are encouraged that despite the small sample, significant effects were found on patients' and partners' psychological responses of avoidance and hyperarousal to the threatening events and that the overall negative impact of the PCa diagnosis was lessened for couples following CECT. The way in which couples communicate their cancer-related concerns has been found to either facilitate or reduce relationship closeness, which, in turn, impacts psychological distress [3]. Facilitating healthy spousal communication about specific PCa issues can maintain better marital satisfaction, even when patients or partners are individually dissatisfied with their sexual relationship [28].

The changes we found in psychological distress on the IES-R need to be treated with caution in view of the small sample size and short time span between the second measure and the conclusion of CECT. Because it was a pilot study, the design did not include a control group; thus, we are unable to confirm specific, rather than common factor, intervention effects. Moreover, no evaluation for between-group facilitator effects was conducted because of the small numbers undertaken by each therapist. These omissions will be rectified in a RCT study.

Despite the acknowledged limitations, we believe the current treatment approach is a promising strategy for couples affected by early stage PCa. It has the flexibility to allow therapists to target the sessions to couples' specific needs and individual's levels of distress and symptoms [29]. It provides for the inclusion of partners and their treatment as co-recipients of care [10]. Sessions are *private*, as opposed to group, allowing couples to address the personal and private nature of the issues affecting them. Moreover, CECT utilises a relevant and fruitful theory-driven cognitive framework that has been positively linked with effectiveness in other treatment groups [29]. Finally, the attrition rate in the pilot study (17%) is favourable compared with that in other intervention studies where men with PCa were enrolled later after completion of treatment (24–54%) [29].

Men with early stage PCa appear to be amenable to an appropriately designed psychological intervention that includes partners, and there are promising signs that couples can benefit from such an intervention psychologically. If the RCT can replicate the effects found in this pilot study and demonstrate that they can be sustained over time, it will encourage advocacy for routine psychological support of this type for all couples facing a PCa diagnosis.

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