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Webinar

# Prostate Cancer – effects on mental health after surgery

**Thursday, 1st March 2018**

"Working together. Working better."

Supported by The Royal Australian College of General Practitioners, the Australian Psychological Society, the Australian College of Mental Health Nurses and The Royal Australian and New Zealand College of Psychiatrists

## Tonight's panel

**Dr. Jane Crowe**
General Practitioner

**Dr. Declan Murphy**
Urologist

**Samantha Clutton**
Psychologist

## Facilitator

**Dr. Mary Emeleus**
General Practitioner

***Audience tip:***
To open the chat box, click the "Open Chat" tab located at the bottom right. The chat will open in a new browser window.

## Ground Rules

To help ensure everyone has the opportunity to gain the most from the live webinar, we ask that all participants consider the following ground rules:

- **Be respectful of other participants and panellists**. Behave as you would in a face-to-face activity.
- You may interact with each other by using the **participant chat box**. As a courtesy to other participants and the panel, keep your comments on topic. Please note that if you post your technical issues in the participant chat box you may not be responded to.

***Audience tip:***
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## Ground Rules cont.

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## Learning Outcomes

Through an exploration of prostate cancer the webinar will provide participants with the opportunity to:

- identify challenges, tips and strategies for building appropriate referral pathways and implementing a collaborative response to assist men having mental health difficulties after surgery for prostate cancer
- implement key principles of providing appropriate therapies and communication approaches to men who have had surgery for prostate cancer
- describe the general principles of providing a safe and supportive environment for men experiencing mental health concerns after surgery for prostate cancer.

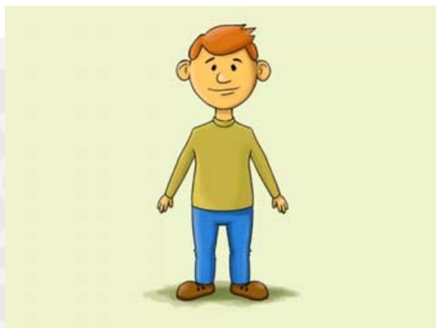
***Audience tip:***
The PowerPoint slideshow, Peter's story and supporting resources can be found in the Resources Library tab at the bottom right.



## General Practitioner perspective

### Peter has prostate cancer and is not coping very well

### Role of GP



Jane Crowe

## General Practitioner perspective

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#### Role of GP

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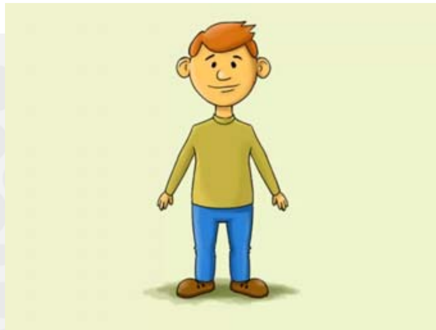

Jane Crowe



## General Practitioner perspective

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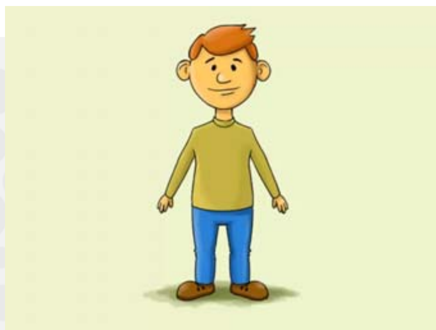

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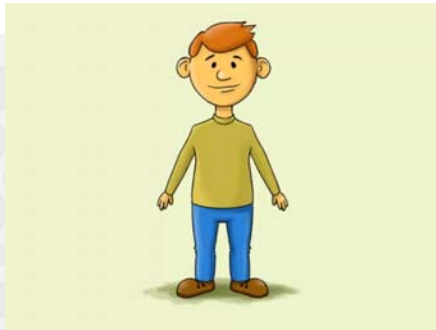

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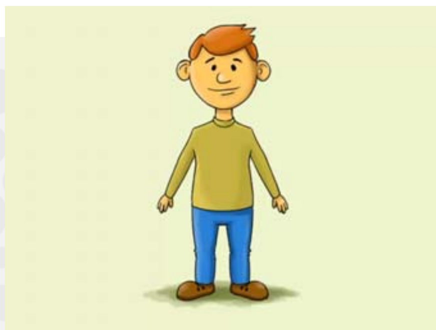

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   - Use of EPC item numbers : GPMP/TCA and GP mental health care plans.

Jane Crowe

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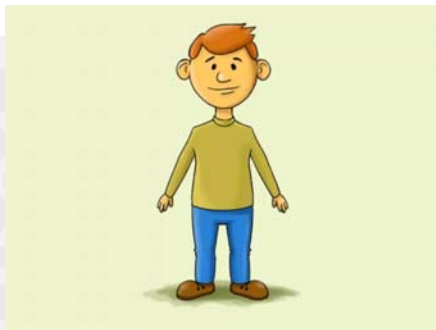

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4. Co ordinate care and help him navigate the healthcare system
   - Use of EPC item numbers : GPMP/TCA and GP mental health care plans
5. Manage rest of Peter's health
   - Eg. smoking, alcohol intake, weight, diet, BP...

Jane Crowe

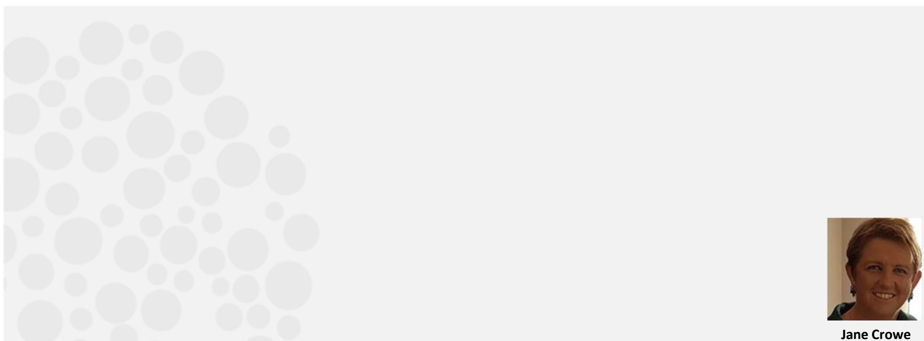


## General Practitioner perspective

### Stage 1: Elevated PSA. Diagnosis uncertain

**Issues:** Peter knows he has an elevated PSA and is now very anxious about what this means.

**Result:** Treatment delay, frustration for Ann, arguments.



Jane Crowe

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**GP Role:**

1. Try and avoid the amount of anxiety for Peter from the outset when counselling him about prostate cancer testing, even before he has the test.

   "If a PSA is elevated we routinely check it again within 3 months and refer if it remains elevated for sorting out".

Jane Crowe



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2. Manage expectations and educate about what happens if the PSA is elevated and a referral is made. What a biopsy entails and what happens if cancer is found on the biopsy.

Jane Crowe

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Jane Crowe

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4. Gauge his level of distress and manage this if high. If distress++ (BEFORE DX) ? psychology at this stage.

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5. Call him if he ignores SMS reminders.

Jane Crowe



# General Practitioner perspective

## Stage 2: Prostate cancer diagnosed

**Issues**: Peter has high grade prostate cancer and will have a radical robotic prostatectomy.

**GP Role:**
May be limited during treatment phase.
Opportunity to phone Peter and ask if he would like to come for an appointment (I suspect he probably won't!)

Jane Crowe

# General Practitioner perspective

## Stage 2: Prostate cancer diagnosed

**Issues**: Peter has high grade prostate cancer and will have a radical robotic prostatectomy.

**GP Role:**
May be limited during treatment phase.
Opportunity to phone Peter and ask if he would like to come for an appointment (I suspect he probably won't!)

1. Let him know you are interested and care about what is going on.
2. What are his expectations with his recovery? Continence, erectile function, time off work.
3. Has he been told about continence physiotherapy, penile rehabilitation?
4. How are his other domains? Family, work, any financial stress?
5. Has he been offered a referral to a psychologist?

**MANAGE EXPECTATIONS** **ENSURE/ENCOURAGE ALLIED HEALTH INPUT.**

Jane Crowe



# General Practitioner perspective

## Stage 3: Recovery and Survivorship

**Issues**: PSA undetectable, depressed, existential issues, urinary urgency and bother, erectile dysfunction (ED), sexual intimacy, relationship problems , partner distress.

**GP Role** : Peter and Ann need help!!!! Require multidisciplinary team care.

Jane Crowe

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Jane Crowe



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4. Exercise prescription: Exercise physiologist: Mood, better cancer outcome, sexual dysfunction, overall health.

Jane Crowe

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**GP:**

- Review and facilitate Mx of mood/relationship/sexual/continence problems. Co ordinate care.
- Clarify post cancer Rx surveillance protocol and ensure adherence via recall/reminder systems.
- Maintain hope.

Jane Crowe



# Urologist perspective

Declan Murphy

# Psychologist perspective

## Psychological Intervention - Key Ingredients

- Basic knowledge of prostate cancer and treatment effects.
- Understanding of 'normal' (individual and couple) psychological adjustment to prostate cancer and surgery.
- Willingness to work with couple – not just individual.
- Ability to quickly foster a therapeutic alliance.
- Access to multi-disciplinary team for cross-referral.

Samantha Clutton



# Psychologist perspective

## Adjustment to Prostate Cancer - Men

- At diagnosis – men experience strong, fluctuating and unfamiliar emotions.
- Most return to normal levels of psychological health and life satisfaction (despite persistent effects of treatment) within weeks of dx/treatment decision.
- A significant minority of men experience distress that increases over time.
- Many relationships are placed under stress.
- Risk factors for poorer adjustment
  - younger age at time of diagnosis
  - persistent urinary and sexual side-effects
  - more traditional masculine identity
  - avoidance as a way of coping
  - reduced expressions of love and intimacy.

Samantha Clutton

# Psychologist perspective

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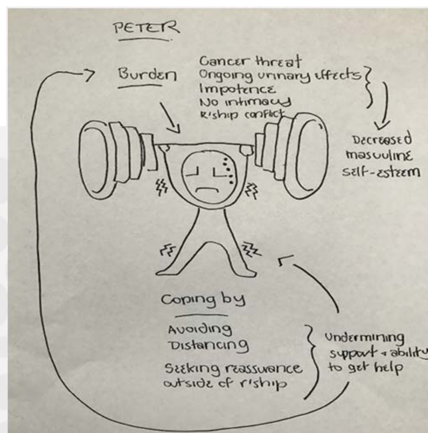
## Formulation




- Transactional Theory of Stress and Coping
  - Perceived threat
  - Perceived ability to cope
  - Mismatch between demands of situation and ways of coping
  - This results in both additional burden and reduced capacity.

Samantha Clutton



# Psychologist perspective

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## Therapy – with couple

**Issue**

- Peter's reluctance to engage.
- Threat of cancer.
- Depression / low self-esteem.
- Peter's infidelity.

**Intervention**

- Normalise issues and demystify therapy
  - Many men/couples experience similar issues.
  - Practical and evidence based steps to improve situation.
  - Link engagement to his desire to protect Ann and relationship.
- Gently assess fears and source of these
  - Ensure has a realistic (vs overly negative appraisal) and direct to accurate information sources (? GP, Urologist).
  - Providing a safe experience of turning towards (versus avoiding) thoughts & feeling regarding cancer.
  - Allow Ann to hear (assist with accurate reflection).

- Assess and address
  - Values – address barriers to engaging in valued activities.
  - Consider referral back to GP for anti-depressant medication and/or individual therapy.
  - ? Exercise – refer to exercise physiologist.
- Address reasons and attempt repair
  - ? Linked to efforts to increase potency "use it or lose it" and to increase masculine self-esteem.
  - Ensure Peter hears Ann's hurt and needs for reassurance.

Samantha Clutton

# Psychologist perspective

## Therapy – with couple (continued)

**Issue**

- Withdrawal from intimacy
- Relationship isolation and conflict
- Ongoing physical effects of treatment

**Intervention**

- Challenge misperceptions and explore alternatives
  - Effort to "protect" leading to NO physical expression of love – Ann reacting to misunderstanding
  - Address misperception that Ann relies on penetrative sex to achieve satisfaction
  - Explore alternative ways to be intimate
- Enhance communication and support
  - Speaker listener skills
  - Schedule regular (weekly) time to practice
  - Practical ways can show support – gain commitment to try
- Address barriers to accessing appropriate rehab
  - Avoidant coping preventing from acknowledging and engaging in optimal rehab
  - Provide reliable sources of information
  - Consider referral to specialist physio, prostate cancer/continence nurse, specialist sex therapist

Samantha Clutton



# Q&A Session

## Tonight's panel

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General Practitioner

**Dr. Declan Murphy**
Urologist

**Samantha Clutton**
Psychologist

## Facilitator

**Dr. Mary Emeleus**
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# Thank you for your participation

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- Each participant will be sent a link to the online resources associated with this webinar within two weeks.

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**Thank you for your contribution and participation**

**Good evening**

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