

This is the peer reviewed version of the following article: Forbat, L., Robertson, J. and McNamee, P. (2018), Couple therapy following prostate cancer surgery: a manual to guide treatment. *Journal of Family Therapy*, 40: S86–S110, which has been published in final form at <https://doi.org/10.1111/1467-6427.12129>. This article may be used for non-commercial purposes in accordance With Wiley Terms and Conditions for self-archiving.

Title: Couple therapy following prostate cancer surgery: A manual to guide treatment

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Abstract

Prostate cancer is the third most common cancer in the UK. Ten-year survival is high; consequently a service priority is addressing survivorship issues to support men living with the longer term consequences of the disease and its treatments. This paper presents a treatment manual which has been tested with couples following prostate cancer surgery to decrease distress in sexual functioning, and improve relational functioning. The content of the manual is described alongside a fictionalised case vignette that illustrates the content and process of sessions. The paper presents the RIPSToP Model (**R**elational **PS**ychosexual **T**reatment for couples with **P**rostate cancer).

The manual was developed and piloted in a mixed-method feasibility and acceptability randomised pilot control trial. Qualitative interviews with clinicians delivering the intervention indicate that the manual was acceptable.

Trial registration: ClinicalTrials.gov Identifier: NCT01842438.

Practitioner Points:

- A systemic manual for supporting couples after prostate cancer surgery has been developed.
- The manual presents a new model, derived from the literature, focusing on family context and the couple dynamic.
- The model impacts psychological wellbeing, relationship functioning and distress related to sexual functioning.

- Practitioners reported positive views of the manual and adhered to its content and structure.

Background

Prostate cancer is the third most common cancer in the UK, with over 42,000 men being diagnosed with this disease in the UK annually (CRUK, 2014a). Survival from prostate cancer is high. Five and ten year survival rates are over 84% and 85% respectively, compared with 50% survival rates across all cancers (CRUK, 2014b). Consequently, a service priority is addressing survivorship issues as these men, and their partners, learn to live with the longer term consequences of the disease and treatments.

Removal of the prostate gland (prostatectomy) is currently a dominant treatment approach for prostate cancer (Djavan et al., 2007). However, surgery often results in erectile dysfunction (Penson et al., 2008), and most men have not returned to their baseline measure of sexual function two years after surgery (Levinson et al., 2011). Long-lasting sexual and urinary difficulties are the most common and troubling side-effects following prostatectomy (Stensvold et al., 2013).

Anxiety, depression (De Sousa et al., 2012; Nelson et al., 2011), and reduced quality-of-life due to changes in urinary and sexual body-image (Harrington, 2011) are common following prostate cancer surgery. Partners of prostate cancer patients also experience considerable psychological distress (Couper et al., 2006; Hutchison et al., 2011; Northouse et al., 2007; Soloway et al., 2005). The difficulties experienced after surgery can impact on couples' relationships; for instance, erectile dysfunction is associated with reduced wellbeing (Ezer et al., 2012; Segrin et al., 2012) and lower levels of dyadic adjustment after surgery (Pereira et al., 2011).

Couples affected by prostate cancer often have significant unmet psychosexual supportive care needs around sexual recovery and rehabilitation (Forbat et al., 2012; Steginga et al., 2001).

Recognition of the impact of sexual dysfunction on relationships has led to the development of couple-based psychosocial interventions (Collins et al., 2013). Previous interventions for couples affected by prostate cancer have targeted sexual functioning (Titta et al., 2006), relationship

functioning (Manne et al., 2011), or combined both aspects (McCorkle et al., 2007; Northouse et al., 2007; Canada et al., 2005; Campbell et al., 2007; Giesler et al., 2005). Sexual rehabilitation therapy has been particularly helpful in increasing use of erectile dysfunction medications (Canada et al., 2005) and re-establishing a sexual relationship (Bronner et al., 2010; Titta et al., 2006).

Devising an intervention framework that has a lasting impact on sexual *and* emotional aspects of the couple relationship is a priority for research (Chisholm et al., 2012). Understanding family-of-origin relationships may be important in supporting sexual functioning in marriage (Strait et al., 2015), and when addressing sexual issues, it is critical to support the relationship more generally (Carr, 2009). Consequently, an approach which is family-relational and psychosexual combines key elements of a potentially fruitful intervention. This paper describes the treatment manual which was developed to address these issues, and which was tested in a pilot feasibility randomised control trial.

While recognising reservations about the tyrannical narrowness of evidence based medicine (Greenhalgh et al., 2015), a mixed method study was adopted to develop and test a manualised approach to supporting couples post prostate cancer surgery. A manualised approach was sought in order to provide evidence which is considered robust by research funders and health service commissioners. Manuals are increasingly being used in clinical practice across therapeutic modalities, and are thereby contributing to the evidence base for therapeutic interventions (Crits-Christoph et al., 2009; Fluckiger et al., 2012; Lusk & Melnyk., 2011; Weck et al., 2011). A recent paper indicates that therapists who use manuals are more positive about them than practitioners without such exposure (Forbat et al., 2015), which provides some assurance that while trials may struggle to claim untainted objectivity, manuals themselves may be an acceptable format of sharing approaches to treatment. Consequently, a manual was developed and its content, theoretical underpinnings, acceptability and feasibility are reported in this paper.

Methods

The full study protocol has been published (Author et al., 2014). However, in brief, the intervention consisted of six sessions (Campbell et al., 2007; Giesler et al., 2005) held at two-to-three week intervals (Northouse et al., 2007) by registered therapy practitioners. The intervention was delivered in third-sector premises, away from the pressures of a busy outpatient hospital urology clinic where there is usually limited time to discuss psychosexual concerns during healthcare consultations (Flynn et al., 2012; Forbat et al., 2012). 43 couples were randomised to the two arm trial of couple support or treatment as usual. Thirty-two couples remained in the trial until completion, with 16 couples in the intervention arm.

Development of the intervention

A treatment manual was developed to guide delivery of the intervention. The manual comprised information about prostate cancer and its effects, principles of therapeutic change, guidance on using the manual and a detailed session structure plan. This manual was based on systemic principles combined with techniques from sex therapy i.e. sensate focus (Sidnell, 2010). Therefore the manual aimed to integrate systemic theory with elements of sex therapy to support intimacy and emotional aspects of the couple relationship. The manual offered an intermediate level of specificity, enabling clinicians to use their own therapeutic style and take some lead from the couple, while meeting the objectives of the intervention. The manual is described in more detail later in this paper.

Training in the intervention

Specialist training for clinicians delivering the intervention was provided by a systemic therapist, research assistant and men who had all received a diagnosis and treatment for prostate cancer in addition to one partner. Training included patients and one partner affected by prostate cancer talking candidly about their experiences of cancer and the psychosexual consequences, and then

engaging in an open question and answer session with the clinicians. The training included discussion of fictionalised vignettes, alongside the model of change and briefings on systemic approaches to clinical practice. Bespoke exercises in discussing psychosexual issues were integrated into the training to encourage clinician comfort and familiarity with talking about sex and intimacy. A final part of the training day involved consideration of the pragmatic and practical elements of the trial, such as record keeping, sharing of outcome measure scores and managing missed sessions. Clinicians engaged in their routine supervision for clinical aspects of the study, with additional team supervision being offered by one of the practitioners involved in the study. An additional training session in sensate focus was offered by one of the practitioners who was competent in this skill.

Participants and measures

Inclusion criteria for couples to be enrolled on the trial were that the patient should: be within ≥ 11 weeks and < 4 years post-surgery for prostate cancer, have a prognosis of over one year, and live in the health board where the intervention was delivered, or in an adjacent health board (to minimise excess travel). All patients needed to have a partner (same or different sex) since the study required an on-going commitment of both patient and partner to attend the intervention. Finally, patients must have scored ≤ 60 (the clinical threshold for potency) on the sexual function domain of the Expanded Prostate Cancer Index Composite (EPIC), which is a well-established validated quality-of-life tool (Wei et al., 2000).

The primary outcome measure was the sexual distress sub-scale in EPIC. Secondary outcome measures included the HADS (Zigmond and Snaith., 1983), Score-15 (Stratton et al., 2014) and a bespoke questionnaire eliciting health service usage in order to gain insight into the economic implications of the intervention. Demographic information was collected at baseline.

Clinicians' experience ranged from recently qualified to over 11 years of practice. Their professional training included psychodynamic, person-centred, integrative and systemic practice.

An adherence checklist was completed by practitioners to document fidelity to the manual. Clinicians recorded ratings from 0-10 to describe the degree to which they had met the sub-objectives of each session, thereby capturing the depth to which each element of the intervention was covered in the session, rather than only whether the area had been discussed. The adherence data was analysed using descriptive statistics. Lowest rated components were identified in this way, highlighting the sections of the manual where practitioners were least faithful to the manual, and which would consequently require modification, or increased training, in any scaled-up trial or implementation.

Analysis

Although the purpose of this pilot feasibility trial was not to estimate the efficacy of the intervention, change in scores on outcome measures were analysed using within-between ANOVAs on SPSS (version 19) to understand the trends in the data. Differences in mean scores on all outcome measures enabled clinically significant changes to be observed and explored.

The significance level applied to all analyses was set at an alpha level of 0.05. Qualitative data were managed in NVivo (version 10) and analysed thematically (Braun and Clarke, 2006). The main outcomes have been reported (Author, 2016).

Ethical permissions

NHS Research Ethics approval was granted by (name of REC to be added after peer review) (12/WS/0255). Informed consent was provided by all participants, with written consent gained from all couples and practitioners. All identifiable details have been removed and data anonymised. The couples randomised to the treatment as usual/control group were offered the intervention after all analysis had been completed and demonstrated that the couple support had been helpful.

The manual

In this section, the manual, model and fictional case vignettes are presented in turn to provide a detailed understanding of the content of the intervention. These details offer in depth contextualisation of the process of change and evidence of credibility, before briefly presenting the findings relating specifically to the therapists' views of delivering the intervention.

The manual was informed by published systemic treatment manuals (Pote et al., 2015; Jones and Asen., 2000). It provided a guide through prostate cancer, its physical and psychological impacts on men and their partners, principles of systemic therapeutic change, and a sequence of session plans for supporting couples through discussions of the impact of the disease. These session plans provided the template for the adherence checklist provided to practitioners.

Designing the manual led to the development of The RIPSToP Model (**Relational PSychosexual Treatment for couples with Prostate cancer**), which is illustrated in Figure 1 below. The model comprises two components (therapeutic content and therapeutic process) which inform the process of change within sessions. This adjustment is achieved by therapeutically addressing the wider family impact, the context of the disease and the couple dynamic to provide a framework for supporting couples as a dyad that includes their sexual relationship.

----Insert Figure 1 here---

This new model is derived from a synthesis of systemic approaches to physical health, for example, the Family Systems Illness Model (Rolland, 1994a; 1994b) and Family Focused Grief Therapy (Kissane and Bloch, 2002) and is informed by the wealth of couple interventions in oncology settings.

The model is built on a recognition that the intervention must begin from the couple's starting point. Consequently, understanding the family and wider context sits at the top of the diagram indicating how its impact cascades into other components. The context is comprised of elements familiar to systemic approaches including consideration of family dynamics, dimensions of social difference

(such as gender, class, age, race, ethnicity), language/narratives and family/cultural beliefs about illness. Added to this is a further contextual component of the disease stage, onset and prognosis. These medical factors are described by Rolland (1994b) as part of the psychosocial typology of illness. Stage (whether contained, or metastatic), onset (whether acute such as presentation to hospital with urinary retention, or chronic such as years of frequent urination) and prognosis (whether curable through surgery alone, or advanced disease that will shorten life-expectancy considerably) all impact on the psychosocial, emotional and relational experience of the disease. Consequently, these medical aspects of context form an important backdrop to the couple's coping. Three core elements of the couple dynamic combine in the centre of the model: dyadic adjustment (Reese et al., 2010; Goodwin et al., 2012; Mishel et al., 2002; Zhou et al., 2011), communication (Zaider & Kissane 2010; Manne et al., 2011; Porter et al., 2009) and emotional disclosure and intimacy (Manne et al., 2004; Porter et al., 2012).

Relational and psychosexual concerns were core outcomes for the intervention and therefore form an important component to the model. Consequently, psychological wellbeing, sexual distress and relationship functioning were foci for the outcome measures of the intervention, and form the lower part of the model into which other elements lead.

The cyclical and flowing nature of the model illustrates the recursive relationship each component has to the others; the model therefore demonstrates a core sense of the interconnectivity, including the primary and secondary outcomes for the intervention.

The session structure for the intervention is summarised in Table 1, alongside illustrative feedback from practitioners on how they experienced that session and use of the manual. The model was supported by detailed fictionalised case vignettes. The vignettes were developed for the intervention drawing on clinical experience with this patient group, in order to inform the training on the manual and support clinicians in interpreting the manual during the course of the trial.

----Insert Table 1 here ----

An abridged vignette illustrating sessions three and four:

Robert has advanced prostate cancer, and both he and his wife Magda share an understanding that prostate cancer will shorten his life. The news about his prognosis came as a shock to them both. They are slowly coming to terms with what this means for their retirement plans. Robert has taken early retirement on health grounds from his job in corporate finance, which has left him feeling that he is unable to contribute to the household by bringing in a wage, and that he has left work 'undone' and unfinished.

He is clear though in recognising that he was unable to keep working. The side-effects from treatment, including fatigue and back pain, were too much to cope with, in addition to the incontinence he frequently faces.

The sessions mid-way through the intervention offer an opportunity to hear about the couple's previous experiences with illness, loss and caregiving. These sessions also create space to ask more about how previous generations adjusted to illness and expressions of affection in later life (including in the context of illness). Both these topics help set the scene for later discussion about their own intimacy and adjustment, enabling the couple to consider what has been handed down across generations and what they have chosen to do differently.

The genogram creates space to talk about a range of concerns and worries which they are both holding. For example, for Robert and Magda, the genogram helps identify that Robert's family has an intergenerational pattern of death by illness in the sixth decade of life. Robert states that he is worried that 'history may repeat itself' and that he will die soon, rather than having the five to eight years that the consultant has predicted.

---Insert Figure 2 here---

Therapist: [working on a genogram with the couple] so you are now 62, and your father died when he was 60, and your mum died when she was 61. What does it mean that you have out-lived your father?

Robert: Not a lot, though it is encouraging that my older brother beat prostate cancer, so he seems to be living through his early 60s. I'm afraid I don't have much time left. And not much time left with Magda.

Therapist: It is interesting that no-one in the family seems to have broken the mould of living into their mid-60s. I'm wondering what these previous losses have been like for the family. Was your father ill for a long time before he passed away, or was it a short illness?

Robert: He went rapidly down-hill all of a sudden. He had not long since retired as a post office worker, then all of a sudden he was struggling for breath and the doctor said it was his heart. He had a massive heart attack one day, and that was that. I was there when he collapsed.

Magda: Yes, I was there too, it was such a terrible shock. It was a Sunday afternoon and we'd just finished our Sunday lunch together. He got up from the table and just collapsed.

Robert: It was all so sudden.

Therapist: That is sudden. Did it mean that you didn't have a chance to say goodbye?

Robert: Yes, there was no time. One minute he was eating his trifle, the next he was on the floor. [Magda is nodding]

Therapist: You mentioned that you were worried that there wasn't much time to spend with Magda now for you. Is that a worry that you both share?

Magda: I don't think Robert's time will come so suddenly. We've a bit more time I think to prepare, which is why we are here, I suppose.

The couple then go on to think about caregiving and the role of others in the family when someone becomes unwell. Magda has been looking after her parents for a long time, and Robert supports her by gardening and buying his in-laws weekly groceries.

Having a progressive illness affords opportunities to prepare each other for the certainty of death.

Comparing sudden with anticipated deaths can give the couple more of a sense of control and mastery over what will happen. A range of questions might be appropriate to map out previous experiences of illness and relating patterns. For example: What sort of relationship did your parents have? Tell me about the grief when your father died? Who was most upset? How was upset shown in the family? Is upset shown any differently now than it was then?

The therapist is also able to explore how the couple perceived their own parents' relationship adjust and change as illness increased:

Therapist: looking at your genogram, it strikes me that there are lots of people over many generations that have cared for each other during illness.

Magda: Yes, that's true isn't it? I know I look after my parents, but I hadn't thought of that as being something which has happened across other parts of the family. I've felt quite isolated with it, but now I can see others have been doing it too. But it makes me cross that I end up feeling responsible for taking care of people. Even if it does seem to be 'in my blood' and what everyone in my family does. It's not that I don't love Robert and want to be there for him, but it's so much that it's my parents too. And what of our daughters, will they end up taking care of us both? I'd hate to think of them feeling like they have to – they have busy lives and it seems so unfair to expect them to look after us in our old age.

Therapist: So the family has a long history of taking care of people who need it. But that isn't something which you necessarily want to pass on to your own kids?

Magda: Yes, I just hope I have the strength to take care of my parents and you Robert. And to talk with our daughters about not assuming they'll do the same. They have their own lives to lead.

Therapist: Has it already been decided that it will be you who provides care for Robert if he should need care? How did you come to decide that?

Magda: Well, we haven't talked about it. I just presumed it. We know our vows "In sickness and in health!"

Robert: I would rather no-one needed to, but we have some money we could use to make sure you aren't getting ill yourself Magda. I know your parents take it out of you and there will come a time when I can't help out with them. I'd prefer if our girls didn't have to take care of me.

The therapist later comes back to the conversation about the impact on the next generation (the two daughters), but chooses in this instance to focus on the marital relationship and how they make decisions about caregiving. In the subsequent session, the couple also talked about how, despite the physical impacts of the disease on Robert and Magda's busy life supporting him and her parents, they were able to maintain couple time, and reflect on how their own parents show affection toward each other:

Therapist: So both sides of your family have considerable experience in illness. I wonder who in your family seems to have been able to also hold on to a sense of affection, closeness and intimacy even when illness has come into the picture?

Magda: It's hard to say. My mother's dementia means she is often angry and upset. My father misses being able to give her a cuddle, I think, because he never knows if she's going to lash out at him. It's a pity really. But your parents never showed any affection did they?

Robert: They weren't a touchy-feely couple that is for sure! Very Victorian values, I think.

Therapist: And how do you as a couple view how you'd like to manage affection and closeness? Do you want to consign your parents' views to Victorian era and focus more on the intimacy of hugs and so on of Magda's parents?

Robert: I don't want illness to get in the way of us enjoying each other. Cancer has taken away enough I think.

Magda: Yes, I think it's different for my parents because dementia affects the brain. So we're lucky that we can decide what we want and talk about it. I'd hate to think that I was pushing you away Robert without even knowing it.

Therapist: How did you manage intimacy before the diagnosis of prostate cancer?

Robert: We like a kiss and a cuddle don't we Magda?

Magda: Oh we do.

Therapist: And has intimacy changed at all since prostate cancer came into your lives?

Robert: Well, to start with yes, I wasn't feeling as romantic or wanting to have cuddles, all I could think was that I didn't trust my body... I don't have as much control as I used to and I didn't want to be running to the loo while we were trying to have a romantic night.

Magda: We've not had that many romantic nights for a while though. I know the doctor prescribed you some Viagra to counteract the diabetes medication, but they never really worked did they?

Robert: I think things are worse now and it would be good to have some of that back!

Therapist: So it sounds like you've managed for a while with less romance than you both want. [To Robert] Who do you think that has been toughest for?

Robert: Well, I don't know, I think we were managing okay before, but it would be good to get back to where we were.

Therapist: How did you manage intimacy before prostate cancer? How often were you intimate with each other?

Magda: I think we fell out of the habit of it, so it's been such a long time, hasn't it Robert?

Robert: It's not been that long!

Therapist: Thinking back to when you were able to be intimate and enjoy each other, clearly you have a few times or you'd have a hard job explaining having children! So thinking back to that time, how did you used to let each other know you were in the mood?

The above dialogue shows how the therapist examines intimacy between the couple. Using feed-forward questions, to create a future in which this shared goal is achieved, the therapist seeks out examples of pre-illness relating patterns. Engaging with the energy which this brings about offers a fruitful line of enquiry into how they can still signal each other about sexual desire.

Findings: Therapist views and use of the manual

The manual was found to be highly acceptable to practitioners. While some harboured initial concerns about the ability for clinical practice to follow a prescribed pathway, all reported that this

difficulty was not borne out in practice. Indeed, many found that the manual was very helpful in giving permission for discussing sensitive topics:

[I was] using the manual as something almost external to the process so that 'Now let's look at the manual and see where we are', using that as a tool almost. (Practitioner 1)

We went very quickly into some of the major issues ...and that felt, and partly that was to do with the questions that we were asked to use. (Practitioner 1)

Another interviewee reported that the structure of the manual helped, especially in orienting to emotional talk:

I actually think structure sometimes really helps, and I do, although I don't use paperwork when I'm counselling I will sometimes say "I wonder if we can have a look at your early relationships today," so I will tell them, so I didn't find it. (Practitioner 2)

The manual was also described as facilitating discussions of sex and intimacy, and providing a structure for clinicians to flag for clients what would be the focus of next session:

[In session 3, I would say] "now, we're going to have to talk about the next session, about intimacy before and after your cancer," so think about what intimacy means to you, think about what you were like before, and think about what you're like now," and so it gave them a, a, well they knew what they were to be thinking about. (Practitioner 5)

While the manual was considered to be a helpful framework, practitioners still felt able to be flexible in their use of it and to be responsive to what the couple brought with them to discuss at each session. Additionally, practitioners felt able to use their own training and experience to address the presenting issues:

I worried it [the manual] was going to be a little bit prescriptive and possibly patronising. [but in the training we learnt that] it's for you to move about within that structure. It's just

to give you somewhere to start. So once I'd heard that from [the trainers] I thought yes that's okay then it doesn't need to be 100 per cent prescriptive. (Practitioner 6)

Participants indicated that the manual had been helpful in providing instructions for each session:

When I'm working with couples [outside of the trial] I don't have any [a manual] ... so the difference is I had it sitting there, beforehand I read it through, at the beginning of the session after we'd had a bit of a, you know, settling in, bit of a chat, then I would say "so ...," so it was very, it was foregrounded you know that this is what we're going to do, and they knew that...so you know I said "this is what ... this is what I'd like to look at today, and is that OK?," and they were happy with that. (Practitioner 2)

Practitioners reported that the manual had been helpful in working with clients, and that couples found it helpful:

I thought it [the manual] was really good and the feedback I got basically from, you know from the other couples basically that it had been really quite helpful (Practitioner 4)

Practitioners' clinical experience was mixed, but despite this diversity there was an agreed feeling that the manual did not prevent them from using their skills but rather presented them with a framework from which to build upon. Adherence to the manual was high, with overall adherence of 84.8%. Completed adherence checklists demonstrated a good level of fidelity, as illustrated in Table 2.

---Insert Table 2 here---

The first and final sessions had the highest rating of adherence overall (8.87 and 8.78 respectively), whilst session four – exploring couple intimacy - had the lowest overall rating of adherence to the manual (7.38). Two components within this session, notably: role of orgasm and sensate focus, were seen to be particularly difficult to address. Role of orgasm had a mean adherence of 4.71 and sensate focus had a mean adherence of 5.14, both significantly below the mean average rating of

8.18. Post-intervention interviews with the practitioners indicated that some couples were unwilling to discuss more sexually-focused components of the intervention, due to an absence of sexual activity before the cancer treatment.

[Couples weren't showing] reluctance, but just [some couples had] not a lot to say really, because you know a lot of them had, I think they had got to the point where they weren't having a very sexual experience. (Practitioner 3)

Role of orgasm and sensate focus were seen as particularly intimate topics that some couples perceived as irrelevant to discussions about their relationships due to the lack of sex. The older demographic of the participants also meant that practitioners experienced some difficulty in addressing such issues:

It's a very delicate area for everybody, and I am stranger to them even though that's session four, in any kind of counselling work like this you can't kind of go straight in with that kind of stuff because people need to get to know you. But not only that you are dealing with people in their late sixties, early seventies, who have been brought up in a different generation by a different kind of people and I am younger than them and I just have to be mindful of being very delicate with that. (Practitioner 6)

Another practitioner indicated that it would be helpful to have a structure for Session 4 if the couple did not wish to talk in detail about intimacy; he viewed the manual as a way of opening up discussion which the couple could choose to engage or not. Consequently, for couples less interested in intimacy, the manual required some further guidance on how to manage the session.

Although not all couples demonstrated interest in talking about sexual activity, one practitioner felt that the manual would be improved with further detail on supporting such intimacy:

For those couples who want to get their sexual relationship back, the sensate focus I think does need [...] a bit more elaboration. (Practitioner 4)

Table 3 provides further detail on the areas identified by practitioners that the manual would benefit from strengthening.

---Insert Table 3 here---

Despite these very limited suggestions, practitioners expressly indicated that the intervention worked well:

[The manual] was a good package, I think it was well-delivered you know in terms of you know being prepared for it, I think it held together really well, very solidly. (Practitioner 4)

The manual was felt to be adaptable to practitioners' own styles of working, as one interviewee reflected on a conversation with others involved in the study:

They [the other practitioners] were very impressed with the way they were able to incorporate their own philosophy of practice with the manual, and some of them found things like doing a genogram really helpful and they hadn't been used to doing something like that before, and they felt it really opened up conversations and helped to almost externalise the family so that they could look at issues, such as, I think we were looking at the narrative of illness and caring in families, and that that had been something that other practitioners would continue to use. (Practitioner 1)

Practitioners reflected on what they felt couples gained from the study, each indicating that both patients and partners made good use of the therapy. The psychosexual element was a core part of this:

in a lot of cases it was about restoring the intimacy which had been lost, you know that, and because it starts off with sort of saying you know ... "let's take the sex out of it and it's just about being intimate, you're doing something you know, with your partner that you wouldn't

do with anyone else”... I remember [one] couple, I remember the partner sort of saying “well, thank you for giving me my partner back”. (Practitioner 4)

Training prior to using the manual was considered important for understanding the practical elements of the intervention and for contextualising the couple therapy in relation to prostate cancer and its effects on patients and partners. Hearing accounts from - and asking questions of - couples affected by prostate cancer was found to be particularly useful for practitioners.

“I had a day-long training here, I thought it was probably one of the best training I've ever been to, it was very well structured, a lot of information but very accessible, I really liked the men [with prostate cancer] being there, I mean that's real, you know, other than that it's ... it's that personal story, and obviously as a counsellor that's what you connect with, so I want to hear from him ‘how was it for you?’” (Practitioner 2)

Overall practitioners found the intervention to be both feasible and acceptable, as did the couples participating in the trial. Full results from the outcome measures have been reported (Author, 2016).

Discussion

With diagnoses of prostate cancer expected to increase dramatically over the next 25 years (Maddams et al., 2012) the number of couples seeking support for unmet psychosexual and relational needs is correspondingly likely to expand. Consequently, this paper has described a manualised intervention framework for delivering support to couples following surgery for prostate cancer. The intervention aimed to combine support for relationship and sexual functioning.

Systemic theory informed the design of the intervention, recruitment criteria and outcome measures. Practitioners reported that the intervention was acceptable, and required only minor modifications to its content. The manual was considered to be a helpful framework for orienting the sessions while accommodating flexibility and responsiveness to what couples wished to discuss at

each session. This supports claims that systemic family therapy can be manualised (Pote et al., 2003), despite concerns from clinicians who have not engaged with manuals who criticise their lack of flexibility and fit with therapeutic process and outcomes (Forbat et al., 2015).

This study and manual's emphasis on sexual and relationship functioning mirrors the findings of Chisholm et al's (2012) review of the efficacy of psychosocial interventions for men with prostate cancer. They found that the most successful interventions were those that included content directly focusing on sexual outcomes, with studies providing individual or couple psychological therapy and counselling demonstrating benefits across a range of sexual function and satisfaction measures. Similar conclusions have been reached in reviews that have examined interventions addressing sexuality in other types of cancer (e.g. Audrain et al., 1997).

The manual would benefit from some minor modifications, including additional structure in the session where intimacy is addressed for those couples who wish to focus on broader relational issues. Further, for those couples who did wish to explore sexual intimacy in their relationship, the manual could be improved with further detail on strategies for discussing and increasing intimacy. Refining this element of the manual would be beneficial in the context of evidence that interventions containing the explicit use of sex therapy techniques have proved most successful in addressing sexual and relationship functioning in men with prostate cancer (Chisholm et al., 2012). Despite lower practitioner adherence rates to the intimacy session, men did report decreased distress with sexual functioning (Author, 2016). This presents a paradox then, with some data presented in this paper indicating discussion of sex and intimacy in the intervention was difficult, and other data indicating that it had resulted in a positive impact on patients. It may be that it may be the opportunity to discuss the cancer/treatment's impact on sexual functioning in a supportive environment was critical. Consequently, amendments to the manual should strengthen opportunities to have such dialogue, and further testing is required with a larger sample of couples

to allow for regression analysis of variables such as baseline sexual functioning to be examined alongside engagement in session 4.

The practitioners in this trial were employed by the same organisation and participated in peer supervision and one ad-hoc peer-led training session during the course of the trial on sensate focus. This peer support appeared to be well-received in the context of participating (for all practitioners) in their first research trial. The value of this support indicates the benefit of a network of engaged practitioners (as used by Flückiger, 2014). Such a network could be achieved virtually, via private email list discussions, as well as video-conferenced peer supervision.

This study was limited by the small sample size of couples and clinicians, which precludes drawing definitive learning from the data. Further, the interviews with clinicians did not seek specific clinical examples, and consequently we are unable to provide illustrative use of the manual, alongside its strengths and limitations.

In conclusion, the manual was well-received by practitioners, who found it helpful to have a defined structure for the couple therapy, while being able to work flexibly and responsively within this framework. Since only six practitioners were involved in delivering the intervention, wider roll-out of the approach may require further feasibility and acceptability testing. Sharing the manual in this journal article allows for further debate, discussion and use of the approach, which will help to refine the intervention and provide a tool for guiding practitioners in supporting this growing client group.

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Acknowledgments

Grateful thanks to all the couples, therapists and urologists involved in this study. The study was funded by Prostate Cancer UK. The full manual is available by emailing the corresponding author.