



Promoting Sexual Well-being for Men and Their Partners Affected by Prostate Cancer

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Objective: To present an overview of the issues related to the sexual well-being of people affected by prostate cancer and their partners, and propose ways to manage and address these by oncology nurses and the wider multi-disciplinary team.

Data Sources: Electronic databases such as PubMed and Cinahl were used to retrieve relevant literature published between 2010 and 2020.

Conclusion: Sexual well-being in patients with prostate cancer and their partners is multifaceted, comprising physical, emotional, social, and cultural aspects.

Implications for Nursing Practice: A combination of pharmacologic and non-pharmacologic interventions, together with enhanced communication, can be successful in providing culturally competent, person-centered care by oncology nurses and the wider multi-disciplinary team.

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Introduction

Worldwide trends on the incidence and mortality for prostate cancer (PCa) indicate a continuous rise, making it the second most common type of cancer in men after lung cancer.^{1,2} Despite these negative trends, the progress of diagnostics and treatment options for this population has had a significant positive effect on patient survivorship; more men now live beyond 5 years from diagnosis, facing the long-term effects of cancer and its treatment. Literature has documented the level of unmet supportive care needs in this population, ranging from fear of cancer recurrence and future uncertainty, to urinary incontinence and affected interpersonal relationships.^{3,4} Sexual well-being, an important aspect of quality of life, has been identified as a key area of unmet need for patients with PCa.^{5–7}

Current treatment options for PCa can have different adverse effects on a person's sexuality. The majority of patients report some level or erectile dysfunction (ED) after surgery, radiotherapy, and/or brachytherapy.^{8,9} Hormone treatments affect testosterone levels, thus affecting libido and erections.¹⁰ Other equally affected components of sexual function include orgasm and ejaculation. Consequently, disrupted sexual function contributes to altered body image, self-esteem, and sense of masculinity, and can result in poor communication directly affecting partner relationships.^{6,11,12}

Although affected sexual function has been well researched within the bio-physical domain, its wider impact on the psycho-emotional and socio-cultural life domains has only received interest in the past decade.¹⁰ Adopting the World Health Organisation's¹³ position that sexuality is instilled in human identity, this article will present an overview of the issues pertinent to the sexual well-being of people affected by PCa and their partners, and will consider ways to manage and address these by oncology nurses and the wider multi-disciplinary team.

Living with and Beyond Impaired Sexuality

The diverse issues that men with PCa experience relating to normal sexual response (libido, erection, ejaculation, and orgasm) are usually explored as side effects of specific treatment modalities, such as radical prostatectomy, brachytherapy, and androgen deprivation therapy. For example, loss of libido is very common in men receiving androgen deprivation therapy,¹² while ED affects as many as 77% of those who undergo radical prostatectomy¹⁴ and 60% of patients receiving radiation therapy.¹⁵ Similarly, radical prostatectomy can cause changes in orgasm in one fifth of patients,¹² while men who are treated with radiotherapy can experience anejaculation ("dry orgasms").¹⁶ Penile deformities and urinary incontinence are also common after surgery and/ or radiotherapy.¹⁷ Of note, the literature on sexual well-being in PCa tends to focus primarily on survivorship care rather than the direct impact of active treatment. This comes as no surprise; when priorities in the initial stages of the cancer trajectory tend to focus on life preservation, sexual concerns move to the

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background. However, such issues and their effects will resurface later on when individuals start to seek ways to return to normality.

The psychological impact of sexual dysfunction on patients and their partners can manifest itself earlier on, during treatment and can have an adverse effect on the couple's relationship.¹⁸ For many men ED can create psychosexual distress because it is experienced as a loss of what was previously considered a normal part of sexual intercourse.¹⁹ For instance, a man's body image affected by hormone treatment that causes gynaecomastia can threaten male identity and masculinity.²⁰ In a recent review, the loss experienced by men with PCa placed them in a more vulnerable place as they struggled to maintain socio-cultural norms related to male identity.²⁰ In fact, it is because of these norms that patients have communication difficulties not only with health professionals, but also within their marital relationships, which can exacerbate distress and can further hinder help-seeking behaviours.⁵

Gay and Bisexual Men

Researchers have primarily focused on the experiences and ways to address the needs of heterosexual men with PCa. It is only in the past decade that the experiences of gay and bisexual men with PCa have been explored.^{8,21} Despite evidence showing similar prevalence for PCa in this group, gay and bisexual men report poorer sexual function and quality of life.²² The greater unmet supportive care needs of this group²³ may be because the majority of rehabilitation services are built around the needs of heterosexual men.²² A recent qualitative meta-synthesis of experiential data indicates that, for gay men, sexual function has a different relational meaning, with the emphasis placed on penile function.²⁴ As a result, ED can significantly affect intimate relationships in a different way compared with heterosexual men.²⁴ Beliefs relating to inability to sustain an erection can lead to a feeling of not being desirable and threaten the relationship with the partner. In fact, relaxing existing relationships and allowing partners to seek sexual intimacy elsewhere was seen as a coping strategy for gay men.²⁴ Other research has suggested that practices like role reversal (ie, going from being the active partner to the receptive one) is less considered as an option to cope with ED because the variety of sexual practices may differ in gay men compared with straight men.²⁵ These factors can have a debilitating impact on masculine identity as well as psycho-emotional well-being: threatened "sexual disqualification"¹⁹ can increase feelings of isolation and increase psychological distress.^{25,26}

Besides the physical factors that impact on the sexual well-being of this group, there are socio-cultural factors that play an important role on overall well-being, some of which may inadvertently affect rehabilitation and consequently sexual function.²⁷ Gay and bisexual men often go unnoticed by health professionals because of pre-assumptions rooting in heterosexual norms.^{24,28} It is common that the support network for this group is not the biological family, but rather friends or what has been defined as a "chosen family."²⁹ Evidence suggests that the different types of social support required for this group are not always offered, which can in turn have adverse effects on patient outcomes.³⁰

The Partner

Cancer's impact on family members has been well established in the literature. However, contrary to the indirect effect it can pose for most other cancers, partners of patients with PCa are directly affected.¹⁸ The reported increased psychological distress has been attributed to a decline in satisfaction from the relationship and an affected sexual function.^{31,32} This chain of effects - affected sexual life, leading to lower quality of life, and eventually affected marital relationship - links closely to the way couples choose to communicate their concerns.³³ According to Manne et al,¹⁸ both patients and

their partners choose to avoid discussions related to sexual concerns, irrespective of the differing reasons for each group. A more recent review further explains that holding back emotions and thoughts was not only a coping mechanism for the couple, but also a means to maintain continuity in the relationship.³³ Researchers identified that a double act of protection is taking place: patients' act was driven by fears of not meeting expectations, while that of partners' was driven by fears of making patients feel inadequate to meet their sexual needs.³³

To adapt to the new reality of PCa, patients and their partners go through key processes to accommodate their experiences. Some authors define them as "grief, restructuring and rehabilitation"³⁴ and others as "cultivating connection versus disengaging" and "accepting change versus seeking continuity."³³ At different points in the cancer trajectory, couples employ different strategies: before surgery experiences of anticipatory grief regarding future expectations on their sexual life are common, and after surgery frustration, anger, and eventually adapting to the new reality are reported.³⁵ Consequently, partners are equally affected and when designing interventions addressing their needs has to be taken into consideration. With evidence pointing out that all domains of need are equally affected (biological, psychological, and social), interventions should encompass more holistic approaches that take into account the persons' place within the relationship as well as how they are processing grief.³⁵ This is further explored below.

Enhancing Sexual Well-being in Prostate Cancer

Evidence-based interventions

A number of pharmacologic and non-pharmacologic interventions have been tested to address impaired sexual function in patients with PCa and their partners. Pharmacologic interventions focus mainly on penile rehabilitation, ie, the use of medication or pharmacologic devices after PCa treatment to improve erectile function recovery. Oral phosphodiesterase type 5 (PDE5) inhibitors are offered as standard of care targeting cavernous nerves after radical prostatectomy.³⁶ However, only 12% to 17% of men will respond within 6 months post surgery.³⁷ The debate on the timing, dose, and duration of penile rehabilitation protocols is ongoing,³⁶ with the majority of the evidence pointing to starting as soon as possible after surgery to prevent irreversible damage to the structure of erectile tissue.³⁸ Another treatment option for patients with non-nerve-sparing surgery includes intracavernosal injections with vasoactive agents (ie, alprostadil). Again, this strategy requires clinicians to consider carefully the timing of administration because it has been associated with painful erections.³⁹ Other interventions, such as vacuum erectile devices and penile implants, are also proposed with varied efficacy results.³⁸

Because of the varying results of pharmacologic treatment to address ED, as well as the recognition that impaired sexual well-being spans over a spectrum of domains, experts now advocate taking into account psycho-emotional needs in favour of a more holistic and effective sexual rehabilitation for this population, which also includes partners.^{6,14,36,40} Psychosocial interventions have been introduced to attempt to address the needs of PCa survivors and their partners in addressing intimacy and relationship factors.⁴¹ These interventions either combine or focus exclusively on psycho-education, psycho-sexual counselling, cognitive behavioural therapy, information provision, additional peer and/or marital support.⁶ Demonstrated positive outcomes of these approaches include stress reduction, increased levels of relationship satisfaction, and a better understanding of the sexual rehabilitation process with a more realistic future outlook.^{18,42-44} Methodologic limitations when testing these interventions include varied and relatively small samples, different delivery modes (face-to-face v telephone conversations v online webinars) and the variable duration of the offered

intervention (ranging from a limited number of hours to 10 weekly sessions). These issues point to a more cautious interpretation of the level of effectiveness.¹⁷

More recently, researchers investigated whether patients and their partners would benefit equally from psychosocial interventions.^{6,17,37} Nelson et al³⁷ highlight that while men with PCa may find more beneficial education about pharmacologic interventions, partners find more useful interventions targeting relationships. Nevertheless, when asked to identify the key elements in interventions, both patients and their partners expressed the need for more information early on regarding the physical and emotional impact of treatment on sexual function, as well as future rehabilitation options.⁶ Moreover, introduction of mindfulness and acceptance-based interventions in the care of this group has also been proposed to enhance patient/partner experience.¹⁷ Experts agree that future interventions should be grounded on theoretical models when trying to address previous methodologic limitations.^{12,35,37,45}

The role of communication and culture

In advocating effective, person-centered care to patients with PCa that minimises health inequalities, communication needs to have a pivotal role. The benefits of effective communication within the wider cancer care context have been highlighted, including increased patient satisfaction and psychological well-being and improved health outcomes.⁴⁶ As a result, communication skills competencies are featured in many guideline and policy documents as a means to support and enhance informed decision-making.^{47,48}

Communication in the context of sexual health care for PCa remains a challenging topic. A recent study in this population reveals that issues around the timing of conversations, the lack of tailored information to the specific needs, and addressing the psychology of sexual intercourse are key in successfully addressing these needs.⁴⁶ Indeed, deciding when it is appropriate to discuss issues relating to sexuality and sexual functioning has been identified as a challenge that oncology nurses and other health professional face in the wider cancer population.⁴⁹ Perhaps identifying that this is an important aspect that can be further explored later on is the optimum approach for the initial stages of Pca treatment, with more emphasis being placed in the psycho-emotional domain and the role of the person within the relationship. These aspects can be further explored and addressed in follow-up consultations at post-treatment. In all, maintaining a balance between the medical jargon of sexual intercourse and the psychosocial impact of deprived sexual function is necessary.⁴⁶

Alongside communication, cultural competency has been identified as another key element of providing sexual health care within a cancer context.⁴⁹ Cultural competency refers to health professionals' principles, practices, and attitudes that facilitate them to provide effective, cross-cultural care.⁵⁰ A culturally competent workforce has the potential to cultivate an environment where patients with PCa and their partners and significant others feel valued and included in their care, thus improving care experiences across the cancer trajectory.^{46,51}

In multi-cultural societies, there is a requirement to provide culturally sensitive training on communication skills. Taking into consideration the societal meanings attributed to sexuality, as well as variations within specific groups, should be factored within any continuing professional development programme.⁴⁹ However, raising cultural awareness of oncology nurses should include not only existing cultural and religious diversity, but also groups like gay and bisexual men. Because of dominant heterosexual societal norms, health services require transition to best supportive models of sexual well-being for gay and bisexual men.²⁸ Identifying the different needs of the varied support network of this population should be a priority.²⁹ Adopting a welcoming and inclusive language that is gender neutral and free of assumptions promotes trust and enhances the therapeutic relationship among patients, partners, and health professionals.⁵⁰

Sexual health care competency and the multidisciplinary team

Currently, different initiatives encourage the inclusion of sexual health care in the management of patients with PCa and offer recommendations on the level of support required.^{47,52,53} The sexual recovery process can be complex, requiring addressing interactions between biological, psychological, and social factors, and therefore requires a multidisciplinary approach to successfully address the needs of the patient in a holistic way.^{54,55} To deal with the ever-changing health care landscape, the multidisciplinary team must increase their skills and advance their practice to include a consultancy role to assist in meeting the needs of men with PCa and sexual health care needs.⁷ Theoretical frameworks are currently available that propose a varying level of knowledge and expertise (entry or champion) with the potential for further career development.⁴⁹ Using a bio-psychosocial framework to guide consultations around sexual implications of treatment, oncology and urology nurses are pivotal in supporting patients and their partners through the cancer trajectory.^{12,55} More expertise in the area of sexual health care can be offered by advanced practice nurses to assess, diagnose, educate, and manage specific sexual health issues for men.³ Researchers propose information tailored to patient need, offering clear advice on the potential long-term effects of treatment and providing specialist care such as ED clinics.⁴⁵

The inclusion of assessment in the context of a holistic supportive care needs evaluation can provide the space and opportunity to make the topic of sexuality part of the conversation and facilitate future discussions for patients and their partners.^{45,49} This should adopt tailored and culturally sensitive language to enable a safe environment that will promote informed decision-making. As part of this assessment, screening for distress and psychosocial needs at diagnosis throughout and after treatment completion can assist in identifying individuals with higher need for support and make referrals for psychosexual counselling to clinical psychologists.⁴ Similarly, the provision of information should be offered in a timely manner, ideally prior to initiation of treatment, and will help set realistic expectations for the rehabilitation stage.^{6,55} Within this discussion, identifying a person's relationship values can help eliminate assumptions and enable the provision of culturally competent care.⁵⁶

Conclusion

Sexual well-being in patients with PCa and their partners is multifaceted, comprising physical, emotional, social, and cultural aspects. Sexual health deficits can be personal and interpersonal, persistent and pervasive. Promoting sexual well-being in the context of PCa should be a key component of person-centred care, and a goal for oncology nurses and the wider multidisciplinary team to strive to achieve.

References

1. Rawla P. Epidemiology of prostate cancer. *World J Oncol.* 2019;10:63–89.
2. International Agency for Research on Cancer (IARC). *Cancer incidence in five continents Vol XI.* 2018. Available at: https://ci5.iarc.fr/CISplus/Pages/table3_sel.aspx. Published. (Accessed April 30, 2020).
3. Bernat JK, Wittman DA, Hawley ST, et al. Symptom burden and information needs in prostate cancer survivors: a case for tailored long-term survivorship care. *BJU Int.* 2016;118:372–378.
4. Chambers SK, Frydenberg M, Dunn J. Quality of life considerations in the treatment of metastatic hormone-sensitive prostate cancer. *Lancet Oncol.* 2019;20:1469–1471.
5. Hyde MK, Newton RU, Galvao DA, et al. Men's help-seeking in the first year after diagnosis of localised prostate cancer. *Eur J Cancer Care (Engl).* 2017;26:e12497.
6. Mehta A, Pollack CE, Gillespie TW, et al. What patients and partners want in interventions that support sexual recovery after prostate cancer treatment: an exploratory convergent mixed methods study. *Sex Med.* 2019;7:184–191.
7. Paterson C, Kata SG, Nandwani G, Das Chaudhury D, Nabi G. Unmet supportive care needs of men with locally advanced and metastatic prostate cancer on hormonal treatment: a mixed methods study. *Cancer Nurs.* 2017;40:497–507.

8. Prostate Cancer UK. Available at: <https://prostatecanceruk.org/>. (Accessed April 30, 2020).
9. Prostate Cancer Foundation of Australia (PCFA). Understanding sexual issues following prostate cancer treatment. Available at: <https://www.prostate.org.au/media/468674/understanding-sexual-issues.pdf>.
10. Klaeson K, Sandell K, Bertero CM. Talking about sexuality: desire, virility, and intimacy in the context of prostate cancer associations. *Am J Mens Health*. 2013;7:42–53.
11. Chambers SK, Ng SK, Baade P, et al. Trajectories of quality of life, life satisfaction, and psychological adjustment after prostate cancer. *Psychooncology*. 2017;26:1576–1585.
12. Katz A, Dizon DS. Sexuality AFTER CANCER: A MODEL FOR MALE SURVIVORS. *J Sex Med*. 2016;13:70–78.
13. World Health Organisation (WHO). Defining sexual health. Available at: https://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/. (Accessed April 30, 2020).
14. Fode M, Serefoglu EC, Albersen M, Sonksen J. Sexuality following radical prostatectomy: is restoration of erectile function enough? *Sec Med Rev*. 2017;5:110–119.
15. Hamstra DA, Mariados N, Sylvester J, et al. Sexual quality of life following prostate intensity modulated radiation therapy (IMRT) with a rectal/prostate spacer: Secondary analysis of a phase 3 trial. *Pract Radiat Oncol*. 2018;8:e7–e15.
16. Sullivan JF, Stember DS, Deveci S, Akin-Olugbade Y, Mulhall JP. Ejaculation profiles of men following radiation therapy for prostate cancer. *J Sex Med*. 2013;10:1410–1416.
17. Bossio JA, Miller F, O'Loughlin JI, Brotto LA. Sexual health recovery for prostate cancer survivors: the proposed role of acceptance and mindfulness-based interventions. *Sex Med Rev*. 2019;7:627–635.
18. Manne SL, Kissane D, Zaidler T, et al. Holding back, intimacy, and psychological and relationship outcomes among couples coping with prostate cancer. *J Fam Psychol*. 2015;29:708–719.
19. Ussher JM, Perz J, Rose D, et al. Threat of sexual disqualification: the consequences of erectile dysfunction and other sexual changes for gay and bisexual men with prostate cancer. *Arch Sex Behav*. 2017;46:2043–2057.
20. Araujo JS, Zago MMF. Masculinities of prostate cancer survivors: a qualitative metasynthesis. *Rev Bras Enferm*. 2019;72:231–240.
21. Stonewall C. *Unhealthy attitudes: The treatment of lgbt people within health and social care services*. 2015. Available at: <https://www.bl.uk/collection-items/unhealthy-attitudes-the-treatment-of-lgbt-people-within-health-and-social-care-services>.
22. Rosser BRS, Capistrant B, Torres MB, et al. The effects of radical prostatectomy on gay and bisexual men's sexual functioning and behavior: qualitative results from the restore study. *Sex Relation Ther*. 2016;31:432–445.
23. Ussher JM, Perz J, Kellett A, et al. Health-Related quality of life, psychological distress, and sexual changes following prostate cancer: a comparison of gay and bisexual men with heterosexual men. *J Sex Med*. 2016;13:425–434.
24. Alexis O, Worsley AJ. The experiences of gay and bisexual men post-prostate cancer treatment: a meta-synthesis of qualitative studies. *Am J Mens Health*. 2018;12:2076–2088.
25. McConkey RW, Holborn C. Exploring the lived experience of gay men with prostate cancer: a phenomenological study. *Eur J Oncol Nurs*. 2018;33:62–69.
26. Matheson L, Watson EK, Nayoan J, et al. A qualitative metasynthesis exploring the impact of prostate cancer and its management on younger, unpartnered and gay men. *Eur J Cancer Care (Engl)*. 2017;26(6).
27. Kelly D, Forbat L, Marshall-Lucette S, White I. Co-constructing sexual recovery after prostate cancer: a qualitative study with couples. *Transl Androl Urol*. 2015;4:131–138.
28. Rose D, Ussher JM, Perz J. Let's talk about gay sex: gay and bisexual men's sexual communication with healthcare professionals after prostate cancer. *Eur J Cancer Care (Engl)*. 2017;26(1).
29. Capistrant BD, Torres B, Merengwa E, West WG, Mitteldorf D, Rosser BR. Caregiving and social support for gay and bisexual men with prostate cancer. *Psychooncology*. 2016;25:1329–1336.
30. Jan M, Bonn SE, Sjolander A, et al. The roles of stress and social support in prostate cancer mortality. *Scand J Urol*. 2016;50:47–55.
31. Manne S, Badr H, Zaidler T, Nelson C, Kissane D. Cancer-related communication, relationship intimacy, and psychological distress among couples coping with localized prostate cancer. *J Cancer Surviv*. 2010;4:74–85.
32. Ramsey SD, Zeliadt SB, Blough DK, et al. Impact of prostate cancer on sexual relationships: a longitudinal perspective on intimate partners' experiences. *J Sex Med*. 2013;10:3135–3143.
33. Collaco N, Rivas C, Matheson L, et al. Prostate cancer and the impact on couples: a qualitative metasynthesis. *Support Care Cancer*. 2018;26:1703–1713.
34. Benoot C, Hannes K, Bilsen J. The use of purposeful sampling in a qualitative evidence synthesis: a worked example on sexual adjustment to a cancer trajectory. *BMC Med Res Methodol*. 2016;16:21.
35. Wittmann D, Carolan M, Given B, et al. What couples say about their recovery of sexual intimacy after prostatectomy: toward the development of a conceptual model of couples' sexual recovery after surgery for prostate cancer. *J Sex Med*. 2015;12:494–504.
36. Chung E, Brock G. Sexual rehabilitation and cancer survivorship: a state of art review of current literature and management strategies in male sexual dysfunction among prostate cancer survivors. *J Sex Med*. 2013;10(suppl 1):102–111.
37. Nelson CJ, Emanu JC, Avildsen I. Couples-based interventions following prostate cancer treatment: a narrative review. *Transl Androl Urol*. 2015;4:232–242.
38. Salonia A, Adaikan G, Buvat J, et al. Sexual rehabilitation after treatment for prostate cancer—part 2: recommendations from the Fourth International Consultation for Sexual Medicine (ICSM 2015). *J Sex Med*. 2017;14:297–315.
39. Yiou R, Butow Z, Parisot J, et al. Is it worth continuing sexual rehabilitation after radical prostatectomy with intracavernous injection of alprostadil for more than 1 year? *Sex Med*. 2015;3:42–48.
40. Ljunggren C, Stroberg P. Improvement in sexual function after robot-assisted radical prostatectomy: a rehabilitation program with involvement of a clinical sexologist. *Cent European J Urol*. 2015;68:214–220.
41. Chambers SK, Schover L, Halford K, et al. ProCan for couples: randomised controlled trial of a couples-based sexuality intervention for men with localised prostate cancer who receive radical prostatectomy. *BMC Cancer*. 2008;8:226.
42. Chambers SK, Occhipinti S, Schover L, et al. A randomised controlled trial of a couples-based sexuality intervention for men with localised prostate cancer and their female partners. *Psychooncology*. 2015;24:748–756.
43. Paich K, Dunn R, Skolarus T, et al. Preparing patients and partners for recovery from the side effects of prostate cancer surgery: a group approach. *Urology*. 2016;88:36–42.
44. Santos-Iglesias P, Rana M, Walker LM. A systematic review of sexual satisfaction in prostate cancer patients. *Sex Med Rev*. 2019. [Epub ahead of print].
45. McCaughan E, Parahoo K, Flannagan C, et al. Development of a conceptual framework to improve sexual wellbeing communication in routine prostate cancer care. *Patient Educ Couns*. 2020;103:1150–1160.
46. Speer SA, Tucker SR, McPhillips R, Peters S. The clinical communication and information challenges associated with the psychosexual aspects of prostate cancer treatment. *Soc Sci Med*. 2017;185:17–26.
47. National Institute for Health and Care Excellence (NICE). *Prostate cancer: diagnosis and management*. 2019. Available at: <https://www.nice.org.uk/guidance/ng131>.
48. Scottish Government. *Nursing 2030 vision: Promoting confident, competent and collaborative nursing for Scotland's future*. Available at: <https://www.gov.scot/publications/nursing-2030-vision-9781788511001/>.
49. Papadopoulou C, Sime C, Rooney K, Kotronoulas G. Sexual health care provision in cancer nursing care: a systematic review on the state of evidence and deriving international competencies chart for cancer nurses. *Int J Nurs Stud*. 2019;100:103405.
50. Radix A, Maingi S. LGBT cultural competence and interventions to help oncology nurses and other health care providers. *Semin Oncol Nurs*. 2018;34:80–89.
51. Wheldon CW, Schabath MB, Hudson J, et al. Culturally competent care for sexual and gender minority patients at national cancer institute-designated comprehensive cancer centers. *LGBT Health*. 2018;5:203–211.
52. Resnick MJ, Lacchetti C, Bergman J, et al. Prostate cancer survivorship care guideline: American Society of Clinical Oncology clinical practice guideline endorsement. *J Clin Oncol*. 2015;33:1078–1085.
53. Prostate Cancer UK. *Prostate Cancer UK Best practice pathway*. Available at: <https://prostatecanceruk.org/about-us/projects-and-policies/best-practice-pathway>.
54. Tracy M, McDivitt K, Ryan M, Tomlinson J, Brotto LA. Feasibility of a sexual health clinic within cancer care: a pilot study using qualitative methods. *Cancer Nurs*. 2016;39:E32–E42.
55. Walker LM, Wassersug RJ, Robinson JW. Psychosocial perspectives on sexual recovery after prostate cancer treatment. *Nat Rev Urol*. 2015;12:167–176.
56. Elliott S, Matthew A. Sexual recovery following prostate cancer: recommendations from 2 established canadian sexual rehabilitation clinics. *Sex Med Rev*. 2018;6:279–294.