✓Treatments That Work™

Cognitive-Behavioral Stress Management for Prostate Cancer Recovery

Facilitator Guide

Frank J. Penedo
Michael H. Antoni
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About Treatments *That Work*™

Stunning developments in healthcare have taken place over the last several years, but many of our widely accepted interventions and strategies in mental health and behavioral medicine have been brought into question by research evidence as not only lacking benefit, but perhaps, inducing harm. Other strategies have been proven effective using the best current standards of evidence, resulting in broad-based recommendations to make these practices more available to the public. Several recent developments are behind this revolution. First, we have arrived at a much deeper understanding of pathology, both psychological and physical, which has led to the development of new, more precisely targeted interventions. Second, our research methodologies have improved substantially, such that we have reduced threats to internal and external validity, making the outcomes more directly applicable to clinical situations. Third, governments around the world and healthcare systems and policymakers have decided that the quality of care should improve, that it should be evidence based, and that it is in the public's interest to ensure that this happens (Barlow, 2004; Institute of Medicine, 2001).

Of course, the major stumbling block for clinicians everywhere is the accessibility of newly developed evidence-based psychological interventions. Workshops and books can go only so far in acquainting responsible and conscientious practitioners with the latest behavioral healthcare practices and their applicability to individual patients. This new series, Treatments *That Work*™, is devoted to communicating these exciting new interventions to clinicians on the frontlines of practice.

The manuals and workbooks in this series contain step-by-step detailed procedures for assessing and treating specific problems and diagnoses.

But this series also goes beyond the books and manuals by providing ancillary materials that will approximate the supervisory process in assisting practitioners in the implementation of these procedures in their practice.

In our emerging healthcare system, the growing consensus is that evidence-based practice offers the most responsible course of action for the mental health professional. All behavioral healthcare clinicians deeply desire to provide the best possible care for their patients. In this series, our aim is to close the dissemination and information gap and make that possible.

This facilitator guide, and the companion workbook for participants, is designed to help men deal with the stress of readjusting to life after surgery for prostate cancer. Prostate cancer is the most common cancer (other than skin cancers) in American men, affecting one in six. However, the prognosis for men surgically treated for localized prostate cancer is overwhelmingly positive.

This group program addresses men's quality of life after treatment. Participants learn Cognitive-Behavioral Stress Management (CBSM) techniques, as well as a variety of relaxation methods. This two-pronged approach is optimal for reducing stress and maintaining overall health. Group discussion and examples speak to having had prostate cancer, adding value to this CBSM program. Those working with this population will find this guide an invaluable resource.

David H. Barlow, Editor-in-Chief,
Treatments *That Work*™
Boston, Massachusetts

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Contents

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Chapter 1 *Introductory Information for Facilitators*

Background Information and Purpose of this Program

The Cognitive-Behavioral Stress Management (CBSM) program for prostate cancer (PCa) is a 10-week group-based psychosocial intervention that was adapted from our group's earlier work with men and women living with human immunodeficiency virus (HIV) infection and women treated for breast cancer (BCa). This program was specifically modified for men treated with surgery (e.g., radical prostatectomy) for localized (Stages I/II) PCa. The CBSM program for PCa combines relaxation and cognitive-behavioral techniques to help PCa survivors improve general and disease-specific (e.g., sexual functioning) quality of life. Our CBSM intervention is designed to (a) increase stress awareness by identifying sources of stress and the nature of the stress response; (b) teach anxiety reduction skills such as deep breathing and progressive muscle relaxation; (c) modify negative thought processes and appraisals by teaching cognitive-restructuring skills; (d) build adaptive coping skills and increase emotional expression; (e) increase availability and utilization of social support networks; (f) enhance interpersonal skills through improved communication skills and assertiveness training; and (g) promote health maintenance through reductions in health risk behavior and medical treatment adherence strategies. This CBSM intervention is specifically tailored to address specific issues relevant to men treated for localized PCa including loss of control, treatment side effects (e.g., sexual dysfunction), illness-related spousal/partner disruption, and social isolation.

The CBSM intervention is a 10-week, manualized, and sequenced group-based intervention that meets weekly for 2–2.5 hours. Each session is divided into two segments: a relaxation training segment and a

stress management segment. All sessions begin with a relaxation training exercise that involves in-session training and practice of a new relaxation technique. The second segment of the weekly meetings covers stress-management; participants learn cognitive-behavioral techniques that can be applied to address ongoing general and prostate cancer-related stressors (e.g., spousal/partner disruption, sexual dysfunction, navigating the medical system). Although other available programs target cognitive-behavioral and relaxation strategies to address PCa concerns, unlike other programs our CBSM intervention is designed to be conducted in groups of six to eight men led by one or two group facilitators. This format provides several unique features to facilitate adjustment and improve quality of life in men treated for localized PCa. By participating in a group with other men who have had similar illness-related experiences, participants develop a sense of commonality and a connection with other men that facilitates learning and sharing of information. Furthermore, group leaders draw from the experiences of the participants and develop a supportive group environment where they (a) commonly serve as coping role models along with the participants and foster positive social comparisons, (b) encourage emotional expression and provide the opportunity to experience social support, (c) assist participants in replacing feelings of uncertainty and develop a sense of self-confidence, and (d) discourage maladaptive coping (avoidance, denial), and encourage adaptive (acceptance, positive reframing) coping responses. More information on the logistics of the group program is provided in chapter 2 of this guide.

Problem Focus

Prostate cancer is the most commonly diagnosed non-skin carcinoma. Most PCa cases are diagnosed at the localized stage (Stage I/II), when the tumor is confined to the prostate capsule. Therefore, survival rates for localized disease are very high, with some estimates approaching 100% survival at 5 years post-treatment (ACS, 2007). Radical prostatectomy (RP; surgical removal of the prostate gland) and external beam radiotherapy (EBR) are the most widely used treatments for localized disease followed by hormone therapy and watchful waiting. Treatment options for PCa are often determined by cancer stage, tumor size, and

prostate-specific antigen (PSA) level, as well as the age, health status, and preference of the individual at the time of diagnosis. Despite high survival rates, available treatments for PCa lead to significant acute and chronic side effects (e.g., sexual, urinary, and bowel dysfunction), which can compromise quality of life (QOL; Potosky et al., 2004). At 2 years after treatment, 82% of RP patients and 50% of EBR patients have erectile dysfunction (ED). After 5 years the adjusted percentages for RP and EBR are 79% and 64%, respectively. In terms of urinary function the proportion of men reporting lack of total urinary control after RP is about 79% at 6 months and 68% by 2 years (Stanford et al., 2000). Whereas many fewer EBR than RP patients are urinary incontinent soon after treatment as well as 5 years later (e.g., 15% RP vs. 4% EBR), men who receive EBR tend to show greater difficulty with obstructive symptoms such as slow urination and urinary urgency (Potosky et al., 2004).

A recent evaluation of the impact of treatment-related dysfunction on more global QOL demonstrated that men with urinary or sexual dysfunction, or both, demonstrate significant decrements in multiple QOL domains (including bodily pain, mental health, emotional role, physical role, vitality, and health status [Penson et al., 2003]). Furthermore, other work suggests that up to 30% of men diagnosed with localized PCa may report clinically significant levels of psychological distress and that such distress is typically associated with sexual and urinary dysfunction, and fear of recurrence (Schover et al., 2002; Wei et al., 2002; Zabora et al., 2001). Therefore, a PCa survivor's ability to sustain a relatively adequate level of QOL and overall adjustment following treatment may to some extent depend on his ability to adaptively face and engage the multiple challenges (e.g., treatment side effects) encountered. It has been documented that factors such as supportive social networks, accurate cognitive appraisals, and adaptive coping strategies are significantly associated with overall positive adjustment and lower levels of depression and anxiety post PCa treatment. That is, PCa survivors with supportive family and friends, and less intrusive thoughts about cancer (Lepore & Helgeson, 1998), as well as those showing a greater capacity to engage in adaptive coping strategies such as active-behavioral (planning, seeking social support) or active-cognitive (acceptance, finding meaning in an illness, reframing) coping have reported better overall adjustment (Ptacek, Pierce, Ptacek, & Nogel, 1999). Finally, one must consider that because

PCa is predominantly a disease of older men, with about 70% of cases diagnosed in men over age 64, normal age-related physical changes, as well as other comorbid conditions, may compound treatment-related side effects and further compromise overall QOL.

Development of this Treatment Program

Over the past 20 years, our group has systematically evaluated the effects of stress management interventions in HIV infection, breast cancer, chronic fatigue, cardiovascular disease, and more recently, PCa (Antoni, Schneiderman, & Penedo, 2007). We developed our CBSM program for localized PCa based on the rationale that while treatment for localized disease is highly successful, persistent and often debilitating treatment side effects, as well as ongoing disease status monitoring (i.e., PSA testing) can present the PCa survivors with a series of chronic challenges that can compromise QOL and overall well-being. Based on a chronic disease model, we propose that the extent to which CBSM modifies emotional distress, maladaptive coping, negative appraisals, and social isolation in the context of coping with PCa treatment-related side effects, the intervention program may also positively impact general and disease-specific QOL, emotional well-being, and overall adjustment.

The development of our intervention program for PCa is based on available empirical studies conducted in localized PCa which suggest that a host of psychosocial factors are associated with QOL in this population (e.g., Eton & Lepore, 2002; Schover et al., 2002; Balderson & Towell, 2003). Based on these observations and our prior work, we developed an intervention model that reflects our findings and suggests that a CBSM intervention in men treated for localized PCa (a) improves overall QOL; (b) enhances stress management skills (e.g., ability to engage in adaptive coping and correct negative thinking); (c) improves positive outlook and benefit finding (BF); and (d) among distressed and anxious participants improves emotional well-being and sexual functioning, respectively (Penedo et al., 2002; 2004a,b; 2006; 2003; Molton et al., 2007; Traeger et al, 2007). Collectively, our CBSM intervention program shows that men treated for localized disease can derive multiple benefits by participating in a group-based stress management intervention.

Evidence Base for Group-Based CBSM Intervention

Our CBSM studies in localized PCa show that the CBSM intervention significantly improves overall QOL among CBSM participants relative to men participating in a 1-day control condition seminar that covers stress management skills. We also identified a mechanism through which the CBSM intervention improves QOL. A measure of perceived stress management skills (PSMS), developed to assess an individual's perceived competence in exercising a range of stress management skills, mediated the relationship between group assignment and QOL and remained a significant predictor of post-intervention QOL. Our findings suggest that the intervention had an impact on men's overall QOL such that these improvements were mediated by men's perceived ability to utilize stress management skills. This improvement was not related to ethnic group membership. Our CBSM intervention in PCa has been successfully delivered to an ethnically and economically diverse group of men, including Spanish-monolingual participants. Although non-Hispanic white participants reported significantly better QOL than Latino/Hispanic or African-American participants at baseline, there was no evidence that the CBSM intervention was effective differentially for any one ethnic group. This suggests that our CBSM intervention adequately addressed the QOL needs and properly targeted stress-management skills in an ethnically diverse sample of men treated for PRCA. We have found that the CBSM intervention also improves BF. Work in other cancer populations has begun to document the possibility that for some patients, the experience of cancer may result in positive psychological benefits and actually promote both better emotional well-being and physiological outcomes (e.g., reduced cortisol output; Cruess, Antoni, McGregor et al., 2000; Antoni, Lehman, Kilbourn et al., 2001). We reported that participation in our CBSM program was associated with significant improvements in both QOL and BF. Moreover, the relationship between group assignment and QOL and BF was also mediated by CBSM-associated changes in perceived stress management skills (PSMS), suggesting that skills gained through participation in our intervention explained the increases observed in our outcomes. Separate analyses also indicated that men appear to have enhanced coping skills and reduced distress as a result of our CBSM intervention, as our findings have also showed that participation in the CBSM group signif-

icantly associated with reductions in denial coping and negative mood and improvements in positive reframing.

In addition to significant improvements in general QOL, coping, BF, and perceived stress management skills, and reductions in negative mood, our CBSM intervention has shown significant improvements in sexual and urinary function. We have found that anxiety moderates the intervention's effect on the sexual functioning scores of surgery participants. After controlling for pre-intervention sexual functioning, we showed that CBSM participants with high anxiety showed significant improvements in sexual functioning relative to a comparison group of men who participated in an only 1-day seminar and showed no improvement in sexual functioning over the 12-week follow-up period. We have also shown that among our surgery participants regardless of anxiety levels, participation in our CBSM intervention is associated with statistically and clinically significant increases in sexual functioning. Participants in our CBSM intervention showed significant improvements from baseline to post-CBSM intervention in sexual functioning. It is worth noting that these effects were only identified among our surgery participants. From our work in localized prostate cancer, we have identified that our EBR participants are older (70 yr. vs. 60 yr. for surgery) and report lower socioeconomic status (SES) and a longer time since treatment. Radiation participants also reported more comorbidities and were more likely to be taking antihypertensives and antidepressants. These differences could explain the lack of effects of CBSM on sexual functioning among patients treated with EBR. We have also demonstrated that the intervention has a significant impact on the urinary functioning scores of surgery patients such that the mean pre-post intervention urinary functioning scores of CBSM participants increase relative to men not participating in the CBSM program. Finally, we also documented the efficacy of the intervention in improving emotional well-being among participants who reported high levels of perceived stress on entry into the study. Moreover, we showed that such CBSM-associated improvements in emotional well-being were mediated by changes in illness perceptions. Specifically, changes in perceived treatment control and illness coherence partially mediated the relationship between CBSM group assignment and post-intervention levels of emotional well-being. Throughout this research program, we have consistently found that this 10-week

group-based CBSM intervention can positively impact multiple outcomes and significantly improve adjustment among PCa survivors. Our findings suggest that while CBSM improves overall QOL, BF, coping skills, mood, and perceived stress management skills for men treated with surgery or EBR, this work also shows that CBSM's impact on sexual functioning is limited to men treated with surgery or men reporting high levels of anxiety and interpersonal deficits. Similarly, CBSM's effects on overall emotional well-being are limited to men reporting high levels of perceived stress. Therefore, men reporting significant levels of psychosocial distress and interpersonal difficulties may derive the most benefit in terms of disease-specific (e.g., sexual functioning) QOL and overall emotional well-being by participating in this program.

What Is CBSM for Localized PCa?

The CBSM intervention for localized PCa is a program that integrates relaxation, stress management, and health promotion theory into practice by means of providing a comprehensive 10-week program aimed at improving QOL and adjustment among PCa survivors. This program brings together various types of relaxation (Berstain & Borkivec, 1973), imagery, and other anxiety reduction techniques coupled with widely used and validated cognitive-behavioral approaches such as cognitive restructuring (Beck & Emory, 1979), coping skills training (Folkman et al., 1991), communication skills, assertiveness training, and anger management (Ironson et al., 1989). The techniques presented over the 10-week intervention period are specifically tailored to meet the needs of PCa survivors and thus improve their QOL by increasing stress awareness, teaching anxiety reduction skills, modifying distorted cognitive appraisals, building coping skills, reducing social isolation, and enhancing communication skills.

Other Intervention Strategies for PCa

Psychosocial interventions specifically tailored to meet the needs of cancer patients include supportive-expressive group therapy (Spiegel & Yalom, 1978), psychoeducational interventions, and multimodal inter-

vention approaches (Fawzy, Fawzy, Hyun, et al., 1993; Fawzy et al., 1997). Research shows that effective therapy components in multimodal efforts include relaxation training (e.g., guided imagery) to lower arousal; disease information and management; an emotionally supportive environment where participants can address fears and anxieties; behavioral and cognitive coping strategies; and social support (Andersen, 1992). Several reviews describe the efficacy of psychosocial interventions among cancer patients (Meyer & Mark, 1995). Our CBSM intervention model is based on these multimodal approaches delivered in a supportive group environment where 6–8 men meet once a week over a 10-week period with two group leaders facilitating the intervention. Nonetheless, other intervention programs have shown some beneficial effects among PCa survivors.

Mishel et al. (2002) has shown that a psychoeducational intervention delivered over the telephone that teaches cognitive and coping strategies (e.g., cognitive reframing, problem solving) and patient-provider communication skills, and provides medical information, can successfully improve cognitive processing and problem solving among a multiethnic and diverse SES sample of PCa survivors. Therefore, whereas our program provides a face-to-face group format to provide relaxation and stress management skills, other delivery modalities for similar interventions may provide some benefits to PCa survivors. Our group is in the process of conducting a feasibility study of a telephone-delivered version of CBSM to men living with advanced PCa. We reasoned that a home-based delivery system would be more feasible because this population is likely to be older and have more comorbid conditions and functional limitations.

Other psychosocial interventions in PCa have involved social support and psychoeducational interventions which have shown some promise. For example, Gregoire et al. (1997) reported that men who participated in a supportive group had a better understanding of their illness, perceived themselves as more involved in their treatment, felt reassured sharing their experiences with others, and had less anxiety and a more positive outlook. In one study evaluating the efficacy of psychosocial interventions in PCa, Lepore & Helgeson (1998) tested the extent to which patients participating in a support group developed self-efficacy through

direct education or social sharing, and lowered cancer-related distress by targeting intrusive thoughts with the support of peers. Men in the 6-week intervention condition had greater improvements in mental health, fewer interpersonal conflicts, larger increases in perceived control over health, and lower distress associated with cancer intrusive thoughts. The intervention was especially beneficial to men with inadequate social resources and low social support from family and friends (Eton, Lepore, & Helgeson, 2001); however, the sample was limited to non-Hispanic white men. In a separate study, Lepore et al. (2003) randomized men recently treated for PCa to a control group, a group-based education intervention (GE), or group-based education plus discussion (GED). The 6-week study significantly increased PCa-specific knowledge in the GE and GED groups relative to control group, and reduced sexual bother was also observed in the GED group. For non-college graduates, both group interventions resulted in better physical functioning scores, and the GED group also reported more positive health behaviors. While there were no overall changes in distress or QOL, this is not surprising given the information-provision focus of the intervention. The results suggest that other interventions with an educational component may be particularly salient for men with less education and possibly limited access to health care information.

Outline of this Treatment Program

The overall aims, general strategies, and specific techniques of the 10-week program are summarized in Table 1.1. Fidelity checklists are included in an appendix and can be photocopied. Each checklist includes an outline of the corresponding session and space for recording time units. Facilitators may want to use these as part of the supervision process or to rate self-adherence.

This CBSM program uses five sets of stress management techniques: cognitive restructuring, coping skills training, assertiveness training, anger management, and social support strategies. About 1–3 weeks are dedicated to training participants in the use of each of these strategies. Each week over the 10-week period a new topic is presented with background

Table 1.1 CBSM Components and Strategies

Aim 1.	**Increase Stress Awareness**	• Identify components of the stress response by focusing on the psychological and physiological responses to stress. • Identify frequently occurring stressors and signs of the stress response. • Understand the experience of tension in the body.
Aim 2.	**Teach Anxiety-Reduction Skills**	• Provide multiple relaxation techniques to reduce anxiety and tension (PMR, deep breathing, autogenics, meditation). • Achieve a sense of mastery over stressors. • Aim to "take the edge off" acute emotional and somatic responses.
Aim 3.	**Modify Cognitive Appraisals**	• Modify appraisals of stressful events. • Use cognitive restructuring and rational thought replacement. • Identify links between thoughts, emotions, and bodily changes. • Enhance familiarity with commonly used distorted thoughts. • Identify steps to replace distortions with rational interpretations.
Aim 4.	**Build Coping Skills and Increase Emotional Expression**	• Challenge and change cognitive, behavioral, and interpersonal coping strategies. • Increase awareness of use of maladaptive ways of coping with stress. • Replace less efficient and indirect ways of coping with direct emotion- and problem-focused strategies. • Increase expression of feelings in response to a stressful situation. • Increase awareness of angry responses and external/internal triggers. • Provide assertiveness and communication skills training and teach anger management.
Aim 5.	**Reduce Social Isolation**	• Identify and use beneficial sources of social support. • Process perceived satisfaction with available social networks. • Identify sources of emotional, financial, and guidance support. • Provide support for others. • Understand the "stress buffering" role of emotional support. • List potential obstacles to maintaining a strong support network.
Aim 6.	**Reduce Risk Behavior and Enhance Treatment Adherence**	• Modify patient beliefs by providing information provision and cognitive restructuring. • Target intentions for health maintenance through motivational enhancement training. • Change negative habits by stimulus control and self-monitoring strategies. • Address barriers to health maintenance through coping skills training. • Enhance physician-patient relations through assertiveness training and coping skills training.

information and in-session exercises. This approach assists participants in increasing their awareness of subtle stress responses that are addressed by the technique being presented. Once a topic is introduced, the facilitators present the rationale for the technique and steps for implementing it. Throughout the remainder of the session, participants are encouraged to discuss ongoing stressors in their lives and how to apply the new stress management technique. This is facilitated through role-playing exercises and breakaways, as well as dyads to maintain the interactive nature of the group experience. Weekly homework assignments are provided to reinforce the techniques presented in each session.

In addition to the stress management topics, the CBSM program provides participants with a set of relaxation exercises that includes progressive muscle relaxation (PMR), deep breathing, guided imagery, autogenic training, diaphragmatic breathing, and various forms of meditation. Most of the relaxation scripts provided in this guide are simplified versions of relaxation methods that are widely used and well validated. Facilitators may want to review full-length versions of many of these procedures in *The Relaxation & Stress Reduction Workbook* (Davis, Eshelman & McKay, 1988), *Hypnosis for Change, 3rd Ed.* (Hadley and Staudacher, 1996), *Guide to Stress Reduction* (Mason, 1986), and *Full Catastrophe Living* (Kabat-Zinn, 1990). The program is designed to have each session introduce either a new technique or a more complex version of a previously introduced relaxation exercise. At the beginning of each session, the group leaders present and review the rationale and steps for carrying out the relaxation technique with the group members. The major part of the relaxation segment of each session is dedicated to having the participants practice the relaxation exercise. Following each exercise, the participants have an opportunity to discuss their experiences. Facilitators then instruct participants to perform the relaxation techniques on their own at least once a day. This format is designed to present the participants over a 10-week period a set of relaxation exercises and skills that they can import into and practice in their home environments. By providing several different techniques, participants will be able to choose a method that they are most comfortable with and thus adhere to over the 10-week intervention and beyond.

Using a Group Format

The CBSM intervention is a group-based, closed structured, and sequenced intervention that meets once weekly for 2–2.5 hours over a 10-week period in groups of six to eight men facilitated by two group leaders. Chapter 2 provides more information on the logistics of running the group program. Using a group format allows us to (a) use group members and group leaders as coping role models where participants can make positive social comparisons and use social support for informational purposes; (b) encourage emotional expression and acceptance, and provide the opportunity to seek emotional and instrumental social support; (c) replace feelings of helplessness with a sense of mastery and altruism (e.g., self-efficacy changes); and (d) discourage avoidance and encourage acceptance, reframing, planning, problem-solving, and other adaptive coping strategies. Furthermore, participating in a group that is composed of other men who share a common experience and possibly similar challenges provides a sense of commonality that may offer an opportunity to access and benefit from various processes that would not be available in individual psychotherapy. Because our groups are led by two facilitators, the intervention occurs in a nurturing and safe environment where participants feel comfortable sharing private and sensitive processes while at the same time providing opportunities for support and challenges by other participants. This format provides an optimal atmosphere for encouraging emotional expression and an opportunity to seek and obtain emotional support from other group members in a safe and confidential environment.

Use of the Client Workbook

The *Cognitive-Behavioral Stress Management for Prostate Cancer Recovery, Workbook* provides group members with the necessary materials to participate in the program and will aid group leaders in delivering the intervention. Each workbook chapter corresponds to a session of the program and includes psychoeducational information about stress management techniques and basic instructions for relaxation exercises. The workbook provides participants with forms and worksheets for completing in-session activities that are designed to raise stress awareness and