THE EFFECTS OF ANDROGEN DEPRIVATION THERAPY ON INTIMATE RELATIONSHIPS

Benefits of early awareness and intervention

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Androgen deprivation therapy (ADT) is an increasingly common treatment for men with prostate cancer. This treatment is associated with many side effects — loss of libido, erectile dysfunction, genital shrinkage, weight gain, loss of muscle mass and emotional lability — which often lead to emasculation and in turn can affect the quality of marital or intimate relationships. The physiologic changes associated with ADT are well documented, and several studies have examined the nature of the psychosocial changes men experience while on ADT. However, the effect that ADT can have on the quality of a man’s intimate relationships has only recently been studied. Emerging literature reveals the alarming finding that ADT often erodes the marital bond. It is therefore important to direct a spotlight on the challenges ADT brings to the lives of couples who are striving to maintain intimacy in spite of treatment. Our paper highlights current target areas for clinicians’ attention, suggests treatment ideas and examines strategies for restoring couples’ sexuality.

Abstract

Androgen deprivation therapy (ADT) is an increasingly common treatment for men with prostate cancer. This treatment is associated with many side effects — loss of libido, erectile dysfunction, genital shrinkage, weight gain, loss of muscle mass and emotional lability — which often lead to emasculation and in turn can affect the quality of marital or intimate relationships. The physiologic changes associated with ADT are well documented, and several studies have examined the nature of the psychosocial changes men experience while on ADT. However, the effect that ADT can have on the quality of a man’s intimate relationships has only recently been studied. Emerging literature reveals the alarming finding that ADT often erodes the marital bond. It is therefore important to direct a spotlight on the challenges ADT brings to the lives of couples who are striving to maintain intimacy in spite of treatment. Our paper highlights current target areas for clinicians’ attention, suggests treatment ideas and examines strategies for restoring couples’ sexuality.

More than 1 in 8 men develop prostate cancer during their lifetime. Androgen deprivation therapy (ADT) is a commonly used treatment in prostate cancer patients; a conservative estimate is that 40,000 North American patients per year are started on this treatment. ADT is increasingly used on younger men with both localized and advanced prostate cancer, and is administered for variable lengths of time ranging from a few months to the remainder of a patient’s life. The average survival time for patients taking ADT is now approximately a decade, and has been climbing steadily since the advent of prostate-specific antigen (PSA) testing, which allows for earlier detection and treatment of prostate cancer.

Patients on ADT have described experiencing many burdensome psychosocial changes, including loss of energy and enthusiasm, decreased self-esteem and reduced ability to identify with traditional masculine ideals. Some report increased stress associated with changes in emotional expression that are difficult to understand, such as increased irritability, sensitivity and anger. Some patients express feeling more depressed or hopeless, with increasing concern about being more emotionally volatile. Commonly, patients on ADT report a complete loss of libido, inability to engage in sexual fantasy and inability to be sexual with their partner.

ADT AND SEXUALITY

While ADT may cause a patient to lose his sexual desire or libido, a couple may still strive to achieve sexual intimacy. This is significant, because it has been asserted that physical closeness can reinforce and reassure an individual’s need to feel desirable and attractive. Understandably but unfortunately, most couples initially ignore sexual concerns during the time immediately surrounding treatment decisions. They commonly assume that they can manage without sexual intimacy and that they should focus entirely on the goal of sustaining life. However, because ADT administration ranges from months to a lifetime, couples will eventually need to address the effects of treatment on their everyday lives. Even when ADT is not indefinite, its side effects can last for years following administration. These side effects interfere with the couple’s attempt to pursue usual intimate
practices after the initial shock of diagnosis has faded. One small but important qualitative study found that 50% of the patient sample experienced marital erosion following ADT administration.8

Although important to patients, the issues of maintaining sexuality and overcoming sexual dysfunction are not often discussed with healthcare professionals.11,12 Reasons for this include the assumption that discussing sexuality is an invasion of patient privacy, the tendency to overlook sexuality while focusing on survival,8,13 inadequate professional education or training, and patient and/or professional embarrassment or discomfort.8,13 Further, research suggests that patients on ADT are typically silent about their treatment due to feeling humiliated by its side effects.8,14-16 Therefore, patients may also be reluctant to initiate discussions on sexuality with their physicians.

Some researchers suggest that if sexual dysfunction in prostate cancer patients is not dealt with appropriately, it can spread beyond the sexual self-concept and into the realm of social relationships.17 Further, a person can develop a disabled emotional and physical intimacy due to their apprehension about sexual intimacy. Matthew et al suggest that this detriment to intimacy leads to relationship challenges and to lack of communication about sexual expectations.17 In one study, 89% of a sample of prostate cancer patients reported bitterness and anger, 75% reported decreased self-esteem and 65% reported sadness.18 A significant proportion of men felt less desirable (38%), guilty (33%) or blamed themselves for not being able to please their partner (21%). As well, 62% of these men indicated that they felt concerned or worried about how their life would develop in the future.18 Additional risk factors for poor adjustment include lack of communication about and abandonment of one’s sex life.19

OTHER INFLUENCES ON LIBIDO
It is often assumed that men on ADT are incapable of a sexual response because they experience a complete loss of sexual desire as a result of castrate levels of testosterone. However, it is possible that lowered testosterone may actually alter a man’s sexual response to be more like that of women.20 As they mature, women often find that their sexual desire shifts from being spontaneous or innate, to being receptive or responsive, and that desire develops after starting to engage in sexual activity rather than preceding it.21 Thus, if one is motivated to engage in potentially arousing sexual activity and if one begins to feel sexually aroused, desire will be triggered. The importance of enhancing motivation and understanding the patient’s fears about engaging in sexual activity are at the forefront of this conceptualization. The implication of this for couples adapting to ADT is that they can no longer rely on the man’s spontaneous sexual desire to be the primary motivator for sexual activity. Clinically, we have found inviting couples to reflect on how they will manage this change to be helpful to them in successfully adapting to the loss of his spontaneous sexual desire.

Women’s sexual responses are strongly influenced by psychologic variables such as distraction, general life stress, fatigue, mood volatility, increased worry or anxiety, low self-image and reminders of a previous negative sexual encounter.22-24 If men on ADT experience similar testosterone levels as women, it is possible that their sexual responses may also be significantly altered by such psychologic influences.23 Therefore, psychosocial variables may be as important as hormonal variables for men on ADT — and behavioural interventions addressing motivational issues may show the same promise in restoring the sexual response of androgen-suppressed men as they have for women with low androgen levels.21 It may be helpful to view a man’s sexual response while undergoing ADT as altered rather than simply absent. In one case report, after addressing several psychologic variables, a man on ADT with complete erectile dysfunction was able to experience a satisfying sexual encounter that resulted in his experiencing more than one orgasm.24 Addressing psychologic factors known to negatively influence sexual responses in women may also help the androgen-deprived male to have improved sexual responses.23,25

IMPACT ON FEMALE PARTNERS
In general, a female partner tends to show more distress at the man’s cancer diagnosis than he does.22,25 One of the most significant predictors of quality of life for female partners of men with prostate cancer is sexuality.22 Further, maintained sexual intimacy can act as a buffer against the negative effects associated with declines in health, marital satisfaction and marital quality.20 Some women may not be disappointed by a reduction in sexual frequency and quality; for example, in one study a partner reported, “After surgery […] we] almost put too much effort to get back to sex again. So for me it was kind of a relief when he didn’t really have a lot of interest in sex”.31 However, some partners show significant distress.22 Because her partner no longer initiates sexually intimate contact, a woman may begin to interpret this change as an indicator of her inadequateness, unattractiveness or lack of feminine appeal. Her partner no longer shows arousal and sexual interest in her as he once did.21 The imbalance in sexual desire that commonly results from ADT can pose significant challenges for the maintenance of intimacy within the marital relationship. One patient described how he
shares his partner’s sense of loss, “It really affects me. Sometimes I sit and cry about it. I have no sexual desire. We try and do different things but she feels that because I can’t have any satisfaction that she shouldn’t. I feel terrible guilt.” Thus, maintenance of sexual intimacy is important for many female partners, despite the common experience of loss of libido on the part of the man. Research suggests that couples who are willing to adjust their definitions of emotional and sexual intimacy may be more likely to maintain healthy and satisfying marriages. It is important that healthcare professionals encourage their patients on ADT to strategize ways of maintaining a close bond with their partners in order to prevent marital erosion.

USEFUL INTERVENTIONS

Despite being warned, many couples assume that their sexual practices will return to their former typical quality and pattern after the patient has recovered from treatment. Others assume that should difficulties arise, they would be satisfied with using medications to restore erectile function. Most couples, however, are not prepared for the reality that waits them. For example, one patient reported, “My wife puts up with it okay, she never bugs me about it [intercourse]. I know she misses it…but you don’t realize what an integral part of your marriage it is…now there is something missing [cries].”

Early resumption of sexual activities after primary prostate cancer treatment has been shown to have positive effects on quality of life and therefore should be encouraged for ADT couples. Currently, however, the majority of methods that aim to restore sexual relationships after treatment for prostate cancer focus entirely on restoring erections (i.e. phosphodiesterase type 5 [PDE5] inhibitors, vacuum erection devices, intracavernous injections etc.). These aids for achieving an erection are largely ineffective and do nothing to address loss of libido. It is estimated that with current erectile dysfunction treatment methods, only about 20% of couples on ADT will regain erectile function.

A handful of psychosocial interventions have been established to help prostate cancer patients overcome sexual dysfunction after undergoing primary treatment, which may be applicable for ADT couples. Providing realistic expectations, educating both partners about potential challenges, and encouraging open sexual discussion between partners should be part of the treatment process. It is also recommended that patients be willing to give up spontaneity and embrace planned sexual activities. Other treatments focus on the need to restore effective communication after a hiatus from sexual activity.

In couples attempting to maintain sexual activity and relational intimacy, treatment methods need to focus on the impact of the difficulties specific to ADT, such as maintaining sexual intimacy when sexual desire is diminished. Sexuality can be understood as the expression of erotic love and physical affection between individuals for the purposes of pleasure and intimacy. Many couples can get stuck in habitual sexual practices and assume that once penetrable intercourse is no longer possible, sexuality ceases to exist. Couples can be encouraged to consider sexuality as including a variety of types of touching and caressing, and that these acts can still be enjoyable without intercourse and with or without orgasm. Couples can begin to see one another as erotic friends who continue to find ways to give and to receive sexual pleasure even when erection problems make penetration impossible. They can begin to understand that while his sexual desire may not develop spontaneously, he may still gladly accept an erotic invitation.

Disclosure

Lauren Walker and Dr. Robinson report having no potential conflicts of interest pertaining to this article.

References


