Erectile dysfunction, masculinity, and psychosocial outcomes: a review of the experiences of men after prostate cancer treatment

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Abstract: Prostate cancer (PC) treatment side-effects such as erectile dysfunction (ED) can impact men's quality of life (QoL), psychosocial and psycho-sexual adjustment. Masculinity (i.e., men's identity or sense of themselves as being a man) may also be linked to how men respond to PC treatment and ED however the exact nature of this link is unclear. This review aims to provide a snapshot of the current state of evidence regarding ED, masculinity and psychosocial impacts after PC treatment. Three databases (Medline/PsycINFO, CINHAL, and EMBASE) were searched January 1st 1980 to January 31st 2016. Study inclusion criteria were: patients treated for PC; ED or sexual function measured; masculinity measured in quantitative studies or emerged as a theme in qualitative studies; included psychosocial or QoL outcome(s); published in English language, peer-reviewed journal articles. Fifty two articles (14 quantitative, 38 qualitative) met review criteria. Studies were predominantly cross-sectional, North American, samples of heterosexual men, with localised PC, and treated with radical prostatectomy. Results show that masculinity framed men's responses to, and was harmed by their experience with, ED after PC treatment. In qualitative studies, men with ED consistently reported lost (no longer a man) or diminished (less of a man) masculinity, and this was linked to depression, embarrassment, decreased self-worth, and fear of being stigmatised. The correlation between ED and masculinity was similarly supported in quantitative studies. In two studies, masculinity was also a moderator of poorer QoL and mental health outcomes for PC patients with ED. In qualitative studies, masculinity underpinned how men interpreted and adjusted to their experience. Men used traditional (hegemonic) coping responses including emotional restraint, stoicism, acceptance, optimism, and humour or rationalised their experience relative to their age (ED inevitable), prolonged life (ED small price to pay), definition of sex (more than erection and penetration), other evidence of virility (already had children) or sexual prowess (sown a lot of wild oats). Limitations of studies reviewed included: poorly developed theoretical and context-specific measurement approaches; few quantitative empirical or prospective studies; moderating or mediating factors rarely assessed; heterogeneity (demographics, sexual orientation, treatment type) rarely considered. Clinicians and health practitioners can help PC patients with ED to broaden their perceptions of sexual relationships and assist them to make meaning out of their experience in ways that decrease the threat to their masculinity. The challenge going forward is to better unpack the relationship between ED and masculinity for PC patients by addressing the methodological limitations outlined so that interventions for ED that incorporate masculinity in a holistic way can be developed.

Keywords: Erectile dysfunction (ED); masculinity; prostate cancer (PC); psychosocial; quality of life (QoL)

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Introduction

Globally, over one million new cases of prostate cancer (PC) were diagnosed in 2012 with incidence expected to increase to 1.7 million cases in 2030 (1,2). PC incidence is highest in western countries such as Australia/New Zealand, North America, and Europe (age standardised incidence rates per 100,000 range from 85.0 to 111.6) (1,2). Parallel to increasing incidence, survival has also increased in the UK, North America and Australia/New Zealand such that approximately 90% of men now survive their PC 5 or more years and over 80% survive at least 10 years (3-5). Although promising, extended survival means that many men live with high and enduring treatment side-effects that can persist for a decade or more (6,7). For instance, treatments such as surgery, radiation therapy, and androgen deprivation therapy (ADT) can have negative effects on urinary, bowel, hormonal, or sexual function (8,9). Regarding the latter, erectile dysfunction (ED) is the most common impact on sexual function and is often accompanied by a loss of sexual desire or difficulty reaching orgasm (10).

The exact incidence of ED following PC therapy is unknown with most epidemiological data derived from the post-radical prostatectomy (RP) cohort. While the exact recovery of erectile function is difficult to compare when reviewing clinical studies due to variables such as the definition of ED, the definition of return of erectile function, the use of erectogenic medication and the use of multimodal PC therapy, it is widely accepted that post-RP ED occurs for around 60–70% of men (11-15) despite advances in surgical techniques and technology. Factors such as the age of the patient, the level of pre-treatment erectile function, the extent of surgical neurovascular preservation, intraoperative changes on erectile haemodynamics, stage of disease and body mass index can contribute to the erectile outcome (13,15,16). In contrast to post-RP ED, radiation-induced ED usually develops later (usually 3-year post-radiation) with the actual rates of ED between RP and radiation groups similar (17). Several pathophysiological mechanisms for ED have been proposed that include cavernous nerve injury, vascular compromise (e.g., accessory pudendal artery ligation), damage to nearby structures, local inflammatory changes relating to surgical and radiation effects, cavernosal smooth muscle hypoxia with ensuing smooth muscle apoptosis and fibrosis, as well as corporal veno-occlusive dysfunction causing venous leakage (11-15).

In addition to physical treatment side-effects, for some men ED has quality of life (QoL) and psychosocial impacts including but not limited to depression, cancer-specific distress, self-esteem, relationship satisfaction, coping and adjustment (18-21). Masculinity (i.e., men’s identity or sense of themselves as being a man) may also be linked to how men respond to PC diagnosis and treatment including their experience of psychological and psychosexual distress and adjustment (22-28). Low masculine self-esteem has been shown to contribute to increased anxiety, depression and cancer-specific distress in men with PC (29). Masculinity has also been implicated in men's reluctance to seek help for their emotional or sexual concerns after PC treatment (24,30,31). However, the exact nature of the impact of ED on psychosocial aspects of men’s experience after PC treatment and how masculinity may feed into this is unclear (20,32).

Thus, the aim of this review is to provide a snapshot of the current state of the evidence regarding ED, masculinity and psychosocial impacts after PC treatment. Our review considers three questions:

(I) How is masculinity described in the literature in relation to ED after PC treatment?

(II) Does masculinity moderate the effects of ED on men’s psychosocial or QoL outcomes after PC treatment?

(III) Is masculinity considered as a state of being that is affected by ED (i.e., masculinity is an outcome) after PC treatment?

Methods

Search strategy

The search strategy occurred in a two-step process. First, Medline and PsycINFO [via Ovid), CINAHL, and EMBASE databases were searched (January 1st, 1980 to January 31st, 2016) using the following keywords:

(I) (“prostat$ cancer” OR “prostat$ neoplasm$” OR “prostat$ carcinoma”);

(II) (masculine OR masculinity OR masculinities OR manhood OR man-hood OR “sex role” OR “sex-role” OR “male identity” OR “male identities” OR “gender identity” OR “gender identities” OR “sexual identity” OR “sexual identities”);

(III) 1 AND 2;

(IV) 3 limit to Human AND English.

Second, targeted searches on Google Scholar were conducted with the terms “prostate cancer” AND (masculinity OR masculine OR hegemonic). Duplicates
were removed prior to examining article titles and abstracts. Cited reference searches of articles which met final inclusion criteria for review were conducted on Web of Science, Google Scholar, and via hand searches of article reference lists. For retrieval and eligibility of articles and data extraction, one author and a research assistant independently completed each stage and consulted with a third independent reviewer to resolve differences in decision-making.

**Eligibility criteria**

Potential articles were identified initially by examining the title and abstract and were then retrieved for more detailed evaluation against the apriori inclusion criteria. Peer-reviewed quantitative or qualitative journal articles containing primary data were included if they met the pre-determined eligibility criteria below:

(I) Participants were men (or a sub-group of men) who had been diagnosed with and received treatment for any stage of PC;

(II) Included a measure of ED or sexual function/dysfunction;

(III) Included a measure of masculinity in quantitative studies or masculinity emerged as a key theme in qualitative studies;

(IV) Included masculinity or psychosocial (e.g., distress, social support, adjustment) or QoL outcome(s);

(V) Published in English language;

(VI) Published after January 1st, 1980 and prior to January 31st, 2016.

Reviews, meta-analyses, editorials, commentaries, books or book chapters, guidelines, position statements, conference proceedings, abstracts and dissertations were excluded.

**Data extraction**

A data extraction form was created prior to the review to identify key characteristics of studies which met criteria for inclusion: source (author, year and country of publication); study design; participants (age, sexual orientation, disease stage, treatment type, time since treatment, ED score); masculinity measure; results corresponding to masculinity outcomes and masculinity as a contributor to (correlate) or moderator of psychosocial or QoL outcomes. Characteristics of included studies are summarised in Tables S1,S2.

**Results**

**Search results**

**Systematic search**

The systematic search identified 759 records for review after duplicates were removed. Of these, 242 underwent full-text review. One hundred and ninety articles were excluded because they focused on pre-treatment decision-making, had no outcomes of interest, or the relationship between masculinity and sexual function was not examined (Figure 1). The remaining 52 articles were reviewed and these included 14 quantitative and 38 qualitative studies. Quantitative research comprised 7 studies that were cross-sectional, 5 prospective, and 2 randomised controlled trials (RCT). Qualitative research included 35 cross-sectional and 3 prospective studies. Studies were published from 1995 to 2016 and most were conducted in the USA (39%), Australia (23%), Canada (14%), Europe (10%), or the UK (8%).

**Sample characteristics**

Sample sizes ranged from 3 to 1,070 (median =20); 68% of studies had less than 50 participants. Twenty-four studies provided a mean age for men and this ranged from 57.0 to 76.2 years. Most studies did not report the sexual orientation of the sample (65%) and where this did occur almost all sampled exclusively heterosexual men (33%); only one study focused on the experience of homosexual men (33). Of the 26 studies reporting disease stage, most men had localised PC (69%) and were treated with RP (45% of studies included mostly men receiving RP, 23% radiation therapy, and 23% hormonal ablation therapy; 9% of studies did not report treatment type). Less than half (45%) of studies reviewed reported time since treatment and this ranged from 0 to 60 months. Nine studies (17%) reported ED scores from validated measures and of these most used the sexual function subscale from the Expanded Prostate cancer Index Composite.

**Masculinity measures**

Measures most often used to assess masculinity in quantitative studies were the masculine self-esteem scale (33-36), Bem Sex-Role Inventory (37,38), or the single item EORTC-QLQ-PR25 measure (‘Have you felt less masculine as a result of your illness or treatment?’) (39,40). Other measures used in a single study were the Sexual Self-Schema scale for Men (41), the Conformity to Masculine Norms Inventory (22), Cancer-related Masculine Threat scale (23), and the Masculinity in Chronic Disease Inventory (32). Two studies
used un-validated measures (38,42).

**Masculinity and sexual function after PC treatment**

PC treatment and subsequent ED, loss of libido, and/or potency was consistently described in qualitative studies as having an impact on, or being a threat to, men’s sense of masculinity (43-50). Some men chose to undergo radiation therapy instead of RP because the former offered a better chance of preserving sexual function which in their view was equivalent to masculinity (51,52). In almost every study, the belief that masculinity was lost (‘no longer a man’) or somehow diminished (‘not a whole man’) was described (26,43,44,48,52-71), and this was a source of anxiety, depression, or embarrassment for men; made them question their self-worth; and created feelings of disempowerment and a fear that they may be stigmatised (27,43-46,49,60,61,70,72-74).

Other qualitative studies described masculinity as framing men’s experiences and adjustment after PC treatment (54). In this regard, due to their sexual dysfunction some men believed that they could no longer live a normal life (63) or respond appropriately in everyday interactions with women (72,73). Men also discussed the possibility that their wives would leave them because they could not satisfy them sexually or be an ‘active partner’ (66,70,75). Men limited social activities which had the potential for sex (e.g., parties) (61,67); adopted strategies that maintained the macho façade such as pseudo courtship or laughing at jokes about ED (66,67); or used traditional (hegemonic) masculine coping responses such as emotional restraint (60), stoicism (60,76), acceptance (66,76), optimism (27,67,69), and humour (47).

Many qualitative studies discussed that men rationalised their ED or sexual dysfunction through active attempts to cognitively reframe their experience which in turn allowed them to preserve their sexual identity or sense of masculinity. Men did this in four main ways: used age as a reference point to normalise or accept their experience (ED is an inevitable consequence of aging, ED is worse for younger men) (26,28,43-46,54,60,61,63,66,67,70); viewed ED or sexual dysfunction as a trade-off for prolonged life or health (health more important, small price to pay for being alive) (26,27,43,47,58,60,63,65-67,77); broadened their definition of sex as encompassing more than an erection and penetration (e.g., hugging, kissing, conversation and company) (27,44-46,60,61,63,66,67,75); and looked for other evidence of masculinity (e.g., already had children, sowed a lot of wild oats, being grateful for prior sexual experiences) (27,60,66).

In contrast to the majority of qualitative work, a small number of studies which sampled older men reported that changes in men’s sexual function had minimal impact on masculinity (28,44-46,76). The potential impact of ED...
on masculinity was also discussed in studies sampling men from a range of ages as something that happened to other men (43,63); ED was viewed as an ill-effect that men could live with (44-46); or ED had minimal impact because men or their partners had already experienced sexual dysfunction due to chronic or co-morbid disease (66,75).

**Masculinity as a moderator**

Two quantitative studies examined masculinity as a moderator of the relationship between sexual function and psychosocial or QoL outcomes. Together these studies showed that when men who had poor sexual functioning endorsed more traditional (hegemonic) masculine values they had worse social functioning, role functioning, and mental health outcomes (22), including depression (41).

**Masculinity as an outcome or correlate**

In the remaining 12 quantitative studies, masculinity was described as an outcome (32-36,38-40,42,78), or as a potential correlate or predictor of sexual function or bother (23,36,37,42). Collectively, these studies showed a consistent correlational relationship between poor sexual function and decreased masculinity (32,34-36,39,40,42,78), or increased masculinity and poorer sexual outcomes (23,36,42). However, this relationship did not hold in two studies when sexual function was included with other variables in a multivariate model as predictors of masculinity (33) or when the impact of masculinity on sexual symptoms at different points on the treatment trajectory were considered (37).

Of these quantitative studies, two also described the conditions under which the relationship between sexual function and masculinity may be strengthened (moderated) by interpersonal variables (36,38). Specifically, men who had sexual dysfunction or bother were more likely to interpret this as a threat to their masculinity if they had higher interpersonal sensitivity which can diminish social support and communication (38), or their spouse perceived low marital affection (36).

**Discussion**

Based on this review it is clear that for most men masculinity is crucial in their experience of PC treatment and ED in two ways: masculinity frames how men interpret what is happening to them; and men's sense of themselves and their masculinity suffers harm. While there is evidence that some men manage to cope with this impact and are able to cognitively reframe their experience relative to aging, prolonged life, the definition of sex, and other evidence of their virility or sexual prowess, this is a task that for many men will be challenging. Therefore, the role of clinicians and health practitioners in the field is to help men and their partners broaden their perceptions of sexual relationships and also to facilitate adjustment by assisting men to make meaning of, or seek alternative meaning for, their experience that presents less of a threat to their masculine identity.

While the proliferation of qualitative research in this context offers some key insights, this work has focused on understanding the masculinity phenomena. There are few quantitative studies and of these most confirm a correlational relationship between ED and masculinity and, with few exceptions, do not extend beyond this. Moving forward, three areas of focus for future research are apparent. First, we need empirical studies that establish the role of masculinity as a mediator or moderator of psychosocial and QoL outcomes for men experiencing sexual dysfunction. Two studies in this review (22,41) suggest a moderation effect for masculinity; men who had ED and more strongly endorsed traditional masculine values experienced poorer QoL and mental health outcomes. However, recent work on men's decisions to seek medical help for their sexual concerns after PC treatment suggests that aspects of masculinity such as emotional self-reliance and placing high value on the importance of sex may be a strength for men to draw upon in promoting help-seeking and ultimately better adjustment (30). The conditions under which masculinity may be a help or a hindrance to PC patient's adjustment require further exploration.

Second, for men experiencing ED after PC treatment, empirical studies are needed to identify factors that may interact with masculinity with regards to its influence on QoL or psychosocial outcomes, and determine their relative importance. Two studies in this review (36,38) reported that interpersonal factors such as marital affection may moderate the extent to which men interpret ED as a threat to their masculinity. However, there are a range of individual (e.g., age, sexual orientation), psychological (e.g., depression, anxiety, pre-treatment expectations), social (e.g., nature and quality of relationships, support) and medical (e.g., co-morbidities, medication use, pre-treatment erectile function, other treatment side-effects, treatment type)
factors that may also be important and these have yet to be explored fully.

Third, to facilitate knowledge advancement about the role and contribution of masculinity, established theory and consistent measurement approaches should be adopted. This review noted a trend toward use of masculinity measures that reflect traditional, hegemonic masculine values and ideals (e.g., Bem Sex Role Inventory, Conformity to Masculine Norms Inventory, Sexual Self-Schema scale for Men) that are not contextualised for men with cancer. Where context-specific scales have been applied, they are ambiguous, single-item measures (e.g., EORTC-QLQ-PR25 question) or capture only one aspect of masculinity (e.g., Masculine Self-Esteem scale). Recent development of two context-specific masculinity scales, the Cancer-related Masculine Threat scale (23) and the Masculinity in Chronic Disease Inventory (32) show promise, however more research is needed to establish the utility of these scales across the diversity of men who have ED after PC treatment, particularly accounting for sexual orientation, ethnic background, and treatment type.

Given the role of masculinity as an influencer of men’s response to ED after PC treatment, our challenge going forward is to develop interventions that are responsive to masculinity, optimally working with masculinity as a potential strength. To do this we need to better unpack masculinity as it relates to ED and PC treatment through context-specific measurement of masculinity; quantitative empirical, prospective studies that consider the experience of men with differing sexual orientations, socio-demographic backgrounds, and PC treatments; assess moderating and mediating factors; and test interventions for ED that incorporate masculinity in a holistic way. In the interim, it is important for clinicians to invite a conversation with men and their partners about their expectations and goals with regards to sexual outcomes after a PC diagnosis and treatment and implement a care plan matched to these. In addition, given the links between a man’s sexual QoL and his psychological outcomes, this care plan needs to also address psychosocial and subjective well-being based on current best practice approaches (79).

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Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

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sexuality, sexual function, and sexual identity. 

**Men who had severe ED reported lower scores on the masculinity measure compared to men who had better sexual function.** 

**Better sexual function was significantly correlated with increased masculine self-esteem (Spearman's correlation coefficient = 0.22, P=0.02).** Men who had easier access to sexual fulfillment were more likely to interpret sexual dysfunction as a threat to their masculine identity, and these men benefited most from the cognitive-behavioural counseling intervention (Impaired quality of sexual function compared to controls). 

**Men with lower sexual self-schema (more traditional concepts of masculinity) had poorer sexual functioning associated with increased depression.** 

**Increased sexual problems were associated with decreases in masculinity.** 

**Loss of masculine identity was more strongly related to sexual bother if a man's spouse perceived low marital affection.** 

**After controlling for sexual function, loss of masculinity was a significant predictor of sexual bother (β = −0.68, P<0.01).** 

**Sexual bother (r=−0.68, P<0.01) and erectile functioning (r=0.37, P<0.01) were significantly correlated with loss of masculine self-esteem.** 

**In the first 18 months post tx, the combination of increased depression-anxiety and increased sexual dysfunction was associated with increased sexual bother, B=0.14, t=4.16, P<0.001**; and feeling less of a man (B=13.85; CI, 3.44–55.81; P=0.001) 

**Sexual bother and erectile functioning was associated with increased depression, B=−0.21, P<0.05**; and anxiety, B=−0.17, P=0.003 

**For men with higher sexual self-schema (more traditional concepts of masculinity), poorer sexual functioning was associated with increased depression.** 

**Increased sexual dysfunction was significantly associated with decreased masculine self-esteem (r=−0.41, P<0.05).** Men who had easier access to sexual fulfillment were more likely to interpret sexual dysfunction as a threat to their masculine identity, and these men benefited most from the cognitive-behavioural counseling intervention (Impaired quality of sexual function compared to controls). 

**Men who had lower sexual self-schema (more traditional concepts of masculinity) had poorer sexual functioning associated with increased depression.**
Participants

20 men interviewed Jan 2010 to Jun 2012;

• ED impacted men's notion of manliness such that it was a 'social stigma' when sexual function was impaired and this had

NR

• Men described hormone therapy as having a negative impact on their masculinity ('manhood dried', not 'being a first

10 men;

• Men described taking an optimistic approach to ED after surgery (e.g., too early to worry about sexual function and focus

• Some men discussed that their lack of sexual function caused them to feel less like a man (e.g., 'feel like I've lost my

• Physical outcomes of PC and tx impacted sense of masculinity ('lost a bit of your manhood', 'not feeling like a man

• Men with UI and ED felt that this impacted their masculinity which contributed to feelings of losing self-respect and esteem

12 men;

• Men described ED, loss of libido and impotency as impacting on their sense of masculinity ('not a man anymore', 'manhood

3 men;

• Many men discussed the impact of tx on their erectile function and their feeling of being 'incomplete' or 'harmless'

• Erectile function for penetrative sex was synonymous with masculinity and ED therefore deprived men of their sexual

NR

Wittman* [2015] (50), USA; PR

Phillips [2000] (69), Canada; PR

Letts [2010] (76), Canada; CX

Gray [2002] (75), Canada; CX

Ervik [2012] (58), Norway; CX

Table S2

Sexual function: NR

Time since tx: NR;

Cancer stage: NR;

SO: heterosexual;

Age: NR;

Tx type: HA with RT or RP;

Sexual function: all men had self-reported none to minimal erectile function

Time since tx: 7–15 months;

Age: mean ± SD, 63.1±3.8 years;

Cancer stage: 59% advanced;

SO: NR;

Time since tx: range, 12–24 months;

Age: mean, 71.0 years;

Cancer stage: NR;

SO: NR;

Time since tx: range, 12–24 months;

Age: range, 50–85 years;

SO: NR;

Time since tx: range, 12–24 months;

Age: range, 50–85 years;

Sexual function: NR

Age: mean, 62.4 years;

Time since tx: NR;

Cancer stage: NR;

SO: NR;

Time since tx: 82% receiving tx at time of focus group;

Cancer stage: 59% advanced;

Age: mean ± SD, 63.1±3.8 years;

Cancer stage: NR;

SO: NR;

Time since tx: NR;

Sexual function: NR

Age: range, 50–70 years;

Cancer stage: NR;

SO: heterosexual;

Time since tx: NR;

Cancer stage: NR;

SO: NR;

Sexual function: NR

Age: range, 48–74 years;

Cancer stage: NR;

Sexual function: NR

Age: range, 50–85 years;

SO: NR;

Time since tx: 82% receiving tx at time of focus group;

Cancer stage: 59% advanced;

Age: mean ± SD, 63.1±3.8 years;

Cancer stage: NR;

SO: NR;

Time since tx: range, 12–24 months;

Age: mean, 71.0 years;

Cancer stage: NR;

Sexual function: NR

Age: range, 50–85 years;

Sexual function: NR

Age: range, 50–85 years;

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Age: range, 50–85 years;

Sexual function: NR

Age: range, 50–85 years;

Sexual function: NR

Age: range, 50–85 years;