Help-seeking for Emotional and Sexual Concerns Among Prostate Cancer Survivors: Examining the Relationships Between Psychosocial Factors and Intention to Seek Help

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Abstract

Many men with prostate cancer (PCa) experience emotional disturbances and sexual difficulties after diagnosis and treatment, yet rates of help-seeking for these issues are low. Given PCa survival rates have increased and PCa significantly impacts men's wellbeing and quality of life, it has become increasingly important to identify predictors of and barriers to help-seeking for psychosocial concerns. Existing literature has predominantly focused on the predictors of men's help-seeking for physical health issues after PCa treatment. However, factors associated with help-seeking for emotional and sexual concerns from psychosocial providers have not been studied on a large scale using a representative sample. To address this gap, the present study used data from a large cross-sectional self-report survey that recruited participants with PCa through the South Australian Prostate Cancer Clinical Outcome Collaborative registry. Potential predictors of help-seeking intention were selected using Andersen's Behavioural Model of Health Services Use and assessed by two hierarchical binary logistic regression models. Results indicated that less time since treatment, radiation as initial treatment, positive attitudes towards seeking professional psychological help, greater unmet psychological need, and greater fear of cancer recurrence (FCR) were significantly associated with intention to seek help for emotional concerns. Significant predictors of intention to seek help for sexual concerns were less time since treatment, greater importance/priority of sex, and greater unmet sexuality needs. These findings have important implications for health promotion, particularly the need for routine screening of FCR and unmet need as well as attitudes-based interventions that appeal to men's ideals about sexual importance.

Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma in any University, and, to the best of my knowledge, this thesis contains no material previously published except where due reference is made. I give permission for the digital version of this thesis to be made available on the web, via the University of Adelaide's digital thesis repository, the Library Search and through web search engines, unless permission has been granted by the School to restrict access for a period of time.

September 2022

Contribution Statement

The broad focus of this thesis was developed by my supervisors. In writing this thesis, my supervisors and I collaborated to narrow the focus of this thesis, generate research aims and hypotheses, and design an appropriate methodological approach. The dataset was compiled and provided by the Health Policy Centre at the South Australian Health and Medical Research Institute. I conducted the literature search and data analyses. I wrote all sections of this thesis with the advice and feedback of my supervisors.

Help-Seeking for Emotional and Sexual Concerns Among Prostate Cancer Survivors: Examining the Relationships Between Psychosocial Factors and Intention to Seek Help

In Australia, prostate cancer (PCa) is the most commonly diagnosed cancer in men; approximately 23% of all new cancer diagnoses and 12% of cancer deaths are due to PCa (Australian Institute of Health and Welfare [AIHW], 2021). Incidence and survival rates have increased in recent decades due to advancements in screening and treatment (Sung et al., 2021), such that men now have a 96% chance of surviving 5 years beyond their diagnosis (AIHW, 2021). While encouraging, extended lifespan also means that many men are having to endure long-term, debilitating challenges and treatment side effects that impact their well-being and quality of life (QoL; Carlsson et al., 2016; Katz & Dizon, 2016).

A large proportion of PCa survivors report moderate to severe sexual difficulties, as well as persistent distress, low mood, and worry following their treatment (Downing et al., 2019; O'Brien et al., 2011). However, studies have indicated that, despite the prevalence of emotional and sexual concerns reported by PCa survivors, rates of help-seeking for these issues are low (Ettridge et al., 2018; Holden et al., 2006; Holden et al., 2005). Moreover, despite recent improvements to the clinical practice guidelines for management of PCa and general guidelines for psychosocial care in oncology, PCa survivors continue to report high levels of unmet psychological and sexuality needs (Hyde et al., 2017). This suggests that simply improving guidelines and knowledge may be insufficient in addressing issues with help-seeking behaviour (Glanz & Bishop, 2010). Investigation into the psychosocial factors that underpin help-seeking for emotional and sexual concerns is required to develop effective guidance for PCa survivorship interventions and pathways.

Side Effects and Sexual Impact of Prostate Cancer Treatments

Key treatments for PCa include radical prostatectomy, hormone therapy (i.e., androgen deprivation therapy [ADT]), and radiation therapy (XRT), all of which have

negative side effects that can impair physical functioning (Smith et al., 2009). These side effects include incontinence, bowel problems, and sexual dysfunction (Skolarus et al., 2014; Smith et al., 2009). Although the severity and extent of impairment in physical function depend on the type of treatment, systematic reviews of longitudinal studies have demonstrated that, for all treatments, the most significant changes in functioning occur within the first 12–24 months post-treatment (Ávila et al., 2018; Lardas et al., 2017). Nonetheless, treatment side effects have been shown to persist up to 15 years post-treatment (Resnick et al., 2013).

Many men experience sexual dysfunction after PCa treatment, which encompasses erectile dysfunction, reduced ejaculatory volume, difficulty achieving orgasm, pain during orgasm, changes in penile length and curvature, and loss of libido (Sanchez Varela et al., 2013; Schover et al., 2002; Smith et al., 2009; Wootten et al., 2014). A population-based study of men with PCa 18–42 months post-diagnosis found that 81% had poor/very poor overall sexual function, 82% had poor/very poor erections, and 77% had poor/very poor ability to reach orgasm (Downing et al., 2019). Changes in sexual functioning vary depending on treatment type; men who have undergone radical prostatectomy tend to have the greatest declines in sexual function, followed by external beam radiation therapy (EBRT) and ADT (Ávila et al., 2018). However, regardless of treatment type, difficulties with erections tend to be the most distressing change in sexual functioning post-treatment (Letts et al., 2010). Many men report withdrawing from any sort of intimate activity with their partners because of these changes, which can negatively impact men's relationships, sense of masculinity, self-worth, and self-identity (Chambers, Chung, et al., 2017; Letts et al., 2010).

Psychological Impact of Prostate Cancer

Sexual difficulties following PCa treatment are associated with adverse psychological outcomes, including higher depression and anxiety, and poorer self-reported QoL (Howlett et

al., 2010). Previous qualitative studies have shown that men of all ages experience some form of psychosexual problem post-treatment, and often report feelings of a loss of manhood, embarrassment, fear, anger, frustration, distress, worry, and grief towards the changes in their sexual functioning (Ettridge et al., 2018; Letts et al., 2010; O'Brien et al., 2011). The prevalence of psychosexual concerns has been further demonstrated in quantitative studies of newly diagnosed men (less than 12 months post-diagnosis), where 47%–54% reported unmet psychological needs and 47%–58% reported unmet sexuality needs (Hyde et al., 2017; Smith et al., 2007).

Existing literature has shown that the mental health burden of PCa is at its greatest immediately following diagnosis and treatment, with 10%–28% of newly diagnosed men reaching clinical levels of distress, anxiety, and/or depression (Chambers et al., 2014; Hinz et al., 2009; Hyde et al., 2017). Risk of suicide is increased for men with PCa compared to the general population (Smith et al., 2018), especially within the first 3 months after diagnosis (Fang et al., 2010). Although most men tend to exhibit anxiety and depression scores similar to the general population after 12 months post-treatment (Hinz et al., 2009), some men experience persistent psychological difficulties, such as health-related distress, worry, and low mood, up to 6 years post-treatment (Chambers, Ng, et al., 2017). Thus, the significant impact of PCa on men's psychological and sexual well-being demonstrates the need for ongoing support for men throughout their cancer journey.

Help-Seeking Behaviour: Definition and Patterns Among Men With Prostate Cancer

Help-seeking behaviour is defined as "any communication about a problem or troublesome event which is directed toward obtaining support, advice, or assistance in times of distress" (Gourash, 1978, p. 414). Help-seeking can be formal, where help is sought from professionals (e.g., doctors and psychologists), or informal, where help is sought from family and peer group sources (e.g., relatives and friends; Grinstein-Weiss et al., 2005).

Men, in general, have been shown to delay help-seeking for psychological and physical health-related concerns (Galdas et al., 2005; Yousaf et al., 2015). Specifically, men with PCa often do not seek formal help for their emotional and psychosocial concerns (e.g., feelings of helplessness, threatened masculinity, social isolation, distress, and anxiety), and are less likely to disclose these concerns to health care professionals in comparison to women with breast cancer (Ettridge et al., 2018; Forsythe et al., 2013; Hyde et al., 2017). Two studies of Australian PCa survivors found that only 27% and 55% of men sought help for their emotional and sexual concerns at a 6-month follow-up, respectively (Goodwin et al., 2020; Hyde et al., 2021). These low rates of help-seeking coupled with the significant psychosexual burden experienced by men with PCa emphasise the need for research in this area.

Importance of Supportive Care

The importance of supportive care following PCa diagnosis and treatment has been well described in the literature; psychosocial and psychosexual interventions (e.g., educational and cognitive-behavioural interventions and support groups) have been shown to improve men's QoL, and reduce anxiety and depressive symptoms (Chambers, Hyde, et al., 2017; Chien et al., 2014; Cockle-Hearne & Faithfull, 2010). Yet, many PCa survivors who could benefit from psychosocial care do not receive it (Ettridge et al., 2018; Forsythe et al., 2013).

Psychosocial survivorship care guidelines have been developed to help address gaps in care post-diagnosis and treatment (Cancer Australia, 2014a, 2014b; Matthew et al., 2015; National Breast Cancer Centre and National Cancer Control Initiative, 2003; Skolarus et al., 2014). However, despite these publications, unmet supportive care needs remain highly prevalent in PCa survivors (Hyde et al., 2017). These survivorship guidelines are limited by substantial gaps in knowledge and a lack of consumer voice (Crawford-Williams et al., 2018; Dunn et al., 2020), with recommendations for future survivorship research to focus on

patient-reported outcomes (Narayan et al., 2020). To help resolve these issues, recent oncology research has focused on identifying psychosocial and demographic factors that predict psychosocial support service use. These predictors include being female, younger, and having greater psychological and cancer-specific distress, fear of cancer recurrence (FCR), more positive outcome expectations, and more positive attitudes towards help-seeking (Compen et al., 2018; McDowell et al., 2011; Steginga et al., 2008; Van Beek et al., 2021). Research of this nature specific to PCa populations is limited and will be discussed in relation to the theoretical framework.

Theoretical Framework

According to Scott and Walter (2010), help-seeking research requires a theoretical underpinning. Yet many studies on help-seeking for cancer-related concerns lack a guiding theoretical framework (Steginga et al., 2008). The present study used Andersen's (1968, 1995) Behavioural Model of Health Services Use as a guiding framework. This model proposes that utilisation of health care services is a function of three components: predisposing characteristics (e.g., age, sex, and health beliefs), enabling resources (e.g., income and access to appropriate care), and need factors (e.g., self-reported health status). The model argues that individuals will only seek support if they perceive a need for help with their concerns (Andersen et al., 2014).

Andersen's model has historically been applied to studies investigating medical help-seeking and has previously been used with a PCa sample to identify predictors of PCa screening participation (Ogunsanya et al., 2016). However, despite its primary application to medical services, various iterations of the model have been used to assess predictors of psychology service utilisation (Graham et al., 2017; Magaard et al., 2017; Mosher et al., 2015; She et al., 2021). The present study draws on this model as a guide in the consideration

of relevant factors that may be associated with help-seeking for emotional and sexual concerns among men with PCa.

The following subsections describe the three components of Andersen's model in the context of the present study and report existing findings relevant to the chosen factors. Although this study is specific to men with PCa, mixed-gender and non-PCa-specific research will be reviewed due to the lack of PCa studies on help-seeking for emotional and sexual concerns.

Predisposing Factors

According to Andersen et al. (2014), factors that predispose individuals to seek help from health care services can be demographic, social, and/or mental. Demographic predisposing factors are typically age and sex; social predisposing factors encompass education, occupation, and social relationships; and mental factors relate to cultural norms and health beliefs, namely attitudes and values individuals hold towards their health and seeking support.

Age. Goodwin et al. (2020) and Hyde et al. (2017) found that age significantly predicted help-seeking behaviour, as younger men were more likely to seek help from a general practitioner for psychological, emotional, and prostate-related concerns compared to older men. Conversely, in a prospective study, Hyde et al. (2021) found that age was not a significant predictor of intention to seek sexual help.

Marital Status. Evidence suggesting that relationship/marital status predisposes individuals to seek help is varied. Qualitative research by Ettridge et al. (2018) suggested marital status may be a barrier to formal help-seeking for emotional concerns, as most married men sought informal support from their partners and, as a result, did not seek further professional help for their concerns. In contrast, quantitative cross-sectional research by Holden et al. (2006) found marital status predicted help-seeking behaviour among men with

erectile dysfunction; men who had never married were significantly less likely to visit a doctor and discuss erectile dysfunction with a health provider. A longitudinal study found relationship status was not significantly correlated with help-seeking for psychological concerns among men with PCa (Goodwin et al., 2020).

Masculinity. Endorsement of masculine gender role norms has been shown to prevent men from seeking help for a range of concerns in numerous contexts (Addis & Mahalik, 2003; Courtenay, 2000a; Fish et al., 2015). Masculine norms are built on the beliefs that men should be independent, strong, self-reliant, and resilient, which are inherently inconsistent with help-seeking behaviour (Courtenay, 2000b). As such, adherence to masculine gender roles can be detrimental to health-related help-seeking in men (Galdas et al., 2005).

A qualitative study of Australian men with PCa found reluctance to disclose prostate-related concerns was often due to feelings of threatened masculinity and a preference for independence and self-management (Ettridge et al., 2018). While Hyde et al. (2016) also found masculine beliefs contributed to men's help-seeking, their findings demonstrated an inverse relationship; help-seeking intentions for sexual concerns were greater for men who were emotionally self-reliant, placed more value on being physically capable of having sex, and regarded sex as highly important to their masculine identity. These findings are inconsistent with previous PCa research that found endorsement of masculine values—namely self-reliance, stoicism, and emotional control—prevented men's help-seeking (Chapple & Ziebland, 2002; Hedestig et al., 2005; Mróz et al., 2013; O'Brien et al., 2011; Wenger & Oliffe, 2014). Hyde et al. (2016) proposed that their contradicting findings suggest a misdirection regarding the perception of masculine traits as barriers to men's help-seeking, or alternatively, that their findings are consistent with the emerging view that treating sexual

dysfunction is socially acceptable and even masculine (Cushman et al., 2010; Walker et al., 2015).

Attitudes Towards Seeking Help. Positive attitudes towards seeking help have been shown to predict help-seeking intentions and use of psychosocial support services for cancer patients and men more broadly (Leppin et al., 2019; McDowell et al., 2011; Smith et al., 2008; Steginga et al., 2008). The first quantitative PCa study to assess predictors of help-seeking for sexual concerns after treatment found positive attitudes towards help-seeking for erectile dysfunction significantly predicted past and intended help-seeking (Schover et al., 2004). More recently, Hyde et al. (2016) and Hyde et al. (2021) demonstrated that sexual help-seeking intentions for PCa-related concerns were associated with more positive attitudes towards sexual help-seeking. It appears no study has assessed the influence of attitudes towards seeking professional psychological help on men's help-seeking intentions for emotional concerns after PCa treatment.

Enabling Factors

Enabling factors that facilitate or prevent access to health care services are either financial (e.g., wealth and income) or organisational (e.g., regular source of care and means of transport to services; Andersen et al., 2014).

Income and Level of Disadvantage. Associations between level of income and service use have been found to vary (Babitsch et al., 2012). Non-cancer-specific research among North American populations has shown that adults living in disadvantaged neighbourhoods with lower incomes are less likely to have a regular source of medical care and seek help from mental and physical health care services (Blackwell et al., 2009; Kirby & Kaneda, 2005). Yet a study of Canadian cancer survivors found that the proportion of those who sought help for emotional and practical concerns decreased as household income increased (Nicoll et al., 2021). Secondary analyses outlined that those survivors with the

lowest annual household incomes were more likely to seek help to address concerns regarding physical changes after treatment (Nicoll et al., 2022). Conversely, income was not significantly related to psychosocial support service use in a study of Australian cancer survivors (Steginga et al., 2008). Further research is warranted due to these inconsistencies. It appears no study has assessed level of disadvantage as a predictor of help-seeking for emotional and sexual concerns among PCa survivors.

Need Factors

Need factors refer to the individual's perceived need for help, as well as evaluated need according to professional judgement and/or objective measurement (Andersen et al., 2014). Perceived need relates to how individuals view and experience their own health and functional state.

Unmet Need. Australian studies have demonstrated that 82%–87% of PCa survivors report having some degree of unmet supportive care need (Hyde et al., 2017; Steginga et al., 2001). Most existing research is concerned with factors associated with unmet need, and few studies have reported the relationship between unmet need and seeking support. A study by Goodwin et al. (2020) demonstrated that 41% of men who reported some degree of unmet psychological need intended to seek help for their concerns, and only 33% of these men did seek support within the following 12 months. Notably, intention to seek help was positively associated with moderate-to-high self-reported psychological need. In contrast, Hyde et al. (2017) found that men with the greatest self-reported unmet sexuality needs were the least likely to seek help for their PCa-related concerns.

Psychological Distress. Numerous oncology studies have demonstrated that psychological distress is associated with increased use of health and psychosocial care services (Clover et al., 2015; Compen et al., 2018; Martínez Arroyo et al., 2019; Steginga et al., 2008; Van Beek et al., 2021). One prospective PCa study showed that men with lower

self-reported depressive symptoms and higher anxiety symptoms were more likely to seek help for their sexual concerns after treatment (Hyde et al., 2021).

Fear of Cancer Recurrence. While some oncology research has shown that higher cancer-specific distress, including FCR, is significantly related to medical and psychosocial help-seeking (Champagne et al., 2018; Lebel et al., 2013; Steginga et al., 2008; Thewes et al., 2012; Williams et al., 2021), multiple studies have found that FCR was not significantly related to greater use of health and psychosocial support care services (Li & Cheng, 2021; McDowell et al., 2011; Otto et al., 2018; Sarkar et al., 2015). To the researcher's knowledge, no studies have assessed the relationship between FCR and help-seeking for emotional concerns among PCa survivors.

Treatment Factors

Time since treatment and type of treatment are two key factors associated with QoL, mental health, and sexual functioning outcomes in PCa survivors (Adam et al., 2019; Litwin et al., 2002; Massoeurs et al., 2021; Talcott et al., 2003). As such, they will be considered as covariates in addition to the aforementioned factors.

Gaps in the Literature

Help-seeking among men with PCa has not been well documented or researched, especially for psychosocial concerns. Previous quantitative studies by Hyde et al. (2016) and Hyde et al. (2017) focused on help-seeking for PCa-related and sexual concerns, respectively. These studies found that education, age, endorsement of masculine norms, depression, and positive attitudes were associated with help-seeking intention and behaviour. However, neither study specifically assessed help-seeking from professional psychosocial providers. In a more recent prospective study, Hyde et al. (2021) investigated help-seeking for sexual concerns from multiple supportive-care providers and found that men who sought help had greater prior help-seeking intention, had sought help recently, and had increased levels of

anxiety. While these studies offer preliminary evidence that men with PCa encounter barriers and facilitators to help-seeking for sexual and prostate-related concerns, they did not directly investigate the factors that prevent or predict help-seeking for emotional concerns.

Patterns of help-seeking for psychological concerns among men in the general population have been well-described (see Yousaf et al., 2015, for a review). Yet little is known about the help-seeking patterns for these concerns among men with PCa. A qualitative study of men with PCa found most men did not seek help for their emotional and psychosocial concerns from a formal source of help (e.g., psychologists, counsellors, therapists, doctors) due to anticipated awkwardness, preference for autonomous coping, not wanting to burden others, unwanted sympathy, and preference for privacy (Ettridge et al., 2018). As a result of these qualitative findings, the need for a larger quantitative study to examine the psychosocial help-seeking barriers experienced by PCa survivors was identified. Such a study will triangulate these findings and establish their prominence in a larger sample of PCa survivors. Furthermore, quantifying barriers and facilitators to help-seeking for various concerns, including emotional and sexual, will assist in identifying key points for intervention (Ettridge et al., 2018).

Research Aims and Hypotheses

The primary aim of this study is to examine what factors are associated with help-seeking intentions for emotional and sexual concerns among men living with PCa, with specific aims to examine whether:

1. Attitudes towards seeking professional psychological help, masculine emotional self-reliance, age, marital status, level of disadvantage, unmet psychological need, FCR, and distress are associated with men’s intentions to seek help for emotional concerns.

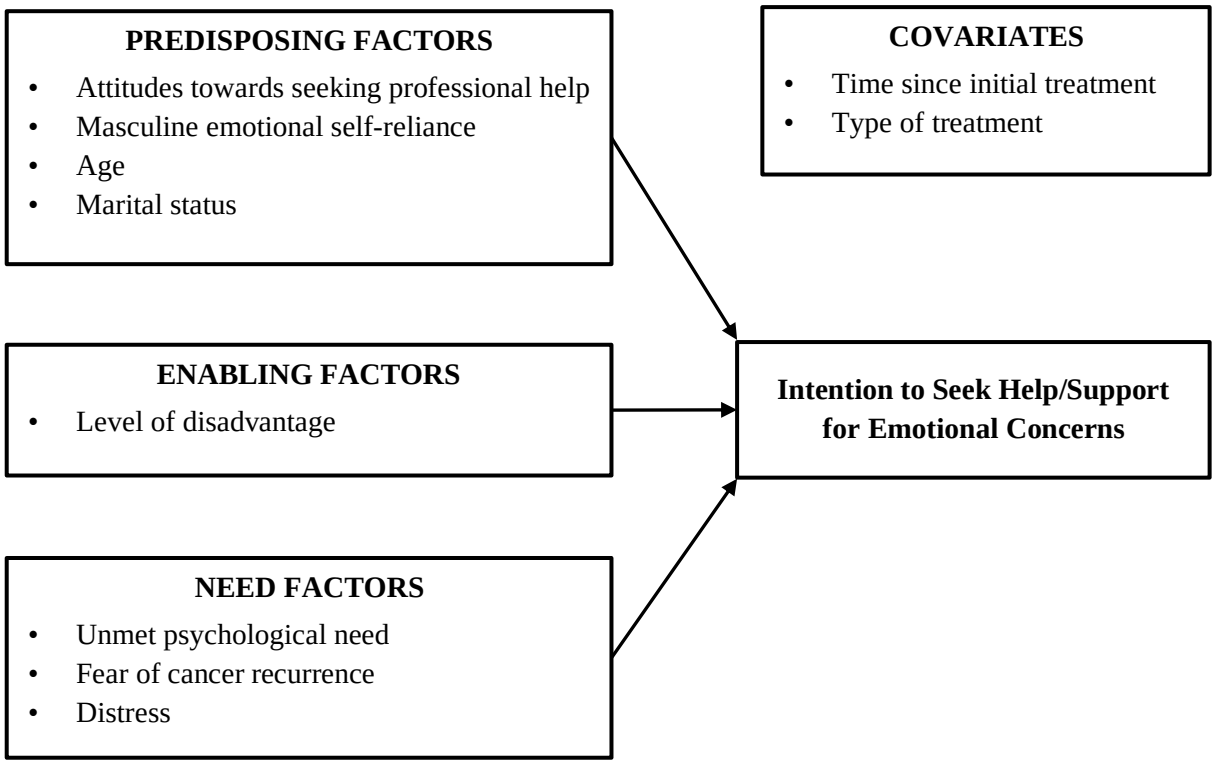
2. Masculine sexual importance/priority, age, marital status, level of disadvantage, unmet sexuality need, and distress are associated with men's intentions to seek help for sexual concerns.

These factors have been selected using an adaption of Andersen's model (see Figures 1 and 2). In accordance with the theoretical model, it is hypothesised that:

1. The need factors will explain the most variance in men's intentions to seek help for emotional concerns.
2. The need factors will explain the most variance in men's intentions to seek help for sexual concerns.

Figure 1

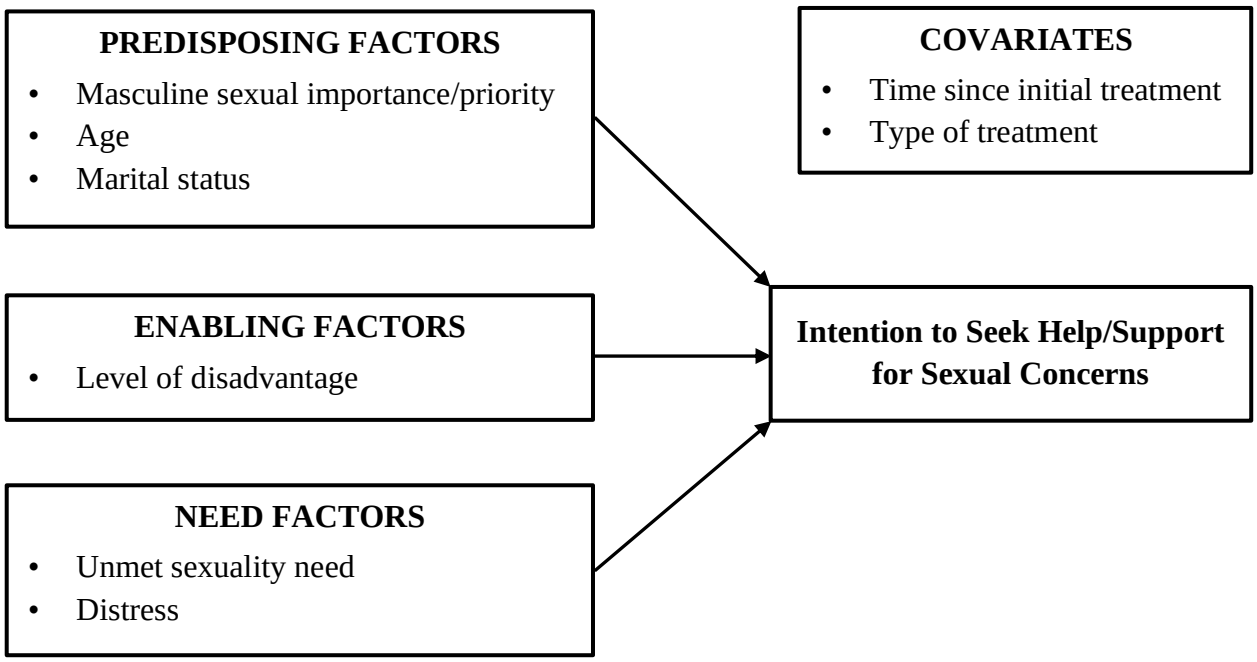
Andersen's Behavioural Model of Health Services Use Adapted for Emotional Help-Seeking



Note. Adapted from "Revisiting the Behavioral Model and Access to Medical Care: Does it Matter?" by R. M. Andersen, 1995, *Journal of Health and Social Behavior*, *36*(1), p. 4 (https://doi.org/10.2307/2137284). Copyright 1995 by American Sociological Association.

Figure 2

Andersen's Behavioural Model of Health Services Use Adapted for Sexual Help-Seeking



Note. Adapted from "Revisiting the Behavioral Model and Access to Medical Care: Does it Matter?" by R. M. Andersen, 1995, *Journal of Health and Social Behavior*, *36*(1), p. 4 (https://doi.org/10.2307/2137284). Copyright 1995 by American Sociological Association.

Method

The present study was a sub-study of a broader cross-sectional self-report survey that collected data through the South Australian Prostate Cancer Clinical Outcome Collaborative (SA-PCCOC) registry. The SA-PCCOC registry gathers longitudinal, observational, PCa-specific data of men with recorded and histologically confirmed PCa. In addition to this clinical data, the registry routinely sends out patient-reported outcome measures (PROMs) at various time points, including measures on global and disease-specific QoL. In 2017, data collection was conducted for an extended PROMs survey to determine the feasibility of incorporating a range of additional psychosocial measures, with detailed results of the study available elsewhere (see Ettridge et al., 2021). The present study reports an analysis of men's help-seeking intentions utilising data collected in this extended PROMs survey. Measures and methodology relevant to the present study are described.

Participants

Participants were recruited through the SA-PCCOC registry as a part of the broader study. Men were eligible to participate if they had histologically confirmed PCa, were diagnosed in South Australia, and had been treated in public hospitals. Three groups of men—6-, 12-, and 24-months post-initial treatment—were invited to participate. Participation was voluntary; men could withdraw from the data collection at any time. A total of 284 participants completed the survey. The overall response rate was 59%, and response rates were consistent across groups (6 months = 61%; 12 months = 60%; 24 months = 57%). Due to the duration of the data collection (12 months), eight participants completed the survey at two time points (6- and 12-months post-treatment). Only one set of data were retained for each of these participants, such that they were randomly included in either the 6- or 12-month data collection. Thus, the total sample comprised 276 participants.

Procedure

The Southern Adelaide Clinical Human Research Ethics Committee granted ethics approval for the broader study (Approval No. 307.14-HREC/14/SAC/315). A paper-based survey containing psychosocial measures in addition to the routinely collected PROMs was sent to the three groups of men (see Appendix for the questions and measures relevant to this study). Data collection ceased once the survey had been sent to 160 participants in each group (480 participants total). Special permission was sought from the SA-PCCOC data custodians prior to conducting the secondary analyses in the present study. Participants were allocated a unique identification number to maintain confidentiality and anonymity during data analysis.

Measures

Demographic, Disease, and Treatment Information

Participants were asked several demographic questions, including country of birth, main language spoken at home, and marital status. Participants were also asked to provide their postcode to calculate level of disadvantage according to the Socio-Economic Indexes for Areas (Australian Bureau of Statistics [ABS], 2011). Other demographic and treatment information recorded by the registry and provided for use in this study included age at diagnosis, time since initial treatment, and type of treatment received.

Help-Seeking for Emotional and Sexual Concerns

Past, current, and future (intentional) help-seeking for sexual concerns related to men's PCa were measured using three questions adapted from Hyde et al. (2017). Participants were asked to respond either "yes" or "no" to whether they (a) had sought advice or help in the past 6 months, (b) currently seek advice or help, and/or (c) intend to seek advice or help in the next 6 months for their concerns from a range of sources (doctor, nurse, psychologist or counsellor, PCa support group, another man with PCa). An open-ended

response option ("other") was available for participants to specify whether they had sought or intended to seek help from a source that was not provided. Another three questions of the same format were used to assess past, current, and intentional help-seeking for emotional/psychological concerns related to men's PCa.

Notably, it was the first time these questions had been asked in this specific format for PCa, hence psychometric evaluations are unavailable. As the focus of this study was help-seeking intention, only the questions assessing intention to seek help for emotional/psychological and sexual concerns were used as the outcome measure.

Attitudes Towards Seeking Help

Men's attitudes towards seeking help were measured using the 10-item Attitudes Toward Seeking Professional Psychological Help Short Form (ATSPPH-SF) scale (Fischer & Farina, 1995). To improve readability, minimise misunderstanding, and ensure the scale was culturally appropriate for a sample of Australian men with PCa, slight changes were made to the wording of some items. For example, "psychotherapy" was replaced with "psychological counselling" as it is more familiar to this population. These changes were made with permission from the authors. Participants rated their level of agreement with 10 statements (e.g., "I might want to have psychological counselling in the future") using a 4-point Likert-type scale (1 = *disagree* to 4 = *agree*). The raw scores were re-coded during data analysis (0 = *disagree* to 3 = *agree*) to simplify interpretation and to be consistent with previous research conducted by Picco et al. (2016) and Vogel and Wester (2003). The five negatively worded items were reversed scored before all items were summed, resulting in total ATSPPH-SF scores ranging from 0 to 30. Higher scores indicated more positive attitudes towards professional psychological help-seeking. Internal consistency of the ATSPPHS-SF was good in both the validation study ($\alpha = .84$; Fischer & Farina, 1995) and in this study ($\alpha = .80$).

Masculinity

Masculine beliefs were measured using subscales of the Masculinity in Chronic Disease Inventory (MCD-I), a masculinity scale developed by Chambers et al. (2016) for men with PCa. The MCD-I consists of 22 items making up six subscales: Emotional Self-Reliance, Sexual Importance/Priority, Family Responsibilities, Strength, Optimistic Capacity, and Action Approach. For the broader feasibility study, a decision was made to only include the two subscales that have previously been found to predict men's help-seeking (i.e., Emotional Self-Reliance and Sexual Importance/Priority) due to constraints on survey length. The Sexual Importance/Priority subscale consists of four items (e.g., "being able to have an erection is important to me"), while the Emotional Self-Reliance subscale consists of two items (e.g., "I keep my feelings to myself"). Participants were asked to rate how true each item was, based on their thoughts and feelings, on a 5-point Likert scale (1 = *not true at all* to 5 = *very true*). Scores were summed, producing total scores ranging from 4 to 20 for the Sexual Importance/Priority subscale, and from 2 to 10 for the Emotional Self-Reliance subscale. Higher scores on each subscale indicated greater importance of these attributes to men. Initial validation of the measure demonstrated good to excellent internal consistency, with Cronbach's alphas of .69 and .92 for the Emotional Self-Reliance and Sexual Importance/Priority subscales, respectively (Chambers et al., 2016). This study also demonstrated good internal consistency, with Cronbach's alphas of .74 and .95 for the Emotional Self-Reliance and Sexual Importance/Priority subscales respectively.

Psychological Distress

Psychological distress was measured using the Kessler Psychological Distress Scale (K10; Kessler et al., 2002). The 10 items of this scale assessed symptoms of anxiety and depression (e.g., "about how often did you feel hopeless?") experienced within the 30 days preceding survey completion. Participants indicated the extent to which they experienced

each of the symptoms on a 5-point Likert scale (1 = *none of the time* to 5 = *all of the time*). Total scores ranged from 10 to 50, where higher scores indicated greater psychological distress. The K10 has well-established validity and has been widely used, including with samples of men with PCa (Banks et al., 2010; Eakin et al., 2006). Internal consistency of the K10 was excellent, with Cronbach's alphas of .92 for both the present study and the validation study (Kessler et al., 2002).

Fear of Cancer Recurrence

FCR was measured using the four-item FCR subscale of the Memorial Anxiety Scale for Prostate Cancer (MAX-PC; Roth et al., 2003). Participants rated their level of agreement with each item (e.g., "I am afraid of my cancer getting worse") on a 4-point Likert-type scale (0 = *strongly agree* to 3 = *strongly disagree*). Total scores ranged from 0 to 12, where higher scores indicated lower FCR. The MAX-PC was chosen due to its brevity, as well as its previous use and validation with PCa patients (James et al., 2022; Roth et al., 2003). Internal consistency of the FCR subscale was good in both the initial validation study ($\alpha = .82$; Roth et al., 2003) and this study ($\alpha = .89$).

Unmet Need

Unmet need was measured using the Supportive Care Needs Survey Short-Form (SCNS-SF34) developed by Boyes et al. (2009). The SCNS-SF34 contains 34 items that assess the level of unmet need experienced by individuals diagnosed with cancer across five domains: Psychological, Sexuality, Physical and Daily Living, Health System and Informational, and Patient Care and Support. This measure has been widely used in cancer research, namely among PCa survivors (Schofield et al., 2012; Steginga et al., 2001). The present study used two of the five subscales, Psychological (10 items) and Sexuality (three items), to measure relevant unmet need. Participants rated their level of need for help with each item (e.g., "feelings of sadness" and "changes in sexual feelings") on a 5-point Likert

scale (1 = *no need/not applicable* to 5 = *high need*). Total scores for the Psychological and Sexuality subscales ranged from 10 to 50 and from 3 to 15, respectively. Higher total scores indicated greater unmet need. Boyes et al. (2009) demonstrated good internal consistency for all subscales of the SCNS-SF34 for a sample of adults with cancer, with Cronbach's alphas ranging from .86 to .96. Internal consistency was very good in the present study, with Cronbach's alphas of .94 and .89 for the Psychological and Sexuality subscales, respectively.

Missing Data

Treatment of missing data was the same for all continuous scales (i.e., ATSPPH-SF, MCD-I, K10, MAX-PC) but the SCNS-SF34, consistent with the broader feasibility study (Ettridge et al., 2021). For the two SCNS-SF34 subscales, total scores were calculated for cases with at least 50% of items answered. Missing item scores were replaced with the mean of the answered items for cases with 50% or less missing data. For all other continuous (sub)scales, total scores were calculated for cases with 75% or more of data present. For cases with 25% or less missing data, the means of the reported data were calculated and multiplied by the total number of items of the particular scale to produce total scores.

Power Analysis

The sample size of the present study was determined by the parameters of the broader study, which required 90+ participants per group (6, 12, and 24 months) to detect medium effects using ANOVA, at .8 power with a significance level of .01 (Cohen, 1992; Ettridge et al., 2021).

Statistical Analyses

Data analyses were conducted using IBM SPSS Statistics (Version 28). Appropriate descriptive statistics (frequencies, central tendency, and/or variability) were run for each measure. Assumptions for binary logistic regression include absence of multicollinearity and linearity. Data were checked for multicollinearity ($r \geq .7$) using Pearson correlations. As none

of the variables had correlations greater than or equal to .7, the assumption was satisfied. Linearity in the logit for the continuous predictor variables was assessed using the Box-Tidwell approach (Hosmer et al., 2013). The log-transformed interaction terms were all non-significant ($p > .05$), meaning all predictor variables were linearly related to the logit of the outcome variables. Hence, the assumption of linearity was satisfied.

A series of four preliminary logistic regression models (covariates, predisposing, enabling, and need) were run for each outcome variable (i.e., eight in total). Predictors were considered for inclusion in the final analyses based on the results of these preliminary regressions, taking into account both statistical significance and conceptual relevance. As there are two outcome variables—intentions to seek help for emotional and sexual concerns—two hierarchical binary logistic regression models were conducted, both adjusted for covariates (time since initial treatment and treatment type). This methodological approach has been supported by previous literature (Azuero et al., 2014).

Results

Description of Participants

Demographic and treatment information of the participants are presented in Table 1. Participants' age at the time of their diagnosis ranged from 41 to 91 years. The mean age at diagnosis was 66.3 years (*SD* = 7.0), which was slightly lower than that of the general Australian PCa population (*M* = 69.1) in 2017 (AIHW, 2022). A majority of participants were married or in a de facto relationship, born in Australia, spoke English at home, and had a radical prostatectomy.

Table 1

Demographic and Treatment Characteristics of the Sample

Characteristics	*n*	%
Age at diagnosis		
Less than 60 years	41	16.0
60–64 years	54	21.0
65–69 years	74	28.8
70+ years	88	34.2
Marital/relationship status		
Married or de facto	232	85.6
Not married (never, divorced, widowed)	39	14.4
Level of disadvantage		
Quintiles 1–3 (most disadvantaged)	131	47.8
Quintiles 4–5 (least disadvantaged)	143	52.2
Country of birth		
Australia	206	76.0
Other [a]	65	24.0
Language spoken at home		
English	259	96.3
Other [b]	10	3.7
Treatment type		
Radical prostatectomy	213	77.2
XRT	38	13.8
Observation	16	5.8
ADT	5	1.8
EBRT/Other [c]	4	1.4
Time since initial treatment		
6 months	93	33.7
12 months	92	33.3
24 months	91	33.0

Note. *N* = 276. Valid percentages reported. Percentages may not add up to 100% due to rounding. XRT = radiation. ADT = androgen deprivation therapy. EBRT = external beam radiation therapy.

[a] Participants born outside of Australia were born in England, Germany, New Zealand, Italy, Scotland, Greece, Philippines, or unspecified. [b] Other languages spoken at home include Italian, Greek, Spanish, Filipino, Polish, Russian, and Japanese. [c] Includes one case of palliative EBRT.

Table 2 presents the descriptive statistics of the continuous measures. On average, participants had low to moderate levels of distress, FCR, and unmet need.

Table 2

Descriptive Statistics (Means, Standard Deviations, Ranges) for Continuous Measures

Measures	*M*	*SD*	Range	
			Observed	Possible
ATSPPH-SF	19.0	6.4	1–30	0–30
MCD-I Emotional Self-Reliance	6.5	2.1	2–10	2–10
MCD-I Sexual Importance/Priority	13.4	5.4	4–20	4–20
K10	14.2	5.3	10–43	10–50
MAX-PC FCR	8.5	3.0	0–12	0–12
SCNS-SF34 Psychological	16.5	8.0	10–49	10–50
SCNS-SF34 Sexuality	5.7	3.2	3–15	3–15

Note. Higher scores indicate greater endorsement for all scales except for the MAX-PC FCR subscale; higher scores on the MAX-PC FCR indicate lower fear of recurrence.

Rates of Help-Seeking

Help-Seeking for Emotional Concerns

Table 3 describes the rates of help-seeking for emotional/psychological concerns. Compared to current and past rates of help-seeking for emotional concerns, a slightly greater proportion of participants intended to seek help from nurses, psychologists/counsellors, and PCa support groups. The most common source of past help-seeking was "other" (e.g., physiotherapist, wife), followed by doctors. In comparison, doctors were the most common source of current and intended help-seeking, followed by another man with PCa. Very few participants had previously sought, were currently seeking, and/or intended to seek help from a psychologist/counsellor or PCa support group for their emotional concerns.

Table 3

Rates of Help-Seeking for Emotional/Psychological Concerns

Source of help	Sought help in the past 6 months		Currently seeking help		Intend to seek help in the next 6 months	
	n	%	*n*	%	*n*	%
Any source [a]	78	29.3	73	27.2	74	29.6
Doctor	51	19.9	54	27.2	54	22.0
Nurse	9	3.7	6	2.5	14	6.1
Psychologist/counsellor	9	3.7	7	2.9	13	5.7
PCa support group	3	1.2	5	2.0	19	8.3
Another man with PCa	40	16.4	36	14.4	40	17.4
Other [b]	74 [c]	26.8	4	1.4	2	0.7

Note. Total number of responses differed for each source of help. Valid percentages reported.

[a] "Any source" represents help-seeking from any of the listed sources of help (including other). Responses from participants who reported multiple sources of help are only recorded once in this row. [b] Other sources of help reported include physiotherapist, friend, and wife. [c] Two participants reported seeing a physiotherapist as their other past source of help, the remaining 72 other sources were unspecified.

Help-Seeking for Sexual Concerns

As shown in Table 4, rates of current help-seeking for sexual concerns were lower than past and intended help-seeking rates. The most common source of help was a doctor for past, current, and intended help-seeking, followed by another man with PCa. No participants had previously sought or were currently seeking sexual help from a psychologist/counsellor, however, seven participants intended to seek help from this source. Although nine participants intended to seek help from a PCa support group for their sexual concerns, only one participant had previously sought help from a support group.

Table 4

Rates of Help-Seeking for Sexual Concerns

Source of help	Sought help in the past 6 months		Currently seeking help		Intend to seek help in the next 6 months	
	n	%	*n*	%	*n*	%
Any source [a]	92	34.6	58	21.6	94	35.5
Doctor	83	31.8	53	20.2	87	33.3
Nurse	8	3.3	4	1.6	11	4.7
Psychologist/counsellor	0	0.0	0	0.0	7	3.0
PCa support group	1	0.4	0	0.0	9	3.8
Another man with PCa	14	5.7	8	3.2	16	6.8
Other	0	0.0	0	0.0	0	0.0

Note. Total number of responses differed for each source of help. Valid percentages reported.

[a] "Any source" represents help-seeking from any of the listed sources of help (including other). Responses from participants who reported multiple sources of help are only recorded once in this row.

Preliminary Logistic Regression Models

Separate preliminary logistic regression models for four groups of predictors (covariates, predisposing, enabling, and need) were used to examine factors associated with help-seeking intention for emotional concerns. The first logistic regression contained potential covariates. As shown in Table 5, time since initial treatment was significantly associated with help-seeking intention for emotional concerns; participants who were 24 months post-treatment had lower odds of intending to seek help than those 6 months post-treatment. Table 5 also depicts results of the second preliminary model with the predisposing factors entered as predictors (adjusted for potential covariates). Attitudes towards seeking professional help was the only predisposing factor significantly associated with help-seeking intentions for emotional concerns; participants with more positive attitudes had higher odds of intending to seek help. Age at diagnosis, marital status, and masculine emotional self-reliance were not significantly associated with intentions to seek help for emotional concerns. Results for the third preliminary model examining the enabling factors as predictors (adjusted for potential covariates) demonstrated that level of disadvantage was not significantly associated with intentions to seek help. The fourth preliminary model that examined the need factors as predictors (adjusted for potential covariates) showed that unmet psychological need and FCR were significantly associated with help-seeking intention for emotional concerns, however, distress was not. Participants with higher levels of unmet psychological need and FCR had increased odds of intending to seek help for emotional concerns.

All significant variables from these preliminary models were included in the final hierarchical binary logistic regression model for emotional concerns. Although XRT only approached significance ($p = .054$), treatment type was included in the final analysis due to its conceptual relevance, namely the impact different treatments may have on emotional functioning (Hashine et al., 2005; Litwin et al., 2002).

Table 5

Results of Separate Logistic Regressions for Predictors of Help-Seeking Intention for Emotional Concerns

Predictor	*B* (*SE*)	Wald χ^2	*OR*	95% CI		*p*	Nagelkerke R^2
				LL	*UL*		
Covariates (unadjusted for any other variables)							.081
6 months since initial treatment (reference)			1.00				
12 months since initial treatment	–0.57 (0.33)	2.90	0.57	0.30	1.09	.088	
24 months since initial treatment	–1.23 (0.38)	10.73	0.29	0.14	0.61	.001	
Radical proctectomy (reference)			1.00				
XRT	0.78 (0.41)	3.70	2.18	0.99	4.84	.054	
Observation	0.06 (0.62)	0.01	1.06	0.31	3.57	.925	
ADT	1.53 (1.04)	2.16	4.63	0.60	35.80	.142	
EBRT/Other	–0.11 (1.21)	0.01	0.89	0.08	9.56	.924	
Predisposing factors (adjusted for covariates)							.139
Attitudes towards seeking help [a]	0.06 (0.03)	5.24	1.07	1.01	1.12	.022	
Masculine emotional self-reliance [b]	–0.01 (0.08)	0.02	0.99	0.84	1.16	.897	
Age at diagnosis	–0.01 (0.02)	0.06	0.99	0.95	1.04	.800	
Never married/divorced/widowed (reference)			1.00				
Married or de facto	–0.78 (0.44)	3.13	0.46	0.19	1.09	.077	
Enabling factors (adjusted for covariates)							.102
Most disadvantaged quintiles 1–3 (reference)			1.00				
Least disadvantaged quintiles 4–5	–0.52 (0.29)	3.19	0.59	0.33	1.05	.074	
Need factors (adjusted for covariates)							.303
Unmet psychological need [c]	0.09 (0.03)	9.63	1.09	1.03	1.15	.002	
Fear of cancer recurrence [d]	–0.14 (0.06)	5.74	0.87	0.77	0.97	.017	
Distress [e]	0.02 (0.04)	0.19	1.02	0.94	1.10	.659	

Note. N = 276. CI = confidence interval; *LL* = lower limit; *UL* = upper limit; XRT = radiation; ADT = androgen deprivation therapy; EBRT = external beam radiation therapy. The outcome variable was coded such that 0 = no intention, and 1 = intention to seek help.

[a] Higher scores indicate more positive attitudes towards seeking professional psychological help (positively worded). [b] Higher scores indicate greater importance of emotional self-reliance. [c] Higher scores indicate greater unmet psychological need (negatively worded). [d] Higher scores indicate lower fear of recurrence (positively worded). [e] Higher scores indicate greater psychological distress (negatively worded).

A similar approach was taken to identify factors associated with help-seeking intentions for sexual concerns for inclusion in the final model, with separate preliminary logistic regressions conducted for the four groups of predictors (covariates, predisposing, enabling, and need factors; see Table 6). Results of the first preliminary model containing potential covariates as predictors are displayed in the top section of Table 6. Time since initial treatment was significantly associated with help-seeking intention for sexual concerns; participants who were 24 months post-treatment had lower odds of intending to seek help than participants 6 months post-treatment. Treatment type was not significantly associated with help-seeking intention for sexual concerns.

Table 6 also depicts the results of the second preliminary model with predisposing factors as predictors. Masculine sexual importance/priority was significantly associated with help-seeking intention for sexual concerns; participants who placed greater value on sexual importance had higher odds of intending to seek help for sexual concerns. Age at diagnosis and marital status were not significantly associated with help-seeking intentions for sexual concerns. The third preliminary model examining the enabling factors as predictors demonstrated that level of disadvantage was not a significant predictor of help-seeking intention. The fourth preliminary model that examined need factors as predictors indicated that unmet sexuality need was significantly associated with help-seeking intentions for sexual concerns, however, distress was not. Participants with higher levels of unmet sexuality need had increased odds of intending to seek help for sexual concerns. All variables found to have significant associations were included in the final hierarchical binary logistic regression for sexual concerns.

Table 6

Results of Separate Logistic Regressions for Predictors of Help-Seeking Intention for Sexual Concerns

Predictor	*B* (*SE*)	Wald χ^2	*OR*	95% CI		*p*	Nagelkerke R^2
				LL	*UL*		
Covariates (unadjusted for any other variables)							.092
6 months since initial treatment (reference)			1.00				
12 months since initial treatment	–0.48 (0.31)	2.43	0.62	0.34	1.13	.119	
24 months since initial treatment	–1.27 (0.35)	13.14	0.28	0.14	0.56	< .001	
Radical proctectomy (reference)			1.00				
XRT	0.18 (0.39)	0.20	1.19	0.55	2.58	.654	
Observation	0.10 (0.59)	0.03	1.10	0.35	3.52	.866	
ADT	–0.24 (1.15)	0.04	0.79	0.08	7.54	.836	
EBRT/Other [a]	–	0.00	0.00	0.00	.	.999	
Predisposing factors (adjusted for covariates)							.206
Masculine sexual importance/priority [b]	0.13 (0.03)	16.96	1.13	1.07	1.21	< .001	
Age at diagnosis	–0.02 (0.02)	0.72	0.98	0.94	1.03	.396	
Never married/divorced/widowed (reference)			1.00				
Married or de facto	–0.11 (0.43)	0.07	0.89	0.38	2.08	.793	
Enabling factors (adjusted for covariates)							.094
Most disadvantaged quintiles 1–3 (reference)			1.00				
Least disadvantaged quintiles 4–5	–0.02 (0.27)	0.00	0.99	0.58	1.68	.956	
Need factors (adjusted for covariates)							.337
Unmet sexuality need [c]	0.35 (0.06)	38.42	1.42	1.27	1.58	< .001	
Distress [d]	–0.02 (0.03)	0.28	0.98	0.93	1.05	.595	

Note. $N = 276$. CI = confidence interval; *LL* = lower limit; *UL* = upper limit; XRT = radiation; ADT = androgen deprivation therapy; EBRT = external beam radiation therapy. The outcome variable was coded such that 0 = no intention, and 1 = intention to seek help.

[a] Results were not reliably estimable due to very small numbers. [b] Higher scores indicate greater importance of sex. [c] Higher scores indicate greater unmet sexuality need (negatively worded). [d] Higher scores indicate greater psychological distress (negatively worded).

Final Hierarchical Logistic Regression Models

Two hierarchical binary logistic regressions (adjusted for covariates on the first step) were performed to ascertain the effects of predisposing, enabling, and need factors on participants' intentions to seek help for emotional and sexual concerns related to their PCa. The outcome variables were coded such that 0 = no intention, and 1 = intention to seek help.

Predictors of Intention to Seek Help for Emotional Concerns

Hypothesis 1 proposed that need factors would explain the most variance in participants' intentions to seek help for emotional concerns. The entry of covariates (time since initial treatment and treatment type) in Block 1 explained 8.4% variance (Nagelkerke's pseudo R^2; see Table 7). Entry of predisposing factors (attitudes towards seeking professional help) in Block 2 explained a further 3.7% variance. Including the need factors (unmet psychological need and FCR) in Block 3 explained a further 23.3% variance and significantly improved the ability of the model to predict intentions to seek emotional help. Thus, as the need factors explained the greatest amount of variance in help-seeking intentions, Hypothesis 1 was supported.

At the final step, the statistically significant model explained 35.4% of the total variance (Nagelkerke's pseudo R^2) in help-seeking intentions for emotional concerns, $\chi^2(9) = 70.1$, $p < .001$, and correctly classified 78.8% of cases. As identified by this final model (Block 3), participants with positive attitudes towards seeking help, greater unmet psychological need, and greater FCR had significantly increased odds of intending to seek help for emotional concerns. Moreover, participants who had undergone their initial treatment 12 and 24 months prior to participation had lower odds of intending to seek help than those who had treatment 6 months prior. Participants treated with XRT had significantly higher odds of intending to seek help for emotional concerns than those who underwent radical prostatectomy.

Table 7

Results of Hierarchical Binary Logistic Regression Predicting Intention to Seek Help for Emotional Concerns

Predictor	Block 1				Block 2				Block 3			
	OR	95% CI		*p*	*OR*	95% CI		*p*	*OR*	95% CI		*p*
		LL	*UL*			*LL*	*UL*			*LL*	*UL*	
Covariates												
6 months since initial treatment (reference)	1.00				1.00				1.00			
12 months since initial treatment	0.55	0.28	1.06	.076	0.51	0.26	1.00	.052	0.35	0.16	0.76	.008
24 months since initial treatment	0.29	0.14	0.61	.001	0.27	0.13	0.57	<.001	0.23	0.10	0.54	<.001
Radical proctectomy (reference)	1.00				1.00				1.00			
XRT	2.24	1.01	5.00	.048	2.34	1.03	5.33	.042	2.57	1.04	6.33	.041
Observation	1.05	0.31	3.54	.936	1.05	0.31	3.54	.943	0.90	0.21	3.86	.892
ADT	4.59	0.59	35.40	.144	6.17	0.78	48.69	.084	6.42	0.71	58.27	.098
EBRT/Other	0.88	0.08	9.40	.913	1.10	0.10	12.53	.937	1.19	0.10	14.26	.890
Predisposing factors												
Attitudes towards seeking help [a]					1.06	1.01	1.12	.011	1.10	1.04	1.16	<.001
Need factors												
Unmet psychological need [b]									1.10	1.05	1.15	<.001
Fear of cancer recurrence [c]									0.84	0.74	0.95	.006
Model summary	Nagelkerke R^2 = .084 Correctly classified 71.4%				Nagelkerke R^2 = .121 Correctly classified 71.8%				Nagelkerke R^2 = .354 Correctly classified 78.8%			

Note. N = 276. CI = confidence interval; *LL* = lower limit; *UL* = upper limit; XRT = radiation; ADT = androgen deprivation therapy; EBRT = external beam radiation therapy.

[a] Higher scores indicate more positive attitudes towards seeking professional psychological help (positively worded). [b] Higher scores indicate greater unmet psychological need (negatively worded). [c] Higher scores indicate lower fear of recurrence (positively worded).

Predictors of Intention to Seek Help for Sexual Concerns

Hypothesis 2 proposed that need factors would explain the most variance in participants' intentions to seek help for sexual concerns. Entry of time since initial treatment in Block 1 of the model explained 7.5% variance (Nagelkerke's pseudo R^2; see Table 8). Entry of the predisposing factor in Block 2 explained a further 9.4% variance. Adding the need factor (unmet sexuality need) in Block 3 explained a further 15.5% variance, significantly improving the ability of the model to predict participants' intentions to seek sexual help. Hence, as the need factor explained the greatest amount of variance in help-seeking intentions, Hypothesis 2 was supported.

At the final step, the statistically significant model explained 32.4% of the total variance (Nagelkerke's pseudo R^2) in intentions to seek help for sexual concerns, $\chi^2(4) = 68.3$, $p < .001$, and correctly classified 75.8% of cases. As identified by this final model (Block 3), participants who had undergone their initial treatment 24 months prior had lower odds of intending to seek help than those who had treatment 6 months prior. Moreover, participants who regarded sex as highly important to their masculinity and had high unmet sexuality need had significantly increased odds of intending to seek help for sexual concerns.

Table 8

Results of Hierarchical Binary Logistic Regression Predicting Intention to Seek Help for Sexual Concerns

Predictor	Block 1				Block 2				Block 3			
	OR	95% CI		*p*	*OR*	95% CI		*p*	*OR*	95% CI		*p*
		LL	*UL*			*LL*	*UL*			*LL*	*UL*	
Covariates												
6 months since initial treatment (reference)	1.00				1.00				1.00			
12 months since initial treatment	0.60	0.33	1.11	.105	0.56	0.30	1.07	.078	0.59	0.30	1.19	.140
24 months since initial treatment	0.29	0.15	0.56	< .001	0.29	0.14	0.58	< .001	0.31	0.15	0.66	.003
Predisposing factors												
Masculine sexual importance/priority [a]					1.12	1.06	1.18	< .001	1.07	1.00	1.13	.034
Need factors												
Unmet sexuality need [b]									1.33	1.20	1.47	< .001
Model summary	Nagelkerke R^2 = .075				Nagelkerke R^2 = .169				Nagelkerke R^2 = .324			
	Correctly classified 63.1%				Correctly classified 70.2%				Correctly classified 75.8%			

Note. N = 276. CI = confidence interval; *LL* = lower limit; *UL* = upper limit.

[a] Higher scores indicate greater importance of sex. [b] Higher scores indicate greater unmet sexuality need (negatively worded).

Discussion

Overview

This study aimed to gain a better understanding of the psychosocial factors associated with help-seeking intentions for emotional and sexual concerns among men with PCa. This study used Andersen's (1968, 1995) behavioural model as a guiding framework. In accordance with the model, it was hypothesised that the need factors would explain the most variance in men's intentions to seek help for emotional concerns (Hypothesis 1) and sexual concerns (Hypothesis 2). Both hypotheses were supported. The present research demonstrated that positive attitudes towards seeking help, greater unmet psychological need, and increased FCR were significantly associated with intentions to seek help for emotional concerns. Additionally, it was found that greater sexual importance/priority and unmet sexuality need were significantly associated with intentions to seek help for sexual concerns.

Rates of Help-Seeking Intention

As with previous research, the low rates of help-seeking intention found in this study reflect the limited uptake of support services by PCa survivors (Ettridge et al., 2018; Forsythe et al., 2013; Hewitt & Rowland, 2002). Fewer men intended to seek help for sexual concerns in this study (35.5%) compared to Hyde et al.'s (2021) study (56.6%). This disparity is likely because of the broader recruitment strategy (via the SA-PCCOC registry) used in this study compared to the convenience sampling (via PCa support networks/groups, cancer helplines, and invitations from doctors) used by Hyde et al. (2021). This is further supported by Goodwin et al. (2020) who recruited participants through the Queensland Cancer Registry and had equivalent rates of help-seeking for emotional concerns to this study (29.6% vs. 29.3%).

Present Study's Findings

Predisposing Factors Associated With Help-Seeking Intention

Masculine Sexual Importance/Priority. Consistent with Hyde et al. (2016) and Hyde et al. (2021), men who regarded sex as highly important to their masculinity and placed more value on being physically capable of having sex had greater odds of intending to seek help for their sexual concerns. This finding conflicts with Schover et al. (2004) who found the importance of erections was not associated with help-seeking for erectile dysfunction among PCa survivors. This discrepancy may be due to the broader conceptualisation of sexual importance (i.e., not limited to importance of erections) in Hyde et al. (2016), Hyde et al. (2021), and this study. Furthermore, the significant association between sexual importance and help-seeking intention is likely reflective of a recent paradigm shift in masculine values; seeking help for sexual dysfunction has become more normalised, socially acceptable, and even masculine, such that the need for better sexual functioning overrides any reluctance to seek help (Walker et al., 2015; Wentzell, 2017). To promote help-seeking for sexual concerns, men with PCa should be encouraged to acknowledge the importance of sex to their masculine identity.

Attitudes Towards Seeking Help. Consistent with findings from general cancer populations, this study found a significant association between positive attitudes towards seeking professional psychological help and help-seeking intentions for emotional concerns (Leppin et al., 2019; McDowell et al., 2011; Smith et al., 2008; Steginga et al., 2008). According to the theory of reasoned action (Ajzen & Fishbein, 1980), attitudes are predicted by one's outcome expectations. In this regard, men who expect a constructive outcome from seeking help (e.g., reduction in distress) are inclined to develop positive attitudes towards seeking help, while men who expect a harmful outcome (e.g., "seeking help will emasculate me") are inclined to develop negative attitudes towards seeking help (Vogel et al., 2005). As

such, interventions should aim to foster constructive outcome expectations and positive attitudes towards seeking professional psychological help.

Age. While age was associated with help-seeking behaviour in studies by Hyde et al. (2017) and Goodwin et al. (2020), it was not significantly associated with help-seeking intentions for emotional or sexual concerns in this study. This inconsistency may be due to participants being closer to treatment (0.1–11.3 months since treatment) in Hyde et al.'s (2017) study than participants from the present study (6–24 months since treatment). Information regarding participants' time since treatment was not provided in Goodwin et al.'s (2020) study. Further research is required to explain this discrepancy. Nonetheless, age should not be overlooked when planning men's survivorship care, particularly as the psychosexual burden of PCa tends to be more debilitating for younger men (Chambers et al., 2013; Chambers et al., 2015; Roberts et al., 2010).

Marital Status and Masculine Emotional Self-Reliance. Qualitative findings by Ettridge et al. (2018) suggested that married men with PCa may be less likely to seek professional help due to informal support from their partners sufficiently meeting their needs. However, consistent with Goodwin et al. (2020), marital status was not significantly associated with help-seeking intentions for emotional or sexual concerns in this study. This may be because men prefer to cope autonomously to not burden others (Courtenay, 2000b; Ettridge et al., 2018). However, if this was the case, one would expect emotional self-reliance to be negatively associated with help-seeking intentions. Yet, consistent with Hyde et al. (2021), there was no significant association between emotional self-reliance and help-seeking intentions for emotional concerns in this study. Together these findings suggest that the effects of marital status and emotional self-reliance on help-seeking may be over-emphasised in the literature. Nevertheless, marital status should be considered when determining men's level of need for psychosexual support following PCa treatment, as single men tend to

experience greater distress because of sexual dysfunction compared to men in established relationships (Chambers, Ng, et al., 2017; Ettridge et al., 2018).

Enabling Factors Associated With Help-Seeking Intention

Level of Disadvantage. This study found that level of disadvantage was not significantly associated with help-seeking intentions for emotional or sexual concerns among PCa survivors. Studies that have found significant associations between level of disadvantage or income and help-seeking behaviour have mostly been among non-PCa-specific North American populations (Blackwell et al., 2009; Kirby & Kaneda, 2005; Nicoll et al., 2021). It may be that income and level of disadvantage are significant barriers for North Americans but not for Australians due to the greater affordability of and access to health care in Australia (Doty et al., 2021; Philippon et al., 2018). Future research might instead explore organisational enabling factors such as a regular source of care, means of transportation, and region of residence, particularly as distance and travel have been identified as barriers to medical and psychological help-seeking among rural cancer survivors (Fish et al., 2019; Fuchsia Howard et al., 2014)

Need Factors Associated With Help-Seeking Intention

As anticipated by hypotheses 1 and 2, the need factors explained the most variance in men's intentions to seek help for emotional and sexual concerns; participants with higher self-reported FCR and unmet psychological and sexuality needs had greater intentions to seek help for their concerns. These results are consistent with Andersen's (1968, 1995) model which posits that individuals will only seek support if they perceive a need for help with their concerns. However, a qualitative study by Ettridge et al. (2018) found that many men did not recognise the substantial effect their PCa had on their psychosocial well-being, and thus did not perceive a need for support, despite describing experiences of distress. Together these findings highlight the importance of routine screening for FCR and unmet need in follow-up

care. This will assist in directing men who are experiencing emotional and/or sexual concerns, but are yet to perceive a need for help, to appropriate support services (Forsythe et al., 2013; Hyde et al., 2017).

Unmet Need. Consistent with Goodwin et al. (2020), greater unmet psychological need was associated with intention to seek help for emotional concerns. However, inconsistent with Hyde et al. (2017), greater unmet sexuality need was associated with intention to seek help for sexual concerns. This discrepancy may be because Hyde et al. (2017) measured help-seeking for PCa-related concerns, whereas this study specifically measured help-seeking for sexual concerns. Thus, the outcome measure used in this study may have been more pertinent to sexuality needs. Overall, these findings are promising as they suggest that despite having high levels of unmet need, men are able to recognise their emotional and sexual challenges following PCa treatment and make proactive choices to seek support for these concerns.

Fear of Cancer Recurrence. Increased FCR was a significant predictor of help-seeking intention for emotional concerns. This finding may be explained by reassurance-seeking; men may wish to remove the uncertainty that is causing their FCR by help-seeking for their concerns (Williams et al., 2021). On the other hand, this finding may simply reflect support-seeking; men may wish to cope with the distress caused by their FCR by seeking psychosocial help. Routine screening can help to identify men with clinical levels of FCR and incorporate suitable support services into their survivorship care plan. Furthermore, effective FCR interventions are needed to help improve individual outcomes and reduce the strain on the health care system (Williams et al., 2021).

Psychological Distress. Previous oncology literature found associations between distress and the use of health and psychosocial care services (Clover et al., 2015; Compen et al., 2018; Martínez Arroyo et al., 2019; Steginga et al., 2008; Van Beek et al., 2021).

However, distress was not significantly associated with men's intentions to seek help for emotional or sexual concerns in this study. This inconsistency may be owing to differences in sample characteristics, as the participants in these previous studies were not limited to men with PCa.

Unlike distress, FCR was significantly associated with men's intentions to seek help for emotional concerns. This is likely because the MAX-PC is a cancer-specific distress measure that provides greater insight into cancer patients' experiences compared to a general measure of distress, such as the K10 (Herschbach et al., 2004).

Covariates Associated With Help-Seeking Intention

This study included time since treatment and type of treatment as covariates due to their association with psychological and sexual functioning outcomes among PCa survivors (Adam et al., 2019; Litwin et al., 2002; Massoeurs et al., 2021; Talcott et al., 2003). The results found that men who had undergone their initial treatment 12 and 24 months prior to participation had lower odds of intending to seek help for emotional concerns than men who had treatment 6 months prior. This suggests that men closer to treatment require support to manage their emotional concerns, but by 12 months men no longer perceive a need for help to cope with these concerns. This aligns with the findings that the psychological burden of PCa is the greatest within the first 12 months post-diagnosis and treatment (Chambers et al., 2014; Hyde et al., 2017). The results also found that men who had undergone their treatment 24 months prior to participation had lower odds of intending to seek help for sexual concerns than men who had treatment 6 months prior. This suggests that men closer to treatment require support to manage their sexual concerns, but by 24 months men no longer perceive a need for help to cope with these concerns. This is consistent with longitudinal studies that found the greatest changes in sexual functioning occur within the first 12–24 months post-treatment (Ávila et al., 2018; Lardas et al., 2017).

Comparatively, treatment type was only a significant predictor of help-seeking intention for emotional concerns. Men treated with XRT had higher odds of intending to seek help for emotional concerns than men who underwent radical prostatectomy. Men treated with XRT tend to report lower QoL and mental health scores than men who undergo radical prostatectomy (Hashine et al., 2005; Jayadevappa et al., 2006; Litwin et al., 2002). This suggests that emotional and psychological concerns are greater for men who are treated with XRT, which would explain the greater rates of help-seeking intention for emotional concerns among these men compared with those who underwent radical prostatectomy. However, we would also expect ADT to be associated with greater help-seeking intention because men treated with ADT tend to have lower QoL scores than men who undergo radical prostatectomy (Bacon et al., 2001). This association may not have been found due to the few participants (n = 5) who were treated with ADT in this study. Future research is needed to better understand the confounding effects treatment type has on predictors of help-seeking behaviour.

Practical Implications

The findings from this study have significant implications for psychosocial interventions and survivorship guidelines. Interventions aimed at promoting more positive attitudes towards seeking professional psychological help are needed to encourage men to seek help for their emotional concerns related to their PCa. This may be achieved through public health campaigns (e.g., Movember) that educate, normalise, and promote help-seeking behaviour. These campaigns coupled with community-based interventions, such as ambassador programs and PCa support groups, may help encourage positive group norms regarding emotional challenges, promote constructive outcome expectations, reduce the stigma associated with PCa and mental health issues among men, and ultimately foster more positive attitudes towards seeking professional psychological help (Hyde et al., 2021;

Ogrodniczuk et al., 2016). Interventions to increase help-seeking intentions and behaviour should also aim to increase knowledge on where and how men can seek help for their emotional and sexual concerns. Moreover, professional support providers should aim to establish trust and rapport with PCa survivors to reduce uncertainty and stigma towards seeking psychological support (Seidler et al., 2018). This particularly pertains to psychosocial providers as very few men intended to seek help from psychologists and counsellors for their emotional and sexual concerns.

Masculine beliefs should be taken into consideration when planning and providing psychosexual care (Chambers, Chung, et al., 2017). Men who view sex as highly important to their masculinity and assign a high value to being physically capable of having sex should be connected to relevant psychosocial providers. Consistent with the emerging shift in masculine values, online and community-based interventions should work to reframe help-seeking behaviour as a courageous act that demonstrates resilience, strength of character, and independence (Hyde et al., 2021; Ogrodniczuk et al., 2016). Furthermore, the benefits of improved psychosexual wellbeing could be linked to greater sexual pleasure and intimacy to appeal to men's ideals about sexual importance.

Strengths, Limitations, and Future Research Directions

Men are known to be challenging to recruit for health behaviour research (Ryan et al., 2019). Hence, the large sample size (N = 276) is a key strength of this study. Further, recruitment via a well-established PCa registry (SA-PCCOC) provided a unique opportunity to explore predictors of men's help-seeking intentions in a more representative sample. Namely, the broad inclusion criteria and absence of exclusion criteria in this study suggests good generalisability (Gliklich et al., 2020).

However, a majority of participants were born in Australia and spoke English at home, and therefore the generalisability of the findings may be limited. Culturally diverse

research is essential as PCa disproportionately impacts racial and ethnic minorities (Mahal et al., 2022). Additionally, over 7.8 million Australians were born overseas as of June 2020 (ABS, 2021). Thus, future research is needed with samples with greater cultural and linguistic diversity to verify the generalisability of the findings beyond the sampled South Australian PCa population.

Other strengths of this study include the extension of previous qualitative research by Ettridge et al. (2018) and application of a widely used theoretical framework. Although it was not the intention of this study to validate Andersen's model for use with PCa survivors and their psychosocial help-seeking behaviour, the results of this study suggest Anderson's model may be useful for explaining men's intentions to seek help for psychosocial concerns. Cultural factors (e.g., religion and cultural health beliefs) were not considered within the model as it was outside the scope of this study. As such, future PCa studies employing Andersen's model should incorporate cultural factors as potential predictors of help-seeking for emotional and sexual concerns.

This study is limited by the use of a cross-sectional design, which only examined help-seeking intention and not behaviour, hence precluding inferences about causality. Although intention is considered to be the primary antecedent of behaviour (Ajzen, 1991), future research could benefit from employing a prospective design in order to provide temporal insight. Additionally, this study did not assess predictors of long-term help-seeking (i.e., beyond 24 months post-treatment) despite psychological difficulties and treatment side effects being shown to persist up to 6- and 15-years post-treatment, respectively (Chambers, Ng, et al., 2017; Resnick et al., 2013). This provides a gap for future studies to assess long-term patterns and predictors of help-seeking among men further from treatment.

The results of this study are also limited by the use of self-report measures, which are often prone to social desirability bias (DeMaio, 1984). For example, participants may have

underreported their level of unmet psychological need or over-reported their intentions to seek help due to social desirability. Future research could address this limitation by assessing observable help-seeking behaviour (e.g., the number of visits to support services), and/or incorporating a measure of social desirability (e.g., The Marlowe–Crowne Social Desirability Scale) into the study.

Future research should also investigate the impact of sexual orientation on men's help-seeking behaviour for emotional and sexual concerns. Gay and bisexual men are an important minority group within the PCa population that tend to report significantly higher psychological and cancer-specific distress, greater ejaculatory concerns, lower health-related QoL, and reduced masculine self-esteem after treatment (Ussher et al., 2016). Issues of hetero-centrism within PCa supportive care may hinder help-seeking behaviour among these men and as such is a crucial area for future study.

Conclusion

This study provides important findings that quantify the factors associated with help-seeking for emotional and sexual concerns among men with PCa. Positive attitudes towards seeking help, greater unmet psychological need, and increased FCR were important factors associated with help-seeking intentions for emotional concerns. Moreover, greater sexual importance/priority and unmet sexuality need were important factors associated with help-seeking intentions for sexual concerns. Need factors explained the greatest variance in men's help-seeking intentions for emotional and sexual concerns, providing evidence that men must first perceive a need for help before intending to seek help. These findings have significant implications for health promotion. Supportive care providers need to be proactive in screening for FCR and unmet need throughout PCa treatment and into survivorship. Interventions should take an attitudes-based approach and appeal to men's ideals about sexual importance to increase help-seeking intention. Future prospective research is recommended

to extend the current findings and assess predictors of long-term help-seeking intention and behaviour.

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Appendix

Emotional Concerns

The next questions are about how you have been feeling **during the past 30 days**.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. About how often did you feel tired out for no good reason?	1	2	3	4	5
2. About how often did you feel nervous?	1	2	3	4	5
3. About how often did you feel so nervous that nothing could calm you down?	1	2	3	4	5
4. About how often did you feel hopeless?	1	2	3	4	5
5. About how often did you feel restless or fidgety?	1	2	3	4	5
6. About how often did you feel so restless you could not sit still?	1	2	3	4	5
7. About how often did you feel depressed?	1	2	3	4	5
8. About how often did you feel that everything was an effort?	1	2	3	4	5
9. About how often did you feel so sad that nothing could cheer you up?	1	2	3	4	5
10. About how often did you feel worthless?	1	2	3	4	5

This survey covers a range of subjects that are related to health and wellbeing. Some of these are sensitive or very personal. If you are concerned about your physical or emotional health and would like some help, you may like to contact:

- **Your nearest Community Health Centre**
- **Cancer Council Australia 13 11 20**
- **Your General Practitioner for advice about who would be the best person in your community for you to talk to;**
- **Lifeline 131 114 (local call). Available 24 hours.**

Seeking Help

Read each statement carefully and indicate your degree of agreement using the scale below.

	Disagree	Partly disagree	Partly agree	Agree
1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention	1	2	3	4
2. The idea of talking about problems with a counsellor strikes me as a poor way to get rid of emotional conflicts	1	2	3	4
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychological counselling	1	2	3	4
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help	1	2	3	4
5. I would want to get psychological help if I were worried or upset for a long period of time	1	2	3	4
6. I might want to have psychological counselling in the future	1	2	3	4
7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help	1	2	3	4
8. Considering the time and expense involved in psychological counselling, it would have doubtful value for a person like me	1	2	3	4
9. A person should work out his or her own problems; getting psychological counselling would be a last resort	1	2	3	4
10. Personal and emotional troubles, like many things, tend to work out by themselves.	1	2	3	4

Seeking Help (continued)

The following questions ask about your views on support and information for coping with cancer. Please indicate your response to the following questions about your past, current or future help seeking for **emotional/psychological concerns** related to your prostate cancer

1. I **intend to** seek advice or help **in the next 6 months** for emotional/psychological concerns **related to my prostate cancer** from a:

	No	Yes
Doctor	☐1	☐0
Nurse	☐1	☐0
Psychologist or Counsellor	☐1	☐0
Prostate cancer support group	☐1	☐0
Another man who has had prostate cancer	☐1	☐0
Other (please list):		

2. I **currently** seek advice or help for emotional/psychological concerns **related to my prostate cancer** from a:

	No	Yes
Doctor	☐1	☐0
Nurse	☐1	☐0
Psychologist or Counsellor	☐1	☐0
Prostate cancer support group	☐1	☐0
Another man who has had prostate cancer	☐1	☐0
Other (please list):		

3. I **have sought** advice or help **in the past 6 months** for emotional/psychological concerns **related to my prostate cancer** from a:

	No	Yes
Doctor	☐1	☐0
Nurse	☐1	☐0
Psychologist or Counsellor	☐1	☐0
Prostate cancer support group	☐1	☐0
Another man who had prostate cancer	☐1	☐0
Other (please list):		

Please indicate your response to the following questions about your past, current or future help seeking for **sexual concerns** related to your prostate cancer

4. I **intend to seek** advice or help **in the next 6 months** for **sexual concerns related to my prostate cancer** from a:

	No	**Yes**
Doctor	☐1	☐0
Nurse	☐1	☐0
Psychologist or Counsellor	☐1	☐0
Prostate cancer support group	☐1	☐0
Another man who has had prostate cancer	☐1	☐0
Other (please list):		

5. I **currently seek** advice or help for **sexual concerns related to my prostate cancer** from a:

	No	**Yes**
Doctor	☐1	☐0
Nurse	☐1	☐0
Psychologist or Counsellor	☐1	☐0
Prostate cancer support group	☐1	☐0
Another man who has had prostate cancer	☐1	☐0
Other (please list):		

6. I **have sought** advice or help in the past 6 months for **sexual concerns related to my prostate cancer** from

	No	**Yes**
Doctor	☐1	☐0
Nurse	☐1	☐0
Psychologist or Counsellor	☐1	☐0
Prostate cancer support group	☐1	☐0
Another man who has had prostate cancer	☐1	☐0
Other (please list):		

Your Needs

To help us plan better services for people diagnosed with cancer, we are interested in whether or not needs which you may have faced as a result of having cancer have been met. For every item on the following pages, indicate whether you have needed help with this issue within the last month as a result of having cancer. Put a circle around the number which best describes whether you have needed help with this in the last month. There are 5 possible answers to choose from:

NO NEED	1	**Not applicable** – This was not a problem for me as a result of having cancer.
	2	**Satisfied** - I did need help with this, but my need for help was satisfied at the time.
SOME NEED	3	**Low need** - This item caused me concern or discomfort. I had little need for additional help
	4	**Moderate need** – This item caused me concern or discomfort. I had some need for additional help.
	5	**High need** - This item caused me concern or discomfort. I had a strong need for additional help

Now please complete the following questions:

In the last month, What was your level of need for help with:	**No need**		**Some need**		
	Not applicable	**Satisfied**	**Low need**	**Moderate need**	**High need**
1. Pain	1	2	3	4	5
2. Lack of energy/tiredness	1	2	3	4	5
3. Feeling unwell a lot of the time	1	2	3	4	5
4. Work around the home	1	2	3	4	5
5. Not being able to do the things you used to do	1	2	3	4	5
6. Anxiety	1	2	3	4	5
7. Feeling down or depressed	1	2	3	4	5
8. Feelings of sadness	1	2	3	4	5
9. Fears about the cancer spreading	1	2	3	4	5
10. Worry that the results of treatment are beyond your control	1	2	3	4	5
11. Uncertainty about the future	1	2	3	4	5
12. Learning to feel in control of your situation	1	2	3	4	5
13. Keeping a positive outlook	1	2	3	4	5

In the last month, What was your level of need for help with:	**No need**		**Some need**		
	Not applicable	**Satisfied**	**Low need**	**Moderate need**	**High need**
14. Feelings about death and dying	1	2	3	4	5
15. Changes in sexual feelings	1	2	3	4	5
16. Changes in your sexual relationships	1	2	3	4	5
17. Concerns about the worries of those close to you	1	2	3	4	5
18. More choice about which cancer specialists you see	1	2	3	4	5
19. More choice about which hospital you attend	1	2	3	4	5
20. Reassurance by medical staff that the way you feel is normal	1	2	3	4	5
21. Hospital staff attending promptly to your physical needs	1	2	3	4	5
22. Hospital staff acknowledging, and showing sensitivity to, your feelings and emotional needs	1	2	3	4	5
23. Being given written information about the important aspects of your care	1	2	3	4	5
24. Being given information (written, diagrams, drawings) about aspects of managing your illness and side-effects at home	1	2	3	4	5
25. Being given explanations of those tests for which you would like explanations	1	2	3	4	5
26. Being adequately informed about the benefits and side-effects of treatments before you choose to have them	1	2	3	4	5
27. Being informed about your test results as soon as feasible	1	2	3	4	5
28. Being informed about cancer which is under control or diminishing (that is, remission)	1	2	3	4	5
29. Being informed about things you can do to help yourself to get well	1	2	3	4	5

In the last month, What was your level of need for help with:	**No need**		**Some need**		
	Not applicable	**Satisfied**	**Low need**	**Moderate need**	**High need**
30. Having access to professional counselling (eg, psychologist, social worker, counsellor, nurse specialist) if you, family or friends need it	1	2	3	4	5
31. Being given information about sexual relationships	1	2	3	4	5
32. Being treated like a person not just another case	1	2	3	4	5
33. Being treated in a hospital or clinic that is as physically pleasant as possible	1	2	3	4	5
34. Having one member of hospital staff with whom you can talk to about all aspects of your condition, treatment and follow-up	1	2	3	4	5
35. Urinary incontinence	1	2	3	4	5
36. Difficulties in passing urine	1	2	3	4	5
37. Hot flushes	1	2	3	4	5
38. Feeling as if you are going through a change of life like women do	1	2	3	4	5
39. Feeling like you've lost part of your manhood	1	2	3	4	5
40. Feeling that what you say is not taken seriously by others	1	2	3	4	5
41. Feeling like you have lost the ability to be aggressive	1	2	3	4	5
42. Problems with your bowel habits	1	2	3	4	5

Beliefs about Your Health

Listed below are a number of statements containing a person's beliefs about their own health. In thinking about the *past week*, please indicate how much you agree or disagree with each statement: strongly agree, agree, disagree, or strongly agree. Please circle the number of your answer.

	Strongly agree	Agree	Disagree	Strongly disagree
1. Because cancer is unpredictable, I feel I cannot plan for the future	0	1	2	3
2. My fear of having my cancer getting worse gets in the way of my enjoying life	0	1	2	3
3. I am afraid of my cancer getting worse	0	1	2	3
4. I am more nervous since I was diagnosed with prostate cancer	0	1	2	3

Your Thoughts and Feelings

The following is a series of statements about how men might think or feel about themselves, and about what is important for men. Thinking about you personally, please indicate how true each statement is for you on a scale of 1 "not at all true", 3 "somewhat true" to 5 "very true". There are no right or wrong answers. Please give the responses that most accurately describe your personal thoughts and feelings.

	Not at all true	A little true	Somewhat true	Mostly true	Very true
1. Being physically able to have sex is important to me	1	2	3	4	5
2. I keep my feelings to myself	1	2	3	4	5
3. Being able to have an erection is important to me	1	2	3	4	5
4. I like to know I am capable of having sex	1	2	3	4	5
5. I tend not to talk about my worries	1	2	3	4	5
6. Being able to have sex is like being able to run	1	2	3	4	5

General Questions

1. In which country were you born?

☐1 Australia
☐2 England
☐3 New Zealand
☐4 Italy
☐5 Viet Nam
☐6 Scotland
☐7 Greece
☐8 Germany
☐9 Philippines
☐10 India
☐11 Other – please specify_____

2. Do you speak a language other than English at home?

☐0 No – English only
☐1 Italian
☐2 Greek
☐3 Cantonese
☐4 Arabic
☐5 Mandarin
☐6 Vietnamese
☐7 Other – please specify _____

3. What is your marital status?

☐0 Never married
☐1 Widowed
☐2 Divorced
☐3 Separated
☐4 Married (in a registered marriage)
☐5 De facto marriage

This survey covers a range of subjects that are related to health and wellbeing. Some of these are sensitive or very personal. If you are concerned about your physical or emotional health and would like some help, you may like to contact:

- **Your nearest Community Health Centre**
- **Cancer Council Australia 13 11 20**
- **Your General Practitioner for advice about who would be the best person in your community for you to talk to;**
- **Lifeline 131 114 (local call). Available 24 hours.**