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Journal

Oncology Nursing Forum, 28(6)

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Publication Date

2001

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Mastery of Postprostatectomy Incontinence and Impotence: His Work, Her Work, Our Work

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Purpose/Objectives: To describe couples' experiences of postprostatectomy incontinence and impotence.

Design: Descriptive, qualitative.

Setting: Northeastern U.S. metropolitan area.

Sample: Subsample of 20 (10 control and 10 intervention) couples from a large quantitative clinical trial of a Standardized Nursing Intervention Protocol (SNIP) postprostatectomy.

Methods: Interviews were conducted using a semi-structured guide. Data were analyzed using grounded theory techniques.

Main Research Variable: Couples' experiences of coping with postprostatectomy incontinence and impotence.

Findings: Managing postprostatectomy incontinence and impotence required work. Men's work focused on regaining mastery and encompassed understanding incontinence as healing, mastering incontinence, networking, confronting impotence and putting it into perspective, and prioritizing. Wives were supportive by managing anxiety, encouraging mastery, putting impotence into perspective, and reassuring their spouses. Established routines brought couples through the experience together while strengthening intimacy. SNIP couples found the nurses to be sources of information, support, and affirmation.

Conclusions: Couples worked to deal with postprostatectomy incontinence and impotence within the context of surviving cancer and maintaining a loving relationship. This gave unique meaning to their symptoms and led the couples to value the fact that the men were alive and work toward regaining mastery. Mastery emerged as a key concept from the findings.

Implications for Nursing Practice: Nurses can gain from an enhanced understanding of postprostatectomy incontinence and impotence as meaningful within the greater context of patients having had cancer. Nurses can hasten couples' abilities to regain a sense of mastery by providing information, supporting couples' work, providing positive affirmation, and being available.

Prostate cancer is the most frequently diagnosed cancer in American men (American Cancer Society [ACS], 2001). In 2001, 198,100 new cases are estimated to present, with 79% diagnosed in the localized stage (ACS). Typically, men with localized prostate cancer have a choice of potentially curative treatment: radiation therapy or radical prostatectomy. These treatments have different short- and long-term side effects. Incontinence and impotence have been identified as major sequelae following radical prostatectomy. In a study

Key Points . . .

- ▶ Prostate cancer affects not only the man diagnosed with the disease but also his wife, who is a key factor in dealing with postprostatectomy incontinence and impotence.
- ▶ The postoperative sequelae of incontinence and impotence take on meaning within the context of having had cancer and having had it removed.
- ▶ Quality of life seems to be maintained through the work of couples as they regain mastery.
- ▶ The inclusion of the wives in nursing research of and interventions for prostate cancer is important.

of 94 men who had radical prostatectomy, Talcott et al. (1997) found that at three months postprostatectomy, 50% of the men who had received a non-nerve-sparing procedure and 65% who had received a nerve-sparing procedure reported using incontinence pads. At 12 months, 14% of the non-nerve-sparing group and 50% of the nerve-sparing group used pads. In the same study, 82%–97% experienced complete impotence or erections inadequate for intercourse at 12 months after surgery. In reviewing literature from 1993–1996, Herr (1997) found rates of 18%–50% for incontinence and 73%–91% for impotence at least one year postprostatectomy. Thus, management



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of these symptoms is an important nursing concern. Central to that concern is an understanding of the adaptation process.

Literature Review

Many studies have been conducted that measured quality of life (QOL) of men after treatment for early-stage prostate cancer (Arai et al., 1999; Braslis, Santa-Cruz, Brickman, & Soloway, 1995; Clark, Rieker, Propert, & Talcott, 1999; Emberton et al., 1996; Fowler et al., 1995; Krupski, Petroni, Bissonette, & Theodorescu, 2000; Litwin et al., 1995, 1999; Lubeck et al., 1999; McCammon, Kolm, Main, & Schellhammer, 1999; Shrader-Bogen, Kjellberg, McPherson, & Murray, 1997; Talcott et al., 1997; Yarbro & Ferrans, 1998). A number of these studies compared QOL measurements postprostatectomy with measurements following radiation therapy. Results demonstrated no significant differences in QOL based on treatment modality despite the presence of post-treatment symptoms (Herr, 1997; Krupski et al.; Litwin et al., 1995, 1999; Lubeck et al.; Shrader-Bogen et al.; Yarbro & Ferrans). Other studies have evaluated QOL following radical prostatectomy only. Comparisons were made before and after surgery (Braslis et al.; Emberton et al.; Stanford et al., 2000) with a comparison group having surgery for benign prostatic hypertrophy (Fowler et al.) or with a group awaiting surgery (Arai et al.). Although these investigators used different measures of QOL, they consistently concluded that QOL was not significantly diminished and, in some cases, improved even with incontinence and impotence. Fowler et al. speculated that the men adapted to these symptoms or tolerated the symptoms because of good overall function or a determination to live with the symptoms (Litwin et al., 1995). However, studies are missing in the literature that specifically explore the adaptation process that measured QOL is not adversely affected.

Limited research has shown that wives of men with prostate cancer face various challenges because of their husbands' disease (Heyman & Rosner, 1996). Male incontinence has the potential to change women's day-to-day lives. Impotence affects women in a variety of intimate ways (Intili, 1998). Spouses of patients with prostate cancer report significantly greater psychological distress and poorer QOL than their husbands (Herr, 1997; Kornblith, Herr, Ofman, Scher, & Holland, 1994). Additionally, in this era of cost containment, wives assume a major role in caregiving postprostatectomy (O'Rourke & Germino, 1997). However, as Heyman and Rosner noted, a dearth of literature exists regarding wives' experiences of their husbands' methods of coping with incontinence and impotence postprostatectomy.

Nurses must understand how men and their wives experience and manage postprostatectomy incontinence and impotence to deliver appropriate interventions. The findings reported here describe the process of coping with incontinence and impotence postprostatectomy for men and their wives.

Background

Nurse researchers are at the forefront of work that includes postprostatectomy spousal concerns and needs. Pickett, Cooley, Patterson, and McCorkle (1996) recommended a homecare regimen that included continence and psychosocial and psychosexual support of men and their spouses. Patient teaching and psychologically based interventions account for 65% of nurs-

ing interventions provided to men postprostatectomy (Robinson et al., 1999). Pelvic floor exercise and biofeedback training have been evaluated for postprostatectomy incontinence and have been well accepted and perceived as helpful in improving continence by patients (Gallo & Fallon, 1996; Jackson, Emerson, Johnston, Wilson, & Morales, 1996). O'Rourke and Germino (1998) supported the importance of considering spouses' needs in an examination of spousal caregiving across the course of prostate cancer emphasizing that wives play a pivotal role. In a study of the meaning of the prostate cancer experience for men and their wives, Heyman and Rosner (1996) found that wives were partners in managing the disease.

McCorkle (1997) conducted a randomized clinical trial of a home nursing intervention to study the effect of postprostatectomy on couples' QOL. The control group received the usual care provided by their urology surgical group consisting of the removal of the catheter approximately three weeks after surgery, an office visit to learn the results of the pathology report, urodynamic testing about three weeks after catheter removal, and a final visit with their surgeons three months postprostatectomy. Couples with questions could call, leave messages, and wait for return calls from a staff member in the urology office. In addition, the experimental group received the Standardized Nursing Intervention Protocol (SNIP) that provided weekly home visits for eight weeks postprostatectomy from an advanced practice nurse. The nurse telephoned couples between visits and provided them with her telephone number to be used when needed. The nurse focused on assisting couples with immediate postoperative care, including catheter management, bowel function, and pain management; management of incontinence, including Kegel's pelvic floor exercises with biofeedback training; intimacy and communication issues; and psychosocial support.

The present study was implemented among a subsample of 20 couples from 42 couples enrolled in the parent study at that time. The purpose was to understand the meaning of postprostatectomy incontinence and impotence from the perspective of men and their wives and to explore their processes for dealing with these symptoms. Additionally, couples' perceptions of the nurse's role relative to these symptoms were examined.

Methods

Design

A qualitative cross-sectional approach was chosen to describe couples' lived experiences at different points in time from three months to one year postprostatectomy to capture the experiences of incontinence and impotence. An interview guide was developed to elicit the experience of each man and his wife from diagnosis to the time of the interview, with specific questions exploring incontinence and impotence within this context. Because 5–25 subjects are considered adequate for thorough description (Creswell, 1998), 20 couples were selected—10 from the intervention group and 10 from the control group.

Sample

Approval was obtained from the human subjects institutional review board at the University of Pennsylvania. The investigator telephoned each couple consecutively enrolled in the parent study who were three months or more postprostatectomy to explain the study. If the couple agreed to participate, an appointment was made to meet.

Procedure

Written informed consent was obtained before proceeding with the interviews, which were audiotaped with the couples' permission. Interviews lasted about two hours each. Most couples ($n = 19$) chose to be interviewed in their homes, but one chose a quiet area of a clinic waiting room. Husbands and wives were interviewed separately, often with the other present. This facilitated observation of intracouple dynamics, although responses may have been different had their spouses not been present. Field notes were dictated regarding the setting and nonverbal behaviors of the couples after each interview. Demographic data were retrieved from the parent study to eliminate duplication of questions.

Data Analysis and Interpretation

Interviews and field notes were transcribed verbatim. Transcripts were checked against audiotapes to verify accuracy. Analysis began concurrently with data collection and continued afterward. Using grounded theory techniques (Strauss & Corbin, 1998), line-by-line coding generated initial conceptual categories. Dimensions of categories then were expanded. Data were analyzed simultaneously for processes of management and changes over time.

To ensure rigor, two researchers independently coded and cross-compared categories and dimensions. Data were analyzed until all variations were identified. Some emerging themes were confirmed with participants, and all were compared to existent literature. Memos were written to preserve ideas throughout data analysis regarding emerging theory (Strauss & Corbin, 1998) providing auditability.

Findings

A total of 20 couples agreed to participate. Nineteen couples were Caucasian, and one was African American. All were married, in middle-to-upper socioeconomic groups, and generally well educated (see Tables 1 and 2). Findings were organized as his work—how men dealt with incontinence and impotence; her work—how women dealt with their husbands' incontinence and impotence; and our work—how the couples worked together in dealing with incontinence and impotence as shown in Figure 1.

His Work: Regaining Mastery

Men's methods for dealing with incontinence and impotence were embedded within the overall pursuit to regain the control that had been lost with the diagnosis of cancer and subsequent surgery. Gaining command over incontinence and impotence was critical to successful progress through recovery work. Men's perceptions of the nurse focused on her role in enhancing their abilities to overcome problems related to incontinence and impotence.

Prioritizing: All of the men set priorities that organized self-management. The highest priority was to "get the cancer out," with regaining continence and erectile function second and third, respectively. However, most men expressed that eliminating the cancer was worth it, even if they did not regain total continence or erectile function. Impotence and incontinence could be "lived with" and managed; however, cancer and the threat of dying could not.

Incontinence as healing: After surgery, the catheter was a major barrier to regaining a sense of control over their bodies for the men. The goal for proficiency focused on managing

Table 1. Demographics of Standardized Nursing Prevention Protocol Couples

Couple	Age	Ethnicity	Time Since Surgery (months)	Education Completed ^a	Occupation	Income x \$1,000
Husband	64	Caucasian	11	BS	Manager	> 90
Wife	61	Caucasian		AS	Manager (part-time)	
Husband	71	Caucasian	10	BS	Self-employed	> 90
Wife	61	Caucasian		BS	Secretary	
Husband	64	African American	9	11th grade	Self-employed	35-40
Wife	70	African American		10th grade	Nurse aid (retired)	
Husband	63	Caucasian	9	HS	Manager	60-70
Wife	64	Caucasian		HS	Secretary	
Husband	54	Caucasian	9	HS	Self-employed	25-30
Wife	49	Caucasian		HS	Secretary	
Husband	59	Caucasian	9	HS	Self-employed	50-60
Wife	47	Caucasian		HS	Secretary	
Husband	61	Caucasian	8	Vo-Tec	Manager	60-70
Wife	60	Caucasian		HS	Homemaker	
Husband	62	Caucasian	7	BS	Manager	> 90
Wife	60	Caucasian		HS	Secretary	
Husband	51	Caucasian	5	MS	Teacher	> 90
Wife	52	Caucasian		MS	Teacher	
Husband	63	Caucasian	4	BS	Pilot (retired)	> 90
Wife	58	Caucasian		MS	Teacher	

^aAS—Associate of Arts; BS—Bachelor of Science; HS—High school; MS—Master's degree; Vo-Tec—Vocational

Table 2. Demographics of Usual Care Couples

Couple	Age	Ethnicity	Time Since Surgery (months)	Education Completed ^a	Occupation	Income x \$1,000
Husband	52	Caucasian	10	AS	Manager	> 90
Wife	51	Caucasian		HS	Manager (retired)	
Husband	56	Caucasian	8	BS	Inspector	60–70
Wife	43	Caucasian		AS	Nurse	
Husband	65	Caucasian	8	MS	Manager	> 90
Wife	58	Caucasian		BS	Homemaker	
Husband	62	Caucasian	7	BS	Manager	> 90
Wife	60	Caucasian		HS	Secretary	
Husband	55	Caucasian	6	MS	Self-employed	80–90
Wife	51	Caucasian		BS	Secretary	
Husband	51	Caucasian	5	BS	Self-employed	> 90
Wife	50	Caucasian		BS	Teacher	
Husband	57	Caucasian	4	MS	Manager	> 90
Wife	57	Caucasian		HS	Secretary	
Husband	54	Caucasian	4	MS	Manager	> 90
Wife	28	Caucasian		AS	Secretary	
Husband	59	Caucasian	3	PhD	Manager	> 90
Wife	54	Caucasian		MS	Teacher	
Husband	56	Caucasian	3	BS	Self-employed	> 90
Wife	52	Caucasian		AS	Secretary	

^aAS—Associate of Arts; BS—Bachelor of Science; HS—High school; MS—Master’s degree; PhD—Doctor of Philosophy

life with a catheter. Adequate healing had to occur internally for the catheter to be removed. Thus, the removal of the catheter was a visible sign of invisible, internal healing, and put an end to painful bladder spasms, irritation, and activity restriction. Removal was a major milestone in the recovery process after which the men “really started to pick up” the pace of recovery work. The men felt “freed up” to begin a regime of Kegel exercises and general conditioning exercise, such as walking with less restriction.

Most men saw incontinence following catheter removal as part of the recovery process rather than a sign of dysfunction. Incontinence provided a visible gauge of progress because the pads used could be counted or the degree of wetness assessed from day-to-day and week-to-week. The men viewed incontinence as manageable and temporary, not something they expected to experience indefinitely.

The nurse facilitated this healing perspective for men in the SNIP group. When the advanced practice nurse did a 24-hour

pad test four and eight weeks after the catheter removal, the men were able to see a decrease in the weight of wet pads. They found this information very useful because, as one man said, it helped in “not letting it get you down.” The nurse confirmed their progress by assisting them to interpret other physical signs. The couples who did not receive SNIP expressed feeling more uncertain about their progress than couples who did.

Gaining control over urinary function and dysfunction: Incontinence management and regaining continence became the focus of recovery work after catheter removal. When incontinence was managed successfully using pads, condom catheters, or clamps, the men started to resume their usual activities on a limited basis (e.g., returning to work part-time, some social activities). Successful incontinence management meant that the men felt confident in their control over urinary elimination, such that the urine remained invisible to others and they “didn’t have to fear accidents.” Adeptness in relation to incontinence did not require them to be dry, just in control.

His Work: Regaining Mastery	Our Work: Going Through it Together	Her Work: Supportive Presence
Prioritizing Incontinence as healing Gaining control over urinary function and dysfunction Purposeful networking Confronting impotence: Putting it into perspective	Establishing a routine Strengthening intimacy	Managing anxiety: Hers and his Facilitating his control Gaining perspective and reassuring him

Figure 1. Concepts and Dimensions: Mastery of Postprostatectomy Incontinence and Impotence

Feeling prepared also was important to gaining a sense of proficiency related to incontinence. Many already had incontinence supplies on hand because they expected to be incontinent.

Most of the men were religious about doing the recommended Kegel exercises. As one man put it, "I Kegel'ed my little heart out." Kegel exercises served two purposes: they were believed to hasten recovery of continence, and they provided some control over stress incontinence.

The men who did not receive SNIP described dealing with incontinence by "trial and error." Those who received SNIP described the nurse as a resource for finding and evaluating incontinence management strategies. They found the nurse's teaching and reinforcement of Kegel exercises invaluable. They were able to return to their lives more quickly because of the exercises.

Purposeful networking: By talking with personal friends and using prostate cancer Internet sites and chat rooms, the men became aware of others who had experienced prostate surgery. Through networking, they discovered what others had done to hasten recovery. To gauge their progress, the men compared their recovery processes to others. They were slightly competitive in their judgments of whether they were on the "power curve" or lagged behind in relation to continence and erectile function.

Those who had SNIP discussed information obtained from their networking efforts with the nurse. She corrected misinformation and assisted in gaining perspective on their progress.

Confronting impotence—putting it into perspective: As incontinence was controlled and continence increased, the men began to confront impotence. Although two men had begun to experience some return of erectile function, none reported being able to achieve an erection sufficient for intercourse. Some had tried Viagra® (Pfizer Labs, New York, NY) with little or no result and expressed disappointment about this. At the three-month medical appointment and no earlier, the urologist prescribed Viagra if the men wanted to try it. Some men did not want to use a pill or any other "unnatural" device to aid erectile function. They hoped that it would return naturally.

Based on information from their urologists, the men saw the one-year point as crucial because they were cautioned that the level of urinary and erectile function acquired by that time was all that would be possible. When interviewed, none were at the one-year mark, so they were uncertain but hopeful about their potential progress. One man was 11 months postprostatectomy and was starting to face the possibility that erectile function might not return naturally. He was beginning to talk about pursuing other options for treatment of erectile dysfunction in the future and felt that the one-year milestone "closing in" on him.

The major work related to prevailing within the context of impotence revolved around gaining perspective. Many projected that impotence would not be devastating for them because of their ages. They said it would have been worse if they were younger, but because they were not going to have anymore children, impotence, while unwanted, was "not that bad." They said there was "more to life and marriage than sex." Consequently, they reported impotence did not alter the strength of their marital relationships.

Despite this perspective, a look of sadness came into the men's eyes, and the tone of their voices dropped when talking about impotence. Even the men who had not had intercourse with their wives for some time prior to surgery because of other medical reasons expressed a sense of loss. The men learned to

live with their current impotence, hoping it would be temporary but fearing it might be permanent. Those who had SNIP used the nurse as a sounding board for their thoughts when they were ready to share their concerns.

Her Work: Supportive Presence

The wives were crucial to the recovery process. "Being there" supportively involved purposeful effort by the wives. They took time off from work and their usual activities to support their husbands physically through caregiving. They were emotionally present as the activities of day-to-day living gradually returned to usual.

Managing anxiety—his and hers: Wives not only managed their own anxiety, but also their husbands' relative to the outcome of surgery and postoperative care. Wives received support for their work from family and friends including concrete assistance, such as transportation to appointments. They received emotional support for their own concerns from other women whose husbands had experienced prostatectomies. These women provided an outlet for the wives to safely express their feelings while still being emotionally supportive for their husbands.

For those who had SNIP, the nurse played a key role in assisting wives to manage anxiety. The wives talked about their concerns with the nurse and then were able to solve troublesome issues. The nurse was a resource for strategies and became part of the wives' supportive network. At times, the nurse provided respite for the wives in coping with their husbands' anxiety. One wife said, "I think I would have strangled him if it hadn't been for the nurse. She dealt with his anxiety when I couldn't anymore."

Facilitating his control: Wives played a major role in facilitating their husbands' efforts to heal. They expressed pride in how well the men managed their incontinence. They respected their husbands' need to regain a sense of control in relation to what was happening in their lives, as well as the need to regain command over urinary function. Most wives indicated that incontinence did not directly affect them because their husbands managed it, even though they were present to handle problems when needed.

After the catheters were removed, wives became less active in their husbands' physical care but remained present emotionally. They sensed the men's frustrations and acted to lessen them by managing the environment. They were gatekeepers for visitors and calls. The wives encouraged their husbands to practice Kegel exercises, and some women did the exercises with their husbands. Some spouses expressed pride in their husbands' tenacity in "religiously" doing their exercises. They made sure their husbands had supplies for managing incontinence. Even as the wives started moving back into their own activities, they still supported the men. Those who received SNIP used the nurse as a resource to create an environment in which recovery work was facilitated.

Gaining perspective and reassuring him: Similar to their husbands, the wives also worked to put impotence into perspective. All of the wives expressed gratitude that their husbands were alive and that the cancer was out. They felt that impotence was not as important as having their husbands healthy. All of the wives, except two, cited age as a rationale for impotence being of less importance. One wife was considerably younger than her husband and was distressed that her sex life might be over. She was not in the SNIP group and sought

individual counseling. Another woman had only been married for three years and interpreted her husband's impotence as meaning that he did not "desire" her sexually. As part of the care received in SNIP, the nurse helped her to realize that her husband's impotence was not caused by a lack of desire but was sequelae of the surgery. This was crucial to her ability to put his impotence into perspective for herself and to reassure him.

Nonetheless, all of the wives reported that the strength of their relationships was not adversely affected by impotence. They talked of expressing affection in ways that already were part of their repertoire, such as "reaching over to hold hands while watching TV" or "cuddling" with their husbands. The wives demonstrated understanding of their husbands' feelings about impotence and the sense of loss that the men felt. They worked to reassure their husbands that they still loved them and that they did not consider them to be less masculine. They were present for their husbands and supportive in intimate and sensitive ways.

Our Work: Going Through It Together

Besides the work that each husband and wife did individually, shared work existed that was more than just the combination of each individual's work. This involved a balancing and rebalancing of roles throughout the course of recovery to enhance the sense of control of urinary function and daily activities. This tacit, dynamic balance of the recovery work facilitated the reestablishment of control overall. As the men mastered incontinence and returned to their normal activities, the wives stepped back to a more supportive role and resumed their usual activities, and as a couple, they then began to deal with impotence. This sensitive balance was needed to transition back into what was each couple's normal life.

Establishing a routine: The couples established routines together that enhanced control over the details of managing incontinence, facilitating rest and activity, bathing with the catheter, catheter care, dressing, and time and place for meals. Some couples went on walks together. Others practiced Kegel exercises together. Upon his return to work, one man's wife routinely called him to come home at approximately 1:00 pm to ensure that he received adequate rest. Having a routine that involved the couple, even though temporary, created a joint effort toward regaining a sense of control overall. As the husbands progressed in recovery, these temporary routines gave way to more permanent ones.

Strengthening intimacy: Although husbands and wives put impotence into perspective separately, ultimately the couples put impotence into perspective jointly. They did this by sharing their thoughts and feelings. Additionally, the couples communicated without words by drawing on past joint experience and the mutual understanding that had developed over the years of their marriages. This involved physical affection in ways that were comfortable and familiar. Several couples said "we've been through hard times before and it made us stronger." Many stated that their relationships had grown as a result of the current experience. They experienced a sense of having faced the challenge together. SNIP couples felt that the nurse affirmed this strengthening of mutuality.

Discussion

Within the context of a cancer diagnosis, the narratives of men and their wives revealed how the meaning of symptoms was transformed by their everyday experiences postprosta-

tectomy. This, in combination with multiple strategies that specifically enhanced the sense of control overall, allowed men and their wives to adapt to incontinence and impotence without directly jeopardizing QOL. Within the context of cancer, incontinence was transformed into a sign of "healing" and impotence was accepted as "manageable." Both husbands and wives initially saw aspects of incontinence as positive factors within the context of recovery postprostatectomy that served overall as a visible gauge of recovery progress. This transformed an uncomfortable, undesirable symptom into a stepping-stone toward healing. Because it was expected to be temporary, the men and their wives looked forward to resolution of the symptom and saw no need for long-term adjustment. With a focus on controlling temporary incontinence through multiple strategies of self-care and daily activities, the couples believed that the men would achieve enhanced urinary function and an increased sense of command over their lives in general.

Similarly, couples hoped that impotence would be temporary, but put it into perspective within the context of their married lives and within the context of cancer such that they felt their relationships were strengthened. They felt impotence could be managed if necessary. Erectile function clearly was significant to the men's sense of self, even though not essential for having good marriages or enjoying life.

The data revealed a recurring theme related to the couples' focus on working to enhance a sense of control. The movement toward increased control was not only associated with the management of incontinence but also included the goal of regaining mastery over what was happening in their lives. Several researchers have identified mastery as a coping strategy employed by people with cancer (Hagopian, 1993; Mishel, Padilla, Grant, & Sorenson, 1991; Mishel & Sorenson, 1991; Pennix et al., 1998). Pearlin and Schooler (1978) originally defined mastery as a psychological resource that aids a person in withstanding threats posed by events and objects in the environment. Skaff, Pearlin, and Mullan (1996) extended this description by stating that mastery referred to one's overarching sense of control over what goes on in one's life. They noted, however, that mastery can increase or decrease depending on the conditions in people's lives. That is, the sense of mastery may have a buffering function in the context of adverse circumstances, but it also may become weakened as a result of stressful circumstances (Skaff et al.). In a study that examined 161 participants with cancer, Pennix et al. (1998) found that mastery acted as a buffer against depressive symptoms. In a related study, Pennix et al. (1996) found that mastery was not a stable unchangeable state but was affected by the presence of chronic diseases, including cancer.

This study's data suggested that the couples needed to regain a sense of mastery that had been weakened or threatened in the context of postprostatectomy incontinence and impotence. This need for a sense of mastery was crucial to their abilities to adjust to the changes that the symptoms brought to their everyday lives. In the context of a stressful situation such as incontinence, an increased sense of mastery buffered the discomfort associated with the symptoms and led to a sense of regaining control, which they understood as part of the recovery process.

Although much of the postprostatectomy work was the men's only, these findings clearly demonstrate that the wives' assistance and the combined efforts of the couples were essential in facilitating mastery of incontinence and impotence. Similar to Heyman and Rosner's (1996) findings that wives focused on the marriage relationship, "her work" was critical

in maintaining the emotional balance of the couple. Also, the caregiving role of wives should not be underestimated. By tending to the provision of incontinence supplies, meals, and rest for their husbands, the wives enabled the men to focus their energies on recovery. Interestingly, very little of "her work" involved physical caregiving. To regain mastery, the men wanted to manage independently and the wives respected and were proud of their husbands for this. "Our work," the joint work of moving through this experience together, served to strengthen each couple's identity and created an atmosphere facilitative of regaining the mastery lost in the process of being diagnosed and treated for cancer.

For those who received SNIP, the nurse's most valuable role from the couples' perspective was assisting in regaining mastery over their lives by helping them to obtain, filter, evaluate, and manage information. Our findings support those of Robinson et al. (1999) who found that patient teaching was the most prevalent category of nursing interventions delivered to men postprostatectomy. In addition, couples valued the emotional support and encouragement received from the nurse who gave them confidence in the new levels of mastery that they attained. Couples who did not receive SNIP expressed frustration at having to try to make sense of the myriad of information alone and were less certain of their own actions in trying to facilitate recovery.

Implications for Nursing Practice

Nursing interventions that promote mastery are key to nurses' abilities in assisting couples as they cope with postprostatectomy incontinence and impotence. This can include the provision of information, assistance with navigating through large amounts of information, dispelling misinforma-

tion, encouraging acquisition of self-care skills, confirming progress, and providing emotional support to decrease anxiety. Further research is needed to determine the best manner in which to provide these types of nursing interventions. Regardless, wives need to be included in these interventions. More intensive nursing interventions also may be needed for those who do not follow the expected postoperative course and for those for whom incontinence and impotence do not resolve following a year postprostatectomy.

Future research is necessary to explore the experiences of couples of various ethnicities and socioeconomic levels postprostatectomy. The couples in this study were predominantly Caucasian and well educated with adequate financial resources. The influence of cultural beliefs about sexual and urinary function on postprostatectomy incontinence and impotence needs to be explored to facilitate the development of culturally sensitive interventions. Also, no research has examined the experiences of same sex partners, other support people, or men who have no support postprostatectomy.

The findings of this study add to the understanding of processes that contribute to the maintenance of postprostatectomy QOL for men and their wives, even when incontinence and impotence are present through work done by the couples. Furthermore, the key role played by nurses in facilitating this process was elucidated, making clear that nursing intervention does make a difference to couples dealing with postprostatectomy incontinence and impotence.

The authors gratefully acknowledge Linda Sarna, DNS, RN, FAAN, for her insightful comments and assistance in editing the manuscript.

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