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# The Integration of Psychological Intervention in the Multimodal Treatment of Patients With Prostate Cancer and Erectile Dysfunction

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**Abstract**: *Male sexual dysfunction refers to a lack of attraction and a lack of normal sexual performance. The most common sexual dysfunction in men is erectile dysfunction. Erectile dysfunction is the inability to achieve an erection or to sustain satisfactory sexual intercourse. Sexual dysfunction is associated with oncological treatment, having a significant impact on the quality of life. Sexuality is a frantic sense of awakening to life, it is excitement and a lot of energy, it gives the feeling of invincibility, it is the opposite of death. For many cancer patients, getting an erection is a negative problematic experience, combined with feelings of hopelessness, depression, accompanied by loss of self-esteem. Taking into account the medical aspect, the present paper highlights the interpersonal psychological aspect with reference to the cognitive-behavioural model. The present analysis describes the problem of sexual dysfunction and illustrates a panorama of therapeutic models to plan an effective intervention. This study aims to perform a review of the evidence on the role of cognitive-behavioural psychotherapy in addressing erectile dysfunction problems in prostate cancer patients. An extensive bibliographic search of online database and relevant manuscripts was followed.*

**Keywords:** *dysfunction, erectile, therapeutic, prostate, cancer .*

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## Introduction

In Romania, there are approximately 8,000 new cases of prostate cancer per year according to Globocan (2020).

The psychological implications of the oncological patient are significant throughout the course of the disease, from the appearance of the first symptoms, to diagnosis, to medical treatment.

The most common psychological interventions in oncology are information and education of the patient and his family, support and counselling (Valcea et al, 2016). Moreover, cognitive-behavioral psychotherapy aims to act on a cognitive, emotional and behavioral level with different techniques, more or less directive (Beck et al., 2019, Schenker et al 2022) depression.

Until now, one of the locations with a high incidence in the male sex is represented by prostate cancer, and not only for the pathology itself, but also for the potential negative consequences on the quality of life, such as sexual impotence, secondary to multimodal oncological therapies. Since the prostate is involved in two very important functions regarding urinary continence and sexual potency, impairment of one or both functions has an impact on the quality of life of patients undergoing surgery.

The manifestation of a disease always involves a change in the previous balance and a crisis situation. A first change refers to the status of the patient who goes from a healthy person to a sick person; he is forced to adapt to a new psychophysical condition, which forces him to face internal and external problems. The first ones refer to the psychological reactions related to the new identity (sick person); the others relate to inevitable changes in diet, lifestyle and work activity. The two sets of issues intersect and influence each other, especially if the scale of change that has occurred is significant. The person who becomes an oncological patient is forced to deeply review the relationship with his own body which becomes observed, analysed and controlled more than ever.

The diagnosis of an oncological disease and hospitalization, whether it is day or continuous hospitalization, are often very critical moments for patients and their families (Rebegea et al., 2018, Paduraru et al, 2019). The diagnosis of cancer represents a stressful event for the individual (Ciuhu et al., 2015), which requires a major adaptation effort, generates an upheaval in daily life - due to the treatments and their side effects - and an important psychological crisis resulting from the unknown evolution of the disease and the threat it represents for the patient's future and life (Alelyani et al., 2023).

Especially in prostate cancer, it is useful to emphasize the critical problems caused by invasive treatments (radical prostatectomy) and possible side effects: urinary incontinence and erectile dysfunction (Terrier et al., 2018) are the two problems resulting from surgical therapy, involving organs on which there is a major emotional investment (Tsao et al., 2022).

For the patient who has undergone radical prostatectomy, obtaining an erection can be a problematic experience often combined with feelings of hopelessness, depression, accompanied by loss of self-esteem (Bickel et al., 2021).

As for erectile dysfunction, there is no doubt that it has a considerable impact on the quality of life. Four domains of quality of life related to male sexuality have been identified: quality of sexual intimacy, daily interaction with women, sexual fantasies, and men's perception of their masculinity (Gracia et al., 2023).

Erectile problems have an impact on all these areas, so both on intimate life and on relationship life, even on the vision of oneself as a sexual being. Erectile dysfunction, the most common side effect of prostate cancer therapy, has profound effects on the lives of affected men.

Psychological suffering affects the relationship with oneself, with one's own body, as well as on relationships with others: with the family, with the social network and with the profitable environment.

An important role is played by interpersonal factors, in the family environment and in the patient-health staff relationship.

A good adaptation of the patient to the status of a sick person requires empathetic participation and the provision of clear, correct and easy-to-understand information from the medical staff (McDaniel et al., 2021).

When the patient is involved in choosing the most effective treatment taking into account the patient's quality of life, communication between doctor and patient takes on a fundamental role.

Some patients want complete and accurate information about the disease, toxicities, complications of oncological treatments as well as information about the prognosis and express their desire to actively participate in the therapeutic choices; others want to be informed at the highest level, but any health care decisions are left to the doctors.

Some want doctors to address their psychological problems, others prefer discretion in this regard.

Erectile disorder is defined in the Diagnostic and Statistical Manual of Mental Disorders as *marked difficulty maintaining an erection until the completion of sexual activity (American Psychiatric Association, 2016)*

Numerous physical and psychological factors are involved in normal erectile function, including neurological, vascular, hormonal, and cavernous factors. Changes in one or more of these factors can cause erectile dysfunction. It can be organic, psychogenic or mixed (due to a combination of organic and psychogenic factors). Most cases of sexual dysfunction can be treated with medication. In cases where erectile dysfunction has predominantly psychological causes, psychological therapy is recommended.

**The context of assessment and therapy**

The most important implications for masculinity are related to the actual treatments and their consequences. Radical prostatectomy or radiotherapy can cause impotence and incontinence. As previously mentioned, cultural ideals of masculinity are linked to heterosexuality, and specifically to heterosexual penetration (potency) and desire, both of which are difficult, if not impossible, following treatments (Nguyen et al., 2021). For these reasons, there are patients who, when they are involved in the choice of treatment, choose the one that compromises their sexual life less than the best recommended treatment. Finally, there are men who claim that they no longer feel like complete men after prostate removal.

Sexual problems due to medical-surgical therapy can lead to the patient's loss of confidence in his own sexuality. This fear paradoxically increases the need for performance, and it is precisely this pretension, obligatory, that has pathogenic effects.

Erectile dysfunction can have a significant impact on the patient's life, undermining his self-confidence and questioning his virility; it can be the cause of emotional detachment from family, friends - even from the wife - triggering unnecessary tension in relationships and drastically compromising the quality of life. Therefore, it is important that patients and their partners have knowledge about erectile dysfunction so that they can be prepared to deal with it if and when it occurs (Gupta et al., 2023).

In erectile dysfunction, only a minority seek psychological treatment, while the majority more easily turn to a doctor, either a family doctor or a specialist in urology.

One obstacle is the stigmatization of all that is "psycho." The patient himself may think that turning to a psychologist or a psychiatrist is an indication of his personal inability to cope with what is happening: asking for the help of a professional would be tantamount to admitting the idea that he is also a weak person, not only sick . A final element that prevents the recognition of suffering is represented by the "stereotype" that the

individual's reaction is an expression of his personality and not a response to the specific life situation (Radulescu et al., 2020).

The listed factors prevent the recognition of distress and consequently prevent the implementation of appropriate containment and healing strategies. Mood disorders have consequences on many aspects of the patient's quality of life - relationships, work, health - but also on medical health services (such as the number of hospitalizations and outpatient consultations). Early diagnosis and treatment of mood disorders becomes urgent given that denial of diagnosis is predictive of subsequent depressive symptoms.

Cancer still equates to death, pain, mourning for the loss of parts of oneself, anguish over something that, despite being part of the body, destroys it, although in the localized stages of prostate cancer local control can be obtained and a long survival. On the other hand, experiencing such emotions constitutes the emergence of a crisis, a change that the person experiences, resulting in the need to be supported. This support function can be fulfilled through specialist psychological interventions within a multidisciplinary team which constitutes, for the patient and his family, an important emotional experience: feeling accepted from a physical, psychological and social point of view.

The specificity of the psycho-oncological intervention therefore lies in the addressability of the patient not only with a psychopathological disorder but also with a traumatic situation of the disease. Psycho-oncology considers mind and body not as separate, independent entities but as two distinct and integrated aspects of the person.

***Objective:*** to improve care and contain the suffering associated with the disease, treatment and hospitalization. The purpose of psychological intervention is to reduce the discomfort and psychological suffering of the patient and to identify and capitalize on personal resources. (Forkus et al., 2022), to ensure psychological and psychosocial support. The therapeutic program also includes family members.

The integration between medical and psychological culture is still little taken into account and has been achieved differently in relation to different hospital institutions. The psychoeducational intervention consists of information, the psychological support has the function of supporting the patient in the affective and cognitive elaboration of the emotional dynamics relative to the disease.

The main objective is to promote a better adaptation to the disease by understanding it and therefore by promoting an active and positive attitude (coping) towards the treatment.

The specific objectives are to provide patients with clear and correct information regarding the various aspects of the disease, to achieve good communication between the patient and the care team; to encourage patients to be actively involved in care management.

Before starting the treatment, it is necessary to carry out a good assessment. First of all, it is necessary to make a correct diagnosis by determining whether the patient's problem is actually an erection problem and not rather premature ejaculation or a low level of desire. It is also necessary to determine whether the causes are biological, psychological or social.

Then, feedback must be provided to the patient and the effectiveness of the treatment predicted; all this is not separated from the therapeutic context and often in this phase the patient, learning new information, can correct and revise his own position in relation to his problem, for example, to no longer see it as a permanent pattern of his personality but more rather like a transitory state. This gives the couple the opportunity to face the problem with optimism.

From what has been reported so far, a significant correlation between erectile dysfunction and quality of life is evident; erectile dysfunction has a negative effect on the quality of life of patients and can be associated with depression, loss of self-esteem, fear, stress. All these elements have a negative impact on the relationship with the life partner, family and friends. Erectile dysfunction can cause the patient to avoid sexual relations, and even simple social relations, thus contributing to a decrease in the quality of life (Af & Jorge Pereira, 2022).

**Relationship problems**

The interaction between the patient and the psychologist can be described as a process and can be both facilitating and inhibiting the goals of therapy (Stefana & Youngstrom, 2023). There are several factors that can negatively influence the interaction and therefore also the goals of the therapy: first of all, the feelings of uncertainty that the psychologist can feel and that can compromise empathy. The age, the origins of the psychologist, the attraction or repulsion they may feel towards each other are also to be taken into account (Vesentini et al., 2022). It may be useful to keep certain assumptions in mind when working with this type of patient: patients feel embarrassed and have difficulty discussing their sexual concerns; it is difficult for them to understand the correct medical terminology; people may be misinformed about sexual function; these patients, in crisis, may have suicidal ideation (Stefana et al., 2022): in this case it is extremely

important to be sensitive to their level of despair and depression (Chaurand et al., 2012).

It is also assumed that such people were not very open as a couple and never discussed their sexual problems.

Regarding the evaluation method for erectile dysfunction, it may be useful to gather information in different ways, taking into account the circumstances: through a clinical interview or questionnaire, or by applying psychophysiological procedures.

*The clinical interview.* The interview phase is central to undertaking therapy. This phase must serve the psychologist to obtain important information and must be conducted in a delicate but at the same time incisive and effective way.

In general, three sessions are used, of which the first two are used to listen to the couple members separately and the third involves both partners: the psychologist has the task of providing clear information about how he structured the previous sessions. The objective is to obtain, in addition to the relationship with the client, all the information necessary to formulate the case and to determine whether sex therapy is appropriate.

A rigid order is not used but the needs of the patient are respected, sometimes there can be problems of non-sexual origin that put the partners in a crisis situation, and these must be treated first. It can be helpful to start with very general questions such as: "How can I help you?" or "Why are you here?". Information about the client's personal history regarding his adolescent friendships, his social status, his sexual experiences (homosexual and/or heterosexual), his self-esteem, his success or failure in school, and any other information that may be Helpful.

In the second session, the partner is first asked whether his partner engaged him in what was discussed in the first session: this aspect leads to the finding of the level of openness between the two regarding communication.

The third session is reserved for the couple and the therapist's task is to have an evaluative estimate on the relationship between the two partners, on their way of dealing with problems, which of the two assumes responsibility predominantly in the couple and in which ways they communicate their needs. The remaining time, in this last phase, is dedicated to the explanation, the work plan, the purpose of the therapy. Finally, it is important to remember the medical problems that must precede psychotherapeutic treatment.

*Self-descriptive questionnaires.* Questionnaires administered to patients are usually standardized so that they can be completed quickly by

themselves. There are several advantages in using questionnaires: more information can be obtained; the client can better organize his thoughts in a reflexive way, which is not always possible to achieve with the help of a direct interview; allows the client to reveal some information that he would not have told directly to the therapist because it would be too reserved and because it is sometimes difficult to verbalize; it also gives the therapist the opportunity to make comparisons with other individuals; with these questionnaires the client is encouraged to think about several aspects of his sexuality.

The couple is invited to complete the questionnaires twice: one for themselves, the second according to how they think the partner could complete it: in this way the level of mutual understanding can be better examined.

Certain questionnaires are useful such as: "Personal sexual history", EORTC QLQ-PR25 (https://www.eortc.org/, n.d.), which incorporates the symptom scale (urinary symptoms, incontinence, bowel symptoms, treatment-related symptoms hormonal) and the functional scale (sexual activity and sexual functioning) (O Leary et al., 2015).

Although the use of questionnaires should not be the only source of information, it remains a useful method for obtaining a more complex picture of the situation.

*Psychophysiological assessment.* This type of approach turns out to be, compared to interviews and questionnaires, less subject to evaluation distortions even if it has the disadvantage of being very expensive. The method consists in recording, during the hours of sleep, the tumescence of the male genital organ: if a man can get an erection during sleep (and this happens to most), but cannot get it under stimulation from the partner, it can be said that the erection problem is mainly psychological and not medical in nature, but if the opposite happens then the problem must be sought at the organic level. It is important to note, however, that the data obtained from this test, called NPT (Genital Organ Tumescence), can be affected in cases where there are sleep problems.

## Integration of data derived from different methods

At this stage it is important to create hypotheses about the causes of the problem: this gives the therapist the opportunity to develop a treatment plan. It is important to communicate to the client that his problem is solvable and that he is understood in terms of his own values, traditions and everything that includes cultural and religious factors (Nizamis et al., 2023).

Taking all this into account, it is possible for the patient to increase his confidence in the therapist who has taken into account all the aspects inherent in his case. It is important to remember that the main goal of therapy is to achieve mutual sexual satisfaction in the couple. There are specialists who emphasize intimacy and pleasure between partners rather than efficiency: in fact, focusing on erection and duration tends to lead to anxiety, resulting in an intensification of the problem and reinforcing the myth that what is most important in a couple is sexuality.

A man who can no longer get an erection can still enjoy other forms of sexual expression. A question to ask is whether it is up to the therapist or the patient to determine the goals of therapy. It can be found that many times clients do not see what their real problem is, as in the situation where the couple requests greater sexual intimacy when their problem is related to communication difficulty. These are the cases where one of the therapist's tasks is to set new goals.

It is also important to remember when starting the therapy the existence of some cognitions that the client has, such as: a stereotyped model about the sexual roles of men and women, a limited definition of sex, little information about diseases that can be transmitted, etc.; in this way the therapist can better plan the intervention plan.

When conducting a sexual therapy, it is important to consider the existence of some obstacles: the most common occurs when the patient, despite the medical recommendation for psychotherapeutic treatment, prefers to follow the pharmacological therapy; or experience an irrational belief that is strictly against sexuality (Jefferson et al., 2023, Dobri et al, 2020).

It is important for the therapist not to form an alliance with one of the two partners and to assess whether there is a problem with substance or alcohol abuse because then that is the problem that needs to be addressed from the start.

It is appropriate for the therapist to assess the possibility that one partner may drop out of therapy and to discuss this openly with the couple.

## Methods of psychological treatment

The intervention focuses on the disease. If a couple already has relationship problems pre-existing the disease, these threaten to worsen the relationship to the point of separation (Ciubara et al, 2016, Iliescu-Bulgaru et al, 2015). The task of the psycho-oncologist is to sort out the causes of the new suffering exacerbated by the disease.

It is necessary for the patient and his partner to receive information about the disease, to be taught how to manage anxiety through appropriate relaxation techniques (Spitz et al., 2023). If the illness becomes a reason or excuse for other problems, it is possible to do an intervention at the level of the couple to help them find a new balance between the two, urging both to find an understanding on an emotional level slightly higher, based on their torque values (Loeb et al., 2022).

Sex is a problem. There is a high percentage of different types of disorders of the couple's sexuality. There is a mutual decrease in desire that results in reduced relationships, pleasure, orgasm. Perhaps because the sick person, feeling less desirable, self-censors in his desire, transferring the same effects to his partner. This happens in cases where interventions are physically visible.

The therapist must help the couple find common ground, build a new sexuality together, thus rebalancing feelings.

The concept of sexuality is learned, it is a process of growth, of acquiring skills, even if the old sexuality has been lost. The first stage is to accept the loss, the wound, the limitation. And this aspect mainly concerns the one who suffered the loss, but the partner can significantly help him overcome this impasse. The partner must not be too affected by this discomfort or be too optimistic, she must acquire that ability to be in an intermediate emotional status (Li et al., 2022).

The process of dealing with loss involves going through the five stages of grief (denial, anger, bargaining, depression and acceptance). The order of the stages of elaboration of the loss of health or of a body part or of the old sexuality is not generally valid. At the time of experiencing the crisis, there are patients who start with the stage of anger, followed by depression, denial, negotiation and acceptance. Or they are oncology patients who show a different order or get stuck in one stage. The goal of the psycho-oncological intervention is to help the patient reach the phase of acceptance of the disease (Rebegea et al., 2019). In the acceptance phase, the patient is compliant with the treatment, adapts to the oncological distress and mobilizes his resources in order to improve the quality of life. It must be specified that in each of the phases listed above, hope is present.

The most extensive intervention is on the couple. First of all, one must know their previous sexuality, then see what can be saved, what has been damaged and what can be maintained. And then there is overcoming the concept of bodily transformation as a result of genital surgerye.

The message to be elaborated is this: the body is not only visual, but consists of senses, thoughts, emotions. If you are ashamed of your body,

you can make love in the dark, but little by little you will have to accept your body and especially learn this new concept of positive sexuality. The couple who has gone through such an extraordinary ordeal has a desire to get out of pain, to recover their life, to return to everyday life, to feel alive. Therefore, it is necessary to address the discourse about sexual activity, which plays a role of primary importance. Let's not forget that sex combats the theme of death, mourning, depression, it always brings with it an element of energy.

The objective of the therapeutic intervention is to help the patient to identify some positive aspects of himself in the context of his own suffering, that is, to change the perspective from what has been lost to what has remained intact. The patient with cancer of the urogenital system looks only at what he has lost, he will feel threatened in the depth of his gender identity, he will constantly compare his current situation with that of a healthy person, he will feel that any recovery effort is useless and you will be able to give in to feelings of self-devaluation, self-deprecation that are really hard to manage.

Exasperation with one role (husband, father) or one personal value will not allow him to use the other potentials that are often available but latent. If the patient finds the courage to consider what remains, he may be able to be more serene and be willing to participate in a psychotherapy program that will help him redefine his own role, his own gender identity, his own existence.

Sex therapy is relatively short in duration, always sets a goal and the psychotherapist discusses with the couple how they can achieve it. Usually 15-20 sessions are enough, but it all depends on the reactive capacity of the person. If the couple reacts well, even ten sessions may be enough.

Therapeutic intervention includes, in addition to specific techniques and depending on the psychopathological state activated by the tumor, "deflection" that can help the patient at least in the acute phase, eliminating performance anxiety.

First, the focus is on sensations rather than performance in order to avoid as much as possible the risk of failure due to increased anxiety: there is a tendency to give the couple specific tasks and directions with the aim of increasing intimacy and if they are followed, it can notice a gradual increase in privacy and the couple can relearn to have different ways of intimacy in giving and receiving pleasure; it is also necessary that everything happens in a secure environmental context for the couple.

In the therapy sessions, ample space is given to the discussion about the exercises done and the problems and emotions that arose from them. Next, more specific indications are given regarding touching in a way that is

not sexual, with the main objective being the experience of mutually pleasant sensations: only later is the inclusion of sexual contact encouraged by bringing to the couple's discussion the factors that encourage or inhibit intimacy. Only at the end is sexual intercourse included, but even in this case the focus is on sensations and not on efficiency.

There are some inherent limits to this method, for example the therapist might give insufficient information about the procedures or the clients follow these recommended procedures too faithfully, thus increasing the level of anxiety in the particularly vulnerable client; instead, it is suggested to give some clues that leave the person with a greater variety of answers. The advantages that can be obtained with this method are various: learning new behaviours for the couple, the possibility for the partner to change his perception towards the other or towards his own person, such as the belief that women are generally considered not as partners beloved, but as an object of pleasure. This method can also have diagnostic value because it can lead to the appearance of other problems.

An essential component of this therapy is the provision of additional information that sometimes corrects the couple's conceptions of sexuality, as misinformation or the perpetuation of myths has been found to have a negative impact on the relationship. There are some myths or misconceptions, such as that caressing necessarily leads to intercourse, that a man is always ready and interested in sex, that having good sex always includes reaching orgasm, that women should not be taken considering during intercourse, that real men do not have sexual problems, etc. Unfortunately, those who believe in these myths create expectations that cannot be met, which lead to inevitable feelings of guilt and resentment. In this sense, therapists are advised to update themselves with different materials or scientific texts and recommend them to patients (Vesentini et al., 2023) who want to obtain information through reading: others prefer to obtain it during therapeutic sessions.

*Stimulus control.* There are sometimes circumstances that hinder the ability to relax and enjoy a sexual relationship and which can therefore contribute to erectile problems (Kocharyan, 2022). For example, reproaches, insults, criticism, underestimating preparations for sexual intercourse, such as kissing, caressing.

Stimulus control refers to the precautions to be taken in order to obtain an environmental context that encourages the expression of sexuality.

It can be helpful to help people change their negative attitudes and reduce destructively interfering thoughts (Ciuhu et al., 2016). As an example, it is quite easy for a therapist to encounter heterosexual couples who are

afraid of having problems with homosexuality in situations where the man does not maintain an erection, and therefore begins to doubt his own masculinity. In such situations the problem must be approached delicately without excluding some individual therapy interventions before moving on to couple therapy.

Dysfunctional thoughts contribute to the exaggeration and maintenance of the erection problem, and the therapist's goal is also to help the patient find alternative thoughts or to remember those he had in the past that contributed favorably to the relationship sexed (Chirita et al., 2012).

It is often helpful for the partner to be asked about the other's problem: this gives the therapist more information about the irrational thoughts the person has about themselves such as "He doesn't love me anymore" or "I'm not attractive anymore", etc. so that individual therapy sessions can also be included (Kieslich & Steins, 2022).

*Communication course.* When dealing with an erectile dysfunction problem, the couple often experience communication problems: such as: "mind reading" when one partner thinks they know very well what the other is thinking, or when the couple discusses an issue and then passes to another, or situations where each of the two listens but continues to believe that the other is always wrong, etc. Since the expression of sexuality is a form of communication (Shrout et al., 2023), it is important to take this into account, and the therapist has the task of proposing himself as a model by listening to the client with great attention and empathy, encouraging him to express freely.

During the sessions it is important to discuss with the couple the areas or areas where there are communication difficulties, observing the process and avoiding determining who is right and who is wrong. On the other hand, it is clear that men who have erection problems lead an unhealthy lifestyle; they are generally people who smoke excessively and are not very moderate in their alcohol consumption. In these cases, it is suggested to follow a more appropriate diet and increase physical activity: often patients do not expect this way of solving the sexual problem, but it can certainly be a valid help (Galvao et al., 2023).

## Conclusions

The cognitive-behavioral approach aims to take into account the oncological stress of patients with an intervention modality that promotes interdisciplinary collaboration, starting from an exhaustive global bio-psycho-social formulation of the case. The principle of cooperation between health specialists and those in related fields promotes treatment compliance.

The psychoeducational model is based on 4 fundamental themes: health education; stress management; coping capacity; psychological support. The psychoeducational program addresses the following topics: adaptation to the disease and to the management of oncological distress (psychologist); surgical and reconstructive aspects (surgeon); oncological medical aspects (oncologist plus professional medical assistant); radiotherapy treatment (radiotherapist plus radiology technician); physical rehabilitation (physician plus physiotherapist).

Organizing a psychoeducational intervention means implementing a pluri and interdisciplinary approach with the aim of addressing the sick person in totality and responding to his global needs.

In order to achieve an effective therapy, it is important to take into account the context, principles, values.

## References

Af, F., & Jorge Pereira, B. (2022). Therapeutic approach to erectile dysfunction—News and future perspectives. *Open Access Journal of Urology & Nephrology*, *7*. https://doi.org/10.23880/oajun-16000201

Alelyani, F., Seday, A., Al-Toub, M., & Alwatban, A. (2023). *Diagnosis of Cancer* (pp. 96–121). https://doi.org/10.2174/9789815124606123010005

American Psychiatric Association. (2016). *DSM-5, Manual de Diagnostic si Clasificare Statistica a Tulburarilor Mintale*. Callisto.

Beck, A. T., Davis, D. D., & Freeman, A. (2019). *Terapia cognitivă a tulburărilor de personalitate*. ASCR.

Bickel, E., Auener, A., Ranchor, A., Fleer, J., & Schroevers, M. (2021). Understanding care needs of cancer patients with depressive symptoms: The importance of patients' recognition of depressive symptoms. *Psycho-Oncology*, *31*. https://doi.org/10.1002/pon.5779

Chaurand, A., Feixas, G., Compañ, V., & Trujillo, A. (2012). *Using personal dilemmas for case conceptualization and treatment planning in depression. Poster presented for the 43th international meeting of the Society for Psychoterapy Research, Virginia Beach, USA.*

Chirita, R., Sacuiu, I., Burlea, A., Chirita, V. (2012). The role of nitric oxide inhibitors in treatment on symptom severity and cognitive deficits in schizophrenia. *International Journal of Neuropsychopharmacology, 15*,113-113

Ciubara, A., Chirita, R., Burlea, L.S., Lupu, V.V., Mihai, C., Moisa, S.M., Untu, I. (2016). Psychosocial particularities of violent acts in personality disorders. *Revista de Cercetare si Interventie Sociala, 52,* 265-272

Ciuhu, A.-N.T.; Rahnea-Nita, G.; Popescu, M.T.; Rahnea-Nita, R.A. (2015). Abstract P5-15-22: Evaluation of quality of life in patients with advanced

and metastatic breast cancer proposed for palliative chemotherapy and best supportive care versus best supportive care. *Cancer Res*, *75*, P5–P15. https://DOI 10.1158/1538-7445.SABCS14-P5-15-22

Ciuhu, A.-N., Badica, R., Popescu, M., Radoi, M., Rahnea- Niţă, R.-A., & Rahnea-Niţă, G. (2016). Defense mechanisms and coping style at very next diagnostic period in advanced and metastatic cancer. *Journal of Clinical Oncology*, *34*. https://doi.org/10.1200/JCO.2016.34.15_suppl.e21610

Dobri M.L., Voinea A.I., Moraru C., Nechita P., & Ciubara A. (2020). Psychosis: Between dreams and perceptual reality. *BRAIN. Broad Research in Artificial Intelligence and Neuroscience*, *11*(3Sup1), 146-152. https://doi.org/10.18662/brain/11.3Sup1/130

Forkus, S., Raudales, A., Rafiuddin, H., Weiss, N., Messman, B., & Contractor, A. (2022). The posttraumatic stress disorder (PTSD) checklist for DSM-5: A systematic review of existing psychometric evidence. *Clinical Psychology: Science and Practice*, *30*. https://doi.org/10.1037/cps0000111

Galvao, D., Chambers, S., Taaffe, D., Cormie, P., Schumacher, O., Gardiner, R., Spry, N., Lopez, P., Joseph, D., Tang, C., Hayne, D., & Newton, R. (2023). Effects of supervised exercise and self-managed psychosexual therapy on sexual health in men with prostate cancer: A randomized clinical trial. *JCO Global Oncology*, *9*, 71–71. https://doi.org/10.1200/GO.2023.9.Supplement_1.71

*Globocan 2020: New Global Cancer Data*. (2020). https://www.uicc.org/news/globocan-2020-new-global-cancer-data

Gracia, A., Antón Solanas, I., Echániz-Serrano, E., Subirón-Valera, A., Rodríguez-Roca, B., Juárez-Vela, R., Satústegui-Dordá, P., Fernández-Rodríguez, M., Gea, V., Tejada-Garrido, C., Cobos-Rincón, A., & Urcola-Pardo, F. (2023). Quality of life after radical prostatectomy: A longitudinal study. *Nursing Reports*, *13*, 1051–1063. https://doi.org/10.3390/nursrep13030092

Gupta, N., Zebib, L., Wittmann, D., Nelson, C., Salter, C., Mulhall, J., Byrne, N., Nolasco, T., & Loeb, S. (2023). Understanding the sexual health perceptions, concerns, and needs of female partners of prostate cancer survivors. *The Journal of Sexual Medicine*, *20*. https://doi.org/10.1093/jsxmed/qdad027

https://www.eortc.org/. (n.d.). *EORTC QLQ PR25*.

Iliescu-Bulgaru, D., Costea, G., Scripcaru, A., & Ciubara, A. M. (2015). Homicide and alcohol consumption. A medico-legal and psychiatric interdisciplinary approach. Multivariate analysis. *Romanian Journal of legal medicine*, *23*(2).

Jefferson, F., Ziegelmann, M., Vencill, J., Helo, S., Köhler, T., & Collins, C. (2023). (223) Sexual therapy: Patient-reported barriers to care. *The Journal of Sexual Medicine*, *20*. https://doi.org/10.1093/jsxmed/qdad060.212

Kieslich, U., & Steins, G. (2022). Long-term couple relationships—Stress, problems and coping processes in couple counseling: Insights based on five case studies with five long-term couples. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.866580

Kocharyan, G. (2022). Hypoactive sexual desire due to physiological conditions, influences of social and psychological factors, disregard for sexual needs of a woman. *Health of Man*, 56–65. https://doi.org/10.30841/2307-5090.3.2022.270828

Li, R., Wittmann, D., Nelson, C. J., Salter, C., Mulhall, J. P., Byrne, N., Nolasco, T., Ness, M., Gupta, N., Cassidy, C., Crisostomo-Wynne, T., & Loeb, S. (2022). Perspectives of partners on addressing unmet sexual needs following prostate cancer therapy. *The Journal of Sexual Medicine*, *19*, S130. https://doi.org/10.1016/j.jsxm.2022.03.552

Loeb, S., Salter, C., Nelson, C., Mulhall, J., Byrne, N., Nolasco, T., Ness, M., Gupta, N., Cassidy, C., Crisostomo-Wynne, T., Li, R., & Wittmann, D. (2022). Comparison of sexual concerns between patients with prostate cancer and their partners. *The Journal of Sexual Medicine*, *19*, S50–S51. https://doi.org/10.1016/j.jsxm.2022.01.111

McDaniel, S., Morse, D., Edwardsen, E., Taupin, A., Gurnsey, M., Griggs, J., Shields, C., & Reis, S. (2021). Empathy and boundary turbulence in cancer communication. *Patient Education and Counseling*, *104*. https://doi.org/10.1016/j.pec.2021.04.002

Nguyen, D.-D., Berlin, A., Matthew, A., Perlis, N., & Elterman, D. (2021). Sexual function and rehabilitation after radiation therapy for prostate cancer: A review. *International Journal of Impotence Research*, *33*. https://doi.org/10.1038/s41443-020-00389-1

Nizamis, K., Kalliakmanis, V., Koutsoupias, N., & Panagiotopoulos, P. (2023). The influence of spirituality and religiosity in palliative care. *European Journal of Social Sciences*, *6*, 46–61. https://doi.org/10.2478/eujss-2023-0005

O Leary, E., Drummond, F., Gavin, A., Kinnear, H., & Sharp, L. (2015). Psychometric evaluation of the EORTC QLQ-PR25 questionnaire in assessing health-related quality of life in prostate cancer survivors: A curate's egg. *Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care and Rehabilitation*, *24*. https://doi.org/10.1007/s11136-015-0958-y

Paduraru I.M., Vollmer, J., Precupanu, D., Ciubară, A. B., Hozan, C. T., Firescu, D., & Ciubară, A. (2019). Anxiety and depression in patients with cancer. A case report. *BRAIN. Broad Research in Artificial Intelligence and Neuroscience*, *10*(3), 55-59.

Rădulescu, I. D., Ciubara, A. B., Moraru, C., Burlea, S. L., & Ciubară, A. (2020). Evaluating the impact of dissociation in psychiatric disorders. *BRAIN. Broad Research in Artificial Intelligence and Neuroscience*, *11*(3Sup1), 163-174

Rebegea, L., Firescu, D., Baciu, G., & Ciubara, A. (2019). Psycho-oncology support. *BRAIN. Broad Research In Artificial Intelligence And Neuroscience*, *10*(3), 77–88. https://www.edusoft.ro/brain/index.php/brain/article/view/929

Rebegea, L., Stefan. A-M., Firescu, D., Miron, D., Romila,A.(2018). Paraneoplastic pemphigus associated with a hypopharynx squamos cell carcinoma. Case report. *Acta Medica Mediterranea*, 2018, 34: 1265, DOI: 10.19193/0393-6384_2018_5_195

Schenker, R. A., Ciurea, M. E., Stovicek, P. O., Ciubara, A., Schenker, M. ., & Marinescu, I. . (2022). Depression and anxiety - risk factors in the evolution of breast cancer in women. *BRAIN. Broad Research in Artificial Intelligence and Neuroscience*, *13*(1Sup1), 135-158. https://doi.org/10.18662/brain/13.1Sup1/309

Shrout, M. R., Weigel, D., & Laurenceau, J.-P. (2023). Couples and concealable chronic illness: Investigating couples' communication, coping, and relational well-being over time. *Journal of Family Psychology: JFP: Journal of the Division of Family Psychology of the American Psychological Association (Division 43)*. https://doi.org/10.1037/fam0001136

Spitz, N., Kivlighan, D., & Aburizik, A. (2023). Psychotherapy alone versus collaborative psychotherapy and psychiatric care in the treatment of depression and anxiety in patients with cancer: A naturalistic, observational study. *Journal of Clinical Psychology*, *79*. https://doi.org/10.1002/jclp.23531

Stefana, A., Fusar-Poli, P., Gnisci, C., Vieta, E., & Youngstrom, E. (2022). Clinicians' emotional reactions toward patients with depressive symptoms in mood disorders: A narrative scoping review of empirical research. *International Journal of Environmental Research and Public Health*, *19*, 15403. https://doi.org/10.3390/ijerph192215403

Stefana, A., & Youngstrom, E. (2023). *Erotic feelings towards patients in the psychotherapy session: Investigating their relationship with the characteristics of the therapist, the patient, and the treatment*. https://doi.org/10.31234/osf.io/rv4ds

Terrier, J.-E., Masterson, M., Mulhall, J., & Nelson, C. (2018). Decrease in intercourse satisfaction in men who recover erections after radical prostatectomy. *The Journal of Sexual Medicine*, *15*. https://doi.org/10.1016/j.jsxm.2018.05.020

Tsao, P., Ross, R., Bohnert, A., Mukherjee, B., & Caram, M. (2022). Depression, anxiety, and patterns of mental health care among men with prostate cancer receiving androgen deprivation therapy. *The Oncologist*, *27*. https://doi.org/10.1093/oncolo/oyab033

Valcea, L., Bulgaru-Iliescu, D., Burlea, S.L., & Ciubara, A. (2016). Patient's rights and communication in the hospital accreditation process. *Revista de Cercetare si Interventie Sociala*, *55*, 260.

Vesentini, L., Van Overmeire, R., Matthys, F., Wachter, D., Puyenbroeck, H., & Bilsen, J. (2022). Intimacy in psychotherapy: An exploratory survey among therapists. *Archives of Sexual Behavior*, *51*, 1–11. https://doi.org/10.1007/s10508-021-02190-7

Vesentini, L., Wachter, D., Puyenbroeck, H., Matthys, F., & Bilsen, J. (2023). Intimate and sexual feelings in psychotherapy: Educational topic or still taboo? *Journal of Mental Health (Abingdon, England)*, 1–8. https://doi.org/10.1080/09638237.2023.2210652