CENTRAL UNIVERSITY

SCHOOL OF MEDICINE AND HEALTH SCIENCES

DEPARTMENT OF NURSING

ASSESSING THE EMOTIONAL AND PSYCHOSOCIAL STRESS MARRIED MEN WITH PROSTATE CANCER EXPERIENCE, A STUDY AT KORLE-BU TEACHING HOSPITAL.

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DECLARATION

We, Bevelyn Owusua Duodu Addo and Georgina Wenawomea Awena do hereby declare that this project work was undertaken by us and supervised by Mr. Sulleh Gbande of Central university nursing department. This project has not been submitted to any institution for the award of a diploma or a degree. We duly acknowledge in the text and list of references, authors and publishers whose work we have used in this study.

Candidate's Signature ……. Date ……...

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Candidate's Signature …… Date ……

Georgina Wenawomea Awena.

Supervisor's Signature…… Date ……

Mr. Sulleh Gbande

DEDICATION.

This research is dedicated to God Almighty for bringing us this Far.

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First and foremost, our heartfelt gratitude goes to our respondents for their time and corporation during our questionnaire distribution

Our sincere appreciation also goes to the entire faculty and staff of the Central University, Department of Nursing for their encouragement and support during our time of study.

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To the staff of Genitourinary ward, Korle Bu Teaching Hospital and the entire staff of Genitourinary ward , we say God bless you for your support during our data collection

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ABSTRACT

This study examined emotional and psychosocial stress married men with prostate cancer experience at the Korle Bu Teaching Hospital. A quantitative descriptive design was used in this study. A convenient sampling technique was adopted to sample fifty (50) patients from the ward. Questionnaire were used for data collection after they were pretested on 10 patients at Ridge Regional Hospital. Validity and reliability of the study were also ensured by making sure that the questionnaires were set base on the objectives of the study and also, making sure that our supervisor moderated the questionnaires. Ethical consideration such as confidentiality of participants were ensured by not disclosing their responses to any other person. Data collected were analyzed using statistical package for social sciences (SPSS VERSION 16). Findings from the data gathered and analyzed indicated that majority (84%) of the participants reported to be angry about their condition. In addition, the study also revealed that 96% of the participants indicated to be psychologically stressed and 56% of the participants also indicated that they have recurrent thoughts. In addition, the study revealed that 42% of the participants had moderate interactions with their spouses. Recommendation; Study reinforced the need to pay attention to the emotional and psychosocial needs of married men with prostate cancer.

CHAPTER ONE

1.0 INTRODUCTION TO THE CHAPTER

This chapter entails the introduction to the chapter, background of the study, problem statement, purpose of the study, research objectives, research questions, and significance of the study, operational definition of terms and literature review.

1.1BACKGROUND

Prostate cancer is a type of cancer that forms in tissues of prostate (National institute of cancer, 2018). The prostate is a gland found only in males, it makes some of the fluid that is part of semen (American cancer society, 2018). Prostate cancer is the second most commonly occurring in men and fourth most commonly occurring cancer overall, there were 1.3 million new cases in 2018 (World Health organization, 2018). Prostate cancer represents major health care issue (Couper, Bloch, Love, Duchesne & Krisane, 2006). For instance, in the United Kingdom over 36,000 new cases were diagnosed in 2007, accounting for almost 25% of the total yearly number of male cancer diagnosis with incidence rates of prostate cancer continue to increase year on year (Watts, Leydon, Birch& Lewith,2008).Similarly, in the United states of America recorded about 217,730 new cases in 2010(Jemal ,Ward & Siegel,2010).Furthermore in china,59.8% out of 1000 men were diagnosed of prostate cancer(Zheng, Zeng, Zhang &Cheng, 2017).Also, the Saudi Cancer Ranked prostate cancer as the 6^{th} in Cancer incidence among Saudi Arabian Men(Alghamidi, Hussain & Sheeny,2014)

Again, in Africa, it is reported that men suffer inappropriately from prostate cancer compared to men from other part of the world (Adeloye, Rotimi, David & Ayo, 2011). In Uganda it was estimated new cases recorded was about 39.6% out of 100,000 (Nakandi, Kirabo, Semugo, Maenu

& Kalungu, 2013). A publication by myjoyonline on the 3rd of August, 2012 stated that almost 1000 Ghanaian men are diagnosed with prostate cancer each year (Obu, 2014). Prostate cancer diagnosis presents emotional and psychosocial challenges for patients (Goodman, 2017). Emotional stress can be considered to be processed by a way of an inhibition -implosion dimension, which means to collapse inwards in a violent manner as a result of external pressure (International Encyclopedia of social & Behavioral Sciences, 2001). Whereas, psychosocial stress can be defined as a threatened need to belong to the society (Kelly, 2003). Depression which is a symptom of psychosocial stress among men with prostate cancer has emerged as a significant issue with prevalence reported at 16% to 30%. (Christie & Sharpley, 2014).

The prolonged and cumulative exposure to multiple stresses associated with this disease contribute to an elevated risk for psychological distress, specifically symptoms of anxiety and depression and for the development of clinically significant anxiety and depression disorder (Rodin, 2017). Socioeconomic disadvantage can lead to psychosocial stress (Elison, Coker, Herbert, Sanderson, Royal & Weinrich, 2001). Patients have a significantly increased psychosocial stress level and Identifying this stress sub group and clarifying the correlation with specific stress and risk factors are important tasks of clinical goal. (Drager, Hack & Sieveit, 2017).

In as much as patient's well-being is an area of growing importance in medicine, one must attend to understand the experiences of surviving cancer and many different variables may interact to determine the psychosocial impact of cancer (Koocher & O'Maily1981). Emotional and psychosocial stress deserves attention not only because of its impact on quality of life but also because of its potential adverse effects on medical treatment compliance, health care utilization, the risk suicide and the desire of hastened death (Rodin, 2019). Once prostate cancer is diagnosed patient face numbers of treatment choice which include surgery, radiation, how to decide upon a

course of action and who to trust to make decision are stressful for patient and caregivers (Peteet, 2017). There is often a sense of guilt for not being able to have intimate relationship due to fear and anxiety, patient loss libido and erectile dysfunctions which is the increase risk of depression and anxiety and fear of the disease to progress (Peteet, 2017).

The choice of primary treatment and what to do about rising prostate specific antigen (PSA) level makes men anxious and depressed (Peteet,2017). The side effect of treatment can be troublesome and even devastating which includes erectile dysfunction with surgery, hot flashes, fatigue, painful urination frequently and bowel irritation which can be associated with anxiety and depression (Peteet, 2017). Disease progression can affect the person emotional status, patient with metastatic prostate cancer may no longer be able to work. Recurrence after the primary surgery or radiation therapy treatment of metastatic prostate cancer and finally end-of-life decisions also pose challenges (Peteet, 2017).

Psychosocial stress, patient with metastatic disease may no longer be able to work and participate in activities that they previously enjoy and patient withdraw themselves from friends and they may think that the future is limited for them.

1.2 PROBLEM STATEMENT

Majority of men diagnosed of prostate cancer have a 10-year survival rates due to improved screening, detection and treatment. (Wong et al, 2016). But unfortunately, these men have heightened risk of depression related to unmet emotional and psychosocial needs (Chambers et al, 2017). A study of 2,426 Swedish prostate cancer patients undergoing robotic laparoscopic prostatectomy reported that the level of emotional shock experienced by prostate cancer patient (Kolberg et al, 2017). Depression which is a symptom of psychosocial stress among men with

prostate cancer has emerged as a significant issue with prevalence reported at 16% to 30%. (Christie & Sharpley, 2014). A research conducted in Deutschland, university of medicine, Rostock, stated that the mean stress level was 4.4% in total out of sample size of 81. 56% of patients indicated the stress level >/= 5. A clinically relevant burden was indicated (dragger, 2017).

In Ghana, Yeboah-Asiamoah, Yirenya-Tawiah, Baafi and Ackumey (2016) researched on perception and knowledge about prostate cancer and attitude toward prostate cancer screening, however much has not been done about the psychosocial and emotional stress married men with prostate cancer experience. That is why the researchers of this research found interest in the psychosocial and emotional stress married men with prostate cancer experience.

1.3 PURPOSE OF THE STUDY

This study is to investigate the emotional and psychosocial stress married men with prostate cancer experience.

1.4 RESEARCH OBJECTIVES.

This study objectives will be to:

1. Describe the emotional stress married men with prostate cancer experience.
2. Assess the psychological stress married men with prostate cancer experience.
3. Determine the social experience married men with prostate cancer experience.

1.5 RESEARCH QUESTIONS

1. What is the emotional stress married men with prostate cancer experience?
2. What is the psychological stress married men with prostate cancer experience?

3. How do married men with prostate cancer experience the disease burden and human interaction?

1.6 SIGNIFICANCE OF THE STUDY

This research will help in counselling section with the patient, this research will serve as a source of information which will help in caring for the patient psychologically and lastly it will serve as appoint of reference for other researcher's and add to literature review.

1.7 OPERATIONAL DEFINITION OF TERMS

Prostate cancer: is a type of cancer which affect the prostate gland in men.

Men: is an adult human male. Singular (man).

Stressors: is any life changes that affect someone.

Psychosocial: is a social factors of an individual's thought and behavior.

Emotional stress: is a physiologic response which is triggered from the external environment and the perception an individual has of it.

1.8 LITERATURE REVIEW

DESCRIBE THE EMOTIONAL STRESS MARRIED MEN WITH PROSTATE CANCER EXPERIENCE.

According to prostate cancer UK (2018), Patients respond in all kinds of ways to being diagnosed and living with prostate cancer. According to Orom, Nelson, Underwood, Homish and Kapoor (2015), cancer patient often experiences elevated levels of emotional distress not only at diagnosis and during treatment but also long past initial treatment. Shock, fear, anger, denial, frustration, sense of loss disappointment (Klett, 2014).

According to Klett (2014). At diagnosis thoughts and feelings involving fear of cancer spread concern for loved ones and impact on sexual health lead to a near immediate adverse impact on patient psyche. A previous study reported that about half of one sample of prostate cancer patients had fears about cancer spread (Lint et al, 2003).

Furthermore, According to Orom, Nelson, Underwood, Homish and Kapoor (2015) There is growing consensus that identifying and intervening to reduce emotional distress in an essential component of cancer care, emotional distress including anxiety, depression and intrusive thoughts about cancer and is highest at diagnosis and decline afterwards, initially about a quarter to a third men experience psychological issues throughout survivorship. To meet the needs of this group screening for emotional distress in cancer patients has been recognized as an important component of cancer care. Although income was not uniquely associated with distress in the multivariable models, in bivariate analyses those with very low incomes had higher mean distress than those with the highest income, Prostate cancer patient with low socioeconomic status are more vulnerable to emotional distress (Orom, Nelson, Underwood, Homish and Kapoor, 2015).

There is treatment for men with localized prostate cancer including surgery, radiotherapy and androgen deprivation, each of these side effect including erectile dysfunction, loss of libido and urine incontinence are all potential cause of emotional change and fear of death, pain, uncertainty of healing and recurrence indicate emotional distress. Some fears associated with emotional-sexual relationship after the experience of the disease are present, especially changes in sexuality, the frustration in treatment for erectile dysfunction, and the fear of being abandoned by wives. According to the result anxiety and stress disorder were most prevalent outcomes and were related to radical prostatectomy (Oliveira, Santos, Rocha, Braga & Souza, 2013).

ASSESS THE PSYCHOLOGICAL STRESS MARRIED MEN WITH PROSTATE CANCER EXPERIENCE.

According to Goodman (2017). Cancer diagnosis presents emotional and psychological challenges for patient and caregivers, and prostate cancer has some unique challenges, men with prostate cancer face decisions that can be stressful, starting with biopsy and diagnosis, choice of primary treatment and what to do about rising prostate-specific antigen (PSA) level. Prostate cancer from the beginning to the end, screening to death is a disease riddled with psychological and emotional torment (Klett, 2014). A study reported nearly two-third of prostate cancer patients experience significant amount of anxiety both before and after biopsies (Zisman et al, 2001).

Also, According to Sharpley, Bitsika and Christie (2018). A recent meta-analysis of 27 studies across eight nations with 4,494 prostate cancer patients reported that the prevalence of depression in these men was 18.44% following treatment. Other data reported elevated anxiety in prostate cancer patients. High levels of anxiety can precede low level illness. About a third of patients are afraid recurrence after primary surgery or radiation therapy (Goodman, 2017). Again,

a study shows that cancer patients are likely to be in acute phase shortly after diagnosis, and may be dealing with issues related to their own mortality, treatment decisions, impact of their diagnosis on family members and efforts to avoid their thoughts and feelings about cancer, they also try to make sense of their diagnosis (Ptatek & Pierce, 2018).

Furthermore, According to Linden, Vodermaier, Mackenzie and Greig (2012). These disorders can add to the overall diseases burden carried by prostate cancer patients and they also impede their recovery from treatment. Although most men showed that sexual problems were a source of psychological stress in men with localized prostate cancer. (Namiki, Saito, Tochigi, Numata, Loritani & Arai, 2006).

DETERMINE THE SOCIAL STRESS MARRIED MEN WITH PROSTATE CANCER EXPERIENCE

According to Levesque, Lambert and Karen (2015). Although there is an increasing recognition of the importance of psychosocial issues in cancer care and survivorship, many patients with prostate cancer and their partners report unmet psychosocial needs. According to a study by Eversten & Wolkenstein, (2009). That reported Stress that comes with diagnosis takes a significant toll on couple's relationship causing increasing tension and even arguing.

According to Ptatek and Pierce, (2018), Moderate levels of distress and a substantial minority of participants had distress levels that were clinically elevated. Intrusive thoughts are active efforts to make sense of one's cancer diagnosis and indicate limited processing of one's experience, whereas avoidance represents active efforts to not process being diagnosed with this disease. Previous research has shown that men with prostate cancer who have strong masculine gender scripts that include self-reliance and emotional control were most likely to report negative mental health functioning. Men's needs for self-reliance and emotional control could possibly explain

why avoidance was common among participants. Other research has shown that cancer survivors are likely to progress through a series of stages as they move from diagnosis, treatment, and recovery; men are likely to be in the acute phase shortly after diagnosis and may be dealing with issues related to their own mortality, treatment decisions, and the impact of their diagnosis on family members.

Halbert, Wrenn, Weather and Ernestine, (2010), found that men who had greater constraints in their relationships with family members and friends were most likely to avoid their thoughts and feelings about prostate cancer. This finding is similar to the results reported by Lepore and Helgeson, (1998) who found that prostate cancer patients who were socially constrained reported greater intrusion and avoidance. Although not statistically significant, avoidance was greater among men who were not married compared to those who were married. Spouses are an important source of support to men who are diagnosed with prostate cancer and they may play an important role during diagnosis by asking questions during consultations and obtaining other medical information. And the importance of having family and friends who allow men to express their concerns freely.

According to Chanite, Hughes, (2010), whereas inverse associations emerged with self-blame, wishful thinking, and avoidance. The association between seeking support and marital satisfaction was strong and positive for men with high perceptions of support but was fairly weak and negative for men with low perceptions of support. Similarly, a high positive correlation emerged between wishful thinking and marital dissatisfaction for men with low perceived support, but a low negative correlation was observed between these variables for men with high perceived support.

CHAPTER TWO

2.0 INTRODUCTION TO THE CHAPTER

This chapter presents the methods that was used in the research. It covers the research design, research setting, target population, sampling techniques and sample size, data collection tool, data collection procedure, validity and reliability of the study ethical considerations and limitation of the study.

2.1 RESEARCH DESIGN

The researchers used a cross -sectional quantitative approach in this research to assess the psychosocial and emotional stress married men with prostate cancer experience. Quantitative research method are methods in which numbers are used to explain findings (Kowalczyk, 2016). Cross-sectional study is defined as an observational research type that analysis data of variables collected at one given point of time across a sample population (Bhat, 2019).

2.2 RESEARCH SETTING

The Korle Bu Teaching Hospital was established on 9th October, 1993, it has grown from an initial 200 bed capacity to 2000. It is currently the 3rd largest hospital in Africa and the leading national referral center in Ghana. Korle Bu, which means the valley of Korle lagoon was established as a general hospital to address the health needs of the indigenous people under the administration of Sir Gordon Guggisberg, the then governor of Gold Coast. Population growth and the proven efficacy of hospital-based treatment caused rise in hospital attendance in Korle Bu by 1953, demand for the hospital's services had escalated so high that the government was compelled to set up a task force to study the situations and make recommendations for the expansion of the

hospital. The government accepted and implemented the recommendations of the task force which resulted in the construction of new structures, such as the maternity, medical, surgical and child health blocks. This increased the hospital's bed capacity to 1200.

Korle Bu gained Teaching Hospital status in 1962, when the University Of Ghana Medical School (UGMS) was established for the training of medical doctors. The UGMS and five (5) other constituents are subsumed under the College of Health Sciences to train an array of health professionals. All the institutions of the college however, undertake their clinical training and research in the hospital. At the moment, the hospital has 2000 beds and 17 clinical and diagnostic departments / unit. It has an average daily attendance of 1500 patients and about 250 patients' admissions. Clinical and diagnostic departments of the hospital include Medicine, Child Health, Obstetrics and Gynecology, Pathology, Laboratories, Radiology, Anesthesia, Surgery, Policlinic, Accident center and Surgical / Medical Emergency as well as Pharmacy, Finance, Engineering, General Administration. The hospital also provide sophisticated and scientific investigative procedure and specializations in various fields such as Neuro-Surgery, Dentistry, Eye, ENT, Renal, Orthopedics, Oncology, Dermatology, Cardiothoracic, Radiotherapy and Radio diagnosis, Pediatric Surgery and reconstructive plastic surgery and burns. The reconstructive and burns center, the national cardiothoracic center, the national center for radiotherapy and nuclear medicine in particular also draw a sizable number of their clientele from neighboring countries such as Nigeria, Burkina Faso and Togo.

Korle Bu Teaching Hospital continues to blaze the trail when it comes to the introduction of specialized service. It recently carried out the first ever kidney transplant in Ghana. It is of the few hospitals in Ghana were DNA tests are carried out. Other specialized service the hospital provides includes brachytherapy interventions for treatment of cancer and keyhole surgeries.

Plans are underway to venture into molecular testing and employ the use of cutting edge technology. All these are grand plans to offer a wide spectrum of specialized care to position Ghana as the hub of health tourism within the West African Sub region.

Institutions

The hospital has a very large campus and has expanded to host number of institutions. The list includes the following:

1. University of Ghana Medical School.
2. University of Ghana Dental School.
3. University of Ghana of Biomedical and Allied Health Sciences.
4. Nurses Training College.
5. Midwifery training college.
6. Ghana Medical Association.
7. Ghana Association of Medical Laboratory Scientist.
8. .School Hygiene (Preventive Medicine).
9. School of Radiology.
10. School of Peri-operative and Critical Care Nursing.
11. Ophthalmic Nursing School.

The Genitourinary ward which is under the department of surgery was one of the early departments established in the Korle Bu Teaching Hospital to provide surgery and consultancy services as well as offer training and conduct research. At present, it is by far the largest department in the hospital with a bed capacity of 612 and staff strength of over 860.

The vision of Korle Bu Teaching Hospital Genito-Urinary Unit is to provide High quality healthcare to Men with the atmosphere of respect, integrity, service, leadership and

multidisciplinary working. Evidence show that specialist care delivered on a dedicated unit and by appropriate skilled multidisciplinary team, improves speed of recovery.

2.3 TARGET POPULATION.

A group of individuals taken from the general population who share a common characteristic such as age, sex, or health conditions (Abroagyua, 2018). The target population included married men with prostate cancer on admission on the G block.

- The inclusive population are married men with prostate cancer who attend hospital at Korle Bu Teaching Hospital and are 18 year and above on admission at the G block.
- And exclusive population are married men with prostate cancer who are not on admission at Korle Bu Teaching Hospital at the sG block.

2.4 SAMPLING METHOD AND SAMPLE SIZE

The sampling technique which was used in the calculation in this research was non probability convenience sampling method. Which is a type of data collection from participants who are available at that moment. Sample size is the count of individual samples or observation in any statistical setting (Zamboni, 2018). The sample size used was 50 participants

2.5 DATA COLLECTION TOOL

The data for this research was collected using a structured questionnaire. The questionnaire was in four different sections which included the socio-demographic data, Assessing the psychological stress married men with prostate cancer experience section, Describe the emotional stress married men with prostate cancer experience section and determine the social stress married

men with prostate cancer experience section. However, in calculating sampling size, Cochran's formula can be used.

$N=Z^2 p (1-p) d^2$

Where N= minimum required sample size

d= margin of error at 5%

Z= confidence level at 95%

2.6 DATA COLLECTION PROCDURE.

Researchers of this research obtained an introductory letter from the head of the nursing department to Korle-Bu Teaching Hospital. The administrators of the hospital approved the research topic and gave the researchers the permission to conduct this research. Researchers gained verbal consent from ward in-charge and participants. Participants were informed of the right to withdraw from the research during the data collection. Questionnaires were given to participants to fill.

Pre-texting of tool was done at Ridge Regional Hospital at the male medical ward to ensure the strength and weakness of the questionnaire and also ensure reliability of the research.

2.7 VALIDITY AND RELIABILITY

Validity is the degree to which a measure truly reflects the phenomenon under study (Berger, 2010). Reliability refers to the extent to which a measure produces a consistent result (Berger, 2010). Questionnaires were prepared and were given to research supervisors for necessary amendments and corrections to be done. Most of the corrections were grammatical hence the questionnaire were reviewed accordingly. For the research to be deemed reliable, the research must

be able to maintain the same result after measuring the variable more than once or when the same results obtained consistent responses (Brockopp, 2002).

2.8 ETHICAL CONSIDERATION

Ethical consideration was a guide for the researchers to collect information from participants and also the source of information. Participants were assured of anonymity, confidentiality and privacy of any information that was provided. Participants were given consent forms to read and agree.

2.9 LIMITATION OF THE STUDY

The researchers were limited by time since the research was done with academic work and clinical practices. Much research was not done on the topic and also researchers were limited by finances since tuition was paid alongside the research cost.

CHAPTER THREE

3.0 INTRODUCTION TO THE CHAPTER

This chapter covered the approach to data analysis, findings, discussion, conclusion and recommendations.

3.1 APPROACH TO DATA ANALYSIS.

The analysis is the systematic organization a synthesis of research data (Polit & Hungler, 1999). The questionnaires were recoded and the data was entered into Statistical Package for Social Sciences version 16 (S.P.S.S). The software produced analysis according to the data input. The data was analyzed using frequency, percentages and pie charts for discussion.

3.2 FINDINGS

This focuses on the presentation and analysis of data collected through questionnaires administered to married men with prostate cancer on the Genito-urinary ward at Korle Bu Teaching Hospital, to assess the emotional and psychosocial stress they experience. In this section, this analysis is used to validate or nullify stated assumption in the study. A simple percentage was used to analyze the data of participants and in analyzing the questions and testing of research hypothesis. A total of 50 questionnaires were distributed to 50 participants.

TABLE 3.1 DISTRIBUTION OF AGES OF PARTICIPANTS

Response	Frequency	Percent
30-35	3	6.0
36-40	3	6.0
41-45	5	10.0
46-50	6	12.0
51-55	17	34.0
56-65	11	22.0
>/=66	5	10.0
Total	50	100.0

Table 3.1 above shows the distribution of ages of participants of the study, of which indicates that the minority of participants 6% were between the ages of 30 years to 40 years followed by 10% between the ages of 41years to 45years and 66years and above with majority participants 34% between the ages of 51years to 55years.

TABLE 3.2 DISTRIBUTION OF MARITAL STATUS OF PARTICIPANTS.

Response	**Frequency**	**Percent**
Married	50	100.0

Table 3.2 above shows that all participants are married.

TABLE 3.3 DISTRIBUTION OF PARTICIPANT'S NUMBER OF CHILDREN

Response	Frequency	Percent
none	6	12.0
1	8	16.0
2	2	4.0
3	9	18.0
4	7	14.0
>/=5	18	36.0
Total	50	100.0

Table 3.3 above shows the distribution of the number of children of participants of the study. The least number of children were 2 with 4%, followed by those who do not have children at all and the highest number of children were 5 and above with 36%.

TABLE 3.4 DISTRIBUTION OF PARTICIPANT'S LEVEL OF EDUCATION

Response	**Frequency**	**Percent**
Primary	12	24
JHS	1	2
SHS	14	28
Tertiary	14	28
None	5	10
O level	2	4
A level	2	4
Total	50	100.0

Table 3.4 above shows the distribution of participants' level of education. With the least percentage (2%) allocated to participants who have achieved junior high level and the highest percentage (28%) allocated to SHS and tertiary.

TABLE 3.5 DISTRIBUTION OF PARTICIPANT'S ETHNICITY.

Response.	**Frequency**	**Percent**
Ga	19	38%
Ewe	11	22%
Akan	16	32%
Hausa	1	2%
Dagomba	1	2%
Dagate	1	2%
Foreigner	1	2%
Total	50	100.0

Table 3.5 above shows the distribution of participant's ethnicity. With the least percentage (2%) for Hausas', Dagombas', Dagatis' and foreigners'', followed by 22% allocated to Ewes' and 32% for Akan's' with the highest percentage 38% allocated to GA's.

TABLE 3.6 DISTRIBUTION OF PARTICIPANT'S RELIGION

Response.	**Frequency**	**Percent**
Christian	29	58%
Traditionalist	9	18%
Muslim	10	20%
No denomination	2	4%
Total	50	100%

Table 3.6 above shows the distribution of participant's religion with the least percentage (4%) allocated to no denomination and the highest percentage (58%) allocated to Christians.

FIGURE 3.7 DISTRIBUTION OF EMPLOYMENT STATUS

Response	Frequency	Percent
Full-time	18	36.0
Part-time	11	22.0
Unemployed	4	8.0
Retired	12	24.0
Self employed	5	10.0
Total	50	100.0

Table 3.7 above shows the distribution of employment status of participants with the least percentage (8%) allocated to unemployment and the highest percentage (36%) allocated to full-time.

FIGURE 3.1 DISTRIBUTION OF PARTICIPANTS VIEWS ON THE SPREAD OF PROSTATE CANCER

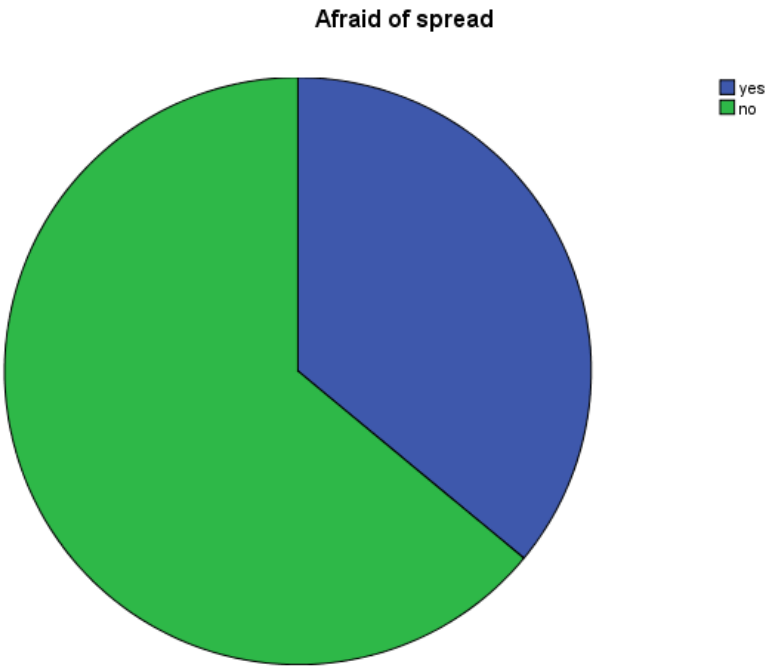

Fig 3.1 above shows the distribution of participants afraid of spread with 36% agreeing to be afraid of spread and with 64% saying no to be afraid of spread.

FIGURE 3.2 DISTRIBUTION OF PARTICIPANTS THAT FEEL ANGRY.

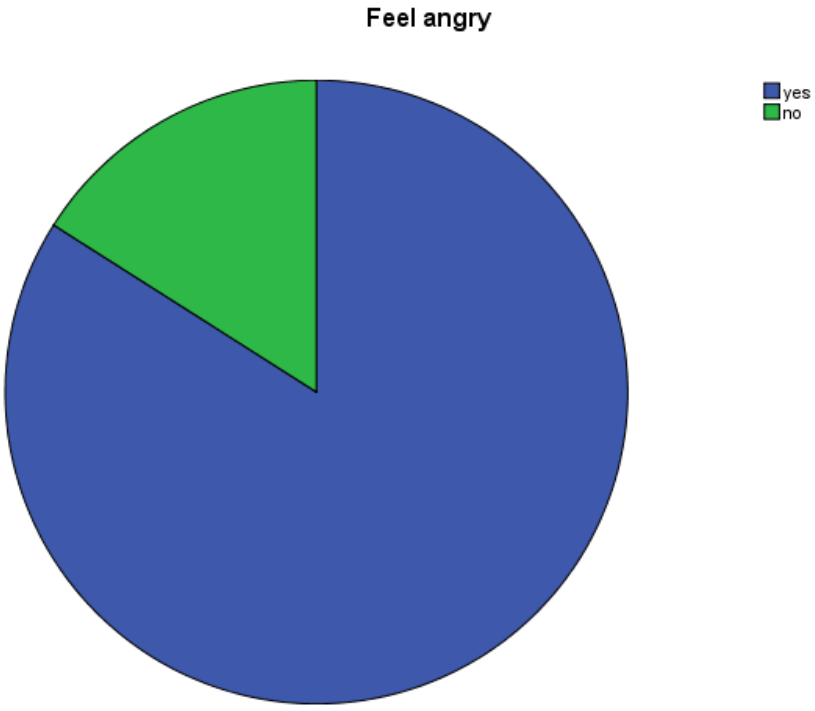

Fig 3.2 below shows distribution of participants that feel angry with 16% saying no to feeling angry and 84% agreeing to feeling angry.

TABLE 3.8. DISTRIBUTION OF PARTICIPANTS EXPERIENCING GUILT

Response	Frequency	Percent
Yes	32	64%
No	18	36%
Total	50	100%

Table 3.8 above shows the distribution of participants experiencing guilt with 36% saying no to experiencing guilt and with 64% agreeing to experiencing guilt.

FIGURE 3.3 DISTRIBUTION OF PARTICIPANTS EXPERIENCING APPREHENSION

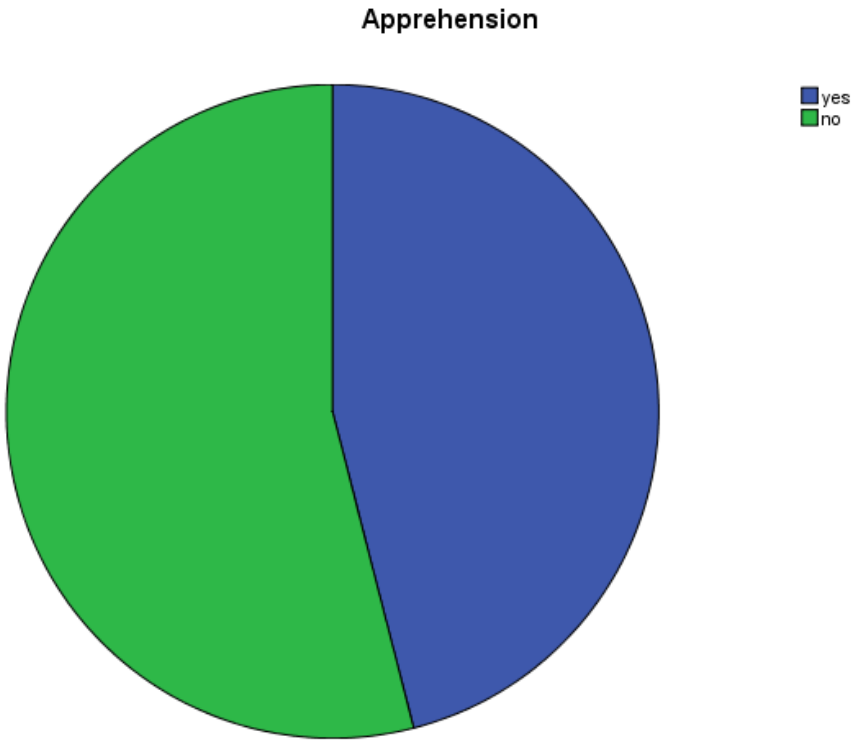

Fig 3.3 above shows the distribution of participants experiencing apprehension with 46% agreeing to experience apprehension and with 54% saying no to experience apprehension

TABLE 3.9 DISTRIBUTION OF PARTICIPANTS WHO ARE OVERWHELMED BY THE CONDITION.

Response		Frequency	Percent
Valid	Yes	16	32%
	No	34	68%
	Total	50	100%

Table 3.9 above shows the distribution of participants who are overwhelmed with the least percentage 32% agreeing to be overwhelmed by the condition and the highest percentage 68% disagreeing to no being overwhelmed.

TABLE 3.10. DISTRIBUTION OF PARTICIPANT IN DENIAL.

Response	**Frequency**	**Percent**
Yes	23	46%
No	27	54%
Total	50	100%

Table 3.10. Above shows the distribution of participants in denial with 46% agreeing to be in denial and with 54% saying no to being in denial.

FIGURE 3.4 DISTRIBUTION OF PSYCHOLOGICAL STRESS AMONGST PARTICIPANTS

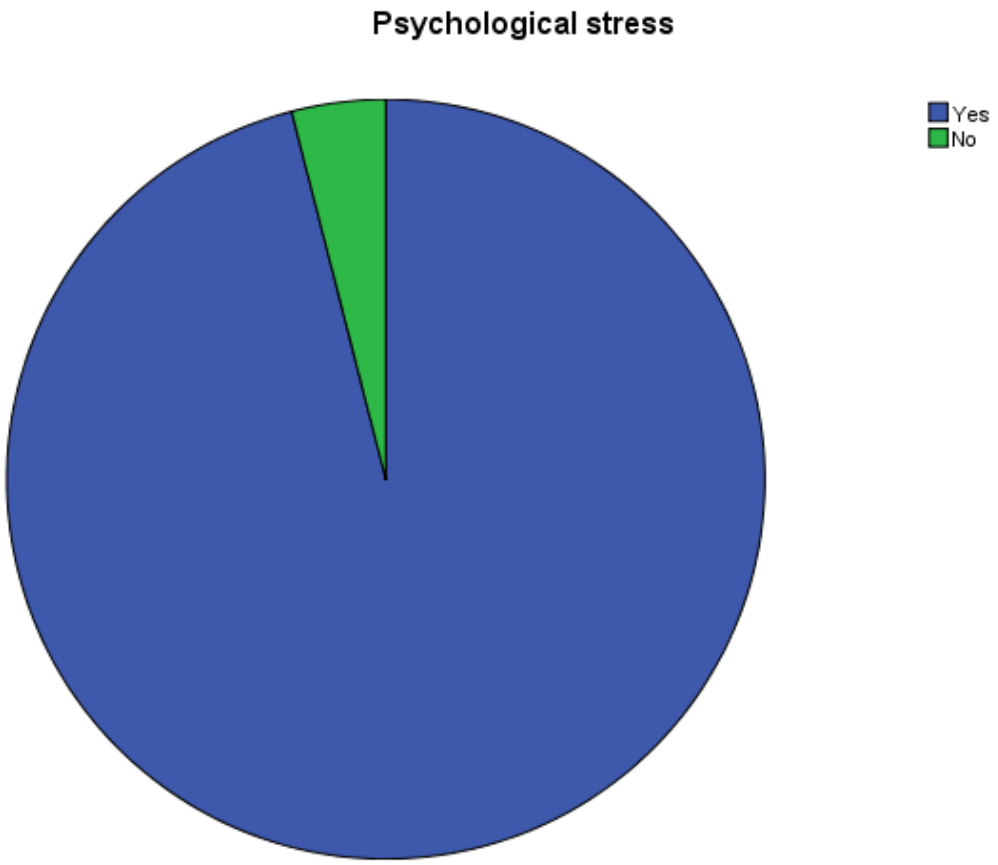

Fig 3.4 above shows the distribution of participants with 4% saying they do not have any psychological stress and with 96% agreeing to have psychological stress.

FIGURE 3.5 DISTRIBUTION OF PARTICIPANTS EXPERIENCING SADNESS

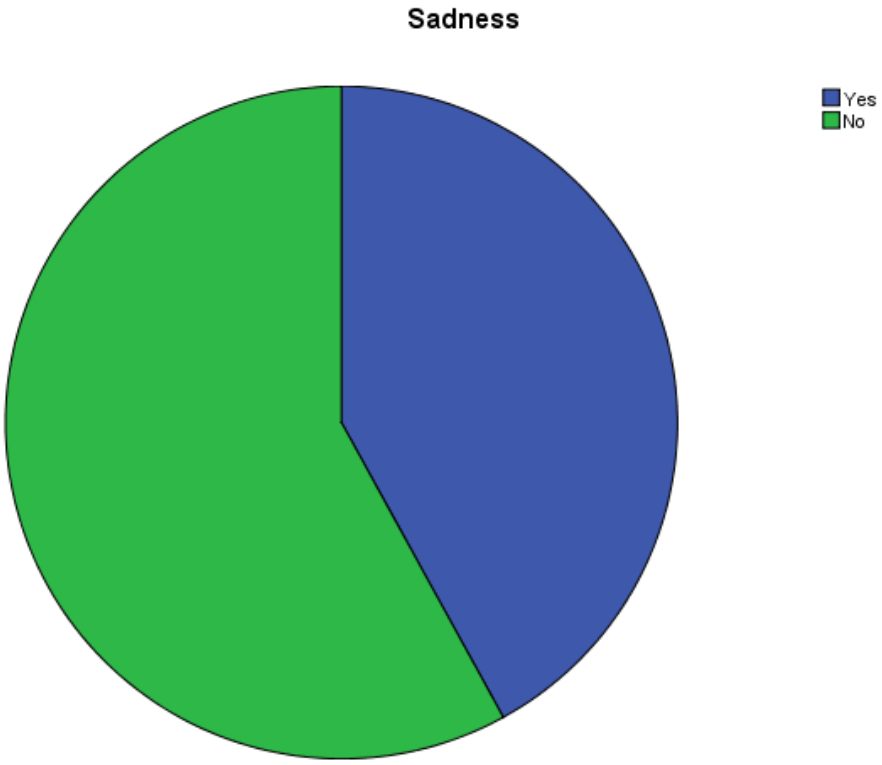

Fig 3.5 above shows the distribution of participants experiencing sadness with 42% saying yes to being sad with 58% saying no to being sad.

TABLE 3.11 DISTRIBUTION OF PARTICIPANTS EXPERIENCING DEPRESSION

Response	Frequency	Percent
Yes	11	22%
No	39	78%
Total	50	100%

Table 3.11 above shows the distribution of participants experiencing depression with 22% agreeing to being depressed and with 78% saying they are not depressed.

FIGURE 3.6 DISTRIBUTION OF PARTICIPANTS EXPERIENCING RECURRENT THOUGHT

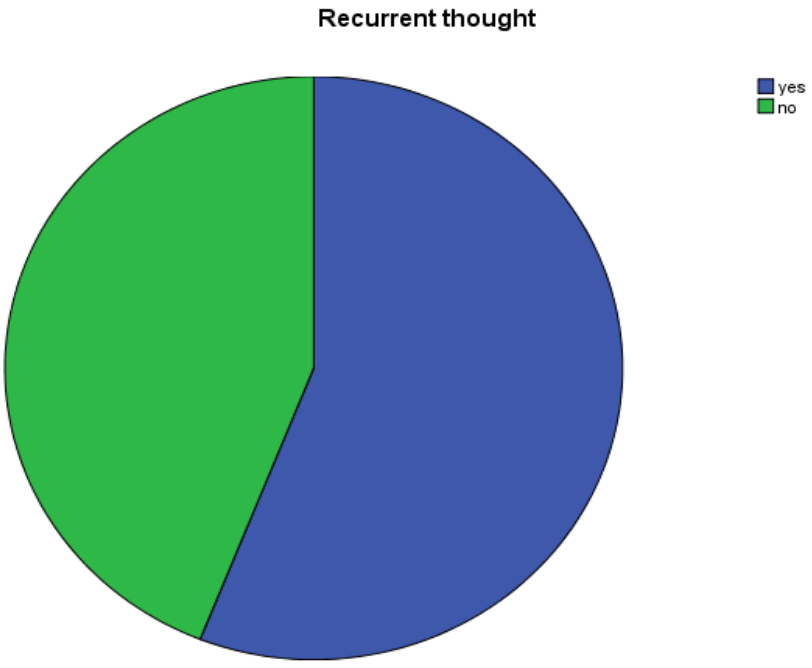

Fig3.6 above shows the distribution of participants experiencing recurrent thought with 44% saying no to experiencing recurrent thought and with 56% agreeing to experience recurrent thought.

TABLE 3.12 DISTRIBUTION OF PARTICIPANTS EXPERIENCING ANXIETY

Response	Frequency	Percent
Yes	12	24.0
No	38	76.0
Total	50	100.0

Table 3.12 above shows the distribution of participants experiencing anxiety with 24% agreeing to be anxious and with 76% saying they are not experiencing anxiety.

FIGURE 3.7 DISTRIBUTION OF PARTICIPANTS EXPERIENCES ON CONFUSION

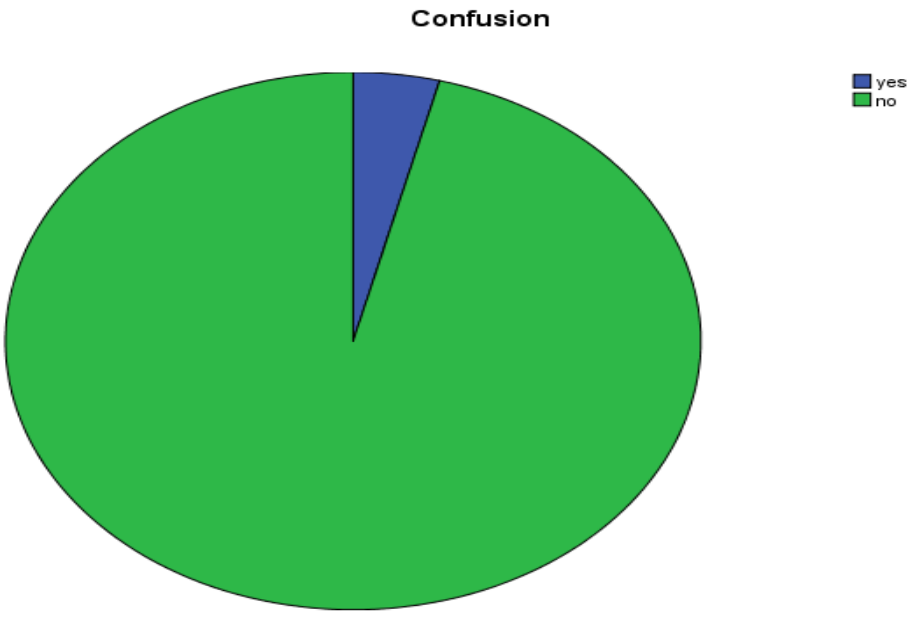

Fig 3.7 above shows the distribution of participants experiencing confusion with 4% agreeing to being confused and with 96% saying no to being confused.

FIGURE 3.8 DISTRIBUTION OF PARTICIPANTS EXPERIENCES ON EXTREME EXCITEMENT

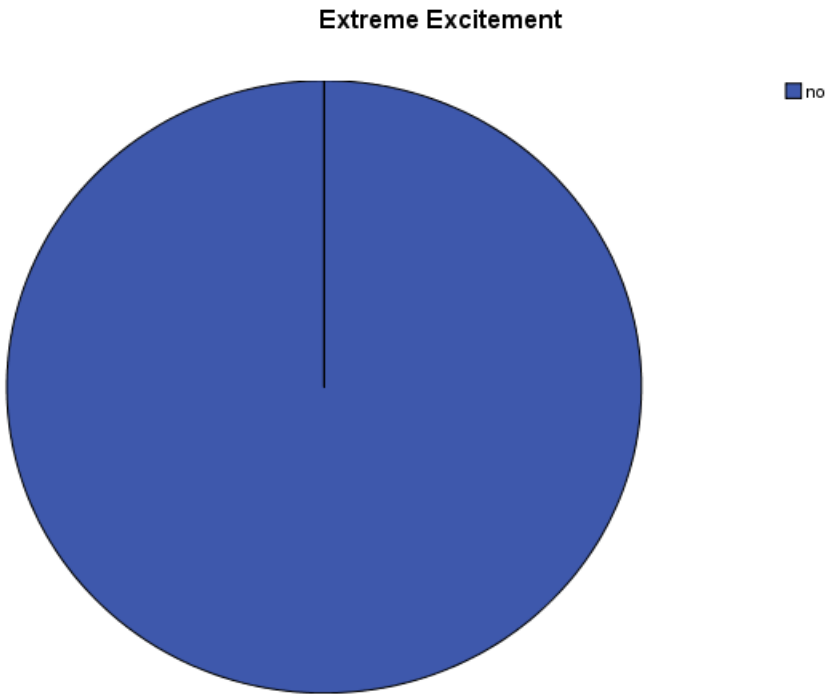

Fig 3.8 above shows the distribution of participants experiencing extreme excitement with none of the participants experiencing extreme excitement.

FIGURE 3.9. DISTRIBUTION OF PARTICIPANTS' INTERACTION WITH SPOUSE

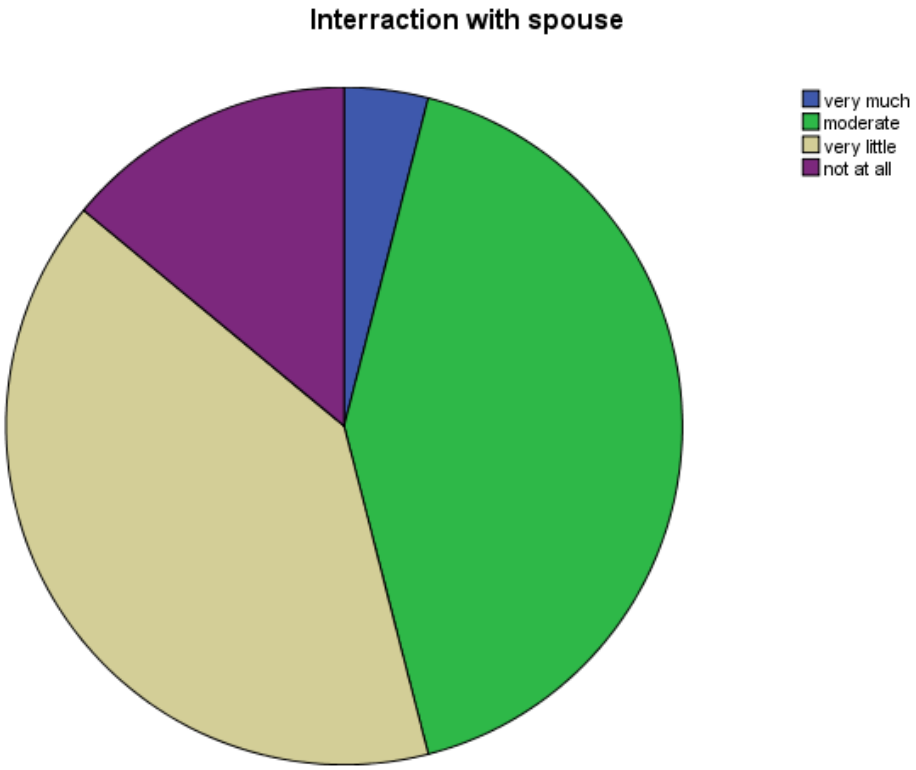

Fig 3.9 above shows the distribution of participants' interaction with spouse with the least percentage, 4% choosing very much interaction with spouse followed by 14% who chose no at all, then 40% allocated to very little interaction with spouse and with highest percentage 42% allocated to moderate interaction with spouse.

FIGURE 3.10 DISTRIBUTION OF PARTICIPANTS EXPERIENCING STIGMA

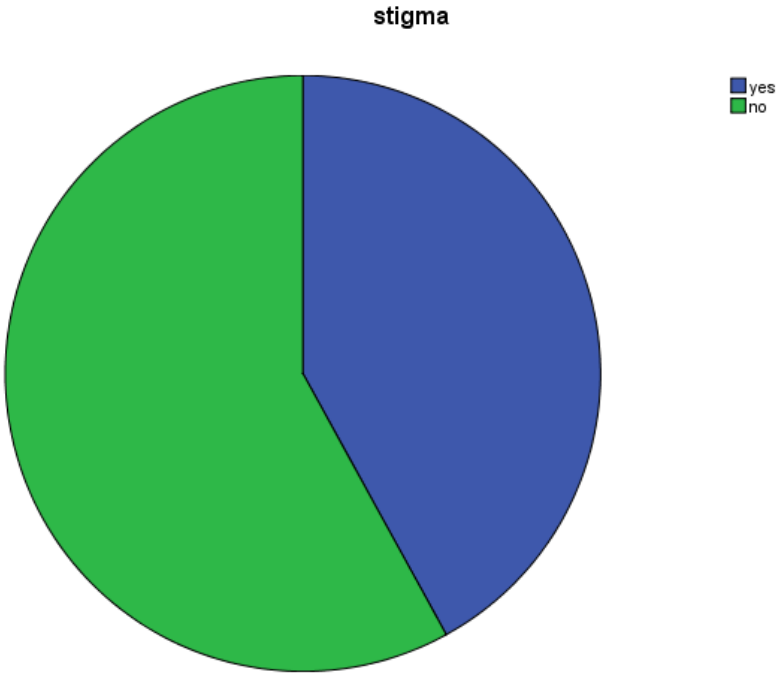

Fig 3.10 above shows the distribution of participants experiencing stigma with 42% agreeing to experiencing stigma and with 58% saying no to experiencing stigma.

FIGURE 3.11 SHOWS THE DISTRIBUTION OF PARTICIPANTS EXPERIENCIN STIGMA AT HOME

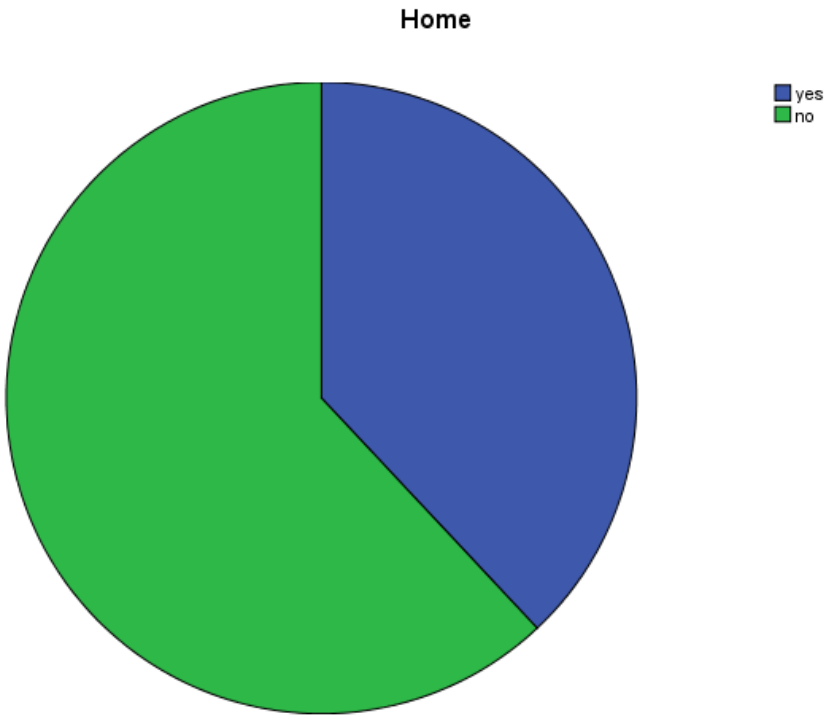

Fig 3.11 above shows the distribution of participants experiencing stigma at home with 38% agreeing to experiencing stigma at home and with 62% saying no to experiencing stigma at home.

TABLE 3.13 DISTRIBUTION OF PARTICIPANTS BEING STIGMATIZED IN THE CHURCH

Response	Frequency	Percent
Yes	1	2%
No	49	98%
Total	50	100%

Table 3.13 above shows the distribution of participants being stigmatized in the church with 2% agreeing to being stigmatized in the church and with 98% saying no to not being stigmatized in the church.

FIGURE 3.12. DISTRIBUTION OF PARTICIPANT STIGMATIZED AT WORK.

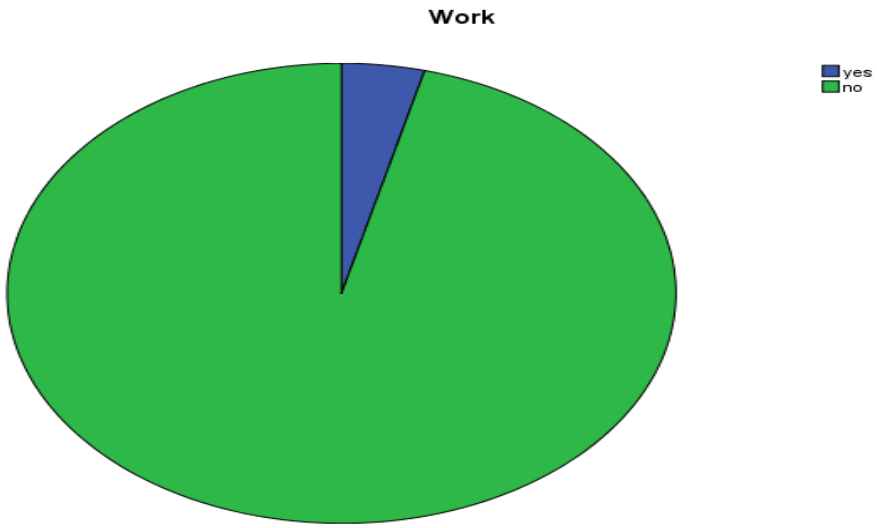

Fig 3.12 above shows the distribution of participants stigmatized at work with 4% agreeing to being stigmatized at work and with 96% saying that they are not experiencing stigmatization at work.

FIGURE 3.13 DISTRIBUTION OF PARTICIPANT STIGMATIZED AT THE MOSQUE.

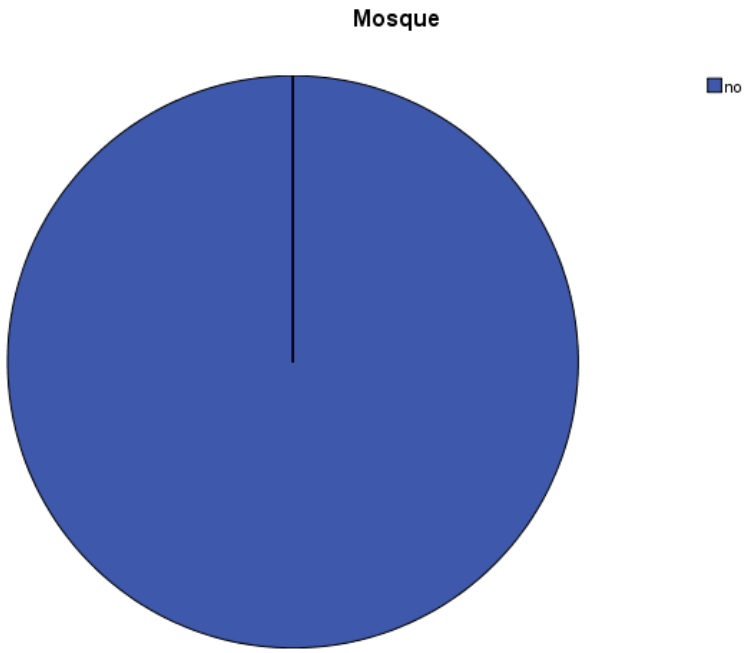

Fig 3.13 above shows the distribution of participants stigmatized at the mosque with no one being stigmatized at the mosque.

TABLE 3.14 DISTRIBUTION OF PARTICIPANTS WHOSE CONDITION HAS EFFECT ON WORK.

Response	Frequency	Percent
Yes	35	70%
No	15	30%
Total	50	100%

Table 3.14 shows the distribution of participants whose condition has effect on work with 30% saying their condition has not affected their work and with 70% agreeing to their work being affected due to their condition.

FIGURE 3.14 DISTRIBUTION OF PARTICIPANTS WITH THREAT OF DIVORCE

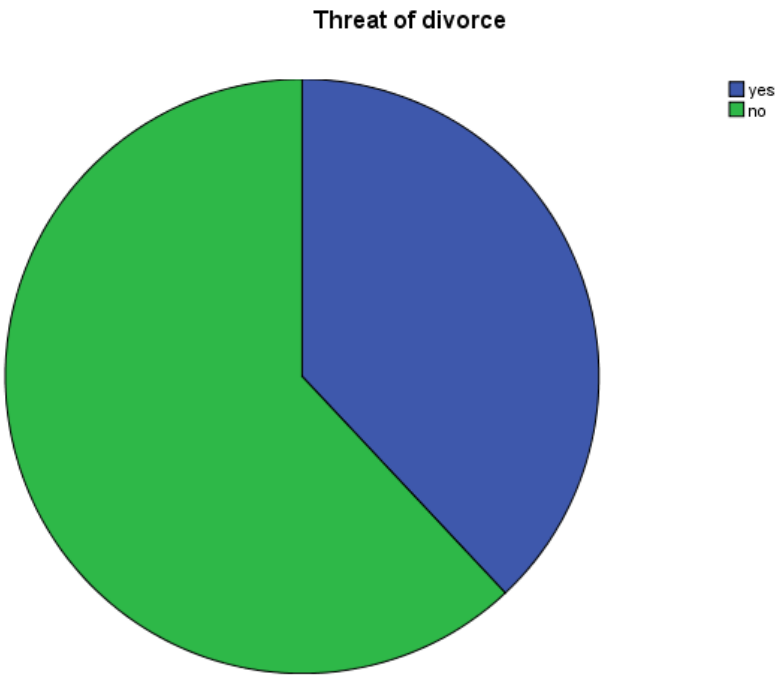

Fig 3.14 above shows the distribution of participants with threat of divorce with 38% agreeing to being threatened with divorce and with 62% saying they have not been threatened with divorce.

FIGURE 3.15 DISTRIBUTION OF PARTICIPANTS WHOSE SPOUSES ARE CHEATING

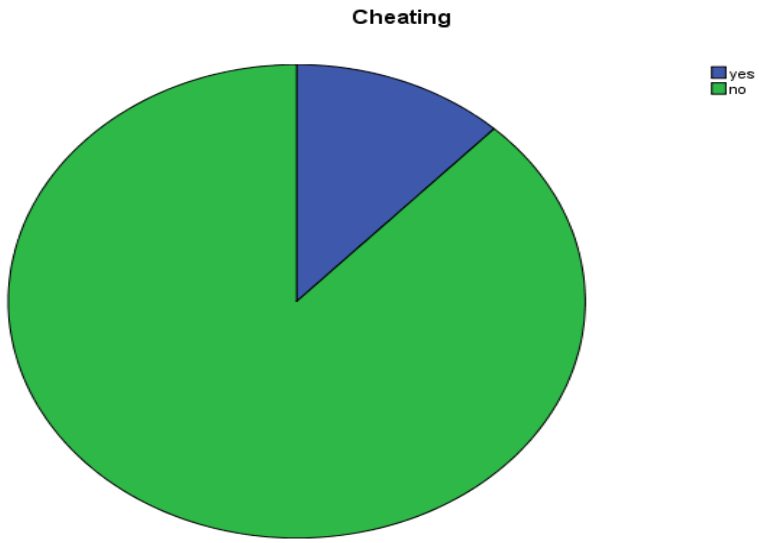

Fig 3.15 shows the distribution of participants whose spouses are cheating with 12% agreeing to have been cheated on and with 88% saying no to being cheated on.

TABLE 3.15 DISTRIBUTION OF PARTICIPANTS EXPERIENCING DISRESPECT

Response	Frequency	Percent
Yes	22	44%
No	28	56%
Total	50	100%

Table 3.15 shows the distribution of participants experiencing disrespect with 44% agreeing to being disrespected and with 56% saying they have not been disrespected.

FIGURE 3.16 DISTRIBUTION OF PARTICIPANTS WHOSE SPOUSES HAVE NEGLECTED THEIR RESPONSIBILITIES

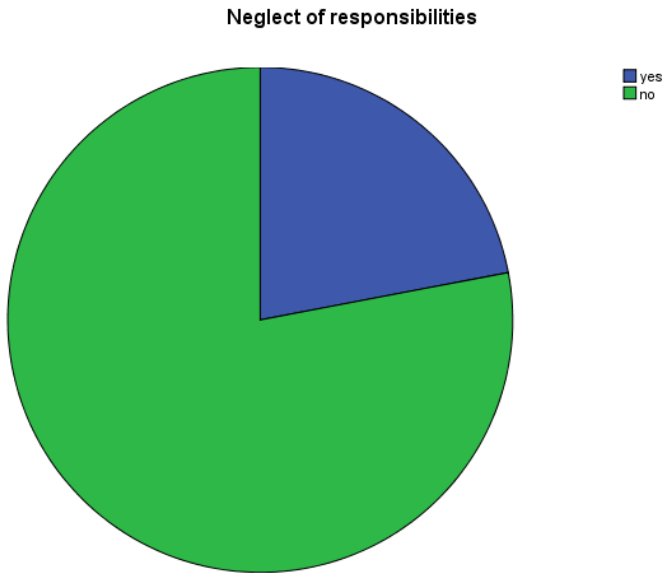

Fig 3.16 shows the distribution of participants whose spouses have neglected their responsibilities with 22% agreeing to their spouses neglecting their responsibilities and with 78% saying no to their spouses neglecting their responsibilities.

TABLE 3.16 DISTRIBUTION OF PARTICIPANTS WHO ARE NOT EXPERIENCING ANY FORM OF THREAT

Response	Frequency	Percent
Yes	4	8%
No	46	92%
Total	50	100%

Table 3.16 above shows the distribution of participants who do not experience any form of threat with 8% indicating yes to experiencing no form of threat and with 92 % who indicate no to any form of threat.

3.3 DISCUSSION.

3.2.0. Background Information/bio data

Findings from the study show that majority (34%) of married men with prostate cancer who took part in the study were between the ages of 51 years to 55 years. This finding differ from a study by the American Cancer Society (2016), where they reported in their study that, married men with prostate cancer were aged between 65Years and above.Again (36%) of respondents had 5 or more children and this result is consistent with the study by Eisenberg,Park,Brinton,Hollenbeck & Schatzin,(2010) in which men with prostate cancer have four(40 or more children. Furthermore, majority (28%) of participants had their highest educational level to secondary.

3.2.1 Objective One: Describe the emotional stress marred men with prostate cancer experience.

In the current study majority (64%) of participants indicated that, they are not afraid of the spread of their condition. These findings are in contrast with a study of Klett (2014) in which prostate cancer patients revealed of being afraid of prostate cancer spreading to other parts of their bodies. The difference in the finding could be due to differences in the external environment of the respondents in each study. For instance, in a case where the external surrounding such as people and health facilities are available to the patients, they will have a positive mind set of good recovery and the inverse is the case where the respondents lack support like health facilities and people around them. Furthermore, majority (84%) of participants in the current study reported of having felt angry about their condition. These findings are in line with a study by in the United Kingdom where they reported that respondents in their study demonstrated anger about their condition during hospitalization (Association of Prostate Cancer Uk, 2018)

.

3.2.2 Objective two: Assess the psychological stress married men with prostate cancer experience.

From the current study, majority (96%) of the respondents reported that they experienced psychological stress. This finding is consistent with Goodman (2017) and Klett (2014) in which patient suffers a significant amount of psychological stress. From the current study findings 42% of participants reported to be feeling sad, 22% of participants reported to be depressed. This also concur with a study by (William & Berk, 2017)

Furthermore, majority (56%) of participants reported to have recurrent thought. This is consistent with Goodman (2017) in which most participants have reoccurrence thought after having receive primary surgery or radiation therapy.24% of participants experienced anxiety and with 4% of participants experiencing confusion due to the condition.

3.2.3 Determine the social stress married men with prostate cancer experience.

Social stress occurs when an individual feels inferior in fitting into society. From the recent study, Majority (42%) of participants reported to have a moderate interaction with their spouses. This is in contrast with Eversten & Wolkenstein, (2009). That reported Stress that comes with this diagnosis takes a significant toll on couple's relationship causing increasing tension and even arguing.

Furthermore, 42% of participants reported to being stigmatized, this finding is in line with a study by Ernst, Mehnert, & Esser, (2017) in which stigmatization ranges from 13% to 84%.And amongst the percentage of respondents facing stigmatization, 38% at home and 4% at work. This finding is congruent with a study by Marlow and Wardle, (2014) where they reported that 15% of prostate cancer stigmatization is family related.

3.4 CONCLUSION.

In summary, the emotional and psychosocial stress men with prostate cancer experience deserves attention not only because of its impact of quality of life but also because if its potential adverse effect on the experiencing person as the study revealed that, 42% of the respondents experienced stigmatization and 92% experienced psychological stress, while 84% felt angry due to their diagnosis and treatment burden. This fining must be attended to as they have long-term effects such as medical treatment noncompliance, health care abscondment of patients, and the risk of suicide. This study provided evidence that men with prostate cancer experience a level of emotional and psychosocial stress. Therefore, they need a level of medical and nursing intervention to care the complications these levels of emotional and psychosocial stress produces.

3.4 RECOMMENDATION

Based on the findings above, the following recommendations have been made;

1. Government and non-Governmental organizations should focus on the awareness campaign of the emotional and psychosocial stress related to prostate cancer.

2. In view the fining that prostate cancer patients gets angry, the Healthcare team should keep exercise extra patience with such patience

3. Efforts should be made to educate families and churches on the causes and treatment of prostate cancer so as to help reduce stigmatization among such patients.

4. The media should focus and encourage men between the ages of 40 to 70 years to go for screening every 3 months to know their prostate specific antigen levels.

5. Government should encourage regional and district hospitals to have a friendly environments, to enable Men to come for screening.

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CENTRAL UNIVERSITY

SCHOOL OF MEDICINE AND HEALTH SCIENCES

DEPARTMENT OF NURSING

QUESTIONAIRE

TOPIC: ASSESSING THE EMOTIONAL AND PSYCHOSOCIAL STRESS MARRIED MEN WITH PROSTATE CANCER EXPERIENCE: A STUDY AT KORLE BU TEACHING HOSPITAL.

Dear respondents, we are final year nursing students of **CENTRAL UNIVERSITY,** conducting research on the topic" assessing the emotional and psychosocial stress married men with prostate cancer experience". This forms a part of the requirement for the award of a BSc. Degree certificate. As such your name and address is not required in all information provided, the information provided will be used only for academic purposes. You have the right to decline or withdraw from the study at any time.

INTRUCTION: Please tick or state where applicable to you.

SECTION A: Background information

1. Age. A.18-29years B. 30-35 years (), C. 36-40years (), D. 41-45years (), E. 46-50years (), F.51-55years (), G. 55-65years (), H.66 years and above ()

2. Marital status. A. Single ( ), B. Married ( ), C. Widowed ( ), D. Divorced ( ),

3. Number of children. A. 1 ( ), B. 2 ( ), C. 3 ( ), D. 4 ( ), E. 5 or more ( ).

4. Level of education. A. Primary ( ), B. Secondary ( ), C. Tertiary ( ). Others, please specify ……

5. Ethnicity. A. Ga ( ), B. Ewe ( ), C. Akan ( ), others, please specify…….

6. Religion. A. Christian ( ), B. Traditionalist ( ), C. Muslim ( ). Others, please specify……..

7. Employment status. A. Employed full time ( ), B. Employed part time ( ), C. Unemployed ( ),

D. Student ( ), E. Retired ( ), F. Self-employed ( ), G. Unable to work ( ).

SECTION B: Describe the emotional stress married men with prostate cancer experience.

8. Have there been a time you were afraid your disease could spread? A. Yes B. No

9. Have there been a time when you feel angry about yourself because of prostate cancer?

A. Yes B. No

10. Do you have any guilt for your condition? A. yes B. No

11. Which of the following have you experienced, since you were diagnosed of prostate cancer.

A. Apprehension

B. Feeling overwhelmed

C. Denial of your condition

SECTION C: Assess the psychological stress married men with prostate cancer experience.

12. Have you ever had a psychological stress before? A. Yes () B. No ()

13. If yes, from question 8 above which of these did you experience.

A. Sadness

B. Depression

C. Recurrent thought

D. Anxiety

E. Confusion

F. Extreme excitement

SECTION D: Determine the social stress married men with prostate cancer experience.

14. Do you have regular interaction with your spouse?

A. very much () B. Moderate () C. Very little () D. Not at all ()

15. Do you feel stigmatized? A. Yes () B. No ()

16. From question 15 above, where do you normally experience the stigmatization?

A. Home () B. Church () C. work () D. Mosque ()

17. Has your condition affected your routine work? A. Yes B. No

18. Which of the following have you experienced due to your condition.

A. Threat of divorce

B. Cheating

C. Disrespect

D. Neglect of household responsibilities.