A TOOL TO ASSESS BARRIERS THAT PREVENT MEN FROM SEEKING SCREENING AND TREATMENT OF BPH

Scholarly Project for the Degree of M. S. N.

MICHIGAN STATE UNIVERSITY

NANCY A. CRUMMEL

1995

A TOOL TO ASSESS BARRIERS THAT PREVENT MEN FROM SEEKING SCREENING AND TREATMENT OF BPH

By

Nancy A. Crummel

SCHOLARLY PROJECT

Submitted to
Michigan State University
In partial fulfillment of the requirements
for the degree of

MASTER OF SCIENCE IN NURSING

College of Nursing

1995

ABSTRACT

A TOOL TO ASSESS BARRIERS
THAT PREVENT MEN FROM SEEKING
SCREENING AND TREATMENT OF BPH

Benign Prostatic Hyperplasia (BPH) affects approximately 14 million older men in the United States. A majority of those men are not seeking screening and treatment for their BPH until their symptoms have reached the severe stage requiring surgery.

The purpose of this project was to design a tool to be utilized by healthcare providers in primary care to assess barriers that prevent men from seeking screening and treatment of BPH. This tool was developed with the theoretical background of the Health Belief Model.

The sources used for the study were published literature pertaining to the diagnoses and treatment of BPH, health-seeking behaviors of men, and evidence supporting how questionnaires facilitate and promote health behaviors.

The designed tool, a questionnaire for men over the age of 45, can be a great asset to a healthcare provider in primary care to identify and remove barriers that their patients have regarding screening and treatment of BPH.

ACKNOWLEDGMENTS

The author could not have chosen a better Chairperson and two Committee Members. Drs. Barbara Given and Suzanne Budd unceasingly gave advise, support, and time along with just the right amount of encouragement. Patty Peek altruistically provided advise, support and time, as well as her sense of humor and perspective of life and work that was greatly appreciated.

The author would also like to express gratitude to her husband, Craig Crummel for his support, understanding, and encouragement.

TABLE OF CONTENTS

Chapter		Page
I.	INTRODUCTION	1
	Statement of Problem	4
	Purpose of Study	4
II.	CONCEPTUAL FRAMEWORK	7
	Health Belief Model	7
	Major Variables Utilized	7
III.	REVIEW OF LITERATURE	15
	Significance of BPH	15
	Treatment Modalities	16
	Sexuality Concerns	17
	Health-seeking Behavior of Men	19
	Value of Questionnaires	21
	Limitations	24
IV.	METHODS	25
	Purpose of Questionnaire	25
	Design of Questionnaire	25
V.	NURSING IMPLICATIONS	30
	Implications for Primary Care	30
	Examples of Use	31
	Evaluation of Tool	33
REFERENCES		37

LIST OF FIGURES

Figure		Page
1.	Health Belief Model	11
2.	Modified Health Belief Model	12
3.	Interaction between Health Belief and Questionnaire	27

CHAPTER I

INTRODUCTION

Brushewietz (1992) reported that benign prostatic hyperplasia (BPH) is a common finding that affects about 14 million older men in the United States. BPH is hyperplasia or enlargement of the prostate. The cause is unknown but thought to be related to an alteration in male hormones. More importantly, Wein (1990) reported that an enlargement of the prostate can cause a man to develop urinary difficulties such as a feeling of not completely emptying the bladder after urination, frequent urination, a strong and sudden desire to urinate that is difficult to delay, a weak urine stream, the need to push or strain to start the urine stream, and/or nocturia. These signs and symptoms that men usually begin to experience around the age of 40 could lead them to seek screening and treatment. The degree to which symptoms negatively impact a man's life often determine his desire or action to seek treatment for the alleviation of these symptoms.

Chute et al. (1993) revealed that the marked impact that urinary symptoms have on ordinary activities of daily living is important and quite possibly under-recognized. While the activities affected are not life-threatening, they can and do adversely affect life-style.

The irritative symptoms of BPH not only affect the man who has the disease, but can affect his entire family. For example, a man who is getting up 3-4 times a night to urinate, is more than likely depriving his wife of a good nights sleep. If his urinary symptoms have progressed to the moderate or severe stages, the middle-aged male may find himself limiting his activities; such as going golfing, or other social outings simply for fear of not always being near a restroom when he experiences urgency. His urinary symptoms could also impede his sexual relations. Although BPH has not been primarily shown to impede sexual functions, sexual function can be affected by certain treatment options such as surgical or medical management. As will be shown later in the paper both the surgical procedure TURP, and the use of the medication Finasteride can cause sexual dysfunction. Also, the embarrassment caused by BPH, such as urinary incontinence, frequency, etc. may impede a man's sexual functioning.

A study done by Tsang and Garraway (1992) revealed that the proportion of men with a negative feeling of well-being was higher in men with BPH than in men who did not have BPH. The proportion of men with a negative feeling was consistent for all aspects of well-being (anxiety, depression, self-control, vitality, being worried or being bothered by illness). This study is limited to only dimensions of the Health Belief Model as it relates to BPH, other dimensions such as depression, anxiety, etc., require further research.

These investigators also reported that men with BPH had a higher level of bothersomeness attributed to urinary symptoms, and more interference in selected daily living activities caused by urinary dysfunction. Higher level of bothersomeness were related to worry or concern over urinary function and prostate cancer, together with a higher level of embarrassment caused by urinary dysfunction, compared with men who did not have BPH.

As reported by Schlegel (1994), The American Urological Association advocates that the screening that can be done for BPH consists of a digital rectal exam (DRE) to determine the size of the prostate and a prostate specific antigen (PSA) blood test to rule out prostate cancer. Roberts (1994) states that there is criticism of the current BPH guideline that begins with men over the age of 50. Roberts (1994) also relates that some healthcare providers argue that the guideline is limited because it is intended only for men over the age of 50 with classic symptoms of prostatism, but with no other severe or confounding medical morbidities.

Schlegel (1994) reported that prostatic diseases are universal in men and that one of the largest growing segments of our population are elderly men. He also pointed out that recent advances in medical treatments and other alternative therapies for BPH have advanced which are less invasive than the commonly used surgical procedures. With the propagation of these treatments and the improved

opportunities for men with BPH, it behooves healthcare providers to have an increased awareness of their patients with BPH so that they can treat them at early stages of BPH with non-invasive treatment.

The problem of BPH is that the majority of men are not seeking screening and treatment until their symptoms have reached the severe state that requires surgery. This statement is made due to the large number of men that are having TURP's performed. According to Petrovich (1993), one-half of the approximately 800,000 men that require treatment for BPH yearly in the United States are managed surgically, making TURP's the most common surgical procedure performed by urologists.

If men would recognize the signs and symptoms of BPH and seek screening and treatment, the negative urological problems could be diagnosed and treated. Men can and should be screened for this disease by their healthcare provider. The direct result of an increased desire for screening would be an early detection of the disease thus slowing the progression of the patient to moderate and severe stages.

The purpose of this project is to develop a tool in the form of a questionnaire to identify barriers of men over the age of 45 that prohibit them from seeking screening and treatment for the symptoms associated with Benign Prostatic Hyperplasia.

The questionnaire can be utilized by primary care healthcare providers. This questionnaire will be targeted

at men 45 years of age and older with the purpose of enabling healthcare providers to easily identify men with signs and symptoms of BPH and to ascertain what perceived barriers their patients have that keep them from seeking screening and treatment. The questionnaire could be distributed to men over the age of 45 upon registering at their healthcare providers office, left in the healthcare providers waiting room for easy access, or individually given to patients upon examination. Then upon taking the patients history and response to questionnaire, the healthcare provider could use the questionnaire as a tool to identify both those at risk as well as barriers preventing men from seeking treatment for BPH.

Through eliminating the barriers which prevent men from seeking treatment and screening, not only would BPH be diagnosed and treated, but there also exists the potential for a higher rate of detection of prostate cancer and earlier treatment before it had advanced.

Healthcare providers can not ethically assume that BPH is a precursor of cancer; however, we can infer that an increase in the amount of screening for BPH mutually presents healthcare providers with the opportunity to examine the prostate for evidence of nodules. Therefore, the early detection of prostatic enlargement as well as nodules can result in the early detection of prostate cancer and ultimately early treatment to decrease the incidence of

fatal prostate cancer as well as have their BPH treated so they don't have that co-morbidity.

CHAPTER II

CONCEPTUAL FRAMEWORK

The conceptual framework of the Health Belief Model will be used. As stated by Becker et al. (1977), the Health Belief Model hypothesized that persons will generally not seek preventive care or health screening unless they perceive themselves as potentially vulnerable and the condition as threatening. The model also postulates that persons need to be convinced of the efficacy of intervention and perceive few difficulties in obtaining the recommended action.

The Health Belief Model is a psychosocial formulation of patients' motivations to carry out health related behaviors. By assessing patients' beliefs in a systematic way, healthcare providers can identify those beliefs that are preventing patients from implementing behavior that can improve their health status. Healthcare providers can also use this information to help patients alter their beliefs so that they can better care for themselves.

Using the Health Belief Model, a healthcare provider can classify the types of motivation that lead to health-related behaviors that influence the decision-making of their patients. The goal of assessing and altering patients' beliefs is to improve their health status.

As stated by Becker et al. (1977), the five major variables of the Health Belief Model that are considered important in explaining and predicting health related

behavior and compliance with treatment regimens are; perceived susceptibility or vulnerability, perceived seriousness or severity, perceived effectiveness or benefits of treatment, perceived relative absence of barriers or impediments to taking action, and perceived cue to actions.

Perceived Susceptibility or Vulnerability: This variable has a strong cognitive component wherein knowledge, in part, leads to action. It is a variable that views the patients perceived risk, their belief that they are likely or probable to get the disease in question. Compliance with screening for BPH would be an example of a patients' perceived susceptibility that he was susceptible to BPH and therefore was willing to undertake a behavior such as screening to prevent it. The variable can help determine such things as: does the individual believe that he might be susceptible to BPH; does the individual believe that he is susceptible to future problems if BPH already exists; and does he feel vulnerable to more severe symptoms if he already has BPH?

Perceived Seriousness or Severity: is defined as an emotional arousal created by that of an illness. Patients as reported by Becker et al. (1977) who perceive that their disease as more severe are more likely to carry out the therapy designed to manage or to cure the disease. An example of this variable would be a man who is having irritative urinary symptoms seeking a BPH screening. To achieve compliance, patients' need to believe that the

screening or therapy will be beneficial. This is an important variable because it can help determine if a male believes that if he develops BPH that it will interfere with his usual life-style or view the complications of BPH as serious.

Perceived Effectiveness or Benefits of Treatment: This variable is defined as the benefits that an individual believes he will receive from whatever course of action has been recommended. It is important that he believes that the therapy will be efficacious in preventing BPH, treating diagnosed BPH, or preventing the complications of BPH.

Perceived Relative Absence of Barriers or Impediments to Taking Action: Becker et al. (1977) also states that patients' need to believe that the benefits of therapy will outweigh things such as inconvenience and cost. Does the individual perceive a relative absence of barriers to taking actions, such as expense, inconvenience, and side effects if drugs are prescribed? Basically, does he view the benefits as outweighing the costs.

The last of the five major variables is the Perceived Cue to Actions: Cues to action can be internal or external. A cue to action may arouse patients' perceptions of their susceptibility, severity, or benefits of therapy. Cues may come from encouragement from family and friends, increased patient-provider interaction, or continuity of providers. Schaie (1992) reviewed the health behaviors of the aging and

reported that "spousal support" was important in evoking changes in health behavior.

Intensity of cues depends on a patients' state of readiness. An example would be if a patient exhibits a decreased readiness, then a more intense cue is needed whereas if a patient exhibits an increased readiness, they would only need a weak cue to elicit action. If a man is experiencing symptoms of BPH, that would be considered an internal cue. Becoming aware of the treatment for BPH through health education messages from the mass media would be an example of external cue.

These variables were utilized to design the questionnaire described in the introduction (see Addendum A). Illustrated in Figure 1 is first an example of the original model of the Health Belief System, followed by Figure 2 which is a modified model with the variables used in this study. The use of this modified model exemplifies the study by utilizing the variables stated in this project as well as incorporates factors such as demographic variables and the likelihood of men seeking recommended preventive health actions such as BPH screenings.

The model used has three divisions: (a) Individual Perceptions, (b) Modifying Factors, and (c) Likelihood of Action. Under the section of Individual Perceptions is one box which contained Perceived Susceptibility to BPH and Perceived Seriousness of BPH. As stated earlier, this is a

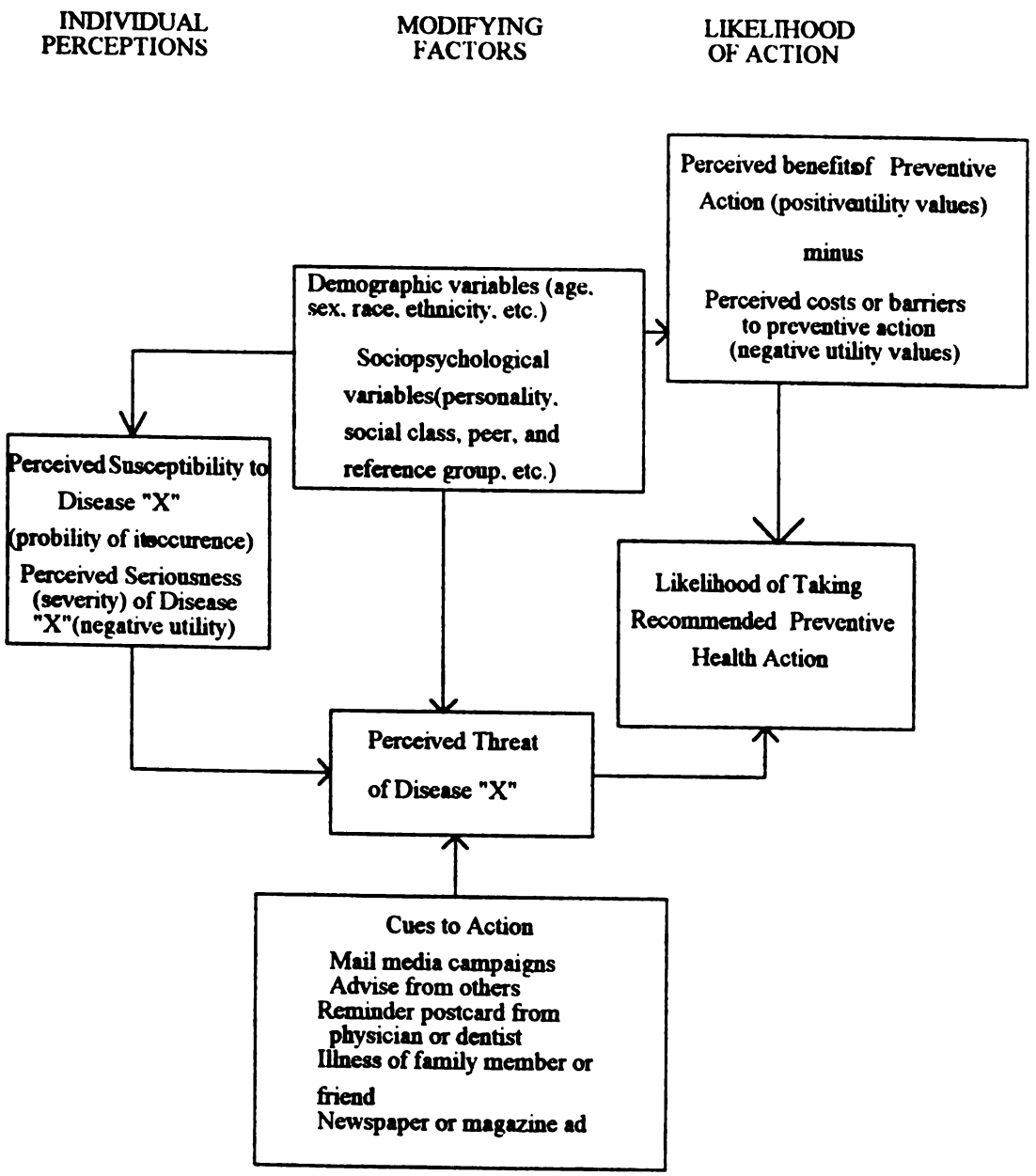

Figure 1. The "Health Belief Model" as predictor of preventive health behavior (from Becker, M. & Maiman, L.A.(1975). Sociobehavior determinants of compliance with health and medical care recommendations Medical Care, 13, (10-24).

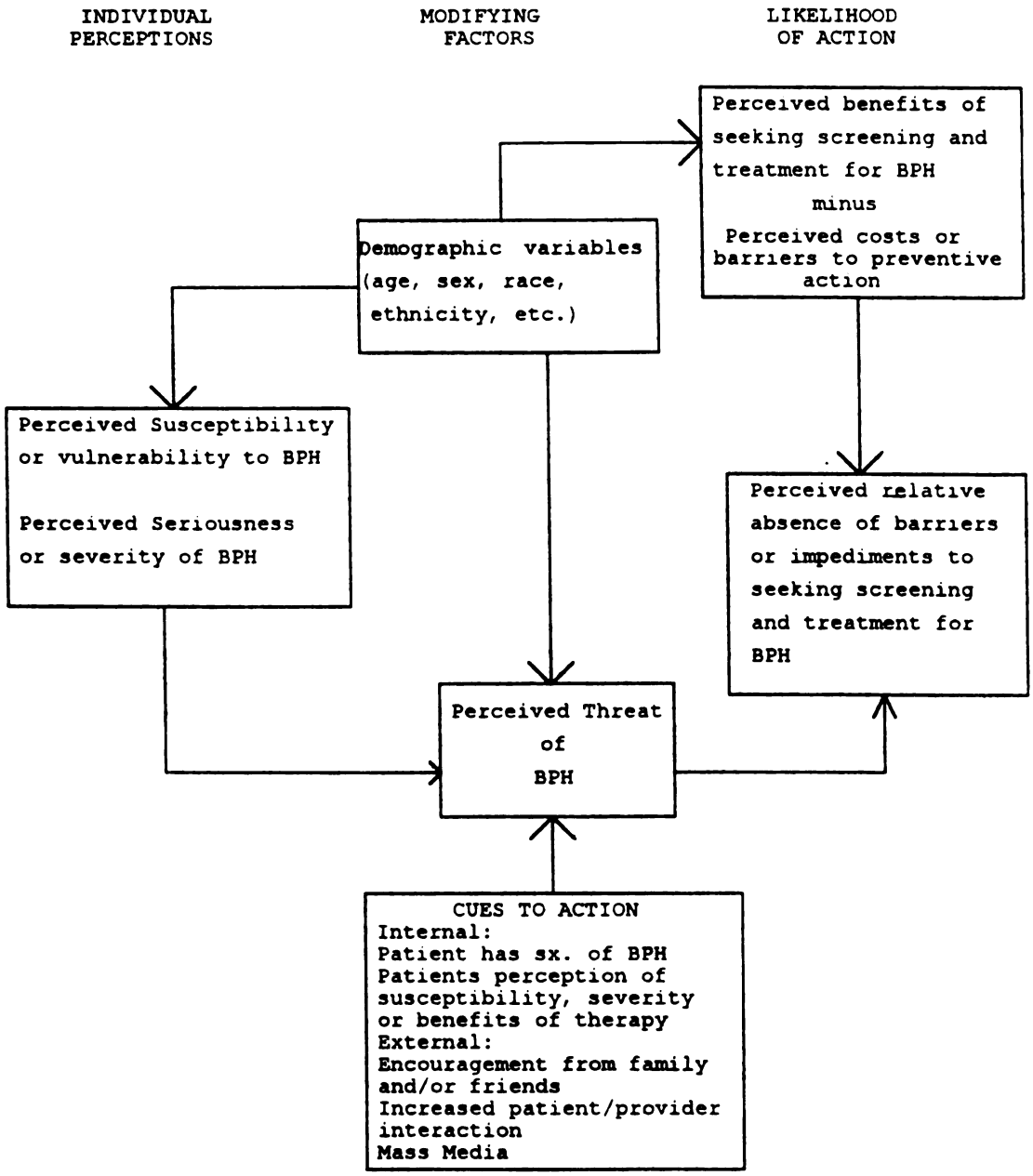

FIGURE 2. Modified by N. Crummel. The "Health Belief Model" as predictor of preventive health behavior (from Becker, M. & Maiman, L.A.(1975). Sociobehavior determinants of compliance with health and medical care recommendations. Medical Care, 13, (10-24).

very important factor as it has been proven that the more a man believes that he is susceptible to a disease and perceives the disease to be a deterrent to his life, the greater the chance he will seek screening and treatment.

Modifying factors contains three areas. The first box includes the Demographic Variables such as age, sex, race, ethnicity, etc.; the next box is the Perceived Threat of BPH. This variable interacts with all other variables because it is what the man's perception of how BPH will affect his life. Does he believe his healthcare provider is doing the right thing, does he feel vulnerable to future problems, how much does he believe that BPH will impact the rest of his life in areas such as his job, sleep, social, physical, family, and daily work. The last box under modifying factors are Cues to Action. These cues can be internal or external. A man's perception of his susceptibility to BPH, its severity or benefits of therapy are internal cues. While encouragement from family and friends, mail media campaigns, newspaper or magazine articles, BPH of family member or friends are examples of external cues. The section of the model containing Likelihood of Action has two boxes: the first one contains Perceived Benefits of seeking screening and treatment for BPH. Perceived Benefits is extremely important as a man must perceive that the benefits to screening and treatment of BPH outweigh the costs or inconvenience. The last box in the model is Perceived Relative Absence of Barriers or

impediments to seeking screening and treatment for BPH. Perceived Relative Absence of Barriers or impediments to seeking screening and treatment for BPH ties together a man's beliefs and perceptions and really is the bottom line of whether he will seek the recommended BPH screening and treatment.

In summary, this modified model of the Health Belief System will be beneficial in assisting a healthcare provider to view, evaluate, and understand the weaknesses and strengths of their male patients in regards to BPH. By having a better understanding, a healthcare provider will be able to assist their male patients in removing the barriers that prevent them from screening and treatment of BPH.

CHAPTER III

REVIEW OF LITERATURE

The review of literature is organized to: (a) demonstrate the significant number of men with BPH, (b) outline the available treatments for BPH, (c) identify possible benefits to early screening, and (d) evidence supporting how questionnaires can facilitate and promote health behaviors for positive outcomes. The review of literature is designed to correlate with the concepts of the Health Belief Model.

It was reported by Barry et al. (1992) that "Benign prostatic hyperplasia (BPH) is a common condition among older men. In the United States approximately 400,000 prostatectomies are performed annually for BPH, making surgery for this condition the second most common major operation for Medicare-aged men." (p.1549.)

After reviewing a compilation of studies, Barry (1990) stated that BPH has physiological and anatomic changes that may lead to obstructive and irritative symptoms. Obstructive symptoms such as a weak stream, need to strain, a sense of incomplete emptying and terminal dribbling are believed to be the direct effect of physiologic obstruction, while irritative symptoms such as nocturia, frequency, and urgency are felt to be uninhibited detrusor contractions, either developing secondary to obstruction, or as an independent process.

Barry (1990) also reports that BPH can affect a patient's ability to function physically and socially. Mental health can be affected by a change in physical functioning, discomfort from symptoms, and worries about future health deterioration. It is for these reasons that awareness, early detection, and barrier reduction of men seeking screening and treatment is very important for healthcare providers. The removal of barriers that prevent men from seeking screening and treatment will lead to an increased number of men being treated for BPH at an early stage.

Following the diagnosis of BPH there are currently three avenues of treatment available to the patient. Those current trends related to the treatment of BPH are: (a) Surgical treatments such as, transurethral resection of the prostate (TURP), balloon dilation of the prostate, open prostectomy, microwave hyperthermia, the placement of a metal prostatic stent, and laser prostatectomy, (b) Medical management involves treatment with either alpha adrenergic blocking agents or androgen suppressant, (c) "Watchful waiting" is the other method used to treat BPH. Watchful waiting according to Payne et al. (1994) is utilized when it is determined that a man has BPH but is not being bothered enough by the symptoms to initiate treatment. The decision to utilize watchful waiting is subjective and its use determined by the healthcare provider with the information that the patient gives them. If watchful waiting is the

method utilized, it is recommended by the American Urological Association that the patient be rechecked in one year or sooner if he develops more severe irritative symptoms.

Sexual functioning is an area of concern for most men who seek treatment of BPH. Boccon-Gibod (1991) reported findings on a study which followed 84 patients for 3 years after transurethral resection of the prostate (TURP) and found that 75% of the patients claimed to be improved, 18% complained of urge incontinence, and 33% complained of decreased or absent erection.

Gormley et al. (1992) reported findings from a 12 month double-blind study which involved 895 men who were placed on Finasteride. The study was performed at 25 centers in the United States and 5 centers in Canada. The results revealed that 3.4% of the men stated that they developed impotence from taking the medication. It was also reported that the men had a significant decrease in irritative urinary symptoms, a 22% increase in urinary flow, and a 19% decrease in prostatic volume.

In summary, BPH can have a great negative impact on a man's life. This study will now focus on the ways in which a healthcare provider diagnoses BPH and some of the barriers that prevent men from seeking the needed screening and treatment of BPH which makes the possibility of diagnosing and treating BPH even more challenging.

There are three valuable tools to assist a healthcare provider in diagnosing BPH: utilization of a Prostatic Specific Antigen (PSA) serum test, performing a digital rectal exam (DRE), and by taking a thorough history from the patient. The review of the literature indicates that the reasons that men are not being properly screened for BPH and/or prostatic cancer are multifaceted. One important reason that was stated by Butler (1994) was that the behavioral issues such as a hesitancy to have their prostate checked and their fear of doctors are important factors that are barriers for men. The appropriate use of blood pressure screens, cholesterol screens, and PSA (prostate specific antigen) exams for prostate disease in conjunction with careful history and clinical examinations could lead to earlier diagnoses and increase survivorship.

Muhlenkamp et al. (1985) used the Health Belief Model as a framework to analyze the effects of demographic variables, health beliefs, and value of health on health-promoting behavior. Their sample of 175 nursing clinic patients were surveyed over a two year period of time and were classified by the type of health care they requested when they appeared at the clinic. Types of health care, according to Muhlenkamp et al. (1985), were health maintenance, health promotion, health restoration, and illness prevention. The study revealed that men were less likely to seek preventive care than women and also that

education and higher self-health ratings were correlated with positive health practices for men and women.

Wiley and Camacho (1980) reported that a study done on 6,928 subjects (of which 1,751 were men) between the ages of 25 and 70 revealed that the percentage of men who practiced healthy behaviors was less than the percentage of women who practiced them. The information regarding the health behaviors of men and women was obtained by having the subjects complete questionnaires. The questionnaires yielded data concerning the respondants disabilities, chronic conditions, impairments, energy levels for daily activities, and extent of practice of many daily or lifestyle behaviors.

Durham and Cohen (1986) pointed out that women may have a socially acceptable and justifiable reason to practice healthy behaviors. They stated that women have been encouraged to seek health care and practice healthy behaviors in areas such as cancer prevention, family planning, and prenatal care. In contrast, men have been socially conditioned into a male role which demands that (a) they do not seek health care until problems are overwhelming. (b) they need to be different from women, and (c) they need to be independent and self-reliant.

In a study done by Hickey (1994), several health seeking habits of the elderly, men in particular, were addressed. There were 669 persons who were 65 years and older who participated in the study. Men were less likely

than women to follow most health-enhancing behaviors. Education and sources of health-related information were most consistently related to the frequency of those behaviors. The study supported the importance of considering the impact of illness or disability on the frequency with which the elderly report preventive health practices. Behaviors that are considered preventive of disease in the general population become part of health management strategies that are prescribed to impede development of a disease process, to restore previous levels of functioning, or to maximize current abilities. Hickey (1994) also revealed that people associate risk of disease not only with behavior, but with factors such as heredity, upbringing, access to resources, occupational risks, environmental pollution, and change (that is, luck, randomness, personal destiny, or divine plan). This study relates well to the importance of a healthcare provider assessing an individuals' barriers so that he/she can better understand why a man is not seeking screening and treatment for BPH. Does he have the barrier of not having easy access to healthcare resources, or does he believe that it is his personal destiny to suffer with BPH?

Most importantly, the general population of men over the age of 45 need to be aware of the signs and symptoms of BPH and healthcare providers need to be aware of what barriers prevent their patients from seeking screening and treatment. This awareness would lead to men being screened

once a year for BPH, and awareness that urological problems related to BPH are treatable and not just a part of "getting old." Resolution of urological problems related to BPH would also lead to men having an increased sense of self-esteem. As reported by Tsang and Garraway (1993) after a study on 410 men between the ages of 40-79, stated that they discovered that the proportion of men with a negative feeling of well-being was higher in men with BPH than in men with BPH than in men who did not have BPH.

Roberts (1994) stated that even with the availability of guidelines, treatment for BPH is predicated on a man seeking the cure of a healthcare provider. Despite the progress of the disease, relatively little is known about the factors leading a man to seek this medical care. Roberts (1994) also reported after reviewing studies that the interrelationships among psychosocial symptoms of worry and embarrassment about urinary function and the health care-seeking behavior in a population-based cohort of men revealed that the presence of symptoms alone does not predict health care seeking behavior of men.

Getting men to seek the care of their healthcare provider is the first step towards treating BPH. This study will focus on some possible methods to promote men to seek the care of their healthcare provider.

According to Rice and Atkin (1987) questionnaires and the media can be successful ways to obtain information and provide education regarding the awareness of the symptoms of

BPH and the need for screening. On the other hand, they warn that television may help to reinforce viewer malaise about the value of health-promoting activities and justify 'live-for-today' attitudes and lack of interest in prevention; with the mind-set that if any problem arises, their healthcare provider will surely provide the cure. Thus, although questionnaires and the media such as television can be a great means to relay information to a large number of people in a short period of time, it is important to realize that messages can also be misunderstood and actually become a barrier. For instance, if a man hears a message on the television regarding BPH screening and becomes fearful of the message as he perceives it, it will create a barrier preventing him from seeking screening and treatment for BPH. Rice and Atkin (1987) also stated that random questionnaires can be a deterrent and create barriers if information is unclear or confusing to a man. However, questionnaires given by a healthcare provider that allow men to ask questions or aide a healthcare provider to identify, discuss, and hopefully remove barriers can be very beneficial. Rice and Atkin (1987) also concluded that it was important to target your audience properly when utilizing questionnaires or the media as the sociocultural/economic characteristics of the goal audiences play a very important role in communicating interventions, due to the difficulty of translating new information into firmly held behaviors.

Kramer (1993) stated that the final decision about any treatment regimen for a prostatic disorder rests solely with the patient, who can make a rational and realistic decision only if he had been given complete and unbiased information by his healthcare provider. This statement is very true, but the healthcare provider must first be able to help a man understand and hopefully remove any barriers that he has identified that prevents him from seeking screening and treatment of BPH. Once the barriers have been identified and discussed, then a man can make a well informed decision on whether or not he wants to seek screening and treatment for BPH.

Many men have set up barriers that prevent them from seeking screening and treatment of BPH. Somers (1994) reported that voiding complaints are generally not volunteered during a medical interview unless the patient is specifically asked about them. Thus, the questionnaire (Addendum A) will provide the healthcare provider the opportunity to remove barriers and facilitate discussions with their male patients regarding signs and symptoms related to BPH.

This study demonstrates the immense problem that BPH can be to men and the negative aspect it can have on their lives. The study outlines the available treatments for BPH, but more importantly, it points out some of the barriers that possibly prevent men from seeking screening and

treatment for BPH. The barriers vary, however, most seem to stem from our cultural society in which men were raised.

The literature was lacking in the area of actual studies done relating to those barriers with any direct relationship to BPH. The literature concerning the Health Belief Model and the variables of interest in this study also showed a paucity of studies investigating the health-promoting behaviors of adult men.

This scarcity of research demonstrates a need for further studies to be done regarding health seeking behaviors of men and the barriers that prevent them from seeking screening and treatment of BPH.

Another paucity in the literature was in regards to the lack of discussion or research of sexual concerns of men and how it relates to seeking screening and treatment of BPH.

CHAPTER IV

METHODS

The questionnaire (Addendum A) was developed to aide the healthcare provider in identifying the barriers that their patients have regarding screening and treatment of BPH so that those barriers can be addressed and removed. This tool will promote discussion with healthcare providers.

The questionnaire was designed to include demographics, signs and symptoms of BPH, and possible barriers preventing men from seeking screening and treatment of BPH.

The demographics section contains information pertinent to age, marital status, race, education, religion, income, and patient's habits regarding visits to healthcare providers as well as the type of healthcare provider. Although the socioeconomic variables are not known to be important with regards to men experiencing BPH, these factors are easily obtained and could be available for future use by a healthcare provider if he/she should desire to review the data of the variables to ascertain which types of patients are likely to experience BPH that they have in their practice.

The section on signs and symptoms was integrated into the questionnaire so that the healthcare provider could have an insight into any urinary difficulties that his/her patient is currently experiencing. The questionnaire will contain the same questions asked to each male patient, thus, the element of inconsistency will be eliminated. Each time

a man visits a healthcare provider he fills out the questionnaire, therefore, there will be no chance of forgetting to inquire or overlook a man's urinary difficulties. This questionnaire can be kept in the patient's chart so that comparisons of urinary changes or difficulties can be made at yearly visits. This would make the questionnaire a valuable tool as healthcare providers would be able to compare any changes in a patients' urinary status from their previous visit with the healthcare provider only having to quickly glance at the questionnaire to note any changes.

The broad range of possible barriers, as well as internal and external cues, was formulated so that a man could in a non-threatening, unbiased manner identify any barriers that prevent him from seeking screening and treatment for BPH. Those barriers cover such areas as fear, cost, pain, etc. The healthcare provider will have the opportunity to review and discuss any barriers that a man has identified while obtaining the subjective data from the examination.

Figure 3 summarizes the different variables utilized in the framework of the questionnaire as they relate to each question.

A limitation of the questionnaire is that the yes/no format utilized does not provide a man an opportunity to deviate from one extreme to the other. The questionnaire forces him to answer completely one way or the other.

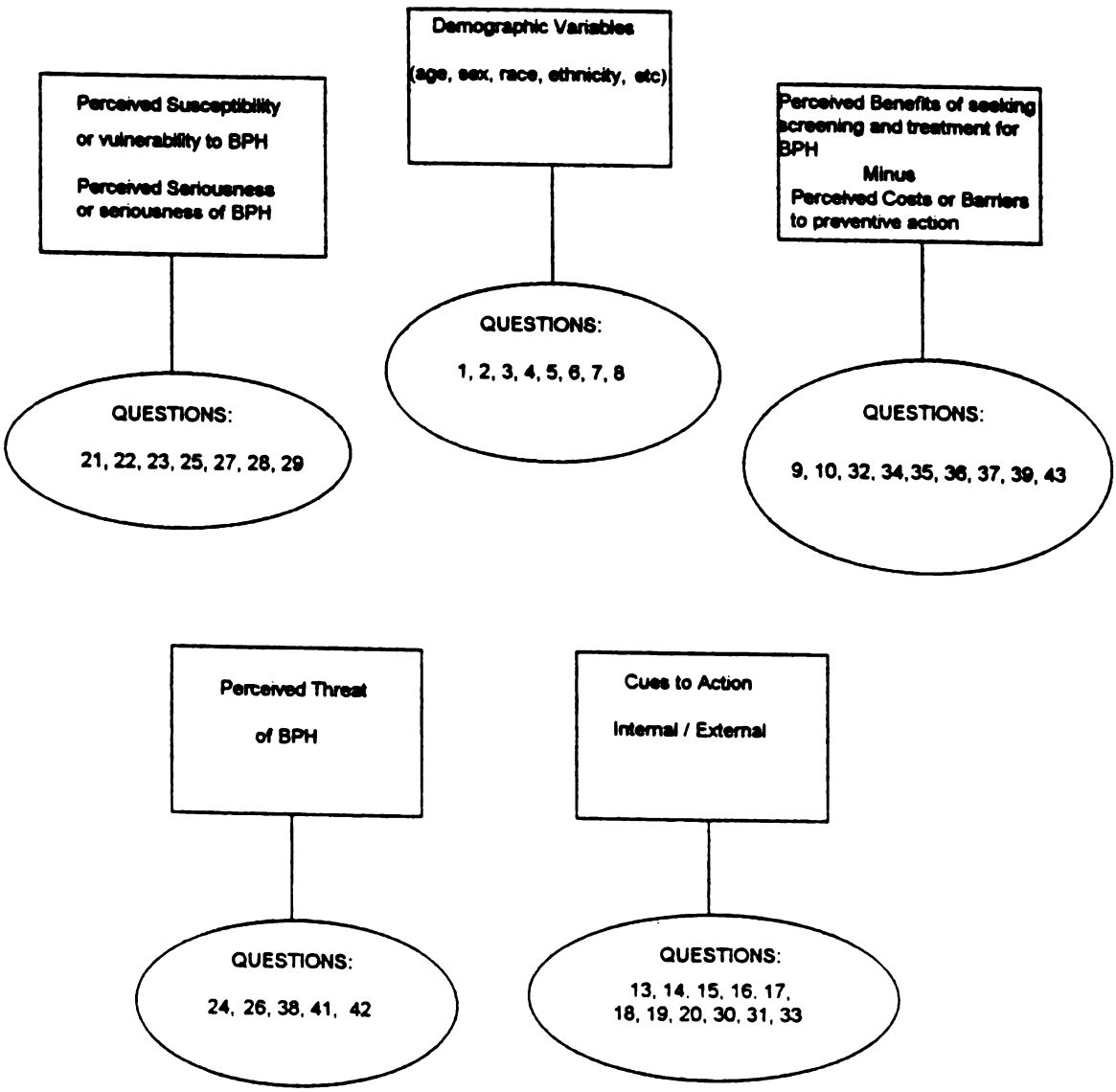

Figure 3. Interaction of variables of Health Belief Model to the Questionnaire.

The questionnaire is designed so that it can be self-administered, thus allowing a man privacy and an unlimited amount of time to ponder and consider each question before answering.

According to Polit and Hungler (1991) self-administered questionnaires eliminate any bias that can be caused by an interviewer as the interactions between respondents and interviewers can affect the subjects response.

The self-administered questionnaire is efficient and can be utilized with a minimal expenditure of money and time. The questionnaire will take about 10 minutes for patients to complete. All dichotomous items are closed-ended.

As stated earlier, these questionnaires can be distributed to men over the age of 45 upon registering at their healthcare providers office, left in the healthcare providers waiting room for easy access, or individually given to patients upon examination.

The preferred method of distribution would be to individually hand one out to all male patients 45 years and older upon registering at the healthcare provider's office. This method would allow the patient adequate time to complete the questionnaire while in the waiting room. This method of distribution would eliminate the possibility of a man not noticing the questionnaire if they were just left in the waiting room, thus not having an opportunity to fill one out. Individually handing the questionnaires would also

eliminate the possibility of a man feeling rushed or hurried to complete the form; particularly if he had already been brought back to an exam room and was anticipating the healthcare providers arrival.

This questionnaire can then be used as a tool for a healthcare provider to recognize, evaluate, and discuss any barriers that a man has identified that would prevent him from seeking screening and treatment of BPH. The questionnaire will open a door of opportunity for the healthcare provider to eliminate any barriers that his/her patient has regarding screening and treatment of BPH. The questionnaire will also heighten awareness of any questions that he has regarding screening and treatment of BPH and give the man an opportunity to discuss it with his healthcare provider. So, all in all, the questionnaire is a win-win situation. The healthcare provider wins because he/she will be able to identify, discuss, and hopefully remove any barriers preventing their patient from seeking screening and treatment of BPH. Healthcare providers may discover barriers that their patient may not have been able to identify or verbalize to them without a questionnaire. More importantly, the patient will win because he will be able to make his healthcare provider aware of any barriers he has regarding BPH in a non-threatening and unbiased manner that could prevent him from seeking screening and treatment of BPH.

CHAPTER V

NURSING IMPLICATIONS

The nursing implications for the use of the questionnaire in the primary care setting are multifaceted. The questionnaire can assist the healthcare provider in primary care to increase awareness of patients experiencing signs and symptoms of BPH. This awareness should lead to an increase in the number of men who will be screened for and diagnosed with BPH which will enable them to be treated at early stages.

The questionnaire can assist healthcare providers in primary care to identify and discuss any barriers that a man has indicated he has regarding BPH. By being able to identify and discuss these barriers with their male patients, the possibility exists that healthcare providers will be able to help their patients remove those barriers.

Utilizing the questionnaire, the Nurse in Advanced Practice can initiate interventions with the patient. The following are examples of such interventions (a) If the patient answers questions on the questionnaire which reveals a lack of perceived susceptibility or vulnerability to BPH, a nurse in advanced practice could provide counseling or educational materials to increase the patients knowledge base of BPH; (b) If a man indicates on the questionnaire that he has symptoms of BPH but does not believe that screening or treatment would be beneficial, the Nurse in Advanced Practice could counsel, as well as educate, the

patient as to the benefits of treatment; (c) If a patient projected on the questionnaire that barriers such as inconvenience, cost, etc. prevented him from seeking treatment, the Nurse in Advance Practice could explore different avenues of problem solving with the patient so that the patient could overcome the barriers.

The questionnaire provides a systematic, non-biased way for healthcare providers in primary care to obtain information from their male patients regarding any signs and symptoms that they may be experiencing in regards to BPH, as well as any barriers that their patients have regarding BPH. These areas of discussion may not be comfortable for male patients to initiate, therefore, the use of the questionnaire will greatly facilitate conversation and assist healthcare providers in primary care to provide information and remove any barriers that their male patients may have regarding BPH.

The three examples that follow represent possible responses that men could indicate on their questionnaires.

Example 1: A 58 year old male circles "yes" to questions 13, 14, 16, 17, and 20. By quickly glancing at the responses to the above questions, the healthcare provider will easily recognize that the man is experiencing several symptoms of BPH. With a minimal amount of time spent to obtain this information, the healthcare provider is able to identify the cues to action and proceed directly to

discussing these symptoms with the patient and possible methods of treatment.

Example 2: A 65 year old male circles "no" to questions 10, 32, 36, and 39. By looking at the questionnaire, the healthcare provider would be tuned in to the fact that their patient has some concerns or doubts regarding the perceived benefits of preventive action regarding screening and treatment of his prostate. The questionnaire will lend the healthcare provider with a tool to discuss these concerns and hopefully be able to remove the barriers preventing the patient form believing that screening and treatment would not be beneficial.

Example 3: A 70 year old male answers yes to questions 21, 22, 27, and 29. The healthcare provider will be able to recognize that the man is experiencing perceived susceptibility and perceived seriousness of BPH. This gives the healthcare provider an excellent opportunity to educate their patient on the available treatment modalities for BPH, as well as alleviate their fears and remove their barriers regarding BPH.

All of the questions in the questionnaire are important and pertinent, however, if a man answers questions 21, 22, 38, 41, 45, and 46 affirmatively or questions 24, 26, 27, or 32 negatively, these should be red flags to the healthcare provider. Responses to the questions as given above indicates that a man has set up barriers that prevent him

from seeking screening and treatment of BPH. Barriers that could be discussed and hopefully removed.

A Nurse in Advanced Practice focusing on the issue of BPH as it affects the men in their practice primarily and the family unit secondarily could utilize the questionnaire in many ways. As stated several times in this paper, the questionnaire can be used strictly as a tool to investigate an individuals urinary dysfunction related to BPH and any barriers associated with seeking treatment. In the broader and perhaps ultimately more useful sense, the questionnaire can become a tool to identify who is at risk for BPH and is not seeking treatment and therefore needs to be targeted by the Advanced Practice Nurse.

Nurses in Advanced Practice, as well as other healthcare providers, can use the questionnaire to obtain different statistics of research of the men in their practice with BPH. For instance, a yearly tabulation could be done on the average age, presenting symptoms, and barriers that men have identified that prevented them from seeking screening and treatment of their prostate. By having this information, the healthcare provider in primary care would know exactly the average age of their patients' presenting with BPH as well as the most frequently presenting symptoms and the most common barriers that prevent their male patients from seeking screening and treatment for BPH. Research could also be done in the area of internal and external cues. By obtaining information

from the questionnaire, a Nurse in Advanced Practice could determine which cues were identified as influential to having the patient seek screening and treatment. Having this knowledge, the healthcare provider in primary care could alter their practice to best meet the needs of their patients.

The data gathered from the questionnaire by one Advanced Practice Nurse could be made available to others, thus making it easier for the next Advanced Practice Nurse working in a similar setting to anticipate particular barriers and therefore plan appropriate and effective interventions. Interventions such as patient education, community education and seminars, articles in the local paper, or public serve announcements on the radio can focus or prevent barriers.

A research question that could be elicited from the questionnaire would be if socioeconomics relates to the incidence of BPH. With the use of the questionnaire, research could also be done by comparing answers on questions to determine if BPH is more prevalent in different geographic settings. An example of this would be if one Advanced Practice Nurse worked predominantly in the rural, farm belt area, another worked in inner cities, one in the south, while yet another one in the west, etc. Answers on the questionnaires from the different areas could be compared to determine if geographic settings made a difference in BPH. Research could also be done to determine

if men who received their healthcare from Advanced Practice Nurses as opposed to other healthcare provider groups reported more or less symptoms of BPH, revealed more or less barriers to screening and treatment or BPH, etc. Use of the questionnaire could also determine if BPH crosses racial, ethnic, or social class boundaries.

It is suggested that this questionnaire be distributed to all healthcare providers in primary care in a designated area with a letter of explanation of its intent and potential benefits. Evaluation and effectiveness of the questionnaire could be made at one, six, and twelve month intervals. This evaluation and effectiveness could be made from information obtained from healthcare providers as to any increases they are experiencing with their patients verbalizing signs, symptoms, or barriers of BPH after the initiation of the questionnaire, the percentage of charts of male patients with completed questionnaires and the increase in the percentage of men screening for BPH, as well as the percentage of men being treated in their practice for BPH before and after the initiation of the questionnaire.

The questionnaire carries educational implications and could be utilized by nursing schools. Nursing students could utilize the questionnaire with their male patients over the age of 45. The benefit would be that the nursing students would gain the knowledge of the signs and symptoms that their patients were experiencing regarding BPH, as well as learn what possible barriers that men have regarding BPH.

Different areas of the country could find it useful to highlight specific areas and questions on the questionnaire related to BPH based upon studies of "their" population.

In summary, there are many implications for nurses in advanced practice. Implications for education to assist a patient to remove any barriers that they might have regarding screening and treatment of BPH. Implications for areas of research that could be done by utilizing the questionnaire, and educational opportunities derived from the use of the questionnaire.

LIST OF REFERENCES

REFERENCES

Algaba, F. (1994). Pathophysiology of benign prostatic hyperplasia. Euro Urol, 25(suppl. 1), 3-5.

Arrighi, H., Metter, E.J., Guess, H.A., & Fozzard, J.L. (1991). Natural history of benign prostatic hyperplasia and risk of prostatectomy. Supplement to Urology, 38(1), 4-8.

Barry, M.J. (1990). Epidemiology and natural history of benign prostatic hyperplasia. Urologic Clinics of North America, 17(3), 495-505.

Barry, M.J. (1990). Medical outcomes research and benign prostatic hyperplasia. The Prostate Supplement, 3, 61-74.

Becker, M.H., Haefner, D.P., Kasl, S.V., Kirscht, J.P., Maiman, L.A., Rosenstock, I.M. (1977). Selected psychosocial models and correlates of individual health-related behaviors. Medical Care, 15(5), 27-46.

Benson, M.C., Whang, I.S., Pantuck, A., Ring, K., Kaplan, S.A., Olsson, C.A., & Cooner, W.H. (1992). Prostate specific antigen density: A means of distinguishing benign prostatic hypertrophy and prostate cancer. The Journal of Urology, 147, 815-816.

Blanchard, E.B. (1992). Introduction to the special issue on behavioral medicine: An update for the 1990's. Journal of Counseling and Clinical Psychology, 60(4), 491-492.

Boccon-Gibod, L. (1991). Benign prostatic hyperplasia: Surgical versus nonsurgical treatment. Eur Urol, 20(suppl 2), 59-62.

Bosch, R.J. (1991). Pathogenesis of benign prostatic hyperplasia. Euro Urol, 20(suppl 2), 27-30.

Bostwick, D.G., Cooner, W.H., Denis, L., Jones, G.W., Scardino, P.T., & Murphy, G.P. (1992). The association of

benign prostatic hyperplasia and cancer of the prostate. Cancer Supplement, 70(1), 291-299.

Boyle, P., McGinn, R., Maisonneuve, P., & Vecchia, C.L. (1991). Epidemiology of benign prostatic hyperplasia: Present knowledge and studies needed. Euro Urol, 20(suppl. 2), 3-10.

Butler, R.N. (1994). Why can't men be more like women? Geriatrics, 49(5), 11.

Bruskewitzm, R.C. (1992). Benign prostatic hyperplasia: Drug and nondrug therapies. Geriatrics, 47(12), 39-45.

Calman, N.S., Hyman, R.B., Licht, W. (1992). Variability in consultation ranges and practitioner level of diagnostic certainty. The Journal of Family Practice, 35(1), 31-36.

Castro, E.P., Chaussy, C., Concort, P., Milroy, D.E., Nordling, J., Rigondet, G., & Zerbib, M. (1992). International consultation on BPH sponsored by WHO. Report of the sub-group on other non medical treatment. Arch. Esp. de Urol, 45(7), 723-743.

Chute, C. G., Stephenson, W.P., Guess, H.A., & Lieber, M. (1991). Benign prostatic hyperplasia: A population-based study. Euro Urol, 20(suppl. 2), 11-17.

Chute, C.G., Panser, L.A., Girman, C.J., Oesterling, J.E., Guess, H.A., Jacobsen, S.J., & Lieber, M.M. (1993). The prevalence of prostatism: A population based survey of urinary symptoms. The Journal of Urology, 150, 85-89.

Cockett, A.T., Barry, M.J., Holtgrewe, H.L., Sihelnick, S., Williams, R., & McConnell, J. (1992). Indications for treatment of benign prostatic hyperplasia. Cancer Supplement, 70(1), 281-283.

Daneshgari, F., & Crawford, E.D. (1993). Benign prostatic disease. Postgraduate Medicine, 93(7), 86-90.

Dubbert, P.M.(1992). Exercise in behavior medicine. Journal of Counseling and Clinical Psychology, 60(4), 613-618.

Durham, J.D., & Cohen, F.L. (1986). Men's health: Forward. Nursing Clinics of North America, 21(1), 1-2.

Epstein, R.S., Lydick, E., Delabry, L., & Vokonas, P.S. (1991). Age related differences in risk factors for prostatism for benign prostatic hyperplasia: The VA normatice aging study. Supplement to Urology, 38(1), 9-12.

Eri, L.M., & Tveter, K.J. (1992). Measuring the quality of life of patients with benign prostatic hyperplasia. Eur Urol, 21, 257-262.

Garraway, W.M., Russell, E.B., Lee, R.J., Collins, G.N., Hehir, M., McKelvie, G.B., & Rogers, A.C. (1993). Impact of previously unrecognized benign prostatic hyperplasia on the daily activities of middle-aged and elderly men. British Journal of General Practice, 43, 318-321.

Geller, J. (1989). Overview of benign prostatic hypertrophy. Supplement to Urology, 34(4), 57-96.

Geller, J. (1992). Nonsurgical treatment of prostatic hyperplasia. Cancer Supplement, 70(1), 339-343.

Goluboff, E., & Olsson, C.A., (1994). Urologists on a tightrope: coping with a changing economy. The Journal of Urology, 151, 1-4.

Gormley, G.J., Stoner, E., Bruskewitz, R.C., Imperato, J., Walsh, P.C., McConnel, J.D.,Andriole, G.L., Geller, J., Bracken, B.R., Tenover, J.S., Vaughan, E.D., Pappas, F., Taylor, A., Binkowitz, B., Ng, J. (1992). The effect of finasteride in men with benign prostatic hyperplasia. New England Journal of Medicine, 327, 1185-1191.

Gormley, G.J., Stoner, E., Bruskewitz, R.C., Imperato, J., Walsh, P.C., McConnell, J.D., Andriole, G.L., Geller, J., & Tenover, J.S. (1993). Benign and malignant neoplasms of the prostate. The Journal of Urology, 149, 932-955.

Grayhack, J.T. (1992). Benign prostatic hyperplasia. Cancer Supplement, 70(1), 275-279.

Guess, H.A. (1994). The Natural history of benign prostatic hyperplasia: Implications for patient care and clinical trial design. Euro Urol, 25(suppl. 1), 10-14.

Hardy, M.E. & Conaway, M.E. (1988). Role Theory: Perspectives for Health Professionals (2nd ed.)(pp. 378-381). Norwalk, Ct: Appleton & Lange.

Hickey, T. (1994). Self care behavior of older adults. Public Health Reports, 109(3), 379-388.

Isaccs, J.T. (1994). Etiology of benign prostatic hyperplasia. Euro Urol, 25(suppl. 1), 6-9.

Jonler, M., Riehmann, M., & Bruskewitz, R.C. (1994). Benign prostatic hyperplasia: Current pharmacological treatment. Benign Prostatic Hyperplasia, 47(1), 66-81.

Kane, M.M., Fields, D.W., & Vaughan, E.D. (1990). Medical management of benign prostatic hyperplasia. Supplement to Urology, 36(5), 5-12.

Kirby, R.S. (1992). The clinical assessment of benign prostatic hyperplasia. Cancer Supplement, 70(1), 284-290.

Kitagawa, N., Ichikawa, T., Akimoto, S., & Shimazaki, J. (1994). Natural course of human benign prostatic hyperplasia with relation to urinary disturbance. The Prostate, 24, 279-284.

Krieg, M., Nass, R., & Tunn, S. (1993). Effect of aging on endogenous level of 5@ dihydrotestosterone, testosterone, estradiol, and estrone in epithelium and stroma of normal and hyperplastic human prostate. Journal of Clinical Endocrinology and Metabolism, 77(2), 375-380.

Lee, Fred, & Littrup, P.J. (1992). The role of digital rectal examination, transrectal ultrasound, and prostate specific antigen for the detection of confined and clinically relevant prostate cancer. Journal of Cellular Biochemistry, 16, 69-73.

Leigh, J.P., & Fries, J.F. (1992). Health habits, health care use and costs in a sample of retirees. Inquiry, 29, 44-54.

Lepor, H., & Machi, G. (1993). Comparison of AUA symptom index in unselected males and females between fifty-five and seventy-nine years of age. Urology, 42(1), 36-41.

Lilja, J. (1993). Significance of different molecular forms of serum PSA. Urological Clinics of North America, 20(4), 681-686.

Loughlin, K.R. (1991). Medical and nonmedical therapies for benign prostatic hypertrophy. Geriatrics, 46(6), 26-34.

Matzkin, H., & Braf, Z. (1991). Endocrine treatment of benign prostatic hypertrophy: Current concepts. Urology, 37(1), 1-12.

McConnell, J.D. (1991). The pathophysiology of benign prostatic hyperplasia. Journal of Andrology, 12(6), 356-362.

McNeal, J. (1990). Pathology of benign prostatic hyperplasia. Urologic Clinics of North America, 17(3), 477-486.

Monda, J.M., Barry, M.J., & Oesterling, J.E. (1994). Prostate specific antigen cannot distinguish stage T1a prostate cancer from benign prostatic hyperplasia. The Journal of Urology, 151, 1291-1295.

Moul, J.W. (1993). Benign prostatic hyperplasia: New concepts in the 1990's. Postgraduate Medicine, 94(6), 141-154.

Muhlenkamp, A.F., & Sayles, J.A. (1986). Self-esteem, social support, and positive health practices. Nursing Research, 35, 334-338.

Oesterling, J.E. (1991). The origin and development of benign prostatic hyperplasia: An age-dependent process. Journal of Andrology, 12(6), 348-355.

Pagano, F., Zattoni, F., Vianello, F., Piazza, G., & Capitanio, G. (1991). Is there a relationship between benign prostatic hyperplasia and prostatic cancer? Euro Urol, 20(suppl. 2), 31-35.

Payne, C.K., Babiara, J.W., & Raz, S. (1994). Genitourinary problems in the elderly patient. Surgical Clinics of North America, 74(2), 401-427.

Petrovich, F.A., Baert, H.B., Boyd, S.D., Brady, L.W., Bruskewitz, D.C., Dixon, C., Perrin, P., & Watson, G.M. (1993). Trends in treatment of benign prostatic hyperplasia and carcinoma of the prostate. American Journal Clinical Oncology, 16(3), 187-200.

Ploch, N.R., & Brawer, M.K. (1994). How to use prostate specific antigen. Supplement to Urology, 43(2), 27-33.

Polit, D.F., & Hungler, B.P. (1991). Nursing research: Principles and methods (4th ed.). Philadelphia: J.B. Lippincott.

Rice, R. & Atkin, M.J. (1987). Public Communications Campaigns. New York: pp. 80-87.

Roberts, R.G. (1994). Novel idea in BPH guideline: The patient as decision maker. American Family Physician, 49(5), 1044-1051.

Roberts, R.O., Rhodes, T., Panser, L.A., Girman, C.J., Chute, C.G., Oesterling, J.E., Lieber, M.M., & Jacobsen, S.J. (1994). Natural history of prostatism: Worry and embarrassment from urinary symptoms and health care-seeking behavior. Urology, 43(5), 621-622.

Schlegel, P.N. (1994). Medical management of prostatic diseases. Advances in Internal Medical, 39, 569-601.

Somers, W.J., & Badalament, R.A. (1994). When do symptoms add up to BPH? Contemporary Urology, 34-40.

Stoller, E.P., & Pollow, R. (1994). Factors affecting the frequency of health enhancing behaviors by the elderly. Public Health Reports, 109(3), 377-378.

Tsang, K.K., & Garraway, W.M. (1993). Impact of benign prostatic hyperplasia on general well-being of men. The Prostate, 23, 1-7.

Wiley, J.A., & Camcho, T.C. (1980). Life-style and future health: Evidence from the Alameda county study. Preventive Medicine, 9, 1-21.

Wu, J.T. (1994). Assay for prostate specific antigen (PSA): Problems and possible solutions. Journal of Clinical Laboratory Analysis, 8, 51-62.

ADDENDUM

ADDENDUM A

BPH

A SELF-ADMINISTERED QUESTIONNAIRE

Please circle the information which best describes you for each question.

1. AGE: 45-49 50-59 60-69 70-79 80 +

2. MARITAL STATUS: Single Married Widowed Divorced

3. RACE: Cauc. Black Native Am. Asian Other

4. HIGHEST GRADE COMPLETED: Grade School Secondary School High School College

5. RELIGION: Protestant Catholic Jewish Other None

6. INCOME LEVEL: Under $10,000 $10,000-$19,999 $20,000-$29,999 $30,000-$39,999 $40,000-$49,999 over $50,000

7. LAST VISIT TO HEALTHCARE PROVIDER: Never 0-1 yr 1-3 yrs 3-5 yrs 5-8 yrs 8-10 yrs 10-15 yrs over 15 yrs

8. WHOM DO YOU SEEK FOR HEALTH CARE: Specialist Family Physician Nurse Practitioner Walk-in Clinic None

9. HAVE YOU EVER HAD YOUR PROSTATE CHECKED BY RECTAL EXAM? YES / NO

10. IF YES, DID YOU ASK TO HAVE YOUR PROSTATE CHECKED? YES / NO

11. DO YOU CURRENTLY HAVE SYMPTOMS OF PROSTATE TROUBLE? YES / NO

12. IF YES, DO YOU THINK THAT THE PROBLEM CAN GET WORSE IN THE FUTURE? YES / NO

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

13. A WEAK STREAM? YES / NO

14. A NEED TO STRAIN TO START URINE STREAM? YES / NO

15. A SENSE OF INCOMPLETE EMPTYING? YES / NO

16. CONSTANT DRIBBLING? YES / NO

17. THE NEED TO GET UP MORE THAN TWICE DURING THE NIGHT TO URINATE? YES / NO

18. URINATING FREQUENTLY? YES / NO

19. URGENCY TO URINATE? YES / NO

20. AVOID GOING PLACES WITHOUT AN AVAILABLE RESTROOM? YES / NO

DO YOU BELIEVE ANY OF THE FOLLOWING TO BE TRUE?

21. THAT PROSTATE TROUBLE IS WORSE THAN CANCER? YES / NO

22. THAT PROSTATE TROUBLE IS WORSE THAN HEART DISEASE? YES / NO

23. THAT PROSTATE TROUBLE COULD INTERFERE WITH YOUR LIFE-STYLE? YES / NO

24. THAT ANYTHING CAN BE DONE FOR PROSTATE TROUBLE? YES / NO

25. THAT HAVING YOUR PROSTATE CHECKED IS BENEFICIAL? YES / NO

26. THAT YOU COULD DEVELOP A COMPLICATION FROM HAVING YOUR PROSTATE CHECKED? YES / NO

27. THAT THERE IS EFFECTIVE TREATMENT FOR PROSTATE PROBLEMS? YES / NO

28. THAT YOUR HEALTHCARE PROVIDER CAN DETERMINE IF YOU HAVE PROSTATE TROUBLE BY DOING A RECTAL EXAM? YES / NO

29. THAT YOUR HEALTHCARE PROVIDER COULD EFFECTIVELY TREAT YOU IF SHE/HE FOUND OUT THAT YOU HAD PROSTATE PROBLEMS? YES / NO

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS

30. DO YOU HAVE TRUST IN YOUR HEALTHCARE PROVIDER FOR EXAM? YES / NO

31. DO YOU KNOW A FRIEND WHO HAS PROSTATE TROUBLE? YES / NO

32. IF YOU DEVELOPED PROSTATE PROBLEMS WOULD YOU SEEK TREATMENT? YES / NO

33. HAS YOUR FAMILY AND/OR FRIENDS EVER ENCOURAGED YOU TO HAVE YOUR PROSTATE CHECKED? YES / NO

34. HAVE YOU READ ABOUT PROSTATE SCREENING AND TREATMENT IN THE PAPER AND/OR MAGAZINES? YES / NO

35. WOULD COST BE A FACTOR IN HAVING YOUR PROSTATE CHECKED? YES / NO

36. DO YOU HAVE HEALTH CARE INSURANCE TO COVER HEALTH PROMOTION? YES / NO

37. IF YOU HAVE INSURANCE, DOES IT PAY FOR SCREENING OF THE PROSTATE? YES / NO

38. ARE YOU BE AFRAID TO HAVE YOUR PROSTATE CHECKED? YES / NO

39. WOULD TIME RESTRAINTS KEEP YOU FROM HAVING YOUR PROSTATE CHECKED? YES / NO

40. WOULD THE DISTANCE THAT YOU HAVE TO TRAVEL TO A HEALTHCARE PROVIDER KEEP YOU FROM HAVING YOUR PROSTATE CHECKED? YES / NO

41. WOULD FEAR OF GOING TO A HEALTHCARE PROVIDER KEEP YOU FROM SEEKING SCREENING AND TREATMENT FOR YOUR PROSTATE? YES / NO

42. ARE YOU AFRAID THAT YOU WILL BE DIAGNOSED WITH PROSTATE TROUBLE IF YOU HAVE YOUR PROSTATE CHECKED? YES / NO

43. DO YOU THINK THAT THERE IS A BENEFIT TO HAVING YOUR PROSTATE CHECKED? YES / NO

44. WOULD THE INCONVENIENCE OF TRAVELING TO YOUR HEALTHCARE PROVIDER PREVENT YOU FROM HAVING YOUR PROSTATE CHECKED? YES / NO

45. ARE YOU AFRAID THAT SEXUAL PROBLEMS COULD DEVELOP FROM PROSTATE PROBLEMS? YES / NO

46. HAVE YOU HAD FRIENDS WITH PROSTATE PROBLEMS WHO HAD SEXUAL PROBLEMS? YES / NO