SEXUAL COUNSELING OF THE POST MYOCARDIAL INFARCTION CLIENT

A THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF MASTER OF SCIENCE

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

SUSAN M. SHEA, B.S.N.

DENTON, TEXAS

MAY 1986

TEXAS WOMAN'S UNIVERSITY
DENTON, TEXAS

February 14, 1986
Date

To the Provost of the Graduate School:

I am submitting herewith a thesis written by Susan Shea entitled "Sexual Counseling of the Post Myocardial Infarction Client." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Nursing.

Lorraine Wolf
Lorraine Wolf, Major Professor

We have read this thesis and recommend its acceptance:

Tommy Waverly
Carolyn Adamson

Accepted

Leslie M. Thompson
Provost of the Graduate School

DEDICATION

This paper is dedicated to:

My Mother and Father for their encouragement and faith,

My Children for their patience, and

My Husband for his support and understanding.

ACKNOWLEDGEMENTS

I would like to thank Dr. Maruri, Dr. Nodarse, Dr. Prakash, and my subjects for their help and cooperation in making this study possible.

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Susan Shea, B.S.N.

May 1986

ABSTRACT

The purpose of the study was to determine if nurses were promoting sexual health by providing sexual health counseling. The population for the study consisted of cardiac clients who had a diagnosis of myocardial infarction. A sample of convience was obtained. The instrument used was the Sexual Counseling Measure. It consisted of three parts: content, adequacy, and satisfaction. The questionnaire was administered in the subjects' homes. The data were analyzed per question into frequencies and percentages of responses. Cross tabulations for comparison and consistency of responses were done for specific items of the instrument. The following conclusions were based on the findings of the study:

1. Nurses provided only 20% of the sexual counseling to post myocardial infarction clients.

2. The clients perceived the information they received as specific and satisfactory in assisting them to resume sexual relations post infraction.
3. Post mocardial infarction clients do want sexual counseling.

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CHAPTER I

INTRODUCTION

Three-quarters of a million people will survive a myocardial infarction in the United States each year. Of those individuals surviving a myocardial infarction, only 25% of the couples sexually active prior to the infarction will resume sexual activity (Stein, 1977). Once the immediate fear of death is no longer paramount, concerns about adjustment to living and the various parameters of life performance that make up the individual's body image become apparent. Significant among those factors is the individual's view of himself as a sexually capable person.

The individual's body image influences his self-concept and self-esteem and has an impact on his sexual self, on his sexual functioning and on sexual roles and relationships. Lion (1982) stated that the internal or external appearance and functioning of the body can be altered by a chronic illness. This alteration may be perceived as a movement away from wholeness and normality and thus may disturb the person's security and threaten self-esteem. Any alteration that is not consistent with the individual's established body image may be accompanied by a loss of self-esteem,

feelings of abandonment and powerlessness, loss of control, loss of competence in the sexual role, and disturbance of interpersonal relationships (Lion, 1982).

Since sexuality is a major aspect of the human experience in both health and illness, nurses can intervene to maintain or help individuals attain sexual integrity which may be threatened by illness and/or hospitalization. By promoting the sexual health of the individual, the nurse views the client as a whole and knows that he cannot be separated into biological, psychological, sociocultural, and spiritual components. Thus, the concept of sexual health implies a positive and holistic approach to the health care of the individual.

Problem of Study

The purpose of this study was to determine if nurses are promoting sexual health by providing sexual health counseling. Are nurses as health professionals providing sexual counseling to post myocardial infarction clients?

Justification of Problem

According to Hogan (1980), sexuality is a basic need that is intrinsic to one's being and an aspect of humanness that cannot be divorced from life events. As a basic need, it should be one of the essential foci of health care.

Maslow (1970) stated that basic physiological needs are the most predominant of all the needs. Sexuality is part of the natural physiologic functioning of the human being; therefore, sexual counseling must be included in health teaching. Lion (1982) stated that the World Health Organization defined sexual health care as "the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love" (p. 8). The nurse, by promoting sexual health, is not only assisting the individual to satisfy a basic need, but is caring for the whole person and not just the individual parts.

Studies have shown that one of the major causes of a decrease in sexual activity following a myocardial infarction is a lack of information (Lion, 1982). Tuttle, Cook, and Fitch (1964) found that two-thirds of the myocardial infarction clients they studied had received no advice regarding sexual activity and had a marked and lasting reduction in the frequency of intercourse. The other one-third received vague and nonspecific advice. These investigators concluded that the change in behavior was based on fear and misinformation. A reduction in sexual activity was also found in a study conducted by Horgan and Craig (1978) of 100 myocardial infarction clients. They found that failure to provide

adequate information resulted in anxiety symptoms in 46 of the clients and 65 believed resumption of sexual activity would result in another heart attack. This lack of information resulted in a reduction of sexual activity in over half of the sample.

Not only does the client need sexual counseling but so does the spouse. Fear and anxiety on the part of either partner may have negative effects on sexual activity. Skelton and Dominion (1973), who studied 65 wives of myocardial infarction clients, found that feelings of loss, depression, anxiety, and guilt were commonly experienced. The period of convalescence was very stressful for the wives because of their sense of loss and fear of recurrent infarction, and by the marital tension that was caused by the husband's increased irritability and dependency. Papadopoulos, Larrimore, Cardin, and Shelley (1980) interviewed 100 wives of post myocardial infarction clients. They found that 31 wives had questions regarding sexual activity while their husband were in the hospital. After discharge, all the wives developed concerns. Forty-five wives received some information prior to their husband's discharge. These women believed that the information they received was incomplete. Larter (1967) also concluded that wives of myocardial infarction clients found their lives

to be most affected in the areas of communication and sexual relations.

A myocardial infarction may also be perceived as a threat to the individual's body image. For many men, sexual function is intimately connected with body image (Siemens & Brandzel, 1982). To many men, a heart attack means the loss of courage, love, and manliness and signifies dependency, incapacity, and inactivity with a resulting threat to sexual self-esteem and identity (Hogan, 1980). Because of lowered self-esteem, cardiac clients may view themselves as less effective spouses, parents, and workers. Sexual activities may be affected by fear of sexual performance and speculation about sexual capabilities. If this self-concept continues, the individual may become a "cardia cripple," frightened to return to work, leisure activities, sex, and society. Therefore, if the cardiac client and the spouse are to resume a normal life, some type of sexual counseling must be included in the post-coronary teaching program (Okoniewski, 1979).

Conceptual Framework

Changes in health can present some complex psychosocial and psychosexual situations that may influence the sexuality of individuals and families. An individual's emtoional and psychological adjustment to a chronic illness is dependent

on past experiences, present resources, and the hope of remaining a whole person, including a sexual person. Each individul attempts to resolve conflicts between personal sexual identity and the stress that is created by a particular illness. The degree and influence a health disruption has on sexuality varies, depending on a variety of factors revolving around self, family, psychosocial environment, and professional or treatment resources (Mims & Swenson, 1980).

A drastic change to the dependent state, required during hospitalization or long bouts of illness, decreases self-worth and can have an adverse effect on the sexual self-concept (Mims & Swenson, 1980). Sexuality can be the key factor in maintaining a sense of wholeness and self-worth that is threatened by prolonged or serious illness and dependency. The client should be encouraged to develop compensating mechanisms in order to reengage in social, sexual, and work opportunities which may help maintain or reestablish a positive self-image. Sexuality, then, may be the main catalyst for rehabilitation (Mims & Swenson, 1980).

The World Health Organization defined the concept of sexual health which gives focus for nursing education and for areas of nursing intervention. There are three elements of sexual health. The first element of sexual health is a

capacity to enjoy and control sexual and reproductive behavior in accordance with the individual's social and personal ethics. The second element is freedom from fear, shame, guilt, false beliefs, and other psychologic factors that may inhibit sexual response and impair sexual relationships. The third element is freedom from organic disorders, diseases, and deficiencies that may interfere with the sexual and reproductive functions (Hogan, 1980).

The role of the nurse in promoting sexual health is that of educator and counselor. As an educator the nurse provides accurate information, clarifies personal attitudes and values, and increases acceptance of sexual values and behaviors in self and others. The goal for the nurse is to provide reliable information that will enable clients to make responsible decisions about sexuality not only for themselves but also in their relationships with others (Lion, 1982). When clients need someone to whom they can express their feelings, someone who can offer understanding and support, and who can provide reliable information and direction in sexual concerns, the role of counselor is activated.

A sexual health knowledge base is necessary in order for nurses to develop attitudes and behaviors based on factual and current information rather than on myths or

misconceptions. The basic nursing skill used in providing sexual health counseling is communication. Nurses who are comfortable with their own sexuality and the sexuality of others, who have a sexual health knowledge base, and who cultivate sensitive and perceptive skills can effectively integrate sexuality into the nursing process (Lion, 1982).

For nurses to be effective in providing sexual health care, they must first develop a sound and comprehensive body of knowledge about sexuality. Second, they must be able to confront their feelings, values and attitudes about sexuality not only in themselves but also in those differing in sexual orientation and practices. Third, they must be able to develop assessment, intervention, and communication skills in all aspects of sexual health (Mims & Swenson, 1980). Therefore, the Mims-Swenson Sexual Health Model provides nurses with a framework for self-assessment, client assessment, intervention and planning nursing education. Mims and Swenson (1978) used Annon's Permission-Limited Information-Specific Suggestions-Intensive Therapy Model as the basis for their Sexual Health Model. The Mims-Swenson Sexual Health Model is composed of four ascending levels with each focusing on behaviors or activities and building on the preceding level. The four levels are life experience, basic, intermediate, and advanced.

The life experience level includes both destructive and intuitively helpful behaviors that a person develops from life experience in a society which continuously gives double and confusing messages regarding sexuality. Sexual attitudes, beliefs, and values are influenced by the complicated interplay of physiological, psychological, and social forces. The destructive behaviors are based on myths, stereotypes, taboos, and fears that are culturally determined. The positive behaviors or intuitive interactions are highly dependent on the quantity and quality of life experiences of the individual (Mims & Swenson, 1980). The problem encountered at this level is the separation of destructive behaviors from those that would facilitate sexual health. Practitioners who operate exclusively from the life experience level may be providing a haphazard method of delivering sexual health care.

The second, or basic, level begins to employ the nursing process and is based on awareness of one's cognitions, attitudes, and perceptions of sexuality. To be effective practitioners, nurses have to reorganize basic facts about themselves and their clients. The nurse must be able to acknowledge how self emotions and sexual values will affect therapeutic intervention. The nurse's values, concerns, and personal experiences must be separated from

from those of the client (Mims & Swenson, 1980). In order to accomplish this the nurse must clarify self values before attempting to assist the client in value clarification. Awareness is necessary in order to acknowledge, identify, and promote sexual health. An awareness and acceptance of the changing values, issues, and behaviors provides a working base for the other levels of intervention (Mims & Swenson, 1980).

The third, or intermediate level, includes communication skills that promote permission and information giving. In the nursing process, communication, counseling, and teaching skills are used at this level. Permission often begins with the taking of the suxual history when the practitioner conveys to the client that sexuality is an important component of health (Mims & Swenson, 1980). By taking a sexual history the nurse gives the client permission to talk about sex. Permission giving may begin when the nurse acknowledges the client's verbal and nonverbal messages. Many clients only need reassurance that they are normal and by providing permission to continue doing exactly what they have been doing may be sufficient in some cases to resolve what might eventually become a very major problem (Annon, 1976). Permission giving may also be giving the client permission to engage in certain sexual

behaviors if he or she chooses to do so.

Clients with short and long term illnesses may have doubts, concerns, and fears that may lead to false assumptions. This fear, ignorance, and misinformation may prevent clients from enjoying sexual activities. The nurse must assess the client's needs before giving permission or information. Nurses must also assess themselves so as not to impose their biases on the client, as well as to acknowledge their limitations regarding sexual concerns. Permission giving will certainly not solve all sexual problems. It can, however, be used in almost any setting at any time. It takes minimal preparation and can be used to cover a number of areas of concern, such as thoughts, fantasies, dreams, and feelings, as well as overt behaviors. However, without providing accurate information to the client, permission giving could be detrimental (Annon, 1976).

Clients need to have basic and factual information concerning anatomy, physiology, and the sexual response cycle in relation to their specific concern. Skills in counseling and patient teaching will be helpful in providing needed information to promote sexual health. Clients have the need and the right to know that certain disease processes, medications, operations, and other treatments

may be responsible for changes in their sexuality (Mims & Swenson, 1980). Frustration, anger, fear, guilt, distrust, and suspicion between partners can often be alleviated or held to a minimum when accurate information is given to both partners about a developing or existing physical and/or mental health condition.

In providing limited information the clinician must remember to provide information that is directly relevant to the client's concern (Annon, 1976). How clinicians use the limited information approach will depend upon depth of knowledge in the sexual area. How they present this information will depend upon the style that they feel most comfortable with and the manner of presentation that they feel will be most beneficial to the client (Annon, 1976). The degree to which clinicians use the limited information level will depend upon their depth of knowledge, theoretical orientation, and value system. The limitations imposed by these factors are the same as those imposed for permission giving.

The fourth, or advanced, level of the Mims-Swenson Sexual Health Model includes suggestion giving, therapy, educational programs, and research projects. Suggestion giving requires specialized knowledge and training of the specific conditions of sexuality. Various techniques,

different positions, specific exercises, and methods of communication that may be used in order to achieve sexual gratification may be given to the client in the form of specific suggestions (Mims & Swenson, 1980).

Before clinicians can give specific suggestions they must first obtain the necessary information. Unlike the basic and intermediate levels which give the client the opportunity to decide if he will change his behavior, specific suggestions are direct attempts to help the client change previous patterns of behavior. Specific suggestions are used within a brief therapy framework which means that the approach is time and problem limited. Most of the suggestions given are those that can be used by a clinician who has only a relatively brief period of time, 10 to 30 minutes, and in those situations where the client is seen on one or several occasions at the most (Annon, 1976).

If the suggestions are not helpful within a relatively brief period of time, then intensive therapy is probably more appropriate. The effectiveness of using specific suggestions will depend on the clinicians' depth of knowledge in the behavioral and sexual area, their skill and experience, and their awareness of relevant therapeutic suggestions (Annon, 1976).

Intensive sexual therapy may be needed to provide an interpretation of the psychodynamics and transactional factors of the conflict. Intensive therapy may involve co-therapy, sex counseling clinics, group counseling, marital counseling, and family counseling. The most common problems needing intensive therapy are impotence, dyspareunia, orgasmic dysfunction, premature ejaculation, homosexual panic, altered body image following an illness or handicap, effects of aging or disease on sexual health and specific psychological stresses. In providing treatment for sexual problems, the therapist utilizes knowledge and skills of the sensate focus exercises, assertiveness training, psychotherapy, deconditioning techniques, group process, role playing, communication games, gestalt techniques, and behavior modification (Mime & Swenson, 1978). In order to provide intensive therapy, advanced education and clinical experiences are necessary.

Nurses, then, can provide comprehensive nursing care to their clients by promoting sexual health through the use of the Mims-Swenson Sexual Health Model and thus assist them in returning to as normal and active a life as possible. Therefore, this model contributes to the conceptual framework of this study by defining and communicating various levels of expertise based on knowledge, attitudes, and

transmittal skills of nurses in providing sexual counseling to post myocardial infarction clients.

Assumptions

For the purpose of this study the following assumptions applied:

1. Sexuality is a basic physiological human need (Maslow, 1970).

2. Human motivation is based on a hierarchy of needs that must be satisfied if health is to be attained and maintained (Maslow, 1970).

3. Sexuality is a significant part of the other higher order needs (Maslow, 1970).

4. Sexuality is present from birth to death and is an inseparable part of building an identity (Mims & Swenson, 1980).

5. The development of an individual's sexuality is influenced by biologic, psychologic, and sociocultural factors (Lion, 1982).

6. Sexuality is an integral part of the individual's body image (Lion, 1982).

Research Questions

For the purpose of this study, the following questions were investigated:

1. Are nurses providing sexual counseling to post myocardial infarction clients?

2. Is the counseling provided by nurses specific and satisfactory in assisting post myocardial infarction clients in the resumption of sexual activity?

Definition of Terms

1. Post myocardial infarction clients - individuals who have had a confirmed myocardial infarction within the past year and are between the ages of 30 to 66 years.

2. Sexual counseling - counseling offered by registered nurses in informing the client about resuming sexual activities and the precautions they may need to be aware of in the resumption of sexual activity. Sexual counseling and specific and satisfactory counseling will both be measured by the Sexual Counseling Measure (Unsain, 1976).

Limitations

For the purpose of this study the following limitation applied:

Subjects were obtained by convenience sampling; therefore, findings may not be generalized beyond this sample.

Summary

The literature indicated that sexual functioning is a major concern of cardiac clients and their spouses. A lack of information or misinformation can lead to changes in the individual's body image. These changes not only affect the cardiac client's view of self as a total person, but also affects relationships with the spouse and significant others. Nurses should be caring for the whole individual by providing sexual counseling. This counseling can be provided by using the Mims-Swenson Sexual Health Model.

The Mims-Swenson Sexual Health Model provides nurses with a framework for self-assessment, client assessment, and intervention. The model is composed of four ascending levels. Nurses may use these various levels depending on their depth of knowledge and expertise concerning sexuality.

CHAPTER 2

REVIEW OF LITERATURE

Sexuality, an important dimension of being a person, is a powerful and purposeful aspect of human nature and a quality of being human (Lion, 1982). Sexuality begins before birth and is present through death. Sexuality is an inseparable part of building an identity and includes a person's cognitive, affective, and psychomotor abilities and values. Sexuality is an integration of idea, emotion, and act and is inherent in the process of self-actualization (Lion, 1982).

The concept of sexuality refers to the totality of being a person. Sexuality includes all of those aspects of the human being that relate to being male or female and is an entity subject to life-long dynamic change. Sexuality reflects our human character, not just our genital nature. For the purpose of this study the literature review was concerned with the developmental, psychological, and psychosocial variables, which by their effects on personality development and interpersonal relations, can in turn affect social structure (Lion, 1982). Based on these variables, the literature was also reviewed for

the cardiovascular responses to sexuality, the need for sexual counseling, and the nurse's role in promoting sexual health.

Development

The first introduction that the infant has to sensuality occurs at birth when the mother greets the infant with her touch (Lion, 1982). Feelings of pleasure, warmth, and satisfaction attained through touch are important early sensual experiences if the infant is to attain sensory and affectional awakening. It is not unusual for infants to touch and explore their genitals. Although probably reflexive, infant girls may lubricate and erections may be observed in male infants (Hogan, 1980).

Social customs also affect the infant's sexuality in the direction of core gender identity and subsequent gender role behavior. Gender identity is one's internal sense of being male or female. Gender involves the identification of a person as male or female, and with that identification, a person develops feelings, attitudes, and behaviors that are appropriate for that sex. Gender identity is the result of biologic factors, genital anatomy, and sex assignment, and rearing including society's

attitudes toward what is masculine and feminine (Hogan, 1980). Immediately after birth, parents begin to identify their infants as male or female. Female infants are described as soft, smaller, finer textured, and delicate. Male infants are described as firmer, larger featured, stronger, and harder (Hogan, 1980).

Core gender identity is firmly established by the time the child reaches 2 to 3 years old (Weinberg & Grossman, 1982). By this time everything the child does indicates to others that he or she is male or female. In the toddler stage, the genitals come into sharper focus because of toilet training. During this stage the toddler's natural interest in the human body typically leads to exploration of the genitals and sex play with other children. The parent's reactions to these activities are often the child's first lesson in sex education. The parents' attitudes toward sex are revealed by their reactions and answers to the child's questions, their behavior toward one another, and their willingness or their reluctance to discuss matters pertaining to sex in an open manner (Steen & Price, 1977).

During the preschool years the child begins to associate with other children of his own age and gradually becomes aware of the differences between the sexes.

According to Hogan (1980), behaviors, such as hugging, kissing, and gift giving are often seen at this stage. Children are curious about reproduction and may be fascinated about each other's bathroom activities (Hogan, 1980). Sex role identification also begins at this stage. The child begins to identify with the parent of the same sex. In the course of this identification, children acquire not only the specific behaviors of the same sex parent, but also attitudes, values, and a variety of other sex role characteristics (Rosen & Rosen, 1981). During the school age years, sex play becomes an important source of sexual information (Rosen & Rosen, 1981). The school age child may engage in masturbation, genital manipulation with peers, same sex and heterosexual play, and genital exhibition (Rosen & Rosen, 1981).

Children have a natural curiosity about their bodies and will probably ask questions about sexuality. Parents should answer these questions like any other question in order to assure the child that sex is not more mysterious than other subjects (Weinberg & Grossman, 1982). Since children tend to discuss with their friends what they have learned, a tremendous amount of misinformation can be accumulated. If children are well educated by their parents, they will understand facts about sexuality and be less

likely to believe erroneous information (Weinberg & Grossman, 1982).

Adolescence is the period that begins with the onset of puberty and ends with adulthood. Puberty is a period when increased hormonal activity results in profound physical changes (Hogan, 1980). In the male, puberty begins with a sharp rise in sex hormones. The first changes to occur are the enlargement of the testes and scrotum. Shortly afterwards the seminal vesicles, epididymis, and prostate begin to mature and pubic hair begin to grow. The penis begins to enlarge, as does the larynx causing the voice to deepen (Weinberg & Grossman, 1982). The growth spurt starts and involves an increase in shoulder breadth, muscalature, and height. Erections will increase in frequency and the first ejaculation will occur. Within a year, the ejaculate will contain viable sperm (Lion, 1982). During puberty, males show a quick upsurge in sexual activity and reach the sexual acme of their lives. Most males will experience orgasm within two years of the onset of puberty (Hogan, 1980).

In females, puberty also begins with a sudden rise in the production and release of sex hormones. The increase in hormones stimulates breast development and growth of the hips and buttocks. There is an increase in the growth

of the external genitalia, uterus, and vagina. Within a year, pubic and axillary hair will begin to grown and the growth spurt will have begun. The growth spurt entails broadening of the pelvic girdle and an increase in height. The most striking occurrence is the onset of menstrual periods. For the first time, the adolescent girl is affected by cyclic hormonal changes. These cycles may cause mood fluctuations as well as physical changes (Weinberg & Grossman, 1982). Ovulation will begin within two years after the onset of menarche (Lion, 1982). In the female, there is no sudden increase in sexual activity as experienced in the male. Women show steady increases in sexual responsiveness that peak in the middle 20s or early 30s (Hogan, 1980).

Masturbation is an important aspect of adolescent sexuality. For most males, the first ejaculation seems to occur during masturbation. In some instances it occurs during sleep, in the form of a nocturnal emission or "wet dream" (Rosen & Rosen, 1981). Masturbation is more common among adolescent males than females. It is, however, a normal part of sexual development and expression in all people (Rosen & Rosen, 1981).

During the teen years, adolescents begin to engage in heterosexual petting activities. Petting serves as an

important function in helping to coordinate the patterns of male and female responses (Rosen & Rosen, 1981). Petting usually progresses from tentative hand holding to kissing, to manual or oral stimulation of the breasts and genitals. Heavy petting, direct stimulation of the genitals of either sex, may serve as an alternative to intercourse (Rosen & Rosen, 1981).

During adolescence, a critical reassessment of body image occurs as puberty changes an adolescent's physical appearance and function. Adjusting to a changing body image is especially difficult for adolescents in that this change echoes and compounds other feelings caused by the many other changes of adolescence. Body image strongly influences other aspects of sexual development, particularly gender identity and sexual self-concept. Gender identity is fundamental to the way a person forms and maintains interpersonal relationships. A person's sense of femaleness or maleness strongly affects such issues within a relationship as dominance and responsibility (Lion, 1982).

Adolescence is a period of stress. Although capable of reproduction, the adolescent is not fully mature, either physically, mentally, or emotionally (Steen & Price, 1977). The adolescent is confronted with integrating a changing body image into his sexual identity. The adolescent is

striving for independence and the peer group becomes an important source of reinforcement and provides a sense of belonging when he or she declares some independence from the family. The adolescent is striving to develop his or her capacities for commitment, intimacy, and nurturance of others, as well as learning to establish and sustain intimate relationships with another person during this period (Weinberg & Grossman, 1982).

Adulthood is that portion of the life cycle typically devoted to parenting and consolidation of the marital relationship (Woods & Woods, 1984). During adulthood, the physiologic growth of adolescence is completed and the physiologic changes of aging begin. During this time, the adult person will be devoted to launching, living, renewing, and reinvesting in their social, sexual, and occupational roles and relationships (Lion, 1982). For adults there are various forms of sexual expression. Some individuals may reject overt sexual activity and lead an inactive or celibate life. Other individuals may adjust to heterosexual activities either within the marital relationship or outside of it. Some individuals may exhibit a bisexuality, engaging in both heterosexual and homsexual activities. Others may reject heterosexuality and depend on masturbation or homosexual relations (Steen & Price,

1977). A crucial component of the adult interpersonal relationship is the sexual relationship. The relationship includes not only the physiological aspects of sexuality but also the partner's concept of self as a sexual being and his or her sex role (Woods & Woods, 1984).

There are also a number of familial and social variables that can influence the adult sexual relationship. Pregnancy often imposes lengthy periods of sexual abstinence, may alter the woman's body image and may decrease sexual desire for both partners. The birth of a child focuses the couple's attention on the infant and initially away from each other. The presence of children may also greatly decrease privacy and consequently the opportunity for sexual gratification.

Demands placed on adults by their careers may physically or emotionally interfere with their sexual interest and activity (Woods & Woods, 1984). Many of the sexual problems arising during adulthood have their roots in the inability to communicate about and negotiate sexual needs (Woods & Woods, 1984).

For the aging adult, many myths and misconceptions surround sexuality. The most commonly encountered myth is that of sexless old age (Lion, 1982). Some people even view interest in sexual activity as abnormal for older people.

These stereotypes tend to make the elderly feel uncomfortable and guilty about their sexuality. These myths and misconceptions, along with developmental and situational events, can directly and indirectly affect the sexuality of older adults (Higgins & Hawkins, 1984). For the older adult, continued sexual relationships are seen as providing an extremely important source of psychological reinforcement. The desires for intimacy, companionship, love, and affection make up an integral aspect of the individual's self esteem. Advancing age is accompanied by definite changes in body image. Often older people are experiencing acute role identity crises (Weinberg & Grossman, 1982). Couples who have had children must return to a relationship involving two parties. Other individuals may be adjusting to retirement, widowhood, or divorce.

Physiological changes are also seen in the sexual function of older men and women. There is a decrease in height, muscle mass, strength, and cardiac power. Frequently there is a gain in weight and often an increase in adipose tissue in the hips and thighs. Changes in the digestive system may cause discomfort and the skin becomes thinner and wrinkles are more pronounced (Woods & Woods, 1984). During this stage is when the woman will experience menopause. As estrogen levels decrease there is an increase in the

intervals between menstrual cycles until the final cessation of menstruation. Changes in estrogen dependent tissues, including breast and vaginal tissue, occurs. Some women experience hot flashes, vaginal irritation, and a variety of emotional symptoms. The origin of menopausal symptoms is most likely multicausal consisting of biologic changes coupled with environmental influences. Androgen levels in men also decrease, but the rate at which androgen diminishes appears gradual (Woods & Woods, 1984). Despite the many physiologic alterations in the sexual response, the older adult still has the capacity to enjoy sexual arousal and orgasm far into later life (Woods & Woods, 1984).

Psychoanalytic Theory

Freud's psychoanalytic theory of development is based on a sequence of stages corresponding to the changing manner in which gratification or pleasure is sought (Hjelle & Ziegler, 1976). Freud postulated that the primary source of energy is the instincts (Salkind, 1981). He believed that the instincts that deal with creation and sustenance of life are very powerful. The sexual instinct became a major life instinct within his theory (Salkind, 1981). The special form of energy that is used by the life instincts is called libido. As the organism matures and develops

according to biological principles, the libido undergoes a corresponding course of development. The source of the sexual instincts is in certain erogenous zones of the body that become irritated when excited. The aim of the instincts is tension reduction (Wiggins, Renner, Clore, & Rose, 1971). Thus, Freud's theory of development is based on psychosexual development.

The first psychosexual stage is the oral stage occurring during the first year of life. The primary focus of stimulation is the mouth and oral cavity. Infants are nourished through sucking and manipulation of the mouth is pleasurable. The mouth is the infant's prime contact with the social and physical environment, capturing most of his sexual energy (Hjelle & Ziegler, 1976). Freud distinguished two phases of the oral stage, the oral passive and the oral aggressive. The infant's first behavior of sucking is characteristic of the oral passive phase of satisfying needs and oral aggressive phase coincides with the onset of teething (Salkind, 1981). Freud (cited in Hjelle & Ziegler, 1976) believed that the mouth remains an important erogenous zone throughout life. Gum chewing, nail biting, smoking, kissing, and overeating are cited by Freudians as evidence of the attachment of libido to the oral zone (Hjelle & Ziegler, 1976).

The second stage of development is the anal stage which occurs from the second to fourth year of life, and is associated with the toilet training period. Initially the child has little control over bowel and bladder functioning. The child must learn to delay necessary elimination functions until the appropriate time and place are available (Hjelle & Ziegler, 1976).

There are two phases of the anal phase. During the anal expulsive phase the child derives pleasure from the expulsion of feces. The anal retentive phase is when the child receives gratification through the retention or holding on of feces (Salkind, 1981). The child is viewed as thinking of the elimination as a giving away a part of the body.

During this stage the child begins to deal seriously with the separation of himself or herself from the surrounding external reality (Salkind, 1981). The anal period is when the child first confronts the need for conformity to social expectations.

The third developmental stage is the phallic stage occurring from approximately the fourth to the sixth year. During this period, the erogenous zones are the genital organs and pleasure is received through organ manipulation (Salkind, 1981). During this stage children can be observed

examining their genitalia, masturbating, and expressing interest in matters pertaining to birth and sex. During this period Freud believed that males must resolve the Oedipus complex and females the Electra complex (Hjelle & Ziegler, 1976).

The Oedipus complex takes place when the male seeks out the primary and original love object, the mother. At the same time the child views the father as a competitive force for the mother's affections. The child's feelings of inferiority are compounded by the comparison between his and his father's sexual organ. The child then becomes fearful of punishment from the father in the form of castration anxiety. The child fears that the father will castrate his sex organs which are the focal point of his maturational and psychological growth (Salkind, 1981). This fear is so strong that the child abandons his incestuous thoughts about his mother and begins to identify with the father.

For females the Electra complex occurs when the child realizes that she does not have the same sex organs as the male. A sense of inferiority results in what Freud called penis envy. The child holds the mother responsible for her lack of a male sex organ. As a result the child rejects her mother and intensifies her attachment to the father.

However, the child eventually realizes that incorporation of a penis is impossible and the desire for one must be channeled into identification with the mother. Freud was much less explicit in detailing the process of the resolution of the Electra complex (Salkind, 1981). At the end of the phallic stage is the solidification of the superego and the establishment of appropriate sex role identity.

The fourth stage is the latency stage which occurs from approximately 6 to 12 years of age. During this period, no new erogenous zones appear and the sexual instincts are presumed dormant (Hjelle & Ziegler, 1976). The child's energy is channeled outward into the environment in nonsexual activities such as education, athletics, and peer relationships. Freud gave this stage of development relatively little attention since it did not represent a genuine psychosexual stage (DiCaprio, 1974).

Freud's fifth and final stage of development is the genital stage. The genital stage is synonymous with adolescence and is marked by the surge of genital sexual development. The erogenous zones become the biological ones associated with adult sexuality. With the onset of the secondary sexual characteristics, the individual is physiologically ready for mature sexual behavior. The genital stage is a period of serious decisions. Earlier

resolutions of conflicts in preceding stages and their resulting distributions of psychic energy are reconsidered. Sex role identity is reconsidered and some real or fantasied forms of homosexuality are thought to occur universally (Salkind, 1981). The ego and superego stand significant tests during adolescence and when this period comes to a close the mature adult personality has been set in place.

Humanistic Theory

Maslow's (1970) humanistic psychology is a holistic-dynamic theory of man. His theory is based on the individual as an integrated, organized whole. Maslow felt that psychologists concentrated on separate events, neglecting the basic aspects of the whole person and his human nature. Maslow's motivational theory is based on motivating the whole individual, not just a part of him (Maslow, 1970). His humanistic movement focused attention on the psychologically healthy person and considered self-fulfillment as the main theme in human life. Thus, his central core of personality is based on unity and totality (Hjelle & Ziegler, 1976).

Maslow's theory of human motivation is based on a concept of needs that must be satisfied if health is to be attained and maintained. He believed that as one personal

desire is satisfied another will surface to take its place. These desires are innately given and are arranged in an ascending hierarchy of priority or potency. The individual must at least somewhat satisfy the lower order, prepotent needs, before they can become aware of or motivated by higher order needs. The farther up the hierarchy the person is able to go, the more individuality, humanness, and psychological health they will display (Hjelle & Ziegler, 1976).

The most basic and powerful human needs are the needs for physical survival; food, liquid, oxygen, sleep, activity, sex, shelter, and elimination. These physiological drives are directly concerned with the survival of the individual. However, sex is an exception since it is not absolutely necessary for individual survival but species survival. If one of these needs remains unsatisfied, the individual becomes dominated by that need, so that all other needs become nonexistent or secondary. Physiological needs are crucial to the understanding of human behavior. The devastating effects on behavior produced by a lack of food or water have been cited in numerous experiments (Hjelle & Ziegler, 1976).

Although physiological needs can be separated and identified easier than higher needs, they cannot be treated as separate isolated phenomena. A person who thinks he is

hungry may actually be feeling a lack of love or security. He may satisfy the hunger need by smoking or chewing gum. Thus, all human needs are interrelated (Goble, 1970).

Once the physiological needs are satisfied, a new set of needs emerge, the safety needs. The safety needs are: security; stability; dependency; protection; freedom from fear, anxiety, and chaos; need for structure, order, and law; limits; and strength in the protector (Maslow, 1970). Maslow (1970) stated that the safety needs are best observed in infants and children because of their relative helplessness and dependence on adults. Children will react when they feel threatened or endangered; whereas, adults have been taught by our society to inhibit these reactions.

The safety needs may become evident when a child experiences an illness. The illness may be perceived as threatening and make the child feel unsafe. Therefore, he may manifest a need for protection and reassurance not seen before the illness. Another indication of the child's safety need is his preference for some kind of undisrupted routine. According to Maslow (1970), children function more effectively in a system that has a least a sketetal outline of rigidity and where there is some kind of schedule which can be counted on in the present and future. Parental quarreling, physical assault, separation, divorce, and

death within the family can be particularly harmful to the child's sense of well being. These factors can render the child's environment unstable and hence unsafe.

Safety needs in adults can be perceived in the preference for a job with tenure and financial protection, the establishment of savings accounts and the acquisition of insurance. Religions and philosophic beliefs may also be interpreted as safety needs. They tend to organize the individual's world and give it meaning and coherency (Maslow, 1970).

Once the physiological and safety needs are met, belongingness and love needs emerge. The individual now seeks affectionate relations with people in general, mainly for a place in his group or family and will strive with great intensity to achieve this goal (Maslow, 1970). These needs take different forms throughout the life span. The child may seek a warm accepting atmosphere with a great deal of physical affection. The teenager wants love in the form of respect, being understood and appreciated. The young adult wants an intimate emotional involvement with a loved one (DiCaprio, 1974). Maslow distinguished between two kinds of love. A less mature form of love which is based on a deficit need where one feels lonely and desires companionship as a means of relieving tension. The other

higher form of mature love is valuing another as he is without any desire to change or use him in any way.

Love and affection, as well as their expression in sexuality, have been looked upon by society with ambivalence and ladened with many restrictions and inhibitions. However, Maslow stressed that love is not synonymous with sex. Although it may be studied as a purely physiological need, sex is multidetermined. Sex is determined not only by the sexual need, but also other needs chief among which are the love and affection needs. Love involves a healthy loving relationship between two people, which involves mutual trust and the giving and receiving of love (Maslow, 1970).

The next needs to emerge are the esteem needs. The esteem needs are classified into two categories, the first being the self-esteem needs. These needs include the desire for competence, confidence, personal strength, adequancy, achievement, independence, and freedom. The second category is esteem from others which includes prestige, recognition, acceptance, attention, status, reputation, and appreciation (Goble, 1970).

Satisfaction of the self-esteem needs generates feelings of self-confidence, worth, strength, capability, and of being useful and necessary in the world. The individual's feelings of worth as a male or female can

also have profound implications for sexual functioning and the development of sexual relationships (Hogan, 1980). Inadequate self-esteem leads to feelings of inferiority and helplessness and may result in neurotic behavior (Maslow, 1970). Maslow emphasized that healthy self-esteem is based on earned respect from others rather than on external fame.

Once all other needs are satisfied, the self-actualization needs emerge. Self-actualization means fulfilling one's individual nature in all its aspects (DiCaprio, 1974). The person who has achieved self-actualization presses toward the full use and exploitation of his talents, capabilities, and potentialities. Love and sex are more closely fused in the individual who has achieved self-actualization (Hogan, 1980).

Psychosocial Aspects

Since sexuality is a major aspect of life it should be considered in both health and illness. Disruptions in health can create specific physical and emotional vulnerabilities. The individual's response to the disruptions is determined by their personal, psychological, and social interpretation. Body image disturbance is a frequent result of illness (Hogan, 198).

Illness and/or hospitalization may have an adverse effect on body image by decreasing self-esteem and altering sexual role identity (Hogan, 1980). A change in any body part or function may be interpreted as a threat to sexual self-esteem. Because body image changes represent a threat to identity the individual may feel different and that he or she is less of a man or woman (Hogan, 1980). The extent and rapidity of the change and the value the individual places on the body part or function also influence the perceived threat.

Sexual role behavior can be considered to have two major components: the usual behavior of individuals to obtain the amount and type of sexual satisfaction they need and other behaviors and activities that individuals consider an intergrel part of their sexual identity (Hogan, 1980). Biologic and psychologic effects of illness may require the individual to change their usual type and amount of sexual activity temporarily or permanently and thus threaten their body image. The ability of the individual to carry out his other roles such as spouse, parent, breadwinner, or homemaker may also affect his body image and his sexual capabilities. The psychological responses of the individual to a change in body image may include denial, depression, anxiety, and shame, as well as

grief and mourning. Any of these responses may compromise sexual function (Hogan, 1980).

The individual who suffers a myocardial infarction has little or no chance to prepare for the altered function, since the heart attack usually occurs suddenly. Since the heart is seen as the symbol of life and is central to body functioning, the knowledge that the heart is damaged may cause severe body image disturbance. If the damaged self-concept does not improve, the individual may become too frightened to return to normal daily activities including sex (Hogan, 1980).

Cardiovascular Responses to Sexual Activity

Masters and Johnson (1966) studied cardiovascular changes during the human sexual response cycle. They divided the male and female sexual response into four successive stages; excitement, plateau, orgasm, and resolution.

The excitement phase is characterized by the onset of erotic feelings and can last from a few minutes to hours. The main feature of this phase is the attainment of an erection in men and vaginal lubrication in women. During this stage, for both men and women, breathing becomes heavier and heart rate and blood pressure increase in direct

parallel to rising tension regardless of the technique of stimulation (Masters & Johnson, 1966).

The second phase is the plateau phase which lasts from 30 seconds to 3 minutes. During this phase the local vasocongestion response of the primary sex organ is at its peak in both genders (Kaplan, 1974). During this stage both male and female have increases in heart rate to an average 100 to 175 beats per minute and the appearance of a respiratory reaction occurs late in the phase. For the woman there is an elevation in the systolic blood pressure of 20 to 60 mm Hg and the diastolic pressure of 10 to 20 mm Hg. For the man there is an elevation in the systolic pressure of 20 to 80 mm Hg and the diastolic pressure of 10 to 40 mm Hg (Masters & Johnson, 1966).

The third stage is the orgasmic phase which lasts from 10 to 30 seconds. The orgasmic phase is considered the pleasurable peak of the sexual experience. The orgasm consists of involuntary spasms of muscle groups throughout the body and involuntary contraction of the rectal sphincter at 0.8 second intervals (Lion, 1982). In the male these contractions result in ejaculation of semen. After orgasm the male is refractory to sexual stimulation. A certain period of time known as the "refactory period" must elapse before he can ejaculate again (Kaplan, 1974).

The female is never physically refractory to orgasm. As long as she remains in the plateau stage she can be stimulated to orgasm until she no longer wishes stimulation (Kaplan, 1974). During this phase respiratory rates increase as high as 40 per minute and heart rate increases to an average of 110 to 180 beats per minute. Higher heart rates reflect more of a variation in orgasmic intensity for females than for males. For the woman there is an elevation in systolic blood pressure of 30 to 80 mm Hg and in diastolic pressure of 20 to 40 mm Hg. For the male there is an elevation in systolic pressure of 40 to 100 mm Hg and in diastolic pressure of 20 to 50 mm Hg (Masters & Johnson, 1966).

The final stage is the resolution phase which lasts from 10 to 15 minutes with orgasm and 12 to 24 hours without orgasm (Lion, 1982). This phase is primarily characterized by a reversal of the processes that resulted in vasocongestion. The general somatic responses to sexual stimuli diminish rapidly. The heart rate, blood pressure, and respirations return to the resting state minutes after orgasm.

Hellerstein and Friedman (1970) performed the first study on the physiological impact of sexual activity in post-coronary men. They compared the sexual activity of

48 post-coronary and 43 normal highly coronary-prone middle-aged men. They found the mean maximal heart rate during sexual activity corresponding to the phase of the orgasm was 117.4 beats per minute. The mean heart rates for minutes two and minute one before the maximal heart rate were 87 beats per minute and 101.2 beats per minute. The mean heart rates for minute one and minute two after the maximal heart rate were 96.9 beats per minute and 85 beats per minute (Hellerstein & Friedman, 1970).

Hellerstein and Friedman (1970) also recorded the blood pressure during ergometric exercise on bicycles at the heart rate that was noted during sexual activity. The average systolic blood pressure while the individual was resting prior to exercise on the bicycle was 126.9 mm Hg and the average diastolic pressure was 85.1 mm Hg. The equivalent blood pressure during the maximal heart rate that was noted during sexual activity was 162/89 mm Hg. They then compared the maximal heart rate during sexual activity with the heart rate while performing other activities. They found the maximal heart rate during the performance of the usual occupational or professional activity was 120.1 beats per minute which is higher than the 117.4 beats per minute that was noted during sexual activity. The highest heart rates were often related to

walking or climbing and similar maximal heart rates were recorded in office, factory, and other urban jobs (Hellerstein & Friedman, 1970). From these findings they concluded that over 80% of postcoronary subjects can fulfill the physiological demands of a majority of jobs and sexual activity without symptoms or evidence of significant strain.

Hellerstein and Friedman were supported by other studies which measured oxygen consumption. The energy expenditure of a person at rest requires an oxygen consumption of 3.5 ml per kilogram of body weight or one metabolic equivalent (met). The average man can attain a level of 12 mets whereas the trained athlete can attain a maximum capacity of 20 mets (Watts, 1976).

Douglas and Wilkes (cited in McLaine, Krop, & Mehta, 1980) found the average energy cost for foreplay to be 3.5 mets and for orgasm 4.7 to 5.5 mets. A Class I uncomplicated post myocardial infarction patient can achieve a maximum capacity of 8 to 9 mets. Class II and Class III cardiac patients can reach a maximum capacity of 6 mets and 4 mets (Watts, 1976). The average expenditure of energy in sexual activity is about 3.7 mets, while the average expenditure for most everyday tasks is 5 to 6 mets (McLane, Krop, & Mehta, 1980). According to this

data, sexual activity is well within the capacity of most cardiac patients.

Larson, McNaughton, Kennedy, Ward, and Mansfield (1980) compared the heart rate and blood pressure responses of sexual activity with a stair climbing test. They found that for eight men with coronary artery disease the mean maximal heart rate was 115 beats per minute during sexual activity and 118 beats per minute during the stair climbing test. For nine healthy men the mean maximal heart rate was 123 beats per minute during sexual activity and 122 beats per minute during the stair climbing test. The mean maximal systolic blood pressure for the coronary group was 144 at orgasm and 164 at the end of the stair climbing test. In the healthy men the mean maximal systolic blood pressure was 146 for both orgasm and the stair climbing test.

The Need for Sexual Counseling

Although the majority of cardiac patients are physiologically capable of returning to previous sexual behavior, the psychological aspects may have far reaching consequences on sexual activity. These changes in behavior are usually based on misinformation and fear.

Tuttle, Cook, and Fitch (1964) studied male cardiac patients one to nine years after their myocardial infarction.

They found that only a third of the men resumed their normal pattern of sexual activity. Two-thirds had a marked and lasting reduction in the frequency of sexual activity. Two-thirds of the sample were given no advice regarding sexual activity. The remainder were given nonspecific or vague advice.

Another study which showed a reduction in sexual activity was done by Bloch, Malder, and Haisaly (1975). They interviewed 88 men and 12 women about their sexual behavior before and after their infarction. The results showed the monthly mean frequency of sexual activity was 5.2 before the infarction and 2.7 after the infarction. Thirty-three percent had a moderate reduction in sexual activity and 29% had a severe reduction. The reduction occurred despite the fact that almost all of the subjects had resumed a normal active life. The reasons given for the reduction were anxiety, depression, lack of desire, spouse's decision, fear of another attack or sudden death, fatigue, angina, and impotence.

Papadopoulos (1978) found a reduction in sexual activity when he performed a study using 118 men and 17 women post myocardial infarction. He found the time of resumption of sexual activity after the infarction varied from 2 weeks to 12 months with an average of 10.7 weeks.

A reduction in the frequency of sexual activity was reported in most cases. Only 25% of the subjects who were sexually active before the infarction maintained prior patterns. Fear of resumption was expressed by 31% of the subjects. Of those who received physician's instructions, 27% expressed fear, but of those who received no advice, 37% expressed fear of another attack or of death during sexual activity. No resumption of sexual activity was reported in 21% of the subjects who had been sexually active before the infarction. In 10% of the sexually active males, impotence developed after the infarction. Of those who resumed sexual activity, 51% reported cardiac symptoms during sexual relations. The study also revealed that only 9.6% of the physicians volunteered information on sexual activity to their cardiac patients. Of all the physicians, 42% provided no information, even when it was requested by the patient.

A reduction in sexual activity was found by Mann, Yates, and Raftery (1981) in a study of 100 subjects. The subjects suffered their first myocardial infarction one year previously and had attended a short rehabilitation course that included discussion of sexual matters. Only 68 of the subjects had been sexually active before the infarction. The mean interval in those who resumed sexual

relations was 9 weeks. Thirteen of the subjects who had previously been sexually active had not resumed relations after one year. Of those remaining active, 33 had a decreased frequency and three showed an increase in frequency. In 19 of the subjects, active sexual relations continued at the same frequency. The mean frequency was 5.6 episodes each month before and 3.7 each month after the infarction. The principal reason given for the decrease in frequency was decreased desire. A small number reported complete or relative impotence. In 12 cases decreased activity was attributed to the patient's spouse. Seven subjects cited organic symptoms as the cause of reduction in sexual activity.

In a study of 100 myocardial infarction subjects, Horgan and Craig (1978) found a reduction in sexual activity to be related to a lack of information. Only a few subjects received advice on resuming sexual activity from either hospital or family physicians, and over half of those who did have discussions had initiated the topic. Eighty-four subjects believed sexual activity should be discussed by the hospital physician and 43 believed it should be further discussed by the family physician. Of the subjects, 46 suffered from some level of anxiety concerning resumption of sexual activity and 65 believed that sexual activity

placed them at a greater risk of another infarction. Fifty-seven subjects reported a significant reduction in sexual desire and 15 male subjects reported some degree of impotence. Six months after the infarction over half of the subjects had not resumed sexual relations. Thirty-four did not resume any type of sexual activity.

Papadopoulos, Larrimore, Cardin, and Shelly (1980) studied the impact of the husband's myocardial infarction on 100 wives. Thirty-one wives had questions about sexual activity while their husbands were still in the hospital, and all the wives developed concerns after discharge. Forty-five wives received some information about sexual activity prior to their husbands' discharge. Nineteen received instructions from a cardiac rehabilitation nurse, 11 from a physician, 3 from both a physician and a nurse, and 12 from their husbands who had been instructed by their physicians. After discharge, 62 wives stated they received instructions. Of the 100 couples, 76 resumed sexual activity. Twenty-two maintained precoronary frequency, five increased, and 49 decreased their frequency. Of the 24 who did not resume activity, 10 never tried and 14 tried but were unsuccessful due primarily to impotence. The reasons reported for the decreased sexual activity were the wife's and/or husband's fear of another attack, wife's

fear of coital death and the wife's and/or husband's lack of desire.

Studies by Massie (1969), and Trimble (1970) show that a reduction in sexual activity is often related to a fear of coital death. A Japanese study (cited in McLane, Krop, & Mehta, 1980) was conducted on 5,559 cases of sudden death. Only 34 deaths occurred during sexual activity. Twenty-five percent of the deaths occurred in hotel rooms, 77% were extramarital, and one-third were in a drunken state (Lion, 1982). The evidence suggests that coital deaths may be more a result of additional stress factors such as the extramarital affair or after heavy consumption of food or alcohol (McLane, Krop, & Mehta, 1980).

Nurse's Role in Sexual Counseling

Studies have shown that the majority of changes in sexual behavior after a myocardial infarction are primarily related to fear and lack of information. The nurse is in a unique position for intervening in the sexual concerns of the individual.

Nurses who accept the role of educator and counselor have several tasks to accomplish. Nurses must first do a self-assessment of their beliefs, values, and attitudes toward sexuality (Krizinoski, 1973). Beliefs, attitudes,

and values are products of culture and experience, and our society has designated nurses to perform certain functions. In assessing values and attitudes, nurses need to examine nursing practices which inhibit, deny, or allow for expression of sexuality in clients (Van Bree, 1975).

The next task is to develop interpersonal skills necessary to create an atmosphere conducive to discussion of sexual concerns (Krizinofski, 1973). Nurses must assess as to whether others perceive them as someone with whom they could discuss intimate concerns. In order to present this atmosphere, nurses need to assess their own comfort in discussing sexual concerns. Nurses must also become aware of the client's nonverbal communication. Because of embarrassment or as a means of testing the nurse's response, sexual concerns are frequently masked. An accepting attitude and open ended questioning can prove beneficial in revealing underlying concerns (Krizinoski, 1973).

The third task nurses must accomplish is to develop their knowledge of sexual physiology, psychology, and functioning throughout the life cycle in health and illness. Once nurses have a thorough knowledge of sexuality, they need to develop the ability to assess the client's perceptions of his sexual concerns. In assessing the client's needs, it is necessary to distinguish whether the problem

is a request for information about anatomy and physiology, a specific sexual problem, a clinical situation directly or indirectly related to sexual functioning, or an organic or situational problem requiring temporary or permanent alteration in the preferred mode of functioning. The nurse must also assess the client's thinking and feeling about the concern, the action he or she is willing to take and the relationship aspects of the concern (Krizinoski, 1973). The last task is to explore the nurse's role in the intervention of the sexual concerns of clients.

Before sexual counseling can begin, the nurse needs to consult with the physician regarding sexual activity for that particular client. In order to individualize the counseling, it is important to assess the client's clinical status to make recommendations for resumption of sexual activity. The factors to be considered are the individual's general health and tolerance for physical activity prior to the infarction; the extent of myocardial damage, the frequency and severity of angina and/or dysrhythmia; medications that are being taken, and the individual's ability to tolerate a progression of activity (Fardy, Bennett, Reitz, & Williams, 1980).

A sexual history should also be obtained so that previous sexual patterns and specific needs of the individual

are identified. The sexual history should include the individual's usual and perferred time and type of sexual activity; usual and perferred amount and variety of sexual activity; previous consumption of alcohol and food associated with sexual activity; previous episodes of decreased sexual urge or desire; impotence and ejaculatory dysfunctions and previous occurrance of any chest pain, fatigue or sleeplessness following sexual activity (Mims & Swenson, 1980). Certain factors which may have influenced sexual activity prior to the infarction should also be considered. These include age, since alterations in specific organ responses may be a result of the aging process rather than ability; diabetes which may cause impotence due to autonomic neuropathy and peripheral vascular disease since vascular occlusion could result in impotence (Fardy et al., 1980).

Both the client and the spouse should be included in the counseling program. A nonthreatening, private environment should be established and sufficient time should be allowed for each session. The client and the spouse should be informed that the data collected and the discussions will be kept confidential in order to reduce their anxiety about discussing intimate matters. Separate counseling sessions may be advantageous for the client and the spouse. By interviewing each one individually allows the opportunity

to express personal concerns which they may not feel confortable sharing with their mate (Scalzi & Dracup, 1978). A conjoint session prior to discharge ensures the couple of hearing the same information and provides the opportunity to reinforce previous information. During these sessions the nurse can assess levels of depression, body image disturbances, and identify the presence of anxiety, fears, and concerns of the client and the sexual partner that may severly compromise sexual rehabilitation.

The sexual rehabilitation program should begin with a discussion about the physiological effects of sexual activity on the cardiovascular system. It may also include a discussion of the stages of sexual behavior. Later sessions may focus on the specific information obtained in the sexual history or in the conversations with the client and partner. Sexual relations can usually be resumed in 4 to 8 weeks. The time of resumption is based on the individual's ability to tolerate progressive activity. Based on physiological research, when the individual is able to climb two flights of stairs or walk several blocks at a brisk pace, sexual activity should not be a hazard (Hogan, 1980). Therefore, many physicians will place the client on a detailed activity program.

Exercise rehabilitation is often started within 48 hours after the infarction if the individual is pain free and the resting pulse is between 50 and 90 beats per minute (Mims & Swenson, 1980). It should be explained to the client that exercise has many benefits for the cardiovascular system. Through exercise training the heart becomes more efficient, the lungs take in more air, more red blood cells are produced, collateral circulation among the coronary arteries may increase, and the heart muscle becomes stronger so that it does not have to beat as fast in order to carry out its work (Scheingold, Dreisinger, & Wagner, 1974). With this conditioning the resting heart rate becomes lower and thus the rate during sexual stimulation is lower (Scheingold, Dreisinger, & Wagner, 1974).

Stein (1977) performed a study on 16 men who attended a 16-week bicycle ergometer training program 3 to 4 months after their first myocardial infarction. A control group of 6 cardiac men who were not trained completed the same testing protocol. He found that exercise training led to an average decrease in peak coital heart rate of 5.5% and an increase in maximum oxygen consumption of 11.5%. The control group showed no change in peak coital heart rate and an increase of only 2% in oxygen consumption.

The nurse may want to discuss coital positions that impose less strain on the cardiac client. The male superior position may cause sustained isometric arm and shoulder muscle contraction which can increase the workload of the heart. For this reason the cardiac client should adopt positions, such as the male inferior position, which do not necessitate use of the arms for sustained periods. However, if anxiety results with the assumption of a new position, less cardiac stress may be experienced by continuation of familiar positions (Hogan, 1980).

Sexual relations should be resumed in usual surroundings. The room temperature should be confortable. Extremes of temperature, especially a hot or humid atmosphere and hot or cold showers or baths produce physiological stress and should be avoided (Hogan, 1980). The client should feel confortable and at ease with their partner. Tension, anxiety, emotional stress, and fear have negative effects by causing increased workload on the heart and circulatory system.

The cardiac client should be informed to engage in sexual relations only when well rested. Fatigue can impair sexual functioning and place an excessive workload on the heart (Hogan, 1980). The best time for sexual activity is after a rest period or in the morning just after awakening.

A rest period after sexual relations can enhance sensuality and prepare the individual for other forms of physical activity (Lion, 1982). The client should be informed to wait approximately 2 to 3 hours after eating a heavy meal or drinking alcohol before engaging in sexual relations. A large amount of blood redirected to the stomach when food is digested results in a decreased amount of blood circulating to other areas of the body. Therefore, the heart must exert a greater amount of effort to support added physical activity. Alcohol causes an increase in the heartbeat and leads to more work for the heart (Czerwinski, 1980).

Sexual relations should be engaged in when the client and partner have plenty of time and are in familiar surroundings since this will reduce the strain on the heart. Abruptly starting and stopping sexual relations can place added strain on the heart. The couple should take their time and enjoy each other (Czerwinski, 1980). The client should be informed to report any symptoms that may occur during sexual activity to the physician. These include rapid heart and respiratory rates lasting 20 to 30 minutes after sexual activity, palpitations continuing 15 minutes after relations, chest pain during or after relations, sleeplessness after sexual activity, and extreme fatigue on the day following relations. Clients who

experience angina during or after sexual relations may be instructed by their physician to take nitroglycerin before sexual relations. The nurse may also want to inform the client that medications such as antihypertensives, tranquilizers, antidepressants, and hypnotics may affect sex and sexuality (Lion, 1982). The client should, therefore, be instructed on the proper use of the prescribed medications, that is route, dosage, action, and side effects.

The primary goal of any sexual counseling program should be to restore the client and partner to pre-illness sexual functioning; to educate the couple about human sexuality, and the adaptations imposed by illness, and to facilitate communication for optimal sexual functioning (Watts, 1976).

Summary

Sexuality is part of human development beginning at birth and continuing throughout the life cycle. Freud's stages of development were based on sexuality and thus, termed psychosexual development. Maslow stated that sex was not only a basic physiological need but was also inherent in the other higher order needs.

Masters and Johnson (1966) studied the human sexual response and the effects of sexuality on the cardiovascular system. They found the maximum heart rate to be 110-180 beats per minute with a return to the resting state minutes after orgasm. Hellerstein and Friedman (1970) performed the first study on the cardiovascular effects of sexuality in post-coronary men. They found the mean maximal heart rate during sexual activity corresponding to orgasm was 117.4 beats per minute. This showed that sexual relations were well within the capabilities of most coronary clients. Other studies were done that supported these findings. According to various studies, fear and misinformation were the main causes of a marked and lasting reduction in sexual activity. Studies were also done on the impact of the husband's myocardial infarction on the wives. These studies showed that the majority of the wives did have questions and concerns about resuming sexual activity.

Nurses are in a unique position to intervene in the sexual concerns of the coronary client by providing sexual counseling. In order to provide counseling, nurses must first be able to assess the client's needs as well as their own beliefs and comfort in discussing intimate concerns. They must next obtain knowledge about sexual physiology, psychology, and functioning. Nurses need to obtain a

sexual history so the specific needs of the individual can be identified. They must also consider other factors which may influence sexual activity such as age or other organic disorders.

Although the sexual counseling program should be constructed to meet the needs of each client it should include discussions about the stages of sexual behavior, the effects of sexuality on the cardiovascular system and precautions that should be considered when resuming sexual activity. The primary goal of the sexual counseling program should be to assist the client and partner in the resumption of optimal sexual functioning.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The problem of this study was to determine if nurses were providing sexual counseling to post myocardial infarction clients and if the information was specific and satisfying in assisting the clients to resume sexual activity. This research was descriptive, and nonexperimental since it only dealt with obtaining insight into the content, source, and adequacy of the information provided to the client (Poliet & Hungler, 1978).

Setting

The setting for this study was a southwestern city of approximately 41,000 inhabitants. The majority of the residents of this city are employed by one of the four major chemical plants located in the area. There are two local hospitals, a corporate owned hospital and a county hospital. The sample was obtained from the files of three physicians, two internists and one cardiologist, whose offices are located within the city. The majority of the clients seen by these physicians also reside within the city limits. The questionnaires were administered in

the subjects' homes.

Population and Sample

The population for this study consisted of cardiac clients who had been treated by at least one of three physicians for a diagnosis of myocardial infarction. A sample of convenience was obtained from the files of two internists and one cardiologist. The sample consisted of clients who met the following criteria:

1. Had a confirmed diagnosis of myocardial infarction.
2. Had experienced the myocardial infarction within the past year.
3. Were within the ages of 30 to 66 years.
4. Were able to read and write English.
5. Had the physician's consent to participate.

After reviewing the files and obtaining a list of clients who met the selection criteria, the list was reviewed with each physician to obtain permission to contact the clients for inclusion in the study. After obtaining the physician's permission, the individual was contacted by telephone to explain the purpose of the study and to advise him that permission to contact him had been obtained from the private physician. The individual was informed that in order to maintain anonymity, names would not be

placed on the instrument, the envelope, or mentioned in the study. Twenty subjects were obtained for this study.

Protection of Human Rights

Protection of human rights was assured by compliance with the requirements of Texas Woman's University Human Subjects Review Committee (see Appendix C), and the approval of the physicians to contact their patients (see Appendix A). Along with the questionnaire all participants received a cover letter explaining the purpose of the study (see Appendix B). The cover letter informed the subjects that their names would not be mentioned in the study and that their names were not to be written anywhere on the questionnaire or the envelope marked SCM. The letter also explained that the return of the questionnaire constituted their consent to be a subject in the study. Ater completing the questionnaire, they were to place it in the envelope marked SCM and seal it.

Instrument

The instrument that was used in collecting the data for this study was a questionnaire entitled the Sexual Counseling Measure (SCM), which was devised by Unsain (1976). The instrument contains 13 forced-choice questions and four Likert-type questions.

The questionnaire is divided into three parts. Part I of the SCM is entitled Content and is concerned with the content of the sexual counseling and who provided the information to the client. Part I consists of 12 sex content information questions. These questions include content that is consistently found in the literature to be information that should be included when providing sexual counseling to post-cardiac clients. The subjects were asked to respond to each question indicating if the specific information had been provided to them. The subjects were also asked to indicate, by checking the space provided, as to whether doctors, nurses, or others provided the information. If the others space was marked, the subjects were to indicate who the person was who provided the information.

Part II of the SCM instrument is entitled Adequacy and is concerned with whether the subjects found the sexual counseling provided useful to them. This section consists of one opinion statement with 13 closed-ended questions. Scoring for Parts I and II of the SCM was done as follows: Yes = 1 and No = 0. The subjects were asked to make each question by indicating yes or no. If no sexual counseling had been given, the subjects were asked not to respond to Part II and to answer only questions 14, 15, and 17 of Part III of the instrument.

Part III of the SCM instrument is entitled Satisfaction and is concerned with the subjects' satisfaction with the sexual counseling provided and whether or not a sexual history had been taken during hospitalization. The subjects were also asked their opinions on whether sexual counseling should be part of routine health care for post coronary clients. Since questions in Part III have Likert-type responses, each response was assigned a value from 4 (high) to 0 (low). The subjects were asked to respond to four questions marking the degree of agreement which most closely reflected their opinion. The degree of opinion scales ranged from highly specific to no counseling provided, highly satisfactory to unsatisfactory, and from strongly agree to strongly disagree.

The initial field test of the instrument was done by Unsain (1976) on eight generic junior and senior nursing students in a university setting. The purpose of this testing was to evaluate the instrument for the amount of time it would take for completion, clarity of instructions, sequence of items, and clarity of each item. The results of this study showed the instrument to be confusing and time consuming. Revisions were made by Unsain and another field test was done using five other junior and senior nursing students of the same university. The same

instructions for evaluating the tool were given to both groups. The results of the second testing found the average time for completion of the instrument to be 14 minutes, the instructions for each part of the instrument were clear, and the individual items were clear and easy to read. No comments were made on the sequence of the items.

After the second field test by Unsain (1976), the SCM instrument was reviewed by a panel consisting of two practicing cardiologists and a nurse. They were asked to evaluate the items of the instrument for adequacy, accuracy, and format. All of the items were accepted by the panel. Unsain (1976) conducted a pilot study using three male post myocardial infarction subjects and found that the subjects took an average of 15 minutes to complete the instrument.

Data Collection

The files of three physicians were reviewed for those subjects who met the selected criteria. The obtained list of clients was then reviewed with the physician to obtain permission to contact the individuals. Each individual was then contacted by telephone and provided with the information necessary for completion of the questionnaire.

Those individuals who agreed to participate were presented, at the time of the home visit, with the

instrument, a cover letter, an envelope marked SCM, and a plain envelope to self-address if they wished to obtain the results of the study. The individuals were informed that questions regarding the instrument could not be discussed prior to or during the administration of the instrument as it might interfere with the results. They were instructed to read the cover letter and instructions on each part of the instrument, not to place their name anywhere on the instrument or envelope marked SCM. They were asked to go into another room to complete the questionnaire, place it in the envelope marked SCM, and seal it. The individuals were then asked to hand the sealed envelope to the investigator. Individuals were informed to direct all questions provoked by the instrument to their private physician. The investigator then thanked them for their time and cooperation and left their homes. Questionnaires were maintained in their sealed envelopes with no identifying marks until all subjects had completed the questionnaires. At that time, the investigator opened the envelopes and tallied the questionnaires.

Treatment of Data

For each part of the instrument the frequency of responses for each closed-ended item were determined by

using a frequency distribution table. Frequencies and percentages were determined for the data or sex, age, and whether the counseling was provided in a cardiac rehabilitation program. The mean was also determined for the ratio data of age.

For Part I of the instrument concerned with the sexual counseling, frequencies and percentages were determined for the categories of yes and no. Frequencies and percentages were also determined for the source of the counseling, such as doctors, nurses, or others. For the other category, the response was written and the responses were then tabulated for frequency. A nominal level frequency distribution table was done including all of the counseling sources.

For Part II a nominal level frequency distribution table was constructed for the categories of yes and no. Frequencies and percentages were determined for each category. For Part III of the instrument a distribution table was developed to include the categories of specificity, degree of satisfaction, and degree of agreement with the range of degree stated for each category. The responses for each degree were tabulated for frequency and percentage. Frequency polygons were used to describe the frequency of responses obtained from the instrument.

A cross tabulation was constructed on question #1 of Part I and subpart m of Part II to determine consistency of responses since they were asking for the same information. A cross tabulation for consistency of responses was also constructed for subpart b of Part II and questions 15 and 16 of Part III.

A cross tabulation for comparison of responses was constructed for the following responses:

1. Specificity to individual needs (Part II, subpart a) and degree of specificity of sexual counseling (Part III, question 15).

2. Degree of specificity of sexual counseling (Part III, question 15) and degree of satisfaction (Part III, question 16).

3. Degree of satisfaction (Part III, question 16) and generality of sex counseling (Part II, subpart b).

CHAPTER 4

ANALYSIS OF DATA

The data for this study were obtained through the use of the Sexual Counseling Measure (SCM). The Sexual Counseling Measure is divided into three parts consisting of content, adequacy, and satisfaction. The data for each part of the Sexual Counseling Measure instrument were analyzed per question into frequencies and percentages of responses. Cross tabulations were made for comparison and consistency of responses between specific items of the instrument.

Description of Sample

The data were obtained from a sample of 20 subjects who were treated by at least one of three physicians for a dianosis of myocardial infarction. A list of 21 subjects was obtained for possible inclusion into the study. From this list, 20 subjects agreed to participate while one subject refused to participate in the study.

The same consisted of 17 men (85%) and three women (15%). The age range was 20 years with the minimum age being 46 years and the maximum age 66 years. The mean age

was 57 years. Of the 20 subjects, nine (45%) attended a cardiac rehabilitation program. The remaining 11 (55%) did not attend a program.

Findings

Whether nurses were providing sexual counseling to post myocardial infarction clients was determined in Part I of the Sexual Counseling Measure. Part I, which consisted of 12 information questions, was concerned with the content of the counseling and who provided the information to the subjects. The subjects were asked to respond either yes or no to each inquiry that the information had been provided to them. Only one subject did not respond to one of the content questions. The remaining 19 subjects responded to all of the content questions. If the subjects received the information they were asked to indicate who provided it: doctors, nurses, or others. If the other category was marked, the source of the information was to be specified. All subjects who marked "other" identified booklets as the source of the information. Of those subjects indicating they received the information, three of the subjects failed to indicate who provided the information.

Of the 20 subjects, 17 (85%) subjects indicated they received counseling as to when they could resume sexual

intercourse. The information was provided to eight of the subjects by doctors. Three subjects did not receive this information (See Table 1).

Eleven (55%) subjects were counseled on avoiding intercourse one to three hours after a heavy meal with food and drink. Nine (45%) of the subjects did not receive this information. Of those who received this information, four subjects stated they were informed by doctors, and four subjects by nurses (see Table 1).

Counseling was provided to seven (35%) of the subjects to avoid drinking alcohol, particularly wine, before having intercourse. The remaining 13 (65%) subjects did not receive this information. The information was provided for three of the subjects by nurses (see Table 1).

Instructions on avoiding eating or drinking extremely hot or cold foods or liquids before having intercourse was provided to six (30%) subjects. Instructions were not provided to 14 (70%) subjects. Three of these subjects indicated nurses as the source of the information (see Table 1).

The information to avoid having intercourse in extreme cold, hot, or high humidity places was given to five (25%) subjects. The other 15 (75%) subjects did not receive

Table 1

Response to Content and Source Counseling

INFORMATION	Total		Doctors		Nurses		Others		Missing	
	n	%	n	%	n	%	n	%	n	%
1. When you could resume intercourse?										
Yes	17	85	8	40	4	20	2	10	3	15
No	3	15								
Total	20	100								
2. To avoid intercourse 1 to 3 hours after a heavy meal with food and drink?										
Yes	11	55	4	20	4	20	1	5	2	10
No	9	45								
Total	20	100								
3. To avoid drinking alcohol, particularly wine, before having intercourse?										
Yes	7	35	2	10	3	15	1	5	1	5
No	13	65								
Total	20	100								

Table 1 (cont)

INFORMATION	Total		Doctors		Nurses		Others		Missing	
	n	%	n	%	n	%	n	%	n	%
4. To avoid eating or drinking extreme hot or cold foods or liquids before having intercourse?										
Yes	6	30	1	5	3	15	1	5	1	5
No	14	70								
Total	20	100								
5. To avoid having intercourse in extreme cold, hot, or high humidity places?										
Yes	5	25	1	5	2	10	1	5	1	5
No	15	75								
Total	20	100								
6. To have intercourse only with usual sexual partner?										
Yes	9	45	1	5	4	20	3	15	1	5
No	11	55								
Total	20	100								

Table 1 (Cont)

INFORMATION	Total		Doctors		Nurses		Others		Missing	
	n	%	n	%	n	%	n	5	n	%
7. To keep your usual sexual pattern but to avoid long or vigorous effort with the arms and shoulders?										
Yes	8	40	2	10	3	15	2	10	1	5
No	12	60								
Total	20	100								
8. To rest after intercourse?										
Yes	10	50	2	10	4	20	3	15	1	5
No	10	50								
Total	20	100								
9. That if you have chest discomfort during intercourse to use nitroglycerine before and/or during intercourse?										
Yes	7	35	2	10	4	20	1	5		
No	13	65								
Total	20	100								

Table 1 (cont)

INTRODUCTION	Total		Doctors		Nurses		Others		Missing	
	n	%	n	%	n	%	n	%	n	%
10. That if you have chest discomfort during intercourse to relax then continue the activity?										
Yes	6	30	1	5	1	5	5	3	1	5
No	14	70								
Total	20	100								
11. That the first time you have sexual intercourse to assume the less aggressive role between you and your partner?										
Yes	11	55	2	10	3	15	4	20	2	10
No	8	40								
Missing	1	5								
Total	20	100								

this information. Of these five subjects receiving the information, two subjects received it from nurses (see Table 1).

Nine (45%) subjects were informed to have intercourse only with their usual partner. This information was not provided to the remaining 11 (55%) subjects. The counseling source was indicated by four subjects to be nurses (see Table 1).

Eight (40%) subjects received counseling on assuming their usual sexual pattern but to avoid long or vigorous effort with the arms and shoulders. Counseling was not provided to 12 (60%) subjects. Nurses provided the information for three subjects (see Table 1).

Ten (50%) subjects were advised to rest after intercourse and 10 (50%) subjects were not given this advice. Of the 10 subjects receiving this advice, four subjects obtained it from nurses (see Table 1).

Instructions were given to seven (35%) subjects that if chest discomfort developed during intercourse to use nitroglycerin before and/or during intercourse. These instructions were not given to 13 (65%) subjects. These instructions were provided by nurses for four of the subjects (see Table 1).

Counseling was given to six (30%) subjects that if chest discomfort developed during intercourse to relax then continue the activity. Counseling was not given to the remaining 14 (70%) subjects. The counseling source was indicated by three subjects as other sources (see Table 1).

To assume the less aggressive role the first time they have sexual intercourse was the instruction provided to 11 (55%) of the subjects. This instruction was not provided to eight (40%) subjects. This instruction was provided for four subjects by other sources (see Table 1).

Six (30%) subjects were informed that elevating the head of the bed 10 to 14 degrees will reduce sensations of pressure in the chest and neck. The remaining 14 (70%) subjects did not receive this information. The information was provided for two subjects by doctors, and for two subjects by nurses (see Table 1).

The data demonstrate that 17 (85%) of the subjects were informed when they could resume intercourse. The information was given to eight (40%) of the subjects by doctors. The information on avoiding intercourse 1 to 3 hours after a heavy meal, to rest after intercourse, and to assume the less aggressive role the first time they have intercourse was provided to 50% to 55% of the subjects. Fifteen to 20%

of the subjects received the information from nurses. The other content areas were less often provided. According to the data nurses were identified most often as the counseling source (see Figure 1).

Whether the counseling was specific to the needs of the subjects was determined in Part II of the Sexual Counseling Measure. The subjects were instructed not to respond to this part of the instruction if, in their opinion, they did not receive any sexual counseling. Eleven (55%) of the 20 subjects responded to Part II. The data showed that in the opinion of 10 (90%) of the subjects, the sexual counseling they received was specific to their needs. One subject (10%) perceived the counseling as not being specific to his needs (see Table 2). Ten (90%) subjects indicated that the counseling was presented so that they could understand it. Sexual counseling was offered to nine (80%) of the subjects, and asked for by five (45%) subjects (see Table 2).

Ten (90%) subjects indicated the counselor provided them the opportunity to ask questions during the counseling sessions. These same subjects also indicated the counseling decreased their anxiety over resuming sexual activity and gave them reassurance that they could resume past patterns of sexual activity. The data are consistent in that 10

FIGURE 1

INFORMATION SOURCES

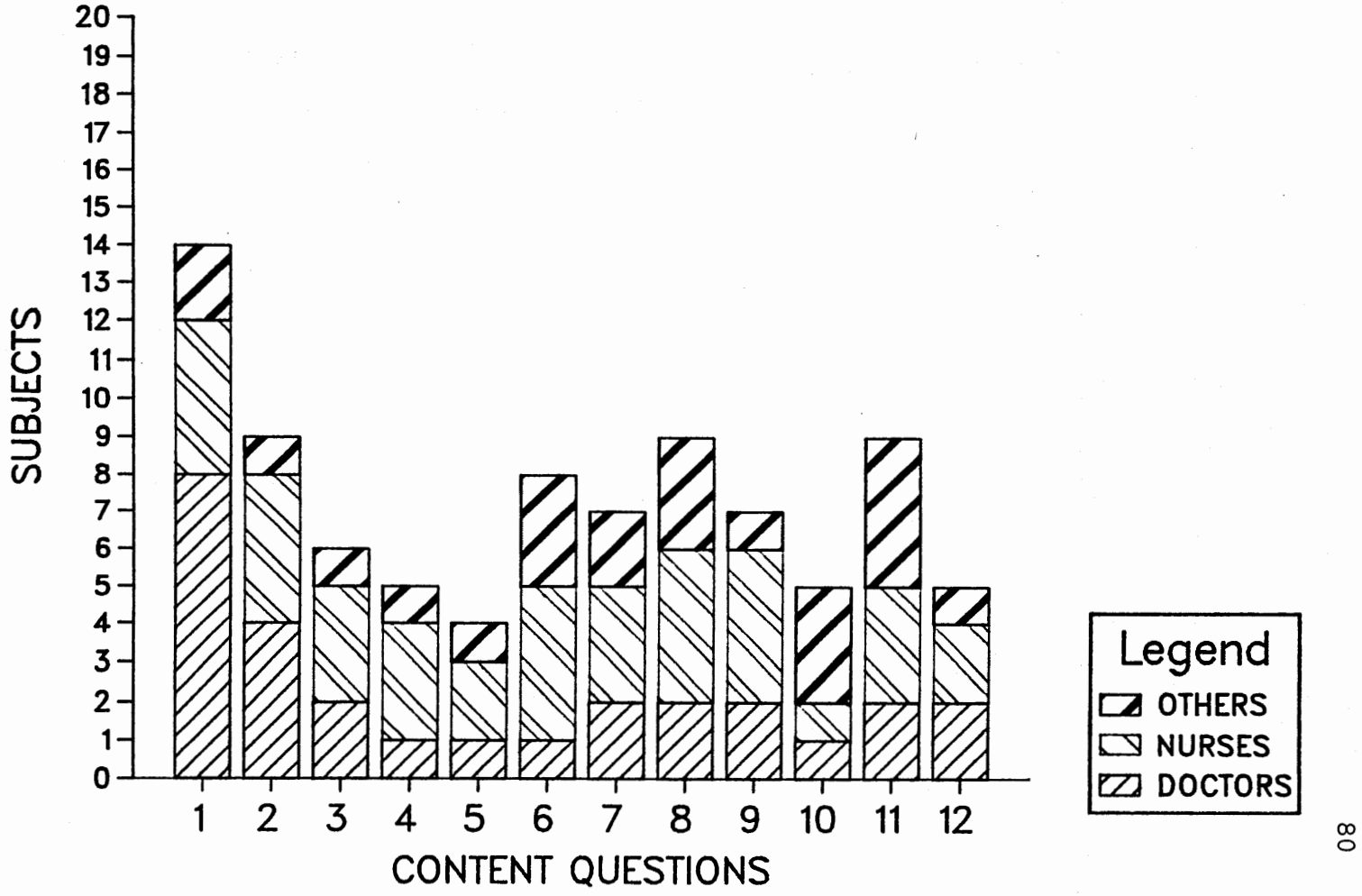

Table 2

Responses Concerned with the Adequacy of the Sexual Counseling

Question		n	%
13. The sexual counseling received:			
a. Was specific to my needs			
	Yes	10	90
	No	1	10
	Total	11	100
b. Was so general that it could apply to anyone			
	Yes	5	45
	No	6	55
	Total	11	100
c. Was presented so that I could understand it			
	Yes	10	90
	No	1	10
	Total	11	100
d. Was asked for by me			
	Yes	5	45
	No	5	45
	Missing	1	10
	Total	11	100
e. Was offered to me			
	Yes	9	80
	No	1	10
	Missing	1	10
	Total	11	100
f. Gave me an opportunity to ask questions			
	Yes	10	90
	No	1	10
	Total	11	100

Table 2 (Cont)

Question		n	%
g. Included my sex partner(s)			
	Yes	7	60
	No	4	40
	Total	11	100
h. Decreased my anxiety over resuming sexual activity			
	Yes	10	90
	No	1	10
	Total	11	100
i. Has given me assurance that I can resume my past pattern of sexual activity			
	Yes	10	90
	No	1	10
	Total	11	100
j. Has prepared me to return to my previous sexual patterns			
	Yes	11	100
k. Has answered questions I had concerning heart problems and sexual activity	Yes	11	100
l. Has answered questions for my sex partner(s) concerning heart problems and sexual activity			
	Yes	9	80
	No	1	20
	Total	11	100
m. Has informed me as to when I can resume sexual activity			
	Yes	11	100

(90%) subjects also stated the counseling they received was specific to their needs (see Table 2).

All 11 (100%) subjects indicated the sexual counseling did prepare them to return to previous sexual patterns, answered their questions concerning heart problems and sexual activity, and informed them when they could resume sexual activity (see Table 2).

Seven (60%) subjects indicated that their sexual partner was included in the counseling. Four (40%) of the subjects stated their partners were not included in the sexual counseling. Questions concerning heart problems and sexual activity were answered for nine (80%) of the subjects' sex partners (see Table 2).

Whether the subjects were satisfied with the sexual counseling was determined in Part III of the Sexual Counseling Measure. The subjects were to answer the questions by indicating the response that most closely reflected their feelings. The subjects who did not respond to Item 13 of Part II were instructed not to answer Item 16 of Part III.

In the opinion of three (15%) of the subjects, the sexual history that was obtained from them during their hospitalization was considered to be highly specific, and four (20%) subjects considered it moderately specific.

Ten (50%) subjects stated that no sex history was taken. Of these 10 subjects, eight of the subjects did not respond to Part II indicating they received no sexual counseling (see Table 3).

Four (20%) subjects considered the sexual counseling they received as highly specific, and five (25%) subjects considered it moderately specific. Seven (35%) subjects indicated that no sexual counseling was given (see Table 3).

Of the 11 subjects who responded to Part II as having received sexual counseling, 10 (90%) subjects rated the counseling as highly satisfactory (see Table 3).

Fifteen (75%) subjects strongly agreed that counseling on sexual functioning after a coronary should be included as part of routine health care (see Table 3).

A consistency of responses was performed on Item 1 of Part I ans subpart m of Part II. Both questions asked if subjects were informed when they could resume sexual activity. The responses were consistent for all of the 11 (100%) subjects who responded to Part II.

Part II and Part III were both concerned as to whether the sexual counseling the subjects received was specific to their needs. Of the 10 (90%) subjects who stated the counseling was specific to their needs in Part II, four

Table 3

Responses to Degree of Specificity of Sexual Counseling and Degree of Satisfaction with the Sexual Counseling

Question		n	%
14.	In my opinion the sexual history obtained from me during this hospitalization was:		
	a. highly specific	3	15
	b. moderately specific	4	20
	c. mildly specific	1	5
	d. non-specific	1	5
	e. no sex history was taken	10	50
	Did not respond to this question	1	5
	Total	20	100
15.	In my opinion the sexual counseling I received during this hospitalization was:		
	a. highly specific	4	20
	b. moderately specific	5	25
	c. mildly specific	3	15
	d. non-specific	0	0
	e. no sex counseling was given	7	35
	Did not respond to this question	1	5
	Total	20	100
16.	I rate the sex counseling I received during this hospitalization as:		
	a. highly satisfactory	10	90
	b. moderately satisfactory	1	10
	c. mildly satisfactory	0	0
	d. unsatisfactory	0	0
	Total	11	100

The number of responses of the subjects who completed Part II of the SCM.

Table 3 (cont)

Question		n	%
17.	Counseling on sexual functioning after a coronary should be included as part of routine health care:		
	a. strongly agree	15	75
	b. agree with reservations	2	10
	c. disagree with reservations	1	5
	d. strongly disagree	0	0
	Did not respond to this question	2	10
	Total	20	100

subjects stated in Part II that the counseling was moderately specific, and four subjects stated it was highly specific (see Table 4).

A comparison of responses was performed between the generality of the sexual counseling (sub-part b of Part II) and the degree of specificity of the counseling (Item 15 of Part III). Of the five (45%) subjects who stated the counseling was general, four of the subjects also stated it was moderately specific. Of the six (55%) subjects who stated the counseling was not general, four subjects indicated it was highly specific (see Table 5).

A comparison was also done between the generality of the sexual counseling (sub-part b of Part II) and the degree of satisfaction (Item 16 of Part III). The six (55%) subjects who stated the counseling was not general were highly satisfied with the counseling. Of the five (45%) subjects who stated the counseling was general, four subjects rated it as highly satisfactory (see Table 6).

How specific the subjects rated the counseling (Item 15 of Part III) was compared to how satisfied the subjects were with the counseling (Item 16 of Part III). Six (30%) subjects stated they received no sexual counseling and rated the counseling as unsatisfactory. Four (20%) indicated

Table 4

Specificity of Sexual Counseling to Individual Needs and Degree of Specificity of Sexual Counseling

Specificity to Individual Needs (Part II)	Degrees of Specivicity to Sexual Counseling (Part III)		
	Highly	Moderately	Mildly
n = a			
Yes	4	4	2
No	0	1	0

[a]Subjects who completed Part II of the SCM instrument

Table 5

Generality of the Sexual Counseling and the Degree of Specificity of the Sexual Counseling

Generality of Sexual Counseling (Part II)	Degree of Specificity of Sexual Counseling (Part III		
	Highly	Moderately	Mildly
n = a			
Yes	0	4	1
No	4	1	1

[a]Subjects who completed Part II of the SCM instrument

Table 6

Generality of Sexual Counseling and Degree of Satisfaction with Sexual Counseling

Generality of Sexual Counseling (Part II)	Degree of Satisfaction (Part III)		
	Highly	Moderately	Mildly
n = [a]			
Yes	4	1	0
No	6	0	0

[a]Subjects who completed Part II of the SCM instrument

the counseling was moderately specific and highly satisfactory and four (20%) indicated the counseling as highly specific and satisfactory (see Table 7).

Summary

In Part I of the Sexual Counseling Measure the subjects indicated if they received certain information on resumption of sexual activity. The subjects who stated they received information most often identified nurses as the source of that information. The only information that was most often provided by doctors was related to resumption of sexual relations. The only information most often provided by literature was for the subject to relax before continuing sexual relations if chest discomfort developed, and the first time having intercourse to assume the less aggressive role.

In Part II of the Sexual Counseling Measure the subjects indicated adequacy of the sexual counseling. Eleven (55%) of the 20 subjects felt they had received sexual counseling. Of the 11 subjects who received counseling, 90% (10) stated it was specific to their needs, decreased their anxiety, and gave them reassurance that they could resume past patterns of sexual activity. One hundred percent (11) of the subjects stated the counseling they

Table 7

Degree of Specificity of Sexual Counseling and Degree of Satisfaction with Sexual Counseling

Degree of Specificity (Part III)	Degree of Satisfaction (Part III)			
	Highly	Moderately	Mildly	Unsatisfactory
Highly	4	0	0	0
Moderately	4	1	0	0
Mildly	2	0	0	1
Non-Specific	0	0	0	0
No Sex Counseling	0	1	0	6

received prepared them to return to previous sexual patterns, answered their questions concerning heart problems and sex, and informed them when they could resume sexual activity.

In Part III of the Sexual Counseling Measure the subjects indicated degree of satisfaction with the sexual counseling. Sixty percent (12) of the subjects rated the counseling as mildly to highly specific. In determining their satisfaction with the counseling, 90% (10) rated it as highly satisfactory and 10% (1) as moderately satisfactory. Seventy-five percent (15) of the subjects agreed that sexual counseling should be a part of routine health care. The data indicated that the majority of the subjects in this study did have questions and concerns about resuming sexual activity and do want health professionals to provide sexual counseling.

CHAPTER 5

SUMMARY, DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of the study was to determine if nurses were promoting sexual health by providing sexual counseling and if this counseling was specific and satisfactory in assisting post myocardial infarction clients in resumption of sexual activity. A review of the literature, the procedure for collection of data, and data analysis have been presented in previous chapters. This chapter summarizes the study, discusses findings and implications, and suggests areas for further study.

Summary

The Sexual Counseling Measure was the tool used to survey 20 post myocardial infarction clients. The purpose was to determine if the clients received any information on resuming sexual activity and if so who provided the information, and if the information received was specific to their needs and satisfactory in assisting them to return to sexual activity. The data were analyzed using descriptive statistics. Frequencies and percentages were used for the demographic data of sex, age, and whether the counseling

was provided in a cardiac rehabilitation program. Frequencies and percentages were used to analyze each category of the questionnaire. Cross tabulations were done for comparison of responses.

Discussion of Findings

The results of the study indicated that 85% (17) of the subjects received information regarding resumption of sexual relations. Forty percent (8) of those subjects received the information from the doctors. The 15% (3) of the subjects who did not receive this information received no information on returning to sexual activity. The information in eight (67%) of the questions was provided to 45% (9) or fewer of the subjects. These results are comparable with the findings of Tuttle, Cook, and Fitch (1964) who found that 67% of their subjects received no advice regarding sexual activity and 33% received vague advice. In 10 (83%) of the questions the information was provided by doctors only 10% of the time. These findings agree with the literature that physicians do not provide information on sexual activity. The study performed by Papadopoulos (1978) revealed that only 9.6% of the physicians provided information on resuming sexual relations, and 42% provided none even when requested by the patient. Nurses

provided the information only 20% of the time and only 45% or fewer subjects received the information. These findings would tend to reflect the literature that nurses tend to be reluctant to discuss sexuality with clients because of inadequate knowledge and understanding (Hogan, 1980).

Of the 11 (55%) subjects who stated they received sexual counseling, 90% (10) felt the counseling was specific and adequate in assisting them to resume sexual relations. Ninety percent (10) of the subjects indicated the counseling reduced their anxiety over resuming sexual activity. These findings agree with those of Papadopoulos (1978). He found that fear of resuming sexual relations was expressed in 27% of the subjects who received instructions.

The sexual counseling was rated as highly satisfactory by 90% (10) of the subjects. Seventy-five percent (15) of the subjects strongly agreed that counseling on sexual functioning after a coronary should be included as part of routine health care. The data agrees with the findings of Horgan and Craig (1978). They found that 84% of their subjects believed sexual activity should be discussed by the hospital physician and 43% by the family physician.

Conclusions and Implications

The purpose of the study was to gain information on

whether nurses were providing sexual counseling to post myocardial infarction clients and if the counseling was specific and satisfactory. The results of this study are not generalizable since it was a small convenience sample taken from only one location.

The following conclusions are based on the findings of this study:

1. Nurses provided only 20% of the sexual counseling to post myocardial infarction clients.

2. The clients perceived the information they received as specific and satisfactory in assisting them to resume sexual relations post infarction.

3. Post myocardial infarction clients do want sexual counseling.

The findings of this study indicate that nurses are not providing sexual counseling to their post myocardial infarction clients. Clients, however, do perceive information on resuming sexual relations as beneficial.

Recommendations

Based on the findings of this study, the following research recommendations are suggested:

1. A replication of this study using a larger sample.

2. A study of nurses' attitudes and knowledge toward discussing sexual matters with patients.

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APPENDIX A

PHYSICIANS' APPROVALS

February 14, 1985

To: Texas Woman's University

I, Dr. Alfredo Nodarse, give my permission to Susan Shea to contact the patients whom I have designated for the purpose of asking them to participate in her research study.

Sincerely,

Dr. Alfredo Nodarse

February 14, 1985

To: Texas Woman's University

I, Dr. Carlos Maruri, give my permission to Susan Shea to contact the patients whom I have designated for the purpose of asking them to participate in her research study.

Sincerely,

Dr. Carlos Maruri

February 14, 1985

To: Texas Woman's University

I, Dr. Swayam Prakash, give my permission to Susan Shea to contact the patients whom I have designated for the purpose of asking them to participate in her research study.

Sincerely,

Dr. Swayam Prakash

APPENDIX B

QUESTIONNAIRE PACKET

Re: Sexual Counseling Measure

Dear Client,

Frequently individuals are invited to participate in research studies which are conducted by health care professionals. The purpose of these studies is to obtain information that will assist them in improving the quality of health care. You have been invited to participate in such a study.

Enclosed is a questionnaire entitled the Sexual Counseling Measure. This is an instrument that was developed to record the opinions of cardiac clients on sexual counseling. The purpose of this study is to obtain information on the counseling that is provided to cardiac clients and to assist us in improving the quality of that counseling. It is also fulfilling my requests for my Masters in Nursing from Texas Woman's University.

Because of the sensitive nature of this quesionnaire, you may experience some embarrassment or anxiety in answering the questions. Also, my presence during the completion of the questionnaire may enhance these feelings. Be assured your name will not be mentioned anywhere in the study and to further guarantee anonymity, please DO NOT place your name anywhere on the questionnaire or the envelope marked SCM. The envelopes will not be opened until all the questionnaires are returned. No medical service or compensation is provided to subjects by the university as a result of injury from participation in research.

The results obtained from the study can be shared with you at your request. If you wish a copy of the results, please self-address the envelope provided to you. After completing the questionnaire, place it in the envelope marked SCM, seal it, and return it to me.

I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

I will wait while you complete the questionnaire and I thank you for your cooperation.

Susan Shea

Susan M. Shea, R.N., B.S.N.

SEXUAL COUNSELING MEASURE

Please answer the following questions by placing a check mark in the space provided.

Male _____ Female _____

Did you attend a Cardiac Rehabilitation Program?

Yes _____ No _____

Please indicate age _____

SCM
PART I - CONTENT

The first part of the instrument is concerned with sexual counseling content and the person who discussed the content with you. At the right of each question are spaces marked yes, no, doctors, nurses, and others (specify). Please mark every question as many times as appropriate. Do not leave out any question.

Since your hospitalization for a heart attack, have YOU been given any of the following information:	YES	NO	Was the information given to you by Doctors	Nurses	Others
1. When you could resume intercourse?					
2. To avoid intercourse one to three hours after a heavy meal with food and drink?					
3. To avoid drinking alcohol, particularly wine, before having intercourse?					
4. To avoid eating or drinking extreme hot or cold foods or liquids before having intercourse?					
5. To avoid having intercourse in extreme cold, hot, or high humidity places?					
6. To have intercourse only with your usual partner(s)?					

	YES	NO	Was the information given to you by Doctors	Nurses	Others
7. To keep your usual sexual pattern(s) but to avoid long or vigorous effort with the arms and shoulders?					
8. To rest after intercourse?					
9. That if you have chest discomfort during intercourse to use nitroglycerine before and/or during intercourse?					
10. That if you have chest discomfort during intercourse to relax then continue the activity?					
11. That the first time you have sexual intercourse to assume the less aggressive role between you and your partner?					
12. That elevating the head of the bed 10 to 14 degrees will reduce sensations of pressure in the chest and neck?					

PART II - ADEQUACY

The second part of the instrument is concerned with determining whether or not the sexual counseling given was or was not useful to you. At the right of each opinion are spaces marked yes and no. If in your opinion, NO sex counseling was given, please DO NOT respond to No. 13, go to the next page and respond ONLY to No. 14, 15, and 17. If in your opinion, sex counseling was given respond to No. 13, 14, 15, 16, and 17.

13. In my opinion the sex counseling I received during this hospitalization:

	YES	NO
a. Was specific to my needs		
b. Was so general that it could apply to anyone		
c. Was presented so that I could understand		
d. Was asked for by me		
e. Was offered to me		
f. Gave me an opportunity to ask questions		
g. Included my sex partner(s)		
h. Decreased my anxiety over resuming sexual activity		
i. Has given my assurance that I can resume my past pattern of sexual activity		
j. Has prepared me to return to my previous sexual patterns		

	YES	NO
k. Has answered questions I had concerning heart problems and sexual activity		
l. Has answered questions for my sex partner(s) concerning heart problems and sexual activity		
m. Has informed me as to when I can resume sexual activity		

SCM
PART III - SATISFACTION

The third part of the instrument is concerned with determing your opinion regarding satisfaction with the sexual counseling. Please select ONE answer for each of the following responses which most closely reflects your feelings.

14. In my opinion the sexual history obtained from me during this hospitalization was:

    a. highly specific
    b. moderately specific
    c. mildly specific
    d. non-specific
    e. no sex history was taken

15. In my opinion the sexual counseling I received during this hospitalization was:

    a. highly specific
    b. moderately specific
    c. mildly specific
    d. non-specific
    e. no sex counseling was given

16. I rate the sex counseling I received during this hospitalization as:

    a. highly satisfactory
    b. moderately satisfactory
    c. mildly satisfactory
    d. unsatisfactory

17. Counseling on sexual functioning after a coronary should be included as part of routine health care:

    a. strongly agree
    b. agree with reservations
    c. disagree with reservations
    d. strongly disagree

APPENDIX C

HUMAN RIGHTS REVIEW COMMITTEE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

PROSPECTUS FOR THESIS

This prospectus proposed by: Susan M. Shea

and entitled:

SEXUAL COUNSELING OF THE POST MYOCARDIAL INFARCTION CLIENT

Has been read and approved by the members of her Research Committee.

This research (check one):

_x_ Is exempt from Human Subjects Review Committee review because

It is a questionnaire research with adults.

___ Requires Human Subjects Review Committee review because

Research Committee:

Chairman _____

Member _____

Member _____