

Sexual Counseling in Post-Myocardial Infarction
Patients

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"I lose my respect for the man who can make the
mystery of sex the subject of a coarse jest, yet when
you speak earnestly and seriously on the subject is
silent." Thoreau

Running head: SEXUAL COUNSELING

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Introduction

The American Heart Association (1985) reported that in 1986, 1,500,000 Americans will have had a myocardial infarction (M.I.). In the last fifteen years, cardiac rehabilitation programs have been developed to assist patients who have survived myocardial infarction. These programs support early and repeated functional testing of the patient to detect abnormalities and provide a basis for treatment modalities, individually prescribed graduated programs of exercise designed to enhance functional capacity, and a rehabilitation team approach involving health professionals skilled at psychologic, dietary, vocational evaluation and counseling (Andreoli, Fowkes, Zipes, and Wallace, 1983).

One component of rehabilitative health counseling is sexual counseling. There is a widely held belief among lay people, that sexual activity following myocardial infarction should be curtailed if not stopped completely. As an element of cardiac

rehabilitation, sexual counseling should inform individuals about normal sexuality and possible adjustments that can be made to allow patients who have had a myocardial infarction to enjoy a normal sex life without cardiac symptoms (Hott, 1980). Resumption of sexual activity is an integral part of rehabilitation (Papadopoulos, 1978). Sexual activity improves general health, self esteem, and self image (Cooper, 1985; Papadopoulos, Larrimore, Cardin, and Shelley, 1980; and Kavanaugh and Shepard, 1977).

Therefore, the thought that an individual's sex life is over after myocardial infarction is a serious myth that needs to be dispelled. Experts agree that there are no physiological reasons why the majority of cardiac clients cannot resume and achieve a satisfactory sexual relationship with their usual sexual partners (Cole, Levin, Whitley, and Young, 1979; Davidson, 1979; Hellerstein and Friedman, 1970; and Larson, McNaughton, Kennedy, and Mansfield, 1980). The often held notion associating sex with overly strenuous physical activity and risk of sudden death is inaccurate.

Studies show that patients who have experienced myocardial infarctions are not receiving adequate counseling about resumption of sexual activity after the infarction. In a study conducted by Tuttle, Cook, and Fitch (1964), men attending a cardiac work evaluation unit were questioned about their sexual activity. Two-thirds reported they received no instruction after their heart attack. Puksta (1977) reported that when instruction occurred, sexual counseling information was too vague to be helpful. Papadopoulos (1980) and Hentinen (1983) examined the sexual concerns and needs of the post-coronary patient's wife. These studies also revealed sexual counseling as inadequate, frequently overlooked, and ineffective in alleviating fears. In the authors' practice, patients have frequently expressed frustration in not receiving instruction regarding resumption of sexual activity after myocardial infarction.

Statement of the Problem

To date, studies examining patient analysis of the various components of sexual counseling following myocardial infarction have not been reported. A review of the literature revealed only incidental reports of concern and questions regarding resumption of sexual activity and the role of health care professionals in education of post myocardial infarction patients. The description of their concerns and exploration of current health care professional practice has not been done.

Knowledge of sexual counseling as a component of cardiac rehabilitation is essential for nurses involved in educating patients who have experienced myocardial infarction. Adequate and helpful instruction given to patients and their sexual partners may alleviate their concerns and prevent unnecessary abstinence or decrease in sexual activity. The purpose of this study is to describe the components of sexual counseling patients receive after myocardial infarction, when they receive the counseling and when they would prefer to receive it.

The purpose is also to discover if there is a correlation between perceived helpfulness of sexual counseling and earlier resumption of sexual activity and to determine if selected demographic variables are associated with frequency and resumption of sexual activity.

Literature Review

In the days following a myocardial infarction patients are confused, concerned and frightened about their health. Although they may know other people who have been through this experience or may even be a member of the health profession, this knowledge base is not adequate to cope with personal illness. Research in the area of sexual counseling post-myocardial infarction is limited. Hellerstein and Friedman, (1969, 1970) reported that a review of 33 cardiology textbooks revealed almost no information regarding sexual counseling or advising. Prior to their study little research had been done in this area.

Current literature about resumption of sexual activity available to these patients describes recommended positions, time of activity, and symptom management which are primarily based on the philosophy of energy conservation. It has not been documented that education delivered by health care professionals and consisting of modification of sexual activities is worthwhile, helpful or followed. In research studies on other topics, respondents frequently volunteered

that sexual counseling was not initiated, did not involve the significant other and did not answer questions.

In 1964, Tuttle, Cook and Fitch interviewed men in a cardiac work evaluation program about their sexual activity. These men had experienced a MI from one to nine years previously. Two thirds reported receiving no advice about sex and one third reported receiving advice that was "vague and unspecific" (p. 140).

Masters and Johnson (1966) found in their study that two-thirds of their patients who had suffered myocardial infarctions received no advice from the medical team, and those who did receive advice frequently found it not useful.

As recently as 1987, Baggs & Karch interviewed a convenience sample of 58 women (age 30-78) prior to discharge following MI. The results of their study described the majority as stating that no one had approached them about sexual counseling. Most of the information they received was in a booklet. When this sample was asked if health professionals should

routinely initiate discussion about sexual activity two-thirds felt they should. Many of this sample also described feelings of shyness, embarrassment and fear about initiating discussions about sexual activity.

Physiologically, there may be a basis for sexual dysfunction post-MI. However, some dysfunction may be subjective perceptions about quality. Tuttle, Cook and Fitch (1964) reported that only one-third of their population resumed levels of sexual behavior equal to those prior to illness. Hellerstein and Friedman (1969) found that one fourth of their sample perceived a significant degree of sexual dissatisfaction from increased tension associated with resuming sexual activities. One author included some dismal predictions regarding the significance and passion of sex after forty (Green, 1975). This review of literature will focus on the most commonly reported components of sexual counseling.

Assessment of Sexual Activity

The assessment of sexual activity prior to illness must occur before initiating counseling (Scalzi, 1982; Abbott & McWhirter, 1978; Friedman, 1978; Green, 1975;

and Hellerstein & Friedman, 1970). The health and attitudes of the spouse or significant other should also be considered (Scalzi, 1982; Green, 1975; and Hellerstein & Friedman, 1970) as several authors have documented (Jenkins, Kent, Mayberry & Colbourne, 1984; Cohen, Wallston, and Wallston, 1976; Koller, Kennedy, Butler & Wagner, 1972; and Wagner, 1975). The assessment of sexual function prior to a myocardial infarction is needed for a baseline against which to evaluate their return to normal function.

In two separate studies on men and women investigators found significant levels of sexual dysfunction in subjects prior to their heart attacks (Wabrek & Burchell, 1980). Abramov (1976), in a survey of 100 female post myocardial infarction patients found sexual frigidity and dissatisfaction among 64%. Waabrek and Burchell surveyed 131 male patients (age 31-86) regarding their sexual activity prior to myocardial infarction and reported two-thirds with significant sexual dysfunction including impotence, decreased frequency and premature ejaculation. In

1980, Papadopoulos described the concerns of wives of post-myocardial infarction patients. Only 45 of 100 women had received any sexual information prior to discharge with a wide disparity in the kind of information received. Seventy-six of these women reported a decrease in the frequency and quality of sexual activity.

Psychological factors such as depression and anxiety will also influence the return to previous levels of function and should be assessed and considered in the counseling process (Friedman, 1978; Green, 1975; and Hellerstein & Friedman, 1970). Scalzi and Dracup (1978) suggest that perceived changes in body image may also contribute to anxiety and depression affecting resumption of sexual activity.

Finally, physiological factors, including cardiovascular status, general health, extent of recovery, severity of damage, and frequency of pain or arrhythmias must be assessed prior to initiation of counseling (Abbott & McWhirter, 1978; Friedman, 1978; Hellerstein & Friedman, 1970; and Wagner, 1975).

Energy Expenditure of Sexual Activity

Sexual activity causes an increase in heart rate, blood pressure, and respirations. The heart rate increases to a rate of 110 to 180 beats per minute, the average heart rate elevating to 117 during orgasm. It is interesting to note in comparison that the average heart rate for sedentary occupations was found to be 120. Systolic blood pressure increases with sexual activity have been noted from 40-80 mmHg. and diastolic elevations from 20-50 mmHg. Respiratory rates increase to 30 to 60 per minute (Cole, Levin, Whiteley, & Young, 1979; Koller, Kennedy, Butler, & Wayner, 1972; and Hellerstein and Friedman, 1970).

Griffith (1973) reported that the oxygen uptake during intercourse is one-half that which occurs during a Masters 2-step test. Energy requirements of sexual activity have also been related to the levels of physical activity performed safely on a treadmill (Davidson, 1979). Puksta (1977) and Koller, Kennedy, Butler, & Wayner (1972) reported that the physical cost of sexual activity is modest for middle-aged, middle-class, long married individuals.

The energy requirements of sexual activity have been compared to several activities of daily living. Cole, Levin, Whitely, & Young (1979), reported that sexual activity on the average, required 3.7 mets, an effort equal to the amount of energy utilized to scrub floors or climb several flights of stairs. This was supported by other researchers (Larson, McNaughton, Kennedy, and Mansfield, 1980; Puksta, 1977; Koller, Kennedy, Butler, and Wagner, 1972; and Hellerstein & Friedman, 1970). Therefore, the energy demands of sexual activity are below those needed for most activities which require 5 to 6 mets. Other activities that parallel energy expenditure of sexual activity are: the raking of leaves (Cooper, 1985), driving a car, engaging in an argument, or discussing business (Puksta, 1977; Koller, Kennedy, Butler, & Wagner, 1972; and Hellerstein & Friedman, 1980). Wagner and Sivarajan (1975) suggested the therapeutic use of masturbation as a method of re-entrance into sexual activity, citing that at the time of orgasm by masturbation the heart rate rises briefly to 110-130.

The calculation of metabolic rates has encouraged many researchers to compare physical activity to sexual activity. Larson, McNaughton, Kennedy & Mansfield (1980) stated that 10 minutes of brisk walking followed by the climbing of two flights of stairs within 10 seconds is a physiological test of readiness to resume sexual activity after a myocardial infarction. Hellerstein and Friedman's (1970) studies showed that the energy levels and demands placed on the heart during sexual activity are equal to walking briskly on the street or climbing one or two flights of stairs. They recommended resumption of sexual activity when the patient states the ability to perform this activity. Abbott & McWhirter (1978), and Koller, Kennedy, Butler, & Wagner, (1972) agreed with this approach. The actual time period for the attainment of this level of physical functioning is 5-8 weeks post-myocardial infarction.

The comparison of physical activity to energy requirements for resumption of intercourse suggests that conditioning may be helpful for overall feelings of wellness and increased sexual functioning.

Hellerstein and Friedman's (1970) subjects were participating in an exercise program and thus may have benefited from improved tolerance. Eliot and Miles (1975) and Gullledge (1975) recommended a conditioning program for those patients who can tolerate the activity. Stein (1977) reported increased aerobic capacity and consequent reduction in peak coital heart rate in 16 men (ages 46-54) who participated in a 16-week bicycle ergometer training program 12 to 15 weeks after myocardial infarction.

Scalzi and Dracup (1978) recommended physical conditioning 6-8 weeks post MI to "enhance exercise tolerance and ability to participate in intercourse" (p.843). Stein (1977) and Hellerstein (1965), have shown that the physically conditioned post-coronary patient can perform a given amount of physical work at a significantly lower heart rate and lower systolic blood pressure than can the untrained cardiac patient.

Roviaro, Holmes and Homsten (1984) surveyed 28 patients who had undergone bypass surgery or had a myocardial infarction and were placed in an

exercise program. Four months later these patients reported numerous positive effects from conditioning, most pertinent being more frequent sexual activity, improved self-concept and improved psychosocial functioning. Stern & Cledary (1981) also reported positive sexual functioning with low-level exercise following myocardial infarction.

Resumption of Sexual Activity:

Puksta (1977) reported that sexual activity may be resumed when a patient can exercise at a level of three to five mets (the equivalent of a Master 2-step test or vigorous walking) without experiencing symptoms, such as an abnormal pulse rate, blood pressure or electrocardiogram changes. Cole, Levin, Whitley, & Young (1979) proposed that routine stress tolerance tests can determine a patient's capacity for resuming daily activities.

There are some patterns of sexual activity that have been described as contributing to the incidence of pain, impotence and further infarction. Guidelines for resumption include, the avoidance of temperature extremes and waiting three hours following a meal or

intake of alcohol before engaging in sexual activity (Griffith, 1973; Semmler & Semmler, 1974; Masur, 1979; and Abbott & McWhirter, 1978). Griffith (1973) and Masur (1979) were even more specific and recommended sex in the morning with rest periods before and after. Masur (1979) and Semmler and Semmler (1974) recommend avoiding emotional stress and fatigue.

The resumption of sexual activity has been limited in some patients by impotence. Authors report that impotence occurred in 10% to 30% of the subjects (Tuttle, Cook, & Fitch, 1964). Bloch, Maeder, & Haissly (1975) surveyed 88 males and 12 females (age range of 28-71 years) regarding their pre- and post-coronary activity. The mean frequency of intercourse was reduced from 5.2 to 2.7 per month, although other levels of normal activity had been resumed. The causes included decreased desire, increased anxiety, fear, fatigue, angina, impotence and the wife's abstinence.

Amsterdam, Amsterdam, Riggs, DeMaria & Mason (1977) interviewed 107 male patients post-coronary and

found that only 53% had resumed sexual activity. Reasons for non-resumption included pain, dyspnea and impotence. This study also surveyed the subjects recall of post-coronary sexual counseling. Only 21% recalled that their physicians initiated discussions, although 65% expressed a desire for information. Fear of sexual activity was reported by 43%. These authors felt strongly that their patients' needs for education were not being met.

Krop, Hall & Mehta (1979) interviewed 100 married male patients who had suffered myocardial infarctions. The discussion of sexual activity was initiated by the physician in only 16% of the cases while 20% were initiated by the patient. No discussion was held with 64% of the patients although 66% expressed concerns about resuming sexual activity. Mehta and Krop (1979) interviewed this same population six months after discharge. At that point, 30% had not resumed sexual activity. Only 29% had intercourse at least once a week as opposed to the 72% who had intercourse at least once a week prior to their infarction. Their reasons for decreasing the frequency of sexual

activity included impotence, chest pain, lack of physical fitness, lack of desire, fear and depression.

As recently as 1983, Papadopoulos surveyed 130 female post-coronary patients. Sexual activity was not resumed by 27%, was unchanged by 27% and was decreased by 44%. Only 45% of the total group received sexual instructions before discharge and in only 18% of the cases did the physician initiate the discussion.

Positions Used During Sexual Intercourse

The literature addressing positions used by cardiac patients during sexual intercourse is contradictory and directed to the heterosexual male population. No information is reported addressing female positions. Scalzi (1973) recommends that patients use the male on bottom (MOB), side by side, or patient seated in an armless chair with feet on the floor positions because these impose less strain on the patient. Koller, Kennedy, Butler, & Wagner (1972) advise patients to assume positions that do not require use of the arms to support their body weight. They recommend MOB and side lying positions.

More current literature failed to confirm that the MOB position during sexual intercourse resulted in less increase in heart rate and blood pressure. The mean maximal heart rate for the MOB position was 117, while for the male on top (MOT) position was 114. Mean blood pressure for the MOB was 161/77 and for the MOT 163/81. Therefore, no statistical or clinical significance was found in relation to position used during sexual intercourse and mean heart rate and blood pressure (Nemec, Mansfield, & Kennedy, 1976). Further data showed that it is not necessary to recommend a change of position during intercourse, especially if the suggested position is unfamiliar (Papadopoulos, Larrimore, Cardin, & Shelley, 1980).

These data demonstrate that there is no physiological basis for advising cardiac patients to utilize the MOB position during sexual intercourse. Rather, it seems more appropriate to refer patients to use positions which are familiar and comfortable.

Sexual Partners and Coital Death

Most sexually related deaths of cardiac patients reported in the literature have occurred under

"abnormal" circumstances. Malik (1979) reviewed two case studies that involve unusual sexual incidents resulting in death when the sexual act occurred in prostitutes' apartments in the afternoon and in extramarital situations (Verhano, 1976, and Felstein, 1977). Malik stated that emotional stress and physical exertion were exaggerated under these conditions. Uneo (1963) found that four out of every five coital deaths were out of wedlock. The occurrence of coital death was low when the patient engages in sex with a partner of many years (Puksta, 1977 and Hellerstein & Friedman, 1970).

These data suggest that cardiac patients should be encouraged to avoid vigorous variations in their sexual patterns. Patients should also be informed that sex with a regular partner has thus far been proven to be safer than having sex with an unfamiliar partner (Hellerstein & Friedman, 1970; Wagner, 1975; Eliot & Miles, 1975; Malik, 1979; and Hott, 1980).

Initiation of an Educational Program

The appropriate timing for sexual counseling has not been well established. Moynihan (1984), in an

educational needs survey with 17 respondents, reported that during phase II (after CCU and on the general ward) sexual education was identified as a need. Some authors recommend introduction as early as in the CCU (Scalzi and Dracup, 1978), while others include counseling during home convalescence (Borgman, 1975). These recommendations are based on the authors' experiences with clients in the practice setting. In the situation of an uncomplicated myocardial infarction, these patients will stay in a CCU for 2-4 days. Total hospital stay without complications ranges from 8-10 days.

In 1978, Scalzi and Dracup suggested that patients may have questions regarding sexuality as early as in the CCU. They suggested introduction of the topic very early and by explaining that most individuals suffering an MI are able to return to all usual or modified activities after an MI. Sexual activities are then included in any discussion of physical activity. The foundation they use for sexual counseling is described by Athanasiou (1973) and expanded by Mims (1975). There are three principles:

1. The acceptance that major value conflicts exist in our society, and there is no consensus among adults on acceptable values in human sexuality (i.e. the counselor must establish a non-judgmental attitude).

2. Guidance should be given by education rather than indoctrination. Counseling is ineffective if the counselor imposes his or her values on the patient rather than the facts.

3. Patients should be assisted toward intelligent self-determination rather than conformation to procedures. Education and counseling must prepare the patient to make his own educated choices (pg. 521).

Assessment for implementation of counseling first assumes physiologic safety. As identified by Maslow (1970) basic needs must be met prior to motivation for self actualization. Once these needs have been met, readiness to learn can be assessed. In this setting, the patient should not be in the throes of an evolving myocardial infarction but should be recovering and pain free.

The readiness of this population to learn has not been established. Redman and Thomas (1985), suggested that "any teaching intervention should be based on limitations of memory; the effects of anxiety on perception and information processing; the usefulness of getting messages through several senses and of exploiting natural readiness to learn when it is available; the need for active involvement and practice in order to internalize learning and to perfect skills" (p. 162).

The need for teaching can be assessed either by request for information or recognition of needs by health care professionals (Redman, 1984). Storlie (1985) states that assessment of needs in the latter case requires expertise, interest and anticipation from the teacher. Included within the assessment is previous knowledge, level of understanding and educational level (Hogan, 1980). The failure of a patient to ask questions shouldn't mislead one into assessing an adequate knowledge base (Redman, 1984).

Kerfoot and Buckwalter (1985) described three possible consequences resulting from exclusion of

sexual counseling in a nursing care plan: clients may not realize that alteration in sexuality may be a reflection of their illness, lack of information about alternative forms of sexual expression may prevent a satisfying portion of life, and disturbances in relationships may occur.

Scalzi (1982) recommended specific areas to include in learning needs assessment for the cardiac patient:

1. Assessment of the patient's past experience with chest pain during sexual stimulation and/or intercourse.

2. Assessment of a previous history of sexual difficulties prior to the heart attack.

3. Assessment of the patient and partner's understanding of when they can resume sexual activity (page 16).

Redman (1984), has divided the goals of learning into three domains; cognitive, affective and psychomotor (Redman, 1984). The affective domain (attitudes) is the most difficult to influence and the most critical in resumption of sexual activity.

Attitudes are best influenced by discussion of feelings, gaining acceptance of feelings and assistance in actualization (Redman, 1984).

Retention of learning in patients is most improved by using shorter words and sentences, explicit categorization, repetition, and use of concrete-specific directions (Ley, 1979). Research focusing on patients recovering from myocardial infarction is needed in this area.

The resumption of sexual activity is frequently mentioned as important to include in the education handbook the patient takes home (Cole, Levin, Whitley, & Young, 1979; Moore, Folk-Lighty & Nolen, 1977). Sexual counseling should also be included in the educational/rehabilitation process at the time of "home convalescence" (Borgman, 1975). Cohen, Wallston, and Wallston (1976) interviewed 17 former cardiac patients and their spouses. From this small sample they found that questions about sexual activity resolve themselves in some way (positively

or negatively) about three to four months post-coronary. Several authors note that most patients may resume sexual activity one to two months after their myocardial infarction (Malik, 1979; Cole, Levin, Whitley, & Young, 1979; and Puksta, 1977). Therefore sexual counseling should be initiated during hospitalization and continue on an outpatient basis.

Conceptual Framework

The literature regarding sexual education following a myocardial infarction contains subjective comments by patients regarding their health status. Some express feelings of chronic illness while others feel healthy and are resuming pre-infarction activities. A conceptual framework incorporating elements of health and illness as integrated entities is most helpful in explaining the various patient responses to illness and resumption of activities of daily living and serves as a guide for nursing actions from a holistic perspective.

The difficulty in defining health is not new. Mercer (1972) felt health was present in the absence of pathological symptoms. Dorothy Orem also described it as an intact versus disrupted state. "Health and healthy are terms used to describe living things . . . when they are structurally and functionally whole or sound. Individual human beings are said to be healthy or unhealthy" (p. 118).

In 1976, Roy described health on a continuum ranging from peak wellness to death. The primary

descriptor of health is the absence of pathology. Neither of these two approaches describes health from the patient's perspective.

A model of health which combines client and biomedical vantage points is delineated by Tripp-Reimer (1984). She used definitions based on a distinction in linguistics between phonemic and phonetic. Pike (1954) coined the terms emic and etic. These terms are based on the study of phonemics which involves the study of sounds used in a particular language. Phonetics is the study of individual languages compared to universal similarities (Tripp-Reimer, 1984). These linguistic terms and their definitions were used by Pike to describe emic as cultural distinctions and etic as objective observation of behavior.

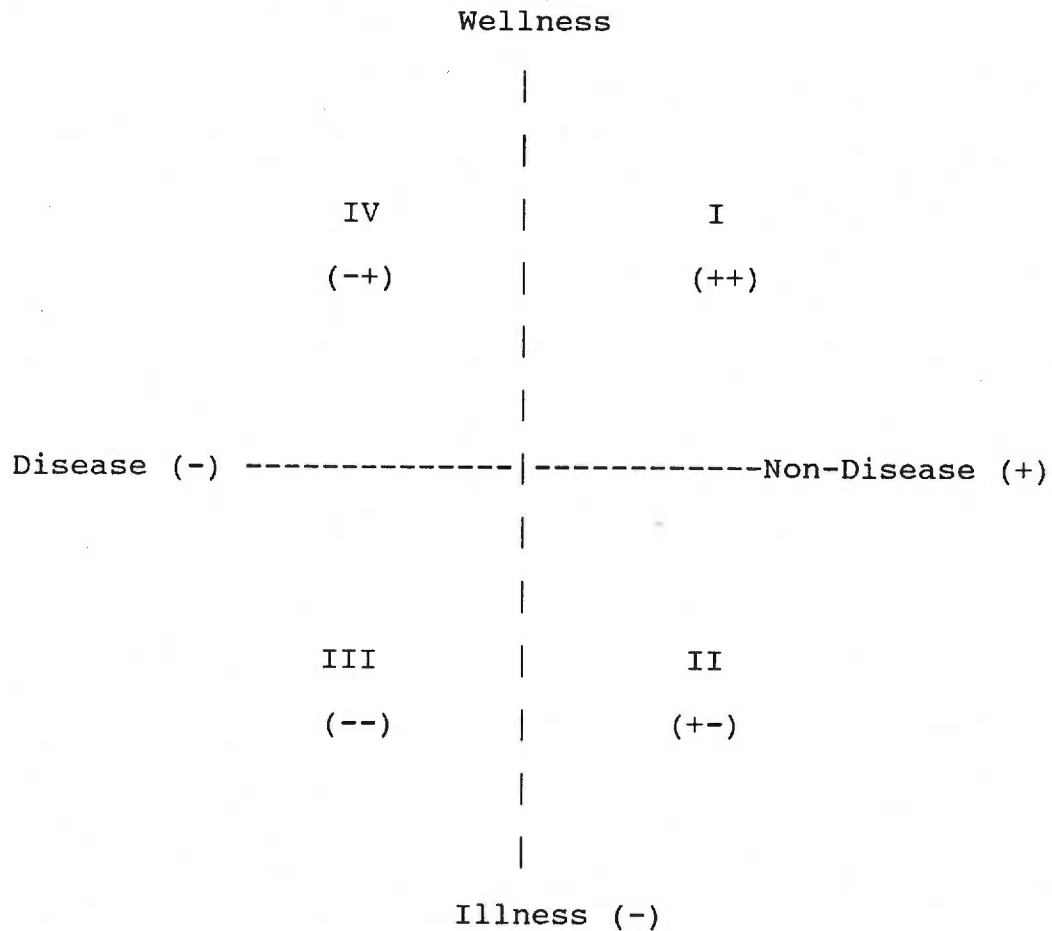
These definitions are then applied to Western biomedicine using etic as objective data from individual clients and emic which focuses on the subjective perspective of the client. Disease is an etic category. It is defined as certain abnormal signs and symptoms which can be observed, measured,

recorded, classified and analyzed according to clinical standards of abnormality (Idler, 1963). Illness is in the emic category. It is a subjective phenomenon in which individuals perceive themselves as not feeling well. Illness describes an individual's perception of self (Idler, 1963).

In development of a health grid, Tripp-Reimer (1984) utilized and incorporated not only the individual categories - but the variations and combinations between. The emic-etic health grid incorporates the two perspectives of disease/non-disease and wellness/illness. Quadrants specify areas of congruence or incongruence with assessments by practitioners (see Figure 1).

The grid graphically demonstrates the etic (objective) and the emic (subjective). The horizontal axis consists of the continuum of disease to non-disease. This etic axis reflects the assessment by a health care practitioner. The vertical emic axis depicts the continuum of illness at the bottom to wellness at the top. This axis then delineates four quadrants of congruence or incongruence.

Figure 1 The emic-ethic health grid.



Note. From "Reconceptualizing the Construct of Health: Integrating Emic and Etic Perspectives" by T. Tripp-Reimer, 1984, Research in Nursing and Health, 7, pg. 104.

Quadrant I represents the intersection of non-illness and non-disease. The patient and practitioner agree. The client subjectively feels fine and the practitioner does not find evidence of disease.

Quadrant III (diagonal from I) also represents congruence. The patient does not feel well and there is evidence of disease. An example of this congruence in the post-infarction patient is the individual who continues to have unstable angina (chest pain) following recovery from MI.

Quadrants II and IV reflect incongruence. The health care provider and the patient view the health state as very different. In quadrant II (non-disease/illness) there is no objective sign of disease. The patient however feels ill. In Quadrant IV (disease/wellness), the practitioner has evidence of disease while the patient feels fine. In the population of post-infarction patients these quadrants can reflect those patients who remain "invalid like" in their activity without evidence of continuing symptoms, as contrasted with those patients with

severe cardiac disease who perceive themselves as well and then may not perceive any limitations on their activity.

The use of this framework assists in clarifying and classifying patients' responses to illness and their feelings (or lack of) of good health.

As stated earlier, experts agree there is little evidence of a physiological basis for not resuming sexual activity post-myocardial infarction. However, the review of literature shows that many post-MI patients reduce their sexual activity and common reasons include impotence, chest pain, lack of physical fitness, lack of desire, fear and depression. A determination of the educational needs of these individuals with appropriate sexual counseling can lead to congruence between the health care professional and patient regarding the individual's health state.

Research Questions

1. When are patients who have had a myocardial infarction receiving sexual counseling?
2. When would patients who have had a myocardial infarction prefer to receive sexual counseling?
3. What components of sexual counseling are patients receiving after myocardial infarction?
4. Did post-MI patients who received sexual counseling and perceived it as helpful, resume sexual activity earlier than those patients who did not receive sexual counseling?
5. Did post-MI patients who received sexual counseling and perceived it as helpful, resume sexual activity earlier than those patients who received counseling but did not perceive it as helpful?
6. Are selected demographic variables associated with frequency and resumption of sexual activity?

Methods

Design

This study employed a descriptive design. The subjects were asked to respond to a questionnaire addressing sexual activity and sexual counseling following a myocardial infarction.

Sample and Setting

A convenience sample of 155 subjects was obtained from the caseload of private physicians and nurse practitioners in a large metropolitan area of the Pacific Northwest. Men and women aged 21 years and older who had a myocardial infarction in the past two years were approached for inclusion in the study. The two year limit was to control for the effects of memory.

Data Collection Procedure

The questionnaires were mailed to those individuals identified as possible participants. A cover letter stating the purpose of the study and procedures for maintaining confidentiality and anonymity was enclosed. (See appendix II)

A self-addressed, stamped envelope was included for the return of the questionnaire. At the end of one week, prompter letters were mailed to all members of the sample. (See Appendix III) At the end of the second week post-mailing, a second prompter letter was mailed. (See Appendix IV) The questionnaires had no marks of identification in order to provide confidentiality and anonymity of response. Thus the total sample received prompter letters. Consent to participate was implied by the act of questionnaire completion. If participants desired a copy of the final results they enclosed their names and addresses in a small sealed envelope which was opened at the conclusion of the study, when results were forwarded to them.

Instrument Development

An in-depth review of the literature revealed a lack of instruments designed to elicit information regarding sexual concerns and counseling for patients post-myocardial infarction. Therefore, the questionnaire used in this study was developed by the investigators. The items included reflect

those areas of concern indicated by researchers in previous studies and those areas thought to be essential in sexual counseling by post-MI patients. The questionnaire was studied for clarity and word use by ten lay people. Their comments were used to revise the tool.

Following the pilot, their comments were used to simplify the language of some questions. In addition, the flow and organization of questions was not clear to the pilot group. The format and arrangement as well as the order of questions were changed to incorporate those comments.

Instrument

The questionnaire seeks demographic data, to include age, sex, date of most recent heart attack, and marital status. Questions designed to elicit information about any sexual counseling, content and timing of counseling follow the demographics. Questions eliciting information about resumption of sexual activity, energy requirements and symptom management were incorporated. A survey of counseling received regarding sexual partners and location of

sexual activity is included. Finally, one fill-in question seeks any information patients would have liked to receive. (See Appendix I).

Plan for Data Analysis

Data from the questionnaires were collated and frequency distributions were obtained on all demographic data as well as on all questions. Measures of central tendency were conducted to answer the first and second research questions regarding the timing of sexual counseling following an MI and the patient's preference for the timing of that counseling.

Frequency distributions were analyzed to determine which components of sexual counseling patients are receiving post MI. Students t was performed to answer research questions four and five regarding resumption of sexual activity. Multiple Pearson correlations were calculated to determine if relationships existed between gender, marital status, and age, and frequency and resumption of sexual activity. These correlations address research question number six.

Results

Fifty-three (34%) questionnaires were returned for inclusion in the study. Forty-two respondents were male and eleven were female. The subjects' ages ranged from twenty-four to seventy-seven years of age (mean of 60). The marital status of the population was as follows: married 34, divorced 7, widowed 6, single 5, and separated, 1. Twenty (38%) reported having a previous myocardial infarction. Of the one hundred and fifty-five questionnaires mailed, 23 (15%) were returned incomplete: twelve because of no forwarding address, seven due to deceased patient, and four who chose not to participate.

Of the 53 subjects, 24 (45%) received instruction about sexual activity after their myocardial infarction. Instruction was provided by nurses (4 cases), doctors (8 cases), nurse and doctor combination (4 cases), books and pamphlets (5 cases), and a combination of literature and nurse (2 cases). One subject did not provide this information.

Instruction about sexual activity was provided before discharge for 11 subjects; in a clinic or doctors office for 5 patients. Four subjects received instruction in both a clinic and the doctor's office. One subject received information in the ICU/CCU, before discharge, and in a clinic or doctors office. Data were missing in three cases. The subjects reported they would have preferred to receive instruction in the ICU/CCU (5), before discharge (35), in a clinic or doctors office (6).

The subjects identified those components of sexual counseling which they received. The results are reported in Table 1.

Research Question #4: Did post-MI patients who received sexual counseling and perceived it as helpful, resume sexual activity earlier than those patients who received counseling but did not perceive it as helpful?

Responses of patients with regard to their perception of the helpfulness of sexual counseling and their resumption of sexual activity were not

sufficient to run tests of statistical significance. Therefore, these research questions relating to perception of helpfulness could not be answered. Thirteen subjects perceived the counseling as helpful, seven did not.

The only demographic variable that was positively correlated with frequency and resumption of sexual activity was marital status, having a p value of .0099. The resumption of sexual activity post-MI in this sample ranged from one to four weeks up to one year post MI. The mean resumption time was at 9 weeks (see Table II). Fifty percent of the respondents had a decreased frequency of sexual activity after their MI as compared to activity before their MI. Almost half the sample (46%) reported their sexual activity to be the same; 3% reported a greater frequency of sexual activity.

Twenty-six percent of the subjects reported they had symptoms that prevented them from participating in sexual activity. A variety of symptoms were given: anxiety, lack of erection, shortness of breath, chest

Subjects listed the following as areas in which they would have appreciated additional information about sexual counseling: effects of blood pressure medication upon the degree of tumescence, coping with physical and emotional changes that occur after an MI, impotence, methods to improve sex life when impotent, medications that cause problems and options for alternate medications, instruction for partner, and anything to resume a normal sexually active life.

Table I

Components of Sexual Counseling

Components	Received Instruction	
	Yes	No
<u>When</u> to resume sexual activity	19	4
can climb two flights of stairs	5	
can walk several blocks at brsk pace	0	
within 3-4 weeks after MI	4	
within 4-8 weeks after MI	7	
other	3	
<u>When</u> to engage in sexual activity	13	8
when rested	9	
avoid after meals	7	
avoid after activity	4	
other	1	
<u>What</u> positions to use	4	18
positions used before MI	1	
change to new position	3	
other	1	

Table I

Components of Sexual Counseling

Components	Received Instruction	
	Yes	No
<u>What</u> to do if angina occurs	17	5
stop sexual activity	8	
take Nitro and resume when pain free	8	
consult doctor	0	
rest, then resume	7	
take Nitro before sexual activity	11	
other	0	
<u>Amount</u> of energy needed to perform sex	6	16
climbing 2 flights of stairs	6	
activities of daily living	1	
masturbation	0	
activities that increase heart rate	0	
other	0	

Note: respondents were asked to mark all that applied in response to these questions.

Table I

Components of Sexual Counseling

Components	Received Instruction	
	Yes	No
<u>Where</u> to have sex	3	19
familiar surroundings	3	
quiet environment	0	
warm (as opposed to cold) room	0	
other	0	
<u>Partner</u> selection (i.e. usual partner)	7	15

Note: respondents were asked to mark all that applied in response to these questions.

Table II
Resumption of Sexual Activity after
Myocardial Infarction

<u>Time</u> -----	<u>Subjects</u> -----	<u>Percent</u>
1-4 weeks	12	24%
5-8 weeks	13	25%
9-12 weeks	6	12%
5 months	1	2%
7 months	1	2%
8 months	1	2%
10 months	1	2%
12 months	1	2%
did not resume	15	29%

* of those who did not resume sexual activity, 11 were not sexually active prior to their myocardial infarction.

Discussion

The response rate of 34% demonstrates that individuals having had an MI are interested enough in the importance of sexual counseling to share answers that are of a private and intimate nature. In addition to the returned questionnaires, the investigators received nine telephone calls from subjects who had questions and/or concerns regarding sexual activity following their myocardial infarction. Several of the respondents wrote down telephone numbers and names on their questionnaires in the event we had further questions. The investigators feel that this release of private and personal information demonstrates the importance of sexual counseling after MI. The wide range of subjects' ages is representative of the younger and older MI population. The median age of 63 in this sample shows that the majority of MIs occur after the middle years.

As previously reported by Hentinen (1983), Papadopoulos (1980), and Puksta (1977), sexual counseling is too vague to be helpful, inadequate, frequently overlooked and ineffective in alleviating fears.

Baggs & Karch (1987), stated that the majority of subjects in their study were not approached about sexual counseling. Our data also demonstrate that the majority of patients are not receiving sexual counseling after an MI. However, it is possible, that the subjects may have been offered sexual counseling but due to the effects of anxiety on perception and information processing with regard to readiness to learn, (were not able to internalize the counseling) (Redman and Thomas, 1985).

Of the 24 subjects who received sexual counseling, 18 were instructed by a health care professional. These results are not surprising to the investigators but they are discouraging. In 1969, Hellerstein and Friedman reviewed 33 cardiology textbooks and found almost no reference to sexual counseling or advising. Today, in 1988, there is still a dirth of information regarding strategies, content and timing of sexual counseling.

As stated in the literature review, several authors note that most patients may resume sexual activity one to two months after their MI

(Malik, 1979); Cole, Levin, Whitley, & Young; 1979; and Puksta, 1977). Our data reflect that patients (74%) would prefer to receive sexual counseling prior to discharge from the hospital. Therefore, we conclude sexual counseling should be initiated during hospitalization and continue on an outpatient basis. A suggestion for further research would be to control the timing and content of sexual counseling and then compare for perceived helpfulness.

Of the seven components identified in sexual counseling, only three were covered with the majority of patients: when to resume sexual activity, when to engage in sexual activity, and what to do if angina occurs during sexual activity. In contrast the remaining four components were scarcely covered: what positions to use, the amount of energy needed to perform sex, the environment for sexual activity and partner selection. The exclusion of these areas of sexual counseling may contribute to an unnecessarily diminished sex life.

There were 13 patients who received sexual counseling and perceived it as helpful. Of those 13, 62% resumed sexual activity within eight weeks post-MI. Of those patients who did not receive sexual counseling (28), twelve did not resume sexual activity. However, nine of those 12 were not sexually active before their MI. Therefore, those nine subjects were not considered when the calculation was made to determine the percentage of patients who resumed sexual activity within eight weeks of their MI. Of the remaining 19 subjects who did not receive sexual counseling, 58% resumed sex within eight weeks after their MI (see Table III). Our assumption was that those who perceived sexual counseling as helpful would have resumed sexual activity earlier than those who did not receive counseling. The results do not support this assumption. A larger sample size may show more variation in resumption time. Perhaps the subjects did not perceive that engaging in sexual activity would pose a problem to their health status. (They didn't identify it as a problem). They may have denied the fact they had an MI.

The results of the resumption of sexual activity

Table III

Resumption of sexual activity in those who received counseling and perceived it as helpful, as compared to those who received no counseling.

Resumption of sex---received counseling--no counseling
perceived as helpful

1-4 weeks	3	4
5-8 weeks	5	7
9-12 weeks	0	3
5 months	1	0
7 months	0	1
8 months	1	0
10 months	1	0
12 months	0	1
<u>did not resume</u>	<u>2</u>	<u>12</u>

with regard to patients who received sexual counseling and perceived it as helpful versus those who did not perceive it as helpful are similar to the discussion above. Of those who perceived it as helpful, 69% resumed sex within eight weeks post-MI. Of those who did not perceive it as helpful, 71% resumed sexual activity within eight weeks after their MI (see Table IV). Again the small sample size may be a limiting factor in the lack of variation in the results.

Marital status was the only demographic variable that was positively correlated with frequency and resumption of sexual activity. The investigators suspect this correlation may be due to the availability of a partner. Recommendations for future research include adding a question about the availability of a regular sexual partner as well as the health status of the partner..

Of the 26 respondents who had a decreased frequency of sexual activity after MI, seven reported they were not sexually active prior to their MIs. This inconsistency of information may be due to an issue of design and clarity. Never the less, there were 19

Table IV

Perception of sexual counseling as helpful versus not helpful, and resumption of sexual activity.

<u>Resumption</u>	<u>-----Helpful</u>	<u>-----not helpful</u>
	<u>perception</u>	<u>perception</u>
1-4 weeks	3	4
5-8 weeks	5	1
9-12 weeks	0	1
5 months	1	0
8 months	1	0
10 months	1	0
did not resume	2	1

remaining subjects who had a decreased frequency of sexual activity post-MI. Of those 19, eight subjects (42%) had symptoms that prevented them from participating in sexual activity. Three of the 19 subjects did not resume sexual activity. Of the 12 subjects that had symptoms during sexual activity, eight, or 66%, did not resume. We feel this number is significant. The following is a list of the symptoms subjects reported. One subject reported he thought his medications were the cause of his symptoms. This subject did not receive counseling regarding medications. Five subjects reported an inability to obtain an erection. Unfortunately, we do not know the reason. For future study we would suggest an exploration of the cause of the patient's inability to obtain an erection. Loss of erection could be due to several factors: medications, anxiety, or decreased vascular function. Other subjects reported symptoms such as: an anxious wife, personal anxiety, shortness of breath and chest pain. These subjects did not receive instruction in symptom management. In future studies, clarification should be obtained to determine if symptoms were of new onset or were present before the MI.

Further research should inquire about the medication regimen post-MI. The low percentage (22%) of subjects who received instruction about medications may reflect patients who were not placed on any medication prior to discharge.

There were only nine subjects who reported that their partners received sexual counseling. Based on the data, 34 subjects were married. This illustrates a very low percentage (26%) of spouses who received instruction about sexual activity. This percentage may be further reduced if we knew whether or not the single, widowed, separated, or divorced subjects had available partners.

Based on the number and variety of suggestions for additional information with regard to sexual counseling and the quantity of personal contacts made by subjects, we conclude that sexual counseling remains inadequate and is perceived as necessary information by patients who have had an MI. As described by Tripp-Reimer (1984), patients' perceptions of their health status may affect their functioning and sense of well-being and health. If the

educational needs of the individuals are not determined and adequate sexual counseling is not provided, patients may not achieve full rehabilitation and a sense of good health. Therefore, we feel that if needs are determined and sexual counseling is provided, MI patients may resume sexual functioning and achieve a fulfilled sense of good health. For future research, some intriguing results might come from subjects placing themselves in one of the quadrants of the health grid. This may give insight to the question of sexual activity and its contribution to the patient's sense of health.

Summary

Cardiac disease is the major cause of adult death in the United States. In the last 15 years, cardiac rehabilitation programs have been developed to return these patients to their optimum state of health. One component of cardiac rehabilitation programs is sexual counseling. There is a widely held belief that sexual counseling would assist these patients in a more rapid return to a positive perception of health.

Research in the area of sexual counseling following myocardial infarction is limited. As recently as 1983, Hentinen reported post-MI patients felt that the counseling they received was inadequate, frequently overlooked and ineffective in alleviating fears. Hellerstein and Friedman (1969), reviewed 33 cardiology text books and found little information on sexual counseling post-MI.

A thorough review of the literature revealed incomplete research upon which health care professionals can base their sexual counseling. Knowledge of sexual counseling as a component of cardiac rehabilitation is essential for nurses in the care of these patients.

The purpose of this study was to describe the content, timing and helpfulness of sexual counseling after an MI. Post MI patients were queried regarding the timing of sexual counseling, the preferred time to receive counseling, and the components of counseling they received. Correlations between perceived helpfulness and resumption of sexual activity, as well as demographic variables associated with resumption and frequency of sexual activity were then conducted.

The investigators mailed 155 questionnaires and had a return rate of 34% (or 53 subjects). Forty-two respondents were male and eleven were female. Their ages ranged from 24-77 years of age (mean, 60 years). The majority of the sample was married. Twenty (38%) reported having a previous myocardial infarction, which was positively correlated with resumption of sexual activity after MI. Of the 53 subjects, 45% received instruction about sexual activity after their MI and 55% did not. Nine subjects reported their partner received instruction on resumption of sexual activity. Instruction was provided primarily

by nurses and doctors. Most of the subjects received instruction prior to discharge from the hospital or in a clinic or doctor's office. The subjects overwhelmingly reported they would prefer to receive instruction prior to discharge from the hospital.

The subject number was inadequate to run tests of statistical difference to determine correlations between perception of helpfulness of sexual counseling and resumption of sexual activity. Resumption of sexual activity post-MI ranged from 1-4 weeks to one year. The majority who resumed sexual activity did so within the first 1-8 weeks. 50% of the respondents reported a decreased frequency of sexual activity following MI. 26% of the subjects reported they had symptoms which prevented them from resuming sexual activity. Of the 26%, two-thirds did not resume sexual activity due to symptoms. Only 22% of the subjects received instruction about possible side effects of medications on sexual activity. Of the seven components identified in sexual counseling, the subjects reported only 3 areas were covered; when to resume sexual activity, when to engage

in sexual activity (e.g. rested), and what to do if angina occurs with sexual activity. The remaining four components; positions to use, amount of energy needed to perform sexual activity, the environment for sexual activity (e.g. familiar), and partner selection (e.g. familiar) were scarcely covered.

Implications for Nursing Practice

Thorough assessments and counseling prior to initiating the teaching plan in the post-myocardial infarction population should occur routinely. Do not exclude those patients that by history do not have an available partner. Sexual counseling ideally should occur in all phases of the patients care (ICU/CCU, prior to hospital discharge, and at follow-up clinic or Doctors office). Unfortunately, because of patient conditions, shortened hospital stays, and sub-optimal resources, this may not be possible. Primary bedside nurses need to be accountable for the coordination of sexual counseling and evaluating that patient needs are met. This study supports the finding that post-MI patients are discharged without sexual counseling.

For those patients that are unable to participate in intercourse, assessment should be performed in terms of what is important to the client regarding sexual activity. Alternate forms of sexual expression should be identified and encouraged according to client preference.

Sexual counseling should also be extended to other client populations. Normal sexuality and changes in sexual activity due to disease processes, medications, and conditions (i.e. pregnancy, aging) should be expored with all clients in order to provide holistic nursing care. Although the results did not overwhelmingly show an earlier resumption when sexual counseling was provided, we strongly feel this is a reflection of our small sample size and not the patients' need for counseling.

Recommendations for Further Study

These investigators recommend further study of the timing and content of sexual counseling. Further study should control for the content and the timing of sexual counseling to maximize the potential of counseling in

in the study to provide increased subjects as well as improved generalization to other populations. Expanding the study to include other populations of patients, i.e. medically ill or other post-op patients may find other similarities that will improve generalizability.

Controlling or at least data gathering medication history and correlations with sexual activity may reap double rewards in terms of prescription of medications/ timing of medication/ and influence on sexual activity.

This topic has yet to be explored in depth. The focus for further research should also consider using the illness/wellness model to find where patients feel themselves to be and then gather data regarding sexual activity and their perception of self.

Several of the respondents also commented on a change in quality of their sexual life. This area should also be considered for study.

This population continues to grow in numbers. The area of sexual counseling in this population has opportunities for growth and exploration with ties to other populations and perceptions of health.

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Appendix 1

Questionnaire

Questionnaire

Today's date _____

Date of most recent heart attack (month/year) _____

Previous heart attack (yes)____(no)____

Age____ Sex (M)__(F)__

Marital Status (circle)

Single Married Divorced Widowed Separated

1. Did you receive instruction about engaging in sexual activity after your heart attack? (yes)__(no)____

(if no, please go to question 6 and continue.)

2. Who gave you instruction about sexual activity?

(check all that apply):

___Nurse

___Doctor

___other (Please describe _____)

3. When did you receive instruction about sexual activity?

(check all that apply)

___in the Intensive Care/Coronary Care Unit

___before discharge from the hospital

___at a follow-up visit at the clinic or

Doctors office.

___other (please describe)_____

4. Was any of the following information discussed:

a. When to resume sexual activity (yes)___(no)___

If yes, were you told you could resume sexual activity (check all that apply):

- ___when you can climb two flights of stairs
- ___when you can walk several blocks at a brisk pace
- ___within 3-4 weeks after your heart attack
- ___within 4-8 weeks after your heart attack
- ___other (please describe) _____

b. When to engage in sexual activity (yes)___(no)___

If yes, were you told you could resume sexual activity (check all that apply):

- ___when you feel rested, like after a nights sleep.
- ___avoid sex after meals
- ___avoid sex after activity
- ___other (please describe) _____

c. What positions to use (yes)___(no)___

If yes, were you told (check all that apply):

- ___positions used before your heart attack
- ___change to a new position - - if you were advised to change, what position were you told to use? _____
- ___other (please specify) _____

d. What to do if angina occurs during sex?
(yes)___(no)___

If yes, were you told you should

(check all that apply):

- ___stop sexual activity
- ___take Nitroglycerin and resume sex when angina (pain) is relieved
- ___consult your Doctor
- ___rest, then resume sex when angina is relieved.
- ___take Nitroglycerin before sexual activity if you have experienced angina (pain) with sex before.
- ___other (please describe) _____

e. The amount of energy needed to perform sex as compared to other activities (yes)___(no)___.

If yes, were you told sex uses as much energy as:

(Check all that apply):

- climbing two flights of stairs
- activities in daily life such as driving a car, discussing business, scrubbing a floor.
- masturbation
- activities that raise the heart beat to 120 (plus or minus 10 beats).
- other (please describe)_____

f. Where to have sex (yes)___(no)___

If yes, were you told to resume sex in

(check all that apply):

- familiar surroundings
- quiet environment
- warm (as opposed to cold) room or comfortable temperature of room.
- other (please describe)_____

g. Were you counseled that it was alright to have sex as long as you were with your usual partner?
yes ___ no ___

5. Was the instruction helpful in knowing when and how to resume sexual activity?
(yes)___ (no)___

6. Were you sexually active before your heart attack?
yes)___ (no)_____

7. When did you resume sexual activity after your heart attack?
 1-4 weeks after heart attack
 5-8 weeks after heart attack
 9-12 weeks after heart attack
 other (please describe)_____

8. Is the frequency of your sexual activity following your heart attack. . .
 less than before your heart attack
 the same as before your heart attack
 greater than before your heart attack

9. Did you have symptoms that prevented you from participating in sexual activity after your heart attack?
(yes)___; what kind of symptoms

- (no)___
10. Did anyone discuss the possible effects of medications and sexual activity?
(yes)___
(no)___
11. Did your sexual partner receive instruction about sexual activity?
___yes
___no
___does not apply.
12. When, in your opinion, would be the best time to begin receiving instruction about sexual activity? (check all that apply):
___In the Intensive Care/Coronary Care Unit
___before discharge from the hospital
___at a follow-up visit at the clinic or Doctors office.
___other (please describe_____)
13. What additional information would you have liked to receive about sexual activity?

Sexual Counseling

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Appendix II

Cover Letter

Cover Letter

Dear Participant:

We are registered nurses in the graduate nursing program at Oregon Health Sciences University and are conducting a research project, as part of the requirements for completion of our degree.

The purpose of this research project is to gather information about the type and amount of sexual counseling given to people who have had a heart attack. This study is important because the results will allow nurses to better meet the needs of patients who have had heart attacks. You were selected for the study because your doctor has consented to help us by allowing us to include his/her patients in our study.

Your identity will remain anonymous throughout the study. The only time we will see your name is when we address the envelopes that contain the questionnaire and when we mail you a reminder letter. We request that you do not put your name or address on the questionnaire or return envelope.

It is our hope that you will choose to participate in the study. The returned questionnaire will be your consent to participate in the study.

We are including our names, addresses, and phone numbers in case you have any questions. Thank you for your thoughtful and considerate response.

Sincerely,

Kathryn A. Meglitsch-Tate
7213 W. 9th Place
Kennewick, WA 99336
(509) 735-4515

Dawn F. Peters
3642 NE 116
Portland, Ore. 97220
(503) 252-4008

If you desire a copy of the final results of the study please enclose your name and address in a small sealed envelope. The envelope will be opened at the conclusion of the study and results will then be forwarded to you. Thank You.

Sexual Counseling

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Appendix III

Follow-up Letter #1

Follow-up Letter

Dear Participant:

Last week a questionnaire was mailed to you requesting information about the sexual counseling you received after your heart attack.

If you have already completed and returned it to us please accept our sincere thanks. If not; please do so today. Your response is important because it will enable nurses to better meet the needs of patients who have had heart attacks.

If by some chance you did not receive the questionnaire, or it got misplaced, please call one of us right now, collect, and we will get another one in the mail to you today.

Sincerely,

Kathryn A. Meglitsch-Tate
(509) 735-4515

Dawn F. Peters
(503) 252-4008

Sexual Counseling

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Appendix IV

Follow-up Letter #2

Follow-up Letter

Dear Participant:

About two weeks ago we mailed a questionnaire to you requesting information about the sexual counseling you received after your heart attack.

If you already completed and returned it to us we thank you. IF not, we urge you to do so today. Your response is extremely valuable in helping us find areas where we may improve the sexual counseling we give to patients who have had heart attacks.

If by some chance you did not receive the questionnaire, or it got misplaced, please call one of us right now, collect, and we will get another one in the mail to you today.

Sincerely,

Kathryn A. Meglitsch-Tate
(509) 735-4515

Dawn F. Peters
(503) 252-4008

Appendix V

Physician Letter

Physician Letter

Dear Dr. _____,

We are graduate students at the University of Oregon Health Sciences Center, interested in studying patients who have suffered a myocardial infarction in the past two years. Specifically, our area of interest is in surveying their perceptions of educational needs with regard to resumption of sexual activity following their myocardial infarction, and how those needs were met.

The tool is a brief questionnaire which inventories the type of education received, the usefulness, and their suggestions regarding sexual counseling post MI. We are seeking a sample size of 100 and would appreciate the referral of any of your patients (male or female) who have suffered a myocardial infarction in the past two years. Subjects will be asked to complete the questionnaire as their participation in the study. It will be a blind study with the standard guarantees of anonymity for respondents.

We have enclosed a consent card indicating your agreement to allow us to approach your patients for inclusion in our study. Please return the enclosed card with your response. If you would like to review the results at the completion of the study, please indicate so with your reply. We will then contact you directly for referrals.

Thank you for your time and consideration. If you have any questions, please call.

Sincerely,

Dawn F. Peters
(503) 252-400

Kathryn Meglitsch-Tate
(509) 735-4515

Advisor: Sharon Clark, R.N., M.N., A.N.P.

Sexual Counseling in Post-Myocardial
Infarction Patients

By: Kathryn Anne Meglitsch-Tate and
Dawn Felch Peters

Date of receiving this degree: June 1989.

Approved _____

Sharon Clark, R.N., M.N., F.N.P., MRP Advisor

A descriptive study of men and women responding to a questionnaire developed by the investigators, eliciting information regarding sexual counseling after myocardial infarction (MI) was undertaken.

The purpose of the study was to describe content, timing, and helpfulness of the sexual counseling that patients received after MI, and additionally to determine if patients who receive sexual counseling resumed sexual activity earlier than patients who did not.

A convenience sample of 53 subjects responded to the questionnaire. Subject names were obtained from the caseload of private physicians and nurse practitioners in a large metropolitan area of the Pacific Northwest. Subject ages ranged from

24 to 77. They had an MI within the past two years. A cover letter stating the purpose of the study and procedures for maintaining confidentiality were enclosed with the questionnaire. A stamped, self-addressed envelope was provided for return of the questionnaire. Prompter letters were sent at the end of one and two weeks after mailing the questionnaire.

Of the 53 subjects, 24 received instruction about sexual activity after their MI, 29 did not receive instruction. Nine subjects reported their partners received instruction on resumption of sexual activity. Of the seven components identified as valuable in sexual counseling, the subjects reported only three were covered with them. Subjects overwhelmingly reported they would have preferred to receive counseling prior to discharge from the hospital. The subject number was inadequate to run tests of statistical significance to determine if a correlation existed between perception of helpfulness of sexual counseling and resumption of sexual activity. The majority of the subjects who resumed sexual activity did so within the first one to eight weeks post-MI. Fifty percent of the respondents reported a decreased frequency of sexual activity after MI. Twenty-six percent reported they had

symptoms which prevented them from resuming sexual activity and of those; two-thirds did not resume sexual activity due to symptoms.

A small, non-random sample limits generalizing the findings of the study to the population, however, several implications for nursing practice regarding sexual counseling should be considered: thorough assessments and counseling prior to initiating the teaching plan, include those patients that by history do not have an available partner, and be aware that many post-MI patients are discharged without sexual counseling. The investigators recommend further study of the timing and content of sexual counseling and strong recommendations for including this topic in post-MI counseling.