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THE SEXUALITY OF CLIMATERIC WOMEN WHO HAVE HEART DISEASE

***[1]Leide Thayane Rolim Cantanhede, [2]Cláudia Teresa Frias Rios, [2]Luzinéa de Maria P. Santos Frias,[3]Paulo Eduardo Sousa Silva, [4]Marli Villela Mamede and [5]Líscia Divana Carvalho Silva**

[1]Nurse. Graduated from the Federal Universityof Maranhão (UFMA).São Luís, Maranhão, Brazil
[2]Nurse. PhD. Professor, Nursing Department, Federal University of Maranhão(UFMA).São Luís, Maranhão, Brazil
[3]Radiologist Physician at the University Hospital, Federal University of Maranhão (UFMA). Diagnostic imaging. SãoLuís, Maranhão, Brazil
[4]Nurse. Post-PhD. Professor, Nursing Department, RibeirãoPreto College of Nursing, University of São Paulo (EERP-USP). Ribeirão Preto, São Paulo, Brazil
[5]Nurse. PhD. Professor, NursingDepartment, Federal Universityof Maranhão (UFMA). São Luís, Maranhão, Brazil

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ABSTRACT

Introduction: Approaching sexuality is a complex task. The discussion of this subject is superficial, oblivious to the needs and does not permeate all institutions. This hinders the necessary interventions to promote active sexuality. **Objective:** To investigate the sexuality of climacteric women with heart disease. **Material and methods:** Thirteen (13) women were selected from a database of a larger project (40 women) through non-probabilistic sampling. Data were collected through individual interviews in January and February 2016 at the Cardiology Outpatient Clinic of the Hospital of the Federal University of Maranhão (UFMA), after approval by the Ethics Committee of the Nursing School of Ribeirão under number 293,900. Inclusion criteria were women between the ages of 45 and 65 who had heart disease and had climacteric symptoms according to the Menopause Rating Scale. The Sexual Quotient - Female version was used as data collection tool. **Results:** In relation to heart disease, the women described tachycardia, palpitation, dyspnea, fatigue, dizziness and asthenia as the more frequent symptoms and they related sexual dissatisfaction with the presence of discomfort, pain, decreased lubrication, tiredness, shortness of breath, dizziness and anxiety. Women presented sexual performance considered null or nonexistent (31%) and sexual function was classified as bad to unfavorable, not presenting satisfaction (38%). Sexuality is not addressed in consultations with health professionals. Most participants reported that due to the fear, anxiety, concern and insistence of the spouse they chose to wait from two weeks to nine months to resume sexual activity and demonstrated dissatisfaction with sexuality, explaining that this was not a priority, or important, or part of their lives. **Conclusion:** Guidance to patients regarding aspects of sexuality during the outpatient follow-up is fundamental. Health professionals should be aware of this and should encourage the clientele to express their sexuality.

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INTRODUCTION

Sexuality is a theme that involves more than sexual intercourse. This theme is not only little discussed, but also little lived, perhaps due to prejudices experienced in the family, especially in the youthandeven more in advancing ages, or even because of the presence of chronic diseases (Sales, 2017).

***Corresponding author:*LeideThayaneRolimCantanhede,**
Nurse.Graduated from the Federal University of Maranhão (UFMA).São Luís, Maranhão, Brazil.

The menopause is a phase of change, transformation, adaptation and that brings questions to woman's life (Freitas, 2015 and Santos, 2016). The discussion on this theme is superficial, unrelated to needs, and does not permeate all institutions. This deficiency is culturally hereditary, and is directly related to the way our ancestors lived their sexuality. It is recognized that cultural, religious and socioeconomic factors strongly influence sexuality (Nery, 2015). We live in a society still marked by inequalities in the construction of masculine and feminine roles. From thisgender perspective, sexuality is considered inappropriate because throughout the process of

socialization women have suffered continuous repression in the organization and expression of their sexuality, which deprives them of expressing their sensibility, leading to constrain the discussions related to thistopic, and increasing prejudice (Ferreira, 2015). Although sexuality is something inherent in life and health, manifested from the birth to death, it is considered a subject impregnated with discrimination and prejudice (Nery, 2014). It is observed that the recommendations provided by health professionals are, for the most part, prescriptive, without space for the dialogue and reflection of women about their needs in the field of sexuality. It is also noted that the conceptions of sexuality mediated by culture and interpersonal relationships are revealed by the way in which women deal with the consequences and repercussions of treatments in their sexual life. Emphasis is placed on the need to establish good communication between the couple so that the intimate and sexual life can be renegotiated after illness. It is important that health professionals take into account the complex interaction between cultural, relational and subjective aspects that are present in the sexual experience (Vieira, 2014).

It is worth noting that sexuality in climacteric women with heart disease may be negatively affected by issues related to menopause and heart disease. Sexual complaints are prevalent throughout the reproductive life, but during climacteric period, women may become more vulnerable to sexual dysfunction. The interaction of menopausal transition factors with alterations in the genital organs, nervous system, and physical, psychological and social factors related to the sexual partner can influence the sexuality of women (Pinto Neto, 2006). In relation to heart disease, all the symptomatological inferences (dyspnea, fatigue, tachycardia, palpitation, anxiety, fear of death, dietary restriction, physical activity) and the need to use drugs that may producing adverse effects (decreased libido and vaginal lubrication, anorgasmia, loss of desire/arousal/orgasm, sexual dysfunction) may also impair their sexuality (Stein, 2006). Insecurity determined by chronic illness leads to physical and psychological problems that may interfere with family relationships, social interaction, and sexual adaptation. In this phase, women move away from social environments and withdraw when it is time to expand the field of relationships (Santos, 2007 and Santana, 2013). Addressing sexuality is a complex task, with greatsense and meaning (Nery, 2014). Unpreparedness and discomfort of health professionals in addressing sexuality hinder the interventions necessary to promotean active sexuality (Ministério da Saúde, 2008). This study aims to investigate the sexuality of climacteric women with heart disease.

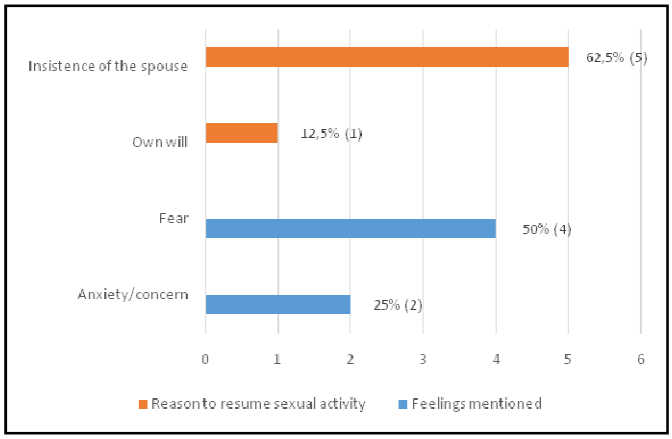
MATERIAL AND METHODS

The study was carried out using the database of the project "Climacteric women and coronary artery disease: revealing senses and meanings", approved by the Research Ethics Committee of the University of São Paulo at RibeirãoPreto College of Nursing - EERP/USP, São Paulo, Brazil, under the number 293,900. The database has forty (40) women aged from 45 and 65 years, with references of climacteric symptoms, with coronary artery disease confirmed by coronary arteriography examination. The exclusion criteria were the occurrence of women with speech difficulties; mental disorders; submitted to oophorectomy and hysterectomy; users of hormone replacement therapy in the last five years; and those who did not present any climacteric symptoms according to the Menopause Rating Scale (MRS) criteria. Thirteen (13) climacteric women with heart disease in this database were selected by non-probabilistic sampling, contacted by telephone and invited to participate in the study. Considering the acceptance and availability of the women, their participation in the research was scheduled. For some women who already had medical appointments scheduled at the outpatient clinic, the interview was made while they were waiting for the consultation.Data were collected from January to February, 2016, at the Cardiology Outpatient Clinic of the University Hospital of the Federal University of Maranhão (UFMA). Data were collected by the researcher after explaining the ethical procedures, ensuring the anonymity and confidentiality of the information. The women were given the questionnaires in a reserved place, where they had their privacy,and the researcher waited until they completed and returnedthem.Considering the acceptance and availability to participate, the interviews were scheduled. The women were given the questionnaires in a reserved place, where they had their privacy, and the researcher waited until they completed and returned them. The data collection instrument used included data on identification(name, age, marital status, education, profession and medical diagnosis), lifestyle (smoking, alcoholism, obesity, diabetes, hypertension, dyslipidemia and drug therapy), and sexuality (sexual activity, symptomatology, hospitalization and guidelines). The instrument Sexual Quotient - Female Version (SR-F)was used[14]. The SR-F has ten items on sexuality such as sexual desire and interest, previous actions that stimulate the continuity of the relationship, female arousal, affinity with the partner, comfortduring sexual intercourse, orgasm and sexual satisfaction.

RESULTS

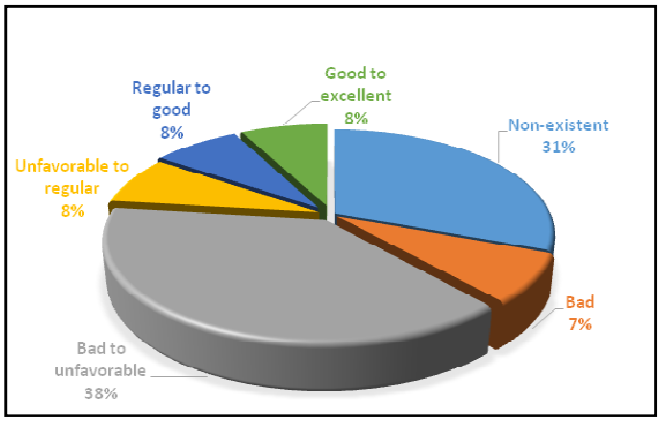
There was a prevalence of: women aged 45 to 51 years (46.1%), with a mean age of 48 years; stable union (69.2%); complete elementary school (53.8%); housewives (30.7%); womenwith hypertension (92.3%), dyslipidemias (76.9%), obesity (38.5%) and diabetes mellitus (30.8%). All women used drug therapy to control heart disease and none of them smoked and/or were alcoholics. More than half of the women had recently been hospitalized (62%) due to cerebrovascular accident (37%), valve stenosis (25%), cardiac catheterization (25%) and myocardial infarction (13%). Hospitalization time ranged from four days to two months.Women described tachycardia, palpitation, dyspnea, fatigue, dizziness and asthenia as the most frequent symptoms related to heart disease. Almost all participants (92.3%) reported that sexuality is not addressed in the consultations. Only one woman reported having talked to the medical professional about it, but she did not consider the guidance satisfactory because she of the feeling of shyness and the excess of people in the environment where the conversation took place. Women emphasized that there was no dialogue about the topic sexuality with health professionals.It was noticed,during the interviews, certain shyness to talk about the subject sexuality, and the participants avoided the word "sex" in their answers. Most interviewees reported that due to fear, they chose to wait from two weeks to nine months to resume sexual activities; others reported not having resumed sexual activity after hospitalization as a result of their heart condition.When asked about the time to resume sexual activity, more than half of the women (75%) returned to sexual activity because of insistence

of the spouse and they mentioned feelings such as fear, anxiety and worry, as shown in Graph 1.



Graph 1. Motives and feelings reported by climacteric women with heart disease to resume sexual activity. Cardiology Outpatient Clinic of the HUUFMA. São Luís - MA, 2016

Regarding the satisfaction and importance of sexuality, we asked what score from zero to ten they would attribute to sexuality in their lives. Most of the participants reported dissatisfaction with sexuality and assigned scores lower than three for the importance of sex, explaining that sex was not a priority. Others denied sexuality and reported having no sexual activity, attributing the lower score of 1 for the importance of sex in their lives. Sexual function was evaluated through the Sexual Quotient - Female Version (SR-F), which includes certain parameters such as such as sexual desire and interest, previous actions that stimulate the continuity of the relationship, female arousal, affinity with the partner, comfort during sexual intercourse, orgasm and sexual satisfaction. A final individual score was obtained and allowed the classification of their sexual performance, as shown in Graph 2.



Graph 2.Sexual function of climacteric women with heart disease in the Cardiology Outpatient Clinicof the HUUFMA. São Luís, 2016

Some women revealed that sexuality was not part of their lives, that is, they presented a sexual performance considered nil or non-existent (31%). Sexual function was classified as bad to unfavorable, i.e., they had no satisfaction (38%) and only one respondent had a sexual performance considered good to excellent (8%). Women related the dissatisfaction of sexuality with the presence of some symptoms such as discomfort, pain, decreased lubrication, and tiredness, shortness of breath, dizziness and anxiety.

DISCUSSION

Age is a determining factor in the development of heart disease in women, especially after menopause. The risk of development and progression of atherosclerotic lesions increases and is aggravated by the presence of risk factors. The realization of domestic services in the own home is still prevalent among women, especially low-income women (Abdo, 2009), and the inability to continue performing household chores is often seen as a moral degradation (Ferreira, 2013). Myocardial infarction and stroke are considered the main causes of death in women older than 50 years in Brazil. Research showed that approximately 60% of women do not have sufficient knowledge about cardiovascular diseases, but most of them (90%) recognize the main associated risk factors such as inadequate diet, sedentary lifestyle and stress (Santana, 2017). Before so many challenges, other aspects of care involving the subjectivity of women do not seem to be recognized as important. Sexuality is not seen as an essential dimension of the human being and of the life of relationships, especially in a situation of serious illness[5], in this case, heart disease. Knowledge about heart disease is usually the result of experiences, common sense and the feelings involved. It is essential that people understand their heart disease and everything that the disease may exert an influence, including personal and interpersonal relationships. In this perspective, guidance and clarification of doubts are fundamental for raising the awareness and the search for knowledge (Freitas, 2013), especially on issues neglected by the health team, such as sexuality.

The institution's own organizational culture contributes to the lack of attention to sexuality during nursing care. The difficulties that stand out are the shortage of time for service provision, with quick consultations that do not allow to go deeper into the issue of sexuality, preventing productive dialogues; the rotation between sectors that negatively interferes with the creation of bond between patients and professionals; the large number of patients and activities performed, often bureaucratic, with a small staff; and the lack of reserved spaces to freely expose concerns and doubts. In addition, there are difficulties related to social interpretation. In the case of women with serious illnesses, there are other more evident concerns that involve life, children and the household. Sexuality, therefore, can no longer be revealed, there are no sexual motivations, because sex is only part of healthy life, and these subjects are shared with the health team. In the interpretation of the professionals, the women present difficulties in detaching themselves from the personal and familiar issues present in their surroundings and they are unable think about sexuality with naturalness amid the so many adverse consequences generated by the process of illness and treatment (Ferreira, 2015). Guidance on resuming sexual activity after a heart event does not seem to follow a protocol among health professionals. The results of this study corroborate a study conducted with patients with myocardial infarction, which revealed that most of them were unaware of the limitations caused by heart disease related to the resumptionof sexual activity (96%). The lack of information/guidance on this aspect has contributed to a significant loss of quality of sexuality. Sexuality is seen by health professionals as a delicate matter, since prejudice on the

subject still prevails in our midst. The patient does not ask and the professional does not respond, and a veiled pact of silence is sealed (Stein, 2006 and Lunelli, 2008). In this way, the approach of the theme is often tainted or even avoided. As this subject is considered sensitive and delicate, belonging to the private sphere and, many women are not comfortable talking about their intimacy in the hospital environment (Ferreira, 2015). It is recognized that in the presence of heart disease, when compared to vigorous physical activity and intense emotional response, sexual activity poses a lower risk of triggering myocardial infarction, that is, the possibility of sexual activity acting as a precipitating factor for infarction is considered low.In sexual activity, the heart rate and blood pressure increase in the same way as in any aerobic activity. Thus, the greater the regularity in the level of activity and aerobic conditioning, the less likely is that sexual activity act as a predisposing factor for a cardiovascular event. Physically better prepared individual, be themheart patients or not, have a protective factor for triggering cardiac events in general (Pinto Neto, 2013). Therefore, only people with unstable cardiopathy or severe symptoms should abstain from sexual activity, and this activity should be evaluated and stabilized with treatment. There are no contraindications in patients with mild or moderate heart disease, asymptomatic or with mild symptoms, or patients with valvular prostheses with normal functioning and with low-intensity cardiopathy (Santana, 2017).

It is emphasized that the time to resume sexual activities after the start of treatment depends on the severity of the disease and the knowledge of the medical, psychological and social dynamics of each case. The couple's attitudes and behavior toward resumption of sexual activity have much influence on the overall rehabilitation process. Guidance on the subject should be part of the approach (Souza, 2011).Although nurses feel responsible for providing sexual guidance, they rarely do so in their daily practice. Nurses can play a key role in sexual counseling because they are often the health professionals who have greatest contact with hospitalized patients.[21]Furthermore, sexual activity should be considered as any other physical activity because it has similar energetic demands. Thus, patients should receive guidance about sexual activity in the same way as they receive information about resuming work and aerobic activities. The spouse should be informed about the situation of the partner in the maximum extent of such counseling (Pinto, 2013). It is known that women spenda significant part of their life in the climacterium, thus having many years to enjoy their sexuality to the full. Some women at this stage may experience a decrease of desire while others experience the reverse, that is, a release of desire and the exercise of a less conflicted sexuality (Nery, 2014). Differences in the exercise of sexuality demarcate modes of being and define unequal relations of power, in which the subjectivation by female sexuality is oriented in the sense of being more restrained, docile, affective, linked to the model of motherhood, triggering dependence and submission to the spouse (Costa, 2013). However, when women feel valued, capable of provoking interest in the opposite sex and performing their activities within society, sexuality is fully and positively lived in the climactericperiod (Silva, 2012) Thus, sex ceases to be a purely biological necessity and becomes mainly a psychological necessity (RennoJunior, 2008).

Although theclimacterium and the heart disease have strong physical, emotional, social and cultural impacts on sexuality, there is an urgent need for the women to elaborate the situation and adapt to the changes and limitations of their lifestyle in the face of the climacteric period. The guidelines and prescriptions in outpatient clinics aim to meet the immediate needs of the patients, but they do not consider important and emergent aspects throughout the treatment (Favarato, 2006 and Souza, 2010).

Conclusion

In relation to heart disease, women described tachycardia, palpitation, dyspnea, fatigue, dizziness and asthenia as more frequent symptoms and related sexual dissatisfaction with the presence of discomfort, pain, decreased lubrication, fatigue, shortness of breath, dizziness and anxiety. Sexuality is not addressed in consultations with the health professional.The participants reported that the spouse's insistence, fear, anxiety, and concernwere the reasons why they chose to wait from two weeks to nine months for sexual resumption and showed dissatisfaction with sexuality, deeming it as non-priority, unimportant, and therefore not part of their lives. According to the Sexual Quotient (SR-F), the women presented sexual performance considered nil or non-existent (31%) and their sexual function was classified as bad to unfavorable, with no satisfaction (38%).Guiding patients about aspects of sexuality during outpatient follow-up becomes essential. The health professionals should be aware of this, and should encourage this clientele to express their sexuality as an important basic and affective need.As limitations of this study, we highlight the use of excerpts and punctual and predefined moments related to the profile of women, the geographic region and the place of data collection.

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