Iranian Nurses' Perspective of Barriers to Sexual Counseling For Patients With Myocardial Infarction

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Abstract

Background: Sexual counseling is an important component of cardiac rehabilitation that. This study aimed to investigate Iranian nurses' perspective of barriers to sexual counseling for patients with myocardial infarction.

Methods: This cross-sectional study was performed on 169 nurses. Instruments included demographic characteristics and barriers to providing sexual counseling.

Results: The strongest barrier was related to patients' religion, and belief (2.83 ± 0.52) and embarrassment (2.82 ± 0.52%), the nurses are not comfortable discussing sexual issues (2.67 ± 0.62), lack of experience in the field of sexual counseling (2.62 ± 0.65), and sexual hesitation in advising patients (2.57 ± 0.7). About organizational barriers, the highest mean scores were related to the lack of support from managers (2.67 ± 0.66) and the lack of a proper supervision system (2.62 ± 0.72).

Conclusion: patient-related barriers were the most common barriers rooted in the culture dominant in society regarding sex issues. Therefore, it should be cultured through continuing education and the mass media so as not to be perceived as a taboo in health care settings. Health professionals should be change the attitudes of patients towards sexuality through sexual health education and counseling to meet patients' needs and improve their sexual health.

Introduction

Sexuality is one of the determinants of human health and has positive effects on physical and mental health [1]. Sexual problems are widely effective in quality of life and can have adverse impacts on emotional health and interpersonal relationships [2]. Sexual health is a state of physical, mental, and social well-being in relation to sexuality [3]

Myocardial infarction, due to its debilitating nature, has many negative effects on different aspects of patients 'lives, including their sexual activity [4, 5]. People with myocardial infarction experience many sexual concerns [6], and a large number of them limit or stop their sexual activity for fear of re-myocardial infarction or sudden death [7, 8]. Returning to sexual activity after a myocardial infarction and reaching sexual satisfaction are major challenges for patients and their spouses [9]. Given the positive effects of treatment for sexual problems, especially an increase of quality of life, early detection, and timely treatment of sexual issues should be a priority of the healthcare team [10]. It should be considered as educational-counseling programs and a part of routine care for cardiovascular patients [4, 9].

Sexual counseling as an important component of patient care, and healthcare providers should strive to better understand the principles, application, and consequences of sexual counseling. Sexual counseling involves interaction with the patient to obtain information about sexual concerns and safe return to sexuality. Sexual counseling also includes evaluating, supporting, and providing specific advice on psychosexual problems, sometimes referred to as psychosexual counseling [11, 12]. Nurses, through

close communication with patients, have the opportunity to interact with patients and their spouses during counseling, and to meet their basic needs for optimal well-being [1], because their spouses are also among important components of cardiac rehabilitation [13]. Although nurses play a key role in providing sexual counseling for cardiac patients [14], they do not consider the exchange of information about sexual concerns of the patients with myocardial infarction as their essential role [15]. Most nurses reportedly do not consider cardiac patients' sexual needs as an essential part of their assessment, do not routinely evaluate their sexual problems, and are reluctant to do so [16, 17].

Given the importance of nurses' role in providing counseling, many barriers are available especially in training sexuality to patients with myocardial infarction [18].The researchers reported a lack of organizational policies and nurses' lack of knowledge of the current barriers [19]. A study also identified lack of time, lack of knowledge or education, type of attitude, and uncertain beliefs in sexuality, irresponsibility, and problems related to the disease [17]. Another researchers categorized barriers into four categories of patient, nurse, organization, and value related ones [20]. some nurses believe that sexual evaluation is unethical [21].

Since sexuality is influenced by the culture, beliefs, and thoughts of society and families, the Iranian community, especially in southeastern Iran, considers talking about sexual issues as taboo. Therefore, the current study aimed to investigate the barriers to sexual counseling for patients with myocardial infarction from the perspectives of nurses working in cardiac care units in hospitals located in southeastern Iran.

Methods

Study design and Setting

This study had a cross-sectional descriptive-analytical design. The study setting included CCUs, Post CCUs and cardiac surgery units of three teaching hospitals affiliated to Kerman University of Medical Sciences, which are the largest centers in southeastern Iran. This study lasted from Nov 2019 to March 2020.

Sample Size and Sampling

The study population consisted of 180 nurses working in CCUs, Post CCUs and cardiac surgery wards in 2019. Inclusion criteria were having diploma or above degrees in nursing and history of caring for patients with heart diseases. 169 nurses participated in this study, so the response rate was 93.88%.

Instruments

Data collection instruments included two questionnaires of demographic characteristics, and barriers to providing sexual counseling for patients with myocardial infarction. Demographic and background information included age, sex, marital status, education and in-service ward and the hospital name,

position, work experience, and duration of working with cardiac patients, and the level of information about sexuality.

The questionnaire of barriers to sexual counseling for patients with myocardial infarction was a researcher-conducted one for which valid sources [19] were used and included 30 items in three areas of patient-related barriers, nurse-related barriers and organizational barriers. A three point Likert scale was used (agree = 3, no idea = 2, disagree = 1). The maximum score was 90, and the minimum was 30. The minimum and maximum scores related to patients' barriers were 13 and 39, respectively. The minimum and maximum scores related to nurses' barriers were 12 and 36, respectively. The minimum and maximum scores related to organizational barriers were 5 and 15, respectively. Ten experts studied and corrected the questionnaire and confirmed its validity by the validity coefficient of 0.80. The reliability of the instrument was assessed after studying 30 nurses who were not in the study population (due to population size limitation), and it was confirmed with Cronbach's alpha coefficient of 0.78.

Data collection

Data collection began after obtaining a code of ethics from the Ethics Committee of Kerman University of Medical Sciences. The researcher visited different ward of each hospital in different shifts. After coordinating with managers and explaining the aims of the study to the nurses, she provided the questionnaire in case the samples were physically, mentally ready, and willing to participate in the study. She delivered the completed questionnaire from the staff at the same or subsequent shifts. The samples were explained about information confidentiality as well as their withdrawal from the study at any time.

Data analysis

Data were analyzed using SPSS 18. Descriptive statistics (frequency, percentage, mean, and standard deviation) were used to describe data. Independent t-test, ANOVA, and Pearson correlation coefficient were used to evaluate the mean scores of barriers of sexual counseling in terms of background characteristics. The significance level was considered to be 0.05.

Results

The mean age of nurses was 36.12 ± 8.06 years. The majority of nurses were female (91.1%), married (84.9%), undergraduate (91.7%) and in nurse position (91.1%). The mean work experience of nurses in cardiac care units was 8 years. 74% of the nurses in CCUs, 13% in post-CCUs and 10.7% in cardiac surgery units participated in the study. The majority of nurses (99.4%) had not passed any specialized or retraining courses on sexual counseling for cardiac patients and believed in the low number of courses as well as limited training about sexual counseling (Table 1).

Table 1
Demographic and background characteristics of nurses in cardiac care units

Variable		M	SD
Gender	Female	154	91.1
	Man	15	8.9
marital status	Single	25	15.1
	Married	143	84.9
Level of education	BSc	155	91.7
	MSc	14	8.3
position	Nurse	154	91.1
	Head nurse	15	8.9
Ward	CCUs	125	74
	Internal heart	22	13
	cardiac surgery	18	10.7
Pass specialized training and retraining	Yes	1	0.6
	No	168	99.4
The courses spent about sexual counseling patients	Much	1	0.6
	medium	10	5.9
	Low	51	30.2
	very little	107	63.3
The internship spent about sex advice	Much	1	0.6
	medium	5	3
	Low	40	23.7
	very little	123	72.7
Variable	**M**	**SD**	
Age	36.12	8.06	
work experience	12.12	7.57	
Experience in cardiac surgery	8.36	7.18	

Results related to the barriers to sexual counseling for patients with myocardial infarction showed that the highest mean scores were related to patients (33.96 ± 57.5), nurse (29.47 ± 4.95), and organization

(12.86 ± 2.65), respectively (Table 2).

Table 2
Barriers to sexual counseling in patients with myocardial infarction (related to Patient)

Statements related to barriers	agree		Disagree		No idea		score	
	N	%	N	%	N	%	M	SD
Short hospital stay	89	52.7	44	26	36	21.3	2.31	0.80
Lack of time for training	91	53.8	60	35.5	18	10.7	2.43	0.68
Cultural differences between patient and nurse	139	82.2	17	10.1	13	7.7	2.75	0.59
Patient's unwillingness to discuss sexual issues	129	76.3	18	10.7	22	13	2.63	0.70
Having or not having a companion	82	48.5	47	27.8	40	23.7	2.25	0.82
Social status of the patient	132	78.1	21	12.4	16	9.5	2.69	0.64
Patient age	127	75.1	17	10.1	25	14.8	2.60	0.73
Patient distrust of nurse to discuss sexual concerns	117	69.2	24	14.2	28	16.6	2.53	0.76
Fear of confidentiality	131	77.5	21	12.4	17	10.1	2.67	0.65
The veil of patients	148	87.6	12	7.1	9	5.3	2.82	0.50
Religious and religious reasons for the patient	151	89.3	7	4.2	11	6,5	2.83	0.52
Not asking the patient about sexual issues.	143	84.6	12	7.1	14	8,3	2.76	0.59
Patient's negative attitude about discussing sex	138	81.7	8	4.7	23	13.6	2.68	0.70
Total score (Barriers related to the patient)							**33.96**	**5.57**

In the areas of patient-related barriers, the highest mean scores were related to patients' religion and belief (2.83 ± 0.52) and embarrassment (2.82 ± 0.52). In the areas of nurse-related barriers, the highest mean scores were related to the nurses are not comfortable discussing sexual issues (2.67 ± 0.62), lack of experience in the field of sexual counseling (2.62 ± 0.65), and sexual hesitation in advising patients (2.57 ± 0.7) (Table 3). In the areas of organizational barriers, the highest mean scores were related to the lack of attention and support from managers for counseling (2.67 ± 0.66) and the lack of a proper supervision system in the field of sex counseling (2.62 ± 0.72) (Table 4).

Table 3
Barriers to sexual counseling in patients with myocardial infarction (related to nurses)

Statements related to barriers	agree		Disagree		No idea		score	
	N	%	N	%	N	%	M	SD
High density of nursing duties	108	63.9	40	23.7	21	12.4	2.51	0.71
Lack of time for patient education	106	62.7	44	26.1	19	11.2	2.51	0.69
Lack of proper communication between the nurse and the patient	100	59.2	51	30.1	18	10.7	2.49	0.68
Lack of nurse motivation for counseling	86	50.9	53	31.3	30	17.8	2.33	0.76
Nurses' disbelief on the impact of counseling on treatment	59	34.9	79	46.8	31	18.3	2.17	0.71
Additional processes such as administrative hierarchy	84	49.7	49	29	36	21.3	2.28	0.80
Nurses are not comfortable talking about sex	126	74.6	30	17.7	13	7.7	2.67	0.62
Lack of nurse knowledge on sex issues	100	59.5	47	28	21	12.5	2.47	0.71
Doubt about providing sexual counseling to the patient	117	69.3	32	18.9	20	11.8	2.57	0.70
Lack of experience in sex counseling	121	71.6	32	18.9	16	9.5	2.62	0.65
Uncertainty about the ability to have sex counseling	89	53.3	50	29.9	28	16.8	2.37	0.76
Nurses' Cultural Beliefs	110	65.5	32	19	26	15.5	2.50	0.75
Total score (Barriers related to the nurses)							**29.47**	**4.95**

Table 4
barriers to sexual counseling in patients with myocardial infarction (related to organization)

Statements related to barriers	agree		Disagree		No idea		score	
	N	%	N	%	N	%	M	SD
Lack of facilities for patient privacy	104	61.5	47	27.8	18	10.7	2.51	0.68
Section restrictions on discussing sexuality	106	62,7	45	26.6	18	10.7	2.51	0.68
Lack of proper environment for consultation	114	67.5	33	19.5	22	13	2.54	0.72
Lack of attention and support from managers for counseling	132	78.1	19	11.2	18	10.7	2.67	0.66
Lack of proper monitoring and feedback system on sexual counseling	128	75.7	17	10.1	24	14.2	2.65	0.72
Total score (Barriers to organization)							**29.47**	**4.95**

Results related to the relationship between demographic variables and scores of barriers to sexual counseling (barriers related to patient, nurse and organization) showed only a significant correlation between nursing education level and organizational barriers (P = 0.015). Therefore, postgraduate nurses got higher mean scores in organizational barriers.

Discussion

The results of this study showed that the most barriers were related to the patient. It seems that most patients do not desire to receive sexual counseling and nurses cannot begin sexual discussions. Therefore, if the patient engages in the sexual discussion, nurses can provide sexual counseling more easily. As mentioned earlier, talking about sexuality is still subject to uncertainty and sometimes fears of being judged. If Patients do not want to talk about it, they will be the major barrier to counseling. The researchers argue that beliefs and attitudes towards sexual well-being are influenced by people's culture [1]. But another study in the Netherlands showed that most barriers were related to the organizational dimension and considered the absence of organizational policies as the biggest obstacle to sexual counseling [19]. However, the organizational dimension of this study was the weakest barrier. The nurses who participated in this study probably believe that if patients do not allow them to provide counseling, it will be impossible to talk about sex even without the organizational barriers. Since nurses working in cardiac units must provide comprehensive information and train patients at the time of discharge, the role of organizational barriers to providing sexual counseling is diminished.

The results showed that from the cardiac nurse's perspective, religion, and beliefs were the most barriers to providing sexual counseling for patients with myocardial infarction. Some studies supported this results [13, 19]. According to studies, 94% of nurses prohibited from talking about sex [22]. Two studies in

Turkey have emphasized that religion and culture were barriers to patients' sexual assessment [23, 24]. It is concluded that in many societies, talking about sex makes clients and even counselors annoyed and embarrassed. It seems that the client's beliefs should be questioned before talking about sex, so that planning and counseling are made properly. The researches argue that traditional religious values lead to shame about sex throughout life. They emphasize that religious beliefs vary across cultures; because sex is a private matter, and it is difficult to talk about it [25].

Embarrassment was another barrier from nurses' perspective. In support of this result, number of studies reported shame and embarrassment to be the barriers to sexual counseling for patients in different countries and patients prohibited from talking about it [26, 27]. It seems that nurses found it difficult to talk about sexuality and provide sexual counseling for patients with myocardial infarction because they considered it to be very private. Another study reported sexual counseling for patients with heart failure to be a silent phenomenon. They also found that German nurses rarely provided sexual counseling for patients [28]. Patients, especially Iranian ones, may feel embarrassed about sexuality, especially sexual intercourse, and may therefore be reluctant to talk about their sexual concerns and may not even respond to such questions. Based on a study patients were not interested in talking about sexuality because of their embarrassment, so they should be prepared in this regard [19].

Results showed that nurses' disbelief in the impact of sexual counseling on the treatment process received the lowest mean score. No similar article was found, but it is clear that nurses are aware of the variety of their roles, including providing sexual counseling for patients. A nurse in the role of a counselor can prepare the patient to deal with changes and problems and cope with new conditions. The researchers believe that healthcare personnel should play an active role in the sexual health of patients [29].

The relationship between nurses' demographic variables and barriers related to providing sexual counseling for patients (barriers related to patient, nurse, and organization) showed a significant correlation only between the nursing education level and organizational barriers. Therefore, postgraduate nurses assigned higher scores to organizational barriers, because they might be more experienced, could provide counseling and better deal with patient-nurse barriers, while dealing with organizational barriers is probably more complicated. A study showed that attention to sexual health problems during undergraduate education can increase their knowledge [20].

The limitation of this study was that the researcher could not determine a specific time for nurses to complete the questionnaires due to the unstable condition of the patients and their constant monitoring. Therefore, the researcher had to wait for the nurses to complete the questionnaires.

The present study had some limitations. There was a cross-sectional design. It would be important to determine if preferences evolve over time with a longitudinal design. The census method was also used for sampling. Therefore, the interpretation and generalization of study results should be done with caution.

Conclusion

The results of the study showed that patient-related barriers were the most important, among which religion, beliefs, and embarrassment got the highest mean scores. Since sexuality is a sensitive issue in most cultures and religions, especially in Islamic countries, some interventions should be done to reduce the sensitivity of the community and the gradual removal of this taboo. To remove barriers to providing sexual counseling, health care providers should provide patients with information about sexual problems. They, as first-line caregivers, should try to change the attitudes of patients towards sexuality through training and counseling so that sexual counseling can be easily done, and the patients' needs are met, and their sexual health is improved.

Declarations

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Availability of data and materials

Data are available by contacting the corresponding author.

Authors’ contributions

PM, MF, TG and RM contributed to designing the study, TG collected the data, RM analyzed the data, and MF, TG and PM wrote the final report and manuscript. All the authors read and approved the version for submission.

Ethics approval and consent to participate

This study was approved by the Ethics Committee of Kerman University of Medical Sciences [No. IR.KMU.REC.1396.1341]. the researcher gave oral and written information and obtained written informed consent from all participants before the interviews. Participation was voluntary, and the participants had the right to withdraw at any time. All methods were carried out in accordance with relevant guidelines and regulations.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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