

Cardiomyopathy in woman: analysis of sexuality.

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Abstract

Cardiovascular diseases are the leading cause of death in the world. Projections indicate that by 2330 million people will die from cardiovascular disease. The impact of heart disease and its treatment with invasive procedures coupled with physiological, psychological changes, changes in lifestyle, recommended therapy among others, can affect sexuality.

Keywords: Cardiovascular, disease, sexuality, aerobic, myocardial infarction.

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Introduction

Sexuality is part of nature and obeys a physiological and emotional need, manifests itself differently in the developmental stages and its expression is determined by organic and mental maturity [1,2]. Sexuality is a form of communication that aims at pleasure, well-being, self-esteem and the search for an intimate relationship, sharing love and desire with another person to create more intense bonds of union [3].

It is known that during sexual activity, heart rate and blood pressure increase in the same way as in any aerobic physical activity. The greater the regularity in the level of physical activity and its aerobic conditioning, the lower the probability that sexual activity is a predisposing factor for some cardiovascular event. The risk of having a myocardial infarction as a precipitating factor for sexual activity is considered low. In cardiac patients, sexual activity, when compared to vigorous physical activity and intense emotional response, represents a lower risk of myocardial infarction. Thus, physically better conditioned individuals, independent of being cardiopathic, have a protective factor for triggering cardiac events in general [4].

Only people with unstable heart disease or severe symptoms should be abstained from sex, and should be evaluated and stabilized with appropriate treatment before engaging in any sexual activity. There are no contraindications in those with mild or moderate valvular heart disease, asymptomatic or with mild symptoms, patients with normal functional valve prostheses and with chronic low-grade heart disease [5]. It is worth noting that sexuality in climacteric women with heart disease may be impaired for two reasons: firstly, the diagnosis of heart disease and all related physiological and psychological inferences (dyspnea, fatigue, tachycardia, palpitation, anxiety, fear of death, Physical activity) and second (Reduction of libido and vaginal lubrication, anorgasmia, loss of desire, arousal, orgasm, sexual dysfunction) [4] and the use of drugs capable of producing adverse effects that impair sexual performance. Sexual complaints are prevalent throughout the reproductive life, but during climacteric women may become more vulnerable to sexual dysfunction. The interaction of menopausal transition factors with alterations in the genital organs, central nervous system and physical, psychological and social factors related to the sexual partner can influence the sexuality of the women [6].

Insecurity determined by the physical problem leads to psychic problems and can interfere with family relationships, social interaction and sexual adaptation. In this phase, the woman moves away from the social environment and retracts, when it is time to expand the field of relationships [7,8]. Addressing sexuality is a complex task, endowed with a lot of meaning, meaning, myths and prejudices. Although sexuality is something inherent to life and health, manifested from the birth of man to death, it is considered a matter impregnated with discrimination and prejudice [9].

The lack of knowledge, the unpreparedness and discomfort of health professionals in addressing sexuality, make difficult the interventions necessary to promote, especially, an active sexuality [10]. A look at this experience through the reception, dialogue, identification of complaints, clarification of doubts and orientations that stimulate and promote women's health and quality of life becomes fundamental and can help in the understanding of biological, psychological, social, cultural relations And of the gender involved, of the perceptions, worries, anxieties, of his life. This study aims to investigate the sexuality of the climacteric women with heart disease treated at the Cardiology Outpatient Clinic of the University Hospital of São Luís-Maranhão, Brazil.

Methodology

A qualitative study carried out at the University Hospital of the Federal University of Maranhão-UFMA, a federal public institution in the city of São Luís, Maranhão, Brazil, for tertiary care and referral to the state for high complexity procedures in cardiology.

Thirteen (13) cardiac-climacteric women included in the larger research project entitled "Climacteric women and coronary artery disease: revealing meanings and meanings" were interviewed, approved by the Research Ethics Committee of the University of São Paulo at Ribeirão Preto College of Nursing- EERP / USP, São Paulo, Brazil, under the number 293,900. Inclusion criteria were women between the ages of 45 and 65 who had some climacteric symptoms according to the Menopause Rating Scale - MRS and who agreed to participate in the study. The excluded women were those who did not present any climacteric symptoms in MRS and who had apparent cognitive deficits and speech disorders.

Data collection was carried out from January to February of 2016, from the database of the aforementioned project, with the women contacted by telephone and invited to participate in the study. Considering the acceptance and availability, the appointment was made for interview. The data were collected by the researcher herself after explaining the ethical procedures, guaranteeing the anonymity and confidentiality of the information. The questionnaires were delivered to women in a reserved place, respecting privacy and awaiting the return of them. The inference and interpretation of the qualitative data were based on the readings referring to gender, feminine identity, climacteric, menopause, cardiopathies, sexuality and sexual activity. The quantitative results were presented through tables, tables and graphs, in order to facilitate the data layout, and also interpreted on the basis of literature. The ethical precepts for the development of the research were respected, being guaranteed the anonymity and confidentiality of the information, emphasizing its use restricted to the proposed studies. To maintain the anonymity of the interviewees, the women were presented with the letter E accompanied by the number that identifies it in the survey, e.g.: E1 (Interviewee 1).

Results and Discussion

When asked about the importance of sexuality, the majority of women reported dissatisfaction with sexuality in their life and gave lower marks to sexuality in their life, justifying not being a priority. Some said they felt satisfied with their sexuality and assigned a maximum grade (ten): I. I feel satisfied. I do not want to have a relationship. Sexuality for me is not very important, note 1. (E6); II. There is no life left. I would give grade 1. (E5); III. I can live without sex, but I do not want to displease my husband who is good for me Note 1. (E2); IV. Not so, very important, before had more. I think note 2. (E7)V. Yes, I feel satisfied. Note10. (E12); Most of the interviewees reported a deterioration in the quality of sexuality in the climacteric phase, and it is not possible to determine if the changes in sexuality come exclusively from climacteric or the establishment of heart disease or both. A correlation between satisfaction with sexuality and absence of climacteric and/or cardiac symptomatology is highlighted. Climacteric complaints do not arise exclusively from the hormonal imbalance inherent in this phase of life, but come from self-image, from expectations and life projects, from social relationships and role in relation to society and the family. All these dimensions contribute to the appearance, duration and intensity of climacteric signs [3]. The occurrence of menopause is seen negatively by some women, associating this event with the loss of their femininity and their ability to fully exercise their sexuality [14]. The organic changes that occur in the woman during the climacteric do not necessarily imply in the decrease of the pleasure, but they can influence the sexual response, that can become slower [10].

When addressed about the presence of some sexual discomfort, women reported weakness, tiredness, decreased desire and pleasure:

- I. My husband always asks me if I'm okay, how I feel better. And he was always quick, which for me is better (E1).
- II. I also feel agony (tiredness) and desire to finish soon (E9).
- III. My discomfort is different. I do not take pleasure in sex (E4).

Women in the climacteric may experience less intense and longer vaginal lubrication, resulting in thinning of the vaginal tissues, which can lead to physical and emotional discomfort, cause of anxiety and dissatisfaction. Some women in this climacteric phase may feel diminished desire while others experience the opposite process, that is, a release of desire and the exercise of a less conflicted sexuality [10].

Cardiac symptoms that arise during sexual activity are mostly related to tachycardia, with heart rate control being a key exercise for successful therapy. The use of nitrates before sexual intercourse is useful in controlling symptoms and relieving fear of sexual activity impaired by angina. In the first month after cardiac surgery, the weight of the partner's body on the surgical scar should be avoided [11].

The interest and availability of the partner are important so that sexuality can continue to be exercised satisfactorily in the climacteric, as in any other time of life, as in the face of an illness. In many situations the lack of communication and even understanding and affection between couples induces the loss of complicity and intimacy [10]. In this perspective, the importance of a good relationship with the spouse is revealed, not only for satisfaction in the favorable sexual performance, but also for the woman to feel understood and loved independently of the importance of sex in her life and the desire to practice it. The testimonies of the women interviewed reveal this

- I. It feels good to be with my husband, but I rarely enjoy sex at this time. I need to go to a gynecologist. (E2);
- II. Good husband gives way to have sex (E9).
- III. More or less. Not so, very important, before had more (E7).

Human sexual behavior is influenced by several factors and psychological and sociocultural aspects and is related to physical and mental health, as well as to the marital and professional relationship, which results in a commitment of interest and sexual response [11,12]. The ways of living sexuality, of experiencing pleasures and desires, rather than problems or issues of individuals, need to be understood as problems or questions of society and culture [13]. Differences in the exercise of sexuality demarcate ways of being and feeling and define unequal relations of power, in which subjectivities 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 Husband [13]. However, when this woman feels valued, capable of provoking interest in the opposite sex and of performing her activities within society, sexuality is fully and positively experienced in the climacteric [14]. Thus, sex has ceased to be a purely biological necessity to be, mainly, a psychological necessity [15]. Although climacteric and heart disease have strong physical, emotional, social and cultural impacts on sexuality, there is an urgent need for the woman to be able to elaborate the situation and adapt to possible limits and changes in their lifestyle in relation to climacteric and the limitations imposed by heart disease [16]. When asked about women's time to return to sexual activity, respondents reported that due to fear, they chose to wait from two weeks to months for sexual return, as follows:

I. Two months or so, I was afraid (E2); II. I waited a month for fear of another heart attack. (E7); III. I waited nine months to return, out of fear (E8); IV. I waited a few months. No will and fear in the beginning. (E9); V. Five months because of fear (E11) SAW. Two months out of fear (E12).

The disinformation of the patients about the disease and the return to sexual activity is not only related to the level of schooling [17]. It is known that the return to sexual activities after the start of treatment depends on the severity of the disease and the knowledge of the clinical, psychological and social dynamics of each case. Despite considering the couple's attitudes and behavior in the overall rehabilitation process, guidance on returning to sexual activity after a cardiac event does not seem to follow a protocol among health professionals. Return to sexual activity after an infarction ranged from 6.7 weeks in hemodynamic patients to 5.9 weeks in angioplasty and 8.2 weeks in those undergoing cardiac surgery. On the frequency and quality of sexual activity, 62.5% of the patients reported decreased frequency and 43% of the quality of sexual intercourse [2].

The presence of doubts about sexuality mainly in relation to the correct moment for the return to sexual activity occurs in 60% of cardiac patients who are discharged from hospital. Some factors may be related to the cardiac patient, especially fear of death, the possibility of reinfection, dyspnea, and angina, changes in libido, worry, anxiety and feelings of guilt. These factors may be associated with the lack of clarification about the climacteric, about heart disease, rehabilitation and the possible risks that the sexual practice may entail [17]. In this study, some interviewees reported not having returned to sexual activity after hospital admission due to their heart condition, according to the reports:

I. I have not had sexual intercourse for nine years, that's when I discovered my heart problem (E3).

II. I do not have sexual activity. After my problem I never wanted (sex), nor did I feel like it (E10).

The fear of losing their partner was one of the main reasons that encouraged them to return to sexuality, even though they did not feel prepared and confident for that moment, as follows:

I. My husband. I have to do it (sex) so he does not look in the street (E7).

II. I am married and my husband tries not to have another woman (E2).

The asymmetry of power in gender relations, established in the education of children and accentuated in adolescence, has a strong discursive ally in sexuality, especially in relation to the normalization of female behavior [13]. Even with all the transformations that have already taken place in the feminine condition, many women still cannot decide on their lives, they do not constitute themselves as subject and remain to the social exclusion by an imposed model [8]. Among the sexual changes related to the return to sexual activity due to the climacteric, there is a reduction or absence of sexual desire (libido), placing the woman in an uncomfortable situation in relation to the spouse, since she does not feel at ease during the act Sexuality, which often provokes repulsion from the partner [18,19]. Cardiopathy patients have a significant reduction in frequency and sexual

quality. It is suggested that this impairment can be minimized with professional guidance and referral to cardiac rehabilitation programs. Engaging patients in cardiovascular rehabilitation programs is imperative, and the approach to sexuality should emphasize and target an active lifestyle. Cardiopathy patients with sexual difficulties should be referred to the specialist in human sexuality [2]. The resumption of sexuality after a cardiac event is an important part of the return to normal life, however, due to the emotional components present, it is pertinent that the couple establish a sincere dialogue in view of the psychological aspects involved. Anxiety, fear, and concern were the main feelings related to the delay in returning to the sexual activity of the study women with heart disease, as follows:

I. The first time I was scared because they said I could not have weight (E11); II. I was a little anxious, but then I relaxed. Over time I felt more unconcerned (E8). III. At first I felt worried and afraid, but my husband is understanding and patient (E2). IV. I did not know what it would be like. I was afraid of having a problem. (E7).

Adequate sexual counseling will contribute to the reduction of fear and anxiety in cardiac patients, thus not compromising aspects related to quality of life [2]. Lack of guidance may generate uncertainties at the time of resuming sexual activities, leading to psychological disorders such as anxiety and depression [20]. After cardiac surgery, usually sexuality can return to normal after the first month, obviously respecting the limits. Addressing people's sexuality involves considering their individuality, their life history, their beliefs, their customs and perspectives on surgery, therapy, recovery, body and return to daily activities [8]. Women were asked if sexuality is addressed during outpatient consultations and if the health professional directs and/or clarifies doubts about the same as the quality and satisfaction, return to sexual activity, care, suitable positions etc. It was observed that almost all the women responded that there was no approach on sexuality with the health professional. Only one woman reported having talked to the doctor about the subject, but did not consider the orientation satisfactory due to the feeling of shyness and the excess of people in the environment (resident doctors), according to the following report:

I was ashamed there were a lot of people (E8).

Sexuality is seen by most doctors and patients as taboo, being stigmatized and not questioned in the different moments of interaction between professionals and their clients. The patient does not ask and the doctor does not respond, being sealed a veiled pact of silence [4]. The guidelines and prescriptions performed in outpatient clinics aim to meet the immediate needs of the patients, without considering important aspects emerged during the treatment [20]. Although practitioners feel responsible for providing sexual orientations, they rarely do so in their daily practices [2]. Sexual activity should be considered as any other physical activity because it has similar energetic demands [4,5]. So patients should receive guidance on sexuality in the same way that they receive information about return to work And aerobic activities. The spouse should be informed about the situation of the partner in the maximum extent of such counseling [4]. Sexuality is a subject little discussed, since prejudice still prevails in our midst. Most of the cardiac patients'

present doubts about sexuality [17]. Orienting patients regarding the aspects of sexuality during the time of hospitalization as well as follow-up of the outpatient clinic become fundamental. The professional should guide and promote the patients' well-being, encouraging them to express their sexuality as an important basic and affective need, as an example, the ideal time for return of sexual activity [7].

Conclusion

Changes in the sexuality of the woman with cardiopathies related mainly to worry, anxiety, fear, decreased desire and pleasure, fatigue, weakness and dizziness were identified. The experience/experience of sexuality for the majority of climacteric women is impaired, however, and it is not possible to determine if the changes in sexuality come exclusively from climacteric or the establishment of heart disease or both. It stands out Correlation between satisfaction of sexuality and the absence of climacteric and/or cardiac symptomatology. The guidance on sexuality offered in routine consultations, in the period of hospitalization and on discharge is quite limited. Health professionals have little dialogue on this issue. The limitations of the study are the shyness of women when discussing sexuality and the characteristics of the qualitative study, such as the population size of a specific group, climacteric women with heart disease.

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