

# A Survey on Sexual Counseling for Patients With Cardiac Disease Among Nurses in Jordan

Raeda M. Abu Ali, MSN, RN; Mona A. Abed, PhD, RN; Amani A. Khalil, PhD, RN; Manal I. Al-Kloub, PhD, RN; Ala F. Ashour, PhD, RN; Intesar A. Alnsour, MSN, RN

**Background:** Recovery among patients with cardiac disease also requires attention to their sexual health. However, cultural, religious, and social factors may make Arab Muslim patients reluctant to disclose their sexual concerns and nurses hesitant to discuss patients' sexuality matters. **Objective:** The aim of this study was to explore sexual counseling (SC) among nurses in Jordan in terms of responsibility, confidence, and practice. **Method:** This was a descriptive, correlational study. Staff nurses were recruited from 10 hospitals in Jordan. Nurses completed the cardiac version of the Survey of Sexuality-Related Nursing Practice and reported their demographics. **Results:** The sample consisted of 379 nurses (female, 59%; mean age, 28.1 years). A significant proportion of nurses viewed assessment/discussion of patients' sexuality matters as not within their responsibilities (39%), did not feel confident to address sexuality matters (50%), and rated themselves as not at all/not very knowledgeable about sexuality (60%). Few nurses were routinely integrating SC in clinical practice (9%). Sexual counseling was associated with nurses' gender (male, higher confidence and practice) and previous training on sexuality in nursing practice. **Conclusions:** Nurses in Jordan, especially female nurses, are neither prepared nor competent to provide SC. Nurses need focused education on sexuality to optimize patients' sexual health.

**KEY WORDS:** Arabs, Jordan, nurses, sex counseling, sexuality introduction

Sexual health is a "state of physical, mental and social well-being in relation to sexuality."<sup>1</sup> Chronic and acute cardiac health conditions, such as heart failure and myocardial infarction, may adversely affect patients' sexual health and result in sexual dysfunction

(eg, problems in desire, arousal, orgasm, ejaculation) due to competing physical symptoms (eg, fatigue), psychological factors (eg, fear, depression, and anxiety), coexisting morbidities (eg, diabetes and hypertension), or interaction of commonly used medications (eg,  $\beta$ -blockers and diuretics).<sup>2,3</sup> Sexual dysfunction prevalence among men and women with chronic heart failure reached 90%.<sup>4</sup> Moreover, up to 59% and 9% of sexually active patients reported declined and no sexual activity, respectively, in the year after myocardial infarction.<sup>5</sup> Sexual dysfunction has a negative effect on patient intimate relationships, self-esteem, and quality of life.<sup>4,6</sup>

Recovery of patients with acute or chronic cardiac health conditions requires attention to their sexual concerns. Sexual counseling (SC) is "an interactive helping process focusing on the need to make adjustments in sexual practice or to enhance coping with a sexual event/disorder."<sup>7</sup> Sexual counseling can improve sexual health and limit or even correct sexual dysfunction when patients' relevant concerns are properly addressed.<sup>8,9</sup> Without attending to patients' sexual concerns, patients may use untrusted sources of information on how to manage their sexual dysfunction.<sup>10</sup> They may also try untested herbs or remedies, which could in turn result in serious adverse effects or adverse interactions with their medications.<sup>10</sup>

## **Raeda M. Abu Ali, MSN, RN**

Lecturer, Department of Medical Sciences, Salt College, Albalqa Applied University, Amman, Jordan.

## **Mona A. Abed, PhD, RN**

Associate Professor, Department of Adult Health Nursing, Hashemite University, Zarqa, Jordan.

## **Amani A. Khalil, PhD, RN**

Associate Professor, Department of Clinical Nursing, The University of Jordan, Amman.

## **Manal I. Al-Kloub, PhD, RN**

Assistant Professor, Department of Maternal, Child, and Family Health, Hashemite University, Zarqa, Jordan.

## **Ala F. Ashour, PhD, RN**

Assistant Professor, Department of Adult Health Nursing, Hashemite University, Zarqa, Jordan.

## **Intesar A. Alnsour, MSN, RN**

Lecturer, Department of Medical Sciences, Salt College, Albalqa Applied University, Amman, Jordan.

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## **Correspondence**

Mona A. Abed, PhD, RN, College of Nursing, Hashemite University, Zarqa, Jordan 13115 (maabed2@g.uky.edu).

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Cultural, religious, and social factors may however interfere with willingness to discuss sexual issues.<sup>10–12</sup> Among Arab Muslims, sexuality is surrounded with an aura of extreme sensitivity and privacy. Islamic norms, as reflected in the sayings of Prophet Muhammad (“The most evil of the people to Allah [God] on the day of resurrection will be the man who consorts with his wife and then publicizes.”), stress the secrecy of one’s sexual matters.<sup>13</sup> Sexual activity is allowed only within the marital bond, whereas other sexual relationships, premarital or extramarital, in addition to homosexuality, are considered major sins and therefore difficult to report.<sup>13,14</sup> Muslims, men and women, are required to show modesty in their speech and behaviors to cultivate a moral climate.<sup>12</sup> Consequently, conversation about sexuality is largely viewed as a taboo or, at least, impolite talk.<sup>15</sup> However, most Arab men may find no embarrassment in discussing general sexual issues with their male peers to demonstrate their knowledge and prove their masculinity. By contrast, Arab women may avoid talking about sex, especially with men, because of fears of losing their chastity or being described as “fallen women.”<sup>11</sup>

In the medical setting, cultural, religious, and social factors may make Arab Muslim patients reluctant to disclose their sexual concerns and nurses hesitant to discuss patients’ sexuality matters.<sup>12,15</sup> The only published study about sexual information needs of Muslim Jordanian patients with cardiac disease (N = 124; mean age, 55 years; men, 72%) revealed significant concerns (eg, fear of having sex and loss of sexual desire) and an intense need to be informed regarding several issues (eg, effect of medications, time to resume sex, warning signs, positions to be used, and foreplay).<sup>15</sup> No study has examined the perspectives of nurses about SC and its integration in clinical practice in the conservative Muslim, Jordanian society. Thus, in this quantitative study, we aimed to explore SC among Jordanian nurses, with regard to patients with cardiac disease, by addressing the following questions:

1. How do nurses in Jordan perceive nurses’ responsibility to counsel patients about their sexual concerns?
2. How do Jordanian nurses rate their confidence in providing SC?
3. How frequently do Jordanian nurses practice SC, and what topics do they commonly discuss?
4. What is the relationship of nurses’ demographics to their practice of SC and perceived responsibility and confidence?

## Methods

### Design, Sample, and Setting

This was a descriptive, correlational study. Staff nurses who were working in coronary care units (CCUs) or a

medical floor at one of the assigned hospitals during data collection were eligible to participate. Nurses with administrative duties, such as head nurses, and those working in outpatient clinics were excluded because they tend to have limited interaction with patients. Recruitment areas included 10 hospitals in Jordan, distributed in 3 crowded governorates (two in the central region [Amman and Zarqa include 56.3% of Jordan’s population] and one in the north region [Irbid includes 18.3% of Jordan’s population]). This involved 2 public, 3 private, 2 university-affiliated, and 3 military hospitals.

### Procedure

The institutional review board of Albalqa Applied University and hospitals approved the current study. The primary investigator met the head nurse of each selected unit or floor to determine the most suitable time to approach potential participants while they were on duty (shifts A to C). The primary investigator explained, either individually or in groups, to potential participants the study’s aims, participants’ rights (eg, withdrawal right, no effect of participation on employment status), and confidentiality of collected data. After signing the consent form, enrolled nurses were asked to fill out the study questionnaires at their own convenience, seal in an envelope provided, and deposit in a sealed box made available in the nurses’ room. No incentives were given for participation, and all completed questionnaires were anonymous.

### Measures

#### Sexual Counseling

The cardiac version of the Survey of Sexuality-Related Nursing Practice (SSRNP) was used to evaluate SC for patients with cardiac disease among nurses in Jordan. The SSRNP was initially developed by Matocha and Waterhouse<sup>16</sup> to study different aspects of SC among nurses, including practice (8 items), perceived responsibility (5 items), and confidence (5 items). Steinke and Patterson<sup>17</sup> revised the SSRNP for patients with different cardiac conditions (eg, heart failure, myocardial infarction) by adding queries on information given (eg, time to resume sex, medication effects, warning signs) and recipients of SC in terms of age and gender. Items in the SSRNP are rated using different intensities (ie, strongly agree, agree, not sure, disagree, strongly disagree) and frequencies (ie, never, seldom, sometimes, usually, always) using self-report Likert-type scales. The total score of each subscale of the SSRNP is the sum of all scores for the items; a higher total score indicates better performance. The content validity and internal consistency reliability of the SSRNP have been previously demonstrated.<sup>18,19</sup>

A panel of Jordanian experts (3 nursing faculty members with PhD degrees, 3 nurses with long experience

in CCUs, and the investigators of this study) discussed whether instrument adaptations were required before using the SSRNP among Jordanian nurses. The panel decided to adopt the original English version of the SSRNP because English is the language of instruction in Jordan's higher education system. In addition, the panel rated the SSRNP subscales responsibility, confidence, and practice relevant and compatible with Jordanian culture because they measure nurses' performance in SC and not cultural values, which tend to vary across different societies. A pilot test that involved 20 staff nurses (female, 45%; mean age, 29.8 years) showed that the SSRNP items were clear, easy to understand, and appropriate. No item was described as offensive or unacceptable. All subscales achieved significant, strong 7-day test-retest correlations. Cronbach's  $\alpha$  of the SSRNP in this study was .84.

### Demographic Data

Nurses were asked to self-report their gender, age, educational level, religion, nursing experience in years, and practice area (ie, hospital name and working unit [floor or CCU]). We also asked nurses whether they had lectures or workshops on sexuality in nursing practice during and after their basic nursing education.

### Statistical Analysis

For data analysis, SPSS (version 19) was used. Data were verified before the analysis. Descriptive statistics were used to present sample characteristics and the study's main outcomes. The variables age and nursing experience were split using the median score to allow for comparisons between equal groups. Independent samples  $t$  tests were used to examine the differences in the mean of the SC subscales (responsibility, confidence, and practice) between nurses dichotomized by their demographic characteristics.

## Results

### Sample Characteristics

The total sample consisted of 379 nurses. The mean (SD) age and nursing experience were 28.1 (4.3) and 5.5 (3.9) years, respectively. Almost all were Muslims and with a bachelor's degree in nursing. More than one-half were married, female, and working in medical floors. Most nurses had attended no lectures on sexuality in nursing practice during or after their basic nursing education (Table 1).

### Sexual Counseling in Terms of Responsibility

The mean (SD) score on the responsibility subscale, which theoretically can range between 5 and 25, was 13.3 (3.6; median, 14; range, 5–24). More than one-third

**TABLE 1** Sample Characteristics (N = 379)

Characteristic	n (%)
Gender	
Male	157 (41)
Female	222 (59)
Education	
Bachelor's degree	350 (92)
Master's degree or higher	29 (8)
Marital status	
Single	150 (40)
Married, divorced, or widowed	229 (60)
Hospital type	
Public	79 (21)
Private	100 (26)
University affiliated	85 (23)
Military	115 (30)
Working unit	
Medical floor	192 (51)
Coronary care unit	187 (49)
Had lectures on sexuality in nursing practice in basic nursing education	123 (33)
Had workshops/continuing education on sexuality in nursing practice after basic nursing education	86 (23)

of the surveyed nurses (39%) disagreed on nurses having a responsibility to discuss patients' sexual concerns, and approximately one-half (46%) viewed discussing patients' sexual matters as inappropriate. With regard to initiating a discussion with patients about sexuality, nurses who believed that it is never/seldom appropriate (56%) were approximately 3 times more than those who believed it is always/usually appropriate (17%). If patients, however, initiated a discussion, the percentage of nurses felt that it is never/seldom appropriate to discuss patients' concerns (35%) became close to those who believed it is always/usually appropriate (30%).

### Sexual Counseling in Terms of Confidence

The mean (SD) score on the confidence subscale, which theoretically can range between 5 and 25, was 14.2 (3.3; median, 15; range, 5–25). In total, more than half of the nurses (60%) rated themselves as not at all/not very knowledgeable about sexuality; one-third (31%), as somewhat knowledgeable; and 1 of 10 (9%), as very/extremely knowledgeable. Half of the sample never/seldom felt comfortable discussing patients' sexual concerns. Feelings of anxiety were usually/always experienced by one-third of the nurses (30%) when addressing patients' sexuality matters.

### Sexual Counseling in Terms of Practice

The mean (SD) score on the practice subscale, which theoretically can range between 8 and 40, was 17.2 (6.3; median, 17; range, 8–36). Less than one-tenth of the nurses (6%–9%) were frequently assessing sexual

health, frequently teaching modifications in sexual practices, and frequently answering or listening to patients' questions and concerns about sexuality while interacting with patients with cardiac disease. Nurses provided information on sexuality to slightly more male than female patients (Figure 1) and to patients aged 20 to 65 years more than those 66 years or older (Figure 2). With regard to the content of SC, most nurses ( $\geq 70\%$ ) had never/rarely provided information on the time of resuming sexual activity, comfortable settings, positions to be used, foreplay and unfamiliar surroundings, warning signs to report, eating and drinking before sexual activity, or comfortable settings (Figure 3).

### Relationship of Nurses' Demographics to Sexual Counseling

As summarized in Table 2, nurses' age, educational level, marital status, working unit, and length of experience in nursing were not related to SC. Male nurses reported higher confidence and practice of SC than female nurses. Having attended lectures/workshops on sexuality in nursing practice during or after nursing basic education was positively related to SC in terms of responsibility, confidence, and practice.

### Discussion

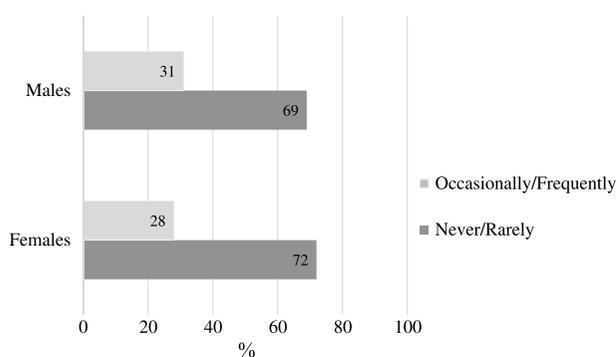
This is the first study that explored the status of SC among nurses in Jordan. Here, the percentage of nurses who disagreed or were not sure about having responsibility to discuss patients' sexual concerns (68%) was higher than that of nurses who agreed (32%). Half of the sample was uncomfortable discussing patients' sexual concerns, most of the nurses (60%) were barely knowledgeable about sexuality, and very few nurses (up to 9%) were routinely integrating SC in clinical practice. In another investigation that surveyed nurses from several European countries, most of the nurses (87%) agreed on having responsibility toward discussing patients' sexu-

ality, one-half were comfortable discussing patients' sexual concerns, 64% were somewhat knowledgeable about sexuality issues, and few nurses (up to 11%) were actually practicing SC.<sup>19</sup>

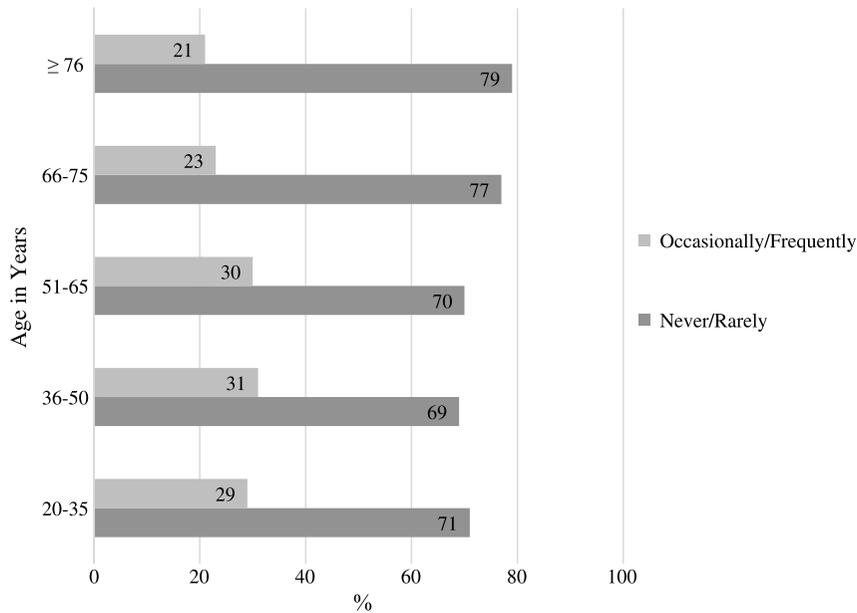
The variation in SC between nurses in Jordan and those in the west confirms a previous conclusion that culture highly matters when it comes to sexuality.<sup>20</sup> Jordanians are generally raised not to talk openly about sexuality.<sup>11</sup> In homes, and even in situations requiring explicit dialogue, such as between mothers and their daughters in preparation of marriage, vital conversations about sex are almost always avoided because of embarrassment.<sup>21</sup> In schools, sex education is restricted to simple information on anatomy and physiology of the reproductive system to protect pupils' modesty. In medical schools, sexual health is weakly emphasized.<sup>22</sup> At the community level, discussing sexuality outside married couples is generally viewed as inappropriate.<sup>11</sup> Hence, the silence on sexuality in conservative societies could be related to how nurses rate their responsibility, confidence, and practice toward SC.

Jordanian nurses' report of poor practice of SC is consistent with Akhu-Zaheya and Masadeh's<sup>15</sup> findings, which revealed that only 1 of the 13 Jordanian patients with cardiac disease informed about sexuality had cited nurses as his/her source of information. Our study further showed that patients' gender and age affect whom nurses discuss sexuality matters with; female and older patients were shown to be less frequent recipients of nurses' education on sexuality. Among Middle Eastern people, Moreira and colleagues<sup>10</sup> demonstrated that women and elderly people were less likely to seek professional help for their sexual problems because of discomfort and some beliefs (eg, sexual dysfunction is not a medical problem, is part of aging, and cannot be solved). The failure of the patients to initiate a discussion about their sexual concerns made the nurses in our study feel less responsible, and possibly less urged, to attend to patients' sexuality matters.

Consistent with a previous report,<sup>23</sup> the age and marital status of nurses were not related to SC, but contrary to another investigation,<sup>23</sup> we demonstrated that nurses' gender was significantly associated with SC in terms of confidence and practice. Our finding that female nurses reported less confidence and practice of SC than male nurses is not surprising because Arab women have to practice extreme caution when discussing sex to preserve their modesty.<sup>11</sup> As other studies showed,<sup>19,24</sup> neither nurses' educational level nor their general experience in nursing was associated with SC. All examined sexuality topics, regardless of how sensitive or intimate, were likely to be never/rarely addressed by at least 70% of the surveyed nurses in our study. This indicates that nurses' general nursing experience or education is insufficient to equip nurses with the necessary knowledge and skills to promote patients'



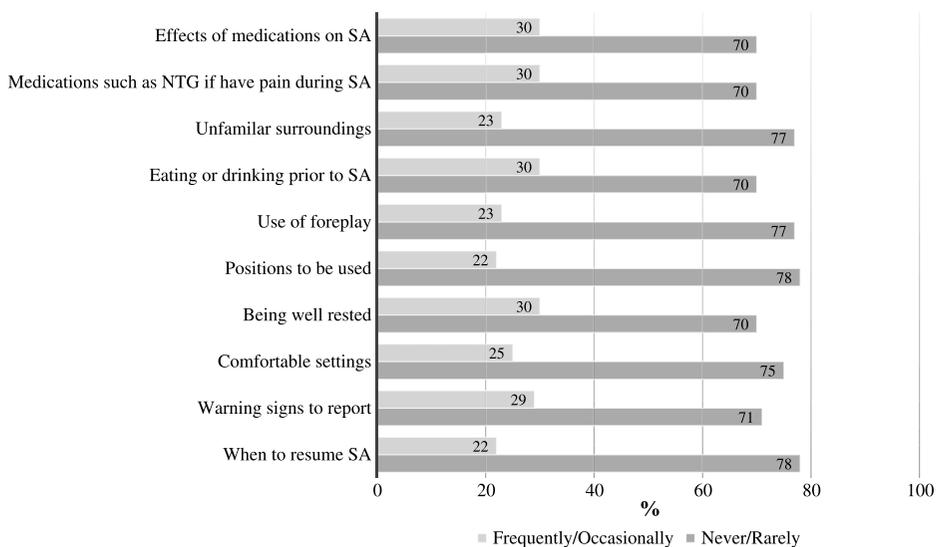
**FIGURE 1.** Frequency of providing information on sexuality to female and male patients with cardiac disease by nurses (N = 379).



**FIGURE 2.** Frequency of providing information on sexuality according to patients' age by nurses ( $N = 379$ ).

sexual health. Without previous education on sexual health, nurses become unfamiliar with patients' SC needs and therefore provide extremely poor SC content. Furthermore, as another investigation showed,<sup>19</sup> having specialized lectures/workshops on sexuality in nursing practice either in basic nursing education or during clinical practice was positively related to SC in terms of responsibility, confidence, and practice. A quasi-experimental study also demonstrated a positive change in student nurses' attitude, knowledge, and self-efficacy with regard to sexual healthcare after implementing a 12-week sexual health education program.<sup>25</sup> This confirms nurses' need for focused training to improve their SC skills. In our study, a limited number of nurses had received specific education or training on sexuality matters.

Besides their need to learn basic information, such as the effect of diseases on sexual health, Jordanian nurses need to develop a more constructive attitude toward SC. Sexual counseling training using role-playing, small-group discussions, and culturally relevant scenarios may afford nurses the opportunity to critically analyze their feelings and beliefs toward SC and also provide them with a nonthreatening environment to express their opinions, fears, and concerns. Reviewing the Islamic perspective on sexuality while training Jordanian nurses on SC is also important. Emphasizing the facts that the Quran and the sayings of Prophet Mohammad have discussed extremely intimate issues, such as intercourse and foreplay,<sup>13</sup> and that embarrassment did not prevent old Muslims, including women, to ask Prophet Mohammad about their sexual issues<sup>13</sup> would be very



**FIGURE 3.** Sexual counseling in terms of discussed topics by nurses ( $N = 379$ ).

**TABLE 2** Sexual Counseling in Terms of Practice, Responsibility, and Confidence According to Nurses' Characteristics (N = 379)

Characteristic	Practice	Responsibility	Confidence
	Mean (SD)	Mean (SD)	Mean (SD)
Age by median, y			
<27	17.5 (6.4)	13.1 (3.6)	14.1 (3.4)
≥27	17.0 (6.2)	13.4 (3.5)	14.3 (3.3)
Gender			
Male	17.9 (6.9) <sup>a</sup>	13.6 (3.5)	15.1 (2.9) <sup>b</sup>
Female	16.2 (5.3)	13.0 (3.7)	13.6 (3.4)
Marital status			
Single	16.5 (6.4)	13.0 (3.7)	13.9 (3.5)
Married, widowed, or divorced	17.6 (6.2)	13.5 (3.4)	14.5 (3.2)
Highest educational level			
Bachelor's degree	17.4 (6.3)	13.3 (3.6)	14.2 (3.3)
Master's degree	17.5 (6.4)	13.1 (3.6)	14.4 (3.9)
Nursing experience by median, y			
<5	17.2 (6.1)	13.1 (3.5)	14.1 (3.2)
≥5	17.2 (6.5)	13.5 (3.6)	14.3 (3.4)
Had lectures on sexuality in nursing practice in basic nursing education			
Yes	18.4 (6.8) <sup>a</sup>	14.2 (3.7) <sup>b</sup>	14.8 (3.3) <sup>c</sup>
No	16.6 (6.0)	12.8 (3.4)	14.0 (3.3)
Had workshops/ continuing education on sexuality in nursing practice after basic nursing education			
Yes	20.0 (6.6) <sup>b</sup>	14.7 (3.2) <sup>b</sup>	15.3 (3.4) <sup>a</sup>
No	16.3 (6.0)	12.8 (3.6)	13.9 (3.2)

<sup>a</sup>*P* < .01.

<sup>b</sup>*P* < .001.

<sup>c</sup>*P* < .05.

helpful for Jordanian nurses to realize that SC is actually concordant with Islamic teachings. Moreover, highlighting the point that nurses can maintain modesty while discussing extremely sensitive issues, by using effective communication skills and appropriate language, may make nurses feel more confident and comfortable to practice SC in real life.

It must be admitted, however, that, without overcoming societal obstacles, SC will remain scarce in clinical settings. How to minimize the taboo from discussing sexuality is a big challenge, especially in conservative societies. Nevertheless, sex education (defined as "informing the individual and providing him/her with experiences related sexual issues based on his/her age and developmental stage, and in accordance with his/her ethical and religious framework to achieve sexual harmony, face sexual problems and eventually achieve

### What's New and Important

- The provision of SC in conservative societies is extremely challenging.
- Jordanian nurses' commitment, confidence, and comfort to address patients' sexual concerns are poor.
- Status of SC among Jordanian nurses is a neglected area of research and demands thorough investigation.

mental and sexual health<sup>21</sup>) can be used to create positive attitudes toward sex and to liberate people from feeling shame and guilt while discussing sexuality.<sup>21</sup> Ashraah and colleagues,<sup>21</sup> based on the fact that Islam does not contradict with human nature including the sexual instinct, developed a sex education framework that can be applied in Muslim homes and schools. Furthermore, to emphasize the notion that sexuality is a healthy topic and can be discussed, education on sexuality should involve people who are sometimes consulted on sexual issues such as teachers, marriage counselors, and religious scholars.<sup>10</sup> In addition, the setting where SC may occur has to be tailored to accommodate the sensitivity of topics related to sexuality to encourage relevant discussion. In healthcare settings, for example, attention should be given to privacy issues, confidentiality of information, counselee-counselor gender matching, and availability of information resources.

This study has limitations that should be acknowledged. This includes reliance on self-reports in evaluating the status of SC among nurses in Jordan. Moreover, although the SSRNP was preassessed by local experts and examined in a pilot test in our study, it was not previously adapted for Arabic Muslim people. Another limitation is the possibility of introducing selection bias by the convenience sampling method.

### Conclusion

Nurses are expected to adopt a proactive role in relation to patients' sexual health. However, Jordanian nurses' perceived responsibility and confidence to provide SC are suboptimal, and their contribution to improve patients' sexual health is limited. Education on sexuality is key to helping Jordanian nurses promote patients' sexual health. In general, research on sexual health in conservative societies is scarce. Therefore, further investigations that involve the perspectives of both patients and nurses on sexuality to optimize this commonly overlooked aspect of health are warranted.

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