

Disease Burden and Sexual Life in Heart Patients: A Phenomenological Study

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Research Article

Keywords: Heart disease, Sexual life, Phenomenological study

Posted Date: May 21st, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-8671832/v1>

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Additional Declarations: No competing interests reported.

Abstract

The aim of this study was to deeply examine disease burden and sexual life in cardiac patients. Phenomenological research design, which is a qualitative research design, was used in this study. This qualitative research was conducted with 13 heart patients. Interviews were conducted individually and face-to-face. Data were analyzed using Colaizzi's phenomenological analysis method. Data analysis revealed two themes (problems experienced and burdens of the disease, effects of the disease on sexual life) and six sub-themes (physical problems, mental problems, social problems, problems related to sexual life, spouse and sexual life, coping with sexual problems). As a result of this study, it was found that cardiac patients experienced psychosocial problems and their sexual lives were negatively affected. Since heart disease is a multifaceted disease, it is necessary to evaluate sexuality in patients in a professional manner, diagnose sexual dysfunctions and take timely measures.

Introduction

Cardiovascular diseases (CVD) are one of the leading causes of morbidity and mortality worldwide, accounting for approximately one-third of all deaths [1]. These diseases, which include many conditions such as ischemic heart disease, myocardial infarction, heart failure, coronary artery disease, peripheral arterial disease and hypertension, negatively affect not only the physiological health of individuals, but also their psychological, social and sexual lives [2, 3].

A satisfying sexual life is an important element for maintaining psycho-physical well-being and maintaining quality of life [4]. Regardless of age, individuals who are interested in sexuality are reported to be healthier and remain sexually active longer [3]. Sexual activity is considered as a mild-to-moderate physical effort that increases heart rate and blood pressure and increases oxygen consumption of the heart muscle in healthy individuals. These physiological changes, which rapidly return to normal after orgasm, generally do not pose a clinical risk for cardiovascular disease [2].

However, in individuals with cardiac disease, this transient physiological response may lead to the emergence of cardiac symptoms or exacerbation of existing symptoms due to increased workload of the heart. Failure to adequately compensate for the oxygen deficit during sexual activity triggers fear of myocardial infarction or sudden death, often leading to a decrease in the frequency of sexual activity and avoidance behavior [5]. This decrease in sexual activity can lead to psychological problems such as low self-esteem, depression, anxiety, and social isolation in individuals, negatively affecting quality of life [5, 6]. These effects include not only the patient but also his/her partner and may lead to consequences such as decreased relational satisfaction, impaired communication and emotional distancing [3].

Today, in healthcare services, it has become increasingly important not only to increase survival in the treatment of CVDs, but also to improve individuals' health-related quality of life. Sexual life constitutes an important but often overlooked dimension of this quality of life [7]. Sexuality is an integral part of biopsychosocial integrity within the multidimensional structure of human beings. Therefore, health professionals, especially nurses, need to address physical, psychological and sexual needs with a

holistic approach in the care of individuals with cardiac disease. In this direction, the current study aims to make sense of the experiences of individuals with CVD regarding disease burden and sexual life phenomenologically [7, 8].

There are few studies in the literature that investigate in depth the burden of illness and its effects on sexual life experienced by heart patients. For all these reasons, it is thought that this study, which was conducted to address the psychosocial problems experienced by cardiac patients treated in a hospital in the north of the country and to examine the effect on sexual life, will contribute to the literature [4, 5, 8].

Materials and Methods

Study Design

Phenomenological research design, which is a qualitative research design, was used to examine the burden of disease experienced by heart patients and to deeply examine the impact of the disease on sexual life. This design was chosen because it offers a high degree of freedom in describing a new phenomenon (event or experience) from the participants' perspective, providing rich data and detailing their experiences [9]. This approach is about uncovering the essence of the phenomenon under investigation and presenting the experience exactly as it presents itself, neither adding to nor subtracting from it [10,11].

Study group

Criterion sampling method, which is one of the purposeful sampling methods, was used to determine the study group of the research. Criterion sampling is the creation of a sample from people, events, objects or situations that have the qualities determined for the problem [12]. The sample of the study consisted of heart patients with heart disease who were treated in a state hospital, met the inclusion criteria and agreed to participate in the study. The inclusion criteria were being treated for heart disease for at least five years and patients who voluntarily agreed to participate in the study. Exclusion criteria were patients who did not agree to participate in the study and had been treated for heart disease for less than five years. In total, all patients who met the inclusion criteria in the public hospital located in the northern region of the country were invited to be interviewed. The sample size was determined according to data saturation and a total of 13 participants were interviewed. In addition, the study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines [9,13].

Data Collection Tools

Heart patients receiving treatment in a state hospital were interviewed. In-depth individual interview method was used in the study. In the interviews with the patients, a voice recorder was used in a suitable environment (bright, sufficiently illuminated, ventilated). The interviews were conducted with a semi-structured interview form prepared by the qualitative research method, which was created by the researchers based on the literature and revised in line with the opinions of three experts. Four main

questions and sub-questions about the burden of disease and its impact on sexual life were used in the interviews

Questions in the semi-structured interview form;

1. According to you, what problems does an individual with heart disease generally experience? (What are your observations, general thoughts?)
2. What are the problems you experience due to your heart disease? What do you do to cope with these problems, what methods do you use, what are your experiences?
3. What are the burdens (difficulties, responsibilities or limitations) that your heart disease brings to you? What are your experiences?
4. Is your sex life affected by your disease? What problems do you experience?

A preliminary interview was conducted with a patient to test the comprehensibility and suitability of the questions and to experience the interview process with the researcher. During the 20 minute preliminary interview, the patient's data were not included in the analysis. The duration of the interviews in the study varied according to the patients' statements and lasted between 30 and 40 minutes.

Data analysis

In the analysis of the qualitative data obtained from the interviews, the 7-step analysis method developed by Colaizzi (1978) for phenomenological studies was used [10]. In this context, the interview texts were first read independently and repeatedly by three researchers. Thus, it was tried to understand what was explained in the data. The important statements in the interview texts were selected, reorganized and expressed in general terms. Then, the data that were tried to be explained in the statements were identified and analyzed. The researchers formulated and validated the meanings by discussing them until they reached a consensus. The researchers then identified and organized the themes into main and sub-themes. The themes and sub-themes of the study were developed with clear wording. In addition, by including the statements of the participants, the reader was able to verify the interpretation and analysis of the data.

Results

Demographic and professional characteristics of the individuals who participated in the study are presented in Table 1.

As a result of the analysis of the data obtained from semi-structured interviews, themes, sub-themes and codes were determined (Table 2).

Theme 1. Problems experienced and burdens of the disease

Subtheme 1. Physical problems

"I was very scared, and I'm still scared. I feel like my heart is going to stop at any moment. I throw up, my chest feels tight, I can't do anything, I cry when I'm scared." (P1)

"I often felt dizzy, blacked out, chest tightness, numbness in my left arm, especially after open heart surgery, I had difficulty swallowing, I was constantly feeling constricted. As a solution, I rested frequently and avoided stress. As an experience, I can give the period I stayed in intensive care as an example (P2).

Subtheme 2. Mental problems

"I am very short of breath, very weak, I have palpitations, dizziness, sometimes I lose consciousness. I can't climb stairs, I can't walk even for a short distance, I get out of breath immediately, my heart beats crazy fast and sometimes my eyes glaze over. In order to cope with these, I consulted many doctors and started treatment immediately. As a method, I preferred not to be alone at all, I was always around people, always chatting. (P3)

"I was very scared, and I'm still scared. I feel like my heart is going to stop at any moment. I throw up, my chest feels tight, I can't do anything, I cry when I'm scared." (P1)

Subtheme 3. Social Problems

"It was the constant heartburn and chest pain that pushed me the most, and my doctor put me on a diet, and dieting at this age made it hard to stay away from my favorite foods." (P4)

"My heart disease forced me the most at home. My housework was disrupted, I had trouble cooking, I needed the help of others because I couldn't move at first. (P10)

Theme 2. Effects of the disease on sexual life

Subtheme 1. Problems related to sexual life

"Who wouldn't be impressed? Of course he was. I could not even stand up on my own so that I could have a sexual life. We had problems for months, I was stressing my husband a lot, and when he was stressed, I felt like a burden and we entered a cycle that continues like this and still continues. Because of my heart, I avoid sexual life in case I have the same problems again. We could not do anything to cope with our problems, we just got used to this process (P7).

"Wouldn't it? My husband and I became very estranged. My husband's workload at home and in the field increased and this reflected badly on me. I don't do anything to cope, I just let it go. (P13)

Subtheme 2. Spouse and sexual life

"It was affected for the first two weeks, yes, but as it started to heal, there was no problem. We progressed in mutual understanding with my husband and it didn't pose a problem for both of us, and if there was a

problem, we talked about it." (P10)

"It was affected because I was in a state of panic, I was avoiding sexual life as much as possible and my husband got angry with this situation. I was crying when I couldn't cope with him, I was trying to tell him my fears. (P1)

Subtheme 3. Coping with problems related to sexuality

"Yes, it affects him a lot. My husband and I slept separately for a while after the surgery. We were fighting a lot. My husband thought that he was taking all the burden on himself and complained that I couldn't get better. This illness had driven a wedge between us. To cope, I explained my illness to him and asked my children to talk to my husband and help him. (P12)

"Isn't it affected? Of course it does. I told you that even a small movement can make me short of breath, but other than that, we don't have any problems. My husband is very understanding, so my illness did not reflect badly on us, we thought of it as a process and did not dwell on it. When there was a problem, we both solved it by talking hand in hand. (P3)

Discussion

The aim of this study is to examine the burdens of heart disease and to deeply examine the impact of the disease on sexual life. Burden of disease and sexual life in cardiac patients are discussed in two categories.

Problems Experienced and Burdens of the Disease

In this study, the testimonies of individuals with cardiovascular disease revealed that the disease is not limited to physical symptoms; it creates a multifaceted burden of illness that includes psychological and social dimensions. Participant testimonies indicate a decrease in daily life functioning, changes in self-perception, emotional vulnerability and significant effects on sexual life. These findings are in line with the literature highlighting the biopsychosocial effects of cardiovascular diseases [2, 3].

The participants stated that they intensely experienced symptoms such as physical weakness, fatigue, shortness of breath and decreased physical capacity after the diagnosis of cardiovascular disease. It was observed that these physical limitations created a significant burden of illness that directly affected not only their activities of daily living but also their sexual lives. Diaconu et al. (2020) reported that sexual dysfunctions and a significant decrease in the frequency of sexual activity were common in individuals who had myocardial infarction [5]. Similarly, Piegza et al. (2025) emphasized that individuals with cardiac disease tend to avoid sexual activity due to symptoms associated with physical exertion. [8]. In parallel with these studies, our study revealed that physical symptoms are one of the main factors limiting sexuality. However, the distinctive aspect of this phenomenological study is that physical problems were interpreted by the participants not only as a biological inadequacy, but also as a loss of

confidence in the body and the perception of "not being able to get back to the way it was". The avoidance behaviors revealed by Piegza et al. (2025) with quantitative findings became visible in the narratives of individuals in this study as an experience deepened by a sense of bodily fragility and loss of control [8].

In this study, the emotional burden caused by cardiovascular disease was characterized by fear of death, anxiety about having another heart attack, anxiety and feelings of uncertainty. Participants expressed that they experienced intense fear and anxiety, especially in the context of sexual activity, and that this increased their avoidance behaviors. Cohen et al. (2022) reported that anxiety accompanying sexual activity in individuals with cardiovascular disease is often experienced as a perceptual threat, independent of a real risk [4]. Similarly, Hyde et al. (2020) showed a significant relationship between depressive symptoms and decreased sexual desire in these individuals [6]. While the findings of our study overlap with this information in the literature, they reveal that mental burden is not limited to measurable levels of depression or anxiety. Phenomenological analysis showed that mental burden is experienced through self-perception and reevaluation of social roles, with participants expressing that they felt "burdened", "inadequate" or "incomplete". In this respect, beyond quantitative studies, our study makes visible how cardiovascular disease is made sense of in the inner world of the individual.

In our study, the effects of cardiovascular disease on social life were evident in the participant narratives. Physical limitations and mental strains reduced individuals' participation in social activities and led to changes in family and social roles. This deepened the burden of the disease by increasing feelings of social withdrawal, loneliness and isolation. Beart et al. (2019) reported that cardiovascular diseases are associated with a decrease in quality of life and deterioration in social relationships [7]. Ziapour et al. (2024) showed that lack of social support negatively affected both psychological well-being and sexual satisfaction. Similarly, in our study, social problems were found to be an important component of disease burden [3]. However, in this study, it was revealed that social burden is not only caused by physical limitations; it is deepened by the inability to discuss an intimate area such as sexuality and the inability to communicate effectively with health professionals. Similarly, studies on counseling needs emphasize that lack of communication on sexual health issues makes it difficult for individuals to share their problems [3, 7]. In this respect, our study shows that social burden is a multidimensional experience intertwined with communication barriers.

Effects of the Disease on Sexual Life

In this study, the experiences of individuals with cardiovascular disease regarding sexual life were not limited to changes in the frequency of sexual intercourse, but emerged as a holistic process shaped by fear, avoidance, change in body perception and transformation in partner relationships. Participant narratives show that sexuality is reinterpreted with its physiological, psychological and relational dimensions in the post-illness period. A large proportion of the participants expressed fear of having a heart attack, sudden death or triggering symptoms during sexual activity. This finding coincides with the findings of Mornar et al. (2018) that lack of information about sexual activity increases fear-based avoidance behaviors. In addition, the "perception of sexuality as a risky act" reported in Piegza et al.'s

(2025) study emerged as a directly expressed experience in the participant narratives in this study [2, 8]. Cohen et al. (2022) emphasized that anxiety accompanying sexual activity in cardiovascular patients is experienced as a perceptual threat. In our study, it was observed that this perception led to the complete suppression of sexuality and relegation of sexual identity to the background [4].

Participants stated that they experienced decreased body confidence, "not feeling as strong as before" and doubts about sexual competence in the post-illness period. Hyde et al. (2020) and Diaconu et al. (2020) also showed that problems experienced in sexuality are related to self-perception and self-esteem. This phenomenological study reveals that sexual problems are experienced by individuals as a decrease in self-worth rather than loss of function [5, 6].

In the study, the effects on sexual life were also evident in the context of partner relationships. Ziapour et al. (2024) reported that sexual communication between couples deteriorated and relational satisfaction decreased after cardiovascular disease [3]. In our study, the overprotective attitude of the partner or the inability to discuss sexuality emerged as an important factor leading to an increase in emotional distance. The majority of the participants stated that they did not receive adequate information about sexual life. The findings of Beart et al. (2019) and Cohen et al. (2022) showing that sexual counseling is inadequately addressed in the cardiac rehabilitation process support the results of this study [4, 7]. However, phenomenological findings reveal that individuals need not only information but also validation, reassurance, and the ability to talk.

In this study, the experiences of individuals with cardiovascular disease were revealed as a multifaceted burden of illness that is not limited to physical symptoms, but intertwines psychological, social and relational dimensions. [14–16]. In particular, the effects on sexual life stand out as a profound area of experience characterized by fear and avoidance behaviors, changes in body perception and transformation in partner relationships. While quantitative studies reveal the frequency of sexual dysfunctions after cardiac diseases, this phenomenological study makes a unique contribution to the literature by making visible how these problems are experienced and made meaningful in the life world of individuals. In this context, it emerges that focusing only on symptom control is insufficient in the care of individuals with cardiovascular disease; psychosocial and relational needs, including sexuality, should be addressed with a holistic and communication-based approach that includes both the individual and his/her partner.

Conclusion

In conclusion, this study provides preliminary evidence that heart disease negatively affects individuals psychosocially. Patients experience serious physical, psychological and social problems due to heart disease and their sexual lives are also negatively affected. Individuals experience significant problems in sexual life due to heart disease. It has been determined that sexual problems affect individuals negatively. Since heart disease is a multifaceted disease, it is necessary to professionally assess sexuality in patients, diagnose sexual dysfunctions and take timely measures.

Limitations

One of the limitations of the study is that all participants were from the cardiology unit of a state hospital in a city in northern Turkey. The results depend on the participants and the setting in which the research was conducted. The small group of participants is not representative of the population of individuals with heart disease.

Declarations

Conflict of Interest

No conflict of interest is declared by the author(s).

Ethical Aspects of the Research

This research was approved by X University Scientific Research and Publication Ethics Committee (numbered E- -95674917-108.99-379652 dated 2025/08).

Consent to Participate

All participant's legal authorized guardians gave their informed consent and participants gave their assent prior to their inclusion and the publication for this study. Details that might disclose the identity of participants were omitted and pseudonym names were used to disguise the real names of participants.

Funding This research has not received any specific grants from funding organizations in the public, commercial or non-profit sectors.

Author Contribution

All authors continued to the development, implementation, and write up of this study. The first draft was written by Esra Aydın, Sevda Uzun and all other authors provided, comments, feedback and revisions for the final manuscript submission. All authors read and approved the final manuscript.

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Tables

Tables 1 and 2 are available in the Supplementary Files section.

Supplementary Files

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- [TABLES.docx](#)