

Women's Perceptions and Feelings about Loss of Their Sexual Desire: A Qualitative Study in Iran

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ABSTRACT

Background: Reduced sexual desire leaves serious impacts on women's life. The current study aims to investigate the perceptions and concerns of Iranian women of reproductive age with female sexual interest and arousal disorder (FSIAD).

Methods: This qualitative research was conducted using content analysis approach. Data were collected through seventeen in-depth interviews from October 2015 to June 2016. Purposive sampling was carried out from among reproductive-aged women suffering from FSIAD who responded to female sexual function index (FSFI) with mean scores of ≤ 3.3 and ≤ 3.4 in desire and arousal domains, respectively and went through validation by a psychologist. Data analysis was performed using Granheim and Lundman's approach. MAXQDA 10.0 software was used for data organization.

Results: The three main themes that emerged in this study included: 1) "Spoiled feminine identity" with two categories of "deteriorated sexual self-esteem" and "deteriorated feminine position", 2) "Struggle in sexual issues" with two categories of concern about losing the relationship and spouse, and surrendering to sexual relationship, and 3) "Deterioration of the couple's relationship" with two categories of deteriorated marital interaction and sexual disharmony between the couple.

Conclusion: Feeling inability to play gender role as a woman and fear of losing the spouse are the most important concerns of women with lack of interest in sex. Training communication skills for sexual talks with the spouse and expression of feelings are the first steps to help such women.

KEYWORDS: Female, Hypoactive sexual desire disorder, Qualitative research, Sexual arousal disorder, Sexuality

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INTRODUCTION

Sexuality is a multidimensional concept involving physical, psychological, and social aspects of an individual's life.^{1,2} According to DSM 5, Hypoactive Sexual Desire Disorder (HSDD) and Female Sexual Arousal Disorder (FSAD) were merged into a syndrome called "Female sexual interest and arousal disorder (FSIAD)".^{3,4} HSDD as the most prevalent sexual dysfunction in women⁵ is a persistent or recurrent deficiency or absence of sexual fantasies and desire for sexual activity⁶ despite having a good relationship with the partner.⁵ In order to diagnose this sexual dysfunction, lack of responsive sexual desire in 75% of sexual experiences for 6 months is essential. Based on a systematic review conducted in Iran, prevalence of HSDD and SAD among the general population was 35% and 33.8 %, respectively.⁷

FSIAD significantly affects women's quality of life,^{5,6} their sense of well-being and interpersonal relationships.⁸ Poor quality of life can be a cause of sexual problems or its consequences.⁹ Findings of a qualitative study demonstrated that low sexual desire can lead to high levels of dissatisfaction with sexual life and partner. Inefficient sexual activity or sex avoidance have considerable negative effects on intimacy and happiness in the couple's relationship.¹⁰ However, according to other studies, this is not always the case.¹¹

Loss of sexual interest challenges the women's perceptions of themselves as women.¹² These women have impaired body image, low self-esteem and have less emotional attachment to their partners.¹³ Corresponding studies indicate that women with sexual reluctance express negative emotions including disappointment, anger and loss of femininity.^{14,15} A qualitative study among women with sexual desire disorder showed that such women experience some degree of distress and boring or even hateful feelings due to their unpleasant sexual experiences; consequently, they avoid sex even though they profess their love for their partners.¹¹ Inconsistent with these studies,

some women have no negative feeling about themselves¹² which, in turn, poses a challenge for further research.

Little is known about the feelings of such women about low sexual desire particularly, with respect to the cultural differences among Iranian women. Qualitative studies are necessary to explore the women's perceptions to identify their problems and needs.

Focusing on women's views about living with HSDD can help to improve their sexual health.¹³ The aim of the present study was to explain the perceptions of women with FSIAD about loss of their sexual desire and its impact on their life.

MATERIALS AND METHODS

This is a qualitative research using conventional content analysis approach. Purposive Sampling was performed from October 2015 to June 2016. Data were collected through 17 in-depth interviews with women suffering from FSIAD who had referred to healthcare centers affiliated to Ardabil University of Medical Sciences for routine healthcare checkups. Based on self-reported low sexual desire, the researcher completed a checklist to exclude women with any diseases or medical conditions. Then, women who had low scores in Female Sexual Function Index (FSFI) based on cut-off points 3.3 and 3.4 in sexual desire and arousal domains, respectively,¹⁶ were identified and referred to a psychologist who validated their sexual dysfunction and rejected any psychological problem.

Inclusion criteria were being 20-45 years old and married, not being pregnant or breastfeeding, having constant sexual relationship for more than 6 months, not having severe marital conflicts before dysfunction, not having any diseases or not taking any medication affecting their sexual function based on a researcher-made checklist. The exclusion criteria of the study were lack of willingness to continue participation in the study. Data collection was performed through personal interviews and continued until data saturation and emergence of categories and

themes. Thus, in the two last interviews, no novel idea or category was achieved.

All of the interviews were done by the researcher in Azeri language. Semi-structured interviews started with an open-ended question such as “Please talk about your sexual desire” and “How do you feel about sexual desire and relationship?” Moreover, probing questions were asked during the interviews to extract more details. MAXQDA 10 was used for data organization. Continuous and concurrent data analysis¹⁷ was performed through data collection using Granheim and Lundman’s approach.¹⁸ At first interviews were transcribed verbatim. The transcript was reviewed line by line for several times to reach a general understanding of their contents. The text was divided into condensed meaning units that were abstracted and labeled with a code. The codes were compared and sorted into more abstract subcategories and categories according to their similarities. Finally, the latent content of categories was formulated to a theme. Guba and Lincoln’s criteria were used to assure the trustworthiness of the data.¹⁸ Credibility of data was obtained using continuous data comparison and long-term engagement with data. Dependability of data was assessed through presentation of the collected data to the research team and discussion about it to make appropriate decisions once every two weeks. For data conformability, some quotations, codes and extracted categories were reviewed by the supervisor and advisor professors who confirmed the accuracy of the coding process. A sampling technique which provided maximum diversity in age, education level and job contributed to data

transferability.

The present qualitative research was approved by the Ethics Committee of Shahid Beheshti University of Medical Sciences with the code of R.SBMU.REC.1395.10. Research objectives were explained to the participants and written informed consent was given by them.

RESULTS

56 out of 75 women who completed FSFI questionnaire were identified with FSIAD; however, following interviews with a psychologist, a definite diagnosis of sexual dysfunction was attributed only to 31 women, five of whom did not agree to continue the research. Finally, the researcher interviewed with 17 women. The mean age of the participants was 34.1±5.4 years. The mean age of marriage was 12.1±4.7 and the mean age difference with the spouse was 6±2.3 years. The mean number of children was 2±0.5. The other demographic characteristics of the participants are displayed in Table 1. The mean scores of desire and arousal domains and full-scale score of the FSFI for the participants were 2.9±0.9, 3.0±1.0 and 20.3±3.7, respectively.

Three main themes, “Spoiled feminine identity”, “Struggle in sexual issues” and “Deterioration of the couple’s relationship”, emerged during data analysis. Categories and sub-categories are displayed in Table 2.

a. Spoiled feminine identity

a.1. Deteriorated sexual self-esteem

Women expressed lower feeling of attractiveness and change in the body image. Such feelings overshadowed their sexual self-esteem. “...*I’m not happy with my body. I have*

Table 1: Demographic characteristics of the participants

Characteristics		N (%)
Education	High school and less	3 (17.7)
	Diploma	8 (46.9)
	Bachelor of Science	3 (17.7)
	Post graduate	3 (17.7)
Occupation	Working	9 (53)
	Housewife	8 (47)

Table 2: Theme, categories and subcategories of the research

Subcategory	Category	Theme
Change in body image Being reproached by spouse Spouse's infidelity Sexual desirability Feeling as an incompetent woman Being rejected by spouse	Deteriorated sexual self-esteem Deteriorated feminine position	Spoiled feminine identity
Accepting sex to maintain the spouse Concern about continued sexual reluctance Pretending to be interested in sex Role playing in sexual relationship	Concern about losing the relationship and spouse Surrendering to sexual relationship	Struggle in sexual issues
Less emotional interactions with spouse Change in the spouse's behavior Reduced affection expressed by spouse lack of sexual talk with spouse sexual avoidance of the woman Sexual coercion by the spouse Annoying sexual demands by the spouse	deteriorated marital interaction Sexual disharmony between the couple	Deterioration of the couple's relationship

sagging breasts and flabby stomach bulging out after child birth which made me very ugly ... I don't feel attractive at all (24 y/o, associate degree).

Some participants had experienced being reproached by their spouse and believed that this behavior had reduced their self-confidence. *"...He permanently finds faults in my body. He blames my loose vagina, my passivity in sex and...; my self-confidence in sex has been reduced"* (44y/o, bachelor).

The spouse's infidelity was also expressed by some women. *"I have noticed his relationships for some years. He has not approached me for several months"* (45 y/o, diploma).

a.2. Deteriorated feminine position

Sexual desirability was mentioned by some participants. *"When I was sexually active, I had more energy and motivation. I felt merriment and lively but I don't, now."* (36 y/o, PhD).

Feeling as an incompetent woman was very challenging for the women who took part in this research. *"Meeting the sexual need of the spouse is the duty of his wife. He wants me to be like other eager women, but I have no interest in sex. I do not act in a feminine manner"* (42 y/o, Master of Science).

Being rejected by the spouse was also stated by some women. *"He says that he*

doesn't want me anymore. When I remember his words, I go mad. I have even cried during intercourse several times" (33 y/o, diploma).

b. Struggle in sexual issues

b.1. Concern about losing the relationship and spouse

Accepting sex to maintain the spouse was mentioned by women. *"He also needs sex. Either I have to accept it or he may have desire for other women"* (40 y/o, bachelor).

Many of housewife women talked about financial support: *"When I need money, I accept the relationship, even an anal intercourse"* (30 y/o, diploma).

Concern about continued sexual reluctance was worrying in some women. *"If my lack of desire continues, I may see his sexual frigidity and our intimate relationship will collapse... I will get miserable"* (24y/o, diploma).

b.2. Surrendering to sexual relationship

Half of the women expressed their pretension to be interested in sex and their role playing: *"I pretend I am interested in sex, but he knows that I'm not behaving like the past". I role-play in sex to satisfy my husband's sexual needs."* (24 y/o, diploma).

c. Deterioration of the couple's relationship

c.1. Deteriorated marital interactions

Less emotional interactions with the spouse was stated by some women. *"I've been avoiding him and I don't get intimate with*

him” (39 y/o, associate degree).

Women believed that change in the spouse’s behavior reduced his attractiveness. “... *If my husband demands sex and I refuse it, he will get grumpy and will find an excuse to begin an argument*” (31 y/o, associate degree).

Reduced affection expressed by the spouse was also mentioned “...*he doesn’t care about me anymore. If I go to my mom’s house from morning to evening, he even doesn’t call to see how I am doing*”. (30y/o, diploma).

c.2. Sexual disharmony between the couple

Lack of sexual talk with the spouse was observed among the majority of participations.

“*I haven’t talked about my problem with him. We do not talk about sexual issues together*” (30 y/o, diploma).

Sexual avoidance of the woman was stated by participants. “*When my husband demands sex, I say I’m busy or sleepy...*” (24 y/o, diploma).

More than half of women referred to sexual coercion by their spouses. “*Sometimes, I have to accept sex. It is very difficult to tolerate it. I feel offended and choked with anger*” (31 y/o, bachelor).

Anal and oral sex were considered as annoying or unusual sexual demands by the spouse “*anal sex according to Islam, it should be avoided ... I also don’t like oral sex. I feel women are insulted to do so. I feel sick when I talk about it*” (22 y/o, diploma).

DISCUSSION

The findings of this study showed that sexual reluctance might be associated with spoiled feminine identity in women and affects the couple’s relationship. Negative impacts of social norms about femininity were demonstrated in some studies.^{12,19} Sexual dysfunction and marital discord have a two-way relationship so that marital conflicts can be the cause of sexual dysfunction or its effects.²⁰ When sexual problem occurs in the context of marital problems, couple therapy should be considered, but when sexual dysfunction leads to marital problems, sex therapy is necessary.²¹ Given

the inclusion criteria of the study including having constant sexual relationship for more than 6 months and not having severe marital conflicts before dysfunction as validated by a psychologist, it seems that the women who entered the study did not have severe marital conflicts, and destruction of marital relationship is the result of sexual distress and not its cause.

In the present study, women expressed a change in their body image and feeling less attractive. In line with our finding, there was a positive association between sexual function and body image in a quantitative study. Self-confidence is also associated with sexual desire.^{22,23} On the other hand, regarding the impact of a confirmed body image on women’s sexual desire in another study,²⁴ a two-way relationship between body image and sexual dysfunction can be assumed.

Some of the participants stated that when a woman’s body is taunted by her husband, she feels unattractive. In this regard, the results of a qualitative study demonstrated that being criticized and rejected by the partner are the main suppressors of female sexual arousal.²⁵ It can be deduced from the participating women’s statements that blaming a woman’s body by her spouse destroys her sexual self-esteem. In the current research, the spouse’s infidelity was pointed out by some women. The results of a qualitative study demonstrated that different sexual and emotional needs as well as self-worth are the cornerstones of the spouse’s attractiveness so that if some of these needs are not met, out-of-marriage relationships may develop.²⁶

Sexual desirability was stated by some women with expressions like feeling of low well-being and mood as well as unhappiness. Consistent with our findings, the negative effects of sexual reluctance on mental health^{6,12,15,27} and occurrence of personal distress were confirmed in other studies.²⁸ Sexual dysfunction affects both emotional and physiological health.¹³

Feeling of incompetence was the main challenge arising from loss of sexual desire. According to women, a pleasant sexual

relationship reinforced their sense of femininity and pleasure. What women felt about themselves was affected by cultural expectations from them.¹² According to the relevant studies, loss of sexual desire comes with feeling of unworthiness,¹² incompetence,^{6,9,29} reduced femininity, and sexual failure.²⁹ Feeling of an incompetent and guilty wife who cannot satisfy her partner's sexual needs was observed in a qualitative study carried out in the UK.¹² Feeling incompetent may be so justifiable that women consider gender role-playing and giving pleasure to their spouses as the main feminine roles according to social and cultural expectations.

Consistent with similar studies,^{12,15,30} concern about continued reluctance and frustration was expressed by some women in our study. Fear and concern can force the patients to do positive healthy behaviors³¹ and this finding can reflect the willingness of our participants to have sexual desire.

Pretending to be interested in sex and role playing were among behaviors performed by some women. A qualitative study on women with HSDD confirmed our findings.²⁸ Despite the unpleasantness of sex for reluctant women, most of them were engaged in sexual relationship to meet sexual needs of their spouses and maintain them.

Less emotional interaction with the spouse and avoidance of sex reported by some women were among behaviors that could induce sexual incompatibility between the couple. Avoiding the situations that can lead to any sexual activity was observed in a study in US.⁹

In the current study, the spouse's misconduct including change in behavior and lower affection for the wife were observed. A woman's sexual satisfaction is associated with physical and sexual intimacy such as being kissed, hugged and caressed by the partner.^{32,33} As inferred from the women's words, the husband's attraction was affected by his reaction to his wife's sexual reluctance.

Lack of sexual talk with the spouse was mentioned by many participants, which may arise from cultural issues. In societies

where gender-based attitudes are dominant, talking about sexual issues is indecent and women consider no role for themselves to meet their own sexual needs.³⁴ Couple's sexual conversation can lead to greater sexual compatibility and satisfaction.³⁵ It seems that sexual incompatibility occurs more often in those couples who don't have sexual dialogue.

Consistent with a quantitative study,³⁴ most of our participants considered sexual demands of the spouse for oral and anal sex as an unusual and unreasonable expectation that could be due to differences in sexual preferences of the couple. However, a recent qualitative study on Iranian engaged couples referred to the changes occurring in sexual preferences.³⁶

Qualitative investigation of the perceptions of women with FSIAD for the first time in the cultural context of Iran was an innovative aspect of the current study. Communicating a good relationship and attracting the participants' confidence to state their feelings were other strengths of this study. The study of individual rather than a couple was one of the limitations of our study.

CONCLUSION

Women consider playing gender role as the most important feminine responsibility in a marital relationship. Feeling unable to play the gender role as a woman and worrying about losing the spouse were the most common concerns of women with lack of sexual desire. They need to become familiar with their self as a woman and learn communication skills to talk with their spouses and express their feelings and sexual needs. Comprehensive planning to prevent and manage the common sexual problems should be considered in pre-marriage counselling. Further research on the husbands of women with FSIAD is recommended to identify their experiences about their wife's sexual dysfunction.

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