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What is going on inside me? Lived experience of married women exhibiting hypoactive sexual desire disorder in long-term relationships: A qualitative study

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Abstract

Introduction: Sexual satisfaction, as a basic human need, has a determining effect on human health, and its absence can cause physical and mental pressures that will threaten individuals' health. Low sexual desire is a common disorder affecting married women and can greatly influence their well-being and disrupt their everyday life. This study aimed to analyze the lived experiences of married women suffering from hypoactive sexual desire disorder in long-term relationships considering cultural drivers.

Materials and Methods: This qualitative study (2019-2020) in Mashhad-Iran, was conducted based on the descriptive phenomenology approach. The research data were collected through 20 in-depth and semi-structured interviews and then they were analyzed using Colaizzi's method of data analysis. The participants were also selected through purposive sampling. A mean score of 22.6±2.9 was obtained for full-scale score of Female Sexual Function Index (FSFI) and 107.11±3.2 for Marital Conflict Questionnaire-Revised (MCQ-R).

Results: The four core themes extracted from the data were (1) incessant everyday life in long-term relationships, (2) de-sexualized roles, (3) traces of old wounds, and (4) misinterpretation of religious teachings.

Conclusion: Personal conflicts and neglected foreplay priorities were the primary causes of married women's low sexual desire in long-term relationships. Couples workshops aimed at preserving and revitalizing relationships and individual treatment of affected women are some potential solutions for alleviating the suffering of this group of women.

Keywords: Hypoactive sexual desire disorder, Marriage, Qualitative research, Women

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Introduction

Sexual desire, like other basic human drives, is ingrained in human biology, psychology, and social nature. As a result, the satisfaction or frustration of this intrinsic desire can significantly affect personal health (1). The term desire refers to the emotional and cognitive aspects of sexual interest. The frequency and intensity of sexual thoughts and fantasies, whether spontaneous or in response to sexual stimulation, determine sexual desire (2). Studies show that women's sexual desire decreases more than men's in long-term relationships (3); however, sexual desire disorder is a broader concept. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) combines Hypoactive Sexual Desire Disorder (HSDD) and Female Sexual Arousal Disorder (FSAD) into a single syndrome known as Female Sexual Interest/Arousal Disorder (FSIAD). For at least six months, this disorder is characterized by a lack/reduction of interest in all sexual activities (4).

The research literature indicates that 40% of women experience sexual disorders during their marital life, the most common being HSDD (5), which affects one-third of the population (6). For example, a study on 1456 married women in Iran showed that more than 52% had experienced sexual dysfunction during their life (7). Other studies have reported a rate of 37% (8) and 69.4% (9), all of which introduced HSDD and anorgasmia as the predominant disorders.

FSIAD can negatively affect women's quality of life, mental health, and interpersonal relationships (10). The findings of a qualitative study showed that low sexual desire in women adversely affected their self-confidence and destroyed their relationships with their partners (11). According to relevant studies, women suffering from HSDD exhibited thoughts unrelated to sexual function, and the lack of stimulating thoughts during sex contributed to their suffering (12). These thoughts caused depression, a lack of sexual pleasure during intercourse, and decreased arousal (13). The lack of sexual interest also leads to difficulties recognizing their place as a woman. In addition, such women exhibited negative emotions such as despair, anger, and lack of femininity (10). A qualitative study of women suffering from HSDD showed that their unpleasant past sexual experiences made them feel certain degrees of distress, dysphoria, or even disgust, forcing them to avoid intercourse even if they loved their partners (14).

There is a small body of research on the lived experiences of women suffering from HSDD, especially considering the cultural context of Iranian women. Therefore, more qualitative studies are needed for an in-depth analysis of this disorder to identify the main problems and propose clinical solutions. This study aims to fill this gap by investigating the views of women suffering from HSDD about their reduced sexual desire and its effect on their lives.

Materials and Methods

This qualitative study used the descriptive phenomenology approach from May 2019 to March 2020. This approach was employed to describe an experience as lived by the participants and understood by the researcher (15). In-depth interviews between the researcher and participants are the main data collection tool in phenomenological studies. The researcher helps the participants articulate their lived experiences without steering the conversation in particular directions, attempting to enter their world and closely explore their lived experiences (16).

The participants were selected through purposive sampling after the research project was approved and registered by the Research Council and the Faculty of Education and Psychology of Ferdowsi University of Mashhad. The participants were selected from married women living in Mashhad- Iran, who exhibited symptoms of HSDD and were willing to participate in this study, and then the sampling continued until saturation. In qualitative research, the sample size is determined directly based on the researcher's judgment, and there are no fixed rules. The sample size was determined through the theoretical saturation of the classes, and saturation occurs when no new ideas emerge from the data (17,18).

The inclusion criteria were 1- clinical diagnosis of absent or reduced sexual desire for at least six months accompanied by related interpersonal problems, 2- being married, and 3- not being menopausal. The exclusion criteria were 1- clinical diagnosis of other physical or mental

illnesses, 2- sexual dysfunctions other than FSAD (which is correlated with HSDD according to DSM-5), 3- pregnancy or childbirth over the past 12 months, 4- marital conflicts (A raw score higher than 150 in Marital Conflict Questionnaire-Revised (MCQ-R) signals an abnormal conflict between the couples), and 5- lack of informed consent. The sexual desire and marital conflicts of the participants were measured using the Female Sexual Function Index (FSFI) and the Marital Conflict Questionnaire-Revised (MCQ-R), respectively.

Research instruments

A) The Female Sexual Function Index (FSFI): It is a measure of women's sexual functioning proposed by Rosen et al. and validated by assessing a group of women suffering from sexual arousal disorder (19). This questionnaire has been used in numerous studies worldwide (20-22) with high internal consistency and validity (23,24). It is composed of 19 items based on a five-point Likert scale (from strongly disagree (1) to strongly agree (5)) and measures women's sexual functioning in six areas (i.e., desire, arousal, moisture, orgasm, satisfaction, and sexual pain). This scale was standardized in Iran with a Cronbach's alpha coefficient of 0.70 for the total scale and 0.80 for the subscales. A total score of less than 28 in FSFI marks reduced a low sexual desire (25).

B) Marital Conflict Questionnaire-Revised (MCQ-R): This questionnaire was used to measure the participants' marital conflict level. It is a 54-item tool developed based on clinical experiences. This questionnaire assesses eight dimensions of marital conflicts: reduced cooperation, reduced intercourse, increased emotional reactions, intensified attraction of children's support, increased personal relationships with relatives, increased relationships with the spouse's relatives and friends, separated financial affairs, and reduced effective communication. The highest and lowest scores of this questionnaire are 270 and 54, respectively. The Cronbach's alpha for the total scale for a group of 270 individuals was obtained at 0.96. Therefore, this questionnaire has high content validity. A raw score higher than 150 in MCQ-R signals an abnormal conflict between the couples (26). The research data were collected through in-depth and semi-structured interviews. The participants were aged 23 to 44 years, 12 employed, and 8 housewives. The face-to-face interviews were conducted in a quiet and private environment at Rahyaab Sexual Health Clinic. After greetings and gaining the participants' trust, they were presented with questions such as "Why/how do you think you lost your sexual desire?", "What do you think about it?", "Can you remember what was going on in your life when you noticed a decrease in sexual desire?", and "Do you think any of these events affected your decreased sexual desire, and if yes, how?" Follow-up questions were asked based on previous responses and continued until no new ideas were emerging. After the 20th interview, no new information emerged indicating theoretical saturation. Each participant attended two qualitative interviews lasting for 60-95 minutes. A digital audio recorder recorded the interviews, and the participants' behavioral and non-verbal cues were also jotted down. The audio files were analyzed carefully immediately after the session and transcribed verbatim. To satisfy the ethical principles, informed consent was obtained for participation in the research and audio recording before the interview. The participants were informed of the research objectives, the reason for the audio recording, the confidentiality of the information, and their identity. This research was registered at the Iran National System for Ethics in Biomedical Research (code IR.UM.REC.1401.067) and at the Department of Psychology, Faculty of Education and Psychology, Ferdowsi University of Mashhad (No. 1573; Meeting No. 719).

Colaizzi's seven-step method, recognized by qualitative researchers as a valid approach in descriptive phenomenological studies, was employed for data analysis (27).

The first step was for the researchers to listen to the audio files several times after the interview to get a general sense of the participants, and then they were transcribed verbatim. Next, the related sentences were extracted after determining and categorizing critical sentences based on their essence (coding). Finally, the third step involved extracting preliminary codes and removing overlapping categories from the list.

The richly formulated responses were organized into theme clusters in the fourth step

(subcategories). Similar codes were combined, and categories were named after their themes and abstracted concepts. The preliminary codes were read and re-read several times, the formulated concepts were assigned to thematic clusters and categories, and level-two conceptual codes (secondary categories) were obtained. The results were compiled into a comprehensive description of the themes in the fifth step. The third-level codes (main categories) were created by combining the first- and second-level codes, allowing the categories to be compared and similar ones to be grouped. In the sixth step, the researchers formulated/summarized the general themes into clear-cut statements about the phenomenon under study. The final step was to measure the final validity by eliciting participants' reactions to the findings. By presenting the research findings to the participants and having them review the text, this step aimed to clarify and validate the results (28). Finally, the accuracy and validity of the qualitative research data were tested using Guba and Lincoln's (29) four validity criteria, i.e., credibility, confirmability, dependability, and transferability. To abide by the ethical considerations, the participants were given the opportunity and right to leave the research at any stage. Moreover, the research data were collected confidentially and anonymously, and the findings were provided to the research units to increase robustness. Finally, the participants were assured that the research data would be published anonymously and confidentially.

Results

Based on the exclusion criteria, 31 of the 51 people who registered for the program were eliminated in the initial interview, leaving 20 married women for subsequent interviews. After the 20th interview, no new information emerged indicating theoretical saturation. The mean age of the participants was 36.4±3.4 years, the mean age of marriage was 13.1±3.7 years, and 2±0.5 for the number of children in the family. The participants were aged 23 to 44 years, 12 employed, and 8 housewives. In addition, a mean score of 22.6±2.9 was obtained for the full-scale score of the Female Sexual Function Index (FSFI) and 107.11±3.2 for the Marital Conflicts Questionnaire (MCQ-R).

The results showed that the four most common factors contributing to decreased sexual desire were incessant everyday life, de-sexualized roles, traces of old wounds, and misinterpretation of religious teachings. The table below summarizes the main categories, secondary categories, subcategories, and examples. In addition, quotes from participants are provided, as well as their age and educational level.

Table 1. The extracted main categories, secondary categories, and subcategories

Main Categories	Secondary Categories	Subcategories
Incessant everyday life in long-term relationships	Loss of romantic feelings	Lack of foreplay and flirting Absence of efforts for keeping the relationship alive
	Mechanical sex	Predictable and repetitive intercourse Focus on orgasm
	Responsibility as an un-arousing agent	Overshadowing of sexual concerns by responsibilities Distance from sexual fantasies
	Reduced self-care	Pregnancy/childbirth marks Delayed medical care Lost senses of self-confidence and personal competence

De-sexualized roles	Child marriage	Entry into adult life with an undeveloped female identity Lack of proper sex education
	Cousin marriage	Lack of sexual desire towards the spouse Forced marriage
	Role incompatibility	Inability to maintain a mother-wife balance Overshadowing of marital relationships by children's presence
	Sense of insecurity and fear of abandonment	Self-harming to save the marriage Fear of betrayal
Traces of old wounds	Dysfunctional beliefs	Sex as duty Disgust of sexual intercourse Distorted information about male sexual needs
	Lack of boundaries	Cohabiting with the partner's parent Lack of confidentiality
Misinterpretation of religious teachings	Wife obedience (Tamkin)	Obedience in sex One-sided intercourse
	Obsessive thoughts during intercourse	Fear of getting dirty Distance from sexual stimuli during intercourse
	Cultural definition of a good woman	No sexual desires (noble, modest, and accountable) Non-initiation of sexual activities Not speaking about sexual needs

-Category 1: Incessant Everyday Life in Long-term Relationships

Routine and repetitive days; completing daily tasks only to repeat them the next day is the foundation of married life. Couples no longer devote time to self-care and relationship development as they once did, resulting in a mechanical, mundane relationship. Romantic feelings fade with time, and couples live a loveless life devoid of intimacy. The participants attributed such changes in their romantic relationships to the long-term commitment known as marriage.

According to them, marriage transitioned from autonomy and freedom to commitment and responsibility. Loss of romantic emotions: Almost all participants desired romance in their relationships and considered its absence the primary cause of decreased sexual desire. They believed that boredom gradually replaced the time spent on foreplay and cuddling after marriage.

Participant No.3, 46 y/o (master's degree), explained: "*We don't look after each other like before; we don't think we need to try to keep the relationship alive, because we are so caught in daily routines after all these years that we wouldn't want to trouble ourselves. It's as if we have agreed to simply earn money and follow our career goals. It's such a depressing relationship... I miss those days when we'd sit side-by-side and my husband would caress me as we drank tea*."

Participant No.5, 38 y/o (bachelor's degree), stated: "*When my husband does something to make me feel special, feel that he loves me or likes to spend time with me, and still finds me attractive, then I want to be with him... for example, I want him to play with my hair, kiss my forehead, or hug me when he comes home from work. Of course, none of these happen anymore. We struggle all day and then sleep next to each other at night like roommates*."

Mechanical sex: Another reported effect of marriage was the ordinary and mechanical nature of sex after marriage. The participants reported that their husbands used to spend more time nurturing a passionate relationship, but it gradually faded away over time and gave way to tedium. For example, participant No.11, 39 y/o (bachelor's degree), said: "*It is as if my husband has a checklist and goes through the items one by one and then over again... He can make me orgasm, but it seems like a routine, mundane relationship... it is not something that'd encourage me to have more sex."*

Participants also mentioned one-sided intercourse in which only their partner would climax. For example, participant No.17, 22 y/o (high school diploma), stated: "*He knows how to make me orgasm and gets straight to work, without any flirting, kisses, or foreplay... he just gets to it... The intercourse usually lasts 5-10 minutes... and all the while, I think he is saying to himself, "Hurry up, climax, so we can take care of other chores, hurry up!" I cannot even climax and most of the time I fake it so he would leave me alone*."

Responsibility as an un-arousing agent: Participants saw "responsibility" as the opposite of sexual intercourse. A 39-year-old participant No. 19 (high school diploma) explained:

"*My mind is preoccupied with getting the children ready for school and sending them off. Next, I have to do the laundry, cook, and clean the house. I pay the water and gas bills when resting and lie awake at night thinking about the due checks. How can I possibly think about sex under the circumstances?*"

Reduced self-care: Participants revealed that they gradually abandoned their self-care priorities and stopped caring about their physical appearance as much as they used to, which was directly related to their sexual desire. They considered their body image unattractive and an impediment to sexual desire. They reported gaining weight after marriage and childbirth and believing they were no longer attractive or sexy.

Participant No.4, 38 y/o (high school diploma), explained: "*I don't like my post-pregnancy body, I got fat... So I don't like to be naked in front of him; I try to keep the room dark during intercourse so he can't see my stretch marks; I never got the chance to go on a diet or visit a skin doctor. Sometimes I think why does he want to sleep with me*?"

Participant No.8, 32 y/o (bachelor's degree) stated: "*During intercourse, I ask myself, is he looking at my breasts? What if he thinks they are saggy and ugly? Does he wish I had a slimmer waist? I wish I could go to the gym... I don't like myself anymore*."

The lack of regular visits to gynecologists and seeking medical care contributed to chronic physical problems and lowered sexual desire. For example, participant No.14, 33 y/o (bachelor's degree), mentioned: "*I had been experiencing pain during intercourse for a while, but I didn't seek medical help and kept postponing it. Until, I started bleeding and had to visit the doctor. She said there was a scar on my vaginal canal, which will take some time to heal. It would have been a simple infection and easily cured if I hadn't put it off*."

-Category 2: De-sexualized Roles

Accepting a feminine role in a marital relationship and developing the opportunity to experience genuine intimacy necessitates a mental state prepared to enter the world of adulthood and the possibility of meeting someone who meets one's standards and preferences. This study identified child marriage and cousin marriage as two major cultural factors influencing women's sexual desire. Furthermore, the participants in the relationships found it

challenging to balance the various and sometimes contradictory roles of motherhood and wifehood.

Child marriage is a formal or informal marriage in which one or both partners are under 18 years old. For example, 29-year-old participant No.2 (high school diploma) said: "*I got married when I was only 13. When I looked at myself in the mirror on my wedding day, I didn't recognize myself; I saw a stranger. I didn't know anything about conjugal relations; no one had told me anything. I was utterly shocked during the consummation; it was like rape*."

Another participant, No.6, 34 y/o (high school diploma) reported: "*I was looking through the door crack at the suitor. I cried until the morning out of the fear of living alone with him. No matter how much I told my mother that I don't want this man, she didn't listen. She told me: It's your father's decision and you must respect it. My husband is a good man; he is 18 years older than me and a successful tradesman, but I have no feelings towards him. Now we have children and it's like I'm one of his children*."

Cousin marriage: A cousin marriage means that the couple shares an ancestor, which is common in the Iranian-Islamic culture. The long years of contact between families make them arrange for their children's marital life more confidently. Nevertheless, the views of participants in this category about their spousal feelings were interesting.

A 34-year-old participant No.9 (bachelor's degree) stated: "*I married my cousin, Hamed. We grew up together and I remember we'd play football together. He is like my brother. In the ceremony of asking for my hand in marriage, I told my mom that I have no feelings for him. She said don't worry, you will later. It's been 17 years since our marriage, but I still don't have any*."

Another participant, No.12, 31 y/o (bachelor's degree), reported: "*My father insisted that I marry my cousin. I told him that we have no feelings for each other. He responded: 'Your marriage was sealed in heavens when you were born (a Persian expression); don't think of objection.' My husband is a good boy, but we still live like cousins and we don't even sleep on the same bed. No one knows this and they think we live a happy life*."

Role incompatibility: The participants reported that their non-sexual roles interfered with their roles as lovers with sexual desires, and they found it difficult to switch between them, particularly between mother and lover roles.

Participant No.1, 35 y/o (master's degree), said: "*When I'm getting ready for sex. I keep thinking that I am a mother, how can I be a sexy woman. I wish there was a button to switch off motherhood and switch on wifehood*."

Another participant, No.7, 30 (high school diploma), mentioned: "*Since our children were born, I feel like I am more a mother than a wife. It is quite conflicting when in the middle of cooking dinner, cleaning the house, washing the clothes, and changing the diaper, suddenly your husband is in bed, and you are expected to get naked and be sexy. I cannot handle switching roles*."

Others, like Participant No.16, 39 y/o (Master's degree), were worried their children would discover their sexual relations. She said: "*I am always worried that my children may wake up or come into our bedroom, and it keeps me from enjoying sex with my husband*."

Sense of insecurity and fear of abandonment: Another frequent theme mentioned by participants was a sense of insecurity about spousal fidelity, mainly if they were not available for sex, which significantly adversely affected their sexual desire.

A 36-year-old participant No. 20 (bachelor's degree) reported: "*My mom always told me that if you don't satisfy your husband's needs, he will seek it elsewhere. There have been many occasions when I wasn't ready for intercourse, but I forced myself, and now I don't even like it. He has asked for anal sex many times, and I have accepted even though it hurts, just so that I won't lose him. It makes me feel terrible*."

A 32-year-old participant No.10 (middle school) narrated: "*During pregnancy, the doctor had ordered cervical cerclage and bed rest due to a history of abortion. I later found out that my husband had contracted a temporary marriage until we could have sex again. So now, even if I have a fever, I give in because I don't want it to happen again*."

-Category 3: Traces of Old Wounds

Couples enter married life with the baggage of their single life at home. Improperly imprinted concepts in a person's mind can negatively affect their relationship.

Dysfunctional beliefs: Conceptions and belief systems act as a filter for detecting arousing events (30). There may be beliefs in married life that are not based on truth, and there is no evidence to support them (13).

A 24-year-old participant No.13 (middle school) reported: "*My mom always told me that sex is only for having children, and we as women are responsible for reproducing and satisfying the sexual needs of our husbands. For a long time, I didn't even know that women too enjoy sex; I thought it was only for men*."

Another participant, No.18, 33 (bachelor's degree), said: "*When I'd listen to my mother and aunts talk, she always talked about her relationship with my father with disgust and once even told me that it is a dirty thing to do; that it's for animals and should be done quickly to get it over with since men are very dependent on it and it's not possible to abandon it altogether. When I take a look at my relationship with my husband I can't help but notice how this conception is engraved on my mind*."

A 25-year-old participant No.15 (high school diploma) retold: "*Any time I think about sex, I imagine a wild man who wants to hurt me. I remember my mom told me that men don't understand anything when they feel the need, and will do anything to satisfy it; and that I must be very careful*."

Lack of boundaries: A healthy relationship includes the definitions of family boundaries and relationships with others. Couples' mental models for communicating with the world and managing their relationships with others can manifest themselves in their sexual relationship. For example, 30-year-old participant No.7 (high school diploma) recounted: "*My husband's grandmother used to live with them and now my mother-in-law lives with us after my father-in-law's death. We can't go anywhere together without her. It really bothers me, but my husband says: 'she's my mother... what can I do?' I've noticed that whenever we go into the bedroom to have sex, she makes lots of noise and doesn't let us be alone for a minute*."

Another participant, No.9, 34 (bachelor's degree), shared: "*My husband's family knows about every little thing in our life; I've repeatedly told my husband that I don't like his family to know about our private issues; he buys a piece of land and they find out before me. At the beginning of our marriage, I couldn't allow sex; my legs would contract unintentionally; he let his entire family know about it. I'll never forget those days*."

-Category 4: Misinterpretation of Religious Teachings

According to Islam, sexuality is an innate instinct and a gift from God. Marriage and conjugal relations are regarded as the family's backbone and a source of peace for couples. The study findings showed that religious teachings are not correctly communicated to families, resulting in misinterpretations and, as a result, marital relationship disruption.

Wife obedience (Tamkin): *Tamkin* means "commitment" and refers to couples' responsibilities to one another. In lay terms, it frequently refers to women's obligations to their husbands' rights. According to religious doctrine, a woman is only required to obey her husband if it does not endanger her health, dignity, or property.

A 33-year-old participant No.14 (bachelor's degree) reported: "*It turns me off that my husband thinks I should make myself available whenever he wants sex. I remember I had recently given birth, still had my stitches, and would occasionally bleed. Meanwhile, he insisted on intercourse as if he couldn't see my condition at all*."

A 39-year-old participant No.19 (high school diploma) retold: "*My husband is a good man and is always there for me except when it comes to our conjugal relationship. He doesn't care about my mood. I was really tired and could sleep for only three hours during our children's infancy. He wanted intercourse every night. Now, I don't want it even though I have free time*."

Obsessive thoughts during intercourse: The importance of cleanliness and ritual purity in Islam is emphasized in numerous verses and narrations. Some teachings emphasize the importance of avoiding unclean (*najis*) substances during intercourse to keep the couple clean. However, parents have frequently failed to teach their children the concept of cleanliness properly.

A 34-year-old participant No.6 (high school diploma) said: "*During sex, I'm always worried that semen will soak through the sheets and reach*

the mattress, at which point I will not be able to wash it. I cannot concentrate and enjoy it. I also expect my husband to take a shower immediately after sex like me and perform the ritual ablution (ghusl), as his body is unclean. But he never listens, and so I prefer to not have sex and not get so frustrated."

The cultural definition of a good woman: A good woman in Iranian culture is noble, chaste, a housewife, and an exemplary mother, free of any erotic characteristics.

A 38-year-old participant No.5 (bachelor's degree) explained: "*Fatimah bint Muhammad has always been my role model since childhood; a generous and noble woman and an exemplary mother. But I've never heard anything about her relationship with her husband. My family's definition of a good woman is a responsible woman who takes good care of her children and husband. I have never heard about her private, marital life*."

A 39-year-old participant No.11 (bachelor's degree) stated: "*I could never be the initiator of sex because my husband thinks that a noble woman will never reveal her sexual desire. He doesn't like me to be active in bed. He equates a good woman with being chaste. He never bought me negligees and never encouraged me to be attractive. One time I tried to tell him how I like to climax, but he indirectly hinted that he doesn't want to hear anything about it*."

Discussion

The study showed that reduced sexual desire in married women could be associated with the mundanities of everyday marital life, endless responsibilities that undermine the relationship, and reduced sexual priorities. Some participants stated that the only solution to their HSDD was to return to the early days of marriage when they enjoyed their husbands' love and attention. According to a similar study, women's sexual satisfaction is closely related to touching and foreplay, such as kissing, cuddling, and caressing (31). Repetitive, emotionless, and duty-based sex was discovered to be one of the leading causes of reduced sexual desire among the participants—another qualitative study linked HSDD to predictable climaxing sex (32). Participants also reported feeling unattractive and unfit for intercourse due to changes in their body image, which discouraged them from having sex. Similarly, another study shed light on the relationship between sexual performance and body image (10). Finally, a quantitative study found a correlation between self-confidence and sexual desire (33). This study also revealed the effect of non-sexual factors such as child marriage and cousin marriage, which are common in the Iranian-Islamic culture and are realized through family compulsion as living conditions devoid of sexual desire toward the spouse. These are also linked to undeveloped female identities and over-familiarity with the spouse, which turn off female sexuality. Another contributing factor was the failure to manage multiple roles during the day. A similar qualitative study highlighted the overshadowing effect of motherhood on other roles, particularly the role of being a lover (32). Some women in the present study also referred to a sense of insecurity and fear of abandonment, leading to sexual reluctance. Fear and anxiety can also encourage or impel interest in intercourse in women. The results of a qualitative study on HSDD in women confirm the findings of the present study (34). Even though the affected women found sex unpleasant, and they most engaged in intercourse to satisfy their partners' sexual needs. Similar to a quantitative study, most participants of the present study gave in to their partner's demand for oral and anal sex even though they found it an unusual and disgusting expectation in hopes of preventing infidelity (35). One of the factors mentioned by almost all participants was their inability to focus on sexual stimulation during intercourse. The role of the individual's cognitive system is crucial in this regard. Personal beliefs, which reflect the teachings of families and society, can affect how one views marital challenges.These absolute beliefs lead to expectations that may undermine marital goals and endanger their sexual health. Previous studies have confirmed a direct relationship between dysfunctional beliefs and active, destructive responses (36). The findings of previous studies indicate that, after experiencing an unsuccessful sexual encounter, dysfunctional beliefs (e.g., "sex is a duty that must be performed properly") activate self-criticism (e.g., "I am unworthy"). This invokes a system of negative thoughts (e.g., "he is taking advantage of me", "I hate this

relationship"), which disturbs the focus on erotic stimulation (lack of erotic thoughts), thus increasing negative emotions and impairing sexual responses (13,37,38). Other influential factors contributing to reduced sexual desire in the participants included the husband's crossing of the relationship boundaries and the lack of confidentiality. The participants believed they no longer had trust in sharing their most private thoughts, which stopped the husband from entering their feminine world. This result is consistent with previous studies (36). The misrepresentation of religious teachings was one of the chief cultural factors affecting the low sexual desire in the participants. In addition, the concept of tamkin and sociocultural expectations can negatively affect women's motivation and interest in intercourse. A quantitative study associates sexual submission (meaning having no right to reject/stop intercourse) with adverse psychological outcomes such as low life satisfaction and failure to enjoy conjugal relationships (39). Some studies state the adverse effects of femininity-related social norms. Cultural expectations influence personal feelings. In a society that defines a good woman as a being devoid of sexual desire, sex-related talks are frowned upon, and women cannot freely express their sexual needs. Many participants complained about not having the chance to share their sexual desires with their husbands, which is attributable to the cultural context. It seems that sexual incompatibility primarily inflicts couples who do not speak about their sexual needs and desires (40). The present study contribution to the literature included a qualitative analysis of the lived experiences of married women suffering from HSDD and trying to uncover their world and mindset within the cultural context of a city of Iran. Research limitations included the purposive sampling of the participants from the educated and the upper middle classes. Future studies can measure the repeatability of the research findings using different sampling strategies and a larger population. The following is a brief list of proposals for preventing and managing sexual problems using the research findings: (a) couples workshops to facilitate conversation between them, (b) individual treatment of affected women, (c) promotion of self-care and alone time away from daily responsibilities, (d) opposition to child marriage and forced marriage, and (e) sex education before marriage. In addition, investigating married women who have not lost their sexual desire for their husbands can produce valuable information about strategies for maintaining and increasing sexual desire in long-term relationships.

Conclusion

According to the findings, personal conflicts and sidelined foreplay priorities are chief causes of low sexual desire. In addition, the feeling of incapability to handle various roles and worrying about losing the husband were among the major concerns of these women.

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