Original Article

Psychological Perceptions of Women With Sexual Arousal Disorder: A Qualitative Study in Iranian Culture

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Abstract

Objective: Psychological perceptions are concerned with how a person perceives and psychologically frames life with an illness. The current study sought to examine the psychological perceptions of women suffering from Female Sexual Interest/Arousal Disorder in the setting of Isfahan, Iran.

Materials and methods: The study was done according a qualitative design, and it was conducted in Isfahan, Iran, from July 2018 to February 2019. Twenty in-depth interviews were performed with 20 patients who were recruited on the purposeful method. The thematic analysis approach was used to analyze the data. The data were organized using MAXQDA software (version 12).

Results: The following four themes were extracted: (i) Dysfunctional cognition, which includes five sub-themes: attention bias, belief bias, memory bias, perceptual bias, and cognitive distortion; and (ii) Relationship and partner factors, which include four sub-themes: psychological maltreatment, aggression, deception, and betrayal.; (iii) lack of life skills, which includes four sub-themes: poor problem-solving, poor sexual knowledge, poor understanding and intimate relationships, and immature defense mechanisms; and (iv) lack of motivation and genuine interest, which includes two sub-themes: forced marriage and lack of initial affection and attraction to the husband.

Conclusion: Internal and interpersonal factors were shown to have a role in the creation of sexual arousal disorder in Iranian women, according to the study. As a result, designing scenarios for cognitive bias modification and educational programs for improving interpersonal skills would be beneficial.

Keywords: Perception; Psychological Sexual Dysfunctions; Qualitative Research

Introduction

Psychological perception is defined as a patient's cognitive evaluation and personal understanding of disease conditions and their related consequences (1). Psychological perception is concerned with how a person perceives and interprets living with an illness (2).

In DSM-5, the DSM-IV categories of desire and arousal disorders (Hypoactive Sexual Desire Disorder and Female Sexual Arousal Disorder) were replaced with a new, considerably wider diagnostic called Female Sexual Interest/Arousal Disorder (3). Previous models separated the terms desire and arousal; however, current models consider the relation between desire and arousal to be reciprocal and mutually reinforcing (4). Many women find it difficult to differentiate between the two states. Sexual arousal is a mental experience as well as a physiological condition (5). According to a systematic review conducted in

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Iran, 48 % of the general population suffers from sexual dysfunction (6). Furthermore, the prevalence of Female Sexual Interest/Arousal Disorder among clinical patients in Iran was 59.6%, compared to 33.8 % in the general population (7).

Sexual interest/arousal is a bio-psychosocial process in which women may exhibit increased genital and subjective sexual arousal as a result of pleasant sexual encounters with their partner in a supportive relationship context (8). Negative sexual experiences and relationships or conflict, on the other hand, may impede genital arousal response and produce lower levels of subjective sexual excitement (9).

Sexual interest/arousal is a multifaceted, multicomponent, and multidimensional process that is activated by both internal and external stimuli and involves a series of cognitive motivational processes (10). Internal stimuli include cognitive processing (11) and the motivational system (12, 13) while external stimuli include interpersonal relationships with a spouse (8).

Importantly, subjective arousal is a description of an experience - the impression of being mentally turned on. Subjective arousal involves a focus on sexual stimuli and a typically favorable assessment of those stimuli. According to Barlow's sexual dysfunction model (14), an attentional shift to internal signals or critical self-evaluative thoughts leads to negative affect and reduces sexual arousal, whereas a sustained emphasis on sexual cues enhances subjective arousal and pleasant effect. Arousal and desire can be facilitated or inhibited by cognitive mechanisms and processes. Negative sexual or asexual beliefs in connection to a partner can influence both mental and sexual arousal (15, 8).

A variety of psychosocial characteristics that might distract women from erotic cues impact the degree to which women are able to cognitively engage in sexual behavior, positively assess a stimulus as sexual, and feel subjective arousal (16). These include interpersonal and/or partner-specific factors, sexual ideas and attitudes, and a history of sexual abuse and/or other unpleasant sexual experiences (17, 18).

Women who are usually satisfied with the quality of their intimate relationships and who report high degrees of emotional intimacy are less likely to experience reduced arousal (19).

Sexual behaviors and beliefs are shaped by social and cultural frameworks. As a result, a proper understanding of women's perspectives of sexual relationships in a particular context is crucial. The aim of this study was to determine the psychological perceptions of female patients suffering from sexual arousal disorder in the context of Isfahan, Iran. In other words, the main research question of this study was "what are the psychological perceptions of women in a married relationship based on their sexual interest/arousal disorder?"

Materials and methods

A qualitative descriptive design using a thematic approach was designed to investigate the psychological perceptions of women with sexual arousal disorder. In this study, in-depth interviews were conducted with women suffering from sexual arousal disorder. From July 2018 to February 2019, participants were screened using checklists filled out by health care practitioners at Community health service centers in Isfahan, Iran. The purposeful sampling method was used to select these centers. Community health centers are healthcare sectors in Iran's healthcare system that provide primary care and public health services. These centers provide services in the area of physical, mental, and sexual care for women by midwives through the electronic health system and refer patients with sexual disorders by screening questions to the psychologist, who interview them based on DSM-5 criteria (5) for sexual interest/ arousal disorder. Inclusion criteria in this study were women aged 25 to 42 years old, Women who were enrolled in the Integrated Health System (SIB) according to the Women's Health Screening Checklist and referred to a psychologist for further examination, women who were early psychologically interviewed (by a psychologist) for having high Mindfulness and Self-Awareness. Participants were excluded if their lack of sexual desire was due to a medical condition, if they were dependent on alcohol or drugs, if they had taken medications affecting sexual desire in the previous month. Other exclusion criteria in the current study were having a history of child abuse, having painful intercourse, or bodily pains related to desire, and having paraphilia.

Eligible individuals were invited to participate; next, in-depth psychological interviews were conducted by the psychologist (Z.H) to investigate the psychological perceptions behind this disorder. It's worth noting that because of the cultural stigma of sexual issues, particularly in the Iranian community, we had to interview volunteer samples. The

interviewees explained the purpose of the study and the interviewer established an empathetic relationship with the interviewees. Interviews were conducted at the Community Health Center of Isfahan University of Medical Sciences. After the interviewees entered the psychologist's room, due to the high cultural awareness of sexual issues in couples' relationships, a general question was first asked, "Do you ever feel sexually reluctant? And then, based on the client's answer, other exploratory questions were asked. For example, has something happened to your spousal relationship? Who takes the sexual relationship lead? Or is your mind concentrated completely on sex relations? If not, imagine in a sex setting, what do you think when you are having sex? In the meantime, the interviewer was looking in patients for impaired cognition. The thoughts of clients during sex were asked to identify the exact dimensions of the desire disorder, particularly the dysfunctional cognition. Finally, 20 face-to-face in-depth interviews lasting 30-50 minutes were conducted with each one of 20 participants.

Most interviews were tape-recorded (with participants' informed consent) and then transcribed verbatim. Audio recordings were not used in four interviews at the request of the interviewees due to cultural issues; these interviews were noted. The data were simultaneously collected and analyzed using MAXQDA software (version 12).

According to the process of Braun and Clarke's Reflexive Thematic Analysis, taking an inductive approach to the data, six steps were taken to analyze the data (20) as follows:

1. In the first step, two researchers (L.H and F.Y) as data coders became familiar with the data through repeated data reading, active data reading, and searching for meanings and approaches.
2. The researchers extracted basic codes from the raw data.
3. After all the basic codes were collected, the researchers arranged and summarized them to achieve a general theme.
4. The themes created were read by key members of the research team in three two-hour sessions and sub-themes were formulated within a generalized model. Also, an agreement was reached among the researchers on the themes.
5. The researchers carefully examined the formation of each theme as well as the overlaps and relationships between the themes and sub-themes. Then, they defined and named the themes and sub-themes that were created.
6. In this step, final analysis and report writing were performed.

To ensure the Trustworthiness of the data, four trustworthiness criteria were used to obtain credibility, prolonged engagement of researchers, adequate participation, and interaction with the participants (member check) was achieved. Besides, we ensured the investigators had the required knowledge and research skills to perform their roles. Confirmability was ensured by the researchers' neutrality (not publicly allowing personal values) and mutual agreement on the codes and themes. Furthermore, we used field notes to enrich the data. Transferability was made possible by providing direct quotes and examples; also, we quantified operational and theoretical data saturation. The operational method was used to determine the number of new codes for each interview over time. This indicates that most of the codes were identified in the initial interviews. Theoretical saturation was achieved by a repetitive process until no new code emerged from the data. The dependability of the research was confirmed by an audit approach, in which the study colleagues along with the external auditor made additional comments about the coding process and the analysis of the interview text as well as cross-checked the data. Furthermore, we measured coding accuracy and inter-coders' reliability of the research team.

The Ethics Committee of the University of Isfahan, Iran approved the present study with the code of IR.UI.REC.1397.128. Participants were informed of the research objectives and asked to sign written consent forms before the interviews began. The confidentiality of their records, as well as their right to withdraw from the study at any time, was also guaranteed.

Results

The participants' mean age was 35±7 years (range 28-42). The education level of participants varied from illiterate to postgraduate (Table 1).

The four themes and 15 sub-themes were extracted from interviews in relation to psychological perceptions of sexual arousal disorder. The total number of codes emerging from the data was 220 (Table 2).

1. Dysfunctional cognition

Mental Engagement in issues other than sex and lack of focus on sex were among common perceptions that some clients reported.

Table 1: Characteristics of the participants included in the study

Participant	Age (year)	Educational status	Profession	Residence
1	31	Diploma	House wife	Urban
2	41	Illiterate and primary education	House wife	Rural
3	35	Undergraduate	Government employ	Urban
4	25	Diploma	House wife	Rural
5	36	Illiterate and primary education	Government employ	Urban
6	38	Undergraduate	House wife	Urban
7	29	Postgraduate	Government employ	Urban
8	32	Diploma	House wife	Urban
9	27	Undergraduate	Government employ	Urban
10	36	Illiterate and primary education	House wife	Urban
11	39	Illiterate and primary education	Government employ	Rural
12	30	Diploma	House wife	Urban
13	33	Undergraduate	House wife	Urban
14	37	Illiterate and primary education	House wife	Urban
15	26	Postgraduate	Government employ	Urban
16	40	Undergraduate	House wife	Urban
17	39	Illiterate and primary education	House wife	Urban
18	35	Diploma	House wife	Rural
19	42	Undergraduate	Government employ	Urban
20	34	Illiterate and primary education	House wife	Urban

1a. Attention bias: Paying attention to the issues and concerns of those around patients, and fearing that the kids may be hearing about sexual relation was among other attention biases. For instance, a 34-year-old participant stated:

"During sex, I keep thinking about nonsensical issues regarding my kids as well as family problems, and I can't direct my attention toward sex. Sometimes during sex, I think that the noise related to our activity goes beyond the room and feel that if I become overwhelmed with pleasure, my children will hear our noise, which keeps me from focusing on enjoying the intercourse." (P12).

1b. Belief bias: Beliefs are very powerful and have profound effects on the sexual functioning of women with arousal disorder. Some of these ideas seem to be strongly influenced by Eastern and Iranian cultural beliefs. For instance, a 35-year-old participant said:

"In my opinion, sex is dirty and pathogenic. After each sexual intercourse, I have to deal with its consequences for several days. I often think that sex is only for reproduction and is otherwise pointless." (P14).

Other ideas in this category include belief in avoiding the sexual fantasies of virtuous women, belief in sexual harassment by men, and infidelity to men.

1c. Memory bias: Recalling memories of negative sexual or non-sexual events during sexual intercourse was another reason for sexual reluctance among some women. For instance, a 38-year-old participant remarked:

"I saw my parents having sex when I was a child; I still can't forget it. In my nightmares, I hear the sound of my parents breathing heavily. When I am having sex with my husband, I remember the scenes." (P8).

Other issues related to memory bias included remembering spousal violence and sexual assault as well as recognizing past sexual encounters with another person.

1d. Perceptual bias: Interviewees in this sub-theme often pointed to topics such as negative perception of self-appearance and perception of self-inadequacy, the male-controlled experience of sexual desire.

As an example of perceptual bias, a 26-year-old participant said:

"I think if I approach my husband [and express my sexual desire], he will not accept me; so, I never approach him." (P3).

1e. Cognitive distortion: We found that some women were protecting themselves with a desire-reduction method due to certain cognitive distortions such as "mind-reading", self-comparison with other women", or unrealistic expectations of sexual functioning.

In this regard, a 32-year-old participant remarked:

"When I don't approach my husband for sex, he comes to me. Of course, I know that he thinks of satisfying his sexual needs, and not my sexual needs." (P18).

Table 2: Themes, Sub-themes and codes related to psychological perceptions of women with sexual interest/ arousal disorder

Theme	Subtheme	Code
Dysfunctional cognition	Attention bias	Focusing on appearance and self-monitoring instead of focusing on sexual pleasure.
		Paying attention to family problems and personal or day-to-day issues instead of focusing on pleasure during sex.
		Being upset about sex and paying attention to sexual noises and fearing that the kids may be hearing them.
	Belief bias	Respectable and modest women should not show their pleasure and arousal, and should not indicate their sexual needs, preferences and desire to their spouse.
		Respectable and modest women should not use sexual fantasies while having sex.
		Sex is a pleasure only for men, and sex is all men think of.
		Sex involves the abuse of women by men.
		Sex is only for reproduction and is otherwise pointless.
		Sex is dirty, animalistic, or pathogenic.
		Men only think about satisfying themselves; men are untrustworthy.
		Sex is a favor to the husband and women need to get enough points from their husband before allowing it to happen.
		Women should be able to reach orgasm without the need for manual stimulation of the clitoris.
	Memory bias	Recalling spousal violence and maltreatment during sex.
		Recalling parental sex observed during childhood.
		Recalling the first intercourse and having nightmares about it.
		Recalling experiences of a former sexual relationship with another person.
	Perceptual bias	Perceptions of insecurity in the communication environment; perceptions of rejection.
		Negative perceptions of women about their appearance and perceived inadequacy.
		Perception of being betrayed by the husband.
		Perception of male sexual control.
	Cognitive distortion	Spouse mind-reading.
		Comparison of one-self to women in porn videos.
Relationship and partner factors	Psychological maltreatment	The humiliation of the woman and her family.
		Disregarding the woman's appearance and comments.
		Mocking the woman's abilities and underestimating her.
		Threatening the woman.
		Controlling the woman and disregarding her independence.
		Disregarding women's sexual rights and needs.
		Criticism of women in public.
	Violence	Insults and derogatory words.
		Beating and physical injury.
		Passive aggression and belatedly fulfilling the demands of the woman; bad temper.
	Deception	Psychological deception.
		Material deception.
	Betrayal	Betrayal in cyberspace.
		Betrayal in reality.
Lack of life skills	Poor problem-solving	Continuation of deadlocked controversy.
		A need to win in the relationship.
	Poor sexual knowledge	Unawareness of couple differences in reaching orgasm.
		Unawareness of women's sexual rights and needs.
		Not assigning enough time for sex; fast sex.
		The habit of leaving the bedroom door open and lack of privacy from children.
	Poor understanding and intimate relationships	Lack of empathy and understanding.
		Poor self-disclosure.
		Low access to husband and poor emotional support
		Sex games to deprive the other party due to poor intimacy
	Immature defenses Mechanisms	Suppressing libido
		Projection; attributing the lack of sexual desire to the male partner.
		Rationalization
Lack of motivation and genuine interest	Forced marriage	Marriage due to social pressure.
		Marriage to escape solitude.
		Marriage to enjoy privileges other than sexual matters.
	Prolonged marital period and decreased desire over time.	Lack of initial affection and attraction to the husband

2. Relationship and partner factors

The theme of relationship and partner factors comprises four sub-themes, Including psychological maltreatment, violence, deception, and betrayal,

2a. Psychological maltreatment: The interviewees complained of many cases of psychological maltreatment. For instance, one interviewee said:

"*My husband doesn't ask my opinion in other areas of communication, such as traveling, shopping, and establishing family relationships. He doesn't take me out." (P2).*

In another case of psychological maltreatment, repeated criticism of the woman was reported as a cause of low sexual desire. In fact, a 36-year-old participant stated:

"My husband insults and criticizes me in front of other men such as friends and brothers." (P13).

Mocking and underestimating women's skills, ignoring the presence and opinions of women, and disregarding women's sexual rights and needs were other concerns posed by interviewees in this category.

2b. Violence: Sometimes violence has expressed itself in the form of verbal aggression. For instance:

"My husband insults me and my family during fights, and I have to go through a lot to forget these insults," (P19), explained a 36-year-old interviewee.

Sometimes it was in the form of humiliating the woman. As an example, one woman aged 36 said:

"*When I am menstruating and am in a bad mood, we fight. My husband screams and remarks about my menstruation in a way such that the neighbors can hear it." (P1).*

2c. Deception: There were various types of deception experienced by the interviewee, including material and psychological deception. a 32-year-old interviewee stated:

"*In various fields of communication, my husband deceives me with superficial explanations regarding his actions. I try to prove to him that he is lying, but he doesn't accept it. For example, my husband sold the land that I had inherited from my father without telling me and asking for my opinion." (P20).*

2d. Betrayal: Also, there were two forms of betrayal raised by the interviewee, namely Betrayal in cyberspace and Betrayal in reality

As an example of betrayal, a 35-year-old woman said:

"I found out that my husband has sexual content on his phone and masturbates while watching video clips on his phone." (P10).

3. Lack of life skills

The theme of lack of skills consists of several sub-themes including poor problem-solving, sexual knowledge, knowledge of intimate relationships, as well as weaknesses in the application of mature defense mechanisms.

3a. Poor problem-solving: People who were involved in the arousal disorder mainly had poor problem-solving skills in the face of problems. For example:

A 35-year-old participant complained: *"We can't settle problems even after arguing for a long time." (P9).*

3b. Poor sexual knowledge: Our observations of interviews with participants demonstrated a lack of sexual knowledge among women and their husbands. This manifested itself in the form of decreased sexual desire, especially in women. For instance, a frustrated 38-year-old participant explained:

"My husband has very little information on sex; he doesn't understand the difference between a woman becoming wet and her becoming satisfied. I tell him that I'm not satisfied yet; he disregards me and tells me that I have already become wet." (P15).

3c. Poor understanding and intimate relationships: A lack of intimate and strong relationships between couples was one reason that was reported for low sexual desire. In this regard, women complained about emotional separation from their husbands.

"We have no emotional intimacy. My husband doesn't talk with me; he only answers the questions that I ask him. I wish we could go out together," (P17), stated a 35-year-old participant.

3d. immature defense mechanisms: Some patients were found to be stubbornly attached to the defense mechanisms that they used to preserve their integrity and identity and extended them to protect themselves in sexual matters. For example:

"*Since childhood, my parents scared us about sex and we never dared to talk about it. Even now, I'm afraid to talk about sex with my husband,"* (P11), a 35-year-old participant complained.

4. Lack of motivation and genuine interest

The theme of lack of motivation and genuine interest consists of two sub-themes, including forced marriage and lack of attraction toward the husband.

4a. Forced marriage: Sometimes, women openly complained that their marriages were forced due to social pressures for getting married. For example, a 36-year-old woman stated:

"At the time of my marriage, I told myself that if I

don't get married now then I won't get another chance and would always remain single and would have to listen to others reproach me for the rest of my life." (P2).

4b. Lack of initial affection and attraction to the husband: In another case, the woman's motivation for marriage was financial or escaping solitude, but not primary sexual attraction. For example:

"I knew that I didn't love my husband, but I got married because he was rich and could finally free me from my loneliness," (P1), mentioned a 29-year-old participant.

Discussion

The present study helped to eliminate the ambiguities regarding the psychological causes affecting women with sexual arousal disorder in a group of Iranian women.

We extracted the first theme in our study, dysfunctional cognition, it was subcategorized into attention, memory, perceptual, beliefs, and cognitive biases linked to sexual issues. Previous research has focused on the link between dysfunctional cognitions and subjective arousal (18, 21, 22), but our study was able to address these dysfunctional cognitions in the form of Extract in patients with sexual arousal disorder accurately and separately. A history of unpleasant sexual experiences influences women's beliefs and attitudes regarding sexual activity, and these beliefs can contribute to consistently low subjective sexual pleasure (18). A prior study (23), which confirms the current study's findings, also emphasized the importance of cognitive processes in women with sexual dysfunction. In a detailed explanation of these factors in the formation of cognitive structures based on Gagnon's social schema theory (24), it has been demonstrated that cultural factors such as cultural sensitivities, values, religious beliefs, socio-cultural beliefs, and stereotypes influence cognitive beliefs in the field of sexual behavior. As for the context of Iranian society, this research clearly reflects significant interpretative justification biases and cognitive distortions, which play major roles in shaping these beliefs (25, 26) In particular, the belief that sexual intercourse with a spouse is immoral and shameful, as well as sex guilt, reflects the influence of cultural values that suppress women's sexual desire (27, 28).

In our study, the second retrieved theme was relationship and partner factors, showing that impairments in emotional intimacy with a partner might negatively influence sexual arousal (29). Similar to the findings of our study, a study on sexual arousal (30) found that negative and hostile perceptions in a couple's dual perception system can have a detrimental impact on their communication system and emotion regulation. In other words, decreased desire or sexual arousal disorder can be a form of cross-regulation of the relationship between couples and is a form of protection for women against hostile perceptions (31, 32).

Concerning Hostility in Couple Relationships, the current study highlighted the destructive role of violence in couple relationships, notably in sexual arousal disorder among Iranian women, which is consistent with previous research (33). For the sake of clarity, the disruptive role of violence and hostility, as well as the use of sexual harassment against women, should be highlighted, since they might lead to women's acceptance of such abuse. This reflects the cultural concepts and features of patriarchal societies in which women are regarded as inferior. This has a negative impact on women's quality of life as it leads to a loss of self-esteem and rejection of their gender roles and sexual rights, which eventually leads to the appearance of psychological and sexual problems. There is some evidence that this tendency of sexual violence toward women in sexual relationships is common in several Sub-Saharan African countries (34, 35) and Arab countries (36) primarily due to cultural and religious backgrounds.

One research has shown that in romantic relationships between men and women there is competition for power (37). Men who had a biased perception of their power (a biased perception of low power) were more aggressive and more hostile to sexism, and these issues had far-reaching effects on men-female interpersonal relationships. It can be said that one of the effects that spousal violence can have on women is women's sexual reluctance. In fact, it is a reaction to the high level of violence in the relationship.

Regarding two sub-themes, deception and betrayal, in line with the current study, A study revealed (38) that the perceived effects of pornography on couples' relationships induce feelings of infidelity and deception, which can contribute to a decrease in sexual desire. Besides, according to a study similar to ours (39), breaking the rules of honesty and deception in romantic relationships between couples can lead to conflicts in interaction, which is one of the areas of conflict between couples and sexual problems.

In terms of the third theme, a lack of life skills-based sexuality education has a negative impact on

sexual function (40) our findings emphasized the importance of a lack of knowledge and awareness in sexual relationships. Previous research conducted both in and outside of Iran (41-43) found similar results in terms of unawareness and lack of knowledge in the areas of sexual physiology, sexual power, and pleasure, all of which can have a negative impact on sexual function. The Iranian community's cultural sensitivities, which forcefully prevent the timely provision of pre-marriage sexual information, may contribute to the emergence of a variety of sexual disorders. It is widely believed in Iran that young people do not need to learn about sexual matters before marrying, as a result, individuals learn information from the wrong sources (44), this lack of information can be the beginning of a variety of disorders, including sexual arousal disorder. In addition, given the value of virginity in our society, the absence of information on sexuality before marriage is reinforced by popular culture. Parents and educational systems passively reveal information to teenagers, which may contribute to the prevalence of sexual arousal disorder in women.

In this study, another subtheme of lack of life skills was the use of immature defense mechanisms such as suppression of sexual desire. A study on adolescent sex offenders found similar results to the current study (45), revealing the use of suppression exercises reduces sexual desire. Also, previous study has shown that immature psychological defense mechanisms are specifically associated with decreased vaginal orgasm (46), and women with a history of childhood sexual abuse have immature defensive mechanisms, dissociative problems, and sexual difficulties (47), it should be emphasized that as sexual desire suppression becomes more frequent in women, sexual arousal disorder may become more common.

According to the fourth theme, "lack of motivation and genuine interest," research has shown that changes in motivational triggers result in varying levels of sexual arousal (48, 49). Sexual arousal can be caused by positive sexual arousal and vice versa. Sexual arousal can be prevented by having unpleasant sexual arousals (50). Similar to our findings, one prior research (51), found that the sexual motivation system plays a key role in a lack of sexual desire. However, it is important to note the importance of cultural factors in Iranian culture while describing how the motivation system might affect sexual desire. At the moment, the growing age of marriage and the possibility of forced marriages, due to fears about not being supplied with better chances, frequently drive a woman to marry someone who does not match her sexual attractiveness requirements. This results in a marriage in which the woman demonstrates her low motivation through a lack of sexual desire. This can also be evident in marriages when sexual desire is not the major motive and other factors such as achieving a high socioeconomic position affect the decision to marry, which can have a detrimental effect on the sexual motivation system.

Conclusion

In general, the study found that internal factors such as cognitive dysfunctions and the motivational system, as well as interpersonal ones such as lack of intimacy with a partner or relationship hostility, play an essential role in the development of sexual interest arousal disorder in women. Patients can recover via the development of innovative approaches, such as cognitive bias modification scenarios and targeted educational programs. Because patients in this study employed incompatible defense mechanisms such as suppression and reasoning, it is recommended that health centers consider training skills in the use of mature defensive mechanisms in interpersonal relationships. Furthermore, policymakers are advised to give greater awareness-raising education in the form of self-awareness, cognition of gender and gender differences.

Among the evident limitations of our work were cultural constraints and prejudices in the field of self-expression, as well as, lack of self-awareness regarding the precise reasons for each situation.

Another drawback of qualitative research is the question of subjectivity. Nonetheless, we analyzed the data with two colleagues and double-checked the results with an external reviewer to ensure that our findings were accurate. Furthermore, the qualitative method of this study restricts the findings' generalizability.

Conflict of Interests

Authors have no conflict of interests.

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