Feeling an Invisible Wall: The Experience of Iranian Women's Marital Relationship After Surgical Menopause: A Qualitative Content Analysis Study

Om Salimeh Roudi Rasht Abadi, Mohammad Ali Cheraghi, Batool Turgari, Nahid Dehaghan Nayeri & Masoud Rayyani

To cite this article: Om Salimeh Roudi Rasht Abadi, Mohammad Ali Cheraghi, Batool Turgari, Nahid Dehaghan Nayeri & Masoud Rayyani (2018): Feeling an Invisible Wall: The Experience of Iranian Women's Marital Relationship After Surgical Menopause: A Qualitative Content Analysis Study, Journal of Sex & Marital Therapy, DOI: 10.1080/0092623X.2018.1440451

To link to this article: https://doi.org/10.1080/0092623X.2018.1440451

Accepted author version posted online: 16 Feb 2018.
Published online: 12 Mar 2018.

Submit your article to this journal

Article views: 13

View related articles

View Crossmark data
Feeling an Invisible Wall: The Experience of Iranian Women’s Marital Relationship After Surgical Menopause: A Qualitative Content Analysis Study

Om Salimeh Roudi Rasht Abadi a, Mohammad Ali Cheraghi b, Batool TIRgari a, Nahid Dehaghan Nayeri c, and Masoud Rayyani d

aDepartment of Medical Surgical Nursing, Nursing Research Center, School of Nursing and Midwifery, Kerman University of Medical Sciences, Kerman, Iran; bCritical Care and Management Nursing Department, School of Nursing and Midwifery, Tehran University of Medical Sciences, Tehran, Iran; cNursing Management Department, Nursing and Midwifery Care Research Center, School of Nursing and Midwifery, School of Nursing and Midwifery, Tehran University of Medical Sciences, Tehran, Iran; dDepartment of Community Health Nursing, Nursing Research Center, School of Nursing and Midwifery, Kerman University of Medical Sciences, Kerman, Iran

ABSTRACT

Sexual relationships after surgical menopause matter when talking about sex is taboo and marriage is the only justified way to meet sexual needs. In this qualitative research study, 22 surgical menopausal women shared their experiences of sexual/marital relationship after surgery through in-depth, face-to-face, semi-structured interviews. Qualitative content analysis technique was used for data analysis. An overarching theme entitled “feeling an invisible wall” reflected this experience. It comprised three categories: (1) declined marital intimacy, (2) disarming, and (3) transformation of societal norms into concerns. This study proposed new contextual information about the marital relationship of Iranian women after surgical menopause that was not openly articulated before and which may be applicable for others in such contexts. Women’s main concern was the emotional separation because of the sexual consequences of the surgery. Healthcare providers should be aware of women’s concerns, which may alter their marital relationship. They must provide individualized care, education, and support for couples to make thoughtful decisions about rebuilding their sexual relationship. Results may also have implications for psychiatrists, sex/marital therapists, and probably clergy who have the authority to openly address this important issue to the public.

Introduction

Sexual dysfunctions are common disorders in women after surgical menopause (Chen et al., 2013; Ishak, 2017; Lonnée-Hoffmann & Pinas, 2014; Lonnée-Hoffmann, Dennerstein, Lehert, & Szoeke, 2014). Any sexual dysfunction can have a devastating effect on interpersonal relationships of women or lead to decreased marital intimacy, satisfaction, stability, or increased probability of divorce. Those who have a more stable relationship with a partner have greater joy and adapt better with surgical complications (Askew & Zam, 2013). Marital bond strength is observed in couples with good sexual function (Jaafarpour, Khani, Khajavikhan, & Suhrahi, 2013).

In recent years, Iranian academics have become increasingly interested in studying sexual issues. Despite the hidden nature of sexuality in Iranian culture (Janghorban, Taghipour, Abbasi, & Isla, 2015),
experts have tried to open up dialogue about sexual issues because of the high prevalence of sexual dysfunctions in women (Ghanbarzadeh, Nadjafi-Semnani, Ghanbarzadeh, Nadjafi-Semnani, & Nadjafi-Semnani, 2013; Jaafarpour, Khani, Khajavikhan, & Suhrabi, 2013; Jafarzadeh Esfehani et al., 2016). The most highlighted studies are those about sexuality after menopause (Bahri, Latifnejad Roudsari, & Azimi Hashemi, 2016; Jamshidi Manesh, Jouybary, Peyrovi, & Sanagoo, 2009; Merghati-Khoei et al., 2014; Nazarpour, Simbar, & Tehran, 2016), sexual function after hysterectomy (Babazadeh, Mirzaeei, & Akhlaghi, 2012; Danesh, Hamzehgardeshi, Moosazadeh, & Shabani-Asrami, 2015), sexual satisfaction and its relation to marital relationship and divorce (Gheshlaghi, Dorvashi, Aran, Shafiei, & Montazeri Najafabadi, 2014; Parsa Yekta, Raisi, Ebadi, & Shahvari, 2015; Rahmani, Merghati Khoei, & Alah Gholi, 2009; Shakerian, Nazari, Masoomi, Ebrahim, & Danai, 2014), and sexual health education and sexual socialization of women in Iran (Latifnejad Roudsari, Javadnoori, Hasanpour, Hazavehei, & Taghipour, 2013; Maasoumi, Lamyian, Khalajabadi-Farahan, & Montazeri, 2013). However, in-depth investigations that describe how sexual dysfunctions after surgical menopause influence women's marital relationships are scarce.

In Iran, sexual relationships outside marriage are not permitted in terms of the cultural, religious, and legal contexts (Rahmani, Merghati Khoei, Moghaddam-Banaem, Hajizadeh, & Montazeri, 2015), and the family is the only institution where women and men can meet their sexual needs. We therefore use the terms sexual relationship and marital relationship interchangeably in this study. Despite the importance of sexual relationships in Iran as an Islamic country, talking about marital and sexual issues is taboo and completely private (Bahri, Latifnejad Roudsari, Tohidinik, & Sadeghi, 2016) and if any problem is encountered, Muslims do not allow themselves to discuss the sexual matters with others for personal reasons and public chastity (Sungur & Bez, 2016). Therefore, sexual disorders may not be detected, remain untreated, and can affect the sexual satisfaction of couples.

Understanding the effect of surgical menopause on the marital relationship in such contexts enables healthcare providers to help women experience this process with fewer difficulties. Considering that there are variations in the experience of menopause across cultures, qualitative studies can provide in-depth insight into the experiences of women in this context. This study aimed to explore the effects of surgical menopause on the sexual/marital relationship and how the expression of Iranian and Eastern views dominates this experience.

Materials and methods

Research design

In this study, a qualitative research approach was used. The researchers used this method to capture in-depth data and explore women's experiences of marital relationships after surgical menopause. Figure 1 summarizes the flowchart of this study.

Research setting and participants

In this study, 22 women were selected through purposive sampling among women living in urban areas of Iran (Tehran, Kerman) and then continued with snowball sampling. The first five women were recruited among family members, close friends, and colleagues of the first author (ORR); 13 women were selected among the eligible patients in the gynecological wards of two educational hospitals in Kerman and the remaining four participants introduced by these women. Eligible participants were premenopausal married women who had undergone hysterectomy with/without bilateral salpingo-oophorectomy (BSO) due to the benign conditions and at least six months had passed since their surgery. Participants had experienced menopausal symptoms after the operation, were keen to share their experiences, and spoke Persian. The cause of the surgery included fibroids, endometriosis, severe uterine bleeding, and suspicion of malignancy in the future. Only six participants had hysterectomy alone but they experienced menopausal symptoms up to six months after the surgery. Other participants
underwent hysterectomy with BSO. Being menopausal in hysterectomized women was established on the basis of presence of menopausal symptoms alone (Hillard, 2016; Kahwati, Haigler, Rideout, & Markova, 2005). In order to increase the probability of discovering different opinions in this group, maximum variation was considered via the selection of participants of various ages, educational level,
time elapsed since surgery, having a child, having children of both genders, employment, and socio-economic status. Sampling was continued until the emerged concepts and categories were saturated and no new data were obtained. Table 1 presents the demographic characteristics of the participants in the study.

**Data collection**

Data were collected through in-depth, semi-structured, face-to-face interviews. Before the interview each participant received a phone call from the nurse researcher (ORR) who introduced herself and described the aim of the study in brief. The presence of a nurse (ORR) who is qualified in teaching reproductive disorders in nursing faculty, along with participants during interviews, provided the patient-centered communication. This strategy enabled her to elicit and understand their perspectives, understand the patient within her unique psychological and cultural context, and reach a shared understanding of patient's values (King & Hoppe, 2013). Interviews lasted between 45 and 90 minutes and were carried out by the first author (ORR). Each participant was interviewed once. Data collection and final revision of the emerged categories took place from September 2015 to September 2017. Because talking about sexual issues in the presence of close family members might be difficult for women, interviews were conducted in a private and comfortable environment such as the workplace of the researcher/participant or a private room in the hospital. After each interview, field notes and memos were made to guide the subsequent interview and research questions. After describing the study objectives, the researcher began to ask the general questions using the interview guide: “Can you tell me about your sexual experience after the surgery?”, “How did you feel after the surgery?”, “How did your sexual relationship change after the operation?”, and “What factors influenced your sexual feelings after surgery?” The interviews were recorded and immediately transcribed verbatim.

**Data analysis**

Interviews were analyzed using Graneheim and Lundman’s (2004) qualitative content analysis guidelines. In qualitative content analysis, the content of text data was interpreted subjectively through the systematic classification process of coding and identifying themes and patterns (Hsieh & Shannon, 2005). In this inductive process, the texts were analyzed in several steps: (1) To achieve a general understanding from the content, the interviews were read several times; (2) parts of the text that included information about the sexual experience of the participants after the surgery were identified as meaning units and labeled with codes; (3) based on similarities and differences in the codes, they were classified into sub-categories and categories (manifest content); (4) after dealing with the emerged themes and categories between the research team and their confirmation, the core meaning that composed the latent content of the women’s experiences was identified as the main theme. In order to manage the coding process, the trial version of the MAX QDA 10 software was used. An example of the condensation-abstraction process of concepts is shown in Table 2.

**Ethical considerations**

Ethical approval was obtained by the Research Ethics Committee of Kerman University of Medical Sciences (IR.Kmu.REC.1394.517). The interviews were conducted by the first author (ORR) who was familiar with the research ethics and the confidentiality of information. All the participants received and signed a written informed consent form. Included in this form were the following: the purpose of the study; the name, telephone number, and work address of the researcher; and information about the availability of professional help in order to alleviate suffering from negative feelings. Additionally, the right of participants to leave the study even after the interview, the process of recording the interviews, and how the participants’ anonymity and confidentiality would be preserved were clarified. Interviews were identified in the system by numbers.
### Table 1. Demographic characteristics of study participants.

<table>
<thead>
<tr>
<th>Participant's No.</th>
<th>Age (yr)</th>
<th>Age at the time of surgery</th>
<th>Education Level</th>
<th>Employment Status</th>
<th>SES</th>
<th>Number of Children and Their Sex</th>
<th>Marital Status</th>
<th>Type of Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>47</td>
<td>45</td>
<td>Elementary</td>
<td>Housekeeper</td>
<td>Working class</td>
<td>3♀, 4♂</td>
<td>Married</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>2</td>
<td>52</td>
<td>47</td>
<td>Bachelor of Science</td>
<td>Housekeeper</td>
<td>Upper middle class</td>
<td>1♀</td>
<td>Married</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>3</td>
<td>44</td>
<td>44</td>
<td>Nursing diploma</td>
<td>Nursing aide</td>
<td>Lower middle class</td>
<td>3♀</td>
<td>Married</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>4</td>
<td>44</td>
<td>34</td>
<td>Secondary</td>
<td>Housekeeper</td>
<td>Working class</td>
<td>2♀, 3♂</td>
<td>Married</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>5</td>
<td>47</td>
<td>44</td>
<td>PhD</td>
<td>Faculty member</td>
<td>Upper class</td>
<td>2♀, 1♂</td>
<td>Married</td>
<td>TAH</td>
</tr>
<tr>
<td>6</td>
<td>50</td>
<td>47</td>
<td>Bachelor of Art</td>
<td>Retired</td>
<td>Lower middle class</td>
<td>1♀</td>
<td>Married</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>7</td>
<td>47</td>
<td>46</td>
<td>High school</td>
<td>Home job</td>
<td>Working class</td>
<td>3♀, 1♂</td>
<td>Married</td>
<td>TAH</td>
</tr>
<tr>
<td>8</td>
<td>50</td>
<td>46</td>
<td>High school</td>
<td>Housekeeper</td>
<td>Working class</td>
<td>1♀</td>
<td>Married</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>9</td>
<td>49</td>
<td>44</td>
<td>Secondary</td>
<td>Housekeeper</td>
<td>Working class</td>
<td>5♀</td>
<td>Married</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>10</td>
<td>47</td>
<td>44</td>
<td>Secondary</td>
<td>Housekeeper</td>
<td>Working class</td>
<td>1♀</td>
<td>Married</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>11</td>
<td>32</td>
<td>30</td>
<td>Bachelor of Art</td>
<td>Actor</td>
<td>Upper middle class</td>
<td>1♀</td>
<td>Married</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>12</td>
<td>46</td>
<td>42</td>
<td>Elementary</td>
<td>Housekeeper</td>
<td>Lower middle class</td>
<td>3♀, 1♂</td>
<td>Married</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>13</td>
<td>49</td>
<td>46</td>
<td>Secondary</td>
<td>Housekeeper</td>
<td>Working class</td>
<td>1♀, 1♂</td>
<td>Married</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>14</td>
<td>50</td>
<td>39</td>
<td>Bachelor of Art</td>
<td>Housekeeper</td>
<td>Upper class</td>
<td>2♀, 1♂</td>
<td>Married</td>
<td>RRBSO</td>
</tr>
<tr>
<td>15</td>
<td>58</td>
<td>43</td>
<td>Bachelor of Art</td>
<td>Retired teacher</td>
<td>Lower middle class</td>
<td>2♀, 1♂</td>
<td>Married</td>
<td>RRBSO</td>
</tr>
<tr>
<td>16</td>
<td>60</td>
<td>40</td>
<td>M.D, PhD</td>
<td>Gynecologist</td>
<td>Upper class</td>
<td>1♀, 1♂</td>
<td>Married</td>
<td>USO</td>
</tr>
<tr>
<td>17</td>
<td>49</td>
<td>45</td>
<td>Midwifery diploma</td>
<td>Midwifery aide</td>
<td>Working class</td>
<td>4♀</td>
<td>Widowed</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>18</td>
<td>43</td>
<td>42</td>
<td>Elementary</td>
<td>Housekeeper</td>
<td>Working class</td>
<td>1♀, 1♂</td>
<td>Married</td>
<td>TAH</td>
</tr>
<tr>
<td>19</td>
<td>51</td>
<td>42</td>
<td>Elementary</td>
<td>Home job</td>
<td>Working class</td>
<td>1♀, 1♂</td>
<td>Married</td>
<td>TAH+BSO</td>
</tr>
<tr>
<td>20</td>
<td>48</td>
<td>45</td>
<td>High school Diploma</td>
<td>Housekeeper</td>
<td>Working class</td>
<td>4♀</td>
<td>Married</td>
<td>TAH</td>
</tr>
<tr>
<td>21</td>
<td>40</td>
<td>39</td>
<td>Secondary</td>
<td>Seller</td>
<td>Lower middle class</td>
<td>2♀</td>
<td>Married</td>
<td>TAH</td>
</tr>
<tr>
<td>22</td>
<td>39</td>
<td>34</td>
<td>High school Diploma</td>
<td>Midwife</td>
<td>Middle class</td>
<td>2♀</td>
<td>Married</td>
<td>TAH</td>
</tr>
</tbody>
</table>

Mean(median) age of the participants(year) 42.18(44) year

**Note.** SES = socioeconomic status; ♀ = girl; ♂ = boy; TAH = total abdominal hysterectomy; BSO = bilateral salpingo–oophorectomy; RRBSO = risk-reducing bilateral salpingo–oophorectomy; USO = unilateral salpingo–oophorectomy.
Table 2. A sample of the trend of condensation-abstraction process in this study.

<table>
<thead>
<tr>
<th>Main Category</th>
<th>Subcategories</th>
<th>Open Code</th>
<th>Meaning Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declined</td>
<td>Experience of sexual dysfunctions</td>
<td></td>
<td>Obvious decrease in sexual desire after the surgery</td>
</tr>
<tr>
<td>marital intimacy</td>
<td>Feeling emotionally far from husband</td>
<td></td>
<td>I rarely desire sex after the surgery. My husband is allowed to have sex with me just once a month by satisfying himself not intercourse.</td>
</tr>
<tr>
<td></td>
<td>Sex as a duty, not pleasure</td>
<td></td>
<td>When sex becomes less, you feel separated emotionally from your husband.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Before the surgery I really enjoyed my sex but now I do it as a duty like household chores.</td>
</tr>
</tbody>
</table>

**Trustworthiness**

In qualitative research, the concepts of credibility, dependability, confirmability, and transferability are used to ensure trustworthiness (Elo & Kyngas, 2008; Graneheim & Lundman, 2004). These criteria were achieved through prolonged engagement with data and some of the participants, adopting maximum variation in the selection of participants, building a friendly environment to talk about sex, and the similarity of the gender of researcher and participants. Meanwhile, reflective journaling of the first author’s preconceptions allowed her to be aware of her biases, bracket them, and prevent their impact on the analysis. Confirmation of the original themes extracted by three participants at separate sessions, the research team and the panel of experts’ consensus in the coding process to achieve the researcher triangulation, and the use of the interview guide and nonparticipatory observation were our other efforts. Also, selection of the key participants, collecting and analyzing data simultaneously, expressing clear and precise description of context and profile of the participants were done to enhance the rigor in this study.

**Results**

The “feeling of an invisible wall” was the main theme and the reflection of women’s experience of sexual/marital relationship after the surgical menopause. This theme consisted of three categories: decline of marital intimacy, disarming, and transformation of societal norms into concerns (Table 3).

**Declined marital intimacy**

Declined marital intimacy is explained in three subcategories: “experience of sexual dysfunction”; “feeling emotionally far from the husband”; and “sexual relationship as a task, not for pleasure.” For women in our study, the marital relationship was a chance for more intimacy with the husband because

Table 3. Main theme, categories, and subcategories that emerged through the data analysis process.

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Category</th>
<th>Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declined marital intimacy</td>
<td></td>
<td>Experiencing sexual dysfunction</td>
</tr>
<tr>
<td>Disarming</td>
<td></td>
<td>Feeling emotionally far from husband</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sex as a duty, not for pleasure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not being a whole woman</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Loss of dignity and respect without the uterus</td>
</tr>
<tr>
<td>Feeling an invisible wall</td>
<td></td>
<td>The need of the uterus for mutual sexual satisfaction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The need of the uterus for fertility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The need of the uterus for maintaining the vitality and happiness of a woman</td>
</tr>
<tr>
<td>Transforming the societal norms</td>
<td>Adopting silence</td>
<td>Hardship in dealing with obedience in sexual relationship</td>
</tr>
<tr>
<td>into concerns</td>
<td>in sexuality</td>
<td>Worried about husband’s polygamy</td>
</tr>
<tr>
<td></td>
<td>to cover the sense of embarrassment, shame, and concealing the surgery</td>
<td></td>
</tr>
</tbody>
</table>
with the presence of children and the observance of the family respect, it was not possible to achieve such intimacy except at bedtime, hence, with the reduction of sexual activity, they felt intimate relationships were almost lost.

After the surgery, all women had lower sexual desire, frequency, and satisfaction. Despite having no pleasure of sexual intercourse after the surgery, they considered the sexual relationship as a factor in increasing the intimacy between men and women that had been damaged by the surgery:

I rarely desire sex, after the surgery. My husband is allowed to have sex with me just once a month by satisfying himself not intercourse. (Participant [P] 10)

Another concern for women was the feeling of emotional separation from their husband due to the reduced sexual activity. Some of them believed that romantic relationships with the husband during sexual activity led to the closeness and connectedness of the spouses, and now they have lost this connection and are no longer as close to each other as they were before:

I’m sure that reduced sexual activity impacted our intimacy. I feel far from my husband and when he wants sex and I refuse, he becomes upset and his behavior changes. (P 21)

For some women, sexual intercourse was a marital task and conducted just at the request of the husband. They themselves were no longer taking the initiative, and it is not for their pleasure:

Before my surgery, I really enjoyed my sexual relationship. Always it was me to start, but now I do it as a duty, just like household chores, the less the better! (P 11)

Disarming

The participants’ experience of losing sexual organs was “disarming.” Removal of the uterus and ovaries caused women to disarm of all those things that make a woman a woman. This category includes “not being a whole woman”; “loss of dignity and respect without uterus”; “the need of the uterus for mutual sexual satisfaction”; “the need of the uterus for fertility”; and “the need of the uterus to maintain the vitality and happiness of a woman”—these comments expressed the attitude of women toward the feminine organs. By losing them, they supposed that they are no longer attractive to their husbands. From their viewpoint, the sense of loss that resulted from disarming strengthened the feeling of an invisible wall between couples:

When the doctor told me it was necessary to remove my uterus and ovaries, I felt that I was no longer a whole and complete woman. (P 2)

For some women, the uterus was not only for carrying a child, but could be a symbol of dignity and respect for them. One of the participants reflected on her sister’s experience:

My sister is much older than me [56 years old], and she has many gynecological problems so that the doctor advised to remove her uterus, but she always says: “The uterus is the cause of a woman’s dignity and respect, and I will never throw it away!!!” I know that some women think so, but for me I don’t think like this. Femininity is beyond these things, whether I have my uterus or not. (P 3)

Many women believed that they have the right to enjoy sexual intercourse and this enjoyment was dependent on the uterus. If they do not have it, then both partners would not be satisfied with their sexual relationship. A young woman expressed her feelings as follows:

I think that the sexual pleasure of women and men is due to the existence of a woman’s uterus. My husband and I enjoyed the sex when I had my uterus, but now we don’t. I feel I put myself at his disposal [her husband] and I’m raped every time because I do not want to do it at all. (P 8)

Even for women who have been reluctant to have more children, losing the uterus due to permanent infertility was unbearable:

When I was supposed to have the surgery, I told myself that you won’t be able to have children after this, even if you want to. I've lost my power. (P 9)
All women believed that their youth and happiness were due to having the uterus. They said that they did not pay attention to their appearance as much as before, and did not want to be visible in public because they felt old and became upset unexpectedly after the surgery:

When you are sexually hot and passionate, you feel young and this makes you feel better and you love to be noticed by others, but now, I do not even want anyone to see me. (P 6)

**Transforming the societal norms into concerns**

The third outcome of the surgery that shaped the sense of an invisible wall was transforming the norms of society into concerns for women. This category includes “adopting silence in sexuality to cover the sense of embarrassment, shame and concealing the surgery”; “hardship in dealing with obedience in sexual relationship”; and “worried about husband's polygamy.” From childhood training, people learned as a norm to be silent about sexual matters. In this study, the strategy of silence was not simply adopted just for being modest but in the sexual issues, it acted as the cover for their shyness and shame, and as a way of concealing the surgery from others. In addition, women's sexual submission (tamkin) and allowing male polygamy are religious rules and norms, but in the context of surgical menopause these norms raised concerns. Women's struggles with these concerns hindered them from effective adaptation to the consequences of surgical menopause. Women who were more educated, modern, and financially independent had less concern about tamkin and polygamy than traditional women with lower education and who were financially dependent, because the former believed that these rights are not a threat to them while the latter supposed they had no choice and were more worried. In this regard, a faculty member said:

We think that marital life is not exclusive to sex. My husband should know that my condition is changed and must adapt with it. (P 5)

Many women never discussed their problems with their spouses, relatives, and even medical staff, and considered their sexual inability as a shame they must bear. It seems that the strategy of silence has been used as a means of protecting women against external threats such as divorce, remarriage, or being labeled as disabled. In this regard, a 46-year-old woman stated that “I have never told my husband or other women the problems I have, I pretend there have been no changes in my life since the surgery because it is unclear what will happen next. Occasionally, people seem to be sympathetic, but maybe others will persuade my husband to remarry …” (P 12).

The women were profoundly alone in handling the changes related to sexuality and its consequences. Most women said that by talking in the interview, they have stated unspoken feelings and unanswered questions after the surgery, while the interview situation was the first time they had spoken to someone about their sexual lives because of the neutrality and anonymity of the interviewer. Silence has imposed the heavy burden of surgical complications on them in loneliness. One participant who was a midwife expressed her feelings with focus on the need for there to be a place for women to share their experiences with each other and to know they are not alone and there are many women like them:

I mourned for the loss of my uterus for a year. For me it was like missing a fetus but I did not speak even to my sisters … you know, they never realized what I am saying. They never experienced it. I preferred to share my feelings with someone who is like me and understands me. (P 22)

One participant expressed her experiences as:

Over the years [10 years], I have never talked to anyone about these things [sexual issues] that I’ve told you, even with my mother and sister. I really don’t know why, maybe because of shyness or something else, but now it’s like the burden of these years has been taken from my shoulders. (P 4)

The embarrassment of raising sexual issues even with the medical staff was a major barrier to receiving counseling and treatment services for participants. The women wanted to obtain information about the changes that surgery had had on them and the future of their marital relationships, but such a connection was not available from the medical staff and they had not initiated a dialogue with women in the area of sexual changes and ways to deal with such changes. Due to low education, lack of
employment, and lack of access to information resources such as electronic media, most women did not know that there are many effective treatments for their sexual problems such as pain, vaginal dryness, or lack of sexual desire. This, along with the women's embarrassment, led to their unawareness of such sources until the interview. Only two of the participants were referred to a gynecologist or pharmacist after the surgery to resolve their sexual problems. One participant stated:

Before the surgery we had serious concerns about sexual life after the surgery but no one was there to address this issue. When I asked her [gynecologist], “Do we encounter sexual hardship afterward?” she told us “No, not at all. If so, there are remedies for it.” Now we face those problems that we were afraid of, and I don’t know what to do. (P18)

One of the other social norms in Iran is the wife’s sexual submission toward her husband (tankin). In fact, it is the legal and religious rules that oblige women to obey. All women participating in the study were devout Muslims, were often bound to religious principles, and were aware that they should respond to the sexual needs of their husbands whenever he wished. While they had no sexual interest after the surgery, they forced themselves to respond. Meeting the sexual needs of the husband, which was less possible after the surgery, in addition to the adherence to religious laws in which a devoted Muslim woman should be sensitive and responsive to her husband's sexual needs, raised some conflicts for them. A traditional woman, who had a great relationship with her husband, said:

I have the duty to fulfill my husband's sexual needs even if I don't want to but now I cannot afford these needs. My husband loves me and he has adapted himself to my wants. I cannot forgive myself for not being able to meet his sexual needs. (P7)

Almost all of the participants were faced with the concern of their husbands remarrying due to their inability to meet their husbands' sexual needs and the availability of legal options for doing so. Despite the difficulty of accepting polygamy, they considered this legal right for men, although only one participant was willing to offer it to her husband. One of the participants who adhered to religious and very traditional principles stated:

While I was trying to decide whether to do the surgery, I thought that he [her husband] may not be able to accept this [surgery]. He is a man and has his sexual needs. I thought that after my surgery, if my children agreed, I myself would introduce another woman to marry him; because I knew I could not be the same as before. (P1)

Family preference of male children was another challenge that had raised husband's remarriage concern for some participants. This was more prominent in traditional families who supposed a boy can support the family, both in the presence and in the absence of his father. One participant who had three daughters expressed her concern after the surgery:

I constantly ask myself, if my husband wants a son and wants to get married again, what will I do? … He always says: “A son ensures that if I am not alive, there is someone to protect the family.” (P4)

Discussion

This study was conducted to explore the effect of surgical menopause on marital relationships in Iranian women. Although some of the emerging themes have been reported in other studies, the overall effect of surgical menopause on marital relationships has not been reported. From the researchers’ viewpoint, the “feeling of an invisible wall” was the best description for this experience, which was shaped by changes in marital intimacy, disarming, and the transformation of societal norms into the concerns and may hinder treatment initiation. Physical and psychological changes caused by surgically induced menopause, along with the participants’ thoughts and beliefs about the lost organs (uterus and ovaries) and the changes in the nature of social norms, led to the decline in marital relationships, negative feelings of self as a woman, and raising concerns about the future. Most of our participants were in their late reproductive stages. Younger women experience more negative mood symptoms than those who are in their early or late menopausal transition, and this may alter women's cognition toward the adverse effects of surgery (Campbell, Dennerstein, Finch, & Szoke, 2017). None of our participants received signals from their husbands that they were unsatisfied after the surgery, but this invisible wall would not allow
women to interact properly and experience the past intimate relationships. This experience is unique to this study, but is similar to the separation-like feelings in other studies in natural menopausal women (Liu & Eden, 2007; Parandavar, Mosalanejad, Ramezanli, & Ghavi, 2014). After surgical menopause, women's sexual lives changed profoundly and led to the experience of “declined marital intimacy.” Some studies have pointed out complications such as dissatisfaction and reduced sexual desire (Danesh, Hamzehgardeshi, Moosazadeh, & Shabani-Asrami, 2015; Fiskin, Sahin, & Guler, 2015; Memon, Jonker, & Qazi, 2014), pain during intercourse (Thakar, 2015; Wong & Nur Liyana, 2007), and feelings of separation and coldness in couples' relationships after menopause or surgeries (Parandavar et al., 2014). At the same time, some studies have reported improved sexual activities after gynecological surgery (Babazadeh, Mirzaeei, & Akhlaghi, 2012) that may be because of symptoms relief and the elimination of further pregnancies. However, in the present study, symptoms relief is simultaneously associated with the severe changes in the physical, emotional, and social aspects of women's lives caused by early menopause that exacerbated this experience. The physical effects of treatments, women's perceptions of their sexual status, concern about sexual partners' reaction, and the quality of women's relationships are responsible for the unpleasant experience of sexual activities in women after invasive therapies (Karabinis, Kountourikos, & Tsaloglidou, 2017). Sometimes women believed that the first reason for interacting with husband is the sexual tasks that end with menopause (Rimaz, Merghati Khoii, Zareie, & Shamsalizadeh, 2013). In another study, couples expressed that the lack of intimacy had negatively impacted their relationship and had contributed to an increase in arguments and marital discord (Ratner, Foran, Schwartz, & Minkin, 2010). Therefore, it is not surprising that our participants felt emotional separation from their husbands because they experienced menopause at an earlier age, and the sexual dysfunctions caused by surgery reduced their sexual activities and, consequently, their marital intimacy.

Another dimension of women's perceived changes after surgical menopause that strengthened the feelings of an invisible wall in marital relationship was reflected as “disarming.” Participants believed that the surgery had stripped them of all the tools that make a woman. They have lost their feminine attributes, behaviors, and roles after surgical menopause while they were not mentally prepared for this loss as natural menopausal women. Postmenopausal women have generally thought of themselves as asexual and unattractive (Ussher, Perz, & Parton, 2015), and some believe that the best days of their life ended with the hysterectomy. They consider surgery as the cause of loss of youth, physical attractiveness, and sexual identity (Bayram & Beji, 2010). They consider themselves to be less like women, hollow, and cold (Martins et al., 2013), all of which are consistent with the results of this study. The removal of the uterus for some women meant the loss of femininity and fertility, so losing such a symbolic organ was not simple and caused anxiety and fear in women afterward (Reis, Engin, Ingec, & Bag, 2008). Similar beliefs were also found in Iranian women after natural menopause (Bahri et al., 2016). Attitudes toward menopause have occasionally been reported positive as it is considered a natural process (Yangin, Kukulu, & Sozer, 2010), and women felt more freedom because they no longer needed contraception, had less child-care responsibilities (Omidvar, Bakouie, & Amiri, 2011), or their spouses are also older (Merghati-Khoei et al., 2014). Our results were not consistent with the aforementioned results because our participants were younger, desired to have more children, and were not prepared for menopause. Our participants' age at the time of surgery significantly influenced their negative experiences of surgical menopause. Younger women are at higher risk for sexual dysfunctions (Mat Napes et al., 2013). For women who were in their near-menopausal age, who had enough children of both sexes, and who had a long-term and stable marriage, the acceptance of changes was easier. Living in societies where women's fertility (Douki, Ben Zeieb, Nacef, & Halbreich, 2007) and their youthfulness (Bahri et al., 2016) are valued, where having male children is preferred (Douki, Ben Zeieb, Nacef, & Halbreich, 2007), and the most important task of a wife is to satisfy her husband sexually (Elson, 2004), the loss of sexual organs and fertility is damaging and causes concern about the future of marital life.

The participants experienced the set of changed emotions that were previously employed as the society norms but in the context of surgical menopause caused concerns. “Transforming the societal norms into concerns” is discussed in three subcategories: “adopting silence in sexuality to cover embarrassment, shame and concealing the surgery,” “hardship in dealing with obedience in sexual relationship (tamkin),” and “worried about husband’s polygamy.” All of these issues were not usually challenging for
women even for natural menopausal women, but in the context of surgical menopause, surgery had become a source of concern due to the sudden physical, sexual, and psychological changes.

In this study adopting silence in sexual relations was not so clear. Maybe it was for maintaining privacy as reported in other studies (Janghorban et al., 2015), shyness, or as the cover. In this study silence acted as a cover to hide women's defects or disabilities. This finding was not mentioned in other studies. Unlike natural menopause whereby women tended to talk about their problems to others (Bahri et al., 2016; Janghorban et al., 2015), when women underwent surgical menopause this behavior was not observed. For some participants the strategy of silence was employed because of fear that others would pursue their husband to remarry. In this study, women sometimes hid their sexual problems from their husbands, as they could take advantage of women and put them under pressure. Women's shyness in expressing sexual problems hindered help-seeking behaviors and led to a feeling of shame about the inability to meet the husband's sexual needs. Their experiences simply revealed how shyness turned into shame. Sekse, Råheim, and Gjengedal (2015) found similar experiences in their study and noted when shyness is offended it reacts with shame, as such, shyness protects humans from shame (Sekse et al., 2015). In Iran, women often respond silently to sexual problems in order to comply with social norms (Maasoumi, Lamyian, Khalajabadi-Farahan, & Montazeri, 2013) because talking about sex by Iranian women is taboo, and they have learned from childhood that it should not be discussed in public (Janghorban et al., 2015; Merghati-Khoei et al., 2014). In summary, adopting silence in our participants is not simply being shy or for maintaining privacy; there is something beyond that requires more investigation.

All participants believed that they have a religious and legal duty to have sex whenever their husbands need (tamkin) and it was an admitted norm for Iranian women. Despite having no desire to have sex, they forced themselves to meet this need and forgo their own right to have pleasure. They were worried that not fulfilling their husbands' sexual needs would lead their husbands to have a sexual relationship outside marriage. Belief in tamkin which has been emphasized in Islam and recommended by religious leaders is an accepted practice for religious women. Obedience in sexual affairs is a feature of an ideal Muslim woman (Merghati Khoei, Whelan, & Cohen, 2008), although it is not exclusive to Muslim communities (Fajewonyomi, Orji, & Adeyemo, 2007; Vieira, Santos, & Antonio dos Santos, 2014). Natural menopausal women also had similar concerns about tamkin but they employed it as a problem-solving strategy that ultimately leads to “self-sacrifice” to cope with sexual problems after menopause (Bahri et al., 2016). So thoughts of not being devoted Muslim women and not being able to do marital tasks made our participants worried about the future. Some participants tried to compensate for the lack of sexual intimacy by focusing on other areas of the relationship such as doing their best for the family, bathing their husband, trimming his hair, or sharing in household expenses. These behaviors were similar to renegotiation of nonsexual intimacy that was reported (Hawkins et al., 2009). Women tried to develop these alternatives to resolve their concerns about not doing their marital task but were never assured that these alternatives worked properly.

Polygamy in Iran is permitted under religious law and is a social norm that allows men to have more than one wife simultaneously but only under certain extenuating circumstances, such as in the case of the woman's infertility and woman's unwillingness to divorce. Polygamy is a concern for our women because sexual dissatisfaction is one of the most important factors leading to divorce or remarrying among men (Rahmani, Merghati Khoei, & Alah Gholi, 2009). A study in Qatar showed that natural menopausal women were also concerned about their husband's remarriage (Murphy, Verjee, Bener, & Geber, 2013). At the same time, infertility after the surgery (Al-Nagashabandi, 1993) and the preference for male children (Douki, Ben Zeieb, Nacef, & Halbreich, 2007) may also increase the concerns about the husband's remarriage. Concerns about remarriage or external marital relations are not exclusive to Muslim societies (Liu & Eden, 2007), but in other countries polygamy is illegal (Tesic, 2016), while in Iran it is protected by law. Although this study did not reflect the experience of men after their wives' surgery, what was learned from the content of women's statements was that all of their negative thoughts were due to their own reflections, not to their husbands’ behavior, and they referred mostly to the supporting role of their husband in reducing their distress. Consequently, in this context it would be better to investigate men's experiences in future studies.
One of the strengths of this study was its use of a qualitative approach to discover women's experience of sexual/marital relationship after surgical menopause, which has been less discussed previously. However, this study has limitations that restrict the use of the results. Despite all the efforts to select key participants with maximum variations, what are mentioned here are only the sexual life experiences of a few married Muslim women after surgical menopause, and not representing the experiences of all Iranian women, especially those who are non-Muslim. The sample size should be larger, but the access to the surgical menopausal women was limited due to improper documentation of patients’ records. Unmarried women with sexual relationships did not participate in this study because in Iran this type of surgery is very low in unmarried woman, and premarital sexual intercourse is unacceptable in terms of religion and social norms (Rahmani et al., 2015). Thus, access to these people was almost impossible but has implications for further studies. All women in this study were heterosexual because Islamic law prohibits homosexuality (Kellogg Spadt et al., 2014). Hence these results cannot be applied to other sexual orientations. Finally, no interviews were conducted with husbands, and their experiences after their wife's surgery have not been reflected.

**Conclusion**

Surgical menopause had significant effects on the sexual/marital relationship of Iranian women. Because of the importance of marital life for Iranian women, surgical outcomes should not be allowed to make them feel separated from their husbands. In Iran, all nurses working in gynecological wards are female and are therefore in the best position to identify women's sexual concerns. By establishing an open discourse, nurses can end women's silence about sexual problems and have them take steps to overcome the complications. Couples must be made aware of sexual changes after the surgery through patient education programs, sex therapy, and post-surgical counseling that can help them to adapt properly. Results may have implications for psychiatrists, sex/marital therapists, and probably clergy who are in a position to address openly this important issue in national media or in two-way forum sessions.

**Acknowledgments**

The authors would like to thank all women who participated in this study and so sincerely shared their experiences. The authors are also so grateful to Kerman University of Medical Sciences for their ethical and legal approval. This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. The authors declare that there is no conflict of interests regarding the publication of this paper.

**Disclosure statement**

All authors had full contribution to this manuscript. Study design, collecting and analyzing the data, and writing the initial draft of manuscript have done by ORR, and M A C, B T, N D N, M R did advise on study design, supervise the analytical process and revised the initial draft of this manuscript.

**ORCID**

Om Salimeh Roudi Rasht Abadi http://orcid.org/0000-0002-9408-8116
Batool Tirgari http://orcid.org/0000-0002-0572-5233

**References**


