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Sexual Dysfunction in Muslim Women Receiving Dialysis: A Qualitative Study

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Abstract
Sexual dysfunction (SD) is common in end stage renal disease (ESRD) patients, affecting their quality of life. Sexuality is not a subject that patient's, particularly Muslim women, discuss when they require assistance. They need to develop strategies to cope with SD. The qualitative study explored how Muslim women with ESRD cope with SD. A phenomenological approach was adopted and data were collected using semistructured individual interviews. Purposive sampling was used to recruit 20 participants from two southern regional hospitals in Thailand between September and December, 2018. Recruitment continued until data saturation was reached. Data were analysed using Colaizzi's phenomenological approach. Participants were aged between 30 and 63 years (mean = 45.25, SD = 8.50). Ten were receiving haemodialysis (HD) and 10 were receiving continuous ambulatory peritoneal dialysis (CAPD). Five themes were identified: (1) receiving compassion and understanding from their partner, (2) being afraid of sin if not taking responsibility as a wife's role, (3) denying and ignoring sexuality, (4) being patient to keep their family together and (5) accepting SD associated with God's will. The findings suggest that understanding Islamic views on SD and how the religion's beliefs and practices influence SD and the way Muslim women cope with it. Hence, it is critical in opening lines of communication with patients and their partners to help them cope with SD.

Keywords Coping · End stage renal disease · Muslim women · Sexual dysfunction · Thailand

Introduction

Sexual dysfunction (SD) is significantly more common in both genders with chronic kidney disease (CKD) than in the general population [1]. Male end stage renal disease (ESRD) patients report SD related to erectile dysfunction (ED). Associated factors of ED in male ESRD patients are diabetes mellitus, advanced age and high pre-dialysis urea level [2, 3]. SD in women with ESRD is affected by a variety of physiological and psychological

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factors and comorbid conditions [4]. Related factors of SD in women with ESRD include advanced age, low education, menopause, diabetes, diuretic therapy and depressive symptoms. These are commonly encountered in women with ESRD and impair the ability of women to become sexually aroused [4]. Women with SD symptoms report reduced libido, difficulty with sexual arousal, lack of vaginal lubrication, pain during intercourse and difficulty in achieving orgasm [5, 6]. Although 50% of these women were fertile, the chances of their pregnancy reaching full term with a normal sized baby was low related to the high risk of spontaneous abortion, which consequently, may affect the spousal role and lead to separation and divorce [7, 8].

SD remains common among women with ESRD; however, SD in ESRD Muslims is a poorly understood and neglected area affecting their quality of life [4]. The beliefs among Muslims in many countries are related to sexuality in Islam. These beliefs may include that Islam views sex positively, which means that sex is recognised as part of human nature [9]. Women are considered successful by fulfilling their sexual duties throughout their marital lives and women who use their full sexual capacities to satisfy sexual duties are believed to be devoted Muslims. Based on religious teachings, women believe they must submit themselves to their husband sexually any time he feels sexual urge. Women's narratives revealed sense of obligation to achieve this religious goal, which is regarded as a way of serving God. However, if a wife refuses her husband's sexual demands she will be cursed by an angel [10, 11]. The emphasis on sexual obedience is so deeply rooted in the Islamic culture that even women who have adequately tried to be sexuality obedient still may feel guilty [10, 11].

Previous studies have used quantitative methods to examine the prevalence and correlation of SD in ESRD women receiving dialysis [1, 4, 12, 13]. Most studies conducted did not focus on Muslim ESRD women. There are many differences in religious and cultural belief systems that could influence the experience of Muslim ESRD women [1–6]. Thus, more research is needed to explore Muslim women with ESRD coping with SD. The current study, undertaken in Thailand, is important to nursing practice, education and research, especially for health care providers who care for Muslim women with ESRD. The findings will inform strategies to enable nephrology nurses to better provide for and support the needs of Muslim ESRD women and their partners related to overcoming SD and enhancing their quality of life. Thus, the purpose of this study was to explore how Muslim women with ESRD cope with sexual dysfunction.

Methods

Study Design

A phenomenological approach was adopted and data were collected using semi-structured individual interviews.

Sample and Recruitment

The participants in this study consisted of 20 Muslim women from two regional hospitals in Thailand between September and December, 2018. Purposive sampling was used to recruit Muslim ESRD women, the inclusion criteria were Muslim ESRD women receiving dialysis for at least one year and can communicate in Thai. A questionnaire was used to

collect demographic data from participants. The questionnaire consisted of age, treatment payment options, income, types of dialysis and comorbidities.

Interview Guide

An interview guide was developed using coping strategies as the conceptual basis to frame the research questions. Data was collected from a pilot study [14] and a review of relevant literature related to women with SD and how they cope with SD [4, 9, 15]. The questions concerned participants' experiences of SD and how they coped with SD. Example interview questions included:

1. Please tell me how you felt when you were diagnosed with SD.
2. Can you tell me how SD affected your life?
3. How do you deal with SD?
4. Is there anything else that you would like to share with me?

When necessary, probing and clarifying questions were used to explore issues participants raised such as 'What did that mean to you?' 'How did you feel about...?' and 'Can you describe or tell me more about...?'.

Procedures

After obtaining permission from the participants, nursing staff in each hospital assisted the researcher to select potential participants who met the inclusion criteria. All participants received a detailed verbal explanation of what the research involved. Participants also had the opportunity to ask questions, make comments and voice concerns before they provided consent. When the participants agreed to participate, they were asked to sign a consent form before being interviewed. The interviews were conducted in a private room in the dialysis unit or another place the participants desired. General demographic data were collected from participants before the interview. The researcher asked permission to audio record before beginning the interview and interviews took approximately one hour. Participants were also asked for permission to contact them again if there was a need to re-interview them at a later date in order to clarify information and ensure the researcher had interpreted their words correctly.

The researcher wrote field notes immediately after each participant left the room while details were still fresh in her mind. Field notes included non-verbal information such as a description of the physical appearance of the participant, the way they talked and other non-verbal information. The researcher also wrote about her reflections on the interview and the information the participant provided. She reflected on whether the way she asked questions and responded to the participant could have influenced the participant's responses. Data saturation was reached after 20 interviews.

Analysis

Colaizzi's phenomenological approach was then used to analyse the data (inductive and deductive) and generate data that described the phenomena of interest [16]. The researchers read all participants' descriptions of the phenomenon for a general overview. The

researchers then selected significant parts or statements from each interview that described the experience of ESRD Muslim women coping with sexual health issues. A total 105 statements were identified. Formulated meanings were then determined from the statements. Next, meanings were clustered into five themes. All data were included in an exhaustive description related to the experiences of Muslim ESRD women coping with SD. The researcher used investigator triangulation by having associate researchers, who were knowledgeable about qualitative methods, analysed each interview independently and then discussed their analysis with each other to reach consensus and confirm the data analysis and interpretation reflected the data.

Trustworthiness

Trustworthiness is important to increase confidence in that the study findings reflect the participants' perspectives [17]. Various strategies were used to enhance trustworthiness of the study findings, as follows: (1) credibility was achieved using the following measures: the interviews were audio-recorded to secure an accurate account of the conversation; interview transcripts were returned to participants, enabling them to check for and inform us of any errors; and a summary of findings was returned to participants, with a request for them to indicate if the findings resonated with their experiences and perceptions, 2) transferability was achieved through: providing a clear description of the sample selection, the study setting, methods of data collection and analysis; and ensure transferability of the findings to other Muslim ESRD women in Thailand, 3) dependability was achieved by: having the same researcher conduct the interviews and transcribe the data verbatim; recording field notes of the researcher's observations and non-verbal responses during interviews; and documenting memos to record the researchers' ideas during data analysis and 4) confirmability was achieved by the researcher asking colleagues experienced in qualitative research to review the process and findings. The audio-recordings were transcribed verbatim and translated into English.

Ethical Considerations

This study was approved by the Human Research Ethics Committee of the Nursing Faculty, Prince of Songkla University, Thailand (PSU IRB 2018-NSt 027) and the ethics committee of the two public hospitals where the study was undertaken reference numbers: 28/2561, and FTA0013/61.

Results

Participants were aged between 30 and 63 years (mean = 45.25, SD = 8.50). Ten were receiving haemodialysis (HD) and 10 were receiving continuous ambulatory peritoneal dialysis (Table 1).

Muslim ESRD Women Coping with Sexual Dysfunction

Five themes were identified: (1) receiving compassion and understanding from their partner, (2) being afraid of sin if not taking responsibility as a wife's role, (3) denying and

Table 1 Demographic data of the 20 ESRD Muslim women receiving dialysis who participated in the study (N = 20)

Demographic variable	Number of participants (%)
Age	
18–33	1 (5%)
34–49	14 (70%)
50–63	5 (25%)
Min = 30 years, Max = 63 year, Mean = 45.25, S.D = 8.53	
Employment status	
Government employee	3 (15%)
Farmer	1 (5%)
Business person	2 (10%)
Others	14 (70%)
Treatment payment options	
Government reimbursement	6 (30%)
National health security office	11 (55%)
Social security fund	1 (5%)
Self-payment	1 (5%)
Income (baht/month)	
No income	13 (65%)
< 5000	1 (5%)
5001–10,000	1 (5%)
> 10,001	5 (25%)
Types of dialysis	
Haemodialysis	10 (50%)
Ambulatory peritoneal dialysis	10 (50%)
Comorbidities	
Hypertension	18 (90%)
Heart disease	1 (5%)
Diabetes	2 (10%)
Others	15 (75%)

ignoring sexuality, (4) being patient to keep their family together and (5) accepting sexual dysfunction associated with God's will.

Receiving Compassion and Understanding from Their Partner

Most Muslim ESRD women described their experience after they developed CKD and were receiving dialysis treatment. They were so tired, especially after HD treatment. They also looked after their children and household. However, their husbands had compassion and understood them and their health issues. Their husbands asked them to have a rest or to get enough sleep and not complain or take it seriously, so they could have sex if the ESRD women were ready and feeling better. For example, one participant said:

> If I felt tired or exhausted my husband was so kind and understood me. He did not bother me to have sex with him if I was so tired. He let me to have a rest. When I felt better and he prompted me to have sex, I just let him do it. [Maree]

Another said:

> My husband will ask me first can I have sex or not; if I said no because I was so tired, he just said it was okay and went to sleep. I felt happy to have him as my husband. [Pranee]

Being Afraid of Sin if Not Taking Responsibility as a Wife's Role

Most Muslim ESRD women expressed that they did not want to have sex with their husband because of feeling tired. However, they also took responsibility as a wife's role to take care of their husband and could not deny when their husband wanted to have sex. If they denied having sex with their husband; they will commit a sin. One participant revealed,

> I think my sexual problem is a big problem for me. Sometimes, I felt, I didn't want to have sex with my husband. But, I cannot deny him because I am afraid of sin. [Suda].

Another also described:

> I felt my sexuality was reduced compared to when I was healthy. Actually, I don't want to have sex anymore. However, if my husband wants to have sex with me, I am fine and I did not deny him. Because of my main reason as a wife's role or religious belief that I cannot deny my husband when he has needs because of sin. [Weena]

Denying and Ignoring Sexuality

Most Muslim ESRD women described the experience related to SD such as difficulties with sexual desire, arousal, vaginal lubrication, achieving orgasm and pain during intercourse. Consequently, they denied and ignored having sex with their husband. For example, one participant stated

> I don't want to have sex with my husband because I felt pain during having sex with him…So, I just say no, I cannot have it [sex] with him. [Yupa]

Another expressed:

> I now think having sex with my husband is so difficult, my vagina is too dry and when we have sex it is so painful. So, it made me to ignore when he asked me to do that. [Jai].

Being Patient to Keep Their Family Together

Some participants reported that after they denied or ignored their husbands several times, they found that their husband had a minor wife or mistress. They expressed that they were upset related to sexual health issues. However, they needed to be patient to keep their family together, as in the following participant's expression:

> I received haemodialysis for two years. I developed lots of complications such as feeling tired, difficult to breath and oedema. This caused my husband to sleep in a

separate room and some nights he sleeps somewhere else. I asked him directly if he had minor wife or not. He admitted it. I was so upset and crying a lots, but I still live with him because of my children. I want to keep our family together. [Darunee]

Another said:

Since I cannot have sex with him, some nights he sleeps with another woman [mistress]. I asked him if he had a mistress and he said yes! I just want to be with him because of my son and to keep my family. [Suda]

Accepting Sexual Dysfunction Associated with God's Will

Participants viewed health, illness, pain and dying as the nature of life and felt SD and relationship constraints were a test set by God. Consequently, they accepted SD patently, as in the following participant's statement,

When I cannot have sex with my husband, I feel worried that he might have another woman. I have been upset related to this problem and I am afraid that no one will look after me in the future [She was silent]. I thought any issues that happen in my life are God's will and that it is a test from God. I will accept it patiently. [Yupa]

Another also described:

If he [partner] wants to have another woman, I am fine and I can accept it. God wills such things [sexual issue, chronic kidney disease] to happen to me and I have to accept it patiently. [Jai]

Discussion

The current study reflects how Muslim women with ESRD on dialysis experience SD. They tired after HD treatment or after cleaning their household as a consequence experienced sexual issues. They described SD as difficulties with sexual desire, arousal, vaginal lubrication, achieving orgasm and pain during intercourse. Likewise, previous studies have highlighted SD affects 80% of women receiving HD. For example, studies undertaken in Europe and South America found women on HD reported either no sexual activity or low sexual functioning such as orgasm (75%), arousal (64%), lubrication (63.3%), pain (60.7%), satisfaction (60.1%), and sexual desire (58%) [6]. Similar study also reported female SD consisted of the reduction or loss of sexual interest or desire, arousal or lubrication difficulties, dyspareunia and loss of the ability to reach orgasm [15].

Previous studies are in line with our findings in considering that SD does not affect the relationship with their partners. This is because most of their partners are concerned and understand the Muslim women with ESRD in relation to their sexual issues [9]. Similarly, in Indonesia, most patients with CKD reported they received support from their partners who helped them to overcome their sexual concerns. They also used positive adaptive techniques to cope with SD such as discussing SD with their partner, and giving love by hugging and kissing instead [18].

According to the Muslim women in our study, even though they developed SD, they tried to be a good wife because they were afraid of sin if they did not take responsibility in their role as a wife. Religious beliefs and practices influence Muslim women with ESRD to fulfil the sexual needs of their partners. In the wife's Islamic role, she cannot deny

having sex with her partner when they need to. According to religious belief and practice, ESRD women who developed SD need to be a patient and good wife and guard against sin [9]. Similarly, Indonesians with CKD interpreted the fulfilment of sexual needs as vital for them. They believed that sexual activity is a human need and can provide their partners with a feeling of mutual affection [18].

Some participants in the current study described that they could not tolerate sexual intercourse because of tiredness, fatigue and exhaustion. They denied and ignored sexuality with their partners and could not maintain their role as a wife. Similarly, Indonesians with CKD felt their partners still expected sexual fulfilment, as they did before. Consequently, this developed conflict between them, resulting in separation or divorce [18]. Similarly, a study in Thailand found fatigue and other symptoms affected participants' interest in sexual activities. Consequently, they avoided sexual contact, which affected their self-concept and relationships with their partners [19].

Our findings and previous studies suggest accepting SD was associated with God's will, and consequently avoided despair and depression [7, 20]. Participants considered their SD as destiny and God's will, as a consequence, they accepted SD patiently. Therefore, God's will enable ESRD women to develop inner-strength. Religious beliefs and practices appear to be positive coping techniques that enable Muslims with ESRD to manage and accept SD [7]. Therefore, health care providers should ask about coping and help them develop appropriate coping strategies that enable them to accept the change in their lives, maintain their role as a wife and come to terms with SD.

Conclusion

The findings contribute to knowledge about the experiences of Muslim ESRD women coping with pain. Health care providers should be aware of Muslim women ESRD patients' expectations, and enhance the disclosure of their SD. Further research is needed to explore the experiences women with ESRD from other religious backgrounds, cultural groups and settings in coping sexual health issues.

Author's contributions KY, BM and MM were involved in the study design. MM collected the data. KY and MM analysed the data and drafted the manuscript. KY and BM revised the manuscript.

Declarations

Conflict of interest The authors do not have any conflicts of interest to declare.

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