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The Relationship Between the Level of Sexual Desire Reported in the Clinical Interview and Sexual Development Characteristics, Sexual Functions, and Clinical Diagnosis in Women

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ABSTRACT

Objective: This study aimed to understand the significance of reported sexual desire levels during clinical interviews. We investigated the relationship between sexual desire, sexual developmental characteristics, and scale results, and the predictive effect of adequate sexual desire on clinical diagnoses.

Method: The medical records of patients who consecutively applied to a Specialized Sexual Dysfunctions (SD) clinic were screened for reported sexual desire. We compared 101 patients who reported adequate sexual desire with 94 patients who reported inadequate desire with an interview. The groups were compared based on their sociodemographic and clinical characteristics, sexual behaviors and the Golombok-Rust Sexual Satisfaction Scale (GRISS).

Results: When the group with adequate sexual desire was compared with the group with inadequate sexual desire, significant differences were found between the two groups. The group with inadequate sexual desire was more likely to have had an arranged marriage, to have no source of sexual information, to view masturbation as natural to a lesser extent and as a sin to a greater extent, to have less frequent marital intercourse, to have higher rates of negative experiences related to sexuality, to have higher rates of negative changes in sexual life after having children, to have higher rates of comorbid SD, and to have higher GRISS frequency, satisfaction, avoidance, touching, anorgasmia subscale and total scores. The source of sexual information and negative experience about sexuality predicted a decrease in sexual desire. Those with reduced sexual desire were diagnosed with an SD 8.5 times more often than those with adequate sexual desire.

Conclusion: Our findings showed the importance of sexual desire adequacy reported in the clinical interview in women in evaluating women's sexual health and functions, and the need for sexual health education.

Keywords: Diagnostic evaluation, female sexual dysfunctions, sexual desire

INTRODUCTION

Although the increasing interest of modern medicine in sexual health in the last half of the 20th century has resulted in significant advances in understanding and treating male sexual dysfunctions, the same progress has not been made in female sexual dysfunctions (Lo and Kok 2014). Currently, female sexual dysfunction (FSD) is a common health problem that negatively affects quality of life (Shifren et al. 2008). "Sexual Desire Disorder" and 'Sexual Arousal Disorder', which were the most common diagnoses of FSD in women, respectively (Laumann et al. 1999, Simons and Carey 2001 Bancroft et al. 2003, Shifren et al. 2008, Shifren et al. 2009, Kingsberg and Woodard, 2015) were combined under the name of Female Sexual Interest/ Arousal Disorder (FSIAD) with the amendment made in DSM-5 and a significant part of female SD was gathered under the roof of a diagnostic group (American Psychiatric Association 2013). The decision to combine desire and arousal disorders in women was supported by findings pointing to the high comorbidity of the two disorders, the fact that most

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women experience desire and arousal as part of the same process, and the difficulties in distinguishing them (Brotto et al. 2009, Carvalheira et al. 2010). Low sexual desire is defined as decreased interest in sexual intercourse, sexual activity or sexual fantasies, inability to respond to sexual stimuli or feeling disconnected despite being in a quality relationship (Kingsberg and Woodard, 2015). In this broad definition, desire refers to being open to sexuality as a complex process under the influence of multiple subcomponents such as desire, responsiveness, arousal and multiple biopsychosociocultural factors affecting them, and also refers to the initiation and maintenance of sexual behaviors and the individual's response to sexual stimuli, sexual expectations, scenarios and physiological/behavioral dimensions. In this context, sexual desire may be an intersection point where sociocultural factors, in addition to biological and physiological variables, have the widest impact (Kaplan 1995, Tolman and Diamond 2001). On the other hand, although FSD is one of the most common psychiatric disorders, the rates of patients applying for treatment and reporting their complaints to physicians during application are low (Vahdaninia et al. 2009). Not expressing sexual complaints as a complaint does not mean that there is no sexual problem, and physicians may avoid questioning sexual problems in cases where the patient does not express a sexual complaint (Kingsberg 2006). In a study supporting this finding, it was found that 70% to 90% of Americans with SD did not receive treatment (Shifren et al. 2009). The inclusion of simple questions evaluating sexual functions in the interviews on this issue, which may be difficult to discuss and may be overlooked, will ensure that this difficult issue is addressed in the clinical interview. Predictive questions are valuable in terms of the diagnostic power of the clinician due to the increased likelihood of both disease and treatment related to sexual problems in psychiatric patients and the limited time available for clinical interviews in health services. At this point, the level of sexual desire determined in the clinical interview may be a candidate.

Sexual desire has a central importance in terms of sexual functions as an intersection point under the influence of many factors including cognitive, emotional and interpersonal processes as well as biological components such as neuroendocrine processes (Kaplan 1995, Tolman and Diamond 2001). In this context, our study aimed to understand the importance of sexual desire adequacy determined in the clinical interview and its predictive effect on clinical diagnosis, and the relationship of sexual desire adequacy determined in the clinical interview with sexual developmental characteristics and scale results evaluating sexual functions was investigated. In the light of the literature, our hypothesis is that inadequate sexual desire will predict a diagnosis of FSD and that the adequacy of sexual desire reported in the clinical interview will provide stronger information about the presence of sexual problems or FSD diagnosis than other phases of sexuality such as arousal and orgasm or problem areas such as sexual pain.

METHOD

The medica records of female patients who applied to the SD Psychotherapy Outpatient Clinic of Bakirkoy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery during a one-year period in 2016 were scanned consecutively according to the sequence number. The interview form, sociodemographic and sexual behaviors data form, clinical data form and Golombok-Rust Sexual Satisfaction Scale (GRISS), which are routinely used in outpatient clinic evaluation, were retrospectively evaluated. Women between the ages of 18-65 years and at least primary school graduates were included in the study, while spousal rejection and relational conflict that could affect the relationship with the partner were accepted as exclusion criteria. The subjects who reported that their sexual desire was adequate were compared with the group who reported that their sexual desire was inadequate.

In the routine procedure of the clinic, a psychiatrist conducts an intake interview and the current complaint that led to the application is questioned. If the patient has more than one complaint, the patient is asked to identify the complaint that causes the most discomfort, and it is defined as the complaint of the application. All patients are asked about sexual desire, arousal, adequacy of orgasm and pain during sexual intercourse, semi-structured sociodemographic and clinical data form information is obtained, and GRISS is applied after the interview. In the evaluation of the age of sexual knowledge, the answer to the question "When and through whom did you start to learn about sexuality?" in the sociodemographic and sexual behaviors data form and the information in the childhood sexual development history were evaluated together. After this preliminary interview, the patient is interviewed by a psychiatrist trained in SD and the clinical diagnosis is made according to DSM-5 diagnostic criteria after this detailed interview and partner interview. Then the treatment phase can be started.

The study was approved by the Ethics Committee of Bakirkoy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery with approval number 2018/465 and was conducted in accordance with the principles of the Declaration of Helsinki.

The Sociodemographic and Clinical Data Form used in the study was a structured questionnaire used to determine sociodemographic information such as age, education, sexual development and sexual knowledge, the stages of sexual desire, arousal, orgasm, pain during sexual intercourse and clinical

characteristics. Golombok-Rust Sexual Satisfaction Scale is a 5-point Likert-type self-report scale consisting of 28 questions used to evaluate the quality of sexual relations and sexual dysfunctions of heterosexual men and women (Rust and Golombok 1985). Participants are asked to read each of the 28 items on the scale and mark the most appropriate option among the options "Never", "Rarely", "Sometimes", "Most of the Time", "Always", which are scored between 0-4 points. Higher total scale and subscale scores indicate deterioration in sexual relationship and functions. In the standardized scores converted from raw scores, a score of 5 and above indicates impaired sexual relationship or functioning. The Turkish translation of the scale, whose psychometric properties were determined by Tugrul et al. (1993), was used in this study.

SPSS package program version 26.0 was used to evaluate the data statistically. Kolmogorov-Smirnov test was used to evaluate the conformity to normal distribution. In statistical evaluations, chi-square test or Fisher's exact probability test was used to compare categorical variables between groups. Mann-Whitney U test was used to compare the continuous variables of the two groups. As a multivariate analysis, logistic regression analysis (enter method) was performed to determine the predictor (risk) variables and predictors of low sexual desire, using the possible variables identified in previous univariate analyses (at $p<0.25$ level) and clinically important variables as independent variables. In the evaluation of all results, $p<0.05$ was accepted as the statistical significance threshold.

RESULTS

All 195 patients who participated in the study were female. Considering the whole sample, it represents a group of 30.35±7.48-year-old women who acquired their first sexual knowledge at the age of 15.98±3.13, had their first masturbation experience at the age of 18.96±4.61, had their first sexual act at the age of 19.95±4.46 and had their first sexual intercourse at the age of 24.07±4.85. The educational status, employment status, marital status, age and duration of marriage, age at important life stages and other sociodemographic characteristics of the cases are shown in Table 1.

Clinical characteristics and comparison between adequate and inadequate sexual desire groups are presented in Table 2.

The comparison of the groups formed according to the answers given to the questions on sexual desire, arousal, whether orgasm was sufficient and whether there was pain during sexual intercourse in terms of GRISS total and subscale scores is given in Table 3.

The results of univariate logistic regression analysis in which age, source of sexual information, attitude towards masturbation and negative experiences related to sexuality were used individually as independent variables in the evaluation of the factors affecting inadequate sexual desire are presented in Table 4.

The results of the multivariate logistic regression analysis conducted with the variables of age, sexual information source, masturbation attitude, negative experiences related to sexuality as independent variables in the evaluation of the variables affecting the inadequacy of sexual desire are given in Table 5.

The findings regarding the evaluation of the relationship between the diagnosis of SD and sexual desire level (adequate or inadequate sexual desire) by logistic regression analysis are presented in Table 6.

Table 1. Comparison of Sociodemographic Data Between Groups with Adequate and Inadequate Sexual Desire

	Whole Sample N=195	Adequate Sexual Desire (N=101)	Inadequate Sexual Desire (N=94)		
	Mean±SD	Mean±SD	Mean±SD	U	P
Age	30.35±7.48	29.74±7.38	31.00±7.57	4150	0.129
Age at Marriage	24.78±4.67	24.55±4.94	25.05±4.38	3758	0.160
Duration of Marriage (months)	67.96±86.15	65.53±91.65	70.65±80.08	3559	0.051
Age of Sexual Knowledge	15.98±3.13	15.83±2.89	16.14±3.38	4494	0.791
Age at First Menstruation	13.52±1.63	13.52±1.57	13.52±1.70	4530	0.574
Age at First Masturbation	18.96±4.61	18.76±5.63	19.14±3.54	1915	0.156
Age at First Sexual Activity	19.95±4.46	20.42±4.77	19.47±4.10	3229	0.231
Age at First Sexual Intercourse*	24.07±4.85	24.27±5.12	23.87±4.59	2880	0.978

U: Independent Samples Mann-Whitney U Test, SD: Standard Deviation
*The average age of those who had sexual intercourse is given.

Table 2. Comparison of Clinical Characteristics Between Groups with Adequate and Inadequate Sexual Desire

		Sexual Desire Adequate (N=101)		Inadequate Sexual Desire (N=94)			
		N	%	N	%	X^2	P
Application Complaint	Inability to have sexual intercourse	54	53.5	41	43.6	13.43	**0.005***
	Sexual reluctance	11	10.9	24	25.5		
	Anorgasmia	8	7.9	16	17.0		
	Sexual problems in the partner	15	14.9	8	8.5		
	Painful sexual intercourse	13	12.9	5	5.3		
Education Status	Primary Education	38	37.6	46	48.9	2.54	0.280
	High School	31	30.7	24	25.5		
	University	32	31.7	24	25.5		
Partner	Yes	96	95.0	88	93.6	0.18	0.665
	No	5	5.0	6	6.4		
Employment Status	Yes	95	94.1	83	88.3	2.03	0.154
	No	6	5.9	11	11.7		
Type of marriage	Self-selected	81	83.5	62	70.5	4.47	**0.034***
	Arranged	16	16.5	26	29.5		
Having children	No	75	74.3	63	67.0	1.23	0.267
	Yes	26	25.7	31	33.0		
Mentioning sexual problems	No	55	54.5	36	38.3	5.84	0.054
	Mother-Father-Sibling	30	29.7	33	35.1		
	Relative/Friend/Other	16	15.8	25	26.6		
Family Attitudes Towards Sexuality	Sexuality is Discussed No Prohibition Information Available	24	23.8	18	19.1	0.61	0.434
	Sexuality Unspeakable Prohibited Little Information	77	76.2	76	80.9		
Source of sexual information	No	7	6.9	24	25.5	12.76	**0.002***
	Family	19	18.8	16	17.0		
	Friends and Media	75	74.3	54	57.4		
Masturbation Frequency	No	58	57.4	61	64.9	5.62	0.131
	Less than once a week	21	20.8	12	12.8		
	1 and more per week	21	20.8	16	17.0		
Attitude Towards Masturbation	Natural	49	48.5	33	35.1	6.202	**0.045***
	Unnecessary	39	38.6	37	39.4		
	Sin	13	12.9	24	25.5		
Level of Premarital Sexual Relationship	No sexual encounter	38	37.6	28	29.8	3.751	0.441
	sexual intercourse	14	13.9	17	18.1		
	Naked lovemaking	15	14.9	9	9.6		
	Clothed / semi-naked sex	11	10.9	11	11.7		
	Holding hands. kissing	23	22.8	29	30.9		
Frequency of premarital intercourse	No	59	60.2	66	74.2	4.970	0.083
	Less than once a week	30	30.6	20	22.5		
	1 and more per week	9	9.2	3	3.4		
Frequency of sexual intercourse in marriage	No	16	16.5	10	11.8	6.559	**0.038***
	Less than once a week	19	19.6	31	36.5		
	1 and more per week	62	63.9	44	51.8		

Table 2. continued

Negative experiences related to sexuality	No	91	90.1	70	74.5	8.263	**0.004***
	Yes	10	9.9	24	25.5		
Changes in Sexual Life after Childbirth	No	16	61.5	10	29.4	6.193	**0.013***
	Worse than before	10	38.5	24	70.6		
Extramarital relationship	No	98	97.0	87	96.7	0.021++	1
	Previously Happened Now Not	3	3.0	3	3.3		
Comorbid Psychiatric Disorder	No	92	91.1	80	85.1	1.677	0.432
	Depression	7	6.9	11	11.7		
	Anxiety Disorder	2	2.0	3	3.2		
Comorbid Non-Psychiatric Illness	No	92	91.1	87	92.6	0.139	0.797
	Yes	9	8.9	7	7.4		
Arousal	Adequate	91	90.1	33	35.1	63.59	**< 0.001***
	Inadequate	10	9.9	61	64.9		
Pain	No	47	46.5	57	60.6	3.891	**0.049***
	Yes	54	53.5	37	39.4		
Orgasm	Adequate	76	75.2	26	27.7	44.19	**< 0.001***
	Inadequate	25	24.8	68	72.3		
Diagnosis	No	37	36.6	6	6.4	60.73	**< 0.001***
	GPPB	54	53.5	33	35.1		
	FSİAD	6	5.9	48	51.1		
	FOD	4	4.0	7	7.4		
Comorbid SD	No	99	98.0	74	78.7	.67	**< 0.001***
	FSİAD	0	0.0	14	14.9		
	FOD	2	2.0	5	5.3		
	GPPB	0	0.0	1	1.1		
Diagnosis in Spouse	No	50	49.5	53	56.4	0.92++	0.390
	Yes	51	50.5	41	43.6		
Treatment outcome	Full remission	34	33.7	22	23.4	4.79	0.188
	Partial remission	17	16.8	19	20.2		
	Discontinued treatment	45	44.6	42	44.7		
	Did not improve with treatment	5	5.0	11	11.7		

X^2: Chi-Square Test. ++: Fisher's Exact Probability Test, *: p<0.05, GPPD: Genital Pelvic Pain/Penetration Disorder, FSİAD: Female Sexual Interest/ Arousal Disorder, FOD: Female Orgasm Disorder

Table 3. Comparison of GRISS Scores According to Sexual Desire, Arousal, Orgasm and Pain Reported at the Interview

	Sexual Desire			**Sexual Arousal**			**Pain**			**Orgasm**		
	Adequate	**Inadequate**		**Adequate**	**Inadequate**		**Adequate**	**Inadequate**		**Adequate**	**Inadequate**	
	M±SD	**M±SD**	**U/P**	**M±SD**	**M±SD**	**U/P**	**M±SD**	**M±SD**	**U/P**	**M±SD**	**M±SD**	**U/P**
N: 195	**101**	**94**		**124**	**71**		**104**	**91**		**102**	**93**	
G fre	5.5±1.8	6.1±1.7	**5735/0.010***	5.7±1.8	5.9±1.9	4756/0.340	5.9±1.5	5.6±2.1	4403/0.393	5.7±1.8	5.8±1.7	4701/0.913
G com	4.7±2.0	5.1±2.0	5451/0.069	4.8±2.0	5.1±2.1	4718/0.396	5.2±1.9	4.5±2.1	3951/0.043	4.9±2.0	4.8±2.0	4633/0.777
G sat	4.2±1.8	5.0±1.8	**5946/0.002***	4.5±1.9	4.8±1.8	4929/0.159	4.7±1.8	4.3±1.8	4201/0.171	4.4±1.9	4.7±1.7	4232/0.188
G avo	4.2±2.1	5.7±1.8	**6741/0.001***	4.6±2.1	5.4±1.8	**5332/0.013***	5.1±1.9	4.6±2.2	4144/0.131	4.7±2.2	5.1±1.9	4190/0.156
G tou	5.0±2.1	5.8±1.8	**5760/0.009***	5.2±2.1	5.8±1.8	5042/0.085	5.6±1.9	5.2±2.0	4142/0.126	5.1±2.2	5.7±1.7	4254/0.205
G vag	6.7±2.3	6.2±2.3	4169/0.135	6.4±2.4	6.5±2.2	4359/0.909	5.1±2.1	8.0±1.4	**1123/0.001***	6.2±2.4	6.7±2.1	4296/0.248
G an	4.2±1.6	4.8±1.5	**5699/0.012***	4.2±1.5	4.9±1.5	**5370/0.008***	4.6±1.5	4.3±1.5	4264/0.216	4.0±1.3	5.0±1.5	**2967/0.001***
G tot	4.9±1.8	5.8±1.7	**5952/0.002***	5.1 ±1.8	5.5±1.9	4977/0.121	5.4±1.7	5.1± 1.9	4138/0.122	5.1±1.8	5.5±1.8	4292/0.242

U: Independent Samples Mann-Whitney U Test, *: p<0.05, M: Mean, SD: Standard Deviation, G fre: GRISS frequency, G com: GRISS communication, G sat: GRISS satisfaction, G avo: GRISS avoidance, G tou: GRISS touching, G vag: GRISS vaginismus, G an: GRISS anorgasmia, G tot: GRISS total

Table 4. Evaluation of the Relationship between Decreased Sexual Desire and Other Variables by Univariate Logistic Regression Analysis

Variables		B	SE	wald	df	OR	%95 CI	p
Source of sexual information (Friends/Media) *	No	1.561	0.465	11.256	1	4.762	1.91 – 11.85	0.001
	Family	0.157	0.383	0.167	1	1.170	0.55 – 2.48	0.683
Negative experiences related to sexuality (No)*	Yes	1.138	0.409	7.755	1	3.120	1.40 – 6.95	0.005
Attitude Towards Masturbation (Natural)*	Unnecessary	0.343	0.322	1.136	1	1.409	0.750-2.645	0.287
	Sin	1.008	0.411	6.006	1	2.741	1.224-6.140	0.014
Age		0.023	0.019	1.365	1	1.023	0.985-1.063	0.243

*Reference category, B: Beta Coefficient, SE: Standard Error, wald: Wald Test, df : Degrees of Freedom, OR: Relative odds ratio, CI: Confidence Interval

Table 5. Evaluation of the Relationship between Decreased Sexual Desire and Other Variables by Multivariate Logistic Regression Analysis

Variables		B	SE	wald	df	OR	%95 CI	p
Source of sexual information (Friends/Media) *	No	1.518	0.482	9.923	1	4.564	1.775-11.739 – 12.03	0.002
	Family	0.187	0.401	0.217	1	1.205	0.549-2.646 – 2.61	0.642
Negative experiences related to sexuality (No)*	Yes	1.070	0.425	6.333	1	2.916	1.267-6.711 – 7.09	0.012
Attitude Towards Masturbation (Natural)*	Unnecessary	0.510	0.344	2.204	1	1.665	0.849-3.266	0.138
	Sin	0.789	0.441	3.210	1	2.202	0.928-5.223	0.073
Age		0.015	0.021	0.514	1	1.015	0.974-1.058	0.473
Constant		-1.317	0.697	3.570	1	0.268		0.059

*Reference category, B: Beta Coefficient, SE: Standard Error, wald: Wald Test, df : Degrees of Freedom, OR: Relative odds ratio, CI: Confidence Interval

Table 6. Univariate Logistic Regression Analysis of the Relationship Between SD Diagnosis and Reported Sexual Desire Level

Variables		B	SE	wald	df	OR	%95 CI	p
level of sexual desire (adequate)*	inadequate	2.138	0.470	20.706	1	8.479	3.377-21.292	<0.001
Constant		0.548	0.207	7.040	1	1.730		0.008

*Reference category, B: Beta Coefficient, SE: Standard Error, wald: Wald Test, df : Degrees of Freedom, OR: Relative odds rati, CI: Confidence Intervalo

DISCUSSION

In line with our hypothesis, the fact that the level of sexual desire provides information on a much broader area than the questions on arousal, pain and orgasm when compared with the GRISS subscales; that SD is diagnosed 8.479 times more in those with inadequate sexual desire than in those with adequate sexual desire; therefore, the inadequate sexual desire declared by the patient in the clinical interview predicts the diagnosis of SD in the applicants. This shows the importance of the level of sexual desire obtained in the clinical interview in women in evaluating women's sexual health and functions. To the best of our knowledge, this is the first study to investigate the relationship between low sexual desire reported in the clinical interview and the diagnosis of FSD.

In the group reporting adequate sexual desire, 90.1% of women were found to have sufficient arousal, while in the group reporting inadequate sexual desire, this rate decreased to 35.1%, which may support the definition of sexual desire and arousal levels together in women, the high comorbidity of the two disorders, and the fact that most women experience arousal and desire as part of the same process (Brotto et al. 2009, Carvalheira et al. 2010). When defined to include desire, responsiveness, and arousal, sexual desire also refers to the physiological processes of arousal, including genital temperature related to vaginal lubrication and blood flow; furthermore, it creates a field that includes the effects of sociocultural variables in addition to biological and physiological variables. In this context, our findings support the unification of desire and arousal disorders in DSM-5 under the name of FSIAD.

While pain was detected in 53.5% of the group reporting adequate sexual desire, this rate decreased to 39.4% in the group reporting inadequate desire. The fact that pain was a less common symptom in the group reporting inadequate desire may be due to the fact that genitopelvic pain penetration disorder (GPPD), which is the most common diagnosis in our sample and in which pain is the main symptom, was more common in the group reporting inadequate desire. Although desire may be related to pain, as in the case of a person experiencing pain while having sex with a person they do not desire, pain seems to be independent of desire.

Another finding in our study supporting this result is that in the comparison of sexual desire, arousal, orgasm and pain in the GRISS subscales, the GRISS vaginismus subscale was found to be only related to pain. While orgasm was detected in 75.2% of the group reporting adequate sexual desire, this rate decreased to 27.7% in the group reporting inadequate desire. Our finding supports the close relationship between desire and orgasm. This finding may indicate that adequate desire and arousal facilitate reaching orgasm. Current studies also find a relationship between sexual desire and subjective orgasm experience (Arcos-Romero et al. 2022).

The fact that GPPD was the most common diagnosis in our study may be due to our clinic being a reference center on this issue, or it may be due to the fact that GPPD is a more common disorder in our country compared to Western countries (Oniz et al. 2007, Aslan et al. 2008). While the rate of not being diagnosed with any SD was 36.6% in the group reporting adequate sexual desire, this rate dropped to 6.4% in the group reporting inadequate desire. This may indicate that those reporting adequate desire are more likely to seek help, even if they are not at the level of a psychiatric diagnosis.

Our finding that 98% of the group reporting adequate sexual desire had no comorbid SD and significantly lower comorbid SD compared to the group reporting inadequate sexual desire is an important finding in showing the central place of sexual desire in sexual functions. DSM-5 emphasizes that more than one sexual dysfunction can be seen together in the same individual and each can be evaluated and diagnosed separately (American Psychiatric Association 2013). Although the hypothesis that the multifaceted and complex nature of sexual dysfunctions in women may increase the likelihood of co-occurrence of different disorders is acceptable, there are almost no studies in this field (Brotto et al. 2016). In this context, we think that the finding that other sexual dysfunctions are very unlikely to be seen comorbidly in cases where sexual desire is adequate, which we found in our study, can be considered as an important subject of investigation in further research.

There was no difference between the two groups in terms of partner diagnosis. Since the presence of SD in partners was found to be significantly associated with low sexual function in women (Aslan et al. 2008, Lianjun et al. 2011, Zhang and Yip 2012, Ibrahim et al. 2013), the absence of a difference in this respect helped to exclude this confounding variable and facilitated the interpretation of the study.

When the GRISS subscales of the groups with adequate and inadequate sexual desire were compared, a significant difference was found in the GRISS frequency, satisfaction, avoidance, touching and anorgasmia subscales and total scores, while no difference was found in the scores obtained from communication and vaginismus subscales. When compared in terms of adequate or inadequate sexual arousal, no difference was found except for avoidance, touching and anorgasmia. On the other hand, the presence or absence of pain was only associated with the vaginismus subscale, while the presence or absence of orgasm was only significantly associated with anorgasmia. In this context, it can be interpreted that the level of sexual desire (adequate/inadequate) determined in the clinical interview provides information in a much wider dimension than the questions of whether arousal and orgasm are adequate or not, whether there is pain or not, and although the GRISS scale alone is inadequate to cover all dimensions of sexuality, it is compatible with a significantly wide area screening in all dimensions except communication and vaginismus. Our finding can be interpreted as an indicator of the central place of desire in the sexual response cycle and that the level of sexual desire is the question that should be asked primarily in the clinical interview.

The evaluation of the variables affecting the reporting of decreased sexual desire in the clinical interview revealed that the source of sexual information and negative experiences related to sexuality predicted the reporting of decreased sexual desire. The fact that sexual desire decreased 4.771 times more in those who had no source of sexual information and 1.216 times more in those who had family as their source of sexual information compared to those who had friends/media as their source of sexual information shows the importance of getting sexual information from friends and media. Although the information on sexuality in the media may be distorted from time to time, the fact that friends/media are more positive sources of sexual information than family may be a reflection of the suppression of sexuality in the family. In our sample, this situation is largely reflected in the definition of the family's attitude towards sexuality as "sexuality is not talked about, sexuality is forbidden, and there is little information". The finding of a 3.117-fold increase in low sexual desire in those with negative experiences compared to those without negative experiences related to sexuality is consistent with the findings of previous studies (O'Loughlin and Brotto 2020, Bell et al. 2022). In a systematic review of 135 studies from forty-one countries, sexual adverse experiences were consistently found to be important risk factors and sexual education was consistently found to be one of the important protective variables (McCool-Myers et al. 2018).

The finding that those who reported inadequate sexual desire were more likely to be diagnosed with SD may indicate that the adequacy of sexual desire determined in the clinical interview has a predictive effect on clinical diagnosis and is an important diagnostic question. In women, especially after childbirth and other important medical, surgical, psychological and life events, sexual health assessment should be a part of routine health examination, but in mental health outpatient services, sexual health may be neglected due to time

constraints and/or reluctance of the patient or physician to initiate the subject (Montgomery 2008). In this context, questioning the level of sexual desire may be considered as a quick and effective question in evaluating sexual functions.

When the sociodemographic characteristics of the two groups were compared, the group reporting inadequate sexual desire was more likely to have had an arranged marriage, to have grown up in an environment where there was a lack of sexual information, to view masturbation as natural to a lesser extent and as a sin to a higher extent, to have had less frequent marital intercourse, to have experienced negative experiences related to sexuality to a higher extent and to have experienced negative changes in their sexual life after having children. Our findings point to the intense influence of sociocultural variables on the desire stage in the sexual response cycle.

The most common complaint reported by the groups with adequate and inadequate sexual desire was inability to have sexual intercourse with 53.5% and 43.6%, respectively. Inability to have intercourse is a result rather than a diagnosis and refers to inability to have intercourse for different reasons. It may be used as an umbrella symptom for complaints that cannot be expressed such as sexual desire, or it may be an indicator of lack of sexual knowledge. In the comparison of the two groups, the finding of a difference in terms of the complaint of application is in line with the expectations since desire is also a complaint of application. On the other hand, an interesting finding was that only 24 (25.5%) of the group who reported inadequate sexual desire in the first evaluation interview expressed sexual desire as a complaint. Of the 70 people who reported decreased sexual desire at the first assessment interview, the complaint was not inadequate sexual desire. However, the clinical diagnosis in this group was FSIAD for 48 people (51.1%). This may be interpreted as a lack of sexual knowledge as well as hesitation, embarrassment or inability to recognize the complaint (Vahdaninia et al. 2009). In previous studies, it was reported that women hoped that physicians would bring up the issue rather than voicing their sexual health concerns (Berman et al. 2003).

The higher rate of arranged marriages in the group with inadequate sexual desire compared to the group reporting adequate sexual desire may be an important finding. In arranged marriages, before the couple can discuss their expectations sufficiently and get to know each other, the family members make the marriage decision for them, which may pave the way for communication difficulties. Although arranged marriages are not forced marriages in all cases, being forced to marry someone they do not want may have a detrimental effect on the couple's relationship with sociocultural pressure. In previous studies, arranged marriages, marriages at a young age, and polygamy were found to be associated with significantly higher SD levels in women (Erbil 2011, Arasteh et al. 2014).

When the group reporting adequate sexual desire was compared with the group reporting inadequate sexual desire in terms of sexual information source, a significant difference was found. The group reporting inadequate sexual desire reported that they had no sexual information source, at a higher rate. Lack of sexual knowledge was found to be a predisposing variable for SD (Abdo et al. 2010, McCool-Myers et al. 2018). On the other hand, a significant protective effect of sexual education in terms of SD has been reported (Lau et al. 2005, Abdo et al. 2010, Najafabady et al. 2011).

Although there was no difference between the two groups, in the group with inadequate sexual desire, the attitude of the family towards sexuality was defined as an environment where sexuality was not discussed, sexuality was forbidden and there was little information, with a rate of more than 80%. This finding is a strong indicator of suppression of sexuality in the study sample. Although we did not find a difference between the two groups, negative family attitudes towards sexuality and lack of sexual knowledge are among the psychosocial variables found to be associated with FSIAD and FSD in previous studies (West et al. 2004, Buster 2013, McCool-Myers et al. 2018). This finding may be a reflection of the fact that both groups were clinical samples.

Negative experiences related to sexuality were found to be significantly higher in the group with inadequate desire. Negative experiences related to sexuality is a finding that has been consistently shown in previous studies as a factor that can reduce sexual desire due to its traumatic effects that can negatively affect all kinds of relationships with others (McCabe and Cobain 1998, Abdo et al. 2010, McCool-Myers et al. 2018).

It is important that our study has a qualified sample selection, consisting of the community assessed in pairs in the Specialized SD clinic with detailed scales and interviews. It is valuable that it is oriented towards clinical practice in the clinical sample and in the everyday patient assessment process, and that it investigates the core symptoms of a disorder created by a new revision in the DSM. However, the retrospective nature of the study imposes limitations on the interpretation or generalization of the results. On the other hand, the fact that the quality of the couples' relationship was not evaluated with a scale or a qualitative analysis should be considered as a limitation. In addition, the lack of data on cases with sexual reluctance who were excluded from the study based on the exclusion criteria of partner rejection and relational conflict at a level that could affect the relationship with the partner should also be added as a limitation. It should be noted as a limitation that the sample of our study consisted mostly of cases with partners. On the other hand, the absence of a non-clinical control group in our study referring to sociocultural variables should be considered as a limitation in terms of showing the differentiation and overlap of the sample with social norms.

CONCLUSION

Our findings showed the importance of the level of sexual desire assessed in the clinical interview in evaluating women's sexual health and functions. Due to the multidimensional nature of sexual health, it is not possible to screen and evaluate all sexual functions with a single question. However, in cases where the time that can be allocated to the patient is limited, especially in psychiatric clinics, the assessment of sexual desire can provide a preliminary evaluation of sexual functions and sexuality. In our study, failure to mention sexual problems, negative attitudes of the family towards sexuality, negative attitudes towards masturbation and lack of sexual information sources indicate an unmet need for sexual health education. The most cost-effective way to address this situation may be sexual education in non-formal education and psychoeducation in clinical encounters in societies where this is not met.

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REFERENCES

Abdo CH, Valadares AL, Oliveira WM Jr et al. (2010) Hypoactive sexual desire disorder in a population-based study of Brazilian women: associated factors classified according to their importance. Menopause 17: 1114–21.

Amerikan Psikiyatri Birliği (2013) Mental Bozuklukların Tanısal ve Sayımsal El Kitabı, Beşinci Baskı (DSM-5) (Çev. ed.: E Köroğlu). Ankara, Hekimler Yayın Birliği, 2015.

Arasteh M, Alizadeh NS, Ghaderi E et al. (2014) Survey of the prevalence of sexual dysfunctions in Kurdish women. J Sex Marital Therapy 40: 503–11.

Arcos-Romero AI, Expósito-Guerra D, Sierra JC (2022) Sexual desire and its relationship with subjective orgasm experience. Int J Impot Res 34: 93-9.

Aslan E, Beji NK, Gungor I et al. (2008) Prevalence and risk factors for low sexual function in women: a study of 1,009 women in an outpatient clinic of a university hospital in Istanbul. J Sex Med 5: 2044–52.

Bancroft J, Loftus J, Long JS et al. (2003) Distress about sex: a national survey of women in heterosexual relationships. Arch Sex Behav 32: 193–208.

Bell AR, Giil E, Træen B (2022) Reduced Sexual Desire in Young Norwegian Women: A Mixed-Methods Study. Sex Cult 26: 1919-39.

Berman L, Berman J, Felder S et al. (2003) Seeking help for sexual function complaints: what gynecologists need to know about the female patient›s experience. Fertil Steril 79: 572–6.

Brotto LA, Heiman JR, Tolman DL et al. (2009) Narratives of desire in mid-age women with and without arousal difficulties. J Sex Res 46: 387-98.

Brotto LA, Basson R, Laan E (2016) Women›s sexual desire and arousal disorders. Human Sexuality and its Problems, 3. Baskı, J Bancroft (Ed.) Elsevier, s.311-37.

Buster JE (2013) Introduction: Sexual health matters. Fertil Steril 100: 897.

Carvalheira AA, Brotto LA, Leal I et al. (2010) Women's motivations for sex: exploring the diagnostic and statistical manual, fourth edition, text revision criteria for hypoactive sexual desire and female sexual arousal disorders. J Sex Med 7: 1454-63.

Erbil N (2011) Prevalence and risk factors for female sexual dysfunction among Turkish women attending a maternity and gynecology outpatient clinic. Sex Disabil 29: 377–86.

Ibrahim ZM, Ahmed MR, Sayed Ahmed WA (2013) Prevalence and risk factors for female sexual dysfunction among Egyptian women. Arch Gynecol Obstet 287: 1173–80.

Kaplan HS (1995) The sexual desire disorders: Dysfunctional regulation of sexual motivation. 1. Baskı Routledge, s.15-24.

Kingsberg SA (2006) Taking a sexual history. Obstet Gynecol Clin North Am 33: 535–47.

Kingsberg SA, Woodard T (2015) Female sexual dysfunction: Focus on low desire. Obstetrics & Gynecology 125: 477–86.

Lau JT, Kim JH, Tsui HY (2005) Prevalence of male and female sexual problems, perceptions related to sex and association with quality of life in a Chinese population: a population-based study. Int J Impot Res 17: 494–505.

Laumann EO, Paik A, Rosen RC (1999) Sexual dysfunction in the United States: Prevalence and predictors. JAMA; 281: 537-44.

Lianjun P, Aixia Z, Zhong W et al. (2011) Risk factors for low sexual function among urban Chinese women: a hospital-based investigation. J Sex Med 8: 2299–304.

Lo SS, Kok WM (2014) Sexual behavior and symptoms among reproductive age Chinese women in Hong Kong. J Sex Med 11: 1749–56.

McCabe MP, Cobain MJ (1998) The impact of individual and relationship factors on sexual dysfunction among males and females, Sexual and Marital Therapy 13: 131-43.

McCool-Myers M, Theurich M, Zuelke A et al. (2018) Predictors of female sexual dysfunction: a systematic review and qualitative analysis through gender inequality paradigms. BMC Womens Health 18: 108.

Montgomery KA (2008) Sexual desire disorders. Psychiatry (Edgmont) 5: 50–5.

Najafabady MT, Salmani Z, Abedi P (2011) Prevalence and related factors for anorgasmia among reproductive aged women in Hesarak, Iran. Clinics (Sao Paulo) 66: 83–6.

O'Loughlin JI, Brotto LA (2020) Women's Sexual Desire, Trauma Exposure, and Posttraumatic Stress Disorder. J Trauma Stress 33: 238-47.

Oniz A, Keskinoglu P, Bezircioglu I (2007) The prevalence and causes of sexual problems among premenopausal Turkish women. J Sex Med 4: 1575–81.

Rust J, Golombok S (1985) The Golombok-Rust Inventory of Sexual Satisfaction (GRISS). Br J Clin Psychol. 24: 63-4.

Shifren JL, Johannes CB, Monz BU et al. (2009) R. Help-seeking behavior of women with self-reported distressing sexual problems. J Womens Health 18: 461-8.

Shifren JL, Monz BU, Russo PA et al. (2008) Sexual problems and distress in United States women: prevalence and correlates. Obstet Gynecol 112: 970-78.

Simons JS, Carey MP (2001). Prevalence of sexual dysfunctions: Results from a decade of research. Arch Sex Behav 30: 177–219.

Tolman DL, Diamond LM (2001) Desegregating sexuality research: cultural and biological perspectives on gender and desire. Annu Rev Sex Res 12: 33–74.

Tuğrul C, Öztan N, Kabakçı E (1993) Golombok- Rust Cinsel Doyum Ölçeği'nin standardizasyon çalışması. Turk Psikiyatri Derg 4: 83-8.

Vahdaninia M, Montazeri A, Goshtasebi A (2009) Help-seeking behaviors for female sexual dysfunction: a cross sectional study from Iran. BMC Womens Health 9: 3.

West SL, Vinikoor LC, Zolnoun D (2004) A systematic review of the literature on female sexual dysfunction prevalence and predictors. Annu Rev Sex Res 15: 40–172.

Zhang H, Yip PS (2012) Female sexual dysfunction among young and middle aged women in Hong Kong: prevalence and risk factors. J Sex Med 9: 2911–8.