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Sexuality amongst heterosexual women with morbid obesity in a bariatric surgery programme: A qualitative study

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Abstract

Aims: The objective of this study is to describe and understand the experiences of sexuality amongst heterosexual women with morbid obesity (MO) who are in a bariatric surgery program.

Background: Morbid obesity is a chronic, metabolic disease that affects women's physical, psychological and sexual health. MO is associated with anxiety, depression and body image disorders. Bariatric surgery is a reliable method for weight loss in people with MO.

Design: A qualitative descriptive study research design was adopted.

Methods: Twenty-one heterosexual women with MO in a bariatric surgery program were recruited through purposive sampling. Data collection included individual semi-structured interviews conducted between November 2018 and May 2019. Interviews were audio recorded, transcribed verbatim and analysed using a computer-assisted qualitative data.

Findings: Three main themes emerged from the analysis: (1) trapped in a body that limits my sexuality; (2) between neglect and hope and (3) the partner as a source of support for sexuality in women with MO.

Conclusion: Women hide a body that they do not accept and ignore their own sexuality, focusing on that of their partner. Although the women have doubts about their partners' desire for them, they share the decision-making process with them whilst waiting for bariatric surgery, on which they place all of their hopes for improved sexuality and quality of life.

Impact: The findings highlight the importance of exploring the experiences and sexual issues faced by heterosexual women with MO in a bariatric surgery program. Bariatric nurses have a privileged position to assess these women's sexuality, recommend alternatives to sexual intercourse or refer them to sexologists. As part of the multidisciplinary team, nurses can contribute to managing the expectations of women with MO and their partners in relation to the improvement of their sex lives following bariatric surgery.

KEYWORDS
bariatric surgery, female sexual dysfunction, morbid obesity, nursing, qualitative research, sexuality, Women's Health Services

1 | INTRODUCTION

Obesity is a chronic-metabolic disease characterised by the accumulation of fat mass and adiposopathy. Thirty-nine percent of adults around the world are overweight, of whom 13% are obese (WHO, 2017). Prevalence varies by country (Mazer & Morton, 2018); in Spain, obesity affects 21.6% of the general population and 20.5% of women (Lecube et al., 2017). Morbid obesity (MO) is associated with cardiovascular disease, diabetes, hypertension (Wingfield et al., 2016), cancer (Rowland et al., 2016), osteoarthritis, pelvic floor dysfunction and urinary incontinence (Sarwer et al., 2012); conditions caused or aggravated by obesity (Oliveira et al., 2019). MO is also related to anxiety, depression, low self-esteem and body image disorders (Lyons et al., 2014; Taskin et al., 2019). Additionally, MO affects sexual health and can be associated with female sexual dysfunction (FSD) and changes in libido, pleasure and sexual relations (Mariano et al., 2014). Research into FSD in MO women has focused on pathology, diagnosis and treatment (Rowland et al., 2016), stigma (Brewis, 2014), self-image or mental health (Sfahani & Pal, 2019); but there is a lack of research into the understanding of female sexuality through exploring the experiences of women themselves.

1.1 | Background

Obesity is defined as having a body mass index (BMI) > 30 kg/m^2 and MO as having a BMI between of 40 kg/m^2 or greater (Mechanick et al., 2009, 2013). MO can be of endogenous origin, due to genetic or metabolic/endocrine problems (Dubern et al., 2017) or exogenous, due to hypercaloric diets, lack of physical exercise or non-healthy lifestyles (Jiménez et al., 2014; Wu & Berry, 2018). Obesity has a social, economic and cultural dimension. Southern European countries are abandoning the "Mediterranean diet", and only 50% of the Spanish population have a healthy diet (Burggraf et al., 2018). With beauty standards that focus on being slim as well as society's negative opinion towards obesity (Medina et al., 2014), Spain has a high relative index of income-related inequality regarding obesity and education in women (OECD, 2019).

The link between MO and sexual function is complex (Rowland et al., 2016); in a woman it comes from hormonal or vascular conditions and other comorbidities (Wingfield et al., 2016).

Although the prevalence of sexual satisfaction in the general female population stands above 75% (Castellanos-Torres et al., 2013; Lammerink et al., 2017), MO is associated with decreased quality of sex life (Sfahani & Pal, 2019). Approximately half of the women with severe obesity are dissatisfied with their sex lives before bariatric surgery (Steffen et al., 2017). Along with the loss of physical movement, a woman with MO may experience menstrual cycle alterations, lack of lubrication, arousal and dyspareunia (Erenel & Kılınc, 2013). These may present alongside a lack of desire and sexual satisfaction (Mariano et al., 2014), difficulty in reaching orgasm and a decreased quality of reproductive health and life as a whole (Broughton & Moley, 2017). MO may also result in stigma and loss of social life (Albano et al., 2019), reduced perception of attractiveness, increase in shame and impaired eroticism and sexual health (Mantelo et al., 2014; Westermann et al., 2015).

The treatment of MO has focused essentially on diet, physical exercise and use of drugs (Annesi, 2018; Srivastava & Apovian, 2018). Bariatric surgery has been shown to be a reliable method for long-term weight loss and improving quality of life (Kabu & Özbayır, 2021; Pichlerova et al., 2019; Wingfield et al., 2016). The inclusion criteria for a person with MO in a bariatric surgery program are as follows: being an adult with a BMI ≥40 kg/m^2; being an adult with a BMI between 35 and 39.9 kg/m^2 and having weight related comorbidities (type 2 diabetes, hypertension, hyperlipidemia) (Landecho et al., 2017; Sabench et al., 2017). In this phase of MO, women may experience severe lack of mobility, confidence and self-esteem (Mariano et al., 2014; Sfahani & Pal, 2019; Wu & Berry, 2018).

Women with MO hope to improve their sexual and reproductive health following bariatric surgery, which is associated with a consequent improvement in self-esteem and body image (Nilsson-Condori et al., 2020). Significant weight loss as a result of bariatric surgery can improve sexual dysfunction in women (Pichlerova et al., 2019), but unrealistic expectations can lead to frustration (Hering et al., 2018). Research into FSD in MO women has focused on diagnosis, treatment and psychological effects. Whilst there have been studies on sexual function and the expectations surrounding bariatric surgery of patients with MO included in a bariatric surgery program (Granero-Molina et al., 2020; Jiménez et al., 2014; Poulsen et al., 2016), little is known about the experiences of women. Our research question is "What are the experiences of heterosexual women diagnosed with MO in a bariatric surgery program in relation to sexuality?" The framework described by Verschuren et al. (2010) allows us to understand how chronic disease (MO) may affect physical, psychological and sexual well-being. Disease activity, complications and treatment may impact sexuality in three ways: direct (genitals), indirect (fatigue, perception changes) or iatrogenic (psychological comorbidity, effects of medication, changes in body image or sexual desire disorder).

2 | THE STUDY

2.1 | Aim

The objective of this study was to describe and understand the experiences of sexuality amongst heterosexual women with MO who are in a bariatric surgery program.

2.2 | Design

A qualitative descriptive study research design was used. This approach has a naturalist perspective, allowing for an in-depth description of a little-known phenomenon by exploring the participants' experiences and using their own words (Sandelowski, 2000). The Consolidated Criteria for Reporting Qualitative Research (COREQ) was used to report the findings of this study.

2.3 | Sample/participants

Through purposive sampling, 21 women diagnosed with MO were selected. The criteria for inclusion were as follows: being a heterosexual woman 18–50 years old, being included in a bariatric surgery program, speak Spanish and having given informed consent. Exclusion criteria were as follows: having recently been pregnant or breastfeeding, reaching menopause, having undergone prior bariatric surgical procedures or refusing to participate in the study. Of the thirty-five women with MO who were contacted for recruitment, three did not answer the telephone, nine refused to discuss the subject and two said they did not have time to be interviewed. A total of twenty-one women were interviewed (Table 1). The study took place in two hospitals in the south of Spain between November 2018 and May 2019.

2.4 | Data collection

Participants fulfilling inclusion criteria were telephoned by nurses. The aims were explained, doubts were clarified, voluntary participation in the study was requested, and if they accepted, they were enrolled. Nurses and participants had met prior to the interview in the context of clinical care. Furthermore, nurses had a master's degree with qualitative research training and did not require additional training. Participants agreed to be interviewed in a part of the hospital outside of the surgical area, and only the researchers and participant were present in the interview. After conducting three pilot interviews, group techniques for data collection were dismissed because the women refused to share/discuss their experiences with other participants. Two nurses from the research team (MJTS, MSN), with five years of experience in the bariatric surgery program, performed the in-depth interviews using the interview protocol (Table 2), which lasted on average 50 min. At the time of the study, three authors (MJTS, MSN, MFM) were working as nurses and a surgeon in a bariatric surgery unit; the remaining authors are academics from the University's Department of Nursing, Physiotherapy and Medicine. All of the researchers have a master's degree and a PhD. Each participant carried out only one individual and private interview, and field notes were collected. Before the interview, in addition to the signed consent form, sociodemographic data of the participants were collected. All of the participants' responses in the in-depth interviews

TABLE 1 Demographic characteristics of interviewees (n = 21)

Participant	Age	BMI, kg/m^2	Onset of obesity	Marital status	Children	Education level	Other weight loss treatment
WDI1	49	50.0	Wedding	Married	2	Primary	Diet/pickups
WDI2	48	40.1	Adolescence	Married	3	Primary	Diet
WDI3	50	40.8	Wedding	Partner	3	No studies	Diet/IGB
WDI4	42	40.2	Pregnancy	Divorced	2	Secondary	Diet/pickups
WDI5	41	43.2	Adolescence	Partner	0	Secondary	Diet/pickups
WDI6	45	41.6	Wedding	Married	3	No studies	Diet/pickups
WDI7	49	40.4	Pregnancy	Married	3	University	Diet
WDI8	46	41.9	Pregnancy	Married	4	Primary	Diet/pickups/IGB
WDI9	44	51.2	Pregnancy	Married	2	Primary	Diet/pickups/gastric band
WDI10	36	42.4	Adolescence	Single	0	Secondary	Diet
WDI11	30	41.2	Adolescence	Single	0	Primary	Diet
WDI12	50	41.3	Pregnancy	Married	3	University	Diet
WDI13	42	40.4	Adolescence	Single	0	University	Diet
WDI14	20	40.5	Childhood	Single	0	Secondary	Diet
WDI15	48	41.1	Adolescence	Married	4	University	Diet
WDI16	32	42.9	Childhood	Single	0	Primary	Diet
WDI17	30	43.8	Childhood	Partner	0	Secondary	Diet/gastric band
WDI18	33	40.3	Adolescence	Single	0	No studies	Diet/pickups
WDI19	42	40.7	Childhood	Married	2	Secundarios	Diet/pickups
WDI20	45	43.1	Childhood	Married	1	Primary	Diet/pickups
WDI21	28	40.3	Childhood	Partner	0	Secondary	Diet/pickups

Abbreviations: BMI, body mass index; IGB, intragastric balloon.

TABLE 2 Interview protocol

Stage	Subject	Content/example questions
Introduction	Motives, reasons	Learn about your experiences in your sex life since your inclusion in a bariatric surgery program
	Ethical issues	Inform about voluntary participation, recording, consent, possibility of withdrawing, confidentiality
Beginning	Introductory question	Tell me about your experience of MO
Development	Conversation guide	How has MO affected your sexuality? How has it affected your relationship to your friends and social relations? How has MO affected the changes in the image of your body? How has MO affected your life with your partner?
Closing	Final question	Is there anything else you would like to tell me?
	Appreciation	Thank them for their participation, remind them that their testimony will be useful, place ourselves at their disposition

Abbreviation: MO, morbid obesity.

were audio recorded, transcribed and analysed with ATLAS.ti. 8. The codification process was developed by three members of the research team (JMHP, ARM, MDRF) and agreed upon by the rest of the research team. Data collection ceased when researchers considered that data saturation had been reached.

2.5 | Data analysis

Thematic analysis was used (Braun & Clarke, 2006), the following steps were followed: (1) Getting familiar with the data: transcription of the data, reading and re-reading, and annotation of initial ideas. (2) Generating initial codes: systematic coding of data groups. (3) Theme search: converting codes into themes. (4) Review of themes: checking code fit with themes. (5) Defining and naming topics: analyzing by fine-tuning the details of each topic. (6) Preparing the report: selecting examples of topics and subtopics, relating the analysis to a research question, and generating a final report.

2.6 | Rigor

To ensure trustworthiness (Lincoln et al., 1985), the criteria for credibility, transferability, dependability and confirmability were taken into account in this study. The researchers were nurses and surgeons with experience in bariatric surgery and sexuality, and it is common to detect problems with sexuality in the bariatric surgery consultation. With the aim to achieve rich data, intentional sampling allowed for a selection of participants with a wide range of characteristics; a qualitative descriptive study ensured the congruence between the methodological positioning and the methods (Caelli et al., 2003). In order to improve credibility, researchers checked and confirmed the interpretations of the interviews. The researchers had a long-standing dedication to research, and the interviews were carried out by nurses with experience in a bariatric surgery program. Transferability was achieved by providing detailed descriptions of the experiences and contexts of the participants during data collection. Dependability was ensured through detailed descriptions of every methodological decision taken throughout the research process. An audit trail was included in the textual transcriptions, the structure of the categories, the field notes and the codification memoranda throughout the study. Confirmability was achieved through including detailed descriptions using extracts of data from the findings.

2.7 | Ethical considerations

The study was carried out in accordance with the ethical standards established by the Helsinki Declaration. Approval was obtained from the Ethics and Research Committee (protocol number...). Before commencing the study, written informed consent and permission to record the interview were obtained. If the researchers detected that the participants were uncomfortable or distressed, the latter were able to choose not to respond to the questions and the interview was paused, at which point the participants were asked whether they wanted to continue with the study. Participants were informed that their participation in the study was independent of the bariatric surgery program. Refusal to participate or withdrawal would not influence their therapeutic or care process.

3 | FINDINGS

Twenty-one women, with an average age of 40.4 years old (SD = 8.37), were recruited. Their average BMI was 42.34 ± 2.96 kg/m^2, and the majority had been diagnosed with MO during adolescence (33.3%) or childhood (28.6%). Forty-seven percent of the sample were married, and 57% had one or more children. Three themes

TABLE 3 Themes, subthemes and units of meaning

Theme	Subtheme	Units of meaning
3.1 Trapped in a body that limits my sexuality	3.1.1 The body as an obstacle	Changes in mobility, limitation of sexual positions, searching for comfort, negative body image
	3.1.2 Retreating within oneself	Low self-esteem, insecurity, rejection of obesity, fear, frustration, introspection
	3.1.3 Obesity, an impediment to sexuality	Body rejection, avoiding coitus, sexual dissatisfaction, do it for him, sex as an outlet for the partner, dyspareunia, less lubrication, no orgasm
3.2 Between neglect and hope	3.2.1 Facing social stigma	Limitations in daily life, rejection of obese people, comments, resilience, puritan panties
	3.2.2 Accepting the consequences and adapting sexual practices	Preserving sexual desire, facing changes, need for sex in my life, hope in surgery
	3.2.3 Managing uncertainty, when the body overtakes the mind	He does not want me due to my physical appearance, it is all in my head, guilt, I do not give him what he deserves, loss of communication, decline in affection, fear of being left
3.3 The partner as a source of support for sexuality in women with morbid obesity	3.3.1 Sharing experiences and reaching agreements	United until surgery, support in the decision-making process (partner), share fears, assess and accept risks and consequences, desired and respected, tolerating abstinence (partner)

and seven subthemes allowed for a description and understanding of the experiences of sexuality amongst women with MO included in a bariatric surgery program (Table 3).

3.1 | Trapped in a body that limits my sexuality

Obesity compromised the physical, mental and social health of women with MO in a bariatric surgery program. Influenced by their body image, they struggled to have a positive relationship with themselves, with their partner, and with their social group. This situation has had significant consequences and brought impediments to their sex lives with their partners.

3.1.1 | The body as an obstacle

Our participants recounted how their bodies gradually transformed and limited their movement during sexual relations. The loss of physical movement was a barrier that prevented them from having a fully developed sense of sexuality. The women also associated MO with a lack of exercise, inactivity, muscular weakness and osteoarthritis, which all generate fatigue, dyspnoea and post-coital pain. One participant expressed these limitations as follows:

> I weigh a lot, I get tired easily … I suffocate him (partner). Positions like me sitting on top of him are difficult due to my belly; even if we try it, it's impossible. (WDI1)

Despite the efforts to adapt, the sexual experiences were tainted by a constant awareness of their body image. Skin folds require special hygiene care as there is a risk of chafing, reddening or foul odour. This situation can cause discomfort, distraction, loss of sexual desire and sexual dissatisfaction in women. For example, one woman said:

> Under the abdomen, under the breasts, when you move you sweat between the folds of the skin, and this can smell bad. You are distracted, aware of your body, … not enjoying yourself. (WDI17)

The women also knew, through the media or other patients that, after bariatric surgery, they might still have excess skin or scars. Although this can affect body image and sexuality, they asked about it in a pre-surgical consultation, but they did not insist or request details. As one participant said, what they wanted now was to lose weight, and they did not worry about the rest: *I know that there may be scars, remnants of skin…, but I'll think about this after surgery, when I go to the beach* (WDI-6).

3.1.2 | Retreating within oneself

The stigma of their weight became internalized, and the participants experienced it in their daily lives, in their interaction and social relations. Many participants felt insecure about their bodies; when they looked at themselves in the mirror, they did not like what they saw and felt feelings of inferiority and low self-esteem. This situation led them to rejecting obesity and themselves, and to feeling less desire to engage in sexual relations. This may reflect the value that society placed on them, rather than their feelings about their own worth. Nevertheless, the women neither fooled nor pitied themselves, and as one participant said, they knew exactly what their problem was.

> I don't feel ugly, I feel fat … the word is fat. I have always undervalued myself but now this feeling of inferiority overwhelms me. (WDI5)

For many women, MO became an insurmountable obstacle for leisure activities such as going to the beach, going for a walk, or going out with friends; it trapped them, confined them to their homes, and took them away from work, their daily routine and their social lives. During this phase, their experiences were centered on comparing their current situation (including sexuality) with their past life, which led to feelings of frustration. As one of the participants stated, they were immersed in a process of introspection that gradually secluded them, prevented them from presenting themselves to others in the way that they would have liked, and this ultimately had consequences on their sexuality.

> I no longer do what I used to do, you lose spontaneity … you make excuses to not have to leave the house, for everything … I'm embarrassed to show myself (in front of others), I'm trapped in my body, which is like a prison. (WDI11)

3.1.3 | Obesity, an impediment to sexuality

MO can be an insurmountable obstacle for a woman's sex life; dissatisfaction with her body affects sexual encounters negatively and can even lead to her rejecting sex. According to the interviews, the women were aware of their body image during sexual relations, they were always tense and failed to relax or enjoy sex. They rejected a body from which they could not detach themselves, and their sexuality was marred by anxiety, lack of concentration and discomfort. As they scrutinized their bodies, they feared that they would pass these feelings on to their partner, and, as a result, they lost interest and confidence. As one participant said:

> I'm not comfortable, sometimes I don't reach orgasm because I'm thinking: how embarrassing, look at my tummy! … Even though he (partner) doesn't say anything, he must be thinking the same as me … that's why if I can avoid it (intercourse), I do. (WDI15)

Although at the beginning this type of avoidance behaviour was more sporadic, it became much more common in the women with MO awaiting bariatric surgery. The loss of desire and lack of sexual appetite did not come from their partners but the women themselves. Some women forgot about their own sexuality to solely focus on that of their partner. Despite coming across as communicative and confident, women faked their arousal and desire in order to please their partners. As one participant explained, they did not want sexual relations but they forced themselves into having sex for the sake of their partner's enjoyment: *He suggests having sex, and we have it at least once a month but not because of me…. I do it for him, because I know he needs it even if he doesn't say so* (WDI3).

For the women, this phase of MO was characterized by dyspareunia, lack of arousal and lubrication and difficulty reaching orgasm. In addition, hormonal disorders and menstrual irregularity may have also complicated the couple's sex life. As one woman said, these difficulties were also experienced by their partners: *Lately, I have noticed more dryness, discomfort during coitus, sometimes I feel more pain, and he does too, even though he doesn't say anything* (WDI6).

3.2 | Between neglect and hope

Women with MO felt ambivalent about their experiences of sexuality. They either preserved their sexuality, adapting it as necessary, or it progressively deteriorated to the point of being lost completely. While waiting for bariatric surgery, the women attempted to adapt to the great high tension between them and their partners.

3.2.1 | Facing social stigma

Body image disorders are linked to social stigma and difficulty in relationships. The women with MO perceived stigma as a problem when looking for a partner, as it had a negative impact on their sexuality. Participants felt stigmatised by strangers and even people close to them in their social or work environment due to perceived gestures, looks and comments about their physical appearance. This situation increased their feelings of fear, insecurity, frustration and social isolation. Our participants described how they forced themselves to make changes in their own behavior to be more accepted; they tried to be more open, assertive or affectionate; however, the majority of the time, the situation did not change. In other situations, it was the women who become obsessed with the idea that other people were looking at them and rejecting them due to their MO. As one of the participants stated, they always feel observed: *They don't look at my bum or boobs with desire, they look at me because I'm fat* (WDI1).

The situation was more difficult for women who were single, divorced, or without a stable partner. Many of them barely left home out of shame and took refuge in their family. However, they still had sexual needs, and despite fear and uncertainty, they strived to find a partner, even lowering their aspirations (in men). Although they had been obese since adolescence and were used to it, having sexual relations with a person they hardly knew made everything much more difficult. This is how one woman described it:

> There is no trust, at first you feel very uncomfortable, afraid. What embarrasses me the most are my tits, … that they see such big tits. I say no, don't take my bottom t-shirt off me! (WDI10)

Self-rejection led to some women having problems in coping with relationships and facing daily activities such as buying clothes. MO limited them to buying in shops with large sizes, choosing from very few styles and buying unfashionable clothing. They could not choose the clothes that they liked, so they made clothes themselves or they bought them on the internet and asked a seamstress to adapt them. These limitations also marked their sexual lives as they did not find

themselves attractive. As one participant said, they did not buy sexy clothes, they did not try to look sexy, and they felt depressed:

> I got tired of looking for sexy clothes, there are none for me. You are forced to put on your usual puritan panties … you gradually lose any illusion of sex appeal. (WDI13)

Clothing is a key factor that pushed them to lose weight and consider surgery, with one participant saying it acted as a detonator, making them face a situation which was important to them: *The clothes just sat in the wardrobe, too small, not wearable, out of fashion … I no longer care!* (WDI3).

3.2.2 | Accepting the consequences and adapting sexual practices

For some women with MO, sexuality continued to be a key part of their lives; as with food, clothing and leisure, they confronted the situation by trying to normalize it. Putting on weight made sexual relations more difficult, but it did not prevent them from having intercourse. They maintained interest in sex and still felt desire; they looked for satisfaction and were able to reach orgasm. For some of the participants, sex continued to be a necessity that they were not willing to relinquish:

> I don't have a problem with being fat, we accept it (partner), we want to do it (intercourse), for me it's essential, I couldn't live without sex. (WDI19)

Women and their partners had to refocus their sexual relations by coming to an agreement to make any necessary adjustments and looking for more comfortable positions. This could be a positive indicator of the couple's maturity, due to their ability to discuss problems and seek solutions for a healthy sex life. As one participant said, she had to look for new adventures, encouraging alternative sexual experiences:

> I can't do it with me on top (intercourse), if I get on all fours, he can't get there. But the hands … they go everywhere! You can do many things with your hands. (WDI8)

Despite never completely relaxing (more for single women or those without a stable partner), our participants managed to feel comfortable when being naked or being seen naked by their partners. If the woman made an effort to maintain her sexuality, to show herself off, her partner responded, they continued to appear attractive, and this was a sign of hope. For example, one participant said:

> When I get out of the shower naked I allow him to see me, look at me, talk to me and touch me (my partner), but it's difficult because I don't like myself! (WDI18)

Women with MO put their hopes in bariatric surgery and thought that it would improve their health, sexuality and quality of life. They expected improvements in physical mobility, body image and social acceptance. They also believed that it would help them to accept themselves and feel more confident and more desired. One of the participants commented that her partner also shared her hopes to improve their sex life after the operation, and they had taken surgical decisions together because they saw it as a shared objective:

> (Surgery) is one of the few dreams we have. When we feel scared, to put ourselves at ease, I say to him: just wait and see, when I've lost all that weight, penetrative sex is going to be better … just wait and see! (WDI14)

3.2.3 | Managing uncertainty when the body overtakes the mind

Participants appeared to have experienced their relationships solely through the lens of body weight. The women were convinced that their partners had hidden negative thoughts about their bodies, and that they were with them only because they felt affection towards them and the time they had spent together. In their opinion, this feeling of resignation was what most pushed them toward bariatric surgery:

> I feel that he is acting strange. I think that he sees me as so being fat that he doesn't feel attracted to me…. I want to get the operation as soon as possible! (WDI13)

Even when the participants lived together as a married couple, the women felt a false sense of security and feared being left. They were afraid that due to a lack of sexual relations their partners would get tired and cheat on them with other women, and so jealousy jeopardised their relationship.

> We have sex, yes, but it's bad and sporadic and … jealousy (she inhales). I can't stop thinking that he is with another woman, that he doesn't want to be with me, that he's going to leave me… (WDI7)

Some women stated that the loss of physical contact led to a loss of communication and affection from their partner. They felt that when they most needed their partners to be involved with their illness, they became distant. In these circumstances, some women said they needed medical help and were treated with antidepressants, which worsened their sex life.

> The pills raise the mood, but not the libido. I was lying on the couch all day, not wanting anything, least of all sex. (WDI15)

When they did not feel a sense of support, they convinced themselves even more that the solution was bariatric surgery. One participant describes it like this: *He's no longer affectionate or expressive he doesn't give me a hug when I'm feeling down … yes, I need to do something now! Surgery will help me* (WDI5).

3.3 | The partner as a source of support for sexuality in women with MO

Despite periods of doubt, women's sexuality involved their partner, and both experienced significant changes. The women put into words the support that they received from their partners in relation to sexuality.

3.3.1 | Sharing experiences, reaching agreements

For women with MO in a bariatric surgery program, their partners were fundamental support figures. Their positive attitude was necessary for the women's self-acceptance and coping mechanisms. Our participants depended on their support to be able to express themselves freely regarding their sexuality, saying what they liked and what made them uncomfortable. The interviewees described the positive consequences of their partners not feeling embarrassed by them in public places, holding their hands, giving them a kiss and encouraging them to get dressed up and wear pretty/sexy clothes. As one participant explained, they felt loved, desired and respected, which was an invaluable source of support for these women.

> He (partner) is always telling me not to worry, that he met me like this, that he loves me like this … that he still likes me physically and that he doesn't worry about my body! (WDI2)

When many positions were impossible, and difficulties in having sexual relations increased, women and their partners adapted their behaviour to improve their sex life. Although most denied it, some participants commented that they resorted to sex toys.

> We had thought about it several times but we didn't dare. One day my husband went to a sex shop and bought (sex) toys … well, well (laughs). (WDI19)

According to the female participants in the study, MO also interfered with the partner's (man's) sexuality, but they accepted it, learnt from it, and adapted to living with their partners' bodies and new sex lives. The partner shared their worries regarding the risks associated with MO, especially bariatric surgery; but they supported the women's decisions and encouraged them to undergo surgery. As the women were not ready for sexual relations, the partner accepted long periods of sexual abstinence, hoping that the situation would change after surgery. This situation was especially worrying to participants, who clearly recognised it:

> I don't feel great about myself, and of course that affects him (partner) too, but he tells me: Don't worry about me, if you choose to have the surgery its for your own health. I've never demanded anything, I manage fine (sexually), I feel fine with you. (WDI18)

4 | DISCUSSION

The aim of our study was to explore and describe the experiences of sexuality among heterosexual women diagnosed with MO and in a bariatric surgery program. The theoretical framework of Verschuren et al. (2010) allowed us to study MO as a chronic disease that affects women on a physical, psychological, and relationship level, impairing their sexual wellbeing and quality of life. In line with the OECD (2019, p. 103), our results also confirm the importance of sociocultural and educational aspects related to MO. Concurring with Mariano et al. (2014), participants stated that MO caused physical limitations, hindering mobility and making sexual positions difficult, thus making their bodies a severe obstacle in relation to their sexuality. Similarly to men with MO, the women reject a body that limits their physical, social and sexual lives (Granero-Molina et al., 2020). Dissatisfaction associated with physical and psychological complexes (Mantelo et al., 2014), together with the woman's body image insecurity, lead to low self-esteem (Yazdani et al., 2018) and prevent the enjoyment of sexuality.

Sexual well-being refers to the person's subjective experience of sexuality and how it is evaluated in the context of their personal relationships (Verschuren et al., 2010). In accordance with Mantelo et al. (2014), social and cultural factors also affect sexual life. Along these lines, our participants felt stigmatized and suffered rejection in their closest social groups (Albano et al., 2019; Brewis, 2014). Although overweight children/youth are at higher risk of feeling excluded or bullied (one in five obese girls report being victims of bullying, OCDE, 2019, p. 25), the study's participants do not refer to abuse in childhood or at the hands of their partners.

Türkben and Kaplan (2020) found a positive correlation between self-esteem and the quality of sex life in women with MO. In alignment with our results, women with MO sometimes discriminate against themselves (Abrahamian & Kautzky-Willer, 2016), and this leads to dissatisfaction and favors FSD (Taskin et al., 2019). Furthermore, women with MO may have symptoms of depression, and antidepressant medication is associated with poorer sexual function (Steffen et al., 2017). The link between body image and sexual function may explain the hope women place on bariatric surgery (Quinn-Nilas et al., 2016; Taskin et al., 2019). Low self-esteem is an indicator of despair amongst patients included in a bariatric surgery program, (Gaudrat et al., 2021). Therapeutic objectives should be defined for each individual patient prior to bariatric surgery, and realistic expectations should be laid out (Hering et al., 2018). Although

people with MO worry about excess skin after bariatric surgery (Kabu & Özbayır, 2021), the participants address this after the intervention as their key focus is weight loss.

As with other chronic diseases (Granero-Molina et al., 2018), the partner is the key support figure for sexuality in women with MO. As in other studies on bariatric surgery (Pories et al., 2016), our participants share experiences and reach agreements with their partners, thus improving intimacy. According to other studies, the partner joins in the struggle against obesity (Ledyard & Morrison, 2008), and this may be a factor that helps to protect them in their marriage (Abidin et al., 2016). The majority of women feel supported by their partners, sexuality forms part of their shared life, and they continue to feel desired. However, they also fear losing their sensuality and male desire towards them (Abidin et al., 2016); they focus on satisfying their partner (Steffen et al., 2019).

In line with Wingfield et al. (2016), our participants place all of their hopes on bariatric surgery. The resulting improvement in self-esteem and body image are associated with positive impacts on female sexual function (Nilsson-Condori et al., 2020). Various studies demonstrate improvements in FSD after bariatric surgery (Pichlerova et al., 2019; Sarwer et al., 2012), together with an increase in frequency, sexual satisfaction (Jiménez et al., 2014), comfort between the couple (Kabu & Özbayır, 2021) and sexual positions during sexual relations (Oliveira et al., 2019). Nevertheless, patients should have follow-ups after bariatric surgery to prevent or detect despair (Gaudrat et al., 2021). In addition, surgery is more effective when it is accompanied by lifestyle changes and a commitment between the couple (Landecho et al., 2017). In order to improve the way women with MO included in a bariatric surgery program cope with, learn about, and care for sexuality, a better understanding of their expectations and experiences is needed (Poulsen et al., 2016). This study has helped to reveal problems which should be taken into account by healthcare providers when giving advice in their medical or nursing consultations (Erenel & Kılınc, 2013).

4.1 | Limitations

Although it is more and more present in social discourse, Catholic morality in Spain makes sexuality a difficult topic to address and may have been responsible for the interviews not being longer. A descriptive design justifies the fact that follow-up interviews were not carried out. Although purposive sampling was used to look for maximum variation, we were not able to recruit women <28 years old. The interview protocol did not include specific questions about a patient's history or sexual abuse trauma. The inclusion of participants from other ethnic groups in the study may have led to different results. All participants declared they were heterosexual and monogamous, and findings could be different for people with other types of sexual orientation (e.g. homosexual) or when both members of the couple have MO. Another significant limitation is not having obtained the perspective of the participants' partners.

5 | CONCLUSION

This study has highlighted the complexity of female sexuality in MO. Our findings point to the presence of physical and psychological limitations, coupled with social stigma and comorbidities. Personal, cultural and social factors may contribute to stigmatization, both from the women themselves or those around them. Some women experience self-image disorders, neglect, and a need to hide their bodies, which may lead to a form of sexuality that is borrowed and excluded. Some women focus their sexuality on satisfying their partners, whom they fear they will lose. However, the findings are not homogenous; as in the case of other women, sexuality continues to be important for their identity and quality of life. MO causes severe limitations on a woman's sexual life; adaptation and coping mechanisms lack not only social and professional support but, sometimes, also that of their partners. In this advanced phase of MO, the women need support, understanding and counselling. The decision-making process, shared with the women's partners, is focused on bariatric surgery, upon which the women place all of the hopes of an improvement in their sexuality and quality of life.

5.1 | Implications for practice and/or policy

- Sexuality in women with MO in a bariatric surgery program is an issue that must be explored. Bariatric surgical nurses have a privileged position in assessing these women's sexuality as well as that of their partners.
- Nurses can recommend alternative practices to sexual intercourse (positions, sex toys…), that improve the sex life of the women with MO and that of their partners. They can also refer them to specialists such as sexologists.
- The women with MO and their partners' high expectations of an improvement in their sex life following bariatric surgery should be managed by the multidisciplinary team in the pre-operative phase so that they are not left frustrated after the surgery.

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CONFLICT OF INTERESTS

The authors declare no conflict of interest.

AUTHOR CONTRIBUTION

MJTS and MSN collected data and wrote the article. JGM designed the study, revised data and wrote the article. MFM analysed data and reviewed the study. CFS designed the study, analysed data and critically reviewed the manuscript. ARM analysed data and critically reviewed the manuscript. MDRF analysed data and critically reviewed the manuscript. JMHP participated in the data analysis,

drafting and critical review of the manuscript. All authors read and approved the final version of the manuscript.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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REFERENCES

Abidin, A., Draman, N., Ismail, S. B., Mustaffa, I., & Ahmad, I. (2016). Female sexual dysfunction among overweight and obese women in Kota Bharu, Malaysia. *Journal of Taibah University Medical Sciences*, *11*, 159–167. https://doi.org/10.1016/j.jtumed.2016.01.009

Abrahamian, H., & Kautzky-Willer, A. (2016). Sexuality in overweight and obesity. *Wiener Medizinische Wochenschrift*, *166*, 121–128.

Albano, G., Rowlands, K., Baciadonna, L., Lo Coco, G., & Cardi, V. (2019). Interpersonal difficulties in obesity: A systematic review and meta-analysis to inform a rejection sensitivity-based model. *Neuroscience & Biobehavioral Reviews*, *107*, 846–861. https://doi.org/10.1016/j.neubiorev.2019.09.039

Annesi, J. J. (2018). Exercise predicts long-term weight loss in women with class 1 and class 2 obesity through effects on emotional eating and its correlates. *Journal of Physical Activity and Health*, *15*, 57–63. https://doi.org/10.1123/jpah.2017-0170

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brewis, A. A. (2014). Stigma and perpetuation of obesity. *Social Science Medicine*, *118*, 152–158.

Broughton, D. E., & Moley, K. H. (2017). Obesity and female infertility: Potential mediators of obesity's impact. *Fertility and Sterility*, *107*(4), 840–847. https://doi.org/10.1016/j.fertnstert.2017.01.017

Burggraf, C., Teuber, R., Brosig, S., & Meier, T. (2018). Review of a priori dietary quality indices in relation to their construction criteria. *Nutrition Reviews*, *76*(10), 747–764. https://doi.org/10.1093/nutrit/nuy027

Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as mud': Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods*, *2*(2), 1–13. https://doi.org/10.1177/160940690300200201

Castellanos-Torres, E., Álvarez-Dardet, C., Ruiz-Muñoz, D., & Pérez, G. (2013). Social determinants of sexual satisfaction in Spain considered from the gender perspective. *Annals of Epidemiology*, *23*(3), 150–156. https://doi.org/10.1016/j.annepidem.2012.12.010

Dubern, B., Clément, K., & Poitou, C. (2017). Genetics of obesity. In J. Weaver (Ed.), *Practical guide to obesity medicine* (pp. 153–161). Elsevier.

Erenel, A. S., & Kilınc, F. N. (2013). Does obesity increase sexual dysfunction in women? *Sexuality and Disability*, *31*, 53–62. https://doi.org/10.1007/s11195-012-9274-4

Gaudrat, B., Andrieux, S., Florent, V., & Rousseau, A. (2021). Psychological characteristics of patients seeking bariatric treatment versus those seeking medical treatment for obesity: Is bariatric surgery a last best hope? *Eating and Weight Disorders: EWD*, *26*(3), 949–961.

Granero-Molina, J., Matarín-Jiménez, T. M., Ramos-Rodríguez, C., Hernández-Padilla, J. M., Castro-Sánchez, A. M., & Fernández-Sola, C. (2018). Social support for female dysfunction in fibromyalgia. *Clinical Nursing Research*, *27*, 296–2314.

Granero-Molina, J., Torrente-Sánchez, M. J., Ferrer-Márquez, M., Hernández-Padilla, J. M., Ruiz-Muelle, A., López-Entrambasaguas, O. M., & Fernández-Sola, C. (2020). Sexuality amongst heterosexual men with morbid obesity in a bariatric surgery program: A qualitative study. *Journal of Clinical Nursing*, *29*, 4258–4269.

Hering, I., Stier, C., & Seyfried, F. (2018). Bariatric surgery: Expectations and therapeutic goals-a contradiction? *Der Chirurg*, *89*(8), 597–604.

Jiménez, C., Macías, P., Pérez, R., Cano, A., & Domínguez-Adame, E. (2014). Impacto de la cirugía bariátrica en la función sexual de la mujer [Impact of bariatric surgery on the sexual function of women]. *Bariátrica & Metabólica Ibero-Americana*, *4*, 590–595.

Kabu, H., & Özbayır, T. (2021). I am as normal as everyone now…: Examination of experiences of patients undergoing bariatric surgery according to Roy's adaptation model: A qualitative study. *Clinical Nursing Research*, *30*, 511–521.

Lammerink, E., de Bock, G. H., Pascal, A., van Beek, A. P., van den Bergh, A., Sattler, M., & Mourits, M. (2017). A survey of female sexual functioning in the general Dutch population. *The Journal of Sexual Medicine*, *14*(7), 937–949. https://doi.org/10.1016/j.jsxm.2017.04.676

Landecho, M. F., Valentí, V., Moncada, R., & Frühbeck, G. (2017). Eligibility and success criteria for bariatric/metabolic surgery. *Advances in Experimental Medicine and Biology*, *960*, 529–543.

Lecube, A., Monereo, S., Rubio, M. A., Martínez-de-Icaya, P., Martí, A., Salvador, J., Masmiquel, L., Goday, A., Bellido, D., Lurbe, E., & García-Almeida, J. M. (2017). Prevention, diagnosis, and treatment of obesity. 2016 position statement of the Spanish Society for the Study of Obesity. *Endocrinology, Diabetes and Nutrition*, *64*, 15–22.

Ledyard, M. L., & Morrison, M. C. (2008). The meaning of weight in marriage: A phenomenological investigation of relational factors involved in obesity. *Journal of Couple & Relationsship Therapy*, *7*, 230–247. https://doi.org/10.1080/15332690802237946

Lincoln, Y. S., Guba, E. G., & Pilotta, J. J. (1985). Naturalistic inquiry. *International Journal of Intercultural Relations*, *9*(4), 438–439. https://doi.org/10.1016/0147-1767(85)90062-8

Lyons, K., Meisner, B. A., Sockalingam, S., & Cassin, S. E. (2014). Body image after bariatric surgery: A qualitative study. *Bariatric Surgical Practice and Patient Care*, *9*, 41–49. https://doi.org/10.1089/bari.2014.0001

Mantelo, H. P., Nogueira, R. C., Trindade, C. A., & Marcon, S. S. (2014). Perceptions of obese women on sexuality. *Revista Mineira De Enfermagem*, *18*, 961–965.

Mariano, M. L., Paula, M. A., Bassi, D. G., & Paula, R. R. (2014). Bariatric surgery: Impact on sexuality of the obese person. *Revista do Colegio Brasileiro De Cirurgioes*, *41*, 412–420. https://doi.org/10.1590/0100-69912014006006

Mazer, L., & Morton, J. M. (2018). The obesity epidemic. In K. Reavis, A. Barrett, & M. Kroh (Eds.), *The SAGES manual of bariatric surgery* (pp. 81–92). Springer.

Mechanick, J. I., Kushner, R. F., Sugerman, H. J., Michael Gonzalez-Campoy, J., Collazo-Clavell, M. L., Spitz, A. F., Apovian, C. M., Livingston, E. H., Brolin, R., Sarwer, D. B., Anderson, W. A., Dixon,

J., Guven, S.; American Association of Clinical Endocrinologists; Obesity Society; American Society for Metabolic & Bariatric Surgery. (2009). American Association of Clinical Endocrinologists, The Obesity Society, and American Society for Metabolic & Bariatric Surgery Medical Guidelines for clinical practice for the perioperative nutritional, metabolic, and nonsurgical support of the bariatric surgery patient. *Obesity*, *17*, S1–S70.

Mechanick, J. I., Youdim, A., Jones, D. B., Garvey, W. T., Hurley, D. L., McMahon, M. M., Heinberg, L. J., Kushner, R., Adams, T. D., Shikora, S., & Dixon, J. B. (2013). Clinical practice guidelines for the perioperative nutritional, metabolic, and nonsurgical support of the bariatric surgery patient -2013 update: Cosponsored by American Association of Clinical Endocrinologists, the Obesity Society, and American Society for Metabolic & Bariatric Surgery. *Surgery for Obesity and Related Diseases*, *9*, 159–191.

Medina, F., Aguilar, A., & Solé-sedeño, J. M. (2014). Social and cultural aspects on obesity: Necessary reflections from public health. *Nutrición Clínica Y Dietética Hospitalaria*, *34*, 67–71.

Nilsson-Condori, E., Järvholm, S., Thurin-Kjellberg, A., Hedenbro, J., & Friberg, B. (2020). A new beginning: Young women's experiences and sexual function 18 months after bariatric surgery. *Sexual Medicine*, *8*(4), 730–739. https://doi.org/10.1016/j.esxm.2020.08.007

OECD (Organisation for Economic Co-operation and Development). (2019). *The heavy burden of obesity: The economics of prevention*. OECD Health Policy Studies, OECD Publishing.

Oliveira, C. F. D. A., dos Santos, P. O., de Oliveira, R. A., Leite-Filho, H., de Almeida Oliveira, A. F., Bagano, G. O., Lima Junior, E. B., Miranda, E. P., de Bessa Junior, J. & Barroso Junior, U. (2019). Changes in sexual function and positions in women with severe obesity after bariatric surgery. *Sexual Medicine*, *7*, 80–85. https://doi.org/10.1016/j.esxm.2018.10.001

Pichlerova, D., Bob, P., Zmolikova, J., Herlesova, J., Ptacek, R., Laker, M. K., Raboch, J., Fait, T., & Weiss, P. (2019). Sexual dysfunctions in obese women before and after bariatric surgery. *Medical Science Monitor*, *5*, 3108–3114. https://doi.org/10.12659/MSM.913614

Pories, M. L., Hodgson, J., Rose, M. A., Pender, J., Sira, N., & Swanson, M. (2016). Following bariatric surgery: An exploration of the couples' experience. *Obesity Surgery*, *26*(1), 54–60. https://doi.org/10.1007/s11695-015-1720-9

Poulsen, L., Klassen, A., Jhanwar, S., Pusic, A., Roessler, K. K., Rose, M., & Sørensen, J. A. (2016). Patient expectations of bariatric and body contouring surgery. *Plastic and Reconstructive Surgery Global Open*, *4*, e694. https://doi.org/10.1097/GOX.0000000000000677

Quinn-Nilas, C., Benson, L., Milhausen, R. R., Buchholz, A. C., & Goncalves, M. (2016). The relationship between body image and domains of sexual functioning among heterosexual, emerging adult women. *Sexual Medicine*, *4*, e182–e189. https://doi.org/10.1016/j.esxm.2016.02.004

Rowland, D. L., McNabney, S. M., & Mann, A. R. (2016). Sexual function, obesity, and weight loss in men and women. *Sexual Medicine Reviews*, *5*, 323–338. https://doi.org/10.1016/j.sxmr.2017.03.006

Sabench Pereferrer, F., Domínguez-Adame Lanuza, E., Ibarzabal, A., Socas Macias, M., Valentí Azcárate, V., García Ruiz de Gordejuela, A., García-Moreno Nisa, F., González Fernández, J., Vilallonga Puy, R., Vilarrasa García, N., & Sánchez Santos, R. (2017). Quality criteria in bariatric surgery: Consensus review and recommendations of the Spanish Association of Surgeons and the Spanish Society of Bariatric Surgery. *Cirugía Española*, *95*, 4–16. https://doi.org/10.1016/j.cireng.2016.09.015

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*, 334–340. https://doi.org/10.1002/1098-240X(200008)23:4<334:AID-NUR9>3.0.CO;2-G

Sarwer, D. B., Lavery, M., & Spitzer, J. C. (2012). A review of the relationships between extreme obesity, quality of life, and sexual function. *Obesity Surgery*, *22*, 668–676. https://doi.org/10.1007/s11695-012-0588-1

Sfahani, S. B., & Pal, S. (2019). Does metabolic syndrome impair sexual functioning in adults with overweight and obesity? *International Journal of Sexual Health*, *31*, 170–185. https://doi.org/10.1080/19317611.2019.1611688

Srivastava, G., & Apovian, C. (2018). Future pharmacotherapy for obesity: New anti-obesity drugs on the horizon. *Current Obesity Reports*, *7*, 147–161. https://doi.org/10.1007/s13679-018-0300-4

Steffen, K. J., King, W. C., White, G. E., Subak, L. L., Mitchell, J. E., Courcoulas, A. P., Flum, D. R., Strain, G., Sarwer, D. B., Kolotkin, R. L., Pories, W., & Huang, A. J. (2017). Sexual functioning of men and women with severe obesity before bariatric surgery. *Surgery for Obesity and Related Diseases*, *13*, 334–343. https://doi.org/10.1016/j.soard.2016.09.022

Steffen, K. J., King, W. C., White, G. E., Subak, L. L., Mitchell, J. E., Courcoulas, A. P., Flum, D. R., Strain, G., Sarwer, D. B., Kolotkin, R. L., Pories, W., & Huang, A. J. (2019). Changes in sexual functioning in women and men in the 5 years after bariatric surgery. *JAMA Surgery*, *154*, 487–498. https://doi.org/10.1001/jamasurg.2018.1162

Taskin, F., Karakoc, A., & Demirel, G. (2019). The effect of body image on sexual quality of life in obese married women. *Health Care for Women International*, *40*, 479–492. https://doi.org/10.1080/07399332.2018.1542432

Türkben, H., & Kaplan, E. (2020). Self-esteem and sexual quality of life among obese women. *Perspectives in Psychiatric Care*. https://doi.org/10.1111/ppc.12660

Verschuren, J. E. A., Enzlin, P., Dijkstra, P. U., Geertzen, J. H. B., & Dekker, R. (2010). Chronic disease and sexuality: A generic conceptual framework. *Journal of Sex Research*, *47*, 153–170. https://doi.org/10.1080/00224491003658227

Westermann, S., Rief, W., Euteneuer, F., & Kohlmann, S. (2015). Social exclusion and shame in obesity. *Eating Behaviors*, *17*, 74–76. https://doi.org/10.1016/j.eatbeh.2015.01.001

Wingfield, L. R., Kulendran, M., Laws, G., Chahal, H., Scholtz, S., & Purkayastha, S. (2016). Change in sexual dysfunction following bariatric surgery. *Obesity Surgery*, *26*, 387–394. https://doi.org/10.1007/s11695-015-1937-7

World Health Organization (WHO). (2017). *Obesity and overweight*. Retrieved from http://www.who.int/mediacentre/factsheets/fs311/es/

Wu, Y. K., & Berry, D. C. (2018). Impact of weight stigma on physiological and psychological health outcomes for overweight and obese adults: A systematic review. *Journal of Advanced Nursing*, *74*, 1030–1042. https://doi.org/10.1111/jan.13511

Yazdani, N., Vahid, S., Amini, M., Sobhani, Z., Sharif, F., & Khazraei, H. (2018). Relationship between body image and psychological well-being in patients with morbid obesity. *International Journal of Community Based Nursing and Midwifery*, *6*, 175–184.

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