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Research Article

Exploring The Lived Experience of Married Women with Female Sexual Dysfunction: A Mixed Method Design

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Abstract

Background: Sexual dysfunction refers to a problem that occurs during the sexual response cycle that prevents the individual from experiencing satisfaction from sexual activity.

- Aim of the study: was to explore the lived experience of married women whohave female sexual dysfunction. **Materials and Methods:** a mixed method design was utilized for the study**,** a purposive sample of 20 women were recruited for the current study. The study was conducted at Al Kasr Al Aini University hospital. Three tools were utilized for data collection; personal background questionnaire, Arabic version Female Sexual Index (AvFSDI) and unstructured open ended questionnaire interview .Research ethics approval was obtained to conduct the study.

Results: The participants' age ranged from 26-40 years with. The duration of marriage ranged from one year and six months to seventeen years, Eight major themes were extracted, as follows; experience of sexual complaints, expressing meaning of sexuality, cultural norms, social and interpersonal stressors, communication, mutual relation, impact of female sexual dysfunction on different life aspects, and seeking-help and advice.

Conclusion: female sexual dysfunction was prevalent among women who are working. most of the participants complained of several sexual problems and lack of satisfaction. All the study participants believed that their sexual complaints had affected negatively on their biopsychosocial aspects of their life.

Recommendation: Sex education programs and counseling must be included in primary health care settings,

Key Words: Female sexual index, the lived experience, Female sexual dysfunction,

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Introduction and Review of Literature

Sexual function is a complex interaction of neurovascular and endocrine actors. It is influenced by biological characteristics, interpersonal relationships, and also the cultural and traditional factors of the persons (Tahrani, Farahmand, Simbar, &Afzali, 2014). Sexual function is an essential component of life. For this reason, sexual dysfunction can have a negative impact on the wellbeing of an individual (McCool, et al., 2016).

Sexual dysfunction encompasses a disturbance in sexual functioning involving one or more phases of the sexual response cycle, including pain associated with sexual activity. Classifications are still evolving; they are a real nosographic "work in progress." Historically, two classification systems have been used for sexual medicine diagnosis: the Diagnostic and Statistical Manual of Mental Disorders (DSM), edited by the

American Psychiatric Association, and the International Classification of Diseases and Statistics (ICD), endorsed by the World Health Organization (WHO). In addition, throughout the past decades, sexual medicine experts from various international societies have been constantly working to revise and redefine the nomenclature of female sexual dysfunctions (FSDs), in order to reflect the updated scientific evidence and the ever-changing standards in clinical care for women with sexual problems (Parish et al 2021).

The manual's fifth and most recent edition (*DSM-5*) describes seven main disorders of sexual dysfunction. Four disorders apply to males only: delayed ejaculation, erectile disorder, male hypoactive sexual desire disorder, and premature (early) ejaculation. Three disorders apply to females only: female orgasmic disorder, female sexual interest/arousal disorder, and genito-pelvic pain/penetration disorder. In addition, three additional diagnoses can apply to both sexes: substance/medication-induced sexual dysfunction, other specified sexual dysfunction, and unspecified sexual dysfunction (Shepardson & Carey, 2016).

In relation to the prevalence of FSD, approximately 40% of women will experience some type of sexual problem over the course of their lifetimes (lidost et al., 2021). Sexual complaint is diagnosed as a dysfunction when the criteria from the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) for sexual dysfunctions are met and it results in personal distress. Although sexual complaints among women are common, the largest and most recent epidemiologic survey places the prevalence of diagnosable sexual disorders at approximately 12% (World Health Organization WHO, 2019)

The most prevalent sexual dysfunction in women across all ages is a lack of sexual desire, previously referred to as hypoactive sexual desire disorder in the DSM 4th Edition, Text Revision (DSM-IV-TR) and female sexual interest and arousal disorder in the DSM5th Edition (DSM-5). Women with hypoactive sexual desire disorder may report little or no interest in sex, an inability to respond to sexual stimuli, or feeling numbness despite havinga good relationship with her partner (Goldstein et al, 2017, Kingsberg & Woodard, 2015; and American Psychiatric Association APA 2013).

Moreover, Goldstein et al, (2017), their study to examine the prevalence and risk factors of female sexual dysfunction, concluded that, FSD is common in the general population and influenced by psychosocial factors with different patho-etiologies underlying recent and lifelong FSD. Grewal et al. (2014), in their study of the prevalence and risk factors of female sexual dysfunction (FSD) among 201 women working as healthcare personnel in selected 3 large healthcare facilities in Malaysia, found that one in eighteen female healthcare personnel suffered from FSD.

Additionally; the global online sexuality survey (GOSS) assess the prevalence and causes of female sexual dysfunction among internet users in the reproductive age group in the middle; the result reveals that, 59.1% of 344 of women participants were suffering ofFSD (Shaeer, Shaeer, & Shaeer, 2011). Moreover, Khreisat et al. (2018) also assess Prevalence and associated risk factors of female sexual dysfunction among Jordanian women, the findings showed that FSD in Jordan is about 64.7%, the desire disorders are the most prevalent domain of FSD, and age is the most significant risk factor for FSD.

Causes of sexual problems are varied and complex. Some problems stem from a simple, reversible physical problem, and others can stem from more serious medical conditions, difficult life situations, or emotional problems. Others have a combination of causes such as relationship problems, Disturbance in other aspects of the relationship; as distribution of labor, childrearing, or money. Such problems can prevent a woman from communicating her sexual wants and needs to her partner. Emotional problems; depression, anxiety (about sex or other things), stress, resentment, and guilt canall affect a woman's sexual function. Lack of knowledge about sexual stimulation and response, and poor communication between partners may prevent a woman from achievinga satisfactory experience and lead to FSD (Stöppler, 2015; Swierzewski, 2015).

Sexual dysfunction in women is a common and often distressing problem that has a negative impact on quality of life and medication compliance. The problem is often multi- factorial, necessitating a multidisciplinary evaluation and treatment approach that addresses biological, psychological, socio-cultural, and relational factors (Faubion, & Rullo, 2015).

Furthermore, a biopsychosocial approach that simultaneously considers physical, psychological, sociocultural, and interpersonal factors is necessary to guide research and clinical care regarding women's sexual function. Psychosocial variables, such as availability of a partner, relationship quality, and psychological functioning, play an integral role in women sexual function. Future directions for research should include deepening our understanding of how to optimize women's sexual function. Overall, holistic, biopsychosocial approaches to women's sexual function are necessary to fully understand and treat this key component of women's well-being (Thomas & Thurstonb, 2016).

Sexual desire disorders had classified into two sub types; hypoactive sexual desire disorder, and hyperactive sexual desire disorder. Hypoactive desire is the most common sexual problem, and it occurs when there is a persistent lack of desire or absence of sexual fantasies. Hypoactive sexual desire is classified according to its cause to psychogenic; due to marital relationship conflict, communication problems, anger, lack of trust, lack of connection, lack of intimacy, and working and overwhelmed females. Also, certain medications such as antihypertensive drugs, antidepressant, using of birth control pills; after menopause among woman under hormonal replacement therapy (HRT), all of these factors can decrease the sexual desire (Stöppler, 2015; Dhar, 2013)

There are scattered qualitative research that examine experience of women with female sexual dysfunction. In a study conducted by Sutherland (2012) that, explored the experience of sexual discomfort in married women and its causes and consequences, aswell as coping mechanisms used to deal

with or minimize this discomfort, concluded that, all women in the study complained of terrible and negative stressing effect of their sexual dysfunction on their intrapersonal, interpersonal, mutual, marital, and spiritual relations of them.

Significance of the study

In Egypt, most of the studies reported that, FSD became to be prevalent amongu clinic at Cairo university hospital on 361 women aged from 18-42 years old, showed that, 57.3% of the sample had sexual problems such as lack of sexual satisfaction, vaginal dryness, lack of orgasm, pain during sexual activity, lack of sexual desire, and lack of genital sensation during sexual activity (47.8%, 42.9%, 36.01%, 32.7%, 25.5%, and 15.8% respectively) (Afefy, 2015).

When a woman has a sexual problem, it can affect many aspects of her life including her personal relationships and her self-esteem. Many women are hesitant to talk about their sexuality with their health care professionals, and many health professionals are reluctant to begin a discussion about sexuality with their patients. Instead, women may needlessly suffer in silence when their problems can be treated. This study may assist health care providers including nurses to enhance their understanding of female clients with sexual dysfunction, which in turn, may lead to more effective therapeutic interventions.

Moreover, participants to understand themselves and their experience could also use the findings obtained in this study. Finally, the results obtained are expected to advance theoretical and empirical knowledge in the area of sexology to assist the health care providers in understanding their clients better and to develop more effective treatment strategies. There is a gap in the literature regarding the experience of women with sexual dysfunction as most research deals with prevalence and types or effects of certain medication or diseases on the level and pattern of female sexual dysfunctions. Therefore, this study aims to explore the lived experience of married women with sexual dysfunction.

Aim of the study

The aim of this study was to explore the lived experience of married women whohave female sexual dysfunction.

Research Question

1- What is the lived experience of married women who have female sexualdysfunction?

a) What is the meaning of sexuality according to the participants' viewpoints?

b) What are the participants' sexual complaints, what are the causes or predisposingfactors as reflected by the experience of participants?

2- What are the impacts of having FSD on the participants' biopsychosocial aspectsof their life?

Subjects and Methods

Research Design

Mixed method design was utilized for the study. In the current study, part of the data were collected through a quantitative approach, while the other part was collected through qualitative approach. Sexual dysfunction assessment and personal background were measured quantitatively through a standardized tool.

Participants

A purposive sample of 20 women were recruited for the current study. Seven women were dropped out because they had heavy workload and had limited time, so they left the study, and one had ascore of 30 in the Female Sexual Function Index FSFI and excluded. So, the saturation was reached with a total number of 12 participants in qualitative study.

Inclusion criteria:

Married, sexually active women with regular marital relation, who got score less than 28 in female sexual function index (FSFI) as an indicator of having sexual problem,who are working at Cairo university hospitals, in their childbearing age (20-40 years old), who had at least primary educational level up to university education.

Exclusion criteria:

Women who have any obstetric and gynecological disorders or chronic medical diseases which affected their sexuality such as diabetes mellitus, hypertension, chronic heart diseases, chronic liver or kidney diseases; were excluded. Also , any woman with neurological disorders or mental disabilities or who is using antipsychotic drugs was excluded; as well as, women suffering from infertility.

Setting

The current study was conducted in Kasr Al Aini hospital, which is affiliated to Cairo University. The interview was conducted in a very private area.

Tools for Data Collection:

Three tools were used to collect the study data; female personal data questionnaire, Arabic female sexual function index (ArFSFI) and semi structured interview.

1- Female personal data questionnaire, this tool was developed by the research investigator and it is self-administered by the women, it includes four parts: a) the personal background data (age, age at marriage, educational level, occupation, residency, b) female obstetrical and gynecological profile (genital mutilation, menstruation regularity, mode and number of previous deliveries c) marital data (duration of marriage, type of housing, Arabic female sexual function index (ArFSFI): this tool was adopted from Anis, Aboul-Gheit, Saied, and Al-kherbash (2011). It includes 19 questions that cover six domains of sexual function (desire, arousal, orgasm, sexual pain). It assesses the sexual function in the last four weeks before the scheduled interview.

Scoring system: This tool contains six sexual domains and the score in each domain questions ranged from 0 to 5, a domain score of zero indicates that no sexual activity was reported during the past month, while score of 5 denotes highest point. The minimum score was 2 and the maximum score was 36. A total score of 28.1was taken as the cutoff score for the ArFSFI to distinguish between women withFSD and women with normal function (sensitivity 96.7%, specificity 93.2%)

2- Semi-structured interview. This tool was developed by the research investigators; it included nine open-ended questions to help women to express their experience of sexual dysfunction. Coding of the data and a written informed consent to conduct

the study was granted by the research Ethics Committee (Institutional Review Board), which is formally designated to approve, monitor and review research with the aim to protect the rights and welfare of the research subjects before the start of the study. Final approval was obtained from the Faculty of Nursing, Cairo University ethical committee after completion of data collection.

Ethical considerations

A primary approval was obtained from the research ethics committee at the Facultyof Nursing, Cairo University, after that the investigator introduced herself to the women who met the inclusion criteria and informed them about the purpose of this research in order to obtain their acceptance to participate in the study. All women were informed that, participation in the research is voluntary and they can withdraw from this research at any time. Moreover, confidentiality of the women data was assured through coding of data and a written informed consent to conduct the study was granted by the research Ethics Committee. . Final approval was obtained from the Faculty of Nursing, Cairo University ethical committee after completion of data collection

Procedures

Once permission was granted to proceed with the proposed study, woman who met the inclusion criteria of the study were recruited. Direct face-to-face contact was initiated through individual interviews; every participant was interviewed individually three times a week. Each interview session ranged from 35-40 minutes .

Interview: The investigator introduced herself to women who met the inclusion criteria and informed them about the purpose of this research in order to obtain their written consent" monitor and review research with the aim to protect the rights and welfare of the research subjects before the start of the study to be recruited in this research as well as to gain their cooperation.

1) 1st interview. The purpose and nature of the study was explained to the participants before starting the interview. A self-administered questionnaire was distributed to the participant, and the researcher obtained the participants FSFI score through pretest using ArFSFI questionnaire to ensure that the participants have FSD. Women who got score less than 28 in FSFI, were included in interview; and those who got score more than 28 was excluded from the interview.

2) 2nd and 3rd Interview. The interview was conducted in Arabic language by the investigator. Two to three sessions were conducted with each participant. The 2nd interview was conducted after the 1st one by one week up to one month according to convenient time of the women and free work time. Interview was conducted either before the official working hours or after work. The semi-structured interview included several open-ended questions.

Statistical Analysis

For the quantitative data, the Statistical Package for the Social Sciences (SPSS) software, version 20, was used for analyzing the quantitative data. Data management wasdone by coding and entering responses into computer. The investigator checked all data to avoid any discrepancies. Data were examined for coding and entering error. Descriptive statistics were used to analyze the sample population. Mean, standard deviation, and frequency distribution were used.

Qualitative Data Analysis:

The data analysis for the current study is based on Colaizzi's 1978 phenomenological method. In this study, the researcher went through the transcripts line by line and word by word very closely, extracting significant statements and coding each of them. Then the codes were merged into categories; which were then clustered together into subthemes; then, major themes. The integration of the major themes into exhaustive description of the phenomenon and validating the identified structure and nature of the phenomenon from the participants' description was then done as a final step.

Limitations of the Study:

Eight participants were withdrawn before conducting the 2nd interview for assessing their experience.

Result

Part I: quantitative Findings

A) Women personal background data

This section includes description of women by their age, age at marriage, years of marriage, level of education, occupation.

Results revealed that the age range of the participant was 26-40 years with a mean age of 33.42 ± 4.59 years, The women's age range at marriage was 22-35 years with a mean age of 25.89 ± 3.41 years, The duration of marriage ranged from 6 month to 17 years with mean of 7.25 ± 5.31 years.

Ninety-five percent of the participants received university education compared to 85% of their husbands. Only 5% of the participants had secondary school education, as for the husbands, 15% had secondary school education.

Moreover, 70% of them were clerical workers, while 20% of participants had managerial positions, compared to 10% of them working in manual works. Eighty percent of the women had a genital mutilation/cutting (FGM). All the study women were in their childbearing age with 80% of them had regular menstruationand 20% having cessation in their menstruation because of pregnancy, (10%) used hormonal contraception. (10%). FGM had affected the sexual desire in 38% of women while 56% of them said that there was no effect .

B) Female sexual function index scores.

This section includes the types of FSFI domains and its score among participants. Lubrication was the lowest affected domain among participants, while the highest affected domain in FSFI was the desire domain (Table, 1)

C) The participants completed the qualitative part of the study: The participants' socio-demographic characteristics (no. = 12). The age range of the participant was 26-40 years with a mean age of 33.42 ± 4.59 years; the women's age range at marriage was 22-35 years with a mean age of 25.89 ±3.41 years. The duration of marriage ranged from one year and 6 month to 17 years with mean of 7.25 ±5.31 years. Seventy five percent of the participant receiveduniversity education. All the participants were working, as this was an inclusion criterion. 16.7% of the participants had managerial positions, while 75% were clerical worker, and 8.3% of them worked in manual works (Table 2).

Part II: qualitative Findings

This part includes the experience of women with female sexual dysfunction. The current study identifies eight main themes in exploring the experience of women who had FSD; I) expressing meaning of sexual health, II) reported sexual complaints, III) cultural norms, IV) social & interpersonal stressors, V) communication, VI) mutual relation, VII) impact of FSD on different life aspects, and VIII) seeking-help and advice. These themes and its subthemes are described in table (3).

Reported Sexual complaints

Regarding the first main theme in the current study, the participant sexual complaints were corresponding to the findings of FSFI as it showed that, the most annoying complaints were; 1) Refusal and lack of sexual desire, 2) Vaginal dryness & painful sex, and 3) lack of orgasm.

1) Refusal and lack of sexual desire: the majority of the participants reportedlack of sexual desire and most of time escape from their husbands' sexual demands and they pretended that they have work or tried to not have sexual relation, the next statements showed that, the subtheme:

Participant's own words

"My sexual drive is very low and most of the time I have a strong desireto refuse the sexual relation"

"I have no desire for sexual relation most of the time, sometimes I have sexual pain but I can tolerate it. Always get out of this relation without feeling happy or satisfied"

"I have a lack of desire in the sexual relationship because it is difficult to get satisfied, not always but most of the times, and at many other times I want to refuse this relationship."

2) Vaginal dryness & painful sex: Vaginal dryness was common with more than two-third of the participants but they reported tolerable pain which not affecting the completion of the sexual intercourse. The forthcoming statements revealed this subtheme:

"I have vaginal dryness that leads to painful sexual relation"

"At the beginning nothing I have. But shortly after my marriage I feel like having dryness and painful feeling during the sexual relation but it was no severe pain so far"

3) Lack of orgasm, although lack of orgasm is a common sexual complaint among Egyptian women in general, this study finding revealed that, only less than one third ofthe participants complaining of lack of orgasm and sometimes anorgasmia, the following statements exhibit this finding: "I've never reached orgasm or have any sexual satisfaction with my husband from the beginning of this marriage till now (she stopped talking and shook her head then said) at the beginning of the sexual relationship I have been happy but after just few minutes I lose my sensation and I want him to finish and leave me"

II- Expressing the meaning of sexuality

As regard the second main theme in the current study, the participants expressedthe meaning of sexual experience and their answers limited to the meaning of satisfaction versus unsatisfaction or unmet sexual needs, so this theme included two subthemes; 1) satisfactory sexual life, and 2) Unsatisfactory sexual life and unmet sexual needs

1) Satisfactory sexual life: the finding of this study revealed that, about half ofthe participants supposed that sexual health is a satisfactory relationship between couples that enhance happiness and wellness in their marital life, the following statements made by participants confirmed this: "The word sexual health means for me to be satisfied so I would be happy

"For me, sexual health means that, husband and wife take care of themselves and personal hygiene during the intimate relationship and avoid sexually transmitted diseases"

"The meaning of sexual health is all what related to the intimate relationship between husband and wife of everything and not necessarilybe successful or satisfactory to me"

2) Unsatisfactory sexual life and unmet sexual needs: about half of the participants live unsatisfactory sexual and marital relation with their husband which reported in their statements as the following: "My sexual life is regular with no satisfaction on my part and I feel like itis a duty, without any response from me"

"Nothing I feel during sexual act, with no feeling of satisfaction after completed, which it leads to less desire to this act"

"I feel that my husband wishes he could make me happy with this relationship as him, but he doesn't know what to do to please me. I'm ashamed to tell him about what makes me happy and what doesn't. Mostof the time the relation is ended without being satisfied"

III- Cultural norms

1) In relation to cultural norms, it was the third main theme derived from the findings of this study and this theme included two subthemes; 1) Basic needs, and 2) religious beliefs.

2) Basic needs: About one third of the participants reported that, sexual relationship is a basic need and a routine relation that is done for physical wellbeing, this meaning was revealed from the following:

"To some extent it is a fairly routine affair especially after approaching the age of40"

"Sex is a basic requirement for the life such as food and water"

"Both of spouses need to know and find information about the sexualrelationship to be a healthy relationship. They have to get of it with satisfaction for both of them because that, would reflect on all of their life aspects"

3) Religious beliefs: two participants expressed that, they practicing sex withtheir husbands as a religious obligation as the following:

"Sexual relation is a physical contact between two people under a legal framework to increase bonding, love, and emotions; to have an interesting and pleasing time for both of them"

"What I'm sure of it that I have a problem, because it's rare to ask for this relationship. And if I do that, that is because of its holiness principle only and not for me"

IV. Social and interpersonal stressors

Regarding to social and interpersonal stressors, it was the fourth main theme experienced by the participants of this study and this theme included4 subthemes; 1) work and home duties, and children affairs; 2) male dominance and neglection of women feelings; 3) social norms; and 4) interpersonal conflicts.

1) Work and home duties and children's responsibilities:

"I think my sexual problem is because of work's pressure,

and kids andthe House demands"

"The Intimate relationship with my husband is irregular because my husband works all over the night's hours he returns back during the day, while my work is on the day' hours. We do not meet in the House except one day a week and sometimes a week goes by without seeing each otherfor his workloads"

"I think my problem can be solved, if I reduce physical and mental preoccupation with family, work, and my kids' problems, to save time tobe together with my husband at home"

"I don't feel that I have any problem. But my husband and I are busy allthe time and don't think about it"

2) Male dominance & Neglection of women's feelings:

"Sex is just a male performance to satisfy himself, without taking intoconsideration my desires and feelings."

"He is always selfish and only thinks about himself and his pleasureonly."

"My husband Neglection of what I exert in our marital relationship and his neglection of my feelings during sexual act; are the reasons for my sexual problem"

"There was no reaction from my husband toward my sexual impairment because he does not paying me any attention and he does not make love with me constantly"

"My problem is the selfishness of my husband in all aspects of our marital life not just the sexual relationship. He doesn't ask me or trying to find or do what I want. He asks for what he wants at any time he wantsbut he refused in insultingly way when I ask for that."

"No reaction at all from my husband toward my sexual complaint"

"Because this is his way, and tried to tell him that this way makes me sad but he does not care or tries to understand"

3) Social norms:

"I never tried to know or imagine what was happening to anyone else forfear not to have it, and I did not compare myself to anyone else. But as Ihear from all the couples, this is the usual in every house"

4) Interpersonal conflicts:

"Our marital life is a rage and quarrel most of the time and each one of us is onhis own"

"My husband harasses me, and treat me nervously when he feels that I have no desire to have sex and I evade from him or when he asks me to do so, I refuse pretending fatigue or that I am busy with the children"

V- Communication

In relation to communication between couples and particularly sexual communication, it is included two subthemes;

1) Effective communication and affection, and

2) Poor communication.

1) Effective communication and affection:

"The husband must understand that my desire is just like him and that he must take into account my feelings and give me a chance to discuss with me in all our life aspects and problems and spend time talking togetherwith romance and caressing. But he makes love quickly and is always busy"

2) Poor communication:

"My husband always said that talking and discussing sexual matters is necessary. But when I wanted to talk to him about what is going on in my mind, his reaction was very bad how he become nervous and angry and shouts at me, so I stopped talking with him in that matter again"

"I try to accept my husband as it is so that life becomes better among us, especially that he is a good person, generous and affectionate with the children, but he does not know how to nurture me or even understand me,

VI- Mutual relationship

Considering mutual relationship, it was experienced by all study participants andthis theme included two subthemes; 1) mutual affection and love, and 2) cold relation.

1) Mutual affection and love

"The relationship between husband and wife must contain a lot of romance, love and understanding not just a physical performance .... (Her tone of voice was higher and angry)

"The relationship between the couple must based on affection, mercy, respect and appreciation without any conflicts or insults so that they enjoya decent life and this will help to get rid of any sexual disorders for both ...It is important in sex that each party wishes to be happy party The other so that the relationship becomes healthy and positive".

2) Cold relation:

"The relationship between me and my husband is just a relationship of maritalpartnership in raising children without love, emotions or feelings"

"Our relationship became very cold and without any feelings or affinity,because of that my desire decreased a lot"

VII- Impact of FSD on different life aspects

This theme is the core of this study findings as it describes the effect of FSD onbiopsychosocial aspects participants' lived experience and it consists of four subthemes: 1) Disturbed relationships with the surroundings; 2) work and self-actualization; 3) physical complaints; and 4) psychological complaints.

1) Disturbed relationship with the surroundings

"I am very nervous with my children, my family, my friends and my colleagues at work; I have avoided social events, and dealing with people.I prefer isolation, and stay at home"

"In the past, this problem was affecting my relationship with my childrenin form of nervousness, shouting, beating; it also affected all my life and my relationship with my family. Now it has no effect and no significance"

"I deal with my children sharply and nervously, because I feel dissatisfied with my life with my husband. I am forced to bear this life because of children. When there is a conflict between my husband, and me, he stops practicing sex with me as a punishment. When I decided to leave him and asked for divorce, I remember my children, but I back down in my decision for my children's sake"

2) Work & self actualization

"I am very stressed at work and unable to concentrate or accomplish anything, despite my boss in work praising my performance at work. But I'm not satisfied with myself and job performance and I feel I can do better than that"

3) Physical complaint:

"I have lower abdominal heaviness and pain, and also in my

both sidesand from my point of view this is due to I'm not satisfied sexually"
"I feel constant congestion in the pelvic area that's of the impact of sexualdissatisfaction"
"Weight gain may be a cause of my sexual problems"

4) Psychological impairment:
This subtheme included seven symptoms of psychological impairment as experienced by the participants as the following:
a- *Distress and tension:*
"I am always nervous about all those around me for trivial reasons and sometimes cry for no particular or clear cause. I eat a lot and have insomnia and I always think about whether I am the only person who have this problem and the defect in me or is it the problem of all women. Or amI different and not sexually satisfied easily and need more"

b. Low self esteem:
"I feel that I am not like other women and less than them, I do not knowhow to be attractive to my husband and admire me"

c. *Confusion and uncertainty*:
"I love my husband very much and I do not imagine that I would be with another man, but inside me, I am angry with him and I had many bad feelings for him but I did not express them so that there would be no conflicts and quarrel"

d. Social withdrawal and depressed mood:
"I do not like going out or visiting and dealing with anyone. And I preferisolation and not going out completely"

e. Negative feelings and impacts:
"At first, I was wondering why I am so undesirable, but over time I adopted to that and it became unimportant to me. It's the same if it occursor not"

f. Guilty feelings
"I am angry with myself and I have a guilt feeling towards my husband because I can't satisfy him in intimate relationship, and I do not feel adesire for him at all"

g. Frustration:
"I am frustrated and depressed because I need my husband to treat mewith romance, feelings and emotions".
VIII- Seeking-help and advice
Six participants reported that, seeking-help is crucial for managing their sexual problem, while the other six participants say seeking-help or advice as an embarrassing and they doubt about the presence of management for these issues. According to this difference on participant's opinion this theme divided into 2 subthemes: 1) feeling embarrassed and avoidance of seeking help; and 2) Seeking help or advice

1) Feeling embarrassed and avoidance of seeking help:
"I feel that there is something wrong but a flaw to say, if I went to thedoctor what to tell her, and if I ask anyone from my family, surely they will say that I am impolite"

2) Seeking help or advice
"I think that issue is psychological and I need psychological intervention, but I am thinking now about going to a psychiatrist and tell her about me, maybe she can help me"
"Yes I once went to a specialist doctor here in the hospital and he said, your husband must come with you but my husband refused and said he is busy so I forgot the matter"

Discussion
In relation to the participants' age, the current study results revealed that, the age range was 26-40 years old with a mean age of 33.42±4.59 years old. More than half ofthe participants were married at age less than 25 years old. About three-quarter of the participants were married for less than ten years. This result was similar to the results of Mishra et al. (2016), who study the prevalence and various factors associated with FSD at India, they found that, FSD is more prevalent among the age group between 26–30 years.

In contrast, Aggarwal et al. (2012); in their research that, explore the prevalence of FSD and its possible risk factors among 500 Indian women they found that, sexual dysfunction is prevalent among women older than 42 years old and the prevalence decreased in younger women who are less than 40 years old. This contradiction might be because of the different age group, different age at marriage, and different sample size in the current study and the mentioned study.

Regarding to duration of marriage, the current study found that, FSD is more prevalent among women who are married for less than ten years. This finding disagreed with Mishra et al. (2016), who reported that, FSD was more prevalent in women who are married for more than 16 years. Moreover, Morton and Gorzalka (2015), in studying the role of novelty in sexual function; they concluded that, sexual function specifically desire and arousal are strong in couples who are in continuous sexual relation for less than 10 years while it is declined with time. This finding was on contrary with the current study findings as most of the participants who have FSD were married for less than 10 years and this may be due to overwhelming with work, home and children affairs and neglection of self and her sexual wellbeing.

Regarding to participants' education, all of the participants and their husbands had university or secondary education. This finding agreed with the results of Jaafarpour, Khani , Khajavikhan , & Suhrabi (2013); in their study that explore the prevalence and associated risk factors for Female Sexual Dysfunction (FSD) in women in Iran; their findings showed that, about 64.4% (258 of 400 women) of the study participants were either secondary or highly educated.

In relation to participants' obstetric profile, most of the participants were para one to para 3 with range of having children from one child to 3 children. In contrary, Jaafarpour, et al. (2013); had explored the prevalence and associated risk factors for Female Sexual Dysfunction (FSD) in Iran, they found that, sexual dysfunction was more prevalent in women who have 3 children or more and less in women with no children but had no infertility. On the other hand, in a study that was conducted in Finland to assess female sexual function and its associations with the number of children, pregnancy, and relationship satisfaction; its finding revealed that, nulliparous women had

sexual complaints and were sexually less satisfied compared to multiparous women with children, regardless of the number of children (Witting et al. 2008). This disagreement in findings might be due to difference in sample size, age group, and cultural differences among the current study and other studies participants.

Considering female sexual mutilation (FGM), the finding of this study revealed that, more than three-quarters of the participants had FGM and about one-third of them reported that, this procedure had affected their sexual function as it decreases their desire and response to sexual act. Researches done on women with FGM revealed that FGM has obvious effect on female sexual function. In this respect, Vital et al. (2016) conducteda study to evaluate sexual function of French women with genital mutilation undergoing surgical reconstruction by using FSFI; they found that, the mean FSFI score was increased after surgery and within six months with a statistical significant difference. Also, Abdel-Azim (2013) reported that, female circumcision can reduce female sexual responsiveness, and may lead to anorgasmia and even frigidity.

Regarding to female sexual function index domain, almost all the participant (95% of them) had less than 28.1 score in FSFI (cutoff score of Arabic version). All six domains of FSFI were affected with mostly affected domain was desire, pain, arousal, orgasm, satisfaction, and lubrication prospectively. A study conducted by Atrash, et al., (2014) at faculty of medicine, at Suez Canal University, Egypt; that assessed the sexual dysfunction in Egyptian women with lower urinary tract symptoms; the study findings showed that, about 75% of the patient who participated in this study had FSD. The result also revealed that, the participants had sexual impact on the six domains of FSFI as the following order from most affected domain to less affected one; desire, orgasm, arousal, pain (dyspareunia), lubrication, and satisfaction. These findings was in agreement with the current study in the affection of the domains of FSFI and disagreed with the study in the number of affected participants. This difference may be due to the difference in the number of participants in the current study representing 20% of the Atrash et al. study.

During the course of this study, several key issues/themes were derived from living with FSD as experienced by the participants. On the same approach, sexual complaints as reported by participants' responses in the interview in the qualitative analysis were close to the findings obtained by the statistical analysis of the FSFI scores.

In this part of the study, the participants reported complaints as: lack of satisfaction, lack of sexual desire, lack of orgasm or anorgasmia, vaginal dryness accompanied by painful intercourse reported as tolerable pain. These findings were in consistent with the findings of a study conducted in Egypt that assessed the factors associated with FSD, the researcher stated that, sexual complaints among the participant were; lack of sexual satisfaction, vaginal dryness, lack of orgasm, pain during sexual activity, lack of sexual desire, and lack or arousability (Afefy, 2015).

In contrary, Knoepp et al. (2010), in their study of sexual complaints, pelvic floor symptoms, and sexual distress in women; they found that, dyspareunia, and decreased arousal during sexual activity were the common sexual complaints among the study participants. This difference may be due to the small number of participants and the approach of the research used.

In relation to the participants' expression of meaning of sexuality, the analysis of their answers showed that, there were differences. About 40% of them thought that,sexuality mean "having a satisfactory sexual life for both partners" while the rest of them considering that, sexual health meaning depends on their actual experience of it and it is "unsatisfactory and unmet of sexual needs".

In a review article of Thomas and Thurston (2016), that assessed the biopsychosocial approach on women's sexual function and dysfunction; they reported that, studies that used theoretical models of female sexual responses or the longitudinal cohort study's findings indicated that, psychosocial factors, such as relationship satisfaction and importance of sex, are the keys factors that affect women's sexual health, as well as, women tend to think about sex from its emotional and psychological aspects, While they did not pay attention to its biological aspect. These findings were similar tothe current study findings as the participants expressed and defined sexuality either satisfactory or unsatisfactory sexual life with their husbands.

In relation to the cultural norms, the study findings revealed that, four participants reported that, sex is a basic need in their life and it is a routine act done between married partners with less attention to its emotional part. Three participants stated that, they were practicing sex with their husbands for "avoiding the wrath of God only". In a systematic review study aimed at assessing the impact of culture and ethnicity on sexuality and sexual function; it is concluded that sexuality can affect and contributed to different cultural, social, and religious communities and must be taken in consideration when assessing or treating the different types of sexual dysfunctions (Heinemann, Atallah, & Rosenbaum, 2016). In this study all participants were Egyptian, and 9 women were Muslims and 3 of them were Christian with orthodox affiliation. All of them had the same cultural beliefs and religious roles and social morals so these concepts had a great influence on their sexuality and their life aspects in general.

Social and interpersonal stressors, working mothers had great loads that contribute to physical and mental burden on women. A study conducted by Stamatiou etal. (2016) who assessed the incidence and prevalence of sexual dysfunction among women (no. = 88) works in health care settings; the study showed that, occupationalstress can affect female sexual dysfunction. Also they noted that, although health professionals have more sexual knowledge that could improve their sexual health than non-health professionals, the results of this study indicated that, health professional have more work related mental and physical stressors that affect their sexuality negatively. In the current study, all of the participants were working as administrators and clerks duties but all of them reported a physical and mental load

that affect their sexual health in a negative way. Also, presence of children increases their load and prevents their sexual fantasies and thoughts.

Also, male dominance can affect female sexuality too, as reported by several studies and scientists at western country expressed this theme as "the act of one man show" (Iconis, 2004); and these problems which lead to aggressively neglecting the female feelings and sexual needs are wide prevalent in Arabic countries generally and in Egypt specifically. a systematic review conducted by McCool, et al. (2016) to assess the prevalence of FSD among premenopausal women by sought studies done from 2000 to 2014; these study findings revealed that, male dominance is a predictor factor of female sexual dysfunction in certain cultural specially in Africa, middle and south Asia.

Interpersonal conflicts between married couples play a significant role in their sexual disorders. Thomas and Thurston (2016) in their narrative review of biopsychosocial approach and its impacts on female sexual function and dysfunction reported that, sociocultural factors and interpersonal relationship between couples play an important role that can affect on FSD and its management. They added that, full understanding and treating couples' conflicts had a vital role in women sexual health and overall wellbeing as well. Moreover, work load, children responsibilities, male dominating culture, financial status, and other sociocultural factors may be contributed to unresolved conflicts between more than half (n = 8) of this study's participants and their husbands.

Communication in general and sexual communication in particular is an essential element of sexual satisfaction among married couples. Fifty percent (n = 6) of the participant reported that there is poor communication or no communication at all between them and their husbands. Two participants of them thought that, it is because of their husband business and their work and home duties, while 4 of them believed that, their husbands did not want to talk or share with them any feeling expression regarding sexuality. Also, Pereira, Arias-Carrión, Machado, Nardi, & Silva, (2013); mentioned that, improvement in couples' communication could enhance sexual function and communication therapy focused on active and passive listening, verbalization of and reflection on feelings. Also, conflict management and assertive behavior seemed to benefit the sexual and mutual relation between couples when used in combination with sex therapy for treating FSD.

Regarding to the seventh theme that described the impact of FSD on different life aspects as experienced by the study's participants, it includes: disturbed relationship with surroundings, work and self-actualization, physical complaints, and psychological impairment. Seventy-five percent of the participants (n = 9) reported that, they experienced a different physical complaints as headache, lower backache and pelvic heaviness after sexual relationship with their husbands and extended to the several hours and sometimes several days. The participants perceived that these symptoms related to lack of sexual satisfaction they are experiencing in their marital and sexual life. Unfortunately, there are no studies assessed or focused on physical complications orphysical consequences of FSD, so further studies are needed to evaluate the impact of these issues/problems on women's physical complaints that thought to be because of unsatisfied sexual life of them.

In a systematic review by Shahhosseini, Gardeshi, Pourasghar, & Salehi (2014) ofa 30 articles exploring the influencing factors on sexual satisfaction in women; the results revealed that, the most important factors in sexual satisfaction is mental health. In most studies, mental health has referred as the strongest influencing factor on sexual satisfaction. In this way, it's stated that mental health refers to the fact that people on personal standards, how to think and feel about their life in general and in specific areas such as sex, interpersonal relationships, physical and mental status. Mental health as a factor has a greatest impact on sexuality, especially sexual satisfaction is defined as a positive and rational evaluation of person from various aspects of life and creates abalance between positive affect such as happiness, will, self-confidence, positive self-image and negative affect like anxiety, stress and depression. Similarly, many studies that assessed and evaluate females with sexual dysfunction concluded that, psychological factors are a linked to FSD for an extent. But which one causes the other and what is the consequences of occurrence still a research inquiry till now.

Moreover, Brotto et al. (2016) evaluate the impact of FSD on psychological and interpersonal dimensions, and they indicated that, assessment of physical and mental disorders that commonly associated with life events should be included as part of theinitial evaluation in persons presenting with sexual complaints. Also, assessment of depression, anxiety, stress, and post-traumatic stress should be carried out as part of the initial evaluation. So, clinicians should attempt to ascertain whether the anxiety and/or depression are a consequence or a cause of the sexual complaint, and treatment should be administered accordingly. Also, cognitive distraction is a significant contributor to sexual response problems in men and women.

In relation to seeking medical help and advice, although 50% of the participants(n = 6) reported that, it was important to seeking medical advice or treatment or at least asking for advice from friends or relative to solve their sexual complaints; the remaining half refused these ideas completely as they believed that, sexual issue is embarrassing and it's ashamed to talk about it with others even if this person is a physician or health care personnel.

Moreover, Vahdaninia, Montazeri and Goshtasebi (2009), in their cross-sectional study that assessed Help-seeking behaviors for female sexual dysfunction on Iranian women; their study findings showed that, the reluctance to initiate a discussion about sexual issues is a dual interaction between patients and doctors. This may be due patients' barriers such as embarrassment, lack of knowledge and indirect presentation of the disease, or lack of appropriate medical training on sexual problems or its management.

In summary, this study explored the experience of women who had FSD using a holistic approach to evaluate the biopsychosocial factors that contributing, maintaining or exacerbating female sexual complaints as reported by the study

participants. Many studies that assessed FSD incidence and prevalence as well as its risky factors concluded that, a biopsychosocial approach that simultaneously considers physical, psychological, sociocultural, and interpersonal factors is necessary to guide research and clinical care regarding women's sexual function (Thomas & thuston, 2016; Malary et al., 2015; Althof & Needle, 2013).

Conclusion:

The current study concluded that, FSD is prevalent among working women in childbearing age of this study. The qualitative analysis of the current study revealed that, there were 8 main themes as follow; sexual complaints, expressing meaning of sexuality, cultural norms, social and interpersonal stressors, communication, mutual relation, impact of FSD on different life aspects, and seeking-help and advice. The study participants admitted that, their sexual complaints had affected negatively on their bio- psychosocial aspects of their life. They were different in their opinions on seeking-help or advice for their sexual complaints; despite all of them had admitted that, they have sexual problems, about half of them reported that, it was embarrassing to talk about this problem with health care personnel or asking for management.

Recommendations:

Based on the results of this study, the following were recommended:

- Sex education and counseling must be included in primary health care settings.
- Bio-psychosocial approach should not be neglected when dealing with women who have female sexual dysfunction.

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Table (1) Distribution of the Participants According to Female Sexual Function Index Domains (n=12)

FSFI Domains	x̄	± SD	Max	Min
Desire	3.3	1.002	1.2	5.4
Arousal	3.75	1.322	1.2	6
Lubrication	4.26	0.956	1.8	5.4
Orgasm	4.02	1.436	1.2	6
Satisfaction	4.16	1.504	1.6	6
Pain	3.42	0.587	2	4.4
FSFI total scale score	22.91	4.369	12.9	30.4

Table (2) Distribution of the Participants According to socio-demographic characteristics (n=12)

Code	Participants Age	Age at marriage	Duration of marriage	Education	Occupation
Participant 1	40	23	17	University	Managerial
Participant 2	40	25	15	University	Managerial
Participant 3	32	22	10	Secondary	Clerical
Participant 4	27	23	4	Secondary	Manual
Participant 5	35	31	4	University	Clerical
Participant 6	37	35	2	University	Clerical

Participant 7	29	26	3	Secondary	Clerical
Participant 8	36	24	12	University	Clerical
Participant 9	26	23	3	University	Clerical
Participant 10	27	25	1.5	University	Clerical
Participant 11	32	27	5	University	Clerical
Participant 12	28	29	7	University	Clerical

Table (3) Themes and subthemes of the qualitative analysis:

Themes	Subthemes
I- Reported sexual complaints	1. Refusal & lack of sexual desire 2. Vaginal dryness & painful intercourse 3. Lack or no orgasm (anorgasmia).
II- Expressing meaning of sexuality	1. Satisfactory sexual life. 2. Unsatisfactory sexual life & unmet sexual needs.
III- Cultural norms	1. Basic needs 2. Religious beliefs
IV- Social & interpersonal stressors	1. Work & home duties and children's responsibilities 2. Male dominance & neglection of woman feelings 3. Social norms 4. Interpersonal conflicts
V- Communication	1. Effective communication & affection 2. Poor communication
VI- Mutual relation	1. Mutual affection & love 2. Cold relation
VII- Impact of FSD on different life aspects	1. Disturbed relationship with the surroundings 2. Work & self-actualization 3. Physical complaints 4. Psychological impairment a) Distress & tension b) Low self-esteem c) Confusion & uncertainty d) Social withdrawal and depressed mood. e) Negative feelings and impacts f) Guilty feelings g) Frustration
VIII- Seeking-help and advice	1. Feeling embarrassed & avoidance of seeking help 2. Seeking help and advice