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The impact of sexual dysfunction on quality of life on nurses

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Nevin Utkualp[1], Hicran Yıldız[2], Elif Velioğlu[3]*

Bursa Uludag University Faculty of Health Sciences, Department of Obstetrics and Gynecology Nursing, Bursa Turkey[1]; Bursa Uludag University Faculty of Health Sciences, Department of Internal Medicine of Nursing, Bursa Turkey[2]; Marmara University, Institute of Health Sciences, Department of Obstetrics and Gynecology Nursing, Istanbul, Turkey[3]

***For Correspondence**: Email: *nutkualp@uludag.edu.tr*; Phone: +90 5366110496

Abstract

The study was conducted to determine the effect of nurses' sexual life on their quality of life. The study was conducted on 76 nurses working in a hospital in Bursa. Data were collected through Descriptive Data Collection Form, the Female Sexual Function Index (FSFI), and the SF-36 Quality of Life Scale. Mann-Whitney U, Spearman correlation, and Kruskal Wallis test were used to evaluate the data. The average age of the nurses is 38.98±8.05. The average duration of nurses' marriage is 13.95±8.96 years, and 49% of them stated that working life affects their sexual life. Sexual dysfunction was detected in 100% of the nurses. The presence of sexual dysfunction in nurses affects the quality of life. It is important to determine the risk factors in nurses' sexual life patterns to improve the quality of life. *(Afr J Reprod Health 2023; 27 [5]: 50-57).*

Keywords: Nurse, sexual dysfunction, quality of life, influencing factors

Résumé

L'étude a été menée pour déterminer l'effet de la vie sexuelle des infirmières sur leur qualité de vie. L'étude a été menée sur 76 infirmières travaillant dans un hôpital de Bursa. Les données ont été recueillies au moyen du formulaire de collecte de données descriptives, de l'indice de la fonction sexuelle féminine (FSFI) et de l'échelle de qualité de vie SF-36. Mann-Whitney U, la corrélation de Spearman et le test de Kruskal Wallis ont été utilisés pour évaluer les données. L'âge moyen des infirmières est de 38,98 ± 8,05 ans. La durée moyenne du mariage des infirmières est de 13,95 ± 8,96 ans et 49 % d'entre elles déclarent que la vie professionnelle affecte leur vie sexuelle. Une dysfonction sexuelle a été détectée chez 100 % des infirmières. La présence de dysfonction sexuelle chez les infirmières affecte la qualité de vie. Il est important de déterminer les facteurs de risque dans les habitudes de vie sexuelle des infirmières pour améliorer la qualité de vie. *(Afr J Reprod Health 2023; 27 [5]: 50-57).*

Mots-clés: Infirmière, dysfonctionnement sexuel, qualité de vie, facteurs d'influence

Introduction

Sexual life is considered to be one of the main factors affecting the quality of life[1-5] . Sexuality is an important part of human life[6] .However, sexuality is also an important health indicator and an integral part of life. Therefore, sexual dysfunction is a crucial health problem[7].

The World Health Organization proposes to integrate sexual health into basic health services, to educate people and healthcare workers on sexual issues, and to support the maintenance of sexual health at an optimal level. Because sexual problems are one of the most unhappy health problems[8,9]. The changes in sexual life affect individual physiologically, biologically, sociologically, and psychologically. On the other hand, sexual life is affected by changes in the individual's life and factors such as cultural, economic, political, social, religious, legal, marital relations, and relationship with the partner[3,4,10] .

Sexual life is an important determinant of women's health and quality of life. Sexual dysfunction is a common problem seen in 30% - 50% of women[10]. Behaviors such as embarrassment and shyness that emerge with the effect of the cultural structure in our country make it difficult to talk about sexual life[11]. Although sexuality plays an important role in women's health, there are limited studies on this subject. The study was conducted to

determine the effect of nurses' sexual dysfunction on their quality of life.

Methods

The study was conducted on nurses working in a hospital in Bursa between 01.04.2019 and 01.10.2019. The population and sample equations were made in the study, and 76 nurses who agreed to participate in the study formed the sample. Data were collected through Descriptive Data Collection Form, the Female Sexual Function Index (FSFI), and the SF-36 Quality of Life Scale.

Descriptive Data Collection Form: The form includes questions about the socio-demographic characteristics, health status, and sexual life of the individuals.

Female Sexual Function Index (FSFI): It consists of 6 sub-dimensions: desire, arousal, lubrication, orgasm, general satisfaction, and pain. A high score means better sexual function, the lowest score is 2, and the highest score is 36.

Quality of Life Scale (SF-36 Health Survey): The Quality of Life Scale SF-36 scale was planned to increase the health-related quality of life as each dimension score increases with positive scoring.The data were evaluated using the Mann-Whitney U, Spearman correlation, and Kruskal Wallis test in the SPSS 22 program.

Ethical aspect of the research

This study was approved by the Bursa Yuksek Ihtısas Traınıng and Research Hospıtal Ethical Committee (19.09.2018; approval number: 2011-KAEK-25 2018/09-08). We informed The participants about the aim and content of this study. This study has been conducted in accordance with the principles set forth in the Helsinki Declaration.

Results

The mean age of the nurses is 38.98 ± 8.05, and 71.4% of the nurses are graduates. The mean professional experience of the nurses is 16.30 ± 9.95 years. 38.8% of the nurses work in the intensive care unit, and the mean duration of work in this unit is 5.63 ± 4.86 years. 61.2% of the nurses work only day shifts. 30.6% of the nurses smoke and 10.2% use alcohol. 4.1% of the nurses exercise regularly.

The mean marriage age of the nurses is 24.89 ± 4.00, 85.7% of the nurses met and got married, and the mean marriage duration is 13.95 ± 8.96 years. 81.6% of the nurses have children., 83.7% of the nurses are in their first marriage. 49% of the nurses stated that working life affected their sex life. The FSFI mean score of the nurses was 19.86 ± 3.65, and it was determined that they got the highest score from the pain subgroup and the lowest score from the satisfaction subgroup. CD was detected in 100% of the nurses. Out of the quality of life scale, nurses got the highest score from the physical function subgroup (80.20 ± 21.38) and the lowest score from the pain subgroup (49.38 ± 21.64). The mean physical dimension score was 61.93 ± 18.77, the mean mental dimension score was 64.41 ± 19.27, and the mean total quality of life score was 63.17 ± 17.95.

With regards to age-arousal and orgasm sub-dimensions and IFSF total score, it was determined that there was a significant relationship between orgasm and years of professional experience. Orgasm with wife's profession; sexual satisfaction with the unit they work in; sexual arousal by the way it works; It was determined that there was a significant difference between regular exercise and sexual arousal ($p < 0.05$) (Table 1).

Marriage age and sexual desire are among the characteristics of nurses related to marriage and birth, duration of marriage and desire, arousal, orgasm, and IFSF total score. It was determined that there was a significant relationship between the age at first birth and desire and pain ($p < 0.05$). Marriage mode of arousal, lubrication, orgasm, and IFSF total score; desire, arousal and IFSF total score with having children; arousal by stillbirth/miscarriage; It was determined that there was a significant relationship between the mode of delivery and orgasm ($p < 0.05$) (Table 2).

Physical function, physical role function, and social function sub-dimensions of sexual desire and quality of life in nurses; all quality of life sub-dimensions except sexual arousal and the mental role and total quality of life; Significant relationships were found between IFSF total score

Table 1: The effect of sociodemographic characteristics on sexual dysfunction in the cases (n = 76)

Variable			Desire	Arousal	Lubrication	Orgasm	Satisfaction	Pain	Total
Age(years)	(Mean±SD)	Rho	0,085	0,388	0,071	0,414	0,166	-0,025	0,402
		p	0,561	**0,006**	0,628	**0,003**	0,255	0,865	**0,004**
Educational Status	High school		3,48±0,78	3,12±1,35	3,66±0,44	3,52±0,52	2,88±0,71	4,16±1,40	20,82±2,62
	Associate Degree		4,32±1,55	3,96±1,22	3,24±0,39	2,72±1,63	2,80±0,74	4,24±0,87	21,28±2,42
	Bachalor's Degree		3,66±1,07	2,67±1,16	3,47±1,13	2,98±1,04	2,44±0,64	4,53±1,55	19,78±3,65
	Graduate		3,90±1,14	2,62±1,23	2,77±1,99	2,20±1,51	2,60±0,51	3,50±2,38	17,60±5,84
	Significance	KW	1,555	4,629	4,143	3,830	2,353	2,039	1,430
		p	0,670	0,201	0,246	0,280	0,503	0,564	0,699
Education status of spouse	High school		4,05±1,42	3,11±1,61	3,45±1,46	2,60±1,62	2,80±0,93	4,10±1,94	20,11±4,61
	Associate degree		3,90±1,00	2,95±1,09	3,52±0,31	3,30±0,64	2,66±0,73	4,03±1,33	20,37±1,84
	License		3,50±1,06	2,78±1,09	3,41±1,09	2,98±1,01	2,41±0,52	4,52±1,55	19,62±3,87
	Graduate		4,20±0,60	2,30±2,12	2,80±2,44	2,13±1,84	2,40±0,40	5,33±1,15	19,16±6,09
	Significance	KW	2,626	0,764	1,525	1,357	2,120	3,921	0,712
		p	0,453	0,858	0,677	0,716	0,548	0,270	0,870
Spouse's job	Officer		3,45±0,97	2,92±0,96	3,55±0,80	3,06±0,80	2,46±0,56	4,56±1,32	20,03±3,06
	Retired		3,60±1,58	3,60±1,08	3,30±0,30	3,73±0,61	3,33±0,46	3,60±0,40	21,16±2,13
	Worker		4,80±2,07	2,20±2,83	2,40±2,07	0,93±1,61	2,26±0,23	3,86±3,35	16,46±7,41
	Self-employment		4,00±0,60	3,16±0,78	3,86±0,46	3,51±0,33	2,71±0,62	4,22±1,18	21,47±1,65
	other		3,90±1,03	2,17±1,72	3,00±2,03	2,50±1,67	1,90±0,68	5,50±1,00	18,97±4,96
	Significance	KW	4,094	3,152	4,852	11,773	9,414	6,740	3,086
		p	0,393	0,533	0,303	**0,019**	0,052	0,150	0,544
Spouse's Employment Status	Working		3,69±1,03	2,88±1,16	3,48±1,03	2,98±1,05	2,47±0,59	4,48±1,43	20,00±3,46
	Not Working		3,60±1,58	3,20±1,41	3,40±0,45	3,33±1,00	3,06±0,92	4,40±1,44	21,00±2,36
	Significance	U	62,000	61,500	45,500	62,500	41,500	60,000	61,000
		Z	-0,238	-0,257	-0,969	-0,219	-1,146	-0,324	-0,277
		p	0,812	0,797	0,333	0,827	0,252	0,746	0,782
Family type	Extended family		3,25±0,90	3,21±1,14	3,55±0,50	3,48±0,50	2,34±0,58	4,22±1,02	20,08±2,31
	Nuclear family		3,81±1,11	2,78±1,24	3,38±1,18	2,85±1,17	2,57±0,66	4,40±1,62	19,82±3,85
	Significance	U	106,000	116,500	129,000	96,500	136,500	114,500	134,000
		Z	-1,190	-0,875	-0,531	-1,483	-0,310	-0,940	-0,372
		p	0,234	0,381	0,596	0,138	0,757	0,347	0,710
Income Status	Less than income		3,50±0,96	3,00±0,65	3,55±0,44	3,20±0,35	2,26±0,41	4,93±1,06	20,45±1,78
	Equivalent to expenses		4,02±1,10	2,92±1,38	3,40±1,22	2,89±1,24	2,49±0,67	4,40±1,58	20,12±4,01
	More than income		3,18±0,96	2,60±1,04	3,36±1,11	2,95±1,08	2,76±0,64	4,09±1,65	18,97±3,48
	Significance	KW	5,183	1,267	0,327	0,114	2,316	1,111	1,827
		p	0,075	0,531	0,849	0,945	0,314	0,574	0,401
Working year in the job	(Mean ±SD)	Rho	0,057	0,214	0,005	0,362	0,110	-0,054	0,276
		p	0,699	0,141	0,975	**0,011**	0,451	0,712	0,055
Working unit	service		4,15±1,23	2,76±1,61	3,04±1,68	2,62±1,52	2,94±0,69	3,48±2,21	19,02±5,50
	intensive care		3,53±1,09	2,82±1,32	3,41±0,93	2,82±1,06	2,23±0,36	4,65±0,88	19,47±2,80
	other		3,60±0,92	2,94±0,65	3,73±0,43	3,37±0,56	2,55±0,71	4,85±1,17	21,05±2,17
	Significance	KW	2,485	0,096	2,291	3,538	8,536	3,811	2,475
		p	0,289	0,953	0,318	0,171	**0,014**	0,149	0,290
Years of work in the unit	(Mean ±SD)	Rho	-0,030	0,150	0,130	0,265	0,012	0,200	0,252
		p	0,840	0,302	0,374	0,066	0,937	0,169	0,081
How it works	only daytime		3,84±1,07	3,18±1,03	3,58±0,77	3,10±1,00	2,52±0,62	4,42±1,35	20,65±2,96
	shift		3,56±1,13	2,32±1,34	3,14±1,48	2,69±1,26	2,56±0,70	4,31±1,84	18,61±4,33
	Significance	U	232,500	185,000	264,000	220,000	285,000	269,500	197,500
		Z	-1,094	-2,061	-0,445	-1,371	0,000	-0,322	-1,796
		p	0,274	**0,039**	0,657	0,171	1,000	0,748	0,073

Smoking Status	Smoker		3,84±1,23	2,88±1,37	3,56±1,08	2,88±1,23	2,45±0,69	4,50±1,61	20,12±3,75
	Gave up		4,50±0,42	2,70±1,27	3,15±0,21	2,60±0,84	2,80±0,56	2,60±0,84	18,35±0,77
	Non-Smoker		3,67±1,04	2,81±1,20	3,35±1,18	2,98±1,11	2,58±0,65	4,38±1,50	19,80±3,81
	Significance	KW	1,488	0,095	2,673	0,930	0,766	3,913	1,581
		p	0,475	0,954	0,263	0,628	0,682	0,141	0,454
Alcohol use	Smoker		3,72±1,15	2,94±1,34	3,84±0,39	3,36±0,45	2,64±0,92	4,80±1,23	21,30±2,22
	Gave up		3,72±1,22	2,58±1,66	2,94±1,68	2,40±1,49	2,24±0,60	5,12±1,75	19,00±4,62
	Non-Smoker		3,73±1,10	2,86±1,18	3,41±1,08	2,96±1,12	2,56±0,62	4,23±1,55	19,78±3,71
	Significance	KW	0,015	0,023	1,430	1,215	1,781	3,016	0,856
		p	0,992	0,989	0,489	0,545	0,411	0,221	0,652
Regular exercise	Yes		2,40±0,00	1,20±0,00	3,15±0,63	2,60±0,28	2,00±0,00	5,40±0,84	16,75±1,76
	No		3,87±1,07	2,91±1,26	3,40±1,19	2,93±1,21	2,65±0,63	4,23±1,60	20,03±3,88
	Significance	U	8,000	6,000	20,500	17,000	10,000	21,000	11,000
		Z	-1,931	-2,026	-1,220	-1,417	-1,849	-1,167	-1,731
		p	0,053	**0,043**	0,222	0,157	0,064	0,243	0,084

KW=Kruskal Wallis, U=Mann Whitney U, Rho = Spearman correlation coefficient * p <0.05

Table 2: The effect of nurses' characteristics of marriage and birth on sexual dysfunction (n = 76)

Variable			Desire	Arousal	Lubrication	Orgasm	Satisfaction	Pain	Total
Marriage age	(Mean±SDS)	Rho	-0,302	-0,235	-0,031	-0,164	-0,148	0,226	-0,226
		p	**0,035**	0,104	0,831	0,260	0,310	0,118	0,118
Form of marriage	Getting married by meeting		3,71±1,13	2,65±1,21	3,31±1,16	2,80±1,13	2,46±0,63	4,39±1,58	19,33±3,66
	Arranged marriage		3,85±0,90	4,02±0,29	3,98±0,41	3,82±0,31	2,97±0,64	4,34±1,37	23,01±1,36
	Significance		129,500	35,500	76,000	31,500	83,000	133,500	37,000
			-0,508	-3,199	-2,093	-3,391	-1,889	-0,390	-3,144
			0,612	**0,001**	**0,036**	**0,001**	0,059	0,696	**0,002**
Duration of marriage	(Mean ±SD)	Rho	0,309	0,421	0,015	0,413	0,328	-0,228	0,411
		p	**0,031**	**0,003**	0,919	**0,003**	**0,022**	0,116	**0,003**
Having children	Yes		3,87±1,03	3,09±1,17	3,47±1,09	2,98±1,10	2,54±0,63	4,38±1,48	20,34±3,64
	No		3,13±1,22	1,73±0,79	3,13±1,21	2,80±1,23	2,53±0,77	4,40±1,88	17,73±3,06
	Significance	U	101,500	50,000	130,500	136,500	165,500	165,000	73,000
		Z	-2,059	-3,371	-1,319	-1,154	-0,387	-0,392	-2,763
		p	**0,040**	**0,001**	0,187	0,248	0,699	0,695	**0,006**
Fist birth age	(Mean±SD)	Rho	-0,283	-0,214	0,056	-0,131	-0,230	0,298	-0,133
		p	**0,049**	0,140	0,703	0,371	0,111	**0,038**	0,363
Delivery method	Cesarean		3,77±1,09	2,85±1,22	3,35±1,20	2,77±1,19	2,46±0,48	4,45±1,60	19,67±3,89
	Normal delivery + episiotomy		3,60±0,97	3,09±1,03	3,75±0,32	3,47±0,47	2,60±0,85	4,47±1,07	20,99±2,02
	Significance	U	228,000	219,500	215,000	150,000	234,500	227,500	206,500
		Z	-0,456	-0,643	-0,768	-2,267	-0,313	-0,467	-0,932
		p	0,648	0,520	0,443	**0,023**	0,754	0,641	0,351
Spouse's marriage number	1,00		3,67±1,07	2,86±1,19	3,43±1,05	2,93±1,09	2,53±0,59	4,47±1,47	19,92±3,54
	2,00		4,05±1,23	2,77±1,44	3,26±1,42	3,00±1,30	2,55±0,95	3,90±1,88	19,53±4,47
	Significance	U	132,000	163,000	163,000	148,500	161,000	130,000	162,500
		Z	-0,879	-0,027	-0,028	-0,431	-0,084	-0,931	-0,041
		p	0,379	0,978	0,978	0,667	0,933	0,352	0,968
The effect of working life on sexual life	Yes		3,95±1,11	3,12±1,23	3,48±1,13	2,88±1,17	2,61±0,60	4,18±1,63	20,24±4,04
	No		3,54±1,06	2,56±1,20	3,32±1,14	2,93±1,09	2,48±0,72	4,57±1,47	19,44±3,42
	Significance	U	216,000	209,000	221,000	252,000	238,000	233,500	217,500
		Z	-1,296	-1,432	-1,207	-0,526	-0,834	-0,915	-1,245
		p	0,195	0,152	0,227	0,599	0,404	0,360	0,213

KW=Kruskal Wallis, U=Mann Whitney U, Rho = Spearman correlation coefficient * p <0.05

Table 3: Distribution of the relationship between the quality of life sub-dimensions and FSFI sexual dysfunction sub-dimensions in the subjects (n = 76)

Variable		Desire	Arousal	Lubrication	Orgasm	Satisfaction	Pain	Total
Physical Function	Rho	-0,327	-0,348	0,017	-0,117	-0,155	0,240	-0,244
	p	**0,022**	**0,014**	0,907	0,425	0,287	0,096	0,092
Physical Role Function	Rho	-0,318	-0,429	-0,093	-0,384	-0,484	0,312	-0,406
	p	**0,026**	**0,002**	0,524	**0,006**	**0,000**	**0,029**	**0,004**
Pain	Rho	-0,077	-0,365	0,062	-0,266	-0,339	0,401	-0,151
	p	0,597	**0,010**	0,674	0,065	**0,017**	**0,004**	0,299
General Perception of Health	Rho	-0,232	-0,532	-0,102	-0,376	-0,585	0,491	-0,393
	p	0,108	**0,000**	0,485	**0,008**	**0,000**	**0,000**	**0,005**
Wellness	Rho	-0,181	-0,367	0,123	-0,033	-0,308	0,441	-0,093
	p	0,214	**0,010**	0,401	0,822	**0,031**	**0,002**	0,526
Social Function	Rho	-0,325	-0,393	0,065	-0,166	-0,367	0,412	-0,197
	p	**0,023**	**0,005**	0,659	0,254	**0,009**	**0,003**	0,175
Mental Role Function	Rho	-0,088	-0,262	-0,054	-0,404	-0,499	0,291	-0,262
	p	0,546	0,069	0,711	**0,004**	**0,000**	**0,042**	0,068
Mental Health	Rho	-0,083	-0,350	-0,022	-0,157	-0,352	0,278	-0,214
	p	0,572	**0,014**	0,883	0,282	**0,013**	0,053	0,140
Physical Dimension	Rho	-0,251	-0,478	-0,002	-0,363	-0,540	0,425	-0,345
	p	0,082	**0,001**	,990	**0,010**	**0,000**	**0,002**	**0,015**
Mental Dimension	Rho	-0,212	-0,430	-0,025	-0,298*	-0,512	0,449	-0,279
	p	0,145	**0,002**	0,867	**0,038**	**0,000**	**0,001**	0,053
SF36 Total	Rho	-0,254	-0,510	-0,026	-0,351	-0,549	0,463	-0,346
	p	0,078	**0,000**	0,859	**0,013**	**0,000**	**0,001**	**0,015**

Rho = Spearman correlation coefficient * $p < 0.05$

and physical role function, general health perception, physical dimension, and total quality of life ($p < 0.05$) (Table 3).

Dıscussıon

The results obtained from the study were discussed under four headings: sexual dysfunction, quality of life, factors affecting sexual dysfunction, sexual dysfunction, and quality of life.

Sexual dysfunction

In our study, sexual dysfunction was found in all of the nurses. In addition, it was determined that the nurses got the highest score from the pain sub-dimension and the lowest score from the satisfaction sub-dimension of the IFSF index. In studies to date, female sexual dysfunction prevalence of 53.2% 39.65-% in Turkey, 82% in India 55,5-%, 79.3% 13,3-% in Brazil, 62% in Iran 1, 45.6% in Egypt, and 20% in the Czech Republic[12--16]. Studies have determined that women mostly experience sexual desire and lubrication problems[13,15,17]. While our study results are similar to other studies in terms of sexual dysfunction experienced the most, they differ in terms of the rate of dysfunction. It is thought that this situation arises from the effects of the physical and psychological workload in the institutions where the studies are conducted and the economic, political, and cultural changes experienced during the period of the studies on the psychology of individuals and interpersonal communication. Nurses' issues and concerns about sexuality negatively affect their interpersonal relationships and work life[18]. It also causes nurses' role-activity balances related to work and quality of life to deteriorate[19].

Life quality

It was found that the quality of life of nurses was moderate. It was determined that nurses got the

highest score from the physical function subgroup and the lowest score from the pain subgroup. The workplace, the way they work, and the type of work they do are important factor affecting the quality of life of nurses [20]. It has been found that the quality of life of nurses are at different levels (low, medium, and good) until today[20,21]. While our study results are similar to some study results, they differ from others. In addition to the fact that the quality of life is a multidimensional concept, it is thought that this is due to the difference in the physical or psychological workload of the environment where nurses work.

Factors affecting sexual dysfunction

In the study, it was found that sociodemographic characteristics of age affect arousal, orgasm, and sexual dysfunction. Along with the increase in age, sexual problems such as a decrease in genital sensitivity, difficulty in orgasm, pain during sexual intercourse, decrease in sexual desire and frequency of intercourse are observed in women due to changes such as thinning of the vaginal walls, vaginal dryness, as a result of the decrease in estrogen levels. In addition to the physiological changes that occur in elderly women, psychological and social changes due to aging also affect the individual's spouse relationships and sexual life[22]. In studies conducted so far, it has been found that the incidence of sexual dysfunction increases with increasing age in women[17,20,21].According to a study conducted by women between the ages of 55-65 have approximately eight times more sexual dysfunction than women aged 40-45[21]. Our study results support the literature. In our study, it was found that the way nurses work affects sexual arousal in a study conducted by Stamatiou *et al*. on female healthcare professionals, it was found that shift workers experience more sexual dysfunction than those who work only during the day shift[22]. In shift workers, cortisol, melatonin, testosterone, and steroid-binding hormone levels change, and depending on these changes, sexual desire and orgasm are negatively affected[19,20].

Nurses working at night have more depression and chronic fatigue due to the decrease in melatonin level than daytime workers[24].Women with depression and/or chronic fatigue have a higher rate of sexual dysfunction[25] . In a study of nurses working more frequently in night shifts, it was reported that the quality of sexual life of nurses was positively improved as a result of an intervention to improve sleep quality[26]. Our study results support other study results. In our study, it was determined that the duration of marriage affects the presence of desire, arousal, orgasm, and sexual dysfunction. Studies have reported that the duration of marriage affects the presence of sexual dysfunction, and the rate of sexual dysfunction increases significantly as the duration of marriage increases[15,16,24].In the study of Chae *et al*, ıt was determined that the risk of sexual dysfunction in women with a marriage duration of more than 20 years is 3.3 times higher than in women with less duration of marriage[27]. Our study results are similar to other study results.In our study, it was determined that having a child affects the presence of desire, arousal, and sexual dysfunction. Mustafa *et al*. and Tehrani *et al*. It was found that sexual dysfunction was negatively related to the number of children in the studies conducted[13,24]. Jafarzadeh Esfehani *et al*. It was found that more sexual dysfunction was observed in those with a higher number of children[15]. Our study results are similar to other study results in terms of having a child affects sexual life. In our study, it was found that the mode of delivery affects orgasm. Eid *et al*. found that vaginal delivery decreased desire, arousal, and lubrication, and cesarean caused decreased appetite[28]. In a normal delivery, vaginal prolapse develops due to hypotonia of the vaginal muscles, and this may cause a decrease in the ability to reach orgasm[28]. Our study results are similar to some study results but differ from others. This is thought to be due to the difference in inclusion criteria, sample size, and study methodologies of the study groups. In the studies conducted to treat nurses with sexual dysfunction problems, it was found that sexual dysfunctions decreased with psychological intervention method (cognitive behavior therapy) and as a result, the health of nurses was positively affected[7].

Sexual dysfunction and quality of life

In our study, it was found that sexual dysfunction in nurses affects the quality of life. In studies conducted with both healthy women and women

with health problems to date, it has been stated that sexual dysfunction affects the quality of life[1-5]. Psychological, relational, environmental, and socio-economic factors and various medical diagnoses and treatments are effective in the emergence of sexual dysfunction and decrease in quality of life[3-5]. In a study conducted by Dogan *et al*, quality of life and interpersonal relationships were reported to be positively affected as women had a good quality of sexual life[29].

Nurses' problems and concerns about sexuality negatively affect their interpersonal relationships and work life[18]. In a study conducted in nurses with sexual dysfunction problems in China, it was reported that problems related to sexual life decreased with regular physical exercise and increased social activity through lifestyle practices of nurses[30]. In the study conducted by Lee *et al*., it was emphasized that the good sexual life of nurses increases their job satisfaction[31]. Our study results are similar to the results of other studies in terms of sexual dysfunction affecting the quality of life.

Conclusıon

Sexual dysfunction in nurses affects the quality of life. It is known that there are many factors affecting the quality of life of nurses. One of them is sexuality, which is one of the basic life needs. It is difficult for nurses to express sexual problems that individuals have difficulty expressing the influence of social structure and culture. It is thought that organizing a training on this subject to make nurses aware of their sexual problems and directing those with sexual problems to places where they can get help will contribute to increasing the quality of life.

In order for nurses to improve their health-related quality of life, it would be worthwhile to take measures such as organizing the frequency of shift work and leave times and creating meaningful and productive activities in the areas of leisure time and self-care. Examining the situation for different professional groups working in shifts, such as nursing, and formulating solutions are among the issues that need to be addressed in terms of further studies.

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