

Social & Interpersonal Marital stressors As Perceived by Working Married Women with Female Sexual dysfunction

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Abstract

Background: Sexual activity is important to the overall health and well-being of an individual. Sexual dysfunction leads to negative effects on interpersonal and social relationships, and on the well-being and the quality of life of women. The aim of this study is to explore social & interpersonal marital stressors as perceived by working married women with female sexual dysfunction. **Methods:** A qualitative descriptive phenomenological design was used for this study. A purposive sample of 12 women was recruited based on certain inclusion criteria. The current study was conducted at Cairo University hospitals at Cairo Governorate. Three tools were used to collect the study data: a) Female personal data questionnaire tool; b) Arabic female sexual function index (ArFSFI); and c) Semi-structured interview. **Results:** The age range of the participant was 26-40 years with a mean age of 33.42 ± 4.59 years; the mean age of marriage was 25.89 ± 3.41 years. The mean duration of marriage was 7.25 ± 5.31 years. Seventy five percent of the participant received university education, 75% were clerical worker. Ninety one point seven percent of participants were multiparous, 33.3% were using combined contraceptive pills and 91.7% of the women had a genital mutilation/cutting. Lubrication was the lowest affected domains mean scores among participants, while the highest mean scores of affected domain in ArFSFI domains among them was the desire domain ($4.26 + 0.956$ compared to $3.3 + 1.002$ respectively). The analysis of raw data related to social and interpersonal marital stressors as perceived by the participants were categories under the following: 1) work / home duties, and children affairs; 2) male dominance and neglecting of women feelings; 3) social norms; and 4) interpersonal marital conflicts. **Conclusion and recommendation:** The current study concluded that, FSD is prevalent among working women in childbearing age and Bio-psychosocial approach should implemented when dealing with women who have female sexual dysfunction.

Key words: Female Sexual dysfunction, working women, social and interpersonal stress, female sexual functional index

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I. Introduction

Female sexual dysfunction is a public health concerns with many physical and psychological consequences that can impact women's quality of care (1). This problem is often multi-factorial, necessitating a multidisciplinary evaluation and treatment approach that addresses biological, psychological, socio-cultural, and relational factors (2).

The woman is considered sexually functioning when she has the ability to achieve sexual desire, arousal, lubrication, orgasm and satisfaction (3). Approximately 40% of women will experience some type of sexual problem over the course of their lifetimes. 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% (4,5).

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 DSM 5th 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 having a good relationship with her partner (6,5).

Sexual difficulties are frequent among women and involve about 20-50% of the female population worldwide (7). In one Brazilian study that evaluated the sexual profile of 904 healthy women, 30% of the of those women who were included in this study experienced sexual difficulties; lack of desire was the most

prevalent problem (34.6%) followed by orgasmic difficulty (29.3%) (8). Moreover, (9) in their study that conducted in United Kingdom (UK) on 1489 to examine the prevalence and risk factors of female sexual dysfunction in their society, concluded that FSD is common in the general population and is influenced by psychosocial factors with different patho-etologies underlying recent and lifelong FSD. A study conducted in Malaysia to determine the prevalence and risk factors of female sexual dysfunction (FSD) among 201 women working as healthcare personnel in selected 3 large healthcare facilities found that one in eighteen female healthcare personnel suffered from FSD (10).

It is not known whether female sexual dysfunction among women health care workers can affect sexual health. However a survey in an international group of sexuality professionals suggests that there are few differences between sexuality professionals and the general public since most health professionals reported that their profession has positive effects on their sexual functioning (11). Similarly to the above, in our study, a significant difference in average SFS score was noted between health professionals and non-health professionals (18.02 and 18.10 for nurse specialists and medical doctors versus 8.81 for hospital administrative employees). Similar trends were recorded in the relative quality of life (QoL) levels (3.11 versus 1.95 average QoL score of nurse specialists and hospital administrative employees respectively). Despite the relative high average SFS score, the associated average QoL score of medical doctors was low (1.47). The reason explaining the above finding is practically unknown. Actually, the experience of sexual dysfunction is highly associated with a number of unsatisfying personal experiences and relationships and it has been shown that medical doctors are highly susceptible to stress at work and experience more negative outcomes of stress than other health care professionals and for this reason, occupational stress is more likely to have an additional impact on female workers sexual dysfunction related QoL (12).

In Egypt, most of the studies reported that FSD became to be prevalent in Egypt among urban and rural areas. In a study that was conducted in the obstetric and gynecological outpatient clinic at Cairo university hospital on 361 women aged from 18-42 years old, shows 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) (11).

Another study examines 509 women who attended gynecology outpatient clinic of obstetrics and gynecology department at Suez Canal University Hospital, for their sexual function using female sexual function index (FSFI); the researchers concluded that, FSD is highly prevalent in these population and lack of orgasm as well as lack of desire scores were the most affected female sexual domains (12).

On the other hand, 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; Discord 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 can all affect a woman's sexual function. Lack of knowledge about sexual stimulation and response, and poor communication between partners may prevent a woman from achieving a satisfactory experience and lead to FSD (13, 14, 3).

There is a scattered review of literature regarding the social and interpersonal stressors perceived by working women with sexual dysfunction as most researches 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 Social & interpersonal marital stressors as perceived by working married women with female sexual dysfunction

Significance of the study

Woman with 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 care professionals are reluctant to begin a discussion about sexuality with their patients. Instead, women may needlessly suffer in silence when their problems could be treated (15, 16).

The phenomenon of female sexual dysfunction has investigated to lesser extent than male sexual dysfunction (17). Hence this study was intended to advance empirical and theoretical knowledge in the area of the female sexuality and sexual dysfunction and serve as a basis for further research and theory development. Although the focus of the study lies on the social & interpersonal stressors as perceived by working women with female sexual dysfunction and it would therefore probably to provide a meaningful profound and complex data on the subjective perception of female sexual dysfunction. Also, 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

Nurses are expected to work with a holistic approach that includes physical, psychological, social, sexual and spiritual dimensions of health to support the women to cope with all kinds of problems in their daily life. The information gained from this study may be useful to highlight educational needs and practice for better integration of women's sexuality in nursing education and practice to provide holistic care. Moreover, the findings obtained in this study could also be used by participants to understand themselves and their experience more fully, as well as, to realize that they are not alone in their experience. 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.

Aim of the study

The aim of this study was to explore social and interpersonal marital stressors as perceived by working married women with sexual dysfunction.

Research Question

To fulfill the aim of this study the following research question was formulated:

- 1- What are the social and interpersonal marital stressors perceived by working women with sexual dysfunction ?

II. Subjects and Methods

Research Design

A qualitative descriptive phenomenological design was used for this study.

Participants

A purposive sample was used in the current study. The logic and power of using purposeful sampling lies in selecting participants who provide rich information. A total number of 12 women were included.

Sample Size

The predetermination of the number of participant for such given design is almost impossible. The sample size in this study would not be determined by the number of the participants but by the data saturation or redundancy. Redundancy is evidenced when no new information was heard about the study phenomenon (19). Saturation and redundancy indicated completion of the data collection phase and this was decided by the researcher. Saturation was achieved among 12 women who were interviewed.

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 child bearing 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 at Cairo University hospitals at Cairo Governorate. Interview was conducted in a more than five different administrative offices in different departments at the Cairo university hospital as: 10 and 21 departments and outpatient clinic in obstetric and gynecological hospital, El-Kasr El-Ani nursing school students' affaire office, and finally dental outpatient clinical reception office.

Tools for Data Collection: Three tools were used to collect the study data;

1. Female personal data questionnaire Tool: This tool was developed by the investigator and it is self administered by the women, it includes four parts: a) the personal background data (age, age at marriage, duration of marriage, educational level, occupation, residency, , educational level, occupation, habits, presence of sexual problem); b) female obstetrical and gynecological profile (genital mutilation, mode and number of previous deliveries, type of contraception used,
2. Arabic female sexual function index (ArFSFI): this tool was adopted from (20). 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 week before the scheduled interview. Scoring system: This tool contain 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 denote highest point. The minimum score was 2 and the maximum score was 36. A total score of 28.1 was taken as the cutoff point for the ArFSFI to distinguish between women with FSD and women with normal function (sensitivity 96.7%, specificity 93.2%). High mean score of each domains means that this domain scores near to the normal.

3. Semi-structured interview. This tool was developed by the research investigator; which included seven open-ended questions to help women to explore social and interpersonal stressors of sexual dysfunction

Content Validity & reliability

Tools was reviewed and tested for content validity by juries of five experts in the related field to reach consensus of the best form to be implemented. For the Arabic female sexual function index (ArFSFI) the results of (20) study revealed that high test–retest reliability (r from 0.92 to 0.98). ArFSFI domains showed high internal consistency (chronbach, $\alpha = 0.85$ to 0.94).

Ethical Considerations:

The research investigator introduced herself to the women who met the inclusion criteria and inform 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 and could not be accessed by other persons than the investigator of the study and then written consent was obtained after the participant agreed to participate in the study.

Procedure:

The data was collected over a period of one year started in August 2017 and ended in July 2018 through two phases; preparation, and interviewing phases which included two interviews.

Preparation: In this phase, Tools were developed by the investigator and revised by 5 experts in maternity nursing, and andrology department. The investigator constructed and developed the other data collection tools, based on the extensive literature review.

1) 1st interview. The purpose and nature of the study was explained to the participants before starting the interview. The investigator introduced herself to women who met the inclusion criteria and inform them about the purpose of this research in order to obtain their written consent. Self administered questionnaire was distributed to the participant, and the researcher obtained the participants FSFI score through using ArFSFI questionnaire sheet 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 Interview. Interview was conducted in Arabic language by the investigator. Two to three sessions was conducted with each participant. The 2nd interview was conducted after the 1st one by One week up to one month according to convenient of the women and free work time. Interview was conducted either before the official working hours or after work. There is no break for the employee. Time would not be scheduled with the participant during their work's break or immediately after work because there is no break time and the leave at their work time-out exactly and sometimes before the work before their leaving time. 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 analyzes the quantitative data. Descriptive statistics were used to analyze the sample population. Mean, standard deviation, and frequency distribution were used.

Analysis of qualitative data using field notes that transcribed verbatim for analysis. The information was used to identify meaningful segments and units and then the segments were reviewed, finally the information were identified.

III. Results

This study intended to explore Social & interpersonal stressors as perceived by working married women with female sexual dysfunction. Findings of this study are presented in 2 main Sections: Section(1) represents the quantitative findings and consists of 4 sub-sections; a) women and demographic characteristics; b) Data related to husbands life style habits and history of sexual problems; c) Participant obstetrical and gynecological profile; and d) female sexual function index scores. Part (2) represents the qualitative analysis of the women perceive social and interpersonal stressors among working married women with female sexual dysfunction.

Section I: Quantitative Findings

• This part includes the 4 sub-section: a) distribution of the participants according to their demographic characteristics, b) Data related to participant husbands life style habits and history of sexual problems) Participant obstetrics and gynecological profile, and d) female sexual function index scores.

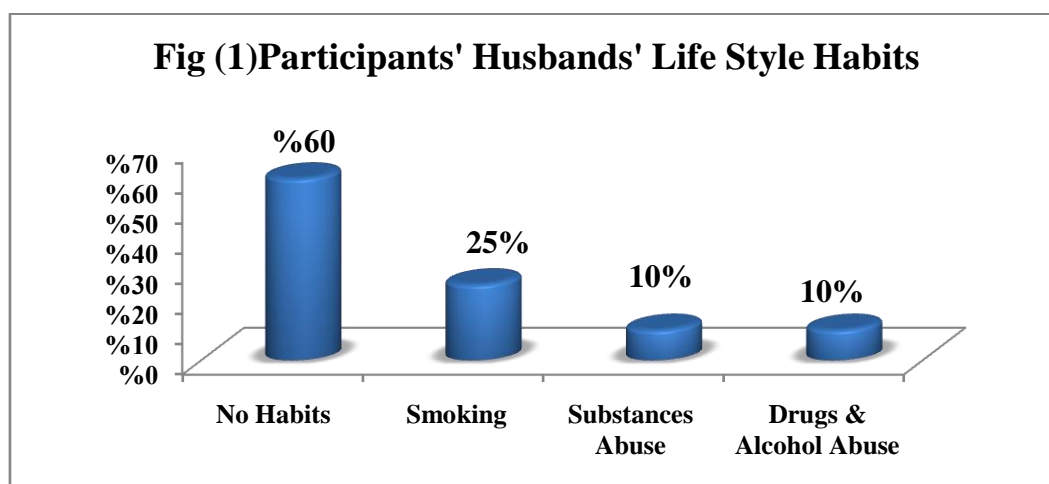
a) distribution of the participants according to their demographic characteristics

Table (1) represents the participants' socio-demographic characteristics. The age range of the participant was 26-40 years with a mean age of 33.42 ± 4.59 years; their age at marriage was 22-35 years with a mean 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 received university education, 75% were clerical worker, 16.7% of the participants had managerial positions, compared to only 8.3% of them worked in manual works.

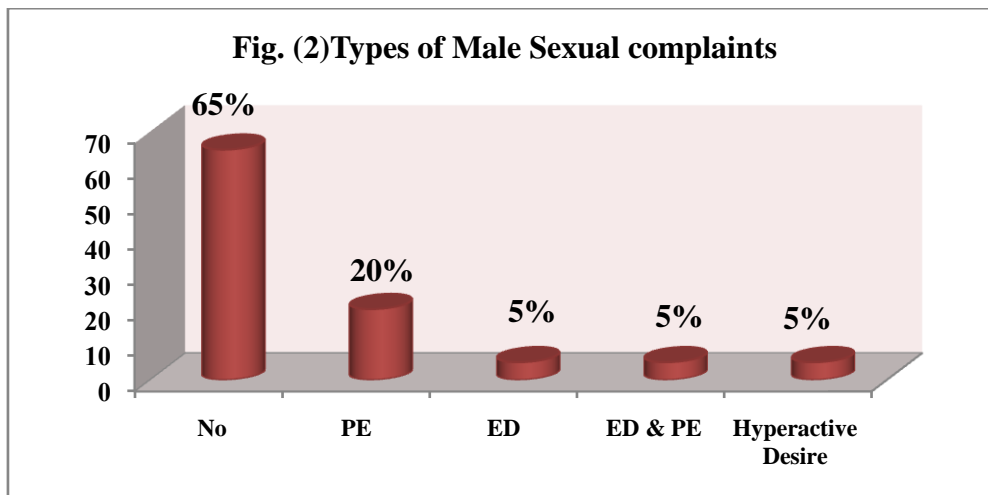
Table (1) Distribution of the Participants According to socio-demographic characteristics

Participants Code	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

b) Regarding to participant husbands' life style habits, the results showed that 60% had no special habits while 25% were smokers with a mean of 25 cigarettes /day, 10% were adapted on substances as cannabis and marijuana smoking, and 10% were drug and alcohol abusers (Fig., 1).



Moreover, 65% of husbands' had no sexual complaint, 20% had premature ejaculation (PE), and 5% either complains of erectile dysfunction (ED), ED and PE, or hyperactive desire (figure, 2).

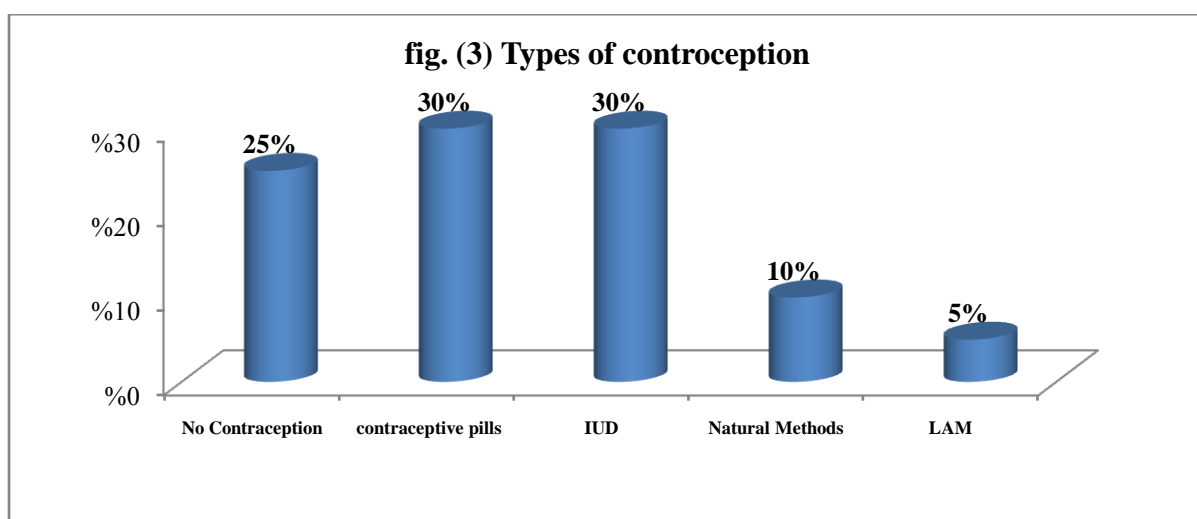


c. Participant obstetrical and gynecological profile

Ninety one point seven percent of participants were multiparous from one to three deliveries; 50% of them had delivered vaginally, while only 41.7 % of the women had delivered through cesarean section. 91.7 % of the participant was using different types of contraception; 41.7% were using intrauterine device (IUD), 33.3% were using combined contraceptive pills, and 16.7% of them were using natural contraceptive methods. Ninety-one point seven percent of the women had a genital mutilation/cutting (Table, 2, Fig .3)

Table (2) Distribution of the Participants According to Obstetric profile

Participants Code	No. of children	Type of delivery	Type of contraceptive method	FGM
Participant 1	2	Vaginal	Natural	Yes
Participant 2	2	Vaginal with episiotomy	IUD	Yes
Participant 3	3	Vaginal	IUD	Yes
Participant 4	2	Vaginal	IUD	Yes
Participant 5	No children	Nullipara	Nothing	Yes
Participant 6	1	CS	Natural	Yes
Participant 7	1	CS	IUD	Yes
Participant 8	3	Vaginal	Hormonal	Yes
Participant 9	2	Vaginal with episiotomy	IUD	Yes
Participant 10	1	CS	Hormonal	Yes
Participant 11	2	CS	Hormonal	Yes
Participant 12	2	CS	Hormonal	No



d) Female sexual function index scores.

This section includes the types of FSFI domains and its score among participant. Lubrication was the lowest affected domain among participants, while the highest affected domain in FSFI domains among them was the desire domain (Table, 3).

Table (3) Distribution of the Participants According to Female Sexual Function Index Domains

FSFI Domains	\bar{x}	\pm 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

Section (2) Qualitative Data Analysis:

Regarding to social and interpersonal stressors as perceived by the participants of this study, The analysis of data includes 4 sub-themes; 1) work / home duties, and children affairs; 2) male dominance and neglecting of women feelings; 3) social norms; and 4) interpersonal conflicts.

1- Work / home duties and children responsibilities:

Participant 1: “I think my sexual disturbance is because of work’s pressure, and kids and the House demands”

Participant 2: “I think my sexual problem is because of work’s and life’s pressures, and children’s issues”

Participant 7: “Working pressure is one of reasons which adversely affected my sex drive. I consider it a secondary thing in my life because I'm always tired and not well because of my workload”

Participant 8: “The Reasons for my problem in my opinion are the effect of life stressors and the pressures at home and work on my mental status”

2. Male dominance & Neglection of women’s feelings:

Participant 1: “Sex is just a male performance to satisfy himself, without taking into account my desires and feelings and he is always selfish and only thinks about himself and his pleasure only ,scarce Foreplay and the relationship occurs without intros or readiness according to his mood”

“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” “For solving this problem, my husband has to understand that I have desire just like him and he must take into account my feelings in general, and during the love making”

Participant 5: “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 wants but he refused in insultingly way when I ask for that.”

Participant 10: “The main cause of this problem is the way that my husband treats me with. His ignorance of my feelings and choosing always the wrong time to have sex with me”. “The man just cares for the sexual act regardless the feelings and affection and he does it to be relieved only.”

3. Social norms:

Participant 6:

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

Participant 8:

“Talking on this subject is socially and religiously unacceptable in our society and this thinking negatively affects women's sexual health”

4. Interpersonal conflicts:

Participant 2:

“Our marital life is a rage and quarrel most of the time and each of us on his own affairs”

Participant 5:

“When I discussed the sexual issues with my husband, he was angry and accused me of not taking his circumstances or his work in my consideration. He said that he give more than enough and If I am dissatisfied, we can get apart (she started to cry and while she was speaking). Then he left the house and went to his other wife for whole a month”

Participant 6:

“The causes of my problem from my point of view are the short period of caressing and continuous marital conflicts between us “

Participant 8:

“We feel annoyed at each other and always yell and be nervous because I'm not asking for sex (pause and smile) and to avoid that I do it as a marital duty (laugh sarcastically but she looks sad)”

Participant 9:

“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 and I refuse pretending fatigue or that I am busy with the children”

Participant 12:

“My relationship with my husband is turbulent. It means irregular or unstable and lacks feelings, and this is because there are many problems between us most of the time. At the beginning of the marriage, things were fine, but when my husband's parents began to interfere in our lives, the problems arose, and he always sided with his family and formed problems to stay with them longest time possible. When a problem occurs between us, he abstains of establishing a sexual relationship with me for two weeks or more. If I ask him for sex, he says that I am badly in need for him.”

IV. Discussion

The aim of the current study was to explore social & interpersonal stressors as perceived by working women with female sexual dysfunction. The discussion will be represented within the following frame of references: 1) the profile of the study's participants who are having FSD, 2) Results of content analysis of social & interpersonal stressors as perceived by the participants.

1. Profile of the study participant: Regarding 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 of the 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 (21), they 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, (22); 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 (21), who reported that FSD was more prevalent in women who are married for more than 16 years. Moreover, (23), 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 decline with time. This finding is 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 neglecting of self and her sexual wellbeing.

Regarding to participant education, all of the participants and their husbands were educated either university or secondary education. This finding agreed with the results of (24) 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.

The current study findings are not supported by (21) findings that the prevalence of FSD is common among middle educated women. Also (22), in their study of FSD risk factors, the study findings indicated that FSD is prevalent among illiterate and primary educated women while FSD is lessen in secondary, university and post graduated women. This contrast may result from participant who agreed to participate were educated enough to admit their sexual complaint while the less educated women have a concept that it's an embarrassing issue and it is forbidden to be discussed with others.

In relation to participants' obstetric profile, most of the participant were para one to para three with range of having children from one child to 3 children. On the contrary, (24) explore the prevalence and associated risk factors for Female Sexual Dysfunction (FSD) in Iran, they found that sexual dysfunction 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 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 (25). 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.

In relation to mode of delivery, the results of the current study revealed that 40% of the multiparous participants delivered normally while one 25% of them were delivered vaginally with episiotomy and 20% delivered by caesarean section. This finding agreed with (26); who investigated 300 married women for sexual behavior in the postpartum period according to the mode of delivery. They concluded that female sexual complaint is common among all participants with different modes of delivery.

Regarding to using contraceptives methods, the results of this study showed that 75% of the participant were using different types of contraception to control their fertility, among those 40% of them were using hormonal contraceptive and also 40% were using IUD while the 20% of them were using natural and physiological methods. This finding agreed with (27) findings of their study that investigate the prevalence and types of FSD and the relationship between hormonal contraceptives (HC) and FSD among 1,086 female German medical students; the finding revealed that women using contraception, especially hormonal contraception, had lower sexual functioning scores. Also in another review of literature about contraception and sexuality, the reviewer mentioned that all hormonal contraceptive types had a negative effect on female sexuality, while IUD and sterilization had positive effect on desire and overall sexual function. Barrier and natural family planning methods are neutral (28).

On the contrary, (29) evaluate and compare sexual satisfaction with the use of three types of hormonal contraceptives methods: sub-dermal hormonal contraception, hormonal vaginal ring, and combined oral contraception; they found that all three types of hormonal contraceptives have improved the sexual behavior among participants and decreased anxiety and discomfort that sometimes accompanied with sexual intercourse due to fear of unwanted pregnancy. This contradictory may be because of different culture and high medical services and follow up for women using contraceptive methods with accurate choosing of the methods and adequate health teaching and information delivered to those women regarding contraceptive methods which not applicable in our public or private women's health clinics.

Considering female sexual mutilation (FGM), the finding of this study revealed that 80% of the participant had FGM and 38% of them reported that this procedure had affected their sexual function as it decrease their desire and response to sexual act. Researches done on women with FGM revealed that FGM has obvious effect on female sexual function. A study conducted by (30) to evaluate sexual function among 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 after that with a statistical significant difference ($p = 0.009$). Also, (31) conducted a review article about Psychosocial and sexual aspects of female circumcision; he mentioned 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 is desire, and then pain, arousal, orgasm, satisfaction, and lubrication prospectively. A study conducted by (32) at faculty of medicine, 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 participant had sexual affection 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. This finding agreed with the current study in the affection of the domains of FSFI and disagreed with it in the number of affected participant, this difference may be because of the difference in numbers of participant.

2) Content analysis of social & interpersonal stressors as perceived by the participants: In the current study, Social and interpersonal stressors perceived by working women had great loads that contribute to physical and mental burden on woman. A study conducted by (33) they assessed the incidence and prevalence of sexual dysfunction among women (no. = 88) works in health care settings, the study shows that occupational stress can affect female sexual function. 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" (34); as 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 (1) to assess the prevalence of FSD among premenopausal women by sought studies done from 2000 to 2014; the study findings revealed that male dominance is a predictor factor of female sexual dysfunction in certain cultural specially in Africa, middle and south Asia.

Moreover, (35), in their study of the prevalence of sexual dysfunction and their correlates among female patients of reproductive age in Nigeria; they indicated that the culture of male dominance which makes women afraid of rejection and threats of divorce if they ever complain about sexually-related matters might be

behind sexual dysfunction among female partners. Sexual dysfunction is a existent social and psychological problem that have to be researched widely and attentively.

Interpersonal conflicts between married couples play a significant role in their sexual disorders. (36) in their narrative review of bio-psychosocial approach and its impacts on female sexual function and dysfunction reported that socio-cultural 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 socio-cultural factors may be contributed to unresolved conflicts between more than half (n = 8) of this study's participants and their husbands.

Summary: this study explore the experience of women who are having FSD using a holistic approach to evaluate the bio-psychosocial 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 bio-psychosocial approach that simultaneously considers physical, psychological, socio-cultural, and interpersonal factors is necessary to guide research and clinical care regarding women's sexual function (36, 37, 38).

V. Conclusion

The current study concluded that, FSD is prevalent among working women in childbearing age. The qualitative analysis of the current study revealed social and interpersonal stressors in the form of work / home duties, and children affairs; 2) male dominance and neglecting of women feelings; 3) social norms; and 4) interpersonal conflicts were the main stressors perceived by study participant .

VI. Recommendations

Based on the results of this study, the following are 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
- Further studies using qualitative approach conducted to provide a clear picture of Egyptian women experience of having FSD among working versus non- working women.
- Studies that involved the partner of women living with FSD are needed in order to identify their knowledge, and understanding of their wives sexual condition.

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