Effect of Guided psychosexual Instructions on Sexual Activity among Hypoactive Women's Sexual Dysfunctions

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Abstract

Female sexual dysfunction (FSD) is a serious health problem because of its high prevalence and deleterious effects on women's quality of life. Practitioners of women's health must care able to detect FSD in its early stage so that timely treatment could be offered. Also, the clinicians have lack understanding about the approach for identification and evaluation of the sexual problem. **The** study **aimed** to investigate the effect of guided psychosexual health instructions on changes in sexual activity among women with reduced sexual dysfunctions (hypoactive). **Methods: A quasi-experimental design was used (pre and posttest one group) Setting:** The study was conducted at Kebly and Bahary Maternal& Child Health Care Centers at Shibin Elkom **Sample** 100 participants of women were selected according to their responses in two-scale of sexual dysfunctions and elicited as hypoactive sexual dysfunctions from MCH **Tools of the study: 1- Structured interview questionnaire** classified into two parts, the first part deal with a biosocial data as age, level of education, and the employment status as well as complaining from physical or gynecological problems hindering them for conducting healthy marital relationship with their partner. **The second part was: The Female Sexual Function Index (FSFI),** A Multidimensional Self-Report Instrument for the Assessment of Female Sexual Function in a 19-item questionnaire, It was developed by **Rosen, et al. (2010)** as a brief instrument for assessing the key dimensions of sexual function in women. **2-Sexual Dysfunction Questionnaire It was developed by Infrasca et, al (2011) to assess women's readiness and preparation for sexual functions disorders** Introduced as a brief self-report inventory. **Results** showed that there was a highly statistically significant difference $P<0.001$ between pre and post-intervention regarding the arousal of their sexual desire as well as vaginal lubrication, orgasm, and degree of satisfaction during sexual activity. **It was concluded that** the use of **guided** psychosexual intervention was effective in managing sexual dysfunctions problems and enhancing satisfaction to reach orgasm. **Recommendations.** All health care providers should include screening questions regarding sexual well-being as a standard of practice. Treating medical, psychosexual, relationship problems, and addressing sociocultural issues, which can be effective in helping women and their partners dealing with hypoactive sexual desire disorder. Health care providers should involve the woman's partner in the assessment and treatment of sexual health concerns when it is appropriate and safe to do so. Also, health guidelines protocol of care for (SD) should be providers to involve the woman's partner in addressing sexual issues,

Keywords: Guided, psychosexual, Instructions, Hypoactive, sexual, Dysfunctions

Introduction

Sexual dysfunction is a common class of disorders, with estimates of current prevalence rates ranging up to 46 % of the general population Frühauf, et, al (2013). It associated with impaired sexual and marital satisfaction as well as reduced quality of life, Lori (2018). Psychosocial factors like societal and religious beliefs, health status, personal experience, ethnicity, and socio-demographic conditions, as well as psychosexual status of the person/couple, play an important role inadequate sexual functioning of a person. In addition, sexual activity incorporates interpersonal relationships, each partner bringing unique attitudes, needs, and responses into the coupling. A breakdown in any of these areas may lead to sexual dysfunction. (Ajit and Sathyanarayana , 2017).

Prevalence estimates obtained from primary care and sexuality clinic samples are characteristically higher. Although a relatively large number of studies have been conducted in the review, the lack of methodological rigor

of many studies limits the confidence that can be placed in these findings. About 45% of women suffer from some form of sexual dysfunction. Despite its high prevalence, few studies have systematically evaluated sex therapy in comparison with other interventions. Sexuality is an integral part of being human, a complex mix of mental, emotional, and physical signals. Love, affection, and sexual intimacy contribute to healthy relationships and individual well-being. The fundamental psychosexual needs of an individual are represented by four psychodynamic factors: includes an attachment, autonomy, sexual identity, and self-esteem. The prevalence of FSD in premenopausal women was estimated to be 40.9% (95% CI = 37.1–44.7, I2 = 99.0%). Prevalence rates of individual sexual disorders ranged from 20.6% (lubrication difficulties) to 28.2% (hypoactive sexual desire disorder). Further analyses showed significantly higher rates of FSD in studies in Africa, studies that used non-validated assessment tools, and studies without pharmaceutical funding Megan &et, al (2016). Sexual disorders are common in women and include desire, arousal, orgasmic, and pain disorders. In addition, questions and concerns related to sexuality constitute an important part of women's life. In some communities, 80% of women feel that sexual relationship is a necessary component of life. One of the hallmarks of physical and mental health as well as a factor of life quality is healthy and proper sexual functioning Maasumeh et, al (2014).

Hypoactive Sexual Desire Disorder (HSDD), from which 1 per 10 women suffer, challenging issues in women's sexual health are the major reasons for their referral to clinics at all ages. The prevalence of sexual dysfunction in the general population is very high. It is suggested that about 43% of women and 31% of men have one or another kind of sexual dysfunction. Acquired sexual dysfunction occurs after a period of normal sexual desire or tendency and is not related to special conditions, situations, or relationships (for example, change of sexual partner). As well the negative effects of HSDD on a woman include feeling less feminine, feeling of sexual failure, low self-confidence, lack of security, and feeling inferior in front of a sexual partner had an unpleasant impact on their normal health Ajit and Sathyanarayana (2017).

Although the underlying biological causes of HSDD remain unknown, generalized HSDD likely involves either a predisposition toward inhibitory processes or neuro-adaptations that result in decreased excitation, increased inhibition, or a mixture of the two. Alterations in brain function and structure may be additionally modulated or reinforced by experience and behavior (experience-based neuroplasticity), further propagating the condition. This perspective is consistent with differential brain activity patterns and structural differences between women with and without HSDD Anita, et, al. (2018).

The most common problems related to sexual dysfunction in women include:

- Inhibited sexual desire. This involves a lack of sexual desire or interest in sex. Many factors can contribute to a lack of desire, including hormonal changes, medical conditions and treatments (for example, cancer and chemotherapy), depression, pregnancy, stress, and fatigue. Boredom with regular sexual routines also may contribute to a lack of enthusiasm for sex, as can lifestyle factors, such as careers and the care of children.
- Inability to become aroused. For women, the inability to become physically aroused during sexual activity often involves insufficient vaginal lubrication. This inability also may be related to anxiety or inadequate stimulation. In addition, researchers are investigating how blood flow problems affecting the vagina and clitoris may contribute to arousal problems.
- Lack of orgasm (anorgasmia). This is the absence of sexual climax (orgasm). It can be caused by a woman's sexual inhibition, inexperience, lack of knowledge, and psychosexual factors such as guilt, anxiety, or past sexual trauma or abuse. Other factors contributing to anorgasmia include insufficient stimulation, certain medications, and chronic diseases.
- Painful intercourse. Pain during intercourse can be caused by many problems, including endometriosis, a pelvic

- Mass, ovarian cysts, vaginitis, poor lubrication, the presence of scar tissue from surgery, or a sexually transmitted disease. A condition called vaginismus is a painful, involuntary spasm of the muscles that surround the vaginal entrance. It may occur in women who fear that penetration will be painful and may stem from a sexual phobia or a previous traumatic or painful experience Rosemary Basson (2018).

The complex nature of female sexual function requires a holistic treatment approach. In this respect, a range of psychosexual therapies may be helpful, including basic psychosexual counseling, cognitive behavioral therapy through treating the underlying physical or psychosexual problems. Other treatment strategies focus on the following, providing education about human anatomy, sexual function, and the normal changes associated with aging, as well as sexual behaviors and appropriate responses, may help a woman overcome her anxieties about sexual function and performance. Enhancing stimulation. This may include the use of erotic materials (videos or books), masturbation, and changes in sexual routines. Providing distraction techniques. Erotic or non-erotic fantasies; exercises with intercourse; music, videos, or television can be used to increase relaxation and eliminate anxiety. Encouraging non-coital behaviors. Non-coital behaviors (a physically stimulating activity that does not include intercourse), such as sensual massage, can be used to promote comfort and increase communication between partners. Minimizing pain. Using sexual positions that allow the woman to control the depth of penetration may help relieve some pain. Vaginal lubricants can help reduce pain caused by friction, and a warm bath before intercourse can help increase relaxation. Relationship counseling, and body awareness education. The sexual activity incorporates interpersonal relationships, each partner bringing unique attitudes, needs, and responses into the coupling. A breakdown in any of these areas may lead to sexual dysfunction. Pyke, and Clayton (2017).

So, sexual health education is an informed process that forms views and beliefs about sex, sexual identity, and sexual intimacy and includes a broad concept ranging from human sexual anatomy and reproductive health to emotional relationships and reproductive rights. It causes individuals to select their sexual behavior, helps prevent sexually transmitted diseases and sexual abuse, and has a fundamental role in fulfilling sexual needs and enjoying healthy sexuality. Brotto& Basson (2014).

The sexual dysfunction should be defined in terms of onset and duration and situational versus global effect. A situational dysfunction occurs with a specific partner, in a certain setting, or a definable circumstance. The presence of more than one dysfunction should be ascertained, because considerable interdependence may exist. For example, a patient complaining about decreased desire might have a primary orgasmic disorder from insufficient stimulation, with decreased desire developing secondarily as a result of unsatisfying sexual encounters. Thus, treating the orgasmic disorder would indirectly enhance desire; whereas, treating a desire disorder would be unsuccessful and perhaps add to patient frustration and perpetuate the cycle of dysfunction. Flynn& et al(2016).

Primary care nurse, skilled in the management and counseling for social and psychosexual disorders as work-related stress and anxiety, concern about sexual performance, marital or relation problems, depression, feelings of guilt, or the effects of past sexual trauma, often feels unqualified to treat patients with sexual dysfunction due to sensitivity of those issues. However, with an understanding of sexual functioning and application of general medical and gynecologic treatments to sexual issues, sexual dysfunction may be effectively approached with the same skills. It includes obtaining a complete patient history, conducting a physical examination, psychosexual preparation, application of basic treatment strategies, providing patient education and reassurance, and recommending appropriate referral when indicated. The use of guidelines makes it easier to overcome certain barriers since they provide the beginning of a dialogue. These can potentially provide more sensitive and accurate measurements of the complex and subjective aspects of the sexual function of women. Also, Information provided by the gynecologist, nurses,

psychologist, and social aspects of sexual function may help the women better assess her sex life and verbalize complaints that can be addressed. Additionally, many women with sexual complaints, but who do not fulfill the criteria for the diagnosis of sexual dysfunction can be helped by basic measures taken by a professional. Sheryl et.al(2019) and Catherine et.al (2014).

Significance of the problem

This area of research is very sensitive to be discussed with any women and lacks in highlight the presence of sexual problems and the associated problems among women. Mamdouh, et al.(2017) suggested Female Sexual Dysfunction in more than half of the women surveyed (53.7%). Domain scores suggestive of sexual difficulties ranged from the highest prevalent difficulty related to desire (82.2%) to the least prevalent one of poor satisfaction (33.4%). For these reasons, we highlight to address most of the commonly associated problems with sexual dysfunctions to deal with it through guided psychosexual instruction to delineate with it.

Operational definitions

Hypoactive sexual desire disorder (HSDD) is defined as persistent or recurrently deficient (or absent) sexual fantasies and desire for sexual activity that causes marked distress or interpersonal difficulty Kingsberg(2014).

Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

Sexual dysfunction refers to a problem(s) that prevents the individual or couple from experiencing satisfaction from sexual activity. Parish, et al. (2016).

Aim of the study

This study aimed to investigate the effect of guided psychosexual health instructions on changes in sexual activity among women with reduced sexual dysfunctions (hypoactive).

Methodology

Hypothesis

1- Women who receive guided psychosexual health instructions for management of sexual dysfunction will have a better sexual desire post-intervention than at pre-intervention
2- Women who receive guided psychosexual health instructions for management of sexual dysfunction will have a better degree of satisfaction to reach orgasm activity post-intervention than at pre-intervention.
3- Women who receive guided psychosexual health instructions for management of sexual dysfunction will have a better sexual desire and degree of satisfaction to reach orgasm activity post-intervention than at pre-intervention.

Design

Quasi-experimental research (pretest, posttest design) design was utilized to achieve the aim of this study

Setting

The study was conducted at Kebly and Bahary Maternal& Child Health Care Centers in Shibin Elkom at Menoufia

Governorate, Egypt. It selected these setting for women continuation of this centers. Health Care Centers consist of clinics for children, gynecologic, family planning methods, pregnancy follow-up, dentists, and analyzes. Also a hall to explain for health education.

Sample

Sample size was calculated at power 80%, margin of error 5% and confidence interval 95%. By the following equation where Z = Z statistic for a level of confidence of 95%, which is conventional = 1.96. SD = Standard deviation. d = precision (in proportion of one; if 5%, d = 0.05).

$$\text{Sample size} = \frac{(Z_{1-\alpha/2})^2 \, SD^2}{d^2}$$

According to the above mentioned equation, the sample will include purposive sample of 100 participants of women volunteers was selected according to their responses in two-scale of sexual dysfunctions and elicited as hypoactive sexual dysfunctions from Kebly and Bahary Maternal& Child Health Care Centers The participant were chosen after interviewing for their sexual relations and excluded for major physical or gynecological problems and not undergoing any psychiatric management, hindering them for accommodation for their sexual life and according to the following inclusion criteria.

The exclusion criterion was having a partner with significant sexual problems (e.g., impotence, erectile dysfunction, and, serious sexual aversion)

The inclusion criterion

- Have a stable partner relationship for at least 12 months.
- Lack of motivation for sexual activity as manifested by: decreased or absent spontaneous desire (sexual thoughts or fantasies); or decreased or absent responsive desire to erotic cues and stimulation or inability to maintain desire or interest through sexual activity
- Loss of desire to initiate or participate in sexual activity, including behavioral responses such as avoidance of situations that could lead to sexual activity, that is not secondary to sexual pain disorders;

Tools of the study

1- Structured interview questionnaire classified into two parts, the first part deal with biosocial questions asking women about their age, level of education, and employment status as well as complaining from physical, psychosexual, or gynecological problems hindering them for conducting healthy marital relationship with their partner.

The second part was: The Female Sexual Function Index (FSFI), The Female Sexual Function Index (FSFI): A Multidimensional Self-Report Instrument for the Assessment of Female Sexual Function in a 19-item questionnaire, It was developed by **Rosen, et al. (2010)**. As a brief instrument for assessing the key dimensions of sexual function in women. It included female sexual arousal disorder (FSAD) and provides scores on six domains of sexual function (desire, arousal, lubrication, orgasm, satisfaction, and pain) Desire taking question number 1, 2 Arousal taking question number 3, 4, 5, Lubrication taking question number 7, 8, 9, 10 Orgasm taking question number 11, 12, 13 Satisfaction taking question number 14, 15, and Pain taking question number 17, 18, 19. These questions ask about sexual feelings and responses during the past 4 weeks. The participant asked to respond to questions as honestly and clearly as possible and their responses will be kept completely confidential. A score of as well as a total score was 36 and the cut-off score ≤26.55 was classified.

2- Sexual Dysfunction Questionnaire It was developed by Infrasca et, al (2011) to assess women readiness and preparation for sexual functions disorders Introduced as a brief self-report inventory, typically requiring 5 min of the women's for completion and it well suited for use in both clinical and research settings. The questionnaire consisted of 19 items, every item responded by always often, sometimes, rarely, and never. And taking the score from 1-5 for 12 items while the other 7 items taking the score from 5 to 1 responded and calculated vice versa taking a total score of 95 and the total score classified into mild sexual dysfunction from 1- 32, moderate from 33-65 and severe sexual dysfunction ranged from 66-95

Validity of the tools:

To determine the content validity of the tool, scoring key and evaluation criteria were submitted to 5 experts who had specializations in obstetric nursing, psychiatric nursing, community health nursing, psychiatric medicine, and obstetric medicine. Suggestions and recommendations given by the experts were accepted and necessary corrections were done to modify the tool.

Reliability of the tools:

Reliability was applied by the researcher for testing the internal consistency of the tool, by administration of the same tools to the same subjects under the similar condition on one or more occasions, answers from repeated testing were compared. (r<92) Qualitative testing revealed adequate comprehension and content validity of the items. The SDQ showed good validity (degree of accuracy with which a test measures what it is designed to measure). Cronbach alpha values > 0.85 indicated excellent internal consistency and the total reliability total Cronbach's Alpha = 0,851 for sexual dysfunction questionnaire

Pilot study

Before the actual study, a pilot study was conducted on 10% of the study sample (10 volunteers) to test the feasibility and applicability of the tools and then necessary modifications were carried out accordingly. Data obtained from the pilot study were not included in the current study.

Ethical consideration

- Ethical approval was obtained from the university and participating MCH to conduct the research.
- Issues of voluntary participation, confidentiality, anonymity, and consent as well as data security were considered and addressed with potential participants and discussion of informed consent.
- Women tiled that they had the right to discontinue the study at any time of research study.
- Written consent from women was taken.

Administrative approval:

Official letters were issued from The Dean of the Faculty of Nursing, Menoufia University sent to the director of the MCH(Kebly and Bahary Maternal& Child Health Care Centers in Shibin Elkom) to get their permission for data collection. The letters explain the purpose of the study to sough their cooperation before starting the data collection. The agreement and the aim of the study were explained to each subject.

The procedure of data collection:

At pre-intervention

Participants were allowed to complete the FSFI alone, in a private room.

Instructions were given to them to respond honestly. These questions ask about their sexual feelings and responses during the past 4 weeks and some concerns the percipient may have about their level of interest in sex during the past 2-3 months. Every woman was instructed to read each statement carefully and choose the answer that best corresponds to her experience and answer questions as honestly and clearly as possible. As well their responses kept completely confidential discussed with women. Also, women were instructed to fulfill a quiz to design a structured intervention for those who are experiencing low sexual desire that is concerning to them to help them decide whether to guide nursing intervention or consult a physician. From this quiz the participants were asked to 'Calculate Score' and the numbers will be added together for a total score which represented that they have sexual dysfunction or not to guide a criterion to be included in the sample for intervention**.**

This study was accomplished in 3 phases: Preparatory, implementation, and evaluation phases.

I- Preparatory phase:

Based on reviewing of past and current literature covering the various aspects of sexual dysfunction were done using books, articles, magazines, and networks about studies related to sexual dysfunction subject. Also prepared tools, the instructional psychosexual guide who's covered all items such as definition, signs& symptoms, the main cause and how to solve those problems, methods of teaching used in this research as, through preparing seminars for discussion and providing examples. Preparing videos, booklet, and pictures were used as media.

The researchers divided the participants into 5 sub-groups. Every sub-group was 20 women, every group attended (10) intervention sessions every session take one hour within two days/week (three groups per day and other day two groups from 10 AM to 11 or 11.30

AM and also from 12 PM to 12.30PM.(for second day to other group). The period of implementation was 10 weeks for each group.

II- The implementation phase: was applied by the researchers through introducing the psychosexual guidelines intervention. It was taken in health education hall of centers.

Psychosexual guidelines intervention:

The general aim of the psychosexual guideline's intervention for management of sexual dysfunction was to enhance knowledge and practice of the women regarding their readiness and preparation for sexual functions disorders.

Psychosexual interventions had to aim to meet at least one of the following objectives:

(1) Modification of dysfunctional cognitions about sexuality; (2) enhancement of sexual arousal and desire; (3) acquisition of control of physical reactions related to the sexual response cycle; or (4) improvement of the relationship between sexual partners.

The intervention took about 3 months from the beginning of October to the end of December 2019, two session per week for each group. At the end of the nursing intervention, 15 minutes were allotted for discussion and feedback. In answering these questions discussing sex-related issues can be embarrassing both for the researcher and the women. they often carry the feeling of failure or that they are abnormal. The researchher anticipates the embarrassment of women and acknowledges that it could be difficult talking about such issues. For example, the clinician may say, “Most people find it difficult to talk about these things and may feel a bit embarrassed. I’d just like to reassure you that everything you say is confidential and that I’d like to help you if I can. The first step is to find out exactly what is going on so that we can figure out how to make things right again. Please feel free to be open with me and to ask questions.

The sessions of the psychosexual guideline's intervention:

- Session one: was carried out by the researchers for orienting the women about the benefits of psychosexual guidelines intervention, collecting baseline socio-demographic data, and given pre-test questionnaires
- Session two and three: These sessions including the knowledge about the sexual dysfunction, causes, its effects on women physically and psychosexually, complications of it on both couples. Also include the information about psychosexual and physiological changes that occur during the sexual response.
- Session four: This session aimed to help the women identify their emotions, and the feelings of others through providing the women with information about emotional regulation; definition, how to deal with emotions efficiently, identify the causes of emotions, avoiding or changing the causes of emotions, how to deal with emotions that can’t be avoided.
- Session five and sex: These sessions aimed to help the women to determine sex education needs to focus on clarifying normal sexuality and reducing negative attitudes toward sex. Besides the use of general relaxation exercises, the relaxation procedure also needs to focus on teaching the women to relax muscles around the inner thigh. Also help them that There have several therapies designed specifically for sexual dysfunctions, as cognitive-behavioral therapy (CBT), sex therapy, behavioral therapy, educational interventions, and other psychotherapies, which include mindfulness meditation therapies, hypnotherapy, and rational emotive therapy
- Session seven and eight: These sessions include sex therapy which is a psychotherapeutic treatment that focuses on immediate factors within a couple's sexual interactions. Therapy aims to improve individual or couple's sexual experiences and reduce anxiety related to sexual activity and include educating the partners, to avoid blaming one's partner or oneself for the sexual problems. The basic concept about sexual intercourse, that it is a mutual act between two individuals, and is not something a man does to a woman

or woman to a man must be conveyed to the couple. Sexual intercourse can be a form of interpersonal communication at a highly intimate level. Educating the couple, improving the communication, heightening sensory awareness, and sensate focus exercises can be taught to the couple. Behavioral exercises include non-demand pleasuring or sensate focus, to allow the individual to re-experience pleasure without any pressure of performance or self-monitoring.

- Session nine and ten: These sessions aimed to help the women apply several therapies for sexual dysfunction as, cognitive-behavioral therapy (CBT): Interventions aiming at modifying dysfunctional beliefs (cognitive restructuring, outside-of-session activities, psycho-education, and acquisition of skills) . CBT incorporates with sex therapy components for modification of thought patterns that may interfere with sexual pleasure. Marital therapy Interventions focusing on relationship problems which Strategies include communication training, social skills training, or cognitive interventions such as perspective taking, to improve mutual understanding. Also, systematic desensitization (SD): A behavior therapy technique in which muscle relaxation is used to reduce the anxiety associated with certain situations. Mindfulness: teach the women how to live in the present and not think in the past or the future and live now and here. It has been found to be an effective component of psychosexual treatments for sexual dysfunction.

III-Evaluation phases and post-intervention

After three months from interventions, the last phase in which the researcher assess the achievement of the aim of the study through reintroducing the research tools (Sexual Dysfunction Questionnaire and The Female Sexual Function Index (FSFI), to assess the effectiveness of the program among women sexual preparation, desire, lubrication, and degree of satisfaction to reach orgasm activity at post-intervention.

Statistical analysis

Percentage distribution and Paired *t*-test were used to compare mean scores of sexual function index before and after the intervention. Paired t-test was also used to compare the mean scores of the sexual dysfunction index before and after the intervention. Correlation between variables was evaluated using Pearson's correlation coefficient (r). Significance was adopted at $p<0.001$ for interpretation of results of tests of significance

Results

Table (1): Represented that the highest percent (69%) of women's age was ranged between 26-30 yrs. Old Also, more than fifty percent of women (59%) had a university education and the majority of them (72%) working. In addition, most women (81%&79%) did not suffer from any physical or gynecological problems hindering them from practicing their normal pattern of sexual functions despite (89%) had a psychosexual problem.

Table (2): Represented total mean and S.D was (30.81&6.495 respectively) assessment of sexual preparations among women at pre-intervention and post-intervention was(34.20&7.122respectively) which showed a significant difference ($P<0.000$) among all items for sexual preparation questionnaire on post than pre-intervention.

Table (3): Showed a comparison between sexual desire among women at pre and post-intervention represented that there was a highly statistical significance difference $P<0.001$ between at pre and post-intervention regarding the arousal of their sexual desire at post than pre-intervention. In relation to feel sexual desire was(73%) a few time before intervention and post intervention was (62%)most of the time. Satisfaction with arousal during intercourse was (47%) a few times and rarely before intervention while post intervention was(85%) most of time.

Table (4): Distribution of vaginal Lubrication (63%) was difficult up to the end before intervention and after intervention was slightly difficult and not difficult (40%&34%respectively). In relation to orgasm

during a sexual activity at pre was56% was difficult and post-intervention was slightly difficult and not difficult (48%&42%respectively). There was a highly statistical significance difference P<0.001 at post than pre-intervention regarding their vaginal Lubrication and orgasm.

Table (5): Distribution for the degree of satisfaction to reach orgasm activity at pre and post-intervention represented that there was a highly statistical significance difference P<0.001 for the post than pre-intervention regarding their satisfaction to reach orgasm activity. In relation to sexual dysfunction at pre intervention was severe (64%) and post-intervention was mild (62%).

Table (6): Distribution for psychosexual problems at pre and post-intervention represented that there was a highly statistically significant difference P<0.000 for the post than pre-intervention regarding psychosexual problems of women.

Figure (1): Represented the total score for sexual dysfunction at pre and post-intervention which showed that most of the cases at post interventions have become mild SD (from 0-31) while the majority at pre-intervention was had moderate SD at pre-intervention

Table (1): Biosocial characteristics of studied women

Biosocial characteristics	No	%
Age of women		
>20 yrs.	8	8.0
20-25 yrs.	10	10.0
26-30 yrs.	69	69,0.
-<31-35	13	10.0
Levels of education		
Primary education	4	4.00
Secondary education	10	10.0
University	59	59.0
Others	27	27.0
Women occupation		
Working	72	72.00
Not working	28	28.00
Presence of minor physical problems		
Yes	19	19.00
No	81	81.00
Presence of minor gynecological problems		
Yes	21	21.00
No	79	79.00
Presence of Psychosexual problems		
Yes	89	89.00
No	11	11.00
Types of Psychosexual problems:		
Work-related stress	67	67.00
Anxiety	52	52.00
Depression	43	43.00
Guilt feeling	23	23.00

Table (2) Assessment of sexual preparations among women at pre and post-intervention

Assessment of Sexual dysfunctions	Pre		Post		Paired T-Test	P. Value
		No	%	No		
Like to talk about sex						
Always	0	0.0	35	35.0	40.015	
Often	6	6.0	55	55.0		.000
Sometimes	24	24.0	10	10.0		
Rarely	16	16.0	0	0.0		
Never	54	54.0	0	0.0		
Like to tell jokes about sex						
Always	14	14.0	47	47.0	8.749	
Often	49	49.0	39	39.0		.000
Sometimes	26	26.0	14	14.0		
Rarely	3	3.0	0	0.0		
Never	8	8.0	0	0.0		
Feel inhibited toward sexuality						
Always	29	29.0	0	0.00	-41.638-	
Often	65	65.0	0	0.00		.000
Sometimes	6	6.00	17	17.0		
Rarely	0	0.00	35	35.0		
Never	0	0.00	48	48.0		
Keep sexuality hidden						
Always	19	19.0	0	0.00	-2.010-	
Often	32	32.0	0	0.00		.000
Sometimes	49	49.0	18	18.00		
Rarely	0	0.00	34	34.00		
Never	0	0.00	48	48.00		
Speak to sex with a partner						
Most of the time	45	45.0	0	0.00	-52.725-	
Almost always	34	34.0	0	0.00		.000
Sometimes	21	21.0	30	30.00		
A few times	0	0.00	41	41.00		
Rarely	0	0.00	29	29.00		
Live sexual in a rigid manner						.
Always	0	0.00	0	0.00	-30.560-	
Often	26	26.00	0	0.00		.000
Sometimes	50	50.00	26	26.0		
Rarely	24	2.400	32	32.0		
Never	0	0.00	42	42.0		
I live better without sexuality						
Always	0	0.00	0	0.00	-5.438-	
Often	0	0.00	0	0.00		.000
Sometimes	29	29.00	26	26.00		
Rarely	49	49.00	32	32.00		
Never	22	22.00	42	42.00		
My sexual life planned						
Always	0	0.00	0	0.00	-32.496-	
Often	40	40.00	0	0.00		.000
Sometimes	44	44.00	18	18.00		
Rarely	16	16.00	28	28.00		
Never	0	0.00	54	54.00		
I like to talk during sex						
Always	0	0.00	2	2.00	3.632	
Often	0	0.00	8	8.00		.000
Sometimes	15	15.0	25	25.00		
Rarely	51	51.0	22	22.00		
Never	34	34.0	43	43.00		
Take an active role during sex						
Always	0	0.00	48	48.0	172.049	.000
Often	0	0.00	50	50.00		
Sometimes	0	0.00	2	2.00		
Rarely	47	47.00	0	0.00		
Never	53	53.00	0	0.00		
Total scoring						
Mean	30.81		34.20		-24.746-	.000
S.D	6.495		7.122			

Table (3): Distribution of sexual desire among women at pre and post-intervention

The sexual desire among women	Pre		Post		Paired T-Test	P. Value
	No	%	No	%		
Did you feel sexual desire?						
Most of the time	0	0.00	62	62.0		
Almost always	0	0.00	38	38.0	49.022	.000
Rarely	27	27.0	0	0.00		
A few time	73	73.0	0	0.00		
Feel sexual desire during intercourse						
Very low	50	50.0	31	31.0	-3.975-	
Low	46	46.0	67	67.0		.000
Limited	4	4.00	2	2.00		
Rate sexual arousal						
No sexual activity	0	0.00	0	0.00		
Very low	21	21.0	8	8.00	-34.420-	.000
Low	58	21.0	18	18.00		
Moderate	21	58.0	38	38.00		
Very high	0	0.00	36	36.00		
Become aware of sexual arousal						
No sexual arousal	15	15.0	1	1.00		
Sometimes	7	7.00	36	36.0	11.215	.000
Most of the time	0	0.00	63	63.0		
Almost always	0	0.00	0	0.00		
Rarely	33	33.0	0	0.00		
A few times	45	45.0	0	0.00		
Satisfaction with arousal during intercourse						
Most of the time	0	0.00	65	65.0		
Almost always	0	0.00	22	22.0	52.779	.000
Sometimes	6	6.00	13	13.0		
A few times	47	47.00	0	0.00		
Rarely	47	47.00	0	0.00		

Table (4): Distribution of vaginal Lubrication and orgasm during sexual activity at pre and post-intervention.

Lubrication during sexual activity	Pre		Post		Paired T-Test	P. Value
	No	%	No	%		
Did you feel lubrication during sexual activity						
No sexual activity	0	0.00	0	0.00	33.080	.000
Almost always	0	0.00	25	25.00		
Most of the time	0	0.00	62	62.00		
Sometimes	22	22.00	5	5.00		
A few time	38	38.00	5	5.00		
Rarely	40	40..0	3	3.00		
Maintain lubrication up to the end						
Difficult to become lubricant	0	0.00	0	0.00		
Extremely difficult	2	2.00	0	0.00		
Very difficult	35	35.00	0	0.00	-29.305-	.000
Difficult	63	63.00	26	26.0		
Slightly difficult	0	0.00	40	40.0		
Not difficult	0	0.00	34	34.0		
Difficult to reach orgasm						
No sexual activity	0	0.00	0	0.00		
Extremely difficult	11	11.0	0	0.00		
Very difficult	33	33.0	0	0.00	-51.000-	.000
Difficult	56	56.0	10	10.0		
Slightly difficult	0	0.00	48	48.00		
Not difficult	0	0.00	42	42.00		

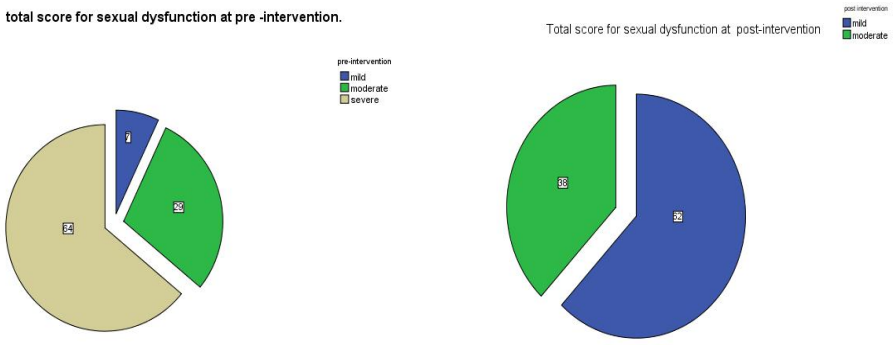
Table (5): Distribution for the degree of satisfaction to reach orgasm activity at pre and post-intervention

Degree of satisfaction to reach orgasm	Pre		Post		Paired T-Test	P. Value
	No	%	No	%		
Satisfaction to reach orgasm						
No sexual activity	0	0.00	0	0.00		
Very satisfied	0	0.00	59	59.00	33.042	.000
Moderately satisfied	0	0.00	21	21.00		
Equally satisfied or dissatisfied	3	3.00	20	20.00		
Moderately dissatisfied	63	63.00	0	0.00		
Very dissatisfied	34	34.00	0	0.00		
Satisfied with closeness intercourse						
No sexual activity	0	0.00	0	0.00		
Very satisfied	0	0.00	26	26.0		.000
Moderately satisfied	0	0.00	54	54.0	32.496	
Equally satisfied or dissatisfied	45	45.0	20	20.0		
Moderately dissatisfied	55	55.0	0	0.00		
Very dissatisfied	0	0.00	0	0.00		
Satisfied with the relationship with your partner						
No sexual activity	0	0.00	0	0.00		
Very satisfied	0	0.00	20	20.0		
Moderately satisfied	0	0.00	54	54.0	35.338	.000
Equally satisfied or dissatisfied	27	27.0	26	26.0		
Moderately dissatisfied	73	73.0	0	0.00		
Very dissatisfied	0	0.00	0	0.00		
Satisfied with overall sex						
No sexual activity	0	0.00	0	0.00		
Very satisfied	0	0.00	36	36.0	51.651	
Moderately satisfied	0	0.00	36	36.0		.000
Equally satisfied or dissatisfied	10	10.0	28	38.0		
Moderately dissatisfied	31	31.0	0	0.00		
Very dissatisfied	59	59.0	0	0.00		
Experience pain during intercourse						
Almost always	50	50.0	0	0.00		
Most of the time	30	30.0	0	0.00	-29.272-	.000
Sometimes	20	20.0	26	26.0		
A few times	0	0.00	49	49.00		
Never	0	0.00	25	25.00		
A total score of sexual dysfunction						
Mild	7	7.00	62	62.0		
Moderate	29	29.0	38	38.0	21.841	0.000
Severe	64	64.0	0	0.00		

Table (6): Distribution for Psychosexual problems at pre and post-intervention

Psychosexual problems	Pre		Post		Paired T-Test	P. Value
	No	%	No	%		
Stress	77	77.00	21	21.0	11.225	0.00
Anxiety	52	52.00	23	23.0	5.591	0.00
Depression	43	43.00	18	18.0	4.180	0.00
Guilt feeling	23	23.00	9	9.0	4.180	0.00

Figure (1): represented the total score for sexual dysfunction at pre and post-intervention.



Discussion

The sexual activity incorporates interpersonal relationships, each partner bringing unique attitudes, needs, and responses into the coupling. A breakdown in any of these areas may lead to sexual dysfunction. Although sexual problems are highly prevalent, these are frequently under-recognized and under-diagnosed in clinical practice. It is often recommended that the treating psychiatrists and collaborating specialists need to possess broad knowledge and an appropriate attitude towards human sexuality. Ajit , and Sathyanarayana (2017).

Biosocial data for this study represented that above two third of women's age was ranged between 26-30 yrs. Old Also, more than fifty percent of women have a university education and the majority of them working. In addition, most women did not suffer from any physical or gynecological problems hindering them from practicing their normal pattern of sexual functions So, The clinical judgment is made taking into consideration factors that affect sexual functioning, such as age and the context of the person's life. The deficiency of sexual functions should be the duty of the clinician, taking the person's age, sex, living conditions, and other sexuality influencing factors individually into account. Rosemary and Gila (2015)**.** Reported that empirical data from cross-sectional studies suggest that the rate of women who never or rarely react with orgasm decreases from half in young adulthood to one fifth at the age of 40 and remains fairly stable with one fifth between the ages of 40 and 59 then increases to 28% over the age of 70. Nevertheless, these data are difficult to evaluate. From the researcher's point of view, women can have an orgasm in the same amount of time as men, and they can achieve multiple orgasms. Personal history, relationship difficulties, lack of education, and lack of knowledge about sexuality may be reasons for the inhibition of the orgasmic response.

Hüseyin (2012) study entitled The influence on women's sexual functions of education given according to the PLISSIT model after hysterectomy results revealed that there was no statistically significant difference between the groups in terms of education, working status, obstetrical features, gynecological history and pre-operative symptoms ($p>0.05$). perception of sexuality, approach to sexuality, comments related to their sexual lives, and state of being satisfied with sexual intercourse($p>0.05$). Also, Chia-et.al.(2015) study about factors affecting sexual function: A comparison between women with gynecological problems or rectal cancer and healthy controls Their results showed that women with gynecological problems had significantly worse sexual function than women without gynecological problems and a negative sexual self-schema were significantly related to poor sexual function. So, healthcare providers should give more attention to sexual issues and contributing factors in women who have undergone treatment for sexual problems especially for those with a negative attitude, In addition, Marita et.al (2016) study entitled Risk Factors for Sexual Dysfunction Among Women and Men: A Consensus Statement from the Fourth International Consultation on Sexual Medicine also, come in the same results line which revealed that Psychosocial factors were considered a risk factors for sexual dysfunction. So, Women with sexual dysfunction should be offered psychosocial evaluation and treatment,

Regarding hypothesis number one

Women who receive guided instructions for management of sexual dysfunction will have a better sexual desire post intervention than at pre intervention. Study results **r**epresented assessment of sexual preparations among women at pre and post-intervention showed a significant difference ($P<0.001$) among all items for sexual preparation and their sexual desire on post-intervention than on pre-intervention. Which highlighted in their responses in which most of the time or often always they become having a feeling of sexual desire, become aware of sexual arousal and satisfied from their sexual intercourses in posttest than in pretest**.** This result was consistent with, Lúcia et, al., (2017) study entitled A Model for the Management of Female Sexual Dysfunctions the influence of psychosexual factors, from their contexts such as stimulus meaning, mood, and cognition, on female sexual desire and arousal. All those specific topics attend during the anamnesis of sexual desire and arousal problems helping women to solve their sexual problems, So, the use of protocols may facilitate the discussion of sexual issues in obstetric and gynecological settings specialized in dealing with women

problems, and has the potential to provide an effective approach to the complex aspects of sexual dysfunction in women. However, this is not continuously occurring due to a lack of guidelines or protocols available to guide the discussion of the topic. Thus, Ob-Gyn professionals should routinely assess female sexual problems. However, previous research has indicated that both patients and doctors experience difficulties when talking about sexuality and that the doctor often feels ill-equipped because of the lack of established protocols valuable for the treatment of sexual complaints and dysfunctions. So, nurses in an excellent position are to deal with such problems according to the written outlines.

In addition comparison between sexual desire among women at pre and post-intervention represented that there was a highly statistically significant difference P<0.001 between pre and post-intervention regarding the arousal of their sexual desire at pre than post-intervention. Topic-related surveys indicate that in the case of women there is neither a subjective nor an objectively measurable real difference between sexual desire and sexual arousal and that the diagnosis of sexual desire disorder and that of sexual arousal disorder show significant comorbidity. For this reason, an expert consensus has suggested combining these two diagnostic categories under the name of "the disorder of sexual interest/arousal. In light of the above results As well, Ibrahim et.al (2013) Study An analysis of collected data in Egypt revealed a high prevalence of FSD above half of sample with sexual desire disorders as the commonest type of sexual dysfunction. The prevalence of desire, orgasm, arousal, pain, and sexual satisfaction disorders were (35%), (29%), (21%), (20%), (15%) respectively entitled Assessment & management of sexual problems in women and review of published prevalence studies listing categories of desire, arousal, orgasm, and pain, with a response rate greater than half of sample (greater than 100 women), revealed that approximately two third of sample experienced desire difficulty; above one third of women experienced orgasm difficulty; below one third of women experienced arousal difficulty; above one quarter of sample experienced sexual pain; and the majority of women had problems persisting for at least several months, of which one quarter of sample persisted for six months or more. From the researcher point of view, the reasons included poor knowledge of their bodies and sexually sensitive areas, as well as personal or psychopathological problems

Also, Maasumeh et.al_(2014) added in the same line (desire arousal – orgasm), was the circular model of the female sexual response, that women rarely initiate sexual activity obeying spontaneous sexual desires; they were more likely to be motivated by a wide range of sexual and non-sexual motives: they would like to experience sexual pleasures, they would like to display their feelings to their partner, they want to give pleasure, they want to feel strong or desirable, they are bored, they would like to avert their attention from the negative thoughts, or just feel obliged to participate in the act. While being together, the proper sexual stimulation creates a state of arousal and the subjective feeling of desire. The rewarding value of the sexual activity then strengthens the future receptiveness. From the researcher's point of view, the clinician should focus their assessment and management on such topics dealing with the two partners.

Distribution of vaginal Lubrication during a sexual activity at pre- and post-intervention represented that there was a highly statistical significance difference P<0.001 between at post than pre-intervention regarding their vaginal Lubrication during sexual activity. Rosemary and Gila (2015) study entitled Medications for female sexual dysfunctions illustrated that persistent or recurrent inability to attain or to maintain lubrication until completion of the sexual activity is a response of sexual excitement, and interpreted the excitement phase in elderly women has much slower than in younger ones. Whereas in young women lubrication occurs after 10–15 seconds, it requires at least five minutes in the postmenopausal women. However, this change is normal and cannot be considered a disorder. Some women produce insufficient vaginal lubrication altogether, and they may need artificial lubricants. Moreover, Anita et.al (2018) study entitled Sexual Health Process of Care for Management of Hypoactive Sexual Desire Disorder in Women stated that the health care professional should be asking about sexual concerns, focusing on issues related to low sexual desire/interest. Diagnosis includes distinguishing between generalized acquired hypo sexual

dysfunctions and other forms of low sexual interest. Bio-psychosocial assessment of potentially modifiable factors facilitates initiation of treatment with education, modification of potentially modifiable factors, and, if needed, additional therapeutic intervention, sex therapy, and hormonal therapy, guided in part by menopausal status. Also, Anita et.al (2018) study, a widely cited, large population-based survey of 50,001 US women (completers, 31,53%; 63% response rate; aged 18-102 years), and reported that low desire was the most common sexual problem, reported in above half of participants; low desire with distress (HSDD) was present in approximately one tenth of women and was more common than distressing arousal or orgasm difficulties which reflected the wide variety of sexual problems among women at a different stage.

Regarding hypothesis number two

Women who receive guided instructions for management of sexual dysfunction will have a better degree of satisfaction to reach orgasm activity post-intervention than at pre-intervention. Results from this study represented that there was a highly statistical significance difference P<0.001 between at post than pre-intervention regarding their satisfaction to reach orgasm. However, the results of some studies were incongruent with our results as Fariba et.al, (2017) study The relationship between sexual dysfunction and quality of the marital relationship has shown that in marital relations, was not a significant difference in terms of sexual activity between patients with myocardial infarction and healthy people, In contrast, Valeska et, al, (2013) study entitled Sex therapy for female sexual dysfunction reported satisfaction from the subject after treatment and get better results in conditioning group. and concluded that psychosexual sex therapy is still the most used form of therapy for sexual dysfunctions; however, the results do not consistently support that this is the best alternative in the treatment of sexual dysfunctions. From the researcher's point of view, the lack of standard criteria across studies makes this large disparity difficult to interpret. As well as many methodological differences across few studies make interpretation of this large range difficult to interpret.

Moreover Farnaz. et.al., (2014) Compare the Effectiveness of Sexual Health Models on Women's Sexual Problems in Tehran, and concluded that seven months after the intervention, the mean (SD) of the sexual distress score decreased and the sexual composite score increased significantly ($P < 0.001$). women were moderate to very satisfied with their sexual life on 1020 about two third of women assessmented and on 513 of 671 above three quarter of women assessmented in which lack of interest was cited as a reason for sexual inactivity. Also, Women indicated an interest in learning about the causes of and treatment for sexual dysfunction on just the minority of all assessments. Moreover, the figure represented the total score for sexual dysfunction at pre and post-intervention showed that most of the cases at post interventions were become mild (from 0-31) while the majority of women at pre-intervention was had moderate sexual dysfunction at pre intervention, In addition, Maria et.al, (2014) study Sexual Function, Activity, and Satisfaction among Women Receiving Maintenance Hemodialysis. About two third of assessments, women reported being moderate to very satisfied with their sexual life, whereas they described being moderate to very dissatisfied on about one fifth of assessments. Above three quarters of assessments in which lack of interest was cited as a reason for sexual inactivity, patients reported being moderate to very satisfied with their sexual life. Of the 102 women who reported that lack of interest in sex was a reason for sexual inactivity, Also, three quarters described being moderate to very satisfied with their sexual life compared with 11 (above half) of the 21 women who did not report that lack of interest in sex was a reason for sexual inactivity (P=0.02 for trend). Women reported experiencing sexual difficulty above one tenth of assessments, whereas they described an interest in learning about causes of or treatment options for sexual difficulty on just minority of assessments.

In addition, Fariba et al,(2017) study The relationship between sexual dysfunction and quality of marital relationship in genital and breast cancers women it is necessary to pay more attention to performing guidelines, preventing, and treating these disorders by healthcare staff. Moreover, it is vital to provide nursing consulting services to solve these sexual dysfunction problems. Also, Frühauf, et.al., (2013) study entitles Efficacy of Psychosexual Interventions for Sexual Dysfunction and stated that the lack of

treatment efficacy studies for particular types of sexual dysfunction and the pronounced use of particular intervention strategies (e.g., sex therapy) was as evidence for the efficacy of psychosexual interventions differed across the target sexual dysfunctions. which revealed effects on symptom severity that were found for patients with Female Hypoactive Sexual Desire Disorder and Female Orgasmic Disorder. For all other sexual dysfunctions, no statistically significant effect was shown. These findings are mostly in line with the results of Nappi et al. (2010): who also concluded that ‘‘well-established treatment of sex problems extend for life long as Female Orgasmic Disorder. The present study additionally showed that well-established psychosexual interventions exist for Female Hypoactive. Moreover Hüseyin (2012) : incongruent with our results and concluded that in his study According to the FSI cut-off value (The cut-≤26.55), there was not a significant difference between the women in both groups (study and control group) during the first and second evaluations in terms of experiencing sexual dysfunction. The rate of sexual dysfunction was high in both groups especially at the second evaluation during which symptoms were present. However, it was determined in the third and fourth evaluations that women in the CG experienced significantly higher sexual dysfunction compared to the women in the study group.

Conclusion

Based on the results of this study, it was concluded that: there were a highly statistical significance difference P<0.001 between pre and post intervention regarding their arousal of their sexual desire as well as vaginal Lubrication, orgasm, and degree of satisfaction during sexual activity.

The use of guided psychological sexual health instructions on changes of sexual activity among women reduced and managing sexual dysfunctions.

Recommendations

1. All health care providers should include screening questions regarding sexual well-being as a standard of practice.
2. Treating medical, psychosexual, relationship problems, and addressing sociocultural issues, can be effective in helping women and their partners dealing with hypoactive sexual desire disorder.
3. Health care providers should involve the woman’s partner in the assessment and treatment of sexual health concerns when it is appropriate and safe to do so.
4. Health guidelines protocol of care for (SD) should be providers to involve the woman’s partner in addressing sexual issues,

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