Middle-aged Lebanese women's interpretation of sexual difficulties:**A qualitative inquiry**

Mathilde Azar. Faculty of Health Sciences – University of Balamand. St George Health Complex, Youssef Sursock Street. P.o.Box. 166378 Ashrafieh, Beirut 1100 – 2807 Lebanon. Email: mathilde.azar@balamand.edu.lb (Corresponding author).

Caroline Bradbury-Jones. School of Nursing, University of Birmingham, Edgbaston, Birmingham, B15 2TT, UK. Email: c.bradbury-jones@bham.ac.uk

Thilo Kroll. School of Nursing, Midwifery and Health Systems. University College Dublin, Belfield, Dublin 4. Email: thilo.kroll@ucd.ie

Abstract

Background: The study explores women's perception and experience of sexual difficulties and the way these difficulties are shaped in relation to the male-centred sexual interactions and social norms. The study is part of a work programme that is guided by a qualitative research design to provide a comprehensive understanding of women's sexuality. The need to address the subject was triggered by the high prevalence of female sexual problems that are defined based on the standards of sexual function and dysfunction. The multidimensional nature of these problems could not be limited to one single definition. Yet, there is a scarcity of research that reflects on women's subjective views on sexual difficulties. This is particularly crucial at the middle-age where women undergo hormonal and psychosocial changes that may affect their sexual life.

Methods: Using in-depth individual and focus groups interviews, 52 Lebanese women aged 40-55 years discussed their thoughts, feelings and behaviours concerning sexual difficulties. In respect to ethical principles, women were recruited purposefully from clinical and non-clinical settings to get maximum sampling variation that provided rich information and deep understanding of the subject. Recordings were transcribed verbatim and analysed in reference to the framework analysis. Many strategies were adopted to ensure rigour.

Results: Women's narratives led to four themes that provided a comprehensive understanding of sexual difficulties. These are women's inability to communicate sexual desires and concerns; male-related sexual difficulties; marital conflicts; and sexual difficulties as context bound. Women's sexual difficulties are driven by double standards and inhibiting sexual socialization in addition to relational and psychosocial burdens.

Conclusion: The study makes a unique contribution in voicing women's views and concerns as sexuality is underreported and poorly researched in Lebanon. It shed light on many aspects of

female sexual difficulties that are multifaceted and contextually bound. Findings have implications on education, clinical practice and research. It is particularly important to provide Lebanese women with a culturally sensitive professional assistance, empower them to recognise their sexual-self and get their needs met. More qualitative research about women's sexual difficulties is warranted to enrich the body of knowledge and promote women's sexual health and overall wellbeing.

Keywords

Female sexual difficulties/problems, sexual health, middle-aged women, qualitative study, semi-structured interviews, focus groups.

Plain English summary

This study explored middle-aged Lebanese women's views and experiences about sexual difficulties. Using face-to-face interviews, women had the opportunity to voice their concerns and talk openly about the way they understand their sexual difficulties. Findings showed that women do not talk about their sexual difficulties in terms of how their bodies function. Sexuality and sexual concerns are affected by many aspects of women's lives, Lebanese culture and their relationships with husbands/partners. Some women lacked awareness about their sexual needs and rights. Shyness, intimidation and lack of knowledge compromise their enjoyment of sex. For many, sexual life remains a taboo subject. Many of them were sexually inexperienced when they got married. Most had sex for the first time with their husband. Sex is perceived as 'forbidden' outside marriage. The women reported difficult experiences that affected their sexual desire and interest. For some the insensitivity and inexperience of their husbands as well their husbands' impaired sexual performance (eg problems with maintaining an

erection) prevented them from enjoying sex. This was made even worse as many husbands were reluctant to seek professional help fearing disclosure of their problems to strangers and negative impact on their masculinity. Facing marital conflicts and lacking love and respect, many women were victims of forced sex or were doing it as a duty. Moreover, daily life stressors and chores further caused sexual difficulties. As sexuality is an important component of overall wellbeing, women should recognise and discuss their sexual difficulties to manage them and enjoy their sexual life.

Background

Satisfying sexual experiences throughout the life course are linked to perceptions of a good quality of life and general wellbeing [1, 2], but with age, sexual functioning and satisfaction may change [3]. For women, the transition to menopause constitutes a major physical and psychosocial challenge at middle-age. From a biomedical perspective, the literature abounds with epidemiological studies about different forms of female sexual disorders affecting women across cultures and age groups [4, 5, 6] in both developed and developing countries [7, 8, 9]. Sexual problems increase three folds in the climacteric [10] and are 2.3 times more likely to happen from pre to post-menopause [11]. The prevalence ranges from 25% to 63% and rises further among postmenopausal women to reach 68% to 86.5% [11].

Studies concerning the effect of hormonal decline and ageing on women's sexual functioning are controversial. Indeed, some aspects of women's sexual functioning may decline or worsen with ageing and reduction of hormonal production [3, 13]. But whether and how these changes affect women depends largely on the way they are perceived [14]. For instance, it is not sure that menopausal changes inexorably affect sexual desire. With ageing, many women report

better sexual functioning [15, 16], an increased frequency of orgasm during intercourse and the number of those who claimed never having had an orgasm decreased [17, 18, 19]. A study by Berra and colleagues [20] also revealed that menopausal women (36.2%) are less distressed by sexual dysfunction in comparison with premenopausal women (64.5%). Moreover, for some women a low sexual desire did not cause distress in the menopausal transition and did not threaten their relationship with the partner [21]. However, other women reported negative impacts of menopause on their interpersonal relationships, marital intimacy, satisfaction and stability that may lead to divorce [21, 22]. A satisfying sexual life, on the other hand, strengthens couples' marital bonds [23].

Female sexual dysfunction as generated by the Diagnostic and Statistical Manual of Mental Disorders, [24, 25] has created a great debate and reflected a lack of consensus on the conceptualisation of this construct. Adding to that, epidemiological studies have faced several methodological limitations [26, 27]. The samples are mostly drawn from clinical settings and do not consider the general population and women of different age groups. The instruments used focus predominantly on biomedical aspects and do not consider relational or contextual factors in the sexual experience. Since female sexuality is a multifaceted construct, it has to be considered in the context of women's lives, their experiences, values and beliefs, and the quality of their relationships in addition to biological, psychosocial and economic factors [21, 22].

Over the past decades, increasing interest has been accorded to qualitative research that represents women's insights and experiences of sexuality and perception of sexual difficulties. But, few of them have focused on sexual difficulties of the middle-aged women. In the Middle-East and in Lebanon in particular, very little research has been conducted to understand sexual

life from the perspective of women. In Lebanese culture, sexuality and sexual concerns are still taboo subjects, especially for the middle-aged and older generation. At this age, there is still a tendency to position women as asexual. Sexual difficulties are neither discussed publicly nor privately. Healthcare providers seldom discuss the subject with their patients. Just like men, women rarely seek help for sexual difficulties probably because they are unaware of the nature of their problems or simply feel ashamed. Just like in other parts of the world, Lebanese women view sexuality vital for marital stability (Azar, Kroll & Bradbury-Jones, 2016). Thus, women face the challenge of navigating the tension between maintaining a satisfying sexual life and staying silent on the issue should sexual difficulties arise. It may not be surprising that sexuality is under-researched and not visible as a topic in the Lebanese health care context. This paper makes a contribution towards opening up the discourse on sexuality and sexual concerns. Its aim is to present a narrative analysis of the meaning and experiences of sexual concerns and difficulties from the perspective of middle-aged Lebanese women.

An improved understanding of the socio-cultural aspects of these experiences will provide critical information for health-care professionals to engage with women purposefully about their sexuality and related concerns.

Methods

Research design

This paper that aims to explore women's construction of their sexual difficulties is part of a programme of work that focuses on women's sexuality. It is a qualitative study guided by an interpretive inductive process, whereby the interpretation of findings of one phase informed the inquiry design of the subsequent phase. This naturalistic and holistic paradigm is well suited

to explore sexuality which is a complex, tacit, sensitive and no well-known topic [29]. The direct contact with the participants using open-ended questions and focus group discussions deconstructed the complexity inherent to sexuality. This was necessary to gain deep insights into their thoughts, feelings, attitudes and experiences concerning sexual difficulties as grounded in the Lebanese social interaction, culture, language and discourse and as influenced by the relationship between the two partners.

Research setting and participants

In this study, the sample was recruited from clinical and non-clinical settings (mammography units of two university hospitals, one private and one public, outpatient clinics, and working organizations) in order to have a holistic and non-medicalised stand of women's thoughts and experiences. The settings have high enrolment rates and attract clients from diverse socio-demographic and cultural backgrounds. This was suggested to optimise heterogeneity and enrich data generation [30]. The access to the participants required the approval of the administrators of the chosen settings. The first investigator of the study (MA) was involved in the recruitment process. Supporting previous researchers' claims [31, 32], this process of involving participants to talk about sensitive topics was long and difficult. Approximately two third of those met refused to participate in the study. Because of the constraint around sexual disclosure, some women expressed their apprehension, uncertainty and timidity concerning the topic. Others did not seem interested or did not perceive a direct benefit in discussing their sexual issues. A notable number was initially willing to participate but declined later on at the time of the interview. Some gave me more than one appointment but in vain. Women's behaviour might have been influenced by their husbands' attitudes. Many declared that their husbands warned them not to reveal the secret of their sex life.

Women were selected purposively by level of education and menopausal status acknowledging their implication in the perception and experience of sexuality [33, 34]. Marital status, religion and occupation were also collected and considered in the research objectives, data analysis and interpretation as they enriched findings. Snowball sampling was added due to difficulties in identifying eligible women and the sensitivity inherent to sexual disclosure. This included only eight women who were selected with a reflective manner to represent different views and avoid compromising the heterogeneity of the sample [35]. Women who participated in the study were 40-55 years old, Lebanese and spoke Arabic, regardless of their marital status and sexual orientation. Women who had acute or chronic physical and mental health problems at the time of the interviews were excluded. Their health condition may interfere with the perception and experience of sexuality, adding another layer of complexity to the interpretation of findings [36]. Data saturation was determined to be reached when no new or conflicting information would arise in interviews [37, 38]. This was done having in mind that thick (quantity) and rich (quality) description was provided to ensure transferability and credibility of findings [37, 38].

Data collection

The first author of the study (MA) conducted 37 individual interviews and three focus groups. A topic guide was developed with a series of open-ended questions that gave the opportunity to the participants to reflect on intimate issues and voice their sexual concerns. In order to overcome the potential sensitivity and embarrassment about discussing sexuality a case description and vignette were used to facilitate the conversation [39]. The participants were asked to comment on a situation that portrays a 49 old woman who was interviewed within a programme of women's health about her sexual health issues. The questions reflected on her

attitude and experience towards the disclosure of sexual issues and sexual changes and difficulties that may happen around the menopausal period. The vignette prompted the participants to get rapidly introduced into the context of the study and reflect on their own experiences. The interviews were audio recorded and transcribed verbatim along with all the fieldnotes and both verbal and non-verbal cues. Reflections, impressions and preliminary interpretations were added.

Data analysis

Informed by Framework Analysis [40], data were analysed in an iterative, analytical and inductive process of comparing and contrasting propositions and developing patterns and themes. This implied different steps which are familiarisation with data, identification of a thematic frame that served to index and chart all transcripts and allow for organising, classifying, comparing and contrasting the extracted data. Mapping and interpretation are the last step whereby the themes and subthemes were identified and structured in a meaningful manner supported by relevant information. The first steps of the analysis were done in Arabic, the native language of the participants. The translation of data into English was done at the level of the thematic chart to preserve the cultural meaning conveyed by the language and the implications this might have on the accuracy of findings.

Rigour

Credibility or internal validity of findings was checked through reflexivity that was facilitated by the use of an audit trail to keep methodological and analytic documentation, follow the thought processes, track all the decisions made and show transparency and rigour [41]. Transferability was ensured by the thick description of data that was provided through individual and focus

group interviews with different purposeful samples chosen from different settings. Within a comfortable environment and good rapport, women extensively reflected on their thoughts and experiences generating lengthy transcripts and rich descriptions which are necessary for meaningful findings [42]. Dependability or reliability was ensured by a meticulous and contextual analysis and interpretation of data. The three authors worked together to agree the coding and analysis process. Strategies used to enhance the confirmability were auditing to make sure of consistency and peer debriefing to have an external evaluation of findings and temper the researchers' subjectivity. Data presentation was extensively supported by quotes.

Results

Sample characteristics

Fifty two women aged between 40 and 55 years participated in the study. Their mean age was 47.40 years. All were married except for five women: one was single, three widowed and one divorced. Sixteen women had enrolled at university, fourteen had a secondary education (grades 10-12), twelve had an intermediate education (grades 7-9) and ten had an elementary education (grades 1-6) or less. Twenty-eight were housewives. Twenty-seven were Christians and the others Muslims, representing the two dominant religions in Lebanon. Twenty-five indicated that they had started the perimenopause or menopausal period.

Themes

Findings from this study pinpoint the contributing factors to sexual difficulties of middle-aged Lebanese women. These are socially constructed and regulated by the institution of marriage and the interpersonal relation with the husband as well as daily life events. Key themes in the onset and sustainability of women's sexual difficulties are: Women's inability to communicate

sexual desires and concerns; male-related sexual difficulties; marital conflicts; and sexual difficulties as context and time bound (table 1). Sexual difficulties are explained and supported by the participants' quotations.

Table 1: Thematic illustration of women's construction of sexual difficulties

Theme	Subtheme	Illustration
Women's sexual difficulties	<i>Women's inability to communicate sexual desires and concerns</i>	<i>Women's inability to enjoy sex because of their sexual inexperience</i>
	<i>Male-related sexual difficulties</i>	<i>Women's sexual difficulties result from the husband's inappropriate sexual performance and behaviour</i>
	<i>Marital conflicts</i>	<i>Women's sexual inhibition due to ineffective marriage communication</i>
	<i>Sexual difficulties as context and time bound</i>	<i>Women's daily life events in addition to physical and psychological challenges negatively affect their sexual wellbeing</i>

1. *Women's inability to communicate sexual desires and concerns*

Contained within this subtheme is the women's reflection on the challenges of experiencing themselves as sexual beings due to the absence of sexual education and no readiness to sexual life.

One cause of sexual problems is the absence of sexual education in Lebanon. This is so wrong.

She does not know how to discover her body and how to enjoy with her husband. In our society,

the woman is not at all aware about sexual life when she gets married. Her husband will not enjoy too. She takes time to discover her body (Faten, married in her 30s).

After many years of marriage, many women described their deep embarrassment, guilt feelings and shyness to see their husbands naked for the first time or to engage in penetrative sex. Thus, frigidity, vaginismus and forced sex were reported as the results. Carmen, a woman who had seven years of psychotherapy due to vaginismus, defined women's sexual difficulties as their inability to enjoy their body due to their inhibiting feelings. She said:

Here you have the taboos, I mean the interdictions, the no, the shame, and this is not allowed ... and until now, many women (single young women) do not know why things are not allowed. The shame and interdictions cause sexual frigidity and lead to problems with the husband after marriage because she is not allowed (to be sexually active) before marriage. Suddenly, she gets married and everything becomes allowed... Psychologically, you are blocked. How she will do it in 24 hours? ... that is why there are a lot of sexual difficulties among women... (Carmen).

Ibtissam's husband forced himself on her during their first sexual intercourse while her mother and mother-in-law waited outside to make sure that things had gone successfully, and that the bride's virginity was confirmed. Kamal was another victim of sexual ignorance although and like Ibtissam, she was a university student at the time of her marriage. Her first negative sexual experiences led to sexual disinterest throughout the long years of her marriage. Her negotiations with her husband to escape this 'tough duty' as she called it, failed. Sexual intercourse was not pleasurable for her. It was just a marital duty done at the husband's request. She recounted:

I am the type who had an upbringing (conservative). When I got married, I told him: I will iron, wash and clean for you, but do not approach me. Imagine the extent to which we were shy and did not have this. Later on, he helped me get used to him progressively. These things (sex) are not important for me. I am not interested in this thing... I do not like (sex). I do it unwillingly. I am not happy with this... is the least of my worries. I don't like it. What is important to me is the way he treats me (Kamal).

Many participants expressed the assumption that sexual difficulties are not female-related because there is a 'general assumption' that women are always 'ready to have sex.

The woman is stronger than man in sex. A man might develop impotence and need to take medication... But I rarely hear of women taking these things. Maybe her hormones are stronger ... the woman does not have issues with her sexual life unless she is physically ill. A woman is always ready to respond to a man's needs (Sara).

2. Male-related sexual difficulties

This section focuses on women's definition of their sexual difficulties associated with their husband's 'poor sexual performance', specifically, erectile dysfunction and early ejaculation. They also accused him of selfishness and forced anal sex describing this sexual behaviour as unpleasant and illegitimate. These problems had negative impacts on women's physical and psychological wellbeing. Ten women highlighted their sexual dissatisfaction due to their husbands' erectile and ejaculatory problems. Their embarrassment was exacerbated by their husbands' avoidance and lack of communication to manage the situation.

Mada, a 46-year menopausal woman with intermediate education who complained of her husband's erectile dysfunction, said:

... Because he does not answer me, I say that there is no need to talk... There is no need at all; it makes no difference (whether I tell him or not)... I do not confront him... I feel that he avoids me because he has poor sexual performance... I ask him but he never answers me. This is frustrating... So I avoid talking with him about these issues (Mada).

Mada stated that her and her husband had not had sex for the past year without any discussion of the topic. During the interview, Mada looked desperate. The need to share her concerns was apparent, considering that her sexual difficulties impacted heavily on her, physically and psychologically.

Some women interpreted their husbands' attitude and behaviour as sexual abuse and neglect. Yet, they felt themselves powerless due to the lack of resources and the cultural norms that do not recognise their sexual rights. Women preferred to keep quiet and sacrifice at the expenses of their sexual satisfaction and overall wellbeing. They accepted their situation as their lot in life. As illustrated by Karine, a 43-year-woman with limited formal education:

But what can a person do; in our community, once the woman gets married, it is finished. You get married and you get children. You have tried to solve your problems but you failed. What do you do? What is the solution? There are children. You have to sacrifice either your children or yourself. I sacrifice myself (Karine).

Karine reported on her endurance of her husband's sexual problems since the time she got married, 21 years ago. Being obedient to her husband who warned her to keep his problem hidden, she was so cautious to discuss her case until she was strongly assured of the confidentiality of the interview.

Lana faced the same communication problem with her husband, whom she accused of sexual impotence. She expressed her rights for sexual pleasure and criticised the gender-based social norms that overlook women's sexual needs. She said:

Man sleeps with his wife and does nothing... You feel that you become used to that... He (her husband) enjoys it and that is. It does not count if the woman enjoys or not. This is also my right, my right. If the situation was reversed ..., I do not think that he would have been patient... He would have blamed me 20 times. He would have cheated on me or married another woman ... But when the problem is from the man, you have to keep quiet (Lana).

Despite her anger, Lana, like the majority of women, expressed her readiness to seek help to satisfy her husbands' sexual needs provided the situation was reversed.

But I am not keen (for sex), it is just for him (her husband); so that he does not say that I neglected him... If he likes it, no, I try; I try to do everything (to please him)... If my husband wants (sex) and I have sexual dysfunction, I treat myself. But if my husband is impotent, why do I have to treat myself?

Other women had the courage to discuss during the interview their husband's sexual behaviours that they found undesirable and painful, particularly the practice of forced and anal sex. As articulated by Sara:

Sexual difficulties? Of course

I told you when he goes beyond the limits and wants to have anal sex. These problems happen. I do not accept this because I am not an animal to be treated in this way. If he loves me, he has to take care of me so that I give him this thing from my heart and with love (Sara).

Sara noted that to prevent her husband's behaviour, she convinced him that anal sex is unhealthy and might cause him fatal infectious diseases. Yet, Zeina was unable to change her husband's "sexual perversion" as she said; being economically independent, she stopped having sex with him. Zeina reported that her sexual deprivation resulted into psychosomatic problems that required psychotherapy.

3. Marital conflict

Common in women's narratives was the perception of the spouses' relationship as central to their sexual difficulties. They complained of a pile-up of events that were difficult to handle with the husband and that led to poor and ineffective communication between the two spouses. Marital conflicts hurt women and created negative feelings towards their husbands such as resentment, indifference and disgust. Believing in the interplay of the physical and psychological factors in sexual life, women asserted that sex cannot be satisfying if it is not driven by emotions and mutual attention between the spouses. Feeling uncomfortable inhibits sexual

desire and pleasure and engenders sexual difficulties. Sex becomes a duty and an abuse for women.

One participant explained that from her perspective, sexual life is not only about penile penetration; otherwise, it becomes what she termed 'disgusting'. In the same vein, another woman declared that at the beginning of her marital life, sex was pleasurable. Presently and because of marital conflicts, she had feelings of rejection and anger towards her husband. She stopped caring for him and completely lost sexual desire and orgasm. This was also the case for Sally who claimed her total sexual disinterest and frigidity as she does not love her husband.

By the way, sorry I do not have any sexual desire. I do it only at his insistence. No way, impossible. I do not have the desire. There is no way that I feel like it. I do not love him (Sally).

Sally supposed that she would have had sexual desire if she was with another man, implying that sexual difficulties are relational rather than biological. Another example was illustrated by Quinana who declared that the main purpose to participate in the study was to talk about what she described as a 'miserable sexual life'. She described herself as an 'automated sex robot' for her husband who she described as rude and abusive. She stated that every time she has sex, she hates herself more and more.

My husband makes me feel that I am only important for this thing (sex). Because of that, I hate sexual life. I need to feel that I am a woman and then take what you want... I accept everything, poverty, misery, taking care of the house, cooking food every day... but I need him to value my efforts and then you can take from me whatever you want. With a strong tone she said: *I give*

you; you do not take by yourself; I give you... This thing makes me really sad... I do not have any rights... I like sex to happen with love... (Quinana).

When asked about why Quinana continues to have sex with her husband, she replied that she obeys him; otherwise, he violently beats her in front of the children and seriously harms her. Lacking love and respect, she reflected on her situation with apparent bitterness and chagrin.

Uguette was another victim of her husband's moral, physical and sexual abuse. She courageously voiced her disappointment in front of women in one of the focus groups:

When you get married, you say that this is the person that I want to live with... get joy with him, and found a nice family... You devote yourself, body and soul; then you are confronted by the truth... The man you dreamed about disappointed you; you become disgusted with him... if he sleeps with you, you do not want him. You just want him to finish and leave you alone. This means that you are not happy and sexual issues are inhibited... It is very important to feel that you are desired, to feel that you are a woman (Uguette).

Conscious of the violation of her sexual rights, Uguette described herself as a passive recipient who is filled and left like 'garbage'. Although she was the wage earner of the family, she 'sacrificed' herself for her children and refused to leave the house to avoid social stigma.

The husbands' reported egoism and selfish sexual behaviour exhausted women and increased their marital conflicts that in turn intensified their sexual difficulties.

Sexual difficulties happen if the man is self-centred and wants to enjoy himself without caring about his wife... the man does not control himself... the insistence on his wife to always have sex just for himself... it is very important that the woman enjoys... This is in his nature; he does not care about his wife if she enjoys or not... Another issue relates to man insistence to have sex regularly ignoring her fatigue and concerns... Man is driven by his instincts. In the majority of sexual relationships, women do not enjoy. It is all about the psychological context of the sexual relation (Dalia).

4. Sexual difficulties as context and time bound

In this subtheme, sexual difficulties are framed within the challenges women face in their daily life as wives, mothers and workers in addition to personal health issues. These overwhelm them and limit their sexual interest and pleasure. For instance, Tamara who is the only bread winner of the family explained:

If I have poor sexual performance, this does not mean that I do not want (to have sex). The problems of life are enormous and you reach a point where you are tired... Social, financial and family burdens affect it (sexual life) without doubt and cause sexual difficulties. You need suitable conditions to accept the other... I often experience these situations... (Tamara).

Reproductive health burdens like delivery, breastfeeding and infertility problems might also cause sexual difficulties. Mirvat who has been facing infertility problems for seven years said:

The feeling that you have put in the extra effort at the expense of your psychological status to stimulate the desire of your husband who himself might arrive from his work hungry and not in

the mood because the timing is right. This is one of the worst things that might happen in marital life... At this moment, (she stopped talking and then in a hesitant voice said) I feel myself destroyed and often (she cries) I have uncontrollable crying when I finish (Mirvat).

Another aspect of women's sexual difficulties was exemplified by Rayan who complained of an altered body-image and low self-esteem due to an excessive weight gain. Such portrayal that is dissonant with the idealised image of women's body triggered her negative feeling about herself and affected her sexual desire and capacity to satisfy her husband's sexual needs. This in turn made her more frustrated. She reported that:

I am upset because I feel sad; I cannot wear what I want. I do not like to sleep with my husband a lot. I pretend that I am tired. I am intimidated because of my obesity. This bothers me. I have been in this way for 5 to 6 months. I can't anymore. He used to enjoy it but I didn't. My husband is still young, only 50 years old (Rayan).

Discussion

This study explored the meaning of sexual difficulties for the middle-aged Lebanese women drawing upon individual and focus group interviews. Findings reveal that sexual difficulties are not always biologically driven and are rarely located solely at an individual level. While aspects within the individual woman may induce sexual difficulties, these are the results of a multitude of factors that are intra-personal, interpersonal and contextual. The complexity inherent to sexual difficulties further challenges their medicalised definition and supports the 'New View' model of women's sexual difficulties [43].

Due to the lack of awareness, more than half of the women in the study were sexually gauche at marriage and had unpleasant sexual experiences. The failure to recognise the cues of sexual arousal might be attributed to sexual inhibition [44]. Women's poor language of sexual-self resulted in inappropriate communication with their partner. This had the consequence that both would misunderstand each other and were irresponsive towards each other's needs. Many of these women were in their thirties and highly educated but were unable to overcome their sexual inhibition. As an example, one participant has suffered of vaginismus for many years. Although she is a psychologist, she associated her problem to a biological cause amenable to medical treatment and dismissed that 'it was all in her head' as she realised after two years of suffering. Sexual problems being not commonly discussed or associated to physical health conditions, women are less likely to promptly identify them. A qualitative study by Bellamy and colleagues [45] suggests that women's understandings of sexual problems resonate within the medical frame. The authors argued that 'problems arising from psychological difficulties were not seen as real problems and more akin to a good excuse' [45, p. 3242].

Women in this study did not perceive sexual difficulties as female related. For instance, one participant declared that woman does not develop sexual problems and is always ready to have sex. Many held men responsible for their problems accusing them of poor sexual performance and neglect of their wives. This might explain why only one woman affirmed the presence of vaginal dryness that caused her painful penetrative sex [dyspareunia] despite the fact that during the interviews nearly half of them had entered the menopausal period. Not attributing sexual symptoms to themselves might affirm the sociocultural conceptualisation of menopause [5], long-term relationship with the husband [46, 47] and other sociocultural factors [3], it reveals that women's shyness and their incapacity to affirm their sexual-self prevent them from

declaring their sexual difficulties. It also reflects the husbands' centrality in women's sexual life that was apparent in the findings.

Women described how erectile and ejaculatory problems and unpleasant sexual behaviours such as forced anal sex affected their sexual satisfaction. These findings were reported by previous studies as significant risk factors of female sexual problems [9] like orgasmic and lubrication difficulties [48] and sexual disinterest and dissatisfaction [49, 50]. This asserts the power of heteronormativity where women's sexual life is genitally focused and their sexual fulfilment is male-centric [45, 51]. Women are socialised to act based on their social gender, perpetuating a perception of sexual life as equivalent to the vaginal-penile intercourse. This predominant misconception about normative heterosexuality is a challenge for men and women when they have poor performance. Women's capacity to negotiate sexual fulfilment away from the genitally focused sexual behaviour and the 'absolute imperative' is fundamental.

For women in this study, sexual distress was reinforced by their husbands' reported resistance to admit the men's sexual problems and seek help. Rather than voicing their concerns, they silently shoulder their husbands' burden as their lot in life and accord particular attention to their husbands' ego at the expense of their own wellbeing. A paradox surfaces between women's portrayal as sexually passive and submissive and their responsibility to protect their husbands of social stigma as their sexual performance is equated with their masculinity. Women might also interpret men's poor sexual performance as their own failure questioning their femininity and seducing capacities. As also revealed in previous studies, findings suggest that gender imbalance of power reinforces women's devotion and sacrifice for their partners [45, 52].

Anal sex does not correspond to women in this study to the 'real sex' as internalised and shaped by the sociocultural rules. This behaviour -defined in Islam as a perversion- appears to be of particular concern for Muslim women; it is illegitimate and justifies the divorce. Thus, women face sexual difficulties because they have sex they do not want, but are unable to refuse it for relational and sociocultural reasons. Because of gender inequalities, the study findings indicate that some women devote themselves to their husbands creating emotional and sexual concerns and confusions [45, 53].

The quality of the relationship is essential to women's experience of sexual difficulties. Otherwise, they perceive themselves as sexual objects for their husbands' pleasure as well as victims of their moral, physical and sexual abuse. This confirms that women's sexuality is not only genitally focused but multidimensional. Basson [54, 55] suggests that sexual life and intimacy are mutually dependent as one affects the other; when sexual activity does not provide women with affection, they are not encouraged to have sex. The claim of some women in this study that sexual life is not worth the price if the marital relationship is not good is supported by other qualitative [45, 56] and quantitative research [57, 58]. The violation of women's ideals inhibits their feelings, mutes their sexuality and produces sexual problems and dissatisfaction. An effective partners' communication has a great effect on the quality of their relationship that in turn positively affects their sexual satisfaction.

Assuming different roles as wives, mothers and workers may overload women and affect their sexual interest. In a list of pressing needs, they tend to relegate their sexuality to a second plan. According to Maslow's 'Hierarchy of Needs' (1943), sexual fulfilment is difficult to achieve in view of other priorities. These factors that were also found in the study of Bellamy and

colleagues [45] should be considered in determining diagnostic criteria for women's sexual difficulties. Another finding that recognises the multidimensional framework of sexual difficulties is the interference of women's reproductive concerns [breastfeeding and infertility] and psychological problems [low body-image and depressive symptoms] with their sexual interest and pleasure. In a heterosexual relation, concern about self-body image, weight, attractiveness, physical and psychological conditions and general well-being affect women's sexual functioning and satisfaction [59, 60].

Limitations

The study findings are based on a sample of middle-aged women who identified themselves as heterosexual and the majority was married. So, other aspects of women's sexuality including sexual orientation and sex outside marriage may not have been captured. Yet, findings enrich the social science literature about a sensitive topic that is poorly discussed particularly among middle-aged women generally and in Lebanon specifically. The use of a vignette in the first interviews was necessary to break the taboo around sexuality a limitation though is it might have induced hypothetical data. Nevertheless, the vignette served to prompt women to talk about and reflect on their experiences and perspectives, adding something new to the literature.

Conclusion

Findings of this study provide further evidence of the New View' model that defines female sexual difficulties based on a comprehensive framework that calls for diversity and openness to women's perception of their sexual difficulties. This is expected to engage health professionals in a complex approach that requires knowledge and skills and positive attitude concerning

sexual health assessment and management. Sexual education should be developed to recognise the importance of sexual life. Women should be particularly targeted to understand their sexual needs and rights and voice their concerns. More studies are needed using qualitative designs to generate further information grounded in women's context considering different age groups, sexual orientations and marital statuses.

Declarations

Ethics approval and consent to participate

At every step of the research process, the researchers carefully attended to the ethical considerations associated with any research and particularly that on a sensitive issue. Ethical approval was obtained from the Research Committee/Institutional Review Board at the University of Balamand and Saint Georges Hospital University Medical Centre. Another one was obtained from Rafik Hariri University Medical Centre. These two medical centres served to recruit clinical cases. Prior to their participation in the study, all participants received an information letter guaranteeing that conditions of confidentiality, anonymity and dignity are met. They were informed about their voluntary involvement in the study and their right to withdraw at any time. The interviews were audio recorded with the participants' consent. All transcripts were identified by pseudonyms and were securely stored in a locked file cabinet. The participants were assured that nobody will have access to the data other than the researchers of the study.

Consent for publication

Not applicable

Availability of data and material

Study participants consented to data sharing only with the research team, and not for additional data use purposes. This is in line with current GDPR legislation. Further, the contextual sensitivity of the data may identify study participants and place them at risk.

Competing interests

The authors declare that they have no competing interests.

Funding

Not applicable

Authors' contributions

All three authors had substantial contribution to the development of this manuscript. They provided valuable conceptual and technical input from the conception till the conclusion of the study. MA designed the topic guide in consultation with CBJ and TK. She conducted the data collection and transcription. MA, CBJ and TK were involved in data analysis. MA drafted the manuscript and all authors have critically revised it. CBJ and TK edited the manuscript and verified the language of the text. The three authors approved the final version.

Acknowledgements

We would like to express our gratitude to the participants who had voluntarily accepted to provide their insights concerning their sexual difficulties. We are also thankful to the administrators of the centres who provided us with their support to get access to the participants.

References

1. DeLamater J, Koepsel ER, Johnson T. Changes, changes? Women's experience of sexuality in later life. *Sex Relatsh Ther.* 2019;34:211-27.
2. Hinchliff S, Tetley J, Lee D, Nazroo J. Older adults' experiences of sexual difficulties: Qualitative findings from the English longitudinal study on ageing (ELSA). *J Sex Res.* 2018;55:152-63.
3. Lo SS, Kok WM. Sexual Behavior and Symptoms among Reproductive Age Chinese Women in Hong Kong. *J Sex Med.* 2014;11:1749-56.
4. Clayton AH, Juarez EM. Female sexual dysfunction. *Psychiatric Clinics.* 2017;40:267-84.
5. Jamali S, Javadpour S, Mosalanejad L, Parnian R. Attitudes about sexual activity among postmenopausal women in different ethnic groups: a cross-sectional study in Jahrom, Iran. *J Reprod Fertil.* 2016;17:47.
6. Obermeyer CM, Reher D, Saliba M. Symptoms, menopause status, and country differences: a comparative analysis from DAMES. *Menopause.* 2007;14:788-97.
7. Ishak IH, Low WY, Othman S. Prevalence, risk factors, and predictors of female sexual dysfunction in a primary care setting: a survey finding. *J Sex Med.* 2010;7:3080-7.
8. Nicolosi A, Laumann EO, Glasser DB, Moreira Jr ED, Paik A, Gingell C. Sexual behavior and sexual dysfunctions after age 40: the global study of sexual attitudes and behaviors. *Urology.* 2004;64:991-7.
9. Zhang H, Yip PS. Female sexual dysfunction among young and middle-aged women in Hong Kong: Prevalence and risk factors. *J Sex Med.* 2012;9:2911-8.
10. Dennerstein L, Randolph J, Taffe J, Dudley E, Burger H. Hormones, mood, sexuality, and the menopausal transition. *Fertil steril.* 2002;77:42-8.
11. Gracia CR, Sammel MD, Freeman EW, Liu L, Hollander L, Nelson DB. Predictors of decreased libido in women during the late reproductive years. *Menopause.* 2004;11:144-50.
12. Nazarpour S, Simbar M, Tehrani FR. Factors affecting sexual function in menopause: A review article. *Taiwan J Obstet Gyne.* 2016;55:480-7.
13. Gracia CR, Freeman EW, Sammel MD, Lin H, Mogul M. Hormones and sexuality during transition to menopause. *Obstetrics & Gynecology.* 2007;109:831-40.
14. DeLamater J, Karraker A. Sexual functioning in older adults. *Curr Psychiat Rep.* 2009;11:6-11.
15. Hinchliff S, Gott M. Challenging social myths and stereotypes of women and aging: Heterosexual women talk about sex. *J Women Aging.* 2008;20:65-81.

16. Dillaway HE. Menopause is the “good old” women’s thoughts about reproductive aging. *Gender Soc.* 2005;19:398-417.
17. Beckman N, Waern M, Gustafson D, Skoog I. Secular trends in self reported sexual activity and satisfaction in Swedish 70 year olds: cross sectional survey of four populations, 1971-2001. *Bmj.* 2008;337:a279.
18. Lee DM, Nazroo J, O'Connor DB, Blake M, Pendleton N. Sexual health and well-being among older men and women in England: Findings from the English Longitudinal Study of Ageing. *Arch Sex Behav.* 2016;45:133-44.
19. Lee DM, Vanhoutte B, Nazroo J, Pendleton N. Sexual health and positive subjective well-being in partnered older men and women. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences.* 2016;71:698-710.
20. Berra M, De Musso F, Matteucci C, et al. The impairment of sexual function is less distressing for menopausal than for premenopausal women. *J Sex Med.* 2010;7:1209–15.
21. Nosek M, Kennedy HP, Gudmundsdottir M. Distress during the menopause transition: a rich contextual analysis of midlife women’s narratives. *Sage Open.* 2012;2:2158244012455178.
22. Abadi OS, Cheraghi MA, Tirgari B, Nayeri ND, Rayyani M. Feeling an Invisible Wall: The Experience of Iranian Women's Marital Relationship After Surgical Menopause: A Qualitative Content Analysis Study. *J Sex Marital Ther.* 2018; doi: 10.1080/0092623X.2018.1440451.
23. Jaafarpour M, Khani A, Khajavikhan J, Suhrabi Z. Female sexual dysfunction: prevalence and risk factors. *Journal of clinical and diagnostic research: JCDR.* 2013;7:2877.
24. American Psychiatric Association. Diagnostic criteria from dsM-iV-tr. American Psychiatric Pub; 2000.
25. Diagnostic AP. statistical manual of mental disorders: DSM-5™. Arlington. VA American Psychiatric Publishing. 2013.
26. Chedraui P, Pérez-López FR. Assessing sexual problems in women at midlife using the short version of the female sexual function index. *Maturitas.* 2015;82:299-303.
27. Chedraui P, Pérez-López FR, Mezones-Holguin E, San Miguel G, Avila C, Collaborative Group for Research of the Climacteric in Latin America (REDLINC. Assessing predictors of sexual function in mid-aged sexually active women. *Maturitas.* 2011;68:387-90.

28. Azar M, Kroll T, Bradbury-Jones C. Lebanese women and sexuality: A qualitative inquiry. *Sexual & Reproductive Healthcare*. 2016;8:13-8.
29. Denzin NK, Lincoln YS. *The sage handbook of qualitative research*. 3rd ed. Thousand Oaks, CA: Sage Publications; 2005.
30. Barbour R. *Introducing qualitative research: a student's guide*. Sage; 2013.
31. Graffy J, Grant J, Boase S, Ward E, Wallace P, Miller J, et al. UK research staff perspectives on improving recruitment and retention to primary care research; nominal group exercise. *Fam Pract*. 2008;26:48-55.
32. Howatson-Jones IL. Dilemmas of focus group recruitment and implementation: a pilot perspective. *Nurse Researcher*. 2007;14:7-17.
33. Obermeyer CM, Reher D, Alcalá LC, Price K. The menopause in Spain: results of the DAMES (Decisions At MEnopause) study. *Maturitas*. 2005;52:190-8.
34. Shifren JL, Monz BU, Russo PA, Segreti A, Johannes CB. Sexual problems and distress in United States women: prevalence and correlates. *Obstet Gynecol*. 2008;112:970-8.
35. Given LM, editor. *The Sage encyclopedia of qualitative research methods*. Sage publications; 2008.
36. Hautamäki K, Miettinen M, Kellokumpu-Lehtinen PL, Aalto P, Lehto J. Opening communication with cancer patients about sexuality-related issues. *Cancer Nurs*. 2007;30:399-404.
37. O'reilly M, Parker N. 'Unsatisfactory Saturation': a critical exploration of the notion of saturated sample sizes in qualitative research. *Qual Res*. 2013;13:190-7.
38. Walker JL. Research column. The Use of Saturation in Qualitative Research. *Canadian Journal of Cardiovascular Nursing*. 2012;22:37-41.
39. Bradbury-Jones C, Taylor J, Herber OR. Vignette development and administration: a framework for protecting research participants. *Int J Soc Res Method*. 2014;17:427-40.
40. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess, A, editors. *Analysing qualitative data*. London: Routledge; 1994. p. 173-194.
41. Ward DJ, Furber C, Tierney S, Swallow V. Using F framework A nalysis in nursing research: a worked example. *J Adv Nurs*. 2013;69:2423-31.

42. Polkinghorne DE. Language and meaning: Data collection in qualitative research. *J Couns Psychol.* 2005;52:137.
43. Kaschak E, Tiefer L. A new view of women's sexual problems. Routledge; 2014 Feb 25.
44. Basson R. A model of women's sexual arousal. *J Sex Marital Ther.* 2002;28:1-0.
45. Bellamy G, Gott M, Hinchliff S. Women's understandings of sexual problems: findings from an in-depth interview study. *J Clin Nurs.* 2013;22:3240-8.
46. Badawi MT. Le désir amputé, sexual experience of Lebanese women. *Al-Raida Journal.* 2002;61-7.
47. Gott M, Hinchliff S. How important is sex in later life? The views of older people. *Social science & medicine.* 2003;56:1617-28.
48. Oberg K, Sjögren KF. On Swedish women's distressing sexual dysfunctions: some concomitant conditions and life satisfaction. *J Sex Med.* 2005;2:169-80.
49. Deeks AA, McCabe MP. Sexual function and the menopausal woman: The importance of age and partner's sexual functioning. *J Sex Res.* 2001;38:219-25.
50. Fisher WA, Rosen RC, Eardley I, Sand M, Goldstein I. Sexual experience of female partners of men with erectile dysfunction: the female experience of men's attitudes to life events and sexuality (FEMALES) study. *J Sex Med.* 2005;2:675-84.
51. Nicolson P, Burr J. What is 'normal' about women's (hetero) sexual desire and orgasm?: a report of an in-depth interview study. *Social Science & Medicine.* 2003;57:1735-45.
52. Duncombe J, Marsden D. Whose orgasm is this anyway? 'Sex work' in long-term heterosexual couple relationships. In: Weeks J, Holland J, editors. *Sexual cultures.* Palgrave Macmillan, London; 1996. p. 220-238.
53. Cacchioni T. Heterosexuality and 'the labour of love': A contribution to recent debates on female sexual dysfunction. *Sexualities.* 2007;10:299-320.
54. Basson R. The female sexual response: A different model. *J Sex Marital Ther.* 2000;26:51-65.
55. Basson R. Using a different model for female sexual response to address women's problematic low sexual desire. *J Sex Marital Ther.* 2001;27:395-403.
56. Ayling K, Ussher JM. "If sex hurts, am I still a woman?" The subjective experience of vulvodynia in heterosexual women. *Arch Sex Behav.* 2008;37:294-304.

57. Bancroft J, Loftus J, Long JS. Distress about sex: A national survey of women in heterosexual relationships. Arch Sex Behav. 2003;32:193-208.
58. Tehrani FR, Farahmand M, Simbar M, Afzali HM. Factors associated with sexual dysfunction; a population based study in Iranian reproductive age women. Arch Iran Med. 2014;17:679-84.
59. Dove NL, Wiederman MW. Cognitive distraction and women's sexual functioning. J Sex Marital Ther. 2000 Jan 1;26(1):67-78.
60. Pujols Y, Meston CM, Seal BN. The association between sexual satisfaction and body image in women. J Sex Med. 2010;7:905-16.