

Should I seek help for sexual difficulties? Middle-aged Lebanese women's views

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Should I seek help for sexual difficulties? Middle-aged Lebanese Women's Views

Abstract

This qualitative study explored the way middle-aged Lebanese women address their sexual difficulties. Data analysis revealed three overarching themes and subthemes. From these we developed a help-seeking behaviour framework for sexual difficulties. The framework focuses on: the perception of the problem, the beliefs about help-seeking and the sources of help. This framework can be used to facilitate access to personalised sexuality-related care based on a better understanding of the complex interplay of personal, socio-cultural and service-related factors that influence help-seeking behaviour for sexual problems.

Keywords: Help-seeking behaviour, sexual health, sexual problems or difficulties, qualitative study, middle-aged women.

Introduction

Sexual health is a right for all; it should be respected, protected and maintained ("Sexual and Reproductive Health," 2017). It is an essential part of individuals' lives (Patrick et al., 2013; Bouman & Arcelus, 2001). Healthy sexuality improves physical, emotional, mental and social well-being (Bouman & Arcelus, 2001; Eden & Wylie, 2009). Many midlife women emphasise the importance of sex and its impact on their quality of life and marital relationship (Cain et al., 2003; Yazdanpanahi et al., 2018). However, the sexuality of middle-aged and older women is still rarely discussed (Czajkowska et al., 2016), and more often than not, women are falsely perceived as being asexual after menopause (Mattar et al., 2008). Many women avoid being sexually demonstrative for socio-cultural reasons and do not express their needs or concerns (Merghati-Khoei et al., 2014). Consequently, they may be reluctant to seek help when sexual problems arise, particularly during the transition to menopause (Avis et al., 2009; Yücel & Eroğlu, 2013). As such, these problems often go unreported or are handled inappropriately (Bagherzadeh et al., 2010; Moreira, Nicolosi, et al., 2008).

Menopause is one of the most critical physiological milestones that happens in the middle-age of women's life. During this transition, women undergo several biopsychosocial changes that make them vulnerable to sexual problems or dysfunction. These are characterized by disorders that range from sexual unresponsiveness, to an alteration of the quality of sex life (Clayton, 2007). Sexual problems are reported to range from between 22–67% of women worldwide (Cabral, Canário, Spyrides, Uchôa, Eleutério Jr, & Gonçalves, 2013; Zhang & Yip, 2012; Chedraui et al., 2012; Shifren, Monz, Russo, Segreti, & Johannes, 2008).

The ageing process and physical problems significantly affect sex life; however, psychosocial burdens substantially contribute to these problems. These may include stress, family and work responsibilities, partners' and relational issues, changes in body image, low economic status and low level of education (Thomas et al., 2018; Cabral et al., 2013; Zhang and Yip, 2012; Avis, Zhao, Johannes, Ory, Brockwell & Greendale, 2005). In turn, sexual problems affect women's health, well-being and quality of life (Bahri et al., 2017; Thomas & Thurston, 2016; Elkowessny, Salama, Abu-Nazel & Gobashy, 2015; Nappi & Lachowsky, 2009). They may engender emotional problems, low self-esteem, mood disturbance and marital and relational problems that can lead to divorce (Kim et al., 2009; Anastasiadis, Davis, Ghafar, Burchardt, Shabsigh, 2002; Basson et al., 2001). Kadri and colleagues reported that sexual problems are the second leading cause of divorce

among spouses in Muslim countries (Kadri, Mchichi Alami & Mchakra Tahiri, 2002). As such, women are expected to seek help promptly to address these problems in order to minimise their damaging effect on the partners, family burden.

Help-seeking is a complex and multifaceted process characterised by an adaptive behaviour whereby a person actively seeks assistance from an external source in response to a perceived need or problem that is not resolvable by his/her resources (Barker et al., 2005; Koldjeski et al., 2004). It is a daily life process that is expected to ensure satisfactory outcomes (Lee, 1999). Help-seeking might be formal, relying on professionals, or informal, provided by the individual's network, through books or other media. Help-seeking could be informational, therapeutic or emotional, depending on what is needed (Andersen, 1995; Rickwood et al., 2005). A Global Study of Sexual Attitudes and Behaviours (GSSAB) conducted in 29 countries found that only 7 – 22% of women sought help for their sexual problems (Moreira et al., 2005); yet a substantial proportion would have liked to do so (Berman et al., 2003; Danielsson et al., 2003). In a survey conducted in the Netherlands, 24% of the women felt they needed to seek sexual health care, and only half of those expressing this need received it (Vanwesenbeeck et al., 2010). In a Chinese study, only 1.5% of the women declared that they had received help, even though 85% of the participants had indicated having sexual problems (Wong et al., 2018). None of the women in a Turkish survey had received help, even though 93.7% of Turkish women had complained of unpleasurable sexual intercourse (Yücel & Eroğlu, 2013). Similarly, most Iranian women adopted a sacrificing role and refrained from seeking any help to cope with their sexual problems in the transitional period to menopause (Bahri et al., 2017). Most often, women rely on informal help, mainly they rely on their husbands and seek the assistance of other experienced women and written and online resources (Moreira et al., 2005; Salinas et al., 2011).

The discrepancy between the need for help and actual help-seeking behaviour suggests that women may face significant barriers that prevent them from requesting and receiving the sexual healthcare they need. This includes health professionals' lack of preparedness to discuss sexual health issues with their patients, perceiving the topic as a violation of their privacy and pointing to a lack of resources and time (Dyer & Das Nair, 2013; Hinchliff & Gott, 2011; McGrath & Lynch, 2014). Health professionals may also overlook the sexual needs of older people considering them as asexual or not interested in sex (Bauer et al., 2016; Hinchliff & Gott, 2011; Hughes et al., 2014; McGrath & Lynch, 2014). Research has shown that healthcare professionals expect that their patients initiate the discussion about their sexual difficulties while, conversely, patients wait to be asked about the topic (Moreira et al., 2005). A study with Turkish women reported that 89% had never been questioned or examined by health professionals about their sexual health (Aslan, Beji, Gungor, Kadioglu & Dikencik, 2008). In a descriptive qualitative study, midwives and general practitioners found that traditional, cultural and religious beliefs and inaccessible services were significant barriers to help-seeking for sexual problems among menopausal women (Ghazanfarpour et al., 2017). These findings were corroborated by other studies revealing that sexual healthcare is stigmatised and difficult to access (Agu et al., 2016; Azar et al., 2013; Bahri et al., 2017). Other barriers are the lack of time, the embarrassment of raising the issue of sexual concerns, and the perception that these difficulties are not severe or only part of the ageing process

and do not require professional assistance (Gott & Hinchliff, 2003; Nicolosi et al., 2005; Zeinab et al., 2015).

The literature suggests that women who prioritise sex in their life are more willing to seek help than those who do not (Hinchliff & Gott, 2011). This occurs mostly when they are troubled by lubrication difficulties and are not sexually satisfied (Moreira, King, et al., 2008; Moreira, Nicolosi, et al., 2008; Laumann et al., 2009). The assistance of health professionals triggers their proactive behaviour. Women are more likely to accept help if doctors address potential sexual concerns during routine visits. Despite the potential for health professionals to support women, many are left untreated, without help (Azar et al., 2013).

Studies about help-seeking for sexual problems **are missing in the** Middle East countries, and particularly in Lebanon. The tacit/hidden nature of sexuality may have prevented researchers from exploring the topic. **Little is known about this important topic in women's lives**, especially middle-aged and older women. A survey reported that 59% of Lebanese women of 45-55 have sexual problems (Obermeyer, Reher and Saliba, 2007). This prevalence was the highest in Lebanon compared to Moroccan, Spanish and United States women of the same study. However, women are reluctant to seek help. Sexual difficulties are neither discussed publicly nor privately. Healthcare providers seldom consider the subject with their patients. Lebanon is a country where the family is the fundamental unit of society and sexual problems may affect the well-being of the family. Women should be willing to seek help to maintain their marital life and protect the family's boundary; they rarely do. It is plausible that women are unaware of the nature of their problems, do not know where to go and whom to consult. They might also feel ashamed to report on this sensitive topic within the Lebanese culture. While similarities may exist globally concerning women's experience of help-seeking for sexual problems, middle-aged Lebanese women's experiences may also differ in critical aspects.

Few studies have explored women's subjective views, perceptions and experiences about help-seeking, and none exist in the Lebanese context. Help-seeking is complex and a comprehensive understanding of the varied factors that may affect decisions to seek help or not is needed (Unger-Saldaña & Infante-Castañeda, 2011). Qualitative research is necessary to generate deep insights into women's thoughts and experiences and to illustrate the multitude and complexity of factors that determine this behaviour (Gulliver *et al.*, 2012). A qualitative approach looks at the help-seeking process from a broad perspective to capture its multidimensional nature. This work is crucial to inform culturally sensitive, contextually-bound, women-centric practices in sexual health services.

This exploratory, qualitative study was conducted to understand the way middle-aged Lebanese women address their sexual difficulties, considering the facilitators and barriers to help-seeking and the different sources of help.

Methods

Design

A cross-sectional exploratory, qualitative design, conducted with middle-aged women in Lebanon.

Setting

The participants were chosen from primary care centres, clinics and non-governmental organisations in the Beirut area. These settings receive women from different backgrounds and sociodemographic statuses, which enriched data and provided different study perspectives. Also, non-clinical settings were chosen to reflect a non-medical view of the topic.

Method and Data Collection tools

The study used semi-structured individual interviews and focus groups discussions. The purpose of the individual interviews was to explore and probe women's responses to gather in-depth and detailed data about their attitudes, values, beliefs, feelings, concerns and experiences about help-seeking for sexual difficulties. This method is adaptable and useful to gather in-depth information about sensitive and taboo topics. It allowed the participants to openly talk about their particular experiences and highlight their concerns and worries in a comfortable and private environment without intimidation or fear of being judged. The focus groups were added to generate rich data from the interaction and discussion among the participants. This method was relevant as it stimulated women who were hesitant and encouraged them to share their ideas. The combination of the two methods of data collection increased the validity of the findings.

A topic guide with open-ended questions was used. Probing questions were used to clarify, widen and deepen generated data. The literature informed the topic guide development. It was piloted and refined to ensure clarity and relevance of the questions. The topic guide is included in Appendix I.

Sampling and data collection

A purposive and snowball sampling strategy was chosen. Sampling criteria included women's menopausal status and sociodemographic characteristics [education, religion, marital status and occupation. Women who had general physical and mental health problems were excluded from the study. Women were selected from clinical centres at two university hospitals and outpatient clinics. They were also chosen from two non-clinical institutions to access those who are not necessarily in contact with health professionals. The access to women was facilitated by the administrators in each settings, who identified the potential participants and introduced them to the first author who took charge of the subsequent steps of the recruitment process and the collection of data.

After the site administrators' approval, women received an information sheet about the study, their voluntary participation and the respect of their confidentiality. All their questions were answered to assist their decision as regards participating in the study. All interviews were conducted by the first author, who is Lebanese and has many years of professional experience in working with women. This facilitated her approach and communication with them about a sensitive topic that is seldom discussed. The interviews were held at a place and time convenient to the participants. Overall, few interviews were conducted at women's house, and the majority took place in a private and comfortable setting of the interviewer's workplace. The individual interviews lasted on average 60 to 90 minutes, and the focus groups 90 to 180 minutes; all of them were audiotaped.

Data analysis

Data analysis was guided by the framework analysis of Richie and Spencer (1994), which informs the development of strategies to improve practice. It is a five-stage hierarchical analytical approach that aids the researchers' critical thinking and creativity to construct data in a meaningful conceptual frame of help-seeking behaviour as uttered by the middle-aged Lebanese women. The first author (MA) listened to all interviews. She transcribed them verbatim, considering the verbal and non-verbal cues, specific impressions and contextual information. She read all transcripts until she got a deep and full sense of each regarding manifest and latent content. A thematic frame was developed in the next step and served to encode data into themes and subthemes. All coded data across the transcripts were then extracted and charted by participants under different themes and subthemes. This organisation and classification allowed for comparing and contrasting the data. Charting was an iterative process that required an inclusive view of data to decide on emerging and then collapsing, of themes and subthemes. At this stage, all data were shifted as raw material to keep the participants' talk's essence and further make sure of the categorisation of the quotes. Then, the selected data were summarised and synthesised, supported by relevant quotes. In the last step, data were further examined, and the themes and subthemes refined to be congruent with the participants' thoughts across the transcripts. A schematic diagram was generated with a higher level of abstraction that links the themes and subthemes in a structured way that reflects middle-aged Lebanese women's views and experiences of help-seeking behaviour for sexual problems.

Ethical consideration

The study was approved by the Research Committee/ Institutional Review Board at the University of Balamand and Saint Georges Hospital University Medical Centre and Ethics Committee of Rafik El Hariri University Medical Centre. Access to women required the approval of the administrators of the selected centres. Potential participants received an information sheet about the study and their participation. They were assured about the privacy of the interviews and the confidentiality of data generated. They were also informed about their right to withdraw their participation at any time. All the participants signed informed consent and were identified by pseudonyms to preserve the data anonymously.

Trustworthiness

Lincoln and Guba (1985) identified credibility, confirmability, dependability and transferability as the four components of trustworthiness. To ensure trustworthiness, we used several techniques in this study. Furthermore, an audit trail and reflexivity increased transparency and contextualisation of data. All decisions were made between the three researchers, and a consensus was reached for the thematic index that guided the coding process and elaborated the themes and subthemes. Some authors recommend analysing the interviewees' language to minimise the misrepresentation of their views (Al-Amer et al., 2016; Irvine et al., 2007). Thus, all the data moved to the thematic chart appeared in the native Arabic language. Then, selected data were summarised and synthesised in English to keep the meaning inherent to the culture. Using the method of back translation, two transcripts were translated from arabic to english and retranslated to arabic with a proficient professional in both languages. The two versions were compared and then we were confident that this process was rigourously conducted.

Findings

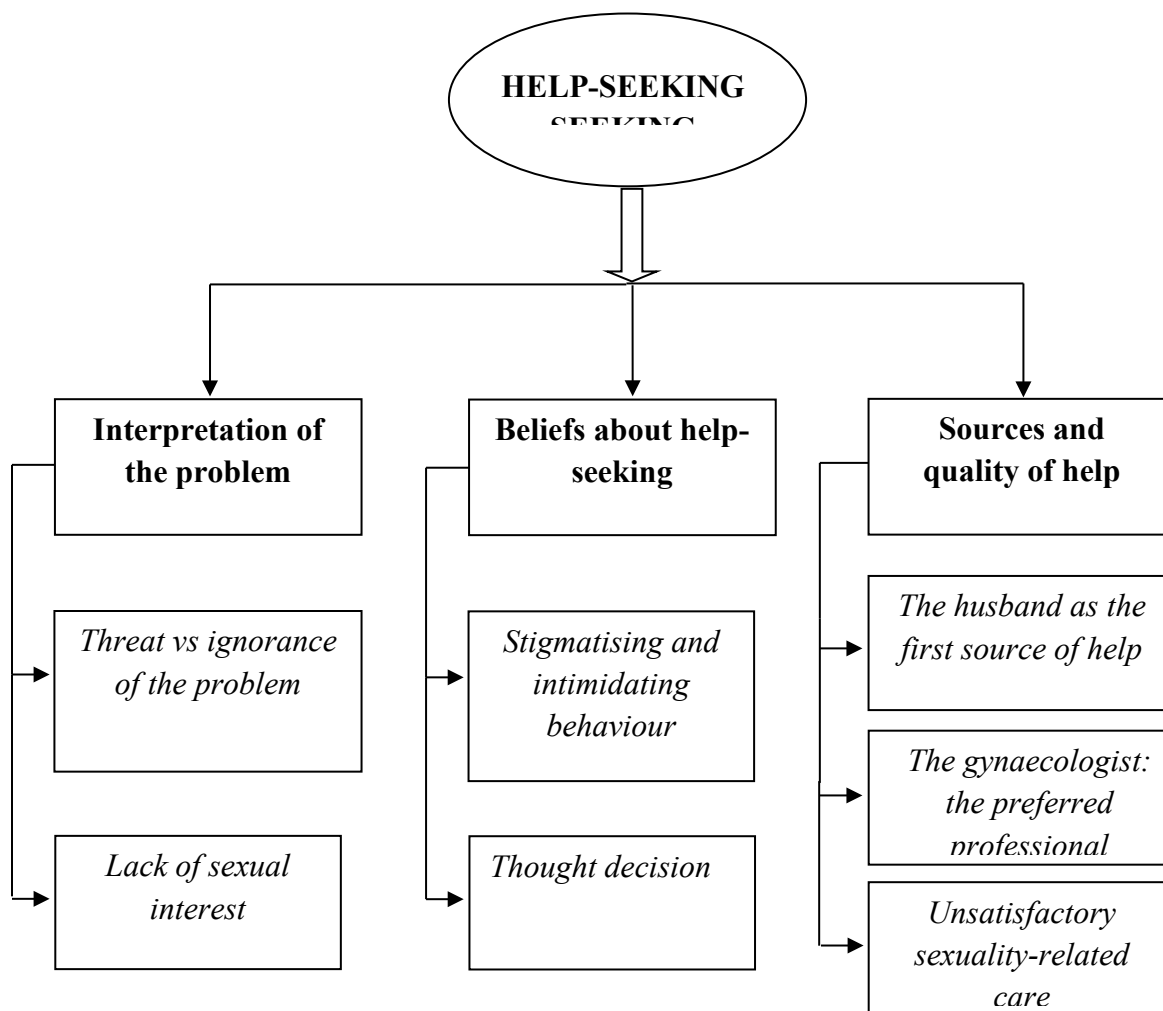
Participants

The sample comprised 52 women. Their age ranged between 40 and 55 years, with a mean of 47.40 years. Most were married. Sixteen had attended university, ten had an elementary education or less and the others had a secondary or intermediate level of education. Twenty-seven were Christians, and the other Muslims. Twenty-eight were homemakers; some had freelance work or were professionals, and the others had low-earning jobs like hairdressers or secretaries. Twenty-five indicated that they had started the perimenopause or menopausal period. Participants' characteristics are presented in Table I, Appendix II.

Themes and sub-themes

The framework of help-seeking behaviour for sexual difficulties is presented in Diagram 1. The three-stage model comprises the '*Interpretation of the problem*', the '*Beliefs about help-seeking and the*' '*Sources and quality of help*'. It explains how the middle-aged women of this study address their sexual difficulties considering the personal, relational and socio-cultural facilitators and barriers that shape help-seeking. The model also presents women's views concerning the accessibility, availability and quality of sexual healthcare services. The themes and sub-themes are defined in table II, Appendix III.

Diagram 1. Framework of help-seeking for sexual difficulties



I. Interpretation of the problem

Women who regarded sexual difficulties as serious enough to affect the relationship with their husbands, reported a greater willingness to seek professional help. Women who seemed to have expressed a lack of sexual interest refrained from seeking help even if sexual difficulties are evident. They do not pay attention to the matter. This is illustrated by two subthemes, including: "Significance of the problem" and "Lack of sexual interest".

Threat vs ignorance of the problem

Women expressed their willingness to seek help when they perceived sexual difficulties as severe enough to threaten personal, relational and family welfare. They saw it as paramount to satisfy their husbands. Gihane illustrated this.

If she has a sexual problem with her husband that is damaging her life, she is encouraged to talk to find a solution. She should talk... This has a great influence on your life with your husband... When it starts causing problems, she talks... If a man does not receive all his rights from her, he either leaves her or cheats on her. I want to talk to avoid pushing him away from me; I want to keep him for me [Gihane]

Women feel committed to saving the marital relationship for the sake of the family because "sexual problems become family problems" (Gabby). In this respect, Dalia opined that these problems are the couple's concerns, and both of them should seek help which is less likely to happen.

On the other hand, being unfamiliar with the nature and severity of sexual difficulties, many women attributed sexual difficulties to men and, as such, did not identify a personal need to seek help. Some of their quotes were "sexual difficulties usually relate to men", "do not happen to women", and "women are always ready for sex".

Other women argued that it was difficult to identify sexual difficulties if there was no physical basis. They added that in Lebanon, people are less likely triggered to seek professional advice without perceiving a medical reason. For instance, Dalia consulted the gynaecologist for her sexual disinterest and absence of pleasure only after one year of suffering. She went to get professional assistance only when she realised that the problem might be a medical issue that requires the physician's assistance. She never thought that women could experience sexual difficulties even though she is highly educated and described herself as generally well-informed. Another example of women's lack of awareness about sexual difficulties was presented by Carmen, who was diagnosed with vaginismus because of her "ignorance and inhibition", as she said.

It was ignorance, so I did not know. I was telling myself that this is it (sexual intercourse), and it is as much pain! Maybe it penetrates (penis) this much only. My husband was aware that there was something wrong. He told me that he felt that there is some blockage that I am unwillingly or unconsciously obstructed. You know you say: me! No, there is nothing wrong with us. I did not believe it...

I talked because we wanted to find a solution. I did not know that there was vaginismus. We did not know. We did not realise the problem as such, nor was it a problem for both of us. That it was an intercourse problem. I went to the gynaecologist to see what was there (in the vagina); cancer? A fibroid? A cyst? There was something. I realised that it was (the problem) in my brain; what I inherited was manifested there [Carmen].

On the other hand, Nay, a housewife with an intermediate education, did not perceive any sexual difficulties that might require professional assistance or impact her sexual life. Nay recounted that in a conservative society like Lebanon, women do not seek help for sexual issues as these are not considered within the medical sphere.

I do not know that a physician deals with these issues... I do not know any physician, any physician; not at all ... I have only known those I see on the TV... In our context, I do not think that you consult a physician for these issues; I do not think so [Nay].

The reason for her was that:

Because they say that it is not a physical problem, they say that it is not a problem by itself. I think that it might not be a problem. The woman can solve it with her husband (talking about herself). I do not think that sexual disease causes a problem. I do not think... I wonder, I wonder if women see a physician for such issues [Nay].

Lack of sexual interest

In this subtheme, women expressed the lack of sexual interest to seek help as sexuality was not considered a priority in their life.

For instance, Odile reported:

I do not think about this subject. First, I am 48 years old [she laughed], he too (62 years), how do they say we are sated with our life. Medically speaking, nowadays, there are surgeries for these issues (reflecting on her husband's erectile problems)... but at this age, I do not believe that we will do this or think about it. The most important is for him to be in good health and for me to be in good health [Odile].

Other women like Adele and Kamal, two highly educated women who entered menopause, claimed that sex has never been a priority for them during their whole life and particularly now. Kamal reported relief since the time her husband had open-heart surgery, and his sexual activity decreased. She claimed that seeking help for sexual problems has never entered her mind. As for Adele, she avowed during the time of the interview being asexual. Although conscious of her lack of sexual desire, she showed a complete unwillingness to address this issue even if her husband should have sexual affairs. She said that she does not want to force herself to have sex at her age.

Adele said:

I am the type who does not like sex much. Some issues make me feel happier than sex. Drinking a beer in nature makes me happier. For instance, I invent something; I paint; I invent things that distract me and are pretty. Art makes me happier than sex. This was especially after menopause. I don't feel like it at all, at all, I do not think about it... Of course, he needs sex, and maybe he is going out. But, I am not interested in addressing this situation... I do not think I will one day see a doctor someday for this... I am not interested, so what for? (Seeing a doctor)... but when I was younger I was not so interested... [Adele].

II. Beliefs about help-seeking

This theme presents women's narratives concerning their own and husbands' perceptions and attitudes about help-seeking. The subthemes are: "*Stigmatising and intimidating action*" and "*Informed choice*".

Stigmatising and intimidating behaviour

This subtheme stemmed from women's narratives concerning their own and their husbands' reluctance to seek help for sexual difficulties. Their attitude was mainly affected by their own and husbands' timidity and fear of social stigma and the absence of seeing a solution for sexual difficulties.

Women identified their husbands' resistance to disclose their sexual problems as the main barrier to help-seeking. The commonly mentioned cause was to see their masculinity threatened. Only one of the husbands who had experienced erectile and ejaculatory problems consulted with a urologist upon his wife's insistence (Odile). Lana and Sara discovered the presence of medication for erectile dysfunction in their husbands' closets. They inquired about the medication with the pharmacist in the neighbourhood as it was not possible to broach the topic with their husbands since they did not admit to having problems. Women's efforts to convince their husbands to seek help seemed to be futile. As a consequence, women experienced considerable physical and psychological discomfort.

Do you know how? But I am suffering. I told him, man, and I am suffering with you. It is enough, enough, either you see a physician or stop it (sexual act). He is now apart (no sexual life). He does not want to be treated, and I suffer, I suffer [Zeina].

Some women consulted a physician on behalf of their husbands., However, this was in vain, as their husbands did not comply with the medical instructions. For instance, Khawla's husband's reluctance to apply safer sex practices and comply with the medication she brought him for sexually transmitted infections made just things worse, and she got infected as well.

The stigma associated with men's virility and sexual problems affected women as regards the extent to which women could disclose these problems. Before agreeing to participate in the study, Karine said she was very concerned about her husband's reaction should he ever find out that she has revealed his sexual problems. In the Islamic faith, in the Sharia' discussing sexuality is considered "Haram" (a sin). Some Christian women also presented religious reasons for covering up their husbands' sexual problems, citing Christian marriage's sacrament.

We were brought up based on our religion, the Ten Commandments; we still have shyness. It is not easy to talk about the subject [Chaten].

Thus, many participants reported ambiguous feelings. They expressed their regret for highlighting very intimate issues of their sexual dissatisfaction; at the same time, they appreciated the opportunity to reflect and talk about their concerns.

Women's caution, fear and hesitancy formed a substantial barrier to help-seeking. Raja, who works as a life coach, said that she sees many women who find it difficult to talk about sexual difficulties

even though these cause them much distress. Raja added that some women stop the sessions when she attempts to raise the issue of sexuality. Kamal attributed her reluctance to discuss sexual issues to her conservative upbringing.

But I am telling that for a woman, to consult a doctor requires audacity and an upbringing different from ours. Our upbringing was so inhibiting. I do not talk about these issues with anybody. I am revealing my insights to you, but really, it is the first time in my life that I talk. Maybe if I were not educated, I would have never discussed this issue with you... [Kamal]

It may be particularly challenging for middle-aged women in Lebanon to find a way to talk about sexuality and sexual difficulties. For instance, Lana expressed sexual distress because of her husband's poor sexual performance and expressed the need for professional assistance. But, being close to menopause, she said:

You are afraid of society. Now, since nobody knows me, I do not have a problem to talk. If somebody knows me, no, I do not talk; Lebanese is a small country (all people know each other)... I prefer to appear happy in my sexual life and not become the talk of the town, maybe because it is shameful to talk. Maybe because I feel that it is arrogant if a woman talks... At this age, I feel it ridiculous to talk about the topic ... the woman in our culture is shy, and this is wrong [Lana].

The reluctance to talk and fear of social stigma were also found in the discussion among participants of the FG1.

- Mirvat. *I see that something is missing in our culture because the psychiatrist is taboo; the psychologist is taboo; what would it be for a sexologist?*
 Zeina. *The woman does not dare to go (to a physician)*
 Raja. *But I also say that this is the religion*
 Tamara. *The timidity does not allow you to go*

Similarly, women of the FG2 conversed:

- Razan. *The woman needs (to have sex), but she hides this issue because she does not have the courage (to seek help)*
 Tressy. *I might seek help for my husband more than for myself*
 Razan. *We do not dare to seek help*
 Tressy. *A woman does not have a lot of sexual desire*
 Racha *Because this is a taboo*
 Sally *We are afraid of social stigma; so we do not do it (seek help)*

Some women did not see how medical help would help if the cause of sexual difficulties is psychological distress resulting from marital conflicts and overwhelming life conditions. Reflecting on their cases, Tressy and Tamara said:

If he consults a physician and he prescribes medication for him, it is not wrong if the reason is sexual. But if the reason relates to poverty and worries, the drug can do nothing because the cause is still there [Tressy].

You have to tell the physician about all that you have and try to solve the problem. But I do not know to what extent the therapy would be effective. But I tell you again; the psychological status is the most important; the psychological factor is essential [Tamara].

Thought decision Some participants viewed sexual difficulties as a normal and inevitable part of life. They considered them similar to any other health problem for which one would seek help. These participants had a positive relationship with their health care providers and felt comfortable to discuss any reproductive or sexual health issue. For instance, Odile did not hesitate to inquire about the consequences of a hysterectomy on her sexual functioning, even though she claimed not being interested in sex anymore. Odile confirmed that her sexual awareness gave her self-confidence in discussing all sexual matters with her husband. In the same vein, Gaby reflected on herself and recounted that:

If the woman is educated, knowledgeable and has a good understanding, she seeks help [Gaby].

Carmen said she felt lost and alienated from her body. Carmen's story is unique, specifically in the Lebanese context. It would not have happened if Carmen and her husband were not highly educated. They became aware that there was a problem and managed to address it by supporting each other.

When I understood that there is a different story (vaginismus)... there is something different in my body ... I searched for it. I went and dated with other men... I went through all the steps a woman should have done in the previous years (at an earlier age) ... These things were a bit late with me. But aaah (showing her glory and satisfaction); the best days of my life, and I am extremely proud of what I did because I was able to get my life back from them (parents) by myself. I mean, I got my life back from them. I got my body back from them because they had possessed it [Carmen].

It is worth noting that few women said they would seek help because they felt sexually dissatisfied. Raja suggested that it would be important to strengthen women's confidence and support them to seek help as this is not traditionally part of Lebanese culture. She emphasised that women need to be made aware of their body and empowered to express their needs. They also need a good understanding of where to turn to for support. She said: *"I cannot change the world around me, but I can work on myself to get what I want"*.

Several women highlighted the importance of accessibility and availability of reliable resources. However, getting appropriate help can be challenging, as detailed in the following sub-theme.

III. Sources and quality of help

Included in this section are women's accounts about their help-seeking patterns, the quality of sexual healthcare, the availability of and accessibility to services and the sources of help. The

subthemes are: *"The husband as the first source of help", 'The gynaecologist as the preferred professional' and 'Unsatisfactory sexuality-related care'.*

The husband is the first source of help

Many women viewed their husbands as their primary source of support as they were most immediately affected by sexual difficulties. However, many husbands seemingly failed to respond to the need for help and avoided conversations about the topic.

The participants' perceived communication between marital partners in a trustful and comfortable environment as critical for a satisfying sexual life.

"Nobody can understand spouses' concerns more than themselves" [Jana].

Talk to your husband and be maximum, maximum transparent. This will solve your problem, not the physician. He is not with you in bed to know exactly what is happening between you and your husband to understand how you behave. As much as you talk, there are a lot of things that remain unrevealed [Elham].

Pamela confirmed that being open to discussing her sexual likes and dislikes with her husband helped her overcome her sexual disinterest associated with family problems. Carmen's husband tolerated his wife's extramarital sexual relations as part of the psychologist's strategy to overcome her inhibition.

As Carmen explained that, he told her, *"go, and I am waiting for you whenever you become ready for our life"*, and he patiently waited for her until she returned to him, and they resumed their marital relationship. Carmen proudly told her story and the exceptional approach of her husband. She said: *"our relation does not resemble any other one"*.

Other women complained about their husbands' lack of communication and their dominant and non-responsive attitude. Racha said that her husband was very supportive when she experienced dyspareunia induced by menopause. Racha's talk triggered the other participants of the FG2 to emphasise the importance of communication that was lacking in their sexual relationship with their husbands.

Racha. It is only the communication (that helps, reflecting on her case with her husband)
Sally. You need sexual education to let him (the husband) understand these issues and communicate... There should be sexual education.
Razan. You want him to understand this subject

Other informal sources of help were the close relatives and friends whose support was informed by their sexual experiences. Zeina referred sought spiritual support from a cleric. Her husband pressured her into anal sex, which she considered being a sinful act. Zeina's story triggered an animated discussion among the participants of FG. Some participants felt that clerics are in the majority misleading rather than supportive. Most said they preferred professional assistance, primarily from their gynaecologists.

The gynaecologist is the preferred professional
While not denying the importance of mental health professionals such as psychologists, women identified the gynaecologist as the preferred source of help. They opted for this professional who provides them with reproductive healthcare and deals with sensitive issues in their life...

In my opinion, there should be a specialist. Nowadays, it is neither the mother nor the father. We should refer to these specialists to help us because we will suffer silently, and we will transmit this issue to our children [Raja].

With a gynaecologist, you are not afraid or shy... A lot of them are aware of the woman's needs; the physician becomes your friend, your brother... [Elham].

To meet women's expectations and gain their trust, the professionals should be knowledgeable, experts, good listeners and honest.

He has to know how to let you talk without shyness. For instance, if Sandrine (a public figure sexologist) was in front of me, I would have talked to her because you feel that she is open and you feel that she is experienced. She simplifies things. She lets you feel that hundreds of women are other than you who live the same feelings [Faten].

Women held different views on whether it mattered if the health care professional was female or male.

Certainly, a woman is better... you are more comfortable with a woman as she understands my needs and it is easier to talk to her. [Oumaya]
No, I prefer to see a man. No, no, he is more competent... [Hasmig].

Both Oumaya and Hasmig had limited formal education. Oumaya is Muslim and homemaker, while Hasmig is Christian and works outside the home.

However, overall, women perceived a limited role for nurses and midwives in sexual healthcare, although opinions differed, like Lea, Carmen and Asma's examples illustrate.

I say the nurse; I say that she is half a physician. There are things that they know almost as much as the physician. But you cannot rely on them in everything; you fully trust the physician... I prefer to go to a specialist. I go directly to him; why should I turn around as long as I am able to go to the physician... [Lea].

The nurse really knows a lot; she knows; her field of study is really immense; she knows a lot, she is close to the patients and their families and has more time than the physician, and you can ask her... the physician! He barely talks to you. The patients need her support unless they are not concerned when they are sick. But you see her (nurse), I see her when I am in the hospital for a visit... and she is overwhelmed, she has a lot of work... [Carmen].

The midwife has a big and important role... I do not know why this is not strongly apparent... she can have a lot of impact on couples; she is the most suitable person to deal with issues and

problems of menopause. Some of them do; why not?! Sexual issues are very intimate, and the midwife is really lovely and very understanding... [Asma].

Some participants said that nurses and midwives should have a more recognisable role in providing sexual health care.

Unsatisfactory sexuality-related care

Some women were very dissatisfied with the healthcare and support services they had received. They viewed professionals as ill-prepared and lacking in competence to meet their sexual health care needs. The theme also refers to the lack of orientation regarding where to turn for help and support.

Carmen, who was suffering from vaginismus, acknowledged the role of the psychoanalyst in giving her as she said: *"the laissez-passer to discover the woman inside me"*. However, she remembered the bad experience she had with the gynaecologist focused on the genital aspect of her problem, neglecting its complexity. She suggested that professionals adopt a more comprehensive approach to sexual problems.

Lana said she had felt embarrassed when the family doctor advised her to satisfy her sexual needs outside marriage. He had failed to understand the nature of the problem and did not investigate the causes of the husband's sexual impotence. Lana accused him of not seeing the seriousness of the problem. She criticised his approach because it was limited to the prescription of a drug for erectile dysfunction. He did not suggest couple therapy or address the psychosocial aspects of the problem.

Asma explained that usually, health professionals inquire about flu, fatigue or anything but sexual health. She added that they take these things for granted as if nobody wants to talk about them; this is part of the culture. Carmen said that the professionals' reluctance to address women's sexual reflects the moral code and restrictive norms of society. Professionals were exposed to the same form of conservative socialisation. She assumed that professionals might be hesitant to address women's sexual concerns as they might be misunderstood and accused of sexual harassment.

No. Initially, this question did not come to my mind. Even if he asks me, I will answer in a restrictive way. I do not like it. Then, I say that these are the secrets of one's own home [Kamal].

No (nobody can ask me), eh, only you. Nobody can interfere with these issues; neither the physician nor anybody else [Elsie].

Highly educated participants acknowledged the importance of including a routine sexual health assessment in clinical practice. Women are often unaware of their sexual concerns or too shy to discuss them. They concluded that professionals should be well prepared to assume this responsibility. Many women are unsure where to find necessary resources or whom to turn to for assistance when problems arise.

If I face now a sexual problem... or a problem in the relationship with my husband, I, I, I currently do not know where to go. I, who was able to assimilate more critical and challenging

problems (than sexual ones)... I do not know. This is because we do not have this culture [Mirvat].

Faten added:

I do not know if there are sexologists in Lebanon; maybe there are not... A lot of women might have problems and do not dare to open their mouths. As I am telling you, they cannot find a person to talk to... If there is a sexologist available for all, this is a very good thing for the person to consult him/her... It is important to consult a sexologist, especially for a bride and a groom [Faten].

Discussion

This paper provides a framework that explains women's decision to seek help for sexual problems. Sexual help-seeking depends on the perception of a problem, the beliefs about help-seeking, and the sources and quality of support. The findings show how women's understanding of sexual problems as a threat to their marital life pushes them to seek help. They are less likely to do so if the problem is trivialised or the behaviour is socially stigmatised. Help-seeking is mainly informal and relies on husbands' support. Women's reliance on professional support depends on the accessibility, availability and quality of service.

Sexual life and related sexual concerns are multifaceted and their causes are complex. Similarly, help-seeking for sexual concerns is not straightforward. Unger-Saldana and Infante-Castaneda (2011) characterise help-seeking as a process involving individual capacities, social interactions and healthcare system factors. This study is the first in Lebanon to examine sexual life among middle-aged women, how they perceive sexual difficulties and what motivates or prevents them from seeking help.

Women were found to weigh up the costs and benefits of help-seeking and because "*sexual problems become family problems*", they sought help to save their family's integrity. Mostly, their intent was to satisfy their husbands, while few took such an initiative for their own sexual pleasure. In support of these findings, previous studies have shown that women are more likely to seek help when they perceive distress, threat and persistence of sexual difficulties (Azar et al., 2013; Maserejian et al., 2010; Mercer et al., 2003; Reed et al., 2012). They may do so to protect the home (Binfa et al., 2009); Hinchliff et al., 2012).

As sexual problems are not necessarily physical and attributed to one cause, they are not easy to recognise. Moreira, King, et al. (2008) suggest that both men and women are more likely to seek medical help when they perceive their sexual problems like erectile dysfunction and lubrication difficulties as physical and best treated by a professional. Women identify the lack of sexual interest as another impediment to help-seeking. Being valued through their reproductive status rather than their sexual performance (DeJong et al., 2005), it is probable that sexuality becomes secondary for them at the middle-age.

Many believe that sexual disclosure is a violation of the couples' privacy and commitment to one another, particularly when the husbands are accused of sexual problems. Supported by religious beliefs, Muslim women admit that in Islam, any revelation of men's sexual problems is "*haram*"

[strictly prohibited by the religion]. It is equated with unfaithfulness towards the husband. It is worth noting that Islam is among the monotheistic religions that encourage women to enjoy sexual intercourse and mutual satisfaction with the partner (Kadri et al., 2010). However, this does not appear to be applied as Muslim participants in this study bear silently to preserve their husband's social image.

Additionally, the high rates of female "sexual dysfunction" are in stark contrast with low rates for help-seeking in countries with an Islamic majority (Elnashar et al., 2007; Safarinejad, 2006). However, it is not religion *per se* that seems to impact help-seeking. Instead, it is the traditional and restrictive normative codes found in many religions that prevent help-seeking. In this study, some Christian women also said they would conceal their husbands' sexual difficulties as they regarded their religious marriage as sacrosanct. Consequently, sexual disclosure would be a sinful act. Women's views reinforce gender sexual power imbalance which constitutes a substantial barrier to help-seeking.

From the findings of our study, we can infer that women opt for self-concealment within the Lebanese patriarchal culture to protect their husbands' ego. It is self-regulation to maintain personal information about emotions, thoughts, behaviours and events (Barr et al., 2008). Self-concealment is central to help-seeking behaviours (Cramer, 1999; Liao et al., 2005; Vogel & Armstrong, 2010), particularly among men who are identified as self-controlled, autonomous and problem-solvers rather than help-seekers (Mackenzie et al., 2006). Also, women might view help-seeking as intimidating. They avoid discussing the topic or disclosing their sexual concerns and needs. They apprehend their husbands' negative judgment and the professionals' negligence of their complaints. Nevertheless, the belief about the normalcy of help-seeking is reinforced by women's high education level, their capacity to claim what they want.

Women identify the husband as the first and most important source of help. The "Global Study of Sexual Attitudes and Behaviors" confirmed these findings (Moreira et al., 2005). Women's views stem from the understanding of sexual problems as psychosocial rather than purely physical. Similarly, Hinchliff and Gott (2011) think that people do not see sexual problems within the remit of medicine. However, a husbands' lack of cooperation constitutes an overarching concern for women in this study. It might be that men are indifferent or unaware of women's sexual needs. It is also plausible that men deny their problems and avoid communication with their wives as it is believed to grant them agency and power they do not admit.

On the other hand, women are unaware of the sources of help for sexual problems; they do not know where to go and whom to refer to. Therefore, the preference is for the gynaecologist, as reported by other studies (Kadri et al., 2010; Shifren et al., 2009). It is not surprising to privilege this physician and consider him/her their second choice after the husbands since s/he accompanies women in all their reproductive health events throughout their lifespan. However, many women do not perceive the quality of sexual healthcare services which probably does not encourage them to seek help. They complain of the professionals' lack of competence and neglect of sexuality excluding it from the remit of their practice and taking it for granted that women do not want to talk about these issues. These professionals who are not well prepared and like women internalise the taboo around sexuality would probably be reluctant to discuss the subject comfortably. This also seems to be the case of other professionals in other contexts (Buvat et al., 2009; Gott &

Hinchliff, 2003; Harsh et al., 2008; Julliard et al., 2008; Moreira et al., 2005; Shifren et al., 2009; Woolhouse et al., 2014).

In Lebanon, there are no studies on help-seeking. Problems with accessibility to and affordability of healthcare services prevail. However, the healthcare system is highly developed, and Lebanon is a party to many international treaties that stipulate human health rights. Appropriate and responsive sexual health services should be made available and accessible to all. It would be interesting to create sexology clinics, local sites and help-lines led by a multidisciplinary group of professionals to provide information, answer women and couples' questions and assist them as needed. It would be interesting to further examine the notion of "help" in the Lebanese context and see how it is perceived compared to other populations. It is particularly interesting to use the model generated from this study to understand the decision-making process and demystify this behaviour's facilitators and barriers. To be confident in their role, health professionals should develop their knowledge and skills in sexual health and integrate sexuality-related care into their daily practice. We suggest that diagram 1 may be a useful tool for education in this respect. Improving women's knowledge and attitudes and assisting them to recognise and claim their sexual needs will encourage help-seeking. Meaningful information that is culturally sensitive, simple and concise could be delivered through brochures, pamphlets and audio-visual messages. This will not be limited to women but target all Lebanese people of all age groups, particularly couples. Moreover, it is necessary to consider the complex and dynamic relational and socio-cultural dimensions of help-seeking to promote sexual health services for women and men.

At an international level, it is also essential that health organisations pay more attention to sexual health. Despite the efforts of the WHO to promote sexual health, this topic still languishes and is not seriously considered on the international health agenda. Studies on help-seeking behaviour for sexual problems are scarce. The available literature corroborates findings of this study at many aspects. In numerous societies, sexual health issues are so difficult to bring to light. This is true for women particularly in patriarchal cultures. Researchers are urged to conduct more studies in the field to get a contextual understanding of the factors that may make women reluctant to report on their sexual concerns. Accordingly, healthcare professionals would act to promote help-seeking and provide the efficient assistance to encourage women to seek help when this is necessary.

Limitations

This study is limited to a sample of middle-aged women. A different sample of men and women of different age groups and backgrounds will help get more insights about the subject, compare help-seeking concerning gender variation and report on the outcomes of this behaviour. All interviewed women identified themselves as heterosexual, and the majority were married and reflected on help-seeking as part of their sexual life with their husband. Women with other characteristics may have provided additional information concerning help-seeking for sexual difficulties.

Conclusion

The findings provide a comprehensive understanding of help-seeking that is shaped by interconnected elements, which are the interpretation of the problem, the beliefs about help-seeking and the sources and quality of help. These elements compete together as facilitators and barriers to this behaviour. They are bound to women's personal but mainly relational context

showing their readiness to seek help to respond to their husbands' needs rather than theirs as their sexuality is mute. When women perceive sexual difficulties as serious, they assume the inevitable need to refer to a professional for help. However, denying the existence or medical aspect of sexual difficulties and perceiving help-seeking as intimidating and stigmatising, this behaviour is less likely to happen, particularly by the husbands. Additionally, women's decision concerning help-seeking depends on the accessibility, availability and quality of sexuality-related care, knowing that the husband is their first and most important support. The framework that we have developed from the empirical data will help support professionals in supporting women more effectively and while arising from the experiences of Lebanese women, we see no reason why it may not be applicable for use in many countries and contexts.

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Appendix I

Topic Guide

1. How would you deal with a sexual problem? What is your experience at this level?
2. Can you tell me about the facilitators and obstacles to seek help for sexual life concerns and problems?
Probe. What might push you to seek help for sexual concerns or problems?
Probe. What might refrain you from seeking help for sexual concerns or problems and why?
3. What are your sources of help? Where do you go? To whom do you talk to?
4. What advice would you have for professionals to better support women who suffer from sexual concerns or problems?
Probe. What are the characteristics of the helper? How would you describe him/her? What do you expect from him/her?